Semester 1 Handbook

MRCPsych Course

2020 – 2022

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

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<tbody>
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<tbody>
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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 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 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.

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**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
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<th>Section</th>
<th>Topic</th>
<th>LEP</th>
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<td>Disorders in adulthood</td>
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Key: LEP – Local Education Programme;
     AP- Academic Programme
     LR – Learning Resources
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<td></td>
<td>2. CASP Checklist</td>
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</table>
### Learning Objectives

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

### Expert Led Session

- Schizophrenia-aetiological theories and epidemiology

### Case Presentation

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

### Journal Club Presentation


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

Please select one topic:

- Neuroleptic malignant syndrome
## Management of hyperprolactinaemia for patients on antipsychotics

## Management of QTc prolongation for patients on antipsychotics

### Statistics ‘555’ Topic

- CONSORT Checklist for RCT’s

### MCQs

1. A long duration of untreated psychosis is strongly associated with which of the following:
   - A. Ethnicity
   - B. Insidious onset
   - C. Level of Education
   - D. Living alone
   - E. Rural residence

2. What is the most likely long-term effect of delirium:
   - A. Accelerated decline in cognition and function
   - B. Better physical outcomes in future
   - C. Increased chance of late-onset psychosis
   - D. Increased hospital readmission rates
   - E. Increased likelihood of future episodes of delirium

3. Which of the following depot antipsychotics has a mandatory requirement of observing the patient for at least 3 hours after administration in a hospital setting:
   - A. Fluphenazine decanoate
   - B. Olanzapine embonate
   - C. Paliperidone palmitate
   - D. Pipothiazine palmitate
   - E. Aripiprazole maintena

4. Which of the following statements is FALSE about ICD-10 criteria of Schizophrenia:
   - A. Symptoms must be present for at least 6 months
   - B. Neologism is included in the symptoms
   - C. Organic brain disorder, alcohol and drug related intoxication, dependence or withdrawal are exclusion criteria
   - D. One of the criteria is: persistent hallucinations in any modality, when accompanied by delusions (which may be fleeting or half-formed) without clear affective content, or when accompanied by persistent over-valued ideas.
   - E. Aripiprazole

5. Which of the following antipsychotic has least effect on QTc interval:
   - A. Aripiprazole
Session 2: Depression-1

Journal theme: Meta-analysis and Systematic review on Depression

Learning Objectives

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

Expert Led Session

- Depression - aetiological theories and epidemiology

Case Presentation

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

Journal Club Presentation

Please select one of the following papers:


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

Please select one topic:

- Agitated, retarded and atypical depression – brief summary
- Antidepressant discontinuation symptoms
- Antidepressants and sexual dysfunction
## MCQs

1. Which of the following is not a well-recognised symptom of depressive illness:
   A. Ruminations of guilt
   B. Thought broadcast
   C. Irritability
   D. Thoughts of worthlessness
   E. Hypersomnia

2. David has chronic back pain and depression that is not responding to SSRI antidepressants. Which one of the following is the best antidepressant of choice in this situation?
   A. Vortioxetine
   B. Trazodone
   C. Venlafaxine
   D. Bupropion
   E. Amitriptyline

3. Which of the following factors is NOT associated with risk of repetition of attempted suicide?
   A. No previous psychiatric treatment
   B. Alcohol or drug abuse
   C. Previous attempts at self-harm
   D. Personality disorder
   E. Criminal record

4. Which of the following medications has RCT evidence for reduction of suicide rate?
   A. Citalopram
   B. Imipramine
   C. Aripiprazole
   D. Bupropion
   E. Lithium carbonate

5. Which ONE of the antidepressants below is safest to use in an individual who becomes depressed following a myocardial infarction, as concluded from the SADHART trial?
A. Fluoxetine  
B. Mirtazapine  
C. Amitriptyline  
D. Sertraline  
E. Citalopram

**Session 3: Bipolar Disorder-1**

**Journal theme: Case-control studies on Bipolar**

**Learning Objectives**

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

**Expert Led Session**

- Bipolar affective disorder- aetiological theories and epidemiology

**Case Presentation**

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

**Journal Club Presentation**

Please select one of the following papers:

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

Please select one topic:
- Mixed Affective states, Rapid cycling disorder – brief overview
- Atypical antipsychotics as mood stabilizers – a rough guide
- Pharmacological prophylaxis in Bipolar Disorder

### Statistics ‘555’ Topic

- Cohort studies and case control studies

### MCQs

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

2. Which of the following most closely reflects the risk of Bipolar Disorder in a first degree relative of an affected proband?
   A. 0.3-1.0%
   B. 1-2%
   C. 5-10%.
   D. 15%
   E. 20%

3. 48 year old woman is stable stabilised on Lithium Carbonate. She has developed hypertension. Which of the following antihypertensive has the least potential for interaction with Lithium?
   A. Losartan
   B. Frusemide
   C. Ramipril
   D. Atenolol
   E. Bendroflumethazide

4. Factors associated with a change of polarity from unipolar to bipolar include all except:
   A. Hypersomnia and psychomotor retardation.
   B. Absence of psychotic features.
   C. Younger age of onset.
D. Family history of bipolar disorder.
E. Antidepressant induced hypomania

5. Select one incorrect statement regarding bipolar depression in comparison with unipolar depression.
A. Slower in onset
B. More frequent
C. More severe and shorter.
D. Cause greater socio-economic burden
E. More likely to be associated with psychotic symptoms

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

Learning Objectives

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

Expert Led Session

- Salient points – Sections 2, 3, 4, 5(2), 5(4), 135, 136

Case Presentation

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

Journal Club Presentation

Please select one of the following topics:


Please select one topic:

- **Independent Mental Health Advocates (IMHAs) – Duties and Powers**
- **Nearest relatives – meaning, identification, powers and displacement**
- **Consent to treatment – T2,T3,T4,T6, CTO11 and CTO12**

### Statistics ‘555’ Topic

- Formulating research questions (PECO) and common literature search databases with what they include (e.g EMBASE, CINAHL, Psychinfo, Pubmed)

### MCQs

1. To prevent deprivation of liberty occurring:
   A. There is no requirement to consider what restrictions are placed before entry into a care home
   B. Involvement of advocacy services should be avoided
   C. It is vital to consider all aspects of the care plan
   D. There is no need to involve carers or relatives in planning care

2. The deprivation of liberty safeguards:
   A. Were introduced to prevent deprivation of liberty in a person’s own home
   B. Facilitate protection of people other than the relevant person from harm
   C. A primary care trust may be responsible for providing the appropriate standard authorisation
   D. The supervisory body issues an urgent deprivation of liberty authorisation.

3. The 2007 amendments to the Mental Health Act abolished the following classifications:
   A. Mental illness
   B. Psychopathic disorder
   C. Mental impairment
   D. Severe mental impairment
   E. All of the above.

4. Under the amended Act, a patient can be detained if the following conditions for treatment are met:
   A. Treatment is legal
   B. Treatment is offered by a psychiatrist
C. Treatment is available and appropriate
D. Treatment has an effect on risk
E. Treatment will cure the mental disorder

5. The provision in the amended Act that helps to uphold the human rights of a patient with personality disorder is:
A. Ease of discharge
B. Provision of statutory advocacy service
C. Right to refuse treatment if the patient possesses capacity
D. Regular contact with ‘nearest relative’
E. More frequent tribunal hearings

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

Learning Objectives

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

• To develop an understanding of surveys and develop skills for critically appraising surveys.

Expert Led Session

• Suicide and self-harm - aetiological theories and epidemiology

Case Presentation

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

Journal Club Presentation

Please select one of the following topics:

‘555’ Topics (5 slides on each topic with no more than 5 bullet points)
- Factors associated with suicide risk and rates of suicides in Schizophrenia, Bipolar disorder and depressive disorder.
- Substance misuse and suicide risk
- Emotionally unstable personality disorder and risk of suicide

Statistics ‘555’ Topic

Types of data (qualitative, quantitative etc)

MCQs

1. What is the single strongest predictor of completed suicide?
   A. Mental illness
   B. Previous self-harm
   C. Recent bereavement
   D. Having a neurodegenerative physical illness
   E. Family history of suicide

2. A patient is refusing life-saving treatment for severe blood loss after cutting her wrists. Under the law in England and Wales, whose responsibility is it to assess capacity to make a decision to refuse treatment?
   A. A consultant psychiatrist
   B. A clinical psychologist
   C. Any psychiatrist who is approved under Section 12(2) of the Mental Health Act
   D. The clinician proposing the treatment
   E. The duty AMHP (Approved Mental Health Professional)

3. Which of the following are the TWO periods of highest risk of suicide? (please pick two)
   A. As an inpatient, during the first week of admission
   B. At home, during the first week following discharge
   C. During the last week of admission when discharge is imminent
D. At home, after the first week following discharge has passed and there is less support
E. In the emergency department, while waiting for an inpatient bed

4. There is RCT evidence for reduction in suicide risk with which of the following medications? (please pick two)
A. Aripiprazole
B. Sodium valproate
C. Clozapine
D. Topiramate
E. Lithium.

5. What is the most current estimate of lifetime risk of suicide for individuals with schizophrenia?
A. 1%
B. 2%
C. 5%
D. 10%
E. 15%

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

Learning Objectives

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

Expert Led Session

- GAD and panic disorder - aetiological theories and epidemiology

Case Presentation

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

Please select one of the following papers:


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

Please select one topic:

- Dissociative disorders – brief overview
- Acute stress reaction and Adjustment disorders
- Pharmacological treatment of Insomnia

Statistics ‘555’ Topic

- Recruitment methods

MCQs

1. Which one of below is not true of body dysmorphic disorder (BDD):
   A. First described by Morselli
   B. DSM-IV classifies BDD as a somatoform disorder
   C. ICD-10 classifies BDD under hypochondriacal disorder
   D. Severe BDD is usually treated with SSRI and CBT as first line
   E. Commonly associated with morbid jealousy.

2. All of the following anxiety disorders are more common in females, except:
   A. Agoraphobia
   B. Social phobia
   C. Panic disorder
   D. Generalised anxiety disorder
   E. None of the above

3. All of the below are poor prognostic factors for OCD, except:
A. Early onset
B. Male
C. No compulsions
D. Family history of OCD
E. Longer duration

4. Which of the following is recommended by NICE as first line treatment for PTSD?
A. SSRI antidepressants
B. Counselling
C. Eye Movement Desensitization and Reprocessing
D. Combination of CBT and SSRI antidepressant
E. Quetiapine

5. Which of the following statement is FALSE?
A. Quetiapine has clear RCT evidence for efficacy in Generalised anxiety disorder.
B. Escitalopram is licenced for treatment of OCD
C. Treatment duration of at least 3 months is usually recommended for treatment of OCD
D. Antipsychotics should not routine be combined with antidepressants for treatment of anxiety disorders
E. Paroxetine, Escitalopram and Citalopram are all licenced for treatment of panic disorder
### CAMHS

#### Session 1: Assessment of Child and Adolescent Psychiatry

**Learning Objectives**

- Undertake assessments of children and young people; to communicate effectively with children, young people and their families across the age range; to take a developmental history; to formulate and prepare a plan and identify appropriate interventions.

Describe how the emphasis of assessments in CAMHS may be different to that in Adult Mental Health.

**Curriculum Links**

Child Psychiatry:

10.1 10.2 10.3

10.4 10.5 10.6

**Expert Led Session**

- This should include consideration of room setting e.g. with appropriate toys and other developmentally appropriate materials/approaches, the differences and similarities between adult and child psychiatry, pointers on taking a developmental history, ICD 11, DSM 5, bio-psychosocial formulation and risk assessment. Should also consider that some trainee’s may have limited experience with young children but have transferrable skills in assessment.

**Case Presentation**

- To highlight multi-disciplinary/multiagency nature of work (should include discussion of school observation/assessment)

- To highlight bio-psychosocial formulation

- Those trainees who are not currently in a CAMHS post should contact their local CAMHS team for the suitable case for presentation.

**Journal Club Presentation**
Review article: Assessing anxiety disorders in children and adolescents Susan H. Spence
https://doi.org/10.1111/camh.12251
Useful overview of different methods of assessment using anxiety as an example

Practitioner Review: Anxiety disorders in children and young people – assessment and treatment
Cathy Creswell, Polly Waite & Jennie Hudson
https://doi.org/10.1111/jcpp.13186
With further exploration of assessment and treatment

- The Clinical Application of the Biopsychosocial Model in Mental Health: A Research Critique:

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

- Risk assessment domains and formulation
- Assessment of a young person after an episode of self-harm young people
- Local Safeguarding processes and organisational structures

**MCQs**

1. Patient should routinely have a neurological examination if they present with all except:
   A. History of an episode of fainting
   B. History of seizures
   C. Developmental delay
   D. Dysmorphic features
   E. Abnormal gait
2. A physical risk assessment for patients with Anorexia Nervosa should include all except:
   A. Assessment of BMI and weight
   B. Assessment of heart rate
   C. Assessment of temperature
   D. Assessment of hydration status
   E. Body fat % measurement

3. During an assessment of a 14 year old patient with low mood in primary care, which of the following would prompt you to refer to specialist CAMHS:
   A. Mild depressive episode in those who have not responded to interventions after 2-3 months
   B. Active suicidal plans
   C. Referral requested by the young person
   D. Moderate to severe depressive episode.
   E. All of the above

4. Assessment of ADHD commonly include all except:
   A. Baseline liver function tests (blood tests)
   B. School observations
   C. History from parents/carers
   D. Questionnaire assessment
   E. History from patient

5. Mental state examination of a 15 year old patient should include all the following except:
   A. Assessment of appearance and behaviour
   B. Family history
   C. Assessment of speech
   D. Assessment of insight
   E. Assessment of cognition
6. The multi axial diagnostic formulation scheme of ICD 10 include:
   A. Axis III: psychiatric disorder
   B. Axis II: medical conditions
   C. Axis IV: adaptive functioning
   D. Axis I: psychiatric disorder
   E. Axis VI: medical conditions

7. An assessment of a 3 year old with suspected Autistic Spectrum Disorder must include:
   A. A home visit
   B. A detailed mental state examination
   C. Observation of the child interacting with others
   D. All of the above A-C
   E. None of the above A-C

8. CAMHS assessments in patients with speech delay should routinely include all except:
   A. Family tree (genogram)
   B. Family history of ASD
   C. Developmental history
   D. Details of whether the patient had the combined MMR vaccine
   E. Medical history

9. The presence of a disorder can be explained in terms of all except:
   A. Predisposing factors
   B. Precipitating factors
   C. Perpetuating factors
   D. Petulant factors
   E. Protective factors
10. In regards to initial CAMHS assessment of children under 5 with speech delay:

A. You should not see them without the presence of their parent/carer in the room
B. You should aim to get the child sat down in a chair for the majority of the assessment
C. You should observe them playing and play too if appropriate
D. You should avoid difficult topics
E. You should use more directed questioning

### Additional Resources / Reading Materials


**Books**

- Clinical topics in Child and adolescent psychiatry Sarah Huline-Dickens (2014)
E-Learning

RCPsych TRon Modules

1. Including:
   - Conceptualising and studying development
   - The development of temperament, language and cerebral functions modules
   - Adolescence and sexual development
   - Family relationships

2. The neurological examination
   - Not specific to children but generally useful in assessment. In this podcast Professor Adam Zeman, Professor of Cognitive and Behavioural Neurology at the University of Exeter Medical School, explains to Dr Raj Persaud how to conduct a neurological examination.

Journal Articles

- The Child and Adolescent Psychiatric Assessment (CAPA).

- Measurement Issues: Neuropsychological assessment with children and adolescents; unlocking the mysticism, methods and measures with the help of Tom Swift: James Tonks Phil J. Yates Huw W. Williams Ian Frampton Alan Slater
  Child and Adolescent Mental Health Volume 19 (2), November 2013
# Session 2: Attention Deficit Hyperactivity Disorder (ADHD)

## Learning Objectives

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

## Curriculum Links

**ADHD:**
10.1 10.2 10.3 10.6 10.7 10.8.3.1 10.8.3.2 10.8.3.3 10.8.3.4 10.8.3.5

## Expert Led Session

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

## Case Presentation

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

## Journal Club Presentation

- Treatment of Children With Attention-Deficit/Hyperactivity Disorder (ADHD) and Irritability: Results From the Multimodal Treatment Study of Children With ADHD (MTA) Lorena Fernandez de la Cruz, PhD, Emily Simonoff, MD, James J. McGough, MD, Jeffrey M. Halperin, PhD, L. Eugene Arnold, MD, MEd, Argyris Stringaris, MD, PhD, MRCPsych J Am Acad Child Adolesc Psychiatry 2015;54(1):62–70.


- Study of user experience of an objective test (QbTest) to aid ADHD assessment and medication management: a multi-methods approach
  
  Charlotte L. Hall, Althea Z. Valentine, Gemma M. Walker, Harriet M. Ball, Heather Cogger, David Daley, Madeleine J. Groom, Kapil Sayal and Chris Hollis
### ‘555’ Topics (1 slide on each topic with no more than 5 bullet points)

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

### MCQs

1. A four year old boy is brought to clinic with his parents. They report that he is inattentive at school, will not sit and play with his siblings at home and on one occasion let go of his mother’s hand whilst shopping and ran out into the road. Following assessment and diagnosis, what would your initial management step be?
   
   A. Refer patient for individualised CBT  
   B. Refer family for Family Therapy  
   C. Refer family to parent training and education sessions  
   D. Commence 5mg methylphenidate daily, titrating up weekly until improvement is seen  
   E. None of the above

2. The parents of a 5 year old girl recently diagnosed with ADHD have cancelled their second group parent training and education session. They tell you this is because their 11 year old son has learning disabilities and is wheelchair bound. They have no extended family or close friends to help with child care arrangements on the days required. What would you advise?
   
   A. Offer to commence medication for the patient as they will not be able to attend the parent training and education sessions  
   B. Offer to hold individualised parent training and education sessions on a day that would better suit them  
   C. Discharge the family from your case load as they have missed two consecutive appointments  
   D. Ask them to contact children and family services to arrange child care whilst they attend the training sessions  
   E. None of the above
4. You have assessed a 7 year old boy with suspected ADHD in clinic. You would like to get further information about his behaviour in school from his teachers. Which of the following regarding consent to discuss the case with school is correct?

A. You will need to document that you have obtained consent from the patient's parents or carers before you contact the school for information
B. You will need to document that you have obtained consent from the patient before you contact school for information
C. You don’t need consent to request information with school
D. You don’t need consent to request information from school as long as you don’t discuss treatment with them
E. You will need verbal consent from the patient’s parents or carers before you contact the school for information

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

A. Refer family to Family Therapy
B. Refer patient for CBT
C. Refer family to parent training and education
D. Commence the patient on medication
E. None of the above

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

A. Record of height and weight plotted on centile chart
B. ECG
C. Heart rate and blood pressure plotted on a centile chart
D. Mental health and social assessment
E. Assessment of cardiovascular symptoms
7. You have been seeing a 12 year old boy with ADHD. Parent training/education sessions proved ineffective. With the parents’ consent you commenced the patient on low dose methylphenidate, 5mg daily. At the following review the methylphenidate is not working and the patient’s behaviour continues to be impairing his social and academic functioning. You are happy that your diagnosis remains correct. He does not describe any side effects on questioning. What would your next step in treatment be?

A. Consider commencing low dose bupropion as an adjunct to methylphenidate
B. Consider stopping methylphenidate and commencing Atomoxetine
C. Stop medication and review diagnosis again
D. Consider stopping methylphenidate and commencing low dose dexamfetamine
E. Consider increasing the dose of methylphenidate

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

A. Convenience
B. To increase adherence
C. To help in facilitating schools who cannot safely store medication
D. Patients with co-morbid tic disorder
E. Reducing stigma

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

A. Inattention, hyperactivity and/or impulsivity persistent for at least 3 months
B. Symptoms are pervasive across situations
C. Symptoms are not caused by other disorders such as autism or affective disorders
D. Symptoms cause impairment in social, academic or occupational functioning.
E. All of the above

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

A. Raised blood pressure
B. Anorexia
C. Insomnia
D. Growth acceleration
E. Exaggeration of tic disorders
Books

  
  Sir Michael Rutter, Dorothy Bishop, Daniel Pine, Steven Scott, Jim S. Stevenson, Eric A. Taylor, Anita Thapar


- Attention Deficit Hyperactivity Disorder” by Professor Russell Barkley.

E-Learning

- Attention deficit hyperactivity disorder in children and adolescents. In this podcast Professor Heidi Feldman, from the Stanford University School of Medicine, talks with Dr Raj Persaud on attention deficit–hyperactivity disorder (ADHD) in children and adolescents; referring to her recent clinical review of the disorder published in the New England Journal of Medicine. 

- Neurobiology of ADHD, by Dr Katia Rubia


Guidelines

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

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

Journal of Psychopharmacology 1–25, 2014
Downloaded from jop.sagepub.com at University of Bristol Library on February 15, 2014
Learning Objectives

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

Curriculum Links

- Old Age Section of the MRCPsych Curriculum: 8.3

Expert Led Session

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

Case Presentation

- Present a case that highlights the importance of a robust assessment, where the results of cognitive assessment have been instrumental in formulation and diagnosis in an older person presenting with cognitive deficits.

Journal Club Presentation


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

- Bedside Testing of the frontal Lobe or parietal Lobe
- Normal age-related changes in cognitive function
- Alzheimer’s vs vascular dementia – distinguishing features in the cognitive profile.

### MCQs

1. A 67 year old male suffered from a cerebral infarct 5 weeks ago. Here is his CT brain scan result.

Which of the following tests is most likely to detect the related cognitive deficits?

- A. Abstract thinking
- B. Go-No-Go
- C. Cognitive estimates
- D. Stroop test
- E. Copying a cube

2. A 54 year old woman has been falling out with friends and her relationship with her husband is increasingly strained. She has been saying things in social situations that she would have previously found mortifying. Her driving has also become more erratic, often jumping red lights. She has also been involved in a couple of road rage incidents which is very unusual for her.

Which of the following screening tools would be most helpful in picking up associated cognitive deficits?

- A. MOCA
- B. 6-CIT
- C. Cornell
- D. MUST
- E. MMSE

3. A 62 year old woman was referred as the GP was concerned she was depressed. She presents with loss of volition, blunting of affect, axial rigidity and problems with vision. They deny feeling depressed. An MRI brain scan demonstrates the ‘hummingbird sign’.

What combination of deficits would you be likely to observe on a cognitive profile?

- A. Constructional apraxia and prosopagnosia.
- B. Impaired episodic memory an object knowledge.
- C. Visuospatial deficits and impaired naming.
D. Dyscalculia and tactile agnosia.
E. Impaired trail making and effortful, halting speech.

4. In Wenicke’s aphasia, an assessment of language is most likely to demonstrate:
A. Effortful speech
B. Telegraphic speech
C. Intact repetition
D. Impaired comprehension
E. Echolalia

5. A 58 year old gentleman presents with early stages of svPPA. Previously a keen amateur cook, he now struggles in the kitchen and keep asking his wife what various kitchen utensils are for. Cognitive tests show fluent speech and intact repetition. However, the content of their speech is vague with obvious word omissions and substitutions.

   **Which brain region has been affected by pathological change?**
A. Medical temporal lobe
B. Hippocampus & entorhinal cortex
C. Anterior inferior temporal lobe
D. Dorsolateral prefrontal cortex
E. Cerebellum

6. A 65 year old woman has been referred to the memory assessment service with forgetfulness causing her significant distress. Her mother had a history of Alzheimer’s dementia. She is not sleeping very well and struggles to enjoy her usual hobbies. Her MOCA score was 20/30. During the assessment she often responded with ‘I don’t know’ or gave approximate answers.

   **Which would be the most appropriate next step?**
A. Re-do the MOCA in 1 week with the support of relatives.
B. Prescribe low dose benzodiazepines.
C. Complete a MADRS scale and consider a trial of antidepressants.
D. Arrange an MRI brain scan.
E. Complete and ACE-III to look at the cognitive profile in more detail.

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**Additional Resources / Reading Material**

**Online:**
- Montreal Cognitive Assessment (MOCA) available at: [www.mocatest.org](http://www.mocatest.org)
- [https://www.alz.org/professionals/health-systems-clinicians/cognitive-assessment](https://www.alz.org/professionals/health-systems-clinicians/cognitive-assessment)
- [http://www.psychiatrycpd.co.uk/](http://www.psychiatrycpd.co.uk/) Bedside assessment of cognition.
Journal Papers:


Guidelines:

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

Other resources:


• Pavol, M.A., 2019. Inpatient Neuropsychological Assessment in Older Adults. In Handbook on the Neuropsychology of Aging and Dementia (pp. 89-103). Springer, Cham.

### Session 2: Alzheimer's Disease

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<th>Learning Objectives</th>
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| - The overall aim is for the trainee to gain an overview of Alzheimer's disease.  
- By the end of the session trainees should: |
| o Understand the epidemiology of Alzheimer's disease. |
| o Understand the risk factors, genetics, neuropathology, neurotransmitters and neuroimaging associated with Alzheimer's disease. |
| o Understand the clinical features of Alzheimer's disease, the assessment process and the principles of management. |
| o Understand the carer burden related to Alzheimer's disease. |

<table>
<thead>
<tr>
<th>Curriculum Links</th>
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<tbody>
<tr>
<td>• Old Age Section of the MRCPsych Curriculum: 8.1, 8.2, 8.3, 8.4, 8.5</td>
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<tr>
<th>Expert Led Session</th>
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<tr>
<td>• A Consultant led session based on the learning objectives listed above</td>
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<th>Case Presentation</th>
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<td>• A case to be presented which highlights the diagnostic process in a case of Alzheimer’s disease and/or management of the related behavioural and psychological symptoms (BPSD) of Alzheimer’s dementia. Please consider the learning objectives above.</td>
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<th>Journal Club Presentation</th>
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### ‘555’ Topic (5 slides with no more than 5 bullet points per slide)

- The use of antipsychotic medication in dementia and associate risks
- The NINCDS-ADRDA or NIA-AA criteria

### MCQs

1. **The prevalence of dementia in the general UK population older than 65 is approximately:**
   - A. 0.5-1%
   - B. 2-4%
   - C. 7%
   - D. 15%
   - E. 20%

2. **In Alzheimer’s Disease, the gene for Amyloid Precursor Protein (APP) is found on the long arm of chromosome:**
   - A. 1
   - B. 12
   - C. 21
   - D. 19
   - E. 27

3. **Which of the following statements regarding biomarkers in Alzheimer’s disease is true:**
   - A. The first biomarker change in Alzheimer’s disease is reflected by a decrease in CSF tau levels
   - B. β amyloidosis can only be detected in venous plasma samples
   - C. Amyloid-β accumulation is not sufficient to cause disease progression
   - D. PET imaging is estimated to be able to predict changes 25 years prior to symptoms
   - E. All individuals that have positive biomarker results progress at the same rate.

4. **A frail elderly gentleman is diagnosed with Alzheimer’s dementia in the clinic. He has a history of moderate COPD and 1st degree heart block. He also has a history of peptic ulcers. Which would be the most appropriate first line drug to prescribe to slow cognitive decline and alleviate the behavioural and psychological symptoms of the dementia?**
   - A. Rivastigmine transdermal patch
   - B. Galantamine
   - C. Risperidone
   - D. Donepezil
   - E. Memantine
5. Which of the following combination of APOE alleles confers the highest risk of developing Alzheimer's disease?

A. 4:2
B. 2:3
C. 3:3
D. 3:4
E. 4:4

Additional Resources / Reading Materials

Online:
- [http://www.psychiatrycpd.co.uk/](http://www.psychiatrycpd.co.uk/) (Dementia: breaking the 'bad news' – a guide for psychiatrists; inappropriate sexual behavior in dementia; Dementia: capacity, empowerment and conflicts of interest.)

Landmark papers


Journal papers:


Guidelines
Other resources


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**MCQ answers**

<table>
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<tr>
<th>Cognition</th>
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<tbody>
<tr>
<td>1. E - the stroke has damaged the parietal lobe and would cause a constructional apraxia. The other tests are related to executive function and the frontal lobes.</td>
</tr>
<tr>
<td>2. A - the MOCA tests for frontal lobe deficits.</td>
</tr>
<tr>
<td>3. E – she is presenting with progressive supranuclear palsy. A non-fluent aphasia and executive impairment is most typical in the early stages.</td>
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<td>4. D</td>
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<td>5. C</td>
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<tr>
<td>6. C – she is presenting with a probable pseudodementia or depressive dysexecutive syndrome. The MADRS would help screen for this before starting appropriate treatment.</td>
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<table>
<thead>
<tr>
<th>Alzheimer’s</th>
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<tr>
<td>1. C</td>
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<td>2. C</td>
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<td>3. C</td>
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<td>4. C</td>
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<td>5. E</td>
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<td>Across the Ages</td>
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# FORENSIC

## Session 1: Psychiatry and the Criminal Justice System

### Learning Objectives

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

### Curriculum Links

<table>
<thead>
<tr>
<th>12.2</th>
<th>Psychiatry and the criminal Justice System</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.2.1</td>
<td>The role of the psychiatrist in the assessment of mentally disordered offenders: during arrest, prior to conviction; prior to sentencing</td>
</tr>
<tr>
<td>12.3</td>
<td>Practising psychiatry in a secure setting</td>
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<tr>
<td>12.3.1</td>
<td>The role of security in a therapeutic environment</td>
</tr>
<tr>
<td>12.3.2</td>
<td>The essential components of a forensic service</td>
</tr>
<tr>
<td>12.3.3</td>
<td>Knowledge of the prevalence of psychiatric disorder in prison populations, suicide in prisoners and psychiatric treatment in prison settings</td>
</tr>
<tr>
<td>12.3.4</td>
<td>Risk management planning in forensic psychiatric practice</td>
</tr>
<tr>
<td>12.3.5</td>
<td>Managing mentally disordered offenders discharged into the community</td>
</tr>
</tbody>
</table>

### Expert Led Session

An introduction to the criminal justice system. To include:

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

### Case Presentation

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

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

Please select one of the following papers:

  

  

  

  
  [http://bjp.rcpsych.org/content/early/2015/11/09/bjp.bp.114.153882](http://bjp.rcpsych.org/content/early/2015/11/09/bjp.bp.114.153882)

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

Please select one topic:

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

MCQs

1. What is the relative risk of psychosis in prisons compared to the general population?
   A. 5
   B. 10
   C. 20
   D. 100
   E. 2

2. How many homicide offenders have active psychiatric symptoms at the time of committing the homicide?
   A. 1 in 10
   B. 1 in 5
   C. 1 in 3
   D. 1 in 2
   E. 1 in 4

3. The rate of suicide is highest in:
   A. Service users in the community
   B. Sentenced prisoners
   C. Service users in general psychiatric wards
   D. Older prisoners facing long sentences
4. Which is the most common psychiatric condition in prisoners?
   A. Depression
   B. Personality disorder
   C. Psychopathy
   D. Psychosis
   E. Neurosis

5. What is the prevalence of major depression in male prisoners?
   A. 10%
   B. 12%
   C. 25%
   D. 3.7%
   E. 50%

EMI Questions

Mental Health Act:
   A. Section 35
   B. Section 36
   C. Section 37
   D. Section 38
   E. Section 45A
   F. Section 47 / 49
   G. Section 48 / 49
   H. Section 41

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

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

Mental Health Act:
   A. Section 35
   B. Section 36
   C. Section 37 +/- 41
   D. Section 38
   E. Section 45A
   F. Section 47 / 49
For each of the following scenarios, which section of the Mental Health Act 1983 would be most appropriate to admit the patient under?

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

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

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

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

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

6. Sandeep has appeared in court charged with assault, for which she is on bail. She has a known history of schizoaffective disorder and is showing signs of relapse. She does not engage with the community team when unwell and will not accept treatment voluntarily. She won’t engage in assessments as to whether her offence was related to her mental disorder. You are of the opinion that she requires admission to hospital urgently.
• Chapters 1, 2, 3, 17 & 18 in ‘Practical Forensic Psychiatry,’ Clark T & Rooprai DS (2011) Hodder Arnold

E-Learning
• RCPsych CPD online: ‘Suicides in prison’

Journal Articles
• Birmingham L, Gray J, Mason D et al (2000) Mental illness at reception into prison. Criminal Behaviour and Mental Health 10(2); 77 - 87
# Session 1: History Taking and Communication in Patients with an Intellectual Disability

## Learning Objectives

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

## Curriculum Links

13.3 Clinical
13.3.1 Assessment and communication with people with intellectual disability.
13.3.2 The presentation and diagnosis of psychiatric illness and behavioral disorder in people with intellectual disability, including the concept of diagnostic overshadowing
13.2.2 Aetiology. The influence of psychological and social factors on intellectual and emotional development in people with intellectual disability, including the concept of secondary handicap.

## Expert Led Session

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

## Case Presentation

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

## Journal Club Presentation

- A guide to intellectual disability psychiatry assessments in the community. Advances in psychiatry Treatment November 1, 2013 19:429-436
- Learning disability in the accident and emergency department. Advances in Psychiatric Treatment January 2005 11:45-57
Please select one of the following:

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

**MCQs**

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

2. According to ICD-10, the following is not a degree of mental retardation:
   A. Borderline
   B. Moderate
   C. Profound
   D. Severe
   E. Mild

3. Disruptive and dissocial behaviour occurs more commonly in which of the following category?
   A. Mild intellectual disability
   B. Moderate intellectual disability
   C. Severe intellectual disability
   D. Profound intellectual disability
   E. Equally common across all categories

4. The prevalence of epilepsy in the intellectual disability population is approximately:
   A. 1-2%
   B. 5-10%
   C. 10-15%
   D. 20-25%


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

A. Denial
B. Fabrication
C. Engagement
D. Digression
E. Suggestibility

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**Additional Resources / Reading Materials**

**Books**

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

**E-Learning**

[http://www.gmc-uk.org/learningdisabilities/](http://www.gmc-uk.org/learningdisabilities/)

**Journal Articles**

### Psychotherapy

**Session 1: Referring to Psychotherapy Services**

#### Learning Objectives

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

#### Curriculum Links

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

*Depending on case material and therapy described.

#### Expert Led Session

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

#### Case Presentation

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

#### Journal Club Presentation

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


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

Select one of the following:

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

---

**MCQs**

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

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

2. Defences:

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

3. A psychotherapy formulation:

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

4. How do you define transference?

   A. The empathy shown by the therapist to the patient.
   B. Defence mechanism where attention is shifted to a less threatening / more benign target.
   C. Therapist’s response to the patient drawn from therapist's previous life experiences.
D. Patient’s response to the therapist based upon their earlier relationships
E. All of the above

5. What would suggest a patient has good psychological mindedness?
   A. Becoming very upset when talking about the past
   B. Finding it hard to step back and observe the situation objectively
   C. Needing to be talked through assessment with lots of prompts
   D. Reasonable sense of self esteem
   E. None of the above.

Additional Resources / Reading Materials


Chess Denman (2011) “The place of psychotherapy in modern psychiatric practice” APT 17:243-249
# Substance Misuse
## Session 1: Diagnosis and Treatment for People with Alcohol Problems
### Learning Objectives
- Assessment, diagnosis and treatment of people with alcohol problems
- To develop awareness of complications associated with alcohol use
- To understand some of the practical aspects of managing people with alcohol problems
- To gain awareness of local provisions and guidelines

### Curriculum Links
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>11.1</td>
<td>Basic pharmacology and epidemiology</td>
</tr>
</tbody>
</table>
| 11.3 | Problem drinking; alcohol dependence; alcohol-related disabilities.  
In-patient and out-patient detoxification |
| 11.4 | Biological, psychological and socio-cultural explanations of drug and alcohol dependence |
| 11.7 | The assessment and management of alcohol misusers |
| 11.8 | Culturally appropriate strategies for the prevention of drug and alcohol abuse |

### Expert Led Session
- Pharmacology / Neuropharmacology
- Classification
- Assessment
- Epidemiology
- Health Consequences
- Treatment issues

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


1. Which of the following statements about Disulfiram is false:
   A. Previous history of CVA is a contraindication
   B. Disulfiram use will result in an decrease in accumulation of acetaldehyde in the blood stream
   C. A loading dose can be used for initiation
   D. Disulfiram may have a role in the treatment of cocaine dependence
   E. Hepatic cell damage is a recognised adverse effect of Disulfiram

2. The following are true of Wernicke Encephalopathy except:
   A. Classic triad is ocular motor abnormalities, cerebellar dysfunction, and altered mental state
   B. Only 20% of patients present with the full triad
   C. Altered mental state occurs in 40%
   D. Altered mental state symptoms include: mental sluggishness, apathy, impaired awareness of an immediate situation, an inability to concentrate, confusion or agitation
E. Ocular motor abnormalities occur in 30%

3. Which of the following is not a reason to consider inpatient setting for alcohol detoxification based on Nice Guidelines:
   A. Drink over 50 units of alcohol per day
   B. Have a score of more than 30 on the Severity of Alcohol Dependence Questionnaire
   C. Have a history of epilepsy, or experience of withdrawal-related seizures or delirium tremens during previous assisted withdrawal programmes
   D. Need concurrent withdrawal from alcohol and benzodiazepines
   E. Consider a lower threshold for inpatient or residential assisted withdrawal in vulnerable groups, for example, homeless and older people.

4. Features required for a diagnosis of dependence within ICD 10 include the following except:
   A. A strong desire or sense of compulsion to take the substance;
   B. Difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use;
   C. A physiological withdrawal state when substance use has ceased or have been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms;
   D. Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses
   E. Returning to substance use after a period of abstinence leads to more rapid reappearance of features of dependence than with non-dependent individuals

5. The following are correct calculation of units of alcohol (percentages are in vol/vol) corrected to nearest whole number:
   A. 750 mls of 11% wine is 8 units
   B. 6 Litres of 4.5% cider is 18 units
   C. 5 cans of 330 mls of 4.8% lager is 8 units
   D. 3 cans of 440 mls of 7.5% strong lager is 10 units
   E. 2 bottles of 700 mls of 17% fortified wine is 24 units
### EMI Questions

**Drugs used in Alcohol Dependence:**

A. Disulfiram  
B. Acamprosate  
C. Naltrexone  
D. Baclofen  
E. Diazepam  
F. Oxazepam  
G. Lorazepam  
H. Vitamin B compound strong  
I. Thiamine  
J. Nalmefene  

1a. Which medication should not be given if serum creatinine >120 micromol/L?  
1b. Which medication used for detoxification should be avoided in patients with impaired liver function?  
1c. Which medication acts as a selective GABA-B agonist?

### Investigations for people with alcohol use

A. Gamma-glutamyl transferase (GGT)  
B. Mean corpuscular volume  
C. Carbohydrate-deficient transferrin (CDT)  
D. Total bilirubin  
E. Albumin  
F. INR  
G. Magnesium  
H. Globulin  
I. Alkaline phosphatase  
J. Platelet Count  

2a. This marker has Sensitivity of 50 to 70% in the detection of high levels of alcohol consumption in the last 1 to 2 months but false positive with hepatitis, cirrhosis, cholestatic jaundice, metastatic carcinoma, treatment with simvastatin and obesity.  
2b. This is used in the calculation of the Maddrey’s Discriminant Function for Alcoholic Hepatitis.  
2c. A reduction in this can lead to increased risk of seizures and can be related to use of proton pump inhibitors.
MCQ Answers

| Q1 | B Disulfiram use will result in an increase in accumulation of acetaldehyde in the bloodstream |
| Q2 | C Answer is 80% |
| Q3 | A Should be that a person drinks over 30 units of alcohol per day |
| Q4 | E is mentioned but not a feature required for diagnosis |
| Q5 | B should be obviously wrong = 27 units, no need to work out all the rest |

Formula is (percent alcohol x volume in ml) /1000
Hence for 750 mls of 11% wine is (750 x 11)/1000 = 8.25 units
However, a litre of x% vol/vol is x units
So, a litre of 6% cider is 6 units
So, 6 litres of 4% cider is 24 units, idea is rather than working them all out, should be able to scan them and identify incorrect number

EMI 1
(1a) B Listed as a contraindication - primarily excreted in the urine and not significantly metabolised
(1b) E This is due to the long half-life of diazepam
(1c) D

EMI 2
(2a) A
(2b) D
Maddrey's Discriminant Function Formula : 4.6 * (Prothrombin Time – Control Prothrombin Time) + Total Bilirubin
If score more than 32 indicates a poor prognosis and potential for steroid use.

(2c) G

Additional Resources / Reading Materials

Books
- Sigman, A. Alcohol Nation: How to protect our children from today's drinking culture

E-Learning
Epidemiological Public Health Data England (Alcohol given as example)
https://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/1/gid/1938132984/pat/6/par/E12000002/ati/101/are/E08000003
GP learning resource centre
- [http://www.smmgp.org.uk/](http://www.smmgp.org.uk/)

Royal College of Psychiatrists CPD Online
- Alcohol and the brain
- Alcohol-related brain damage
- Driving and mental disorders

Royal College of Psychiatrists Faculty of Addictions Psychiatry
- [http://www.rcpsych.ac.uk/workinpsychiatry/faculties/addictions.aspx](http://www.rcpsych.ac.uk/workinpsychiatry/faculties/addictions.aspx)

Society for study of addictions
- [https://www.addiction-ssa.org/knowledge-hub/](https://www.addiction-ssa.org/knowledge-hub/)

Journal Articles


