North West
School of Psychiatry

Semester 3 Handbook

MRCPsych Course

2020 – 2022

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

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Brief guidelines for case conference presentation

The objectives of case conference are:

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

Guidelines for presenters:

1. Please use PowerPoint for the presentation (or if you are using other tools make sure that they are compatible with your local IT facilities).

2. You have to present a case that is relevant to the theme of the day on which you are presenting.

3. Please meet with your educational/clinical supervisor at least 4-6 weeks prior to the presentation to identify an appropriate case to present. If there is no suitable case in the team that you work in, you may have to approach other teams/consultants to identify a case.

4. Cases can be chosen for their atypical presentation, diagnosis, complexity or for exploring management options.

5. It would be helpful if you can identify specific clinical questions that would you would like to be discussed/answered at the end of the presentation.

6. We would recommend the following structure for the presentation:

- Introduction (include reasons for choosing the case)
- Circumstances leading to admission (if appropriate)
- History of presenting complaint
- Past Psychiatric history
- Medical History/ current medication
- Personal/family History
- Alcohol/Illicit drugs history
- Forensic history
- Premorbid personality
- Social circumstances
- Mental state examination
- Investigations
- Progress since admission (if appropriate)

- A slide with questions that you would you like to be discussed
- Discussion on differential diagnosis including reasons for and against them.
- Management / treatment

7. The structure of the presentation can vary as long it is logical and concise. Please build into the presentation some natural points to stop and discuss the case.

8. 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 13: Psychosis-3
Journal theme: Meta-analysis / Systematic Review on Psychosis

Learning Objectives

- To develop an understanding of the biopsychosocial management of schizophrenia
- To develop an understanding of evidence-based treatment
- To develop an understanding of the use of antipsychotics in special cases e.g. liver and renal impairment
- To develop an understanding of Meta-analysis / Systematic Review and develop skills for critically appraising them.

Expert Led Session

- Schizophrenia: Biopsychosocial management and evidence based treatment.

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)

- Leucht S, Komossa K, Rummel-Kluge C, Corves C, Hunger H, Schmid F, Asenjo Lobos C, Schwarz S, Davis JM (2009). A meta-analysis of head-to-head comparisons of second-generation antipsychotics in the treatment of schizophrenia. Am J Psychiatry, 166(2):152-63. doi: 10.1176/appi.ajp.2008.08030368
- Souza JS, Kayo M, Tassell I, Martins CB, & Elkisa H. (2013). Efficacy of olanzapine in comparison with clozapine for treatment-resistant schizophrenia: evidence from a systematic review and meta-analyses. CNS Spectrums; 18 (2), 82- 89. DOI: http://dx.doi.org/10.1017/S1092852912000806
- Leucht S, Cipriani A, Spineli L, Mavridis D, Örey D. (2013). Comparative efficacy and tolerability of 15 antipsychotic drugs in schizophrenia: a multiple-treatments meta-analysis. The Lancet; 382 (9896), 951–962. DOI: http://dx.doi.org/10.1016/S0140-6736(13)60733-3

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

- Recommendations for antipsychotics in liver disease
- Recommendations for antipsychotics in renal impairment
- Antipsychotics and sexual side effects

Statistics '555' topic

- t tests, p values and statistical significance

MCQs

1. Which one of the following led a trial that proved Clozapine's effectiveness in treating resistant schizophrenia?
   A. Kretschmer
   B. Cade
   C. Kraepelin
   D. Kane
   E. Bleurer
2. Choose the correct match from the following pairs:
   A. Risperidone: dibenzoxapine
   B. Droperidol: butyrophenones
   C. Aripiprazole: benzisothiazole
   D. Thioridazine: diphenyl butyl piperidine
   E. Flupentixol: dihydroindole
3. Which of the following atypical agents have the shortest half-life?
   A. Quetiapine
   B. Aripiprazole
   C. Olanzapine
   D. Clozapine
   E. Risperidone
4. The patients who are prescribed clozapine or olanzapine should have their serum lipids measured every:
   A. 6 days whilst on treatment
   B. One year whilst on treatment
   C. 3 months for the first year of treatment
   D. 6 weeks for the first year of treatment
   E. 6 months for the first year of treatment
5. What percentage of patients develop Tardive Dyskinesia with every year of typical antipsychotic exposure?
   A. More than 50%
   B. 2-5%
   C. 5-10%
   D. 20-25%
   E. 10-20%

Session 14: Depression-3
Journal theme: Qualitative study on depression

Learning Objectives

- To develop an understanding of the biopsychosocial management of Depression.
- To develop an understanding of evidence based treatment.
- To develop an understanding of the use of antidepressant in special cases e.g. liver and renal impairment.

- To develop an understanding of Qualitative study and develop skills for critically appraising them.

Expert Led Session

- Depression- Biopsychosocial management and evidence-based treatment

Case Presentation

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

Journal Club Presentation (Select 1 paper)

- Coupe N, Anderson E, Gask L, Sykes P, Richards DA, et al. (2014). Facilitating professional liaison in collaborative care for depression in UK primary care; a qualitative study utilising normalisation process theory. BMC Family Practice; 15:78. DOI: 10.1186/1471-2296-15-78
- Gask L, Rogers A, Oliver D, May C, Roland M (2003) Qualitative study of patients' perceptions of the quality of care for depression in general practice. Br J Gen Pract., 53(489):278-83.
- Gask L, Dixon C, May C, Dowrick C (2005) Qualitative study of an educational intervention for GPs in the assessment and management of depression. Br J Gen Pract, 55(520):854-9.

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

- ECT – indications and contraindications
- Depression – important rating scales
- Treatment of refractory depression- first choice (evidence-based)

Statistics '555' topic

- Basic statistics- mean, median, mode, range, standard deviation, standard error

MCQs

1. Which of the following neurotransmitters does Venlafaxine act on?
   A. Serotonin only
   B. Noradrenaline and Serotonin
   C. Dopamine
   D. Noradrenaline, Serotonin and Dopamine
   E. GABA

2. Which of the following statements about Trazodone is FALSE?
   A. It is relatively safe in overdose
   B. It does not have strong antihistamine properties
   C. It is not a MAO-A and MAO- B inhibitor
   D. It does not block 5-HT reuptake
   E. It is a 5HT2 agonist

3. Which of the following are not common side effects of Sertraline?
   A. Tachycardia and arrhythmias
   B. Nausea, vomiting, abdominal pain
   C. Sexual dysfunction
   D. Agitation, anxiety
   E. Insomnia

4. Laura is a depressed 61-year-old woman who has not responded to an SSRI and has urinary incontinence. Which one of the following antidepressants is the best choice in this situation?
   1. Phenelzine
   2. Mirtazapine
   3. Vortioxetine
   4. Trazodone
   5. Duloxetine

5. Hypertension is a common side effect of which of the following antidepressants?
   A. Venlafaxine
   B. Paroxetine
   C. Escitalopram
   D. Trazodone
   E. Mirtazapine

Session 15: Bipolar Disorder-3
Journal theme: RCT on bipolar disorder

Learning Objectives

- To develop an understanding of the biopsychosocial management of Bipolar disorder.
- To develop an understanding of evidence-based treatment.
- To develop an understanding of the use of mood-stabilizers in special cases e.g. liver and renal impairment.

- To develop an understanding of Randomized Controlled trials and develop skills for critically appraising them.

Expert Led Session

- Bipolar disorder- Biopsychosocial management and evidence-based treatment.

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)

- Jones SH, Smith G, Mulligan LD, Lobban F, Law H, et al. (2010). Recovery-focused cognitive–behavioural therapy for recent-onset bipolar disorder: randomised controlled pilot trial. The British Journal of Psychiatry; 206 (1) 58-66. DOI: 10.1192/bjp.bp.113.141259
- Castle D, White C, Chamberlain J, Berk M, Berk L, Lauder S, Murray G, Schweitzer I, Piterman L, Gilbert M (2010) Group-based psychosocial intervention for bipolar disorder: randomized controlled trial. BJPsych, 196: 383-388.
- Kemp D, Gao K, Fein E, Chan P, Conroy C, Obral S, Ganocy S, Calabrese R (2012) Lamotrigine as add-on treatment to lithium and divalproex: lessons learned from a double-blind, placebo-controlled trial in rapid-cycling bipolar disorder. Bipolar Disord., 14(7):780-789.

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

- Monitoring requirements for mood stabilizers
- Bipolar I Vs Bipolar II – differences in diagnosis and treatment
- Role of Psychotherapy in long term management of Bipolar Disorder

Statistics '555' topic

- Intention-to-treat analysis & Last Observation Carried Forward (LOCF)

MCQs

1. Sodium valproate:
   A. Is mostly renally metabolised
   B. Commonly causes hypertrichosis
   C. Reduces lamotrigine levels
   D. Is licensed for prophylaxis of BPAD
   E. Is a first line choice in acute mania
2. Which of the following drugs has a high therapeutic index:
   A. Lithium
   B. Carbamazepine
   C. Phenytoin
   D. Warfarin
   E. Gabapentin

3. The risk of Ebstein's anomaly in babies born to woman taking lithium is:
   A. 1:10
   B. 1:100
   C. 1:500
   D. 1:1000
   E. 1:10000

4. Which of the following commonly causes hypercalcaemia:
   A. Lithium
   B. Valproate
   C. Risperidone
   D. Quetiapine
   E. Clozapine

5. Lithium levels in once daily nocte dosing should be taken:
   A. 4 hours post dose
   B. 12 hours post dose
   C. 6 hours post dose
   D. Immediately before the next dose
   E. 8 hours post dose

6 . Match the following to a drug from the list below:

1. Spina Bifida
2. Tricuspid valve defect
3. Cleft palate
4. Microcephaly

A - Lithium

B - Benzodiazepines

C - Valproate

D - None of the above

7. Match the following mood stabilisers to their chemical structure:

1. Haloperidol D
2. Risperidone A
3. Olanzapine C
4. Quetiapine B

A. Benzizoxazole

B. Dibenzothiazepine

C. Thienobenzodiazepine

D. Butyrophenone

Session 16: Anxiety disorders-2 (GAD, panic disorder, phobic anxiety disorders)

Journal theme: case –control studies on the topic

Learning Objectives

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

- To develop an understanding of Case-control studies and develop skills for critically appraising them.

Expert Led Session

- Biopsychosocial management of GAD, panic disorder and phobic anxiety disorders.

Case Presentation

- A case where either GAD, panic disorder or phobic disorder is the main diagnosis or a differential diagnosis.

Journal Club Presentation (Select 1 paper)

- Lipka J, Miltner WH, Straube T (2011) Vigilance for threat interacts with amygdala responses to subliminal threat cues in specific phobia. Biol Psychiatry, 70(5):472-8.
- Santos MA, Ceretta LB, Réus GZ, Abelaira HM, Jornada LK, Schwalm MT, Neotti MV, Tomazzi CD, Gulbis KG, Ceretta RA, Quevedo J (2014) Anxiety disorders are associated with quality of life impairment in patients with insulin-dependent type 2 diabetes: a case-control study. Rev Bras Psiquiatr., 36 (4):298-304.
- Kiropoulos L, Klien B, Austin D, Gilson K, Pier C, Mitchell J and Ciechomski L (2008) Is internet-based CBT for panic disorder and agoraphobia as effective as face-to-face CBT? Journal of anxiety disorders 22(8), 1273-1284.

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

- CBT for agoraphobia- principles
- Principles of use of benzodiazepines for anxiety disorders
- Prognosis in GAD and Panic Disorder

Statistics ‘555’ topic

- Null hypothesis, Type-1 error and type-2 error

MCQs

1. Venlafaxine of not licenced for which of the following indications?
   A. Social anxiety
   B. PTSD
   C. Panic disorder
   D. Depression +/- Anxiety
   E. GAD

2. The following are TRUE of the pharmacokinetics of benzodiazepines:
   A. When long-acting they have long elimination half-life.

B. When short-acting they have a small distribution volume.
C. When long-acting they have no active metabolites
D. When short-acting they have high accumulation
E. Benzodiazepines with a half-life of 12 hours tend to be used as anxiolytics.

3. Which of the following statements is FALSE about the effects of hypnotics no sleep?
A. Benzodiazepines supress stage IV sleep.
B. With chronic Benzodiazepines use suppression of REM sleep in the early part of the night occurs
C. On withdrawal of Benzodiazepines a rebound increase above the 'normal' amount of REM sleep occurs.
D. It may take up to 6 weeks to see a return to a normal sleep pattern on Benzodiazepine withdrawal.
E. Barbiturates are more likely to suppress REM sleep than are Benzodiazepines.

4. With regards to the NICE guidelines on GAD, which of the following is FALSE?
A. SSRIs (particularly Sertraline) are the first line medications.
B. SNRIs are second line.
C. If the patient cannot tolerate SSRI or SNRI, offer Pregabalin.
D. Antipsychotic should be offered for the treatment of GAD in primary care.
E. Do not offer a benzodiazepine for the treatment of GAD in primary or secondary care except as a short-term measure during crises

5. With respect to the NICE guidelines on psychological intervention for GAD, which of the following is FALSE?
A. CBT for people with GAD should be based on the treatment manuals used in the clinical trials of CBT for GAD.
B. CBT for GAD usually consist of 12–15 weekly sessions (fewer if the person recovers sooner; more if clinically required), each lasting 1 hour.
C. Practitioners providing high-intensity psychological interventions for GAD need not have regular supervision to monitor fidelity to the treatment model.
D. If a person with GAD chooses a high-intensity psychological intervention, offer either CBT or applied relaxation.
E. Consider providing all interventions in the preferred language of the person with GAD if possible.

Session 17: Suicide/self-harm-2
Journal theme: Any study method on the topic

Learning Objectives

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

Expert Led Session

- Suicide & self-harm- comprehensive risk assessment

Case Presentation

- Cases related to any type of clinical presentations where suicide and/ or self-harm is the central theme

Journal Club Presentation (Select 1 paper)

- Quinlivan L, Cooper J, Steeg S, Davies L, Hawton K, Gunnell D, Kapur N (2014) Scales for predicting risk following self-harm: an observational study in 32 hospitals in England. BMJ Open, doi: 10.1136/bmjopen-2013-004732.
- Kapur N, Gunnell D, Hawton K, Nadeem S, Khalil S, Longson D, Jordan R, Donaldson I, Emsley R, Cooper J (2013) Messages from Manchester: pilot randomised controlled trial following self-harm. BJPsych 203: 73-74.
- Kapur N, Turnbull P, Hawton K, Simkin S, Sutton L, Mackway-Jones K, Bennewith O, Gunnell D (2005) Self-poisoning suicides in England: a multi-centre study. Q J Med, 98: 589-597.

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

- National Confidential Inquiry into suicide by people with mental illness – Key findings of the latest annual report
- Purpose of a Coroner's Inquest
- Epidemiological factors associated with suicides

Statistics '555' topic

- Standard error and confidence intervals

MCQs

1. **Which of the following has been shown to be associated with increased rates of suicide?**
   A. Peptic ulcer
   B. Non-delusional body dysmorphia

C. Huntington’s chorea
D. Epilepsy
E. All of the above

2. Deliberate self-harm is more common in:
A. Males
B. Rural areas
C. Age over 35 years
D. Lower socioeconomic status
E. Married

3. Predictors of repetition of DSH include all except:
A. Personality disorder
B. Alcohol misuse
C. Male gender
D. Previous DSH
E. Younger age of onset

4. Which of the following is associated with suicide in patients with schizophrenia?
A. Akathisia
B. Older patient
C. Poor premorbid functioning
D. Short duration of illness
E. Presence of positive symptoms

5. Which of the following physical health problems are associated with increased risk of suicide?
A. AIDS
B. Huntington’s disease
C. Cushing’s disease
D. Porphyria
E. All of the above

Session 18: Perinatal psychiatry

Journal theme: Study with any method

Learning Objectives

- To understand the impact / risks of major mental disorders on pregnancy and post-partum period. To understand the general principles of prescribing; and the risks & benefits of prescribing psychotropic medications in pregnancy, post-partum period and breast feeding.

Expert Led Session

- Evidence-based recommendations for psychotropic medications in pregnancy [antipsychotics, antidepressants, mood stabilizers and anxiolytics].

Case Presentation

- A case of any mental disorder in pregnancy or post-partum period.

Journal Club Presentation (Select 1 paper)

- Ennis, Z. and Damkier, P. (2015). Pregnancy Exposure to Olanzapine, Quetiapine, Risperidone, Aripiprazole and Risk of Congenital Malformations. A Systematic Review. *Basic & Clinical Pharmacology & Toxicology*, 116(4), pp.315-320.
- Boden, R., Lundgren, M., Brandt, L., Reutfors, J., Andersen, M. and Kieler, H. (2012). Risks of adverse pregnancy and birth outcomes in women treated or not treated with mood stabilisers for bipolar disorder: population based cohort study. *BMJ*, 345(nov07 6), pp.e7085.
- Uguz, F. (2016). Second-Generation Antipsychotics During the Lactation Period: A Comparative Systematic Review on Infant Safety. *Journal of Clinical Psychopharmacology*, 36(3), pp.244-252.

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

- Post-partum risks of relapse in schizophrenia, bipolar disorder and depression
- Congenital malformations associated with Lithium, Valproate, Carbamazepine, Lamotrigine and Paroxetine- salient points
- Use of SSRIs in pregnancy – salient points

Statistics ‘555’ topic

- Absolute risk reduction, relative risk reduction, Number needed to treat and number needed to harm

MCQs

1. During pregnancy the following physiological changes occur

   A. Plasma volume markedly increases and eGFR increases

   B. Plasma volume markedly decreases and eGFR increases

   C. Plasma volume markedly increases and eGFR decreases

   D. Plasma volume markedly decreases and eGFR decreases

   E. There is no change in either plasma volume or eGFR

2. Which of the following is NOT associated with exposure to SSRIs in the Perinatal period?

   A. Perinatal Death

   B. Persistent Pulmonary Hypertension of the Newborn

   C. Postpartum haemorrhage

   D. Poor neonatal adaptation syndrome

   E. Preterm birth

3. Which of the following statements is TRUE regarding NICE guidelines?

   A. Benzodiazepines can be offered in pregnancy for medium term treatment of anxiety

   B. Consideration of medication dose changes do not have to be made during pregnancy

   C. If this is a first pregnancy a women's previous response to medication should not influence the choice of antidepressant (being pregnant dictates the choice)

   D. Lithium can be continued if the women is at high risk of relapse and an antipsychotic is unlikely to be effective

   E. Measure prolactin levels in women planning pregnancy who are taking a prolactin raising antipsychotic as raised prolactin increases the chances of conception

4. Which of the following statements is TRUE?

   A. Valproate is associated with reduced fertility in women and men

   B. Taking Folic acid 5mg with Valproate will reduce teratogenicity

   C. Valproate monotherapy is not associated with an increased risk of Attention Deficit Hyperactivity Disorder

D. Valproate monotherapy only affects the child in the 1st and 3rd trimester

E. Valproate passes in higher concentrations than Lamotrigine in breastmilk

5. Which of the following is TRUE regarding breastfeeding?

A. Patients with postpartum mental health disorders who require pharmacotherapy should generally be discouraged from breastfeeding

B. All psychotropic medications are transferred to breast milk in varying amounts

C. Psychotropics should be chosen with regard to longer half life and less protein binding

D. Mothers should change their pregnancy medication for breastfeeding

E. Methadone and Nicotine Replacement Therapy are incompatible with breastfeeding

CAMHS
Session 5: Attachment

Learning Objectives

- Describe the concept of attachment and its relevance for the mental health of children and young people.
- To understand the relevance of attachment theory to emotional development, affect regulation and relationships across the lifespan.
- To understand the different classifications of attachment, the conditions that promote healthy attachment or otherwise and the clinical relevance of failure to develop selective attachments.

Curriculum Links

Attachment disorders:

10.8.1.1 10.8.1.2 10.8.1.3 10.8.1.4 10.8.1.5

Expert Led Session

- Should cover assessment, diagnostic challenges and MDT approach in managing attachment disorder. Can also discuss the role of specialist LAC services.

Case Presentation

- To discuss key features in history and presentation and discuss overlap with intrinsic disorders, such as ASD/ADHD.

Journal Club Presentation

- Quasi-autistic patterns following severe early global privation. English and Romanian Adoptees (ERA) Study Team. Rutter M et al. J Child Psychol Psychiatry. 1999 May; 40(4): 537-49.
- Specificity and heterogeneity in children's responses to profound institutional privation. Rutter ML1, Kreppner JM, O'Connor TG; English and Romanian Adoptees (ERA) study team. Br J Psychiatry. 2001 Aug; 179:97-103.

- Genetic, environmental and gender influences on attachment disorder behaviours. Minnis H, Reekie J, Young D, O'Connor T, Ronald A, Gray A, Plomin R. Br J Psychiatry. 2007 Jun; 190:490-5.
- The impact of a statewide trauma-informed care initiative in child welfare on the well-being of children and youth with complex trauma. Bartlett, JD et al. Children and Youth Services Review. 2018 84(1), pp.110-117

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

- Evidence based interventions in attachment disorder
- Risk factors for attachment disorder
- Comorbid diagnosis in attachment disorder

MCQs

1. The biological basis of attachment behaviour is:

A. The child developing relationships with other children

B. The mother wanting to protect her child from any harm

C. The child seeking proximity to the attachment figure

D. The mother's instinct to rear children

E. All of the above

2. Attachment theory has been developed by:

A. Freud

B. Bowlby

C. Skinner

D. Piaget

E. Klein

3. Fearfulness and "frozen watchfulness" are part of which ICD 10 diagnosis:

A. Generalised anxiety disorder

B. Phobic anxiety disorder

C. PTSD

D. Reactive attachment disorder

E. Paranoid personality disorder

4. Select a feature that does NOT form part of Reactive Attachment Disorder (ICD 10) but points towards Pervasive Developmental Disorders:

A. Abnormal pattern of social responsiveness that improves if child is placed in normal rearing environment

B. Aggressive responses towards their own or other's distress

C. Restricted, repetitive interests and behaviours

D. Strongly contradictory social responses

E. None of the above

5.Reactive Attachment Disorder of early infancy and childhood (DSM V) and Reactive Attachment Disorder (ICD 11) share common diagnostic criteria. Which of the following is NOT a diagnostic feature in ICD 11:

A. Developed before age of 5 years

B. Does not turn to primary caregiver for comfort

C. Does not display security seeking behaviour

D. Does not respond when comfort is offered

E. None of the above

6.Which of the following features is NOT part of Disinhibited Social Engagement Disorder (ICD 11):

A. Approaches adults indiscriminately

B. Exhibits overfamiliar behaviour with strangers

C. Features develop within the first 5 years of life

D. Occurs in the context of grossly inadequate childcare

E. Abnormal speech development including echolalia

7. Which of the following cognitive age ranges must a child reach to develop an attachment relationship:

A. 2-5 months

B. 7-9 months

C. 2 years

D. 5 years

E. 7 years

8. What is the procedure called that assesses a child's attachment behaviour:

A. Novel Situation Test

B. Attachment Assessment Procedure

C. Strange Situation Procedure

D. Mother - Infant Attachment Battery

E. None of the above

9. Symptoms of Reactive Attachment Disorder have to be present before which age:

A. 3 years

B. 9 months

C. 18 months

D. 8 years

E. 5 years

10. The current hypothesis is that Attachment Disorders develop as a result of:

A. Children having been brought up by a single parent

B. Children having had limited opportunities to form selected attachments

C. Children having received a vegetarian diet

D. Children having intrinsic difficulties in forming secure attachments

E. Children having a specific gene mutation

Additional Resources / Reading Materials

Books

- Attachment – Attachment and Loss. Bowlby J (first published 1969)
- A Short Introduction to Attachment and attachment disorder – Colby Pearce (second edition 2017)
- Why Love Matters – Sue Gerhardt

E-Learning

- Attachment and how it relates to psychiatry (podcast)

  Dr Helen Minnis discusses the issue of attachment in psychiatry and the importance of attunement in the caregiving relationship, taking a look at the current controversies over child care and giving guidance for psychiatrists on how to work with attachment difficulties. http://www.psychiatrycpd.org/default.aspx?page=3301

  Growing an Emotional brain: www.youtube.com/watch?v=fzn9OuBqKYs

  An introductory blog on Adverse Childhood Experiences (ACEs)

  https://www.connectedforlife.co.uk/blog/2017/6/17/the-adverse-childhood-experiences-ace-study

  And a summary of ACEs literature from a Scottish charity, with hyperlinks to a range of publications and resources, and an educational perspective

  https://www.iriss.org.uk/resources/esss-outlines/aces

Journal Articles

- The relationship between Adult Attachment and Mental Health Care utilization; a systematic review. Adams G, Wrath A, Meng X. Canadian Journal of Psychiatry 2018 Oct; 63(10): 651–660. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6187440/
- Making and Breaking of Affectional Bonds. Bowlby J BJPsych 1977 130: 201-10 and 421-431.

Guidelines

NICE guidance on Children’s Attachment (2015) https://www.nice.org.uk/guidance/ng26

Session 6: Assessment of Mental Health Problems in Child & Adolescents with Intellectual Disability (ID)

Learning Objectives

- To understand the influence of developmental factors on the presentation and treatment of psychiatric disorders.
- To understand the principles and practice of assessment, diagnosis and treatment, including therapeutic modalities, psychoactive medication and environmental manipulations of patients presenting with intellectual disability

Curriculum Links

Intellectual Disability:

13.1 13.2.1 13.2.2 13.3

Expert Led Session

- Should cover assessment and the role of other professionals (OT, LD nurses, LD psychologist) and specialist schools. Evidence based management strategies.

Case Presentation

- To cover presentation and assessment of mental health problems of a child or young person with ID; including how these differ from the non ID population and management strategies (environmental, psychological and medical).
- Those trainees who are not currently in a CAMHS post should contact their local CAMHS team for the suitable case for presentation. Specifically you should identify which Consultants see Children with Learning Disabilities, so an appropriate case can be identified well in advance

Journal Club Presentation
- Vereenooghe L, Flynn S, Hastings RP, et al. Interventions for mental health problems in children and adults with severe intellectual disabilities: a systematic review. BMJ Open. 2018;8(6):e021911. Published 2018 Jun 19. doi:10.1136/bmjopen-2018-021911 - Einfeld SL, Ellis LA, Emerson E (2011) Comorbidity of intellectual disability and mental disorder in children and adolescents: A systematic review. Journal of Intellectual and Developmental Disability 36 (2) pp137-143. - Chadwick et al, (2008). Factors associated with the risk of behaviour problems in adolescents with severe intellectual disabilities. Journal of Intellectual Disability research 52, (10),864- 876.
'555' Topics (1 slide on each topic with no more than 5 bullet points)
- Cognitive assessment tools in ID (child) - Child Development assessment tools in paediatrics - Approaches to assessment in children and young people with limited communication
MCQs
1. People with intellectual disability have previously been classified as: A. Mentally retarded B. Learning disabled C. Sub-normals D. Imbeciles E. All of the above 2. Intellectual disabilities are defined by which 3 core criteria? A. Lower intellectual ability B. Onset during childhood C. Onset before the age of 8 D. Significant impairment of social or adaptive functioning E. IQ scores are not fixed throughout life

3. Which of the following are generally accepted ranges (ICD-10, DSM-IV) for severity of ID (choose 4)?

A. Mild (IQ 50-70)

B. Mild (IQ 70-90)

C. Moderate (IQ 50-70)

D. Moderate (IQ 35-50)

E. Severe (IQ 20-35)

F. Severe (IQ 25-50)

G. Profound (IQ below 25)

H. Profound (IQ below 20)

4. Which of the following 2 statements are true?

A. Mild ID accounts for approximately 80% of children with ID.

B. Approximately 50% of children with ID have moderate severity.

C. Severe ID accounts for approximately 7% of the ID group.

D. Profound ID affects 10% of children with ID.

5. The prevalence and incidence of ID varies according to gender, age, ethnicity and socioeconomic circumstances. Which statement is false?

A. Studies generally report a female predominance in LD

B. Increased maternal age is likely to lead to an increase in incidence of LD

C. Ethnicity influences prevalence and incidence levels in ID due to the associated links with poverty, access to healthcare, and communications barriers amongst other factors

D. Lower socioeconomic position is associated with higher prevalence of mild and moderate LD, but not severe LD.

6. Psychiatric illnesses frequently exist comorbidly with ID. Which of the following statements is false?

A. Prevalence of psychiatric co-morbidity ranges from 30-70%

B. There is often over diagnosis of co-morbid psychiatric conditions

C. Practically all categories of mental illness are represented in the ID population

D. Co-morbid psychiatric problems can vary and change with age

7. Match the following co-morbid problems with the age group they are most likely to present in:

1. Eating and sleep disorders	A. Adolescents
2. Self-injury	B. Very young children
3. ADHD	C. School age children

8. Which one of the following psychiatric conditions is not generally associated with LD?

A. Attention deficit hyperactivity disorder

B. Mood disorders

C. Anxiety disorders

D. Psychotic illness

E. Obsessive compulsive disorder

F. Anorexia nervosa

G. Autistic spectrum disorder

9. Behavioural analysis involves which ABC?

A. Antecedents

B. Awareness

C. Boundaries

D. Behaviour

E. Consequences

F. Circumstances

10. Which statement about management of ID is inaccurate?

A. Medications are commonly under-prescribed when managing challenging behaviour associated with ID.

B. Behavioural techniques are useful in managing ID

C. Families provide the majority of support for most people with ID

D. Social services provide the majority of support for people with ID outside of families

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

Cerebra resources

http://w3.cerebra.org.uk/research/research-papers/self-injurious-behaviour-in-children-with-intellectual-disability/

Journal Articles

- Developing mental health services for Children and Adolescents with Learning Disability: A toolkit for clinicians
  http://www.rcpsych.ac.uk/pdf/devmhservcaldbk.pdf
- Mental health of children with learning disabilities. Pru Allington-Smith, Advances in Psychiatric Treatment, 2006, vol. 12, 130–140.

Nice Guidelines

Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges

https://www.nice.org.uk/guidance/ng11

Old Age

Session 5: Mood Disorders in the Older Person

Learning Objectives

- The overall aim of the sessions is for the trainees to gain an overview of mood disorders in later life.
- By the end of the session trainees should:
  - Understand the epidemiology, aetiology and the classification of mood disorders in the elderly.
  - Understand how mood disorders present in the elderly
  - Understand the assessment process including rating scales and neuroimaging
  - Understand the principles of treatment, including treatment resistance.
  - Understand the increased risk of suicide in the elderly.

Curriculum Links

- Old Age Section of the MRCPsych Curriculum: 8.3, 8.4, 8.5, 8.6, 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 key issues in an older person presenting with a mood disorder. Please consider the learning objectives above.

Journal Club Presentation

- Hedna, K., Sundell, K.A., Hamidi, A., Skoog, I., Gustavsson, S. and Waern, M., 2018. Antidepressants and suicidal behaviour in late life: A prospective population-based study of use patterns in new users aged 75 and above. European journal of clinical pharmacology, 74(2), pp.201-208.

- Lawrence, B.J., Jayakody, D.M., Bennett, R.J., Eikelboom, R.H., Gasson, N. and Friedland, P.L., 2020. Hearing loss and depression in older adults: a systematic review and meta-analysis. The Gerontologist, 60(3), pp.e137-e154.

- Soysal, P., Veronese, N., Thompson, T., Kahl, K.G., Fernandes, B.S., Prina, A.M., Solmi, M., Schofield, P., Koyanagi, A., Tseng, P.T. and Lin, P.Y., 2017. Relationship between depression and frailty in older adults: A systematic review and meta-analysis. Ageing research reviews, 36, pp.78-87.

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

- Grief - when does it become pathological?
- Suicide in the elderly

MCQs

1. The features suggestive of depression-executive dysfunction syndrome would include all except:

A. There is a long history of memory impairment and difficult with ADLs

B. The patient complains of poor memory

C. Assessment of cognitive function often results in 'don't know answers'

D. The onset is fast

E. There is often a history of depression or an identifiable precipitant

2. An 84 year old lady presents with severe depression. She had a myocardial infarction 3 months ago and her QTc is 490ms. Which antidepressant is the best choice?

A.Sertraline

B.Mirtazapine

C.Paroxetine

D.Citalopram

E.Duloxetine

3. An 87 year old man has lost his wife recently. Which of the following clinical features would most suggest that this was an abnormal grief reaction?

A. Loss of sleep

B. Loss of appetite

C. Laying the dining table for the deceased at meal times

D. Anxiety

E. Suicidal ideation

4. Which is not a feature of serotonin syndrome?

A. Blurred vision

B. Confusion

C. Akathisia

D. Elevated white cells

E. Hypomimia

5. Which rating scale is most helpful in detecting depression in people with dementia?

A. Cornell

B. MMSE

C. GDS

D. AMTS

E. Hamilton Rating Scale

6. You have a patient on lithium with a consistently elevated blood pressure. What is your most appropriate action?

A. Start amiloride

B. Lithium must be stopped

C. Start furosemide

D. Start lisonopril

E. Start candesartan

Additional Resources / Reading Materials

Online:

- CPD Online: Quick bite: Suicide in the elderly, treating depression in later life, bereavement

Landmark studies

- Alexopoulos, G.S., Abrams, R.C., Young, R.C. and Shamoian, C.A., 1988. Cornell scale for depression in dementia. Biological psychiatry, 23(3), pp.271-284.

- Cipriani, A., Furukawa, T.A., Salanti, G., Geddes, J.R., Higgins, J.P., Churchill, R., Watanabe, N., Nakagawa, A., Omori, I.M., McGuire, H. and Tansella, M., 2009. Comparative efficacy and acceptability of 12 new-generation antidepressants: a multiple-treatments meta-analysis. The lancet, 373(9665), pp.746-758.

- Glassman, A.H., O'Connor, C.M., Califf, R.M., Swedberg, K., Schwartz, P., Bigger Jr, J.T., Krishnan, K.R.R., Van Zyl, L.T., Swenson, J.R., Finkel, M.S. and Landau, C., 2002. Sertraline treatment of major depression in patients with acute MI or unstable angina. Jama, 288(6), pp.701-709.

- Rush, A.J., Fava, M., Wisniewski, S.R., Lavori, P.W., Trivedi, M.H., Sackeim, H.A., Thase, M.E., Nierenberg, A.A., Quitkin, F.M., Kashner, T.M. and Kupfer, D.J., 2004. Sequenced treatment alternatives to relieve depression (STAR* D): rationale and design. Controlled clinical trials, 25(1), pp.119-142.

- Trivedi, M.H., Rush, A.J., Wisniewski, S.R., Nierenberg, A.A., Warden, D., Ritz, L., Norquist, G., Howland, R.H., Lebowitz, B., McGrath, P.J. and Shores-Wilson, K., 2006. Evaluation of outcomes with citalopram for depression using measurement-based care in STAR* D: implications for clinical practice. American journal of Psychiatry, 163(1), pp.28-40.

Journal Papers:

- Agüera-Ortiz, L., Claver-Martín, M.D., Franco-Fernández, M.D., López-Álvarez, J., Martín-Carrasco, M., Ramos-García, M.I. and Sánchez-Pérez, M., 2020. Depression in the elderly. Consensus statement of the Spanish Psychogeriatric Association. Frontiers in Psychiatry, 11.

- Aizenstein, H.J., Baskys, A., Boldrini, M., Butters, M.A., Diniz, B.S., Jaiswal, M.K., Jellinger, K.A., Kruglov, L.S., Meshandin, I.A., Mijajlovic, M.D. and Niklewski, G., 2016. Vascular depression consensus report–a critical update. BMC medicine, 14(1), pp.1-16.

- Andreas S, Dehoust M, Volkert J, Schulz H, Sehner S, Suling A, Wegscheider K, Ausín B, Canuto A, Crawford MJ, Da Ronch C. Affective disorders in the elderly in different European countries: Results from the MentDis_ICF65+ study. PloS one. 2019;14(11).

- Arthur, A., Savva, G.M., Barnes, L.E., Borjian-Boroojeny, A., Dening, T., Jagger, C., Matthews, F.E., Robinson, L. and Brayne, C., 2020. Changing prevalence and treatment of depression among older people over two decades. The British Journal of Psychiatry, 216(1), pp.49-54.

- Baez, S., Pinasco, C., Roca, M., Ferrari, J., Couto, B., García-Cordero, I., Ibañez, A., Cruz, F., Reyes, P., Matallana, D. and Manes, F., 2019. Brain structural correlates of executive and social cognition profiles in behavioral variant frontotemporal dementia and elderly bipolar disorder. Neuropsychologia, 126, pp.159-169.

- Büchtemann, D., Luppa, M., Bramesfeld, A. and Riedel-Heller, S., 2012. Incidence of late-life depression: a systematic review. Journal of affective disorders, 142(1-3), pp.172-179.

- Cai W, Mueller C, Shetty H, Perera G, Stewart R. Predictors of mortality in people with late-life depression: A retrospective cohort study. Journal of Affective Disorders. 2020 Jan 10.

- Caixeta, L., Soares, V.L., Vieira, R.T., Soares, C.D., Caixeta, V., Ferreira, S.B. and Aversi-Ferreira, T.A., 2017. Executive function is selectively impaired in old age bipolar depression. Frontiers in Psychology, 8, p.194.

- Cattell, H. 2000. Suicide in the elderly. Advances in Psychiatric Treatment, 6(2), 102-108.

- Cipriani, A., Furukawa, T.A., Salanti, G., Chaimani, A., Atkinson, L.Z., Ogawa, Y., Leucht, S., Ruhe, H.G., Turner, E.H., Higgins, J.P. and Egger, M., 2018. Comparative efficacy and acceptability of 21 antidepressant drugs for the acute treatment of adults with major depressive disorder: a systematic review and network meta-analysis. Focus, 16(4), pp.420-429.

- Conwell, Y., 2014. Suicide later in life: challenges and priorities for prevention. American Journal of Preventive Medicine, 47(3), pp.S244-S250.

- Cooper, C., Katona, C., Lyketsos, K., Blazer, D., Brodaty, H., Rabins, P., de Mendonça Lima, C.A. and Livingston, G., 2011. A systematic review of treatments for refractory depression in older people. American Journal of psychiatry, 168(7), pp.681-688.
- Djernes, J.K., 2006. Prevalence and predictors of depression in populations of elderly: a review. Acta Psychiatrica Scandinavica, 113(5), pp.372-387.
- Dols, A., Kessing, L.V., Strejilevich, S.A., Rej, S., Tsai, S.Y., Gildengers, A.G., Almeida, O.P., Shulman, K.I., Sajatovic, M. and International Society for Bipolar Disorders Task Force for Older Adults with Bipolar Disorder, 2016. Do current national and international guidelines have specific recommendations for older adults with bipolar disorder? A brief report. International journal of geriatric psychiatry, 31(12), pp.1295-1300.
- Draper, B. M. 2014. Suicidal behaviour and suicide prevention in later life. Maturitas, 79(2), 179-183.
- Fancourt, D. and Tymoszuk, U., 2019. Cultural engagement and incident depression in older adults: evidence from the English Longitudinal Study of Ageing. The British Journal of Psychiatry, 214(4), pp.225-229.
- Gadzhanova, S., Roughead, E.E. and Pont, L.G., 2018. Antidepressant switching patterns in the elderly. International psychogeriatrics, 30(9), pp.1365-1374.
- Geduldig, E.T. and Kellner, C.H., 2016. Electroconvulsive therapy in the elderly: new findings in geriatric depression. Current psychiatry reports, 18(4), p.40.
- Haigh, E.A., Bogucki, O.E., Sigmon, S.T. and Blazer, D.G., 2018. Depression among older adults: a 20-year update on five common myths and misconceptions. The American Journal of Geriatric Psychiatry, 26(1), pp.107-122.
- Hegeman, J.M., Kok, R.M., Van der Mast, R.C. and Giltay, E.J., 2012. Phenomenology of depression in older compared with younger adults: meta-analysis. The British Journal of Psychiatry, 200(4), pp.275-281.
- John A, Patel U, Rusted J, Richards M, Gaysina D. Affective problems and decline in cognitive state in older adults: a systematic review and meta-analysis. Psychological medicine. 2019 Feb;49(3):353-65.
- Kok, R.M. and Reynolds, C.F., 2017. Management of depression in older adults: a review. Jama, 317(20), pp.2114-2122.
- Lawrence, B.J., Jayakody, D.M., Bennett, R.J., Eikelboom, R.H., Gasson, N. and Friedland, P.L., 2020. Hearing loss and depression in older adults: a systematic review and meta-analysis. The Gerontologist, 60(3), pp.e137-e154.

- Lisanby, S.H., McClintock, S.M., Alexopoulos, G., Bailine, S.H., Bernhardt, E., Briggs, M.C., Cullum, C.M., Deng, Z.D., Dooley, M., Geduldig, E.T. and Greenberg, R.M., 2020. Neurocognitive effects of combined electroconvulsive therapy (ECT) and venlafaxine in geriatric depression: phase 1 of the PRIDE study. The American Journal of Geriatric Psychiatry, 28(3), pp.304-316.

- Liu, L., Gou, Z. and Zuo, J., 2016. Social support mediates loneliness and depression in elderly people. Journal of health psychology, 21(5), pp.750-758.

- Luppa, M., Sikorski, C., Luck, T., Ehreke, L., Konnopka, A., Wiese, B., Weyerer, S., König, H.H. and Riedel-Heller, S.G., 2012. Age-and gender-specific prevalence of depression in latest-life–systematic review and meta-analysis. Journal of affective disorders, 136(3), pp.212-221.

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- Van Assche, L., Van de Ven, L., Vandenbulcke, M. and Luyten, P., 2019. Ghosts from the past? The association between childhood interpersonal trauma, attachment and anxiety and depression in late life. Aging & Mental Health, pp.1-8.

- Volkert J, Härter M, Dehoust MC, Ausín B, Canuto A, Da Ronch C, Suling A, Grassi L, Munoz M, Santos-Olmo AB, Sehner S. The role of meaning in life in community-dwelling older adults with depression and relationship to other risk factors. Aging & mental health. 2019 Jan 2;23(1):100-6.

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Books:

- Dening T., Thomas A., 2013. The Oxford Textbook of Old Age Psychiatry, 2nd edition. Oxford University Press.
- 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.(sections on mood disorders including prescribing in older adults).
- World Health Organisation, 1992. ICD-10: The ICD-10 Classification of Mental and Behavioural Disorders : Clinical Descriptions and Diagnostic Guidelines. WHO.

Session 6: Psychosis in the Older Person

Learning Objectives

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

Curriculum Links

- Old Age Section of the MRCPsych Curriculum: 8.3, 8.4, 8.5, 8.6, 8.7, 8.8, 8.9

Expert Led Session

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

Case Presentation

- A case involving an older person presenting with probable psychosis. Please consider the learning objectives above.

Journal Club Presentation

- Howard, R., Cort, E., Bradley, R., Kelly, L., Bentham, P., Ritchie, C., Reeves, S., Fawzi, W., Livingston, G., Sommerlad, A. and Oomman, S., 2018. Antipsychotic treatment of very late-onset schizophrenia-like psychosis: a randomised controlled double-blind trial. The Lancet Psychiatry.
- Stafford, J., Dykxhoorn, J., Sommerlad, A., Dalman, C., Kirkbride, J. and Howard, R., 2020. Association between risk of dementia and very late-onset schizophrenia-like psychosis: a Swedish population-based cohort study.
- Zhang, H., Wang, L., Fan, Y., Yang, L., Wen, X., Liu, Y. and Liu, Z., 2019. Atypical antipsychotics for Parkinson's disease psychosis: a systematic review and meta-analysis. Neuropsychiatric disease and treatment, 15, p.2137.

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

- Antipsychotics and the elderly – factors to consider when prescribing
- Schizophrenia in adults vs older adults - the key differences.
- Charles Bonnet syndrome

MCQs

1. A 76 year old lady is diagnosed with 'late paraphrenia'. Which of the following delusions is the GP most likely to find?

A. Hypochondriachal

B. Delusions of misidentification

C. Religious delusions

D. Delusions of reference

E. Persecutory delusions

2. Very late onset schizophrenia is characterised by onset after:

A. 40 years

B. 60 years

C. 65 years

D. 70 years

E. 80 years

3. Which antipsychotic is most likely to cause postural hypotension:

A. Aripiprazole

B. Risperidone

C. Haloperidol

D. Quetiapine

E. Sulpiride

4. Which of the following drugs should not be used in renal failure?

A. Amisulpride

B. Aripiprazole

C. Chlorpromazine

D. Olanzapine

E. Quetiapine

5. 'Sensitivity to antipsychotics' is a core feature of which disorder?

A. Alzheimer's Disease

B. Dementia with Lewy Bodies

C. Late onset Schizophrenia

D. Organic mood disorder

E. Huntington's Disease

Additional Resources / Reading Material

Online:

- RCPsych CPD online. The management of hyperprolactinemia in psychiatric practice, psychotropic medication and the heart

Landmark papers

- Howard, R., Cort, E., Bradley, R., Harper, E., Kelly, L., Bentham, P., Ritchie, C., Reeves, S., Fawzi, W., Livingston, G. and Sommerlad, A., 2018. Antipsychotic treatment of very late-onset schizophrenia-like psychosis (ATLAS): a randomised, controlled, double-blind trial. The Lancet Psychiatry, 5(7), pp.553-563.

- Howard, R., Rabins, P. V., Seeman, M. V., & Jeste, D. V. 2000. Late-onset schizophrenia and very-late-onset schizophrenia-like psychosis: an international consensus. American Journal of Psychiatry.

Journal Papers:

- Almeida, O.P., Ford, A.H., Hankey, G.J., Yeap, B.B., Golledge, J. and Flicker, L., 2019. Risk of dementia associated with psychotic disorders in later life: the health in men study (HIMS). Psychological medicine, 49(2), pp.232-242.

- Andreas, S., Schulz, H., Volkert, J., Dehoust, M., Sehner, S., Suling, A., Ausín, B., Canuto, A., Crawford, M., Da Ronch, C. and Grassi, L., 2017. Prevalence of mental disorders in elderly people: the European MentDis_ICF65+ study. The British Journal of Psychiatry, 210(2), pp.125-131.

- Bartels, S.J., Fortuna, K.L. and Naslund, J.A., 2018. Serious Mental Disorders in Older Adults: Schizophrenia and Other Late-Life Psychoses. Aging and Mental Health, pp.241-280.

- Ferenczi, E.A., Erkkinen, M.G., Feany, M.B., Fogel, B.S. and Daffner, K.R., 2020. New-Onset Delusions Heralding an Underlying Neurodegenerative Condition: A Case Report and Review of the Literature. The Journal of Clinical Psychiatry, 81(2).

- Fischer, C.E., Ismail, Z., Youakim, J.M., Creese, B., Kumar, S., Nuñez, N., Darby, R.R., Di Vita, A., D'Antonio, F., de Lena, C. and McGeown, W.J., 2019. Revisiting Criteria for Psychosis in Alzheimer's Disease and Related Dementias: Toward Better Phenotypic Classification and Biomarker Research. Journal of Alzheimer's Disease, (Preprint), pp.1-14.

- Lange, S.M., Meesters, P.D., Stek, M.L., Wunderink, L., Penninx, B.W. and Rhebergen, D., 2019. Course and predictors of symptomatic remission in late-life schizophrenia: A 5-year follow-up study in a Dutch psychiatric catchment area. Schizophrenia research, 209, pp.179-184.

- Lapid, M.I. and Ho, J.B., 2020. Challenging our beliefs about delusional disorder in late life. International Psychogeriatrics, 32(4), pp.423-425.

- Louhija, U.M., Saarela, T., Juva, K. and Appelberg, B., 2017. Brain atrophy is a frequent finding in elderly patients with first episode psychosis. International psychogeriatrics, 29(11), pp.1925-1929.

- Maglione, J.E., Thomas, S.E. and Jeste, D.V., 2014. Late-onset schizophrenia: do recent studies support categorizing LOS as a subtype of schizophrenia?. Current opinion in psychiatry, 27(3), p.173.

- Rossi, M., Farcy, N., Starkstein, S.E. and Merello, M., 2020. Nosology and Phenomenology of Psychosis in Movement Disorders. Movement disorders clinical practice.
- Rothenberg, K.G. and Rajaram, R., 2019. Advances in Management of Psychosis in Neurodegenerative Diseases. Current treatment options in neurology, 21(1), p.3.

- Suen, Y.N., Wong, S.M., Hui, C.L., Chan, S.K., Lee, E.H., Chang, W.C. and Chen, E.Y., 2019. Late-onset psychosis and very-late-onset-schizophrenia-like-psychosis: an updated systematic review. International Review of Psychiatry, 31(5-6), pp.523-542.

- Swann P, O'Brien JT. Management of visual hallucinations in dementia and Parkinson's disease. International psychogeriatrics. 2019 Jun;31(6):815-36.

- Tampi, R.R., Young, J., Hoq, R., Resnick, K. and Tampi, D.J., 2019. Psychotic disorders in late life: a narrative review. Therapeutic advances in psychopharmacology, 9, p.2045125319882798.

- Van Assche, L., Morrens, M., Luyten, P., Van de Ven, L. and Vandenbulcke, M., 2017. The neuropsychology and neurobiology of late-onset schizophrenia and very-late-onset schizophrenia-like psychosis: a critical review. Neuroscience & Biobehavioral Reviews, 83, pp.604-621.

- Van Assche, L., Van Aubel, E., Van de Ven, L., Bouckaert, F., Luyten, P. and Vandenbulcke, M., 2019. The neuropsychological profile and phenomenology of late onset psychosis: a cross-sectional study on the differential diagnosis of very-late-onset schizophrenia-like psychosis, dementia with Lewy bodies and Alzheimer's type dementia with psychosis. Archives of Clinical Neuropsychology, 34(2), pp.183-199.

- Zharkova, T. and Kyomen, H.H., 2018. Treatment Dilemmas: Managing Antipsychotic Medication Risks in Elderly with Major Neurocognitive Disorder, Stroke and Psychosis. The American Journal of Geriatric Psychiatry, 26(3), pp.S100-S101.

Guidelines:

- Psychosis and schizophrenia in adults: prevention and management. NICE guidelines [CG178]

Books:

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

- Vannorsdall, T.D. and Schretlen, D.J., 2019. Late-onset schizophrenia. In Handbook on the europsychology of Aging and Dementia (pp. 711-725). Springer, Cham.
- Stahl, SM, 2017. Prescriber's Guide: Stahl's Essential Psychopharmacology, 6th edition Cambridge University Press.
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- 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.

MCQ answers
Mood disorders
1. **A** - a long history of memory impairment and difficulty with ADLS more suggestive of dementia 2. **A** – sertraline as supported by the SADHART trial results 3. **E** 4. **E** 5. **A** 6. **A**
Psychosis
1.**E** 2.**B** 3.**D** 4.**A** 5.**B**

Session 3: Liaison Across The Ages

Learning Objectives

- To gain an understanding of the he interaction between psychosocial factors and health problems both physical as well as mental.
- To develop an understanding around illness behaviour, sick role, medically unexplained symptoms, interface between psychiatry and general physical health services and the difficulties faced by patients, family, psychiatrists as well as the physicians.

Curriculum Links

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

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

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

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

2b: Describe the various biological, psychological and social factors involved in the predisposition to, the onset of and the maintenance of psychiatric disorders across the age range, including trauma (as described, ILO 1, 1a) history

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

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

3c: Accurately assess the individual patient's needs and whenever possible in agreement with the patient, formulate a realistic treatment plan for each patient for adult patients with common presenting problems.
3c: Be able to do the above with psychiatric problems as they present across the age range

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

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

Expert Led Session (incorporating case discussion)

- A Consultant led session based on the learning objectives listed, which examines the similarities and differences in depression across the ages
- Session coordinated by LEP Lead, with panel of 3 Expert Consultant Colleagues, representing child, old age and general/liaison psychiatry
- Local Education Providers have flexibility on how to run this session

MCQs

1) You have joined your consultant in a paediatric diabetes clinic, and you are asked to assess a 16year old boy who is doing well at school, but has not been able to attain control of their diabetes. Which 3 areas must you consider?

A) Mood and concentration
B) Weight and body image
C) Paranoid and hallucinations
D) Post-traumatic symptoms
E) Alcohol and smoking

2) You are contacted about 14 year old girl who has been treated for a paracetamol overdose in A&E. Her father has arrived and offered to take her home and bring her to see you tomorrow. He does not want her admitted into the paediatric bed that has been identified. What 3 things do you do?

A) Meet with the father and child and obtain consent to interview the child alone
B) Contact social services as this sounds suspicious
C) Meet with the father and child and ask why he wants to take her home
D) Admit the child to the ward under the Mental Health Act
E) Speak to the nurses in A&E to learn more about the child's presentation before the father arrived, and what their interaction has been like

3) Factitious disorder

A) Is more common in Males
B) Is less common in healthcare workers
C) Comprise 20% of referrals from General Medicine to Psychiatry
D) Rarely involves presentations of chest pain
E) Is commonly associated with depression

4) Which of the following is not true?

A) Pancreatic cancer confers high risk of developing depression
B) Paraneoplastic syndromes are commonly associated with small cell lung cancer
C) Autoimmune Limbic encephalitis is always associated with neoplasms
D) Body image disturbance is present in 50% of women with breast cancer
E) Treatment with steroids can result in development of psychotic symptoms

5) Which is true with regards to differences in pharmacokinetics in older vs younger adults?

A) Older adults have reduced body fat
B) Older adults have increased body water
C) Creatinine and GFR are not effected by age
D) Volume of distribution of lipophilic drugs increases in older adults
E) The T½ of psychotropic drugs is constant across the adult age range

6) Regarding mental disorder in acute hospital patients, which statement is false?

A) 30% of inpatients have a mental disorder
B) 30-60% of outpatients have medically unexplained symptoms
C) Dementia and depression are the most frequent disorders in older adult inpatients
D) Depression is frequently unrecognised in older adult inpatients
E) The presence of mental disorder does not affect mortality

Additional Resources / Reading Materials

- Edwards TM, Stern A, Clarke DD, et al. (2010) The treatment of patients with medically unexplained symptoms in primary care: a review of the literature. Ment Health Fam Med 7(4):209–221
- Henningsen P, Zipfel S, Herzog W (2007) Management of functional somatic syndromes. Lancet 369(9565):946–955

- Yon K, Nettleton S, Walters K, et al. (2015) Junior doctors' experiences of managing patients with medically unexplained symptoms: a qualitative study. BMJ Open 5(12):e009593, doi:10.1136/bmjopen-2015-009593
- Burton C, McGorm K, Richardson G, et al. (2012) Healthcare costs incurred by patients repeatedly referred to secondary medical care with medically unexplained symptoms: a cost of illness study. J Psychosom Res 72(3):242–24
- Salmon P, Peters S, Stanley I (1999) Patients' perceptions of medical explanations for somatisation disorders: qualitative analysis. BMJ 318(7180):372–376
- Stone J, Wojcik W, Durrance D, et al. What should we say to patients with symptoms unexplained by disease? The 'number needed to offend'. BMJ 2002;325:1449–5
- Chew-Graham CA, Heyland S, Kingstone T, et al. Medically unexplained symptoms: continuing challenges for primary care. Br J Gen Pract 2017;67:106–7

Forensic

Session 3: **Relationship between crime and mental disorder**

Learning Objectives

- To develop an understanding of the role of mental disorder in offending
- To develop an understanding of the frequency of and types of offences committed by those with serious mental illness
- To understand the role of special syndromes in offences
- To develop an understanding of vulnerability and suggestibility in mentally disordered offenders

Curriculum Links

12.1 Relationship between crime and mental disorder

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

12.1.3 Special syndromes: morbid jealousy, erotomania, Munchausen and Munchausen by proxy

12.1.5 Effect of victimisation and vulnerability: anxiety states including post-traumatic stress disorder; suggestibility; anger and aggressive behaviour. Effect of compensation on presentation

Expert Led Session

to include:

- Substance Misuse
- Epilepsy

- Schizophrenia
- Bipolar affective disorder
- Neuro-developmental disorders
- Personality disorders

Case Presentation

Case presentation on 'a special syndrome in relation to forensic psychiatry'. To include either morbid jealousy, erotomania, Munchausen or Munchausen by proxy.

Options for case presentation:

- If trainee has a suitable case of a special syndrome 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 Allitt inquiry' as the basis of the case presentation. (Munchausen by proxy)

Journal Club Presentation

Key points to be summarised from the following three papers:

- Rose J, Cutler C, Tresize K et al (2008) Individuals with an intellectual disability who offend, British Journal of Developmental Disabilities 106, 19 – 30

  http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&cad=rja&uact=8&sqi=2&ved=0CCUQFjAA&url=http%3A%2F%2Fwww.researchgate.net%2Fpublication%2F228505583_Individuals_with_an_intellectual_disability_who_offend%2Flinks%2F0deec51817f57baef7000000&ei=3YngU_Pil-nb7Aazh4DABg&usg=AFQjCNEg9xYeimpgqJchT70fngkh2vkPTA&sig2=KXDBJ1CC_DT2OPQG6mr2KA
- Fazel S, Wolf A, Chang Z et al (2015). Depression and violence: a Swedish population study. Lancet Psychiatry 2: 224 – 32
- Elbogen EB & Johnson SC (2009) The intricate link between violence and mental disorder: results from the national epidemiological survey on alcohol and related conditions. Archives of General Psychiatry 66(2): 152 – 161

http://www.ncbi.nlm.nih.gov/pubmed/19188537

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

- Human rights legislation – articles 5 / 6 / 8
- Ethics

MCQs

1. Which is the biggest risk factor for violence in psychosis?

A. Non-compliance with medication

B. Co-morbid personality disorder

C. Homelessness

D. Unemployment

E. Co-morbid substance misuse

2. With respect to Munchausen’s by Proxy, which of the following is incorrect?

A. More common in mothers

B. The annual incidence of fabricated or induced illness in children under 16 is 0.5 per 100,000

C. There is no clear relationship with any specific mental disorder

D. 50% perpetrators had a personality disorder

E. 21% have a history of alcohol and / or drug misuse

3. Which of the following regarding mood disorder and violence is incorrect?

A. The prevalence of depression in male prisoners is 10%

B. The prevalence of depression in female prisoners is 25%

C. Manic patients are likely to show aggression and violence associated with admission to hospital

D. 7% homicide perpetrators have a lifetime diagnosis of mood disorder

E. Most perpetrators of homicide-suicide are male

4. Which is the correct statement relating to substance use and the MacArthur Violence Study?

A. Substance use increases the rate of violence among both those with and without mental illness

B. The rate of violence for those with a mental disorder and no substance use is 25%

C. The rate of violence for those with a mental disorder and substance use is 50%

D. Substance use is a protective factor for violence

E. The highest rate of violence was for those with mood disorder and substance use

5. Which is the incorrect statement about epilepsy and offending?

A. Ictal violence is more likely in complex partial seizures

B. Most offending occurs in post-ictal or inter-ictal period

C. Violence in epilepsy is usually a feature of the disease

D. The prevalence of epilepsy in prisoners is 1 – 2%

E. The prevalence of epilepsy in the general population is 0.5 – 1%

EMI Questions

Fire Setting:

A. Crime concealment

B. Financial compensation

C. Suicidal

D. Extremism

E. Vandalism

F. Psychosis

H. Pyromania

Match the most-likely motivation for fire-setting with the clinical scenario below.

1. Wayne is a 14 year old who whilst truanting from school with a gang of boys sets fire to an abandoned warehouse. He waits around for the fire service to arrive and watches from a safe distance as they put the fire out.

2. Vincent is a 48 year old man with Asperger's Disorder. He has a history of setting fires when he is angry. He enjoys looking at how things burn. He is upset by another resident shouting at him and so set a fire. He feels an inner tension that is relieved when he has set the fire. He calls the fire brigade and becomes excited when they arrive.

3. Stephanie sets fire to a university research laboratory, where she believes the researchers are carrying out experiments on elephants. Two weeks ago she suddenly realised that the

University were dissecting elephant trunks in order to test the effects of snorting cocaine so that the Government could develop a synthetic drug to distribute in the community.

4. Alison is a 50 year old woman who has recently separated from her husband after he left her for another woman. Divorce proceedings have begun and she is concerned that she may have to leave the family home because she can't afford to pay the mortgage. She is depressed with low mood, poor sleep, anhedonia and poor concentration. She feels that if she loses her home she won't have anything to live for. She sets fire to her house using petrol in 3 seats in the living room, hallway and upstairs bedroom. She calls the fire brigade from her mobile phone in the garden.

Human Rights:

A. Article 2
B. Article 3
C. Article 5
D. Article 6
E. Article 8
F. Article 9
G. Article 12

These Articles of the European Convention of Human Rights (ECHR) are important in the detention of mentally-disordered offenders. Match the correct Article with the freedom or right it describes.

1. Right to respect for private and family life
2. Prohibition of torture
3. Right to marry
4. Right to life
5. Right to liberty and security
6. Freedom of thought, conscience and religion
7. Right to a fair trial

Additional Resources / Reading Materials

Books

- Chapters 14, 16, 17, 18, & 26 in 'Forensic Psychiatry: Clinical and ethical issues' Gunn J & Taylor P, (2013) CRC Press
- Chapters 7, 8 & 9 in 'Practical Forensic Psychiatry,' Clark T & Rooprai DS (2011) Hodder Arnold
- Chapter 3 in 'Oxford Specialist Handbook: Forensic Psychiatry,' Eastman N, Adshead G, Fox S et al (2012) Oxford Medical Publishing

E-Learning

- RCPsych CPD online: 'FREDA – a human rights-based approach to clinical practice'
- RCPsych CPD online: 'Morbid jealousy'
- RCPsych CPD online: 'Understanding and safely managing paranoid personality disorder'

Journal Articles

- Arsenault L, Moffit T, Caspi A et al (2000) Mental disorders and violence: results from the Dunedin study. Archives of General Psychiatry 57: 979 – 986
- Barrowcliff AL & Haddock G (2006) The relationship between command hallucinations and factors of compliance: a critical review of the literature. Journal of forensic psychiatry and psychology 17(2): 266 – 298
- Booles CN, Neale BA, Meadow SR (1994) Munchausen syndrome by proxy: a study of psychopathology. Child abuse and neglect G 18: 773 – 788
- Fazel S, Langstrom N, Hjern A et al (2009) Schizophrenia, substance abuse, and violent crime. Journal of the American Medical Association 301(19): 2016 – 2023
- Gudjonsson GH & Henry L. (2003) Child and adult witnesses with intellectual disability: the importance of suggestibility Legal and Criminological Psychology 8(2), 241 – 252
- Large M, Smith G, Swinson N et al (2008) Homicide due to mental disorder in England and Wales over 50 years. British Journal of Psychiatry 193: 130 – 133
- Newhill CE, Eack SM & Mulvey EP (2009) Violent behavior in borderline personality disorder. Journal of Personality Disorders 23: 541 – 554

- Nielson O & Large M (2010) Rates of homicide during the first episode of psychosis and after treatment: a systematic review and meta-analysis Schizophrenia Bulletin 36(4): 702 – 712
- Roberts ADL & Coid JW (2010) Personality disorder and offending behaviour: findings from the national survey of male prisoners in England and Wales. Journal of forensic psychiatry and psychology 21: 221 – 237
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ID

Session 3: Behavioural Issues in Intellectual Disability

Learning Objectives

- Understanding challenging behaviour and awareness of methods of recording/ assessing
- Aetiology of challenging behaviours
- Management options

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 to the observed high rates of psychiatric behavioural disorders in this group

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

Expert Led Session

- Challenging Behaviour Talk

Case Presentation

- Case presentation of local patient with intellectual disability presenting with behavioural 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 summary

Journal Club Presentation

Please select one of the following papers:

- Unwin G.L. and Deb S. (2008) A multi-centre audit of the use of medication for the management of behavioural problems in adults with intellectual disabilities. British Journal of Learning Disabilities, 36, 2, 140-143
- 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.
- Group-based cognitive-behavioural anger management for people with mild to moderate intellectual disabilities: cluster randomised controlled trial BJP October 2013 203:288-296;

‘555’ Topics (5 slides on each topic with no more than 5 bullet points)
Please select one of the following: • Review of Frith Guidelines on management of Patients with ID that present with Aggressive or Self Injurious behaviours. (Read the Guidelines in particular the flow charts) • Describe challenging behaviour and the various phases of the cycle of challenging behaviour (Focus on nature of behaviours, communication ability of the patient, issues of any change). • 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). Steps involved, would include ABC charts or functional assessments and basic behavioural interventions

MCQ’s
1. Causes of challenging behaviour in a person with learning disability: A. Pain B. Overstimulation C. Under stimulation D. Wanting attention E. All of the above 2. The following statements are true of factors increasing challenging behaviours in a person with learning disability except which option? A. Undetected physical illness B. Communication problems C. Underlying mental illness D. Environmental issues E. Problem solving ability 3. Inappropriate behaviours may be maintained by re-enforcement from others. Which of the following is a process that helps to identify factors maintaining that behaviour? A. Functional analysis B. Statistical analysis **C.** Procedural analysis **D.** Behavioural analysis **EMI Questions** Match each of the following psychological strategies to their possible effects:

A. Proactive Strategies
B. Positive Programming
C. Focused Support
D. Reactive Strategies

1. Systematic instructions given for greater skills and competence development which improves social integration

2. To produce rapid results and reduce reactive strategies

3. Designed to manage the behaviours at the time they occur

4. To produce change over time

Additional Resources/ Reading Materials

E-Learning

www.LD-Medication.bham.ac.uk

British Psychological Society and Royal College of Psychiatrists (BPS & RCPsych, 2006). Challenging behaviour: a unified approach. Available:

http://www.rcpsych.ac.uk/pdf/23%2009%202011%20LD%20PSYCH%20READING%20LIST.pdf

Psychotherapy

Session 3: Psychological approaches to Depression

Learning Objectives

To increase awareness of the psychological aspects of Depressive Disorder.

To have an introductory knowledge of the main psychological models for depression.

To have an overview of psychological treatments for Depression

Curriculum Links

1.1, 1.2, 1.3, 1.3.4, 2.3, 2.4, 2.6, 2.8, 6.1, 7.1.1, 9, 14

Expert Led Session

An overview of psychological therapies for Depressive Disorder

Case Presentation

This should be of a patient with depression, not necessarily one who is in / has had therapy. There should be sufficient background history to generate a discussion about the psycho-social factors in aetiology

Journal Club Presentation

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

- Driessen et al (2015) The efficacy of short-term psychodynamic psychotherapy for depression: A meta-analysis update Clinical Psychology Review 42: 1-15
- Gottems Bastos et al (2015) The efficacy of long-term psychodynamic psychotherapy, fluoxetine and their combination in the outpatient treatment of depression Psychotherapy Research 25(5): 612-624
- (Other paper suggested by expert if applicable – contact the person doing ELS)

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

Select one of the following:

- Psychological factors in the aetiology of depression

- Psychological symptoms of depression
- Current psychological treatments for depression recommended by NICE

MCQs

1. NICE guidance (CG90):

A. Recommends Computerised CBT for mild-moderate depression
B. Recommends Psychotherapy for severe depression
C. Advises not combining medication with psychological therapies
D. Recommends Cognitive therapy for relapse prevention
E. Defines Short-term Psychodynamic Psychotherapy as 10-15 sessions over 3-4 months

2. Cognitive Therapy:

A. Is originally based on the work of Judith Beck
B. Identifies Cognitive Errors that lead to or maintain depressive thoughts
C. Focuses on non-conscious thought content
D. Is enhanced by concurrent antidepressant treatment
E. Should not be used in older patients

3. Psychodynamic Therapies:

A. Have no evidence base for effectiveness
B. Are based on the model of the mind put forward by Freud
C. Seek to eradicate a patient's defences
D. Were among the first to link depression to loss
E. Focus on the past

4. Psychological factors in the aetiology of depression include

A. Parental indifference
B. Social circumstance
C. Maternal Depression
D. Cognitive biases or distortions
E. Bereavement

5. Evidence of effectiveness in the treatment of depression exists for:

A. Psychoanalytic therapy
B. Interpersonal Therapy
C. 'Low intensity' therapy in IAPT
D. Mentalization based CBT
E. EMDR

Additional Resources / Reading Materials

Sigmund Freud "Mourning and Melancholia" (1917 [1915]) Standard Edition **14**: 237-258
Aaron Beck "Cognitive Therapy and the Emotional Disorders" 1976

Substance Misuse

Session 3: Diagnosis and Management of People with co-occurring mental health and alcohol/drug use conditions

Learning Objectives

- To develop understanding of key aspects in the diagnosis and treatment of patients with co-occurring mental health and alcohol/drug use conditions
- To increase awareness of complications with pharmacological treatment in patients with co-occurring mental health and alcohol/drug use conditions
- To develop knowledge of risk issues in people with co-occurring mental health and alcohol/drug use conditions
- To understand how local services are implemented to manage people with co-occurring mental health and alcohol/drug use conditions

Curriculum Links

11.1	Basic pharmacology and epidemiology
11.5	Effect of drug and alcohol use on psychiatric illness

Expert Led Session

- Diagnosis and Management of People with co-occurring mental health and alcohol/drug use conditions
  - Concepts
  - Epidemiology
  - Case studies
- There is sufficient material for a separate lecture if spare capacity on the programme.
- If feasible joint presentation by Substance Misuse Consultant and General Adult Psychiatrist for both sessions

Case Presentation

- Examine risk aspects of people with co-occurring mental health and alcohol/drug use conditions
- Relationship of the substance use to development of the symptoms

Journal Club Presentation

- Asher CJ, Gask L. (2010) Reasons for illicit drug use in people with schizophrenia: Qualitative study. *BMC Psychiatry,* 10:94.
- Chitty, K., Dobbins, T., Dawson, A., Isbister, G., & Buckley, N. (2017). Relationship between prescribed psychotropic medications and co-ingested alcohol in intentional self-poisonings. *British Journal of Psychiatry,* 210: 203-208 .
- Newton-Howes, G., Foulds, J., Guy, N., Boden, J., & Mulder, R. (2017). Personality disorder and alcohol treatment outcome: systematic review and meta-analysis. *The British Journal of Psychiatry,* 211:22-30.

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

- Personality disorder and substance misuse
- Depression and alcohol
- Psychotropic drug interactions with opioid substitution medications
- Public health concerns of Chemsex

MCQs

1. Which of the following have not been associated with misuse potential:

A. Acamprosate

B. Hyoscine butylbromide

C. Loperamide

D. Pregabalin

E. Codeine phosphate

2. Intoxication of the following substances can be associated with psychosis in DSM 5 except :

A. Alcohol

B. Cannabis

C. Sedatives

D. Opioids

E. Inhalants

3. Which of the following symptoms is not associated with Benzodiazepines withdrawal using CIWA B

A. Loss of appetite

B. Yawning

C. Problems sleeping

D. Difficulties with concentration

E. Sensitivity to light / blurred vision

4. Percentage of patients attending Community Mental Health Teams reporting past-year problem drug use and/or harmful alcohol use has been found to be approximately:

A. 24%

B. 34%

C. 44%

D. 54%

E. 64%

5. Which of the following is likely to predate Alcohol and other Drug use disorder in most cases;

A. Generalised anxiety disorder (GAD),

B. Panic disorder,

C. Depression

D. Dysthymia

E. PTSD

EMI Questions

Drugs that may induce psychiatric symptoms:

A. Gamma-Hydroxybutyric acid (GHB)

B. Lysergic acid diethylamide (LSD)

C. Ketamine

D. Phencyclidine (PCP)

E. Diazepam

F. Amphetamine

G. Cocaine

H. Alcohol

I. Cannabis

J. Butane

1a. This psychoactive component of this drug acts through the type 1 form of the receptors which are found in high concentrations throughout the cerebellum, hippocampus, basal ganglia, cortex, brainstem, thalamus and hypothalamus

1b. This compound acts as an agonist at 5HT2A receptor

1c. One of the main mechanisms of action of this drug is by reverse transfer of the neurotransmitter dopamine

Psychotropic medications used in people with co-occurring mental health and alcohol/drug use conditions:

A. Diazepam
B. Quetiapine
C. Risperidone
D. Citalopram
E. Amisulpride
F. Sertraline
G. Baclofen
H. Olanzapine
I. Aripipazole
J. Fluoxetine

2a. Disulfiram can inhibit the metabolism of this compound

2b. This antipsychotic should be considered in patients with impaired liver function

2c. This agent may increase risk of compulsive behaviour such as gambling

MCQ Answers

Q1 A Acamprosate (Used for alcohol dependence)

Q2 D Opioids see DSM 5

Q3 B Yawning in COWS

Q4 C 44% see Weaver (2003)

Q5 E PTSD see Swendsen (2010)

EMI 1

(1) I (Nestler 2008)

(2) B

(3) F Cocaine works mainly by reuptake inhibition

EMI 2

(1) A

(2) E

(3) I

Additional Resources / Reading Materials

E-Learning

Royal College of Psychiatrists CPD Online

- Dual diagnosis: the diagnosis and treatment of depression with co-existing substance misuse.

Journal Articles

- Agabio, R., Trogu, E., & Pani, P. (2018, 4). Antidepressants for the treatment of people with co-occurring depression and alcohol dependence. The Cochrane database of systematic reviews, 4, CD008581.
- Aichhorn, W., Santeler, S., Stelzig-Schöler, R., Kemmler, G., Steinmayr-Gensluckner, M., & Hinterhuber, H. (2008). Prevalence of psychiatric disorders among homeless adolescents. *Neuropsychiatrie: Klinik, Diagnostik, Therapie und Rehabilitation: Organ der Gesellschaft Osterreichischer Nervenarzte und Psychiater*, *22*(3), 180-188.
- Baandrup L, Ebdrup BH, Rasmussen JØ, Lindschou J, Gluud C, Glenthøj BY. Pharmacological interventions for benzodiazepine discontinuation in chronic benzodiazepine users. Cochrane Database of Systematic Reviews 2018, Issue 3. Art. No.: CD011481. DOI: 10.1002/14651858.CD011481.pub2.
- Bebbington, P., & McManus, S. (2009). Adult psychiatric morbidity in England, 2007 : results of a household survey. London: National Centre for Social Research.
- Beijer, U., Andréasson, A., Ågren, G., & Fugelstad, A. (2007). Mortality, mental disorders and addiction: a 5-year follow-up of 82 homeless men in Stockholm. *Nordic Journal of Psychiatry*, *61*(5), 363-368.
- Busto, U.E., Sykora, K. & Sellers, E.M. (1989). A clinical scale to assess benzodiazepine withdrawal. Journal of Clinical Psychopharmacology, 9 (6), 412–416.
- Caton, C., Hasin, D., Shrout, P., Drake, R., Dominguez, B., Samet, S., & Schanzer, B. (2006). Predictors of psychosis remission in psychotic disorders that co-occur with substance use. *Schizophrenia Bulletin,* 32(4), 618-25.
- 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.
- Colizzi, M., & Murray, R. (2018, 4 20). Cannabis and psychosis: what do we know and what should we do? *The British Journal of Psychiatry,* 212(04), 195-196.
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- Darker CD, Sweeney BP, Barry JM, Farrell MF, Donnelly-Swift E. Psychosocial interventions for benzodiazepine harmful use, abuse or dependence. Cochrane Database of Systematic Reviews 2015, Issue 5. Art. No.: CD009652. DOI: 10.1002/14651858.CD009652.pub2.
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