

Foreword from Dr Chris Rusius, Trent Division Chair



Hello and a very warm welcome to the latest edition of the e-newsletter; the first of 2017.

Firstly let me thank Dr Sam Tromans as Editor of the Newsletter, for the hard work he puts in to this to such good effect. Once again, we are grateful to those who have submitted articles and we are delighted by both the variety and also the high quality of the submissions. Sam's Editorial outlines some of the areas covered so I won't repeat this; suffice to say I'd be amazed if you can't find various articles of interest in this Edition.

It's been a time of great change at the Trent Division Office in Birmingham. The office covers both Trent Division and also East Midlands Division; Nikki (previous Trent Division Manager) and Sue were both wonderful, but unfortunately both left about a year ago. We were delighted that Heather took over as the Trent Division Manager, but unfortunately she has also now left. I'm certain this is pure coincidence! But it sometimes happens that various people leave at once, and this can leave places very short staffed. We are very fortunate to have Angela Appleby and Gloria Zachariou in the office, who are both doing a fantastic job. However trying to cover Trent as well as East Midlands Division is impossible, so please bear with them whilst we recruit to get back to manageable levels. However don't let this put you off contacting us at any point, there may just be a slight delay in us getting back to you.

Despite the above, we are delighted with the continued work of Division. Since the last Newsletter, the Trent Annual Conference took place in November 2016. The agenda had a slightly different focus to most conferences with a great variety of topics which were fantastic, with the added "question time" style session, the research presentations and the ever popular debate session with expert debaters. I would like to formally thank all contributors. The audience feedback was absolutely excellent. Division has also continued to monitor all job descriptions and deal with many questions. The Trent Executive Meetings continue to be well attended. Some Executive members are coming up towards the end of their term, so keep an eye out for the forthcoming vacancies and you may want to consider applying. Also do bear in mind the roles of Division that you may want to consider it as part of your network of contacts in certain situations; the Trent Executive Committee has a "Lead" in various areas of work as well as Sub-Specialty Representatives and Regional Advisors. They are closer at hand and may be more easily contactable than someone at the Central College, so do consider contacting us if needs be. Although we may not be able to answer the question, we will try and help if we can.

Advert over. Back to the Newsletter - Enjoy!

With best wishes

Dr Chris Rusius

Chair of Trent Division

Consultant in Old Age Psychiatry

Sheffield

Editorial from Doctor Samuel Tromans
Dear Colleagues,

Many thanks to all of you whom contributed to the Summer 2016 edition of the newsletter, I hope that you all enjoyed the variety of articles on offer. I will be flying solo from an editorial standpoint for this Winter 2016 edition, but will likely have a co-editor in place by Summer 2017.

The Winter 2016 edition includes a diverse selection of articles from Trent Division members. To give just a few examples, we have a comprehensive review of the evolution of the concept of [First Episode Psychosis \(FEP\)](#), [a discussion of a survey on improving access to psychiatric services for people with Parkinson's Disease](#), and the prize-winning elective [report from Nottingham University Medical Student Jessica Roscoe](#), about her experiences from working in a psychiatric setting in Australia. We also have a [message from Professor Nisha Dogra, the Associate Dean for Equality, Diversity and Inclusion](#).

Our [e-interview](#) is with Tom Dening, Professor of Dementia Research at the Institute of Mental Health (University of Nottingham) and Honorary Consultant in Old Age Psychiatry (Nottinghamshire Healthcare NHS Trust). He talks to us about his career, influences and interests outside of clinical practice.

As always, if you are interested in contributing to the next edition of our Newsletter in Summer 2017, we would love to hear from you. Some suggestions for possible articles are as follows:

- **Interest articles:** This can pertain to some local or national work you are personally involved in and would like to increase awareness of, or a topic in mental health which you yourself find interesting and would like to share with your colleagues.
- **Events:** This could be a review/feedback from conferences or other mental health related events that you have attended. Alternatively, if you are planning an event within the Trent Division that you wish to promote, this would also be welcomed.
- **Opinion pieces/ reflective writing:** Any issues in mental health that you are passionate about and wish to discuss with a wider audience.
- **Cultural contributions:** This could be in the form of artwork, photography or poetry pieces, though we are open to other ideas in a similar vein.
- **Research/Audits:** any innovative and interesting projects that you have been involved in and would like to share with a wider audience.
- However, do not feel constrained by these choices; if you wish to submit an article that does not neatly fit into one of these headings get in touch with us via e-mail, and we are happy to discuss this further.

Additionally, we would like to hear from those of you regarding your Special Interests within Psychiatry, as we plan to make this a new, regular feature for future editions.

Please also note that certificates can be provided on request for your professional portfolios for any accepted articles (though the presence of the article itself on the Royal College of Psychiatrists website will also serve as evidence of this).

We endeavour to make this newsletter a valuable resource for all members of the Trent Division and catering to a wide range of interests, so would welcome any feedback to help us continue developing this platform. Please contact Vivine Muckian (Vivine.Muckian@rcpsych.ac.uk) and myself (Samuel.Tromans@leicspart.nhs.uk) regarding any feedback, recommendations or submissions for future editions.

Sam

Specialist Registrar in Psychiatry of Intellectual Disability and Editor of the Royal College of Psychiatrists Trent Division Newsletter



A Physical Health App Quality Tool Project

Background

The Royal College of Psychiatrists report "Whole-person care: from rhetoric to reality: Achieving parity between mental and physical health" in 2013 recommended¹:-

- "People with mental health problems will receive the same quality of physical healthcare as those without mental health problem"
- "People with mental health will receive appropriate intervention and support to address the factors affecting their much higher rates of health risk behaviour".

The life expectancy of many groups of people with mental illness is at least 20% less than that for the population as a whole in high-income countries². Blood pressure, cholesterol, glucose intolerance and cardiovascular disease are most likely to be effected³. It is also known 46% of people in England with a mental illness also have a chronic physical illness, compared to 30% of the general population³. In England, the average provision of physical health checks for people with a severe mental illness is 76%¹.

Given these alarming statistics it was felt that improving the physical health care patients receive while an inpatient needed to be prioritised.

What is the App?

Our project is a specially designed app based on the LESTER tool. The LESTER tool is a summary poster to guide health workers to assess the cardiometabolic health of people experiencing psychosis and schizophrenia, enabling staff to deliver safe and effective care to improve the physical health of mentally ill people⁶. The app has been developed and is now in an electronic downloadable PDF form that allows the user to navigate around the 6 key headings of the LESTER tool:-

Smoking, Blood pressure, Blood Glucose regulation, Lifestyle and life skills, Weight and blood lipids.



Each section uses NICE guidance to highlight the recommended interventions and targets.

The aim of the app is to improve the quality of physical health management in psychiatric wards and also increasing the confidence of clinical staff in dealing with the most common physical health issues. The intention is that nursing staff will be able to use the app when they are writing physical health care plans for inpatients.

What is the Project?

The app will be piloted initially over 3 rehabilitation wards at Discovery House, Lincolnshire partnership NHS foundation trust, with evaluated outcomes including user experience, quality of care plans and interventions. The hope would be to expand its use to other inpatient wards within the trust.

We are currently conducting the pre implementation evaluation on the care plans for current inpatients. Over a four week period we hope to deliver teaching sessions to the nursing staff within the unit on the importance and use of the app. The intention is for staff to be regularly using the app to write and update care plans. A post implementation evaluation will also be conducted as well as obtaining feedback from the nursing staff on their experience of using the app. Once completed, it is our intention to write up our findings and submit these to the Royal College of Psychiatrists.

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Project Lead: Dr Jaz Phull, Consultant Forensic Psychiatrist, Lincolnshire Partnership Trust

What the hell happened to my brain?

Living beyond dementia and Kate Swaffer

Kate Swaffer is phenomenal. Diagnosed with frontotemporal dementia before the age of 50, she has been a leading advocate for dementia ever since, with a much-followed blog site (<https://kateswaffer.com>/<https://kateswaffer.com/>), addresses at numerous conferences, and author of the best-selling book whose title heads this article. She is a member of the World Dementia Council and co-founder and chair of Dementia Alliance International, the first global organisation exclusively for people with dementia. It is entirely fitting that she is the South Australian nominee for Australian of the Year 2017, and of course we hope she wins. Last year's victor was Chief of the Army and in 2015 the winner was a campaigner against domestic violence.

The book makes interesting reading, with some biographical material, some very illuminating descriptions of the difficulties Kate has with memory, words and so on, and then a lot of material aimed to support people with dementia in their lives but also a call to action for people with dementia to be more involved. She acknowledges that there is some repetition in her style, and this is indeed the case. However, points made more than once are perhaps the important ones. I don't want to post a conventional book review but would like simply to discuss the two points that most struck me.

One experience Kate has often had is being challenged over her diagnosis. It seems that if you appear to be functioning well or speaking at an international conference, there is an assumption that you can't have dementia and thereby there is an implication of fraud. Kate describes how offensive this is. You would not be challenged if you said that you have cancer or diabetes, or just about any other condition, so why is dementia different? Surely, the earlier that cases are diagnosed, the more likely that people will be less impaired and therefore well able to express themselves, especially if there is support for their writing. It is unlikely that most people would choose to have a diagnosis of dementia, especially if they don't have the condition*, so as it is not appropriate to interrogate people about their medical histories, then we must accept what they say and we should regard such questioning as rude and inappropriate when we hear it.

Kate has an ear for a strong catch phrase and one of these is 'Prescribed Disengagement', which she has trademarked, hence the capitals. This is what happens in most cases after a diagnosis of dementia. The person is advised to stop work, stop driving, stop most things, and concentrate on living out what remains of their life. Kate quite rightly points out that this is the opposite of every other medical condition, where the patient is encouraged to fight the disease, keep going, press for reasonable adjustments to enable them to keep working, and so on. She also makes a strong argument that if she had the same impairments that she has, but due to another condition such as brain injury or stroke, she would expect to be offered a whole list of rehabilitative opportunities, e.g. speech and language therapy, dietary advice, counselling (including grief work), social work and so on. This of course is completely unjustifiable and I'd totally agree. I have suggested myself that we consider 'the Deal for Dementia' and this is to some extent reflected in the current interest in post-diagnostic support. Though I fear that what is considered is still pathetic in relation to what people with dementia really need.

Tom Dening, Professor of Dementia Research at Nottingham University and Honorary Consultant in Old Age Psychiatry at Nottingham Healthcare NHS Foundation Trust

*You may remember the Guinness case of 1991, where a defendant was released from prison because he was said to have Alzheimer's disease. However, this seemed to resolve quite nicely after his release.

How my carer experience inspired me to pursue psychiatry

Since the age of thirteen, I have been the sole carer for my mother who lives with bipolar disorder. At this young age, I was completely naïve to mental health but after a family dispute I took on the responsibility of caring for my mother because my elder brother decided to leave home. As time went on, I have had to take on more responsibility and develop an understanding of mental health which inspired me to pursue a career in the complex, yet fascinating, medical field of psychiatry.

As a carer, I provide both practical and emotional support for my mother on a daily basis. In order to do this, I have had to devise strategies to manage my time so that I can provide this support to my mother whilst maintaining my education. This has helped me appreciate the time I have and taught me to use my time effectively, which I believe has helped me overcome any time management issues I have found myself faced with. I think that having an increased responsibility of caring for my mother has helped me to prioritise my time so that I can work towards achieving good grades whilst ensuring I am caring for her.

I also support her with regard to navigation of the health and social care system. Regular contact with her doctor provided me with an insight into the work of a psychiatrist. I could observe the consultations and the process of detailed history taking, which allowed the doctor to get to know my mother on a deeper level. My mother's history was taken back its beginnings, in detail, all the way to the present day. This not only built up her trust and connection with the doctor but also provided a large amount of information for him. I felt as though the way this information was collected gave the doctor a real understanding of his patient.

Getting more time to understand the patient and gather an insight to the events which have led to the patient attending the appointment allows a psychiatrist to work out the best management plan. This is one of the prospects of psychiatry that I believe would be most interesting and challenging. Being a carer, I have had some exposure to the intimate level of detail which may have contributed to a person's condition and this is one of reasons that being a carer has inspired me to pursue psychiatry.

Caring has taught me the importance of compassion, empathy and resilience, three values that have helped define the person I am. Being compassionate and empathetic toward my mother is something that allows me to connect with her and to talk to her in depth about her feelings during episodes of either mania or depression. Although listening can be difficult at times, especially during episodes of severe depression. These experiences have encouraged me to be resilient, as I know that personal emotions cannot discourage my mother from talking about her thoughts and feelings.

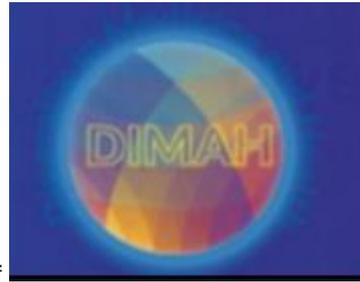
I have learned that when my mother cannot discuss her feelings, her thoughts become cycles of negativity which can lead to insomnia and depression, but once this cycle begins it is very difficult to break out of. Often, these periods can result in mania which can escalate to aggression or erratic behaviours. Being able to communicate in a way that completely respects my mother's dignity allows me to develop my understanding of how she feels during these particularly difficult times. This has always inspired me to want to improve my understanding of mental health further so that I can do more than listen.

Before I applied to medical school, one of my work experience placements was in psychiatry of intellectual disability (ID). During my time in ID, I observed some of the most disadvantaged and disabled patients, many with severe intellectual disability, mental illness and autism. During this placement, I was able discuss the different aspects of mental health and improve my knowledge of how mental health impacts upon a person's life. Despite the differences in diagnosis between some of the patients I observed during my placement and my mother, I could use the skills learned from my caring experiences to empathise with them and reflect on some of the issues they face. This was an eye-opening experience for me, as it gave me direct exposure to some of the difficult patients and the complicated cases that a psychiatrist must manage on a daily basis.

In conclusion, my experience as a carer has given me the opportunity to explore psychiatry. As a carer, I have observed the benefits of input from psychiatric services, but also as an aspiring medical student I have learned invaluable skills through personal experience. I believe that overcoming the challenges which are presented to my mother whilst maintaining a high standard of education has given me an insight into the human condition. My personal experiences as a carer have always motivated me toward psychiatry as a career, and if I am successful in my application to medical school I look forward to expanding my knowledge of medicine and psychiatry in particular.

Mr Harry Dudson, A-Level Student, Leicester

A Message from the Associate Dean for Equality, Diversity and Inclusion



I am delighted to have the opportunity to take on the role of Associate Dean for Equality, Diversity and Inclusion for the Royal College of Psychiatrists. I have worked in diversity education for nearly twenty years, and am committed to promoting diversity education to improve patient experience and ensure we see patients as more than their illness. However, this role is broader than that and provides an opportunity for us to ensure that we integrate diversity in every aspect of our functioning as a College. Much of the work I have undertaken in diversity education is transferable to other contexts.

For those reading this who may feel that diversity is overrated and just about being politically correct, I hope you will join the conversation. From my perspective, this role is not about representing the interests of any specific group but ensuring that we promote diversity in a way which uses the talents of all our colleagues for our common goals. I have some ideas about what our common goals with respect to diversity may be. However, to ensure that the goals represent the interests of the college at all levels, part of my role will be exploring different perspectives. For those committed to supporting diversity, I hope you see this role as an opportunity to share ideas and help support or make change that improves the lives of psychiatrists and our patients. Please do feel free to contact me regarding any thoughts you have about the role.

In case you are wondering, my credentials for the role are innovation of teaching in diversity to medical students, developing transparent educational models that support seeing patients as people and being a key member of the group who established diversity in medicine and health (www.dimah.co.uk), a group which I currently chair. However, as I said earlier, this role is much broader than diversity education and I look forward to developing it with colleagues.

Professor Nisha Dogra,

**Professor of Psychiatry Education and Honorary Consultant in
Child and Adolescent Psychiatry, Leicestershire Partnership Trust**



The Multidisciplinary Mental State Examination (MSE): Should Psychiatrists be Teaching MSE to our Nursing Colleagues?



I have been prompted recently by a graduate entry nursing student to wonder why the MSE is generally the preserve of doctors.

The MSE is our flagship skill, I would argue. It is something we do throughout every working day, and becomes second nature with experience. Just as the cardiologist uses the stethoscope, ultrasound and angiogram to explore and assess the function of the heart, so we use our eyes, ears (and not infrequently our noses) to gain an understanding of the function of the mind and brain of our patients. I often think it is a skill we underestimate and should be more proud of. But while nearly every psychiatrist will possess a copy of Fish's Clinical Psychopathology or Sims Symptoms in the Mind, our nursing colleagues develop their own language and methods for considering mental state largely independently. Should it be like this?

Psychiatry is a specialty where the nursing and medical teams work as closely as in any other, especially in an inpatient setting. The nursing staff spend a great deal more time observing and interacting with the patients than we do, and we rely heavily upon their impressions at ward rounds. Would it help us to have a shared structure and common language for discussing mental state? I argue that it might. When my nursing student colleague gave a presentation about the medical model of MSE to registered nurses in an Inreach Team it was almost a revelation to them to see how psychiatrists approach and record this, and they asked why this was not taught to mental health nurses at university. We will have all heard nursing staff give detailed and skilled accounts of psychopathology, but these tend to be documented in prose form in running records, and become hard to access and utilise when preparing tribunal reports or discharge summaries, for instance. If MSE as psychiatrists practise were taught as a shared technique, our notes would become much more recognisable between disciplines and this is in keeping with the movement towards single clinical care records involving all professions.

Also, the traffic would not be one-way; nurses, by the very nature of their work have different, broader interactions with patients in a ward environment and in the community. They have a longitudinal impression of how 'kempt' the person is, hear their speech as it takes place outside of the formal ward round, with peers and family members and gain an impression of cognitive function based upon observation of activities of daily living. Moving beyond the limited terminology of 'responding' to and being 'distracted' by unseen stimuli would lead to a richer, shared approach to examining and documenting mental state which could well improve long term care as a result, giving a clearer picture of a person's history and presentation for staff unfamiliar with them. Teaching MSE to nursing colleagues could also foster stronger interdisciplinary working relationships, helping to show we recognise and value what they contribute to the assessment of patients.

I am not ashamed to say that I've seen MSE's documented by Liaison Team nurses that put some of mine to shame. Sharing the MSE as a way of organising and communicating our thoughts can only help us in bringing nursing and medical expertise together. Let's start speaking the same language and develop a truly multidisciplinary mental state examination.

Jason Holdcroft, Specialty Doctor in Psychiatry, Radbourne Unit, Derby

E-interview with Professor Tom Dening



Tom Dening was appointed in October 2012 as Professor of Dementia Research at the Institute of Mental Health, University of Nottingham; and Honorary Consultant in Old Age Psychiatry, Nottinghamshire Healthcare NHS Foundation Trust. He studied Medicine at Newcastle University and trained in Psychiatry in Cambridge and Oxford. From 1991 to 2012, he was a Consultant Psychiatrist in Old Age Psychiatry in Cambridge. From 1999 to 2002 was seconded part-time to the Department of Health as a Senior Professional Adviser, including work on the National Service Framework for Older People. From 2002 to 2011, he was the Medical Director of the Cambridgeshire & Peterborough NHS Foundation Trust. His interests include the epidemiology of mental disorders in older people, treatment of dementia and depression in older people, psychiatric services, dementia and technology, care homes and other clinical topics. He is one of the editors of the Oxford Textbook of Old Age Psychiatry, the leading international work in this field. He has also published papers on neuropsychiatry, psychiatric symptoms and the history of psychiatry.

1. Tell us something about yourself that most people don't know.

When I get the opportunity, about once a year, I work as a volunteer guide at Happisburgh Lighthouse in north Norfolk <http://www.happisburgh.org/lighthouse/>. It is a brilliant and moving place and being at the top is wonderful. I'd recommend a visit to anyone.

2. What trait do you deplore in others?

I'm not sure that it is for me to judge anyone really but I certainly don't find arrogance and intolerance to be attractive qualities. I am depressed by misogyny and bad behaviour towards women as there seems to be no end to it.

3. Tell us about either a film or a book that left an impression on you?

I read voraciously and books that have influenced me are too numerous to mention. Perhaps I'd single out Eugene Onegin (by Pushkin but also opera by Tchaikovsky). I came across this a few years ago at a critical point in my life. For me, it shows how you shouldn't pass up opportunities at the time they present themselves because you won't have them later on. There's more to the poem than that but for me the message was that it's important to have as few regrets at the end of your career about things you could/should have done but didn't. If in doubt, go for it. It may be interesting and lead you somewhere you haven't thought of.

4. When not being a psychiatrist, what do you enjoy?

Watching non-league football or televised Bundesliga games featuring Borussia Dortmund. In the summer, cricket at Trent Bridge.

5. Which people have influenced you the most?

Aside from my parents, the spark for my career was lit by Professor German Berrios in Cambridge. He is one of the great psychiatrists of his time and probably the biggest polymath I have personally known. He supervised my MD research and we had a great time. It was a great pleasure that he was my best man when I got married again.

6. If you were not a psychiatrist what other profession would you choose?

Goodness knows. I have been a psychiatrist for so long I can't imagine much else. I think that being a bishop must be interesting. But perhaps I would do something different, like being a cheesemaker or piloting car ferries between the Orkney or Shetland Islands.

7. How would you like to be remembered?

Fondly by those who loved me. Otherwise I am content with the notion that the sand will swiftly wash away my footsteps.

My Elective in Psychiatry



Earlier this year I undertook an elective in Sydney at the Royal Prince Alfred Hospital, a public teaching hospital with a dedicated psychiatric unit. I studied with a variety of clinical specialists both in and out of the community. This placement included work within the remit of Aboriginal mental health and with the local community mental health crisis team.

I chose an elective in psychiatry because although I have had multiple experiences in the field of intellectual disabilities and child psychiatry, I have had few experiences of psychiatry in the community. I felt the need to expand my knowledge of other psychiatric subspecialties to help me consider potential career possibilities.

Considering my elective, I have subdivided the experience into the following categories:

Clinical

I was able to spend time with ward staff and patients within Sydney's inpatient unit. My daily placement included ward rounds with the mental health liaison team (visiting medical patients with psychiatric comorbidities), home visits with consultant psychiatrists (supporting patients who were unable to attend clinic) and community visits with the crisis team (attending acute psychiatric incidents, often with police escorts).

I joined the mental health crisis team for multiple shifts attending to patients suffering from acute illnesses. One particularly memorable patient was a young aboriginal man known to the crisis team for drug-induced psychosis. He had not attended recent meetings with his caseworker, arousing suspicion with the team, who decided to visit him on a quiet evening shift. He was found markedly intoxicated (likely with both alcohol and 'ice' - a potent form of methamphetamine) and sleeping on the steps outside his home. He was poorly communicative and mildly violent so it took a prolonged period of time to establish that he had been locked out of his home for several days and did not want to accept input from any services we suggested. After an in-depth team discussion, the decision was made to schedule him (the Australian equivalent of sectioning). Due to his significant history of violence the help of several police officers was required to transport him from his steps and into the back of an ambulance. He was convinced that the only reason for his scheduling was racism due to his aboriginal heritage.

Aboriginal mental health

Prior to my elective starting I was intrigued by how different service provision would be in Australia compared to the UK. I found that inpatient care was largely the same, however the most noticeable difference was the requirement of a specialist division to care for patients of proven Aboriginal heritage. I was educated about the significant hardships Australian Aboriginal people had suffered in the recent past and was shocked to see first-hand the ongoing racism many Aboriginal people endured. I met patients from the stolen generation who were forcibly removed from their families and was saddened by the psychological impact of such an avoidable act.

Research

Unfortunately, despite attempting to prearrange a research project, I was unable to complete the project due to data protection issues. This is my one regret of the elective as I was intrigued about the use of 'ice' in Australia - a drug that is endemic in urban areas and has been associated with significant mental health issues including delusional parasitosis. The planned research project was to consider the readmission rates for patients admitted with methamphetamine-induced psychosis and consider if changes could be made to the follow up care that they received in order to reduce readmission dates.

Summary

I was also able to explore the sights of Sydney including the opera house, Sydney Harbour Bridge and the famous Vivid Sydney light, music and ideas festival. I found the city itself to be truly magical!

In conclusion, this fantastic opportunity has made me incredibly excited for my upcoming foundation year doctor post in old age psychiatry and a potential career in this diverse field.

Jessica Roscoe, Medical Student, Nottingham University

Evolution of the Concept of First Episode Psychosis (FEP): Where it began and where it stands



Abstract

The development and implementation of Early Intervention in Psychosis (EIP) services has led to an increasing focus, in both clinical and research settings, on the early course of psychotic illness. The term 'First Episode Psychosis' (FEP) has emerged alongside the development of early intervention services. However, FEP has been historically ill-defined, is not described in diagnostic criteria and there is no consensus, operational definition. In this review we discuss the origins and evolution of the term FEP, from its early use as a synonym for first episode schizophrenia, to the current broader concept, which captures a range of heterogeneous psychotic illnesses and presentations with psychotic symptoms. We evaluate the usefulness of this concept from both clinical and research perspectives. FEP is a much more heterogeneous concept compared to schizophrenia. The concepts of Duration of Untreated Psychosis (DUP) and a critical period have been related to schizophrenia and not to FEP. However, it was the arguments around trying to reduce DUP and target the critical period which led to the development of early intervention in psychosis (EIP) teams throughout the world. The development of the concept of FEP around EIP services has been explored in this article and the impact on clinical practice and research has been discussed.

Keywords: FEP, psychosis, early intervention, schizophrenia,
Introduction

Since the landmark Early Psychosis Prevention and Intervention Centre (EIPPIC) programmes were established in Melbourne (McGorry, Edwards, Mihalopoulos, Harrigan & Jackson, 1996), other seminal programs in Europe, including the Birmingham Early Intervention Service (EIS) (Edwards, McGorry & Pennell, 2000), have followed. EIP services have since been implemented worldwide. A central tenet of these services is intervention in the shortest time frame possible. The goal is to change the trajectory of psychotic illness and maximise recovery (McGorry, Edwards & Pennell, 1999). EIP services aim to target the first episode of psychosis, to reduce the duration of untreated symptoms and reduce stigma (Department of Health, 2001).

The initial stages of psychotic illness are crucial in setting the parameters for long-term disease trajectory and outcomes (Harrison et al., 2001). A cornerstone of the early intervention approach is the critical period hypothesis (Birchwood, Todd & Jackson, 1998). Between 2-5 years following symptom onset, biological, social and psychological factors are most plastic. This formative period offers a unique opportunity for secondary prevention (Birchwood & Fiorillo, 2000). The most pronounced decline occurs at illness onset; vulnerability to aggressive deterioration and clinical progression continues during this window (Birchwood & Fiorillo, 2000; Harrison et al., 2001). Following the critical period, a plateau is frequently reached, with more stable remission or chronicity (Thara, 2004; McGlashan, 1988). Specialist EIP services take advantage of the malleability of the critical period.

A closely related concept is DUP. There is evidence that prolonged periods of untreated psychotic symptoms have detrimental effects on social and clinical outcomes. Several systematic reviews have found long DUP is a significant risk factor for poorer outcomes, disability and poor quality of life (Marshall et al., 2005; Norman & Malla, 2001; Perkins, Gu, Boteva & Lieberman, 2005). Periods of untreated psychosis may have toxic biological effects (Wyatt, 1991; Wyatt, 1995) and there is evidence of early progressive brain loss (Keshavan, Tandon, Boutros & Nasrallah, 2008; Wang et al., 2008). A long DUP reduces the time available within the critical period for effective early intervention. EIP services therefore aim to reduce DUP to less than 3 months (World Health Organisation [WHO], 2002a).

With the development of EIP services and the focus on the early stages of psychosis, the term FEP emerged. Not only is it clinically justified to target the first episode, because of the critical period and negative impact of long DUP, but there are also advantages from a research perspective. Most notably, the effects of antipsychotic medication can be avoided by using FEP patients who are uniquely drug naïve.

Initially the term FEP was used interchangeably with first episode schizophrenia. It was first used by Targum (1983) to describe patients with schizophreniform disorder in investigating the transition to schizophrenia. Early on, many authors used FEP to refer to schizophrenia only. However, towards the turn of the century, FEP became a separate concept referring to a broad range of individuals with the whole spectrum of psychotic diagnoses. With the broadening of the FEP concept came prominent issues of definition. No consensus has been attempted in the literature and the exact nature of FEP is not clearly defined. Unlike schizophrenia, FEP is not

part of diagnostic criteria and has not been subjected to rigorous tests of validity (Taylor & Perera, 2015). The heterogeneity of operational definitions makes it difficult to make meaningful and valid comparisons between studies using FEP samples.

Clarity of definition is not only important in research, where it is crucial to capture patients with meaningfully similar characteristics, but also in the clinic, where identifying patients with similar service needs is vital. Some clarification and standardisation in the definition of FEP is needed to permit cross-study comparison and meaningful interpretation of data (Keshavan & Schooler, 1992).

This review considers how the term FEP has developed from its early use to its current conceptualisation. The different definitions authors have used and the issues surrounding this non-consensus approach are discussed. The need for a consistent operational definition is considered and the potential value of a broad FEP concept in both research and clinical settings is explored.

First episode schizophrenia

Before the 1990's, much research was concerned with the later stages of schizophrenia in chronic patients. There had been a historically pessimistic view of schizophrenia (McGorry, 2002), with the assumption of poor prognosis, ineffective treatment and inevitable chronicity (Bleule, 1974). However, towards the turn of the century, the development of newer antipsychotics with better side effect profiles, and the introduction of EIP services, led increased optimism for recovery and prevention. Clinical strategies of early intervention and secondary prevention shifted research and clinical focus towards the early course of schizophrenia. At this time there was a relatively narrow focus on schizophrenia, to the exclusion of other psychoses. The diagnostic manuals of the time (DSM-III, American Psychiatric Association, 1980) gave the narrowest definition of schizophrenia than any previous editions (Tandon, Nasrallah & Keshavan, 2009). Despite emerging concerns around the heterogeneity of patients with schizophrenia (Farmer, McGuffin & Spitznagel, 1983), much research continued to adhere strictly to diagnostic criteria in the study of schizophrenia, and to exclude other psychotic illnesses.

With the emergence of early intervention, the term "first episode schizophrenia" arose. There was considerable confusion and inconsistency as to the definition of "first episode", creating a criterion variance. Many studies used first admission as the benchmark for the beginning of a "first episode" (Barrelet, Ferrero, Szigethy, Giddey & Pellizzer, 1990; Lieberman et al., 1992). However, others used the patient's first experience of symptoms (Farde et al., 1990), or first formal diagnosis as the benchmark. Furthermore, there were differences in the diagnostic criteria used and the diagnoses that were included within the term first episode schizophrenia. Keshavan and Schooler (1992) reviewed 53 first episode schizophrenia studies and found heterogeneity in definitions.

First episode psychosis

Towards the year 2000, with the publication of the ICD-10 (WHO, 1992) and DSM IV (APA, 2000) the definition of schizophrenia was broadening. More emphasis was placed on the spectrum of schizophrenic and psychotic illnesses, rather than on schizophrenia alone. With this came a move away from the term first episode schizophrenia, towards the broader FEP. Despite some initial use of the term FEP as a synonym for schizophrenia, it eventually grew to become a distinct concept itself. Sheitman, Lee, Strauss and Lieberman (1997) argued that FEP should not be used interchangeably with first episode schizophrenia. FEP requires a broad differential diagnosis and is not indicative of one specific diagnosis. Rather, the early presence of psychotic symptoms is a feature of the broad spectrum of psychotic illnesses.

Psychosis describes a syndrome involving mainly positive symptoms, hallucinations and delusions which are often accompanied by negative symptoms or mood disturbances (McGorry, Killackey & Yung, 2008). Because of the duration of illness criteria required for a diagnosis of schizophrenia, the FEP label began to play a useful role in EIP services as a way-station for critical treatment decisions early in the course of illness (McGorry et al., 2008). Unlike first episode schizophrenia, FEP can include other disorders such as schizophreniform disorder and schizo-affective psychosis (Baldwin et al., 2005). From a clinical perspective, this broad symptom led approach is beneficial in reducing stigma and treating psychosis as early as possible, even before a definitive diagnosis is reached. Previously excluded disorders such as acute and transient psychoses, drug-induced psychoses and affective psychoses began to gain increased research attention under the rubric of FEP.

Advantages of the FEP sample

Within the early intervention model clinicians were increasingly reluctant to diagnose young people with schizophrenia, and services aimed to reduce stigma. The broadening concept of FEP allowed a positive diagnostic uncertainty which services embraced. The concept of FEP also had a massive impact on research at this time. By recruiting samples of FEP patients from EIP services, often before diagnosis, it is possible to investigate subsequent diagnosis as a variable for study (Keshavan & Schooler, 1992). This affords unique opportunities for prospective, longitudinal research into biological, psychological and social aspects of psychosis as well as the possibility to investigate diagnostic stability. Data from FEP patients also facilitates investigation of diagnostic boundaries (McGorry et al., 2008). In addition, the effects of neuroleptic medication, institutionalisation and varying levels of chronicity are minimised in FEP samples. From both clinical and research perspectives FEP samples offer unique opportunities and methodological advantages. There is the potential for first episode psychosis as a concept to encourage integration of research and clinical practice.

Continuing issues of Definition

A major issue for FEP samples is whether they actually capture those in their first episode. There was a dramatic increase in the number of studies using the term FEP from the year 2000 and the issues of definition became increasingly apparent.

Psychosis is hallmarked by positive symptoms. However, in research samples of FEP patients there is often no indication of number or severity of symptoms required to label a patient psychotic. There is no consensus as to what makes up the psychotic syndrome. With this broad and non-specific definition there is little surprise that FEP patients are an enormously heterogeneous group. However, even if the broadest definition of psychosis is accepted, there is still the issue of how to define the temporal boundaries of the “first episode”. Breitborde, Srihari and Woods (2009) identified three key operational definitions commonly used; (i) first treatment contact; (ii) duration of antipsychotic medication use; (iii) duration of psychosis. Regardless of the definition used there is considerable variability on all dimensions.

First treatment contact is a simple definition, those presenting to services for the first time are deemed to be in the midst of a first episode. This includes patients seeking help for the first time for psychotic symptoms (Cullberg, Levander, Holmqvist, Mattsson & Wieselgren, 2002) and those referred to primary /secondary services (Morgan et al., 2006). However, a patient may have experienced a significant period of DUP prior to reaching services or have made previous, unsuccessful, attempts to access treatment (Lincoln, Harrigan & McGorry, 1998). First contact reflects the timing of intervention, not always the first emergence of psychosis. The maximum length of antipsychotic medication use authors stipulate also varies widely. There are a number of arbitrary cutoffs ranging from as little as 3 days lifetime use (Emsley, 1999) to 6 months continuous medication (Murray et al., 2008).

Perhaps most importantly in defining FEP is the inclusion/exclusion of different diagnoses. Not all studies use the same diagnostic system or include the same disorders. The majority of FEP studies confine their samples to “non-affective psychoses”. However, the inclusion of different diagnoses has varied from the specific inclusion of only schizophrenia to broader definitions including all forms of psychosis. In a one-year outcome study of FEP (Cullberg et al., 2002), diagnoses of schizophrenia, schizophreniform psychosis, schizo-affective disorder, delusional disorder, brief psychosis, psychotic disorder NOS and affective disorders with non-congruent psychosis were all included as FEP. An even broader definition comes from Morgan et al. (2006) whose large aetiological study included ICD-10 (WHO, 1992) diagnoses F10-F29 and F30-F33 (all substance-induced psychoses, the entire spectrum of schizophrenic illness and all affective psychoses). With such varied inclusion criteria, there is a real conceptual challenge in characterising FEP.

FEP in the Context of EIP Service Development

In 2004 the Newcastle declaration was released to an international audience (Bertolote & McGorry, 2005; WHO, 2002b). Written in collaboration with the World Health Organisation (WHO), the Initiative to Reduce the Impact of Schizophrenia group (IRIS) and mental health charity Rethink, it contained a set of key values and a consensus statement on what patients and families should expect from EIP services. The Newcastle declaration was of landmark importance in the development of EIP services and emphasised the importance of promoting both clinical and functional recovery, as well as reducing stigma, improving access to services, reducing DUP and promoting mental health awareness. A part of these goals involved moving away from rigid and stigmatising diagnoses to a broader and symptom focused FEP concept.

Around this time the term First Episode Psychosis was increasingly abbreviated to FEP. It became an accepted and ubiquitous term within clinical and research settings, much like the concepts of DUP or EIP. The ethos of EIP services in promoting recovery, reducing stigma and improving access were embodied in the broad and all-encompassing FEP. Those presenting to services with psychotic symptoms have a shared service need, the term FEP became fundamental in detecting and treating suspected cases of psychosis.

Discussion

The clinical landscape continues to change, moving further from the narrow concept of schizophrenia to a broader focus on psychosis. Now more than ever the heterogeneity of schizophrenia and psychosis is recognised and the need for clinicians and researchers to transcend diagnostic boundaries is an increasing priority (McGorry et al., 2008).

FEP has been central in EIP service delivery, but it has also impacted empirical research. There have been several recent biomarker (Koike et al., 2013), and neuroimaging (Achim et al., 2007; Bodnar et al., 2012; Takahashi et al., 2009) studies in FEP samples. These take advantage of the medication naivety of this group to investigate neural or biological mechanisms involved early in the disease. Additionally, there are several other key areas of interest in the current literature. These include investigations of the factors affecting medication adherence (Abdel-Baki, Ouellet-Plamondon & Malla, 2012; Hon, 2012; Montreuil et al., 2012; Segarra et al., 2012), as well as the psychological, social and side effect factors affecting relapse (Alvarez-Jimenez et al., 2012; Kam, Singh & Uptegrove, 2015; Malla et al., 2008).

Many of the issues with the operational definition of FEP suggest the concept is too broad and variable. However, a strict and specific “one-size-fits-all” definition is likely to be too restrictive.

Conclusions

The role of FEP as a concept in EIP services has developed over the decades in recognition of the fact that not all patients presenting with possible psychosis have ongoing psychotic illnesses. The broadness of the term has embraced a clinical need of the present where a substantial proportion of patients presenting to EIP services have possible personality disorders, complex psychological trauma to social chaos or drug induced psychosis/psychotic symptoms. Hence the lack of a universal definition or operational criteria has resulted from the requirement of the service to be able to embrace heterogeneity and deal with diagnostic uncertainty.

The development of FEP as a term for a service which was initially developed around evidence surrounding the prognosis of schizophrenia is an interesting phenomenon in the history of psychiatry. The clinical need and relevance overshadowing the original research in an age of evidence based medicine is a significant development in the opinion of the authors.

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Standard Setting for the Mock Clinical Assessment of Skills and Competencies CASC Examination: A Review of Potential Options and a Proposed Way Forward



Course and Assessment Process

I have been involved in the local mock Clinical Assessment of Skills and Competences (CASC) examination at my local trust. Passing the CASC proper is required for entry into higher specialty psychiatry training, and it is thus a high stakes examination. The mock is designed in the same format as the exam proper; with sixteen Observed Structured Clinical Examination (OSCE) style stations, covering a variety of scenarios assessing psychiatry-based skills (Hussain & Husni, 2010).

The mock CASC is currently assessed using a criterion-referenced standard setting method. De Champlain (2014) defines a criterion-referenced assessment as having 'the standard set as a function of the amount of knowledge of the domain that the candidate needs to demonstrate, irrespective of group performance.' As with the CASC proper, to pass the mock CASC examination, candidates need to pass a minimum of 12 of 16 stations. Checklist scores (covering specific competencies for each station) as well as global ratings are made by the consultant examiner for each station, who uses these to inform pass/fail decisions. At the present time, these decisions are made by virtue of the consultant examiners expertise with the CASC examination, and the mock CASC is not subject to any further statistical standard setting techniques (e.g. Angoff method).

Standard Setting Methods

With the exception of the **Angoff method**, I have focussed on examinee-centred methods of standard setting (rather than test-centred methods), as these are generally preferred in multi-dimensional performance-based clinical assessments such as the CASC (Boulet, De Champlain, & McKinley, 2003).

In the Angoff Method, each examiner reviews each test item (i.e. each checklist item in the CASC) in turn to estimate the proportion of borderline acceptable candidates that would provide the correct answer for said item (e.g. 0.5 for 50%) (Buckendahl, Smith, Impara, & Plake, 2002). This proportion represents the examiners judgment of the perceived difficulty of each item, and these proportions are totalled to give an overall score for each examiner. An average (mean or median) is calculated from all examiners scores to yield the cut-score for the examination (De Champlain, 2014), though there is a modified Angoff method where examiners meet to discuss (and potentially revise) their decisions beforehand (Smee, 2003). The Angoff method is both user-friendly and has a large evidence base of supporting research (Norcini, 2003). However, reviewing every individual item can be fatiguing and time-consuming for judges, particularly on tests with many items such as the CASC (Ferdous & Plake, 2005).

For the **Borderline Group Method (BGM)**, examiners score candidates performances on both a checklist score as well as a globalised rating scale for each element of the examination, where candidates performing at a borderline acceptable level are identified (T. J. Wood, Humphrey-Murto, & Norman, 2006). The scores for these borderline candidates are then plotted, and the (usually median) average score is used as the cut-off score (De Champlain, 2014). A key benefit of the BGM is in its simplicity of application. However, the resultant cut-score can be volatile, particularly when the cohort of candidates categorised as borderline acceptable is small (Livingston & Zieky, 1982).

In the **Borderline Regression Method (BRM)** linear regression modelling is used to calculate the cut-off score through regressing checklist scores against global rating scores. Checklist and global rating scores are treated as dependent and independent variables in a linear regression model, providing an equation which can be plotted graphically, enabling prediction of corresponding checklist score for a particular global rating score. This enables calculation of the checklist score representing borderline performance (and thus the cut-off score) as a function of the global rating scale score (De Champlain, 2014; Hejri et al., 2013). An advantage of the BRM over the BGM is that it incorporates data from all candidates, rather than only those whom are borderline, creating a more stable cut-off value (T. J. Wood et al., 2006).

For the **Contrasting Groups Method (CGM)**, a random sample of candidates are chosen to undertake the examination, and one by one, the judges make a collective decision whether individual candidates have performed at a 'pass' or 'fail' level. The scores of the passing and failing candidates are plotted as two separate curves on a graph with examination score on the x-axis and frequency on the y-axis (Norcini, 2003). In situations where false-negative and false-positive scores are of equal importance, the point of intersection between the curves is typically selected as the cut-off score. However, in clinical assessments the cut-off score is set higher, to reduce the likelihood of passing candidates that should not have passed (false-positives), which would be detrimental to patient safety (De Champlain, 2014). A limitation of the CGM is that the constituent curves (and

thus the curve intersection point) can vary massively, depending on the examiners' judgments of what constitutes a pass/fail performance (Shepard, 1980).

A drawback of the aforementioned criterion-referenced approaches is that they can potentially lead to unacceptably low or high numbers of candidates passing examinations based on the cut-off score arrived at following standard setting (De Champlain, 2014). The **Hofstee method** provides a compromise where values for minimum and maximum acceptable failure rates (Fmin and Fmax) and cut-off score values (Cmin and Cmax) are determined by the examiners prior to the assessment (Cusimano & Rothman, 2003; De Champlain, 2014). A cumulative score distribution curve of the candidates results is then plotted, with points P1 (Cmin, Fmax) and P2 (Cmax, Fmin) also plotted on the graph. A line drawn between these two points should contain all the theoretically acceptable permutations of these values (failure rates and cut-off score combinations). The standard is set at the point where the candidates' cumulative results curve crosses this line (Cusimano & Rothman, 2003). However, occasionally the curve may not cross the line, and in such circumstances, the standard becomes the minimum or maximum failure rate by default (depending on which side of the line the curve crosses adjacent to). For this reason, the Hofstee method is not ideal for high-stakes examinations, and is instead often utilised to supplement another approach (Norcini, 2003).

Method Selection and Justification

The approach that I would select for the mock CASC examination is the **Borderline Regression Method (BRM)**. As the pass mark will be calculated using all of the candidates scores, it has a superior reliability to other methods focussing on borderline candidates alone (i.e. BGM and CGM), crucial in a high-stakes examination. Similarly, in a direct comparison of BRM and Angoff for an OSCE examination Kramer et al (2003) concluded that BRM represented a more reliable and credible measure, as well as being practically feasible for most centres to use. Yousuf et al (2015) found BRM to have superior convergent validity with other methods, relative to BGM and Angoff. Similar studies have yielded findings offering further support to the superiority of BRM in performance-based assessments (Boursicot et al., 2007).

Although a basic statistical program is required to calculate the regression equation, the BRM is still considerably less labour intensive in its application than many measures (e.g. Angoff) (Hejri et al., 2013) and less preparatory training is required than for the Hofstee method (Cusimano & Rothman, 2003). Additionally, the potential issue of passing excessive false-positive candidates with BRM can also be addressed, by slightly raising the cut-score yielded from the resultant regression equation, typically by one standard error of measurement (Pell & Roberts, 2006).

Another advantage of the BRM is that the global rating given by an individual assessor will not lead to a pass or fail, but rather contributes a singular data point upon regression analysis used to determine the pass mark, which is based on all scores from every assessor for the entire candidate cohort. As such, any variance in marking from one examiner will affect all students equally following regression analysis (Pell & Roberts, 2006).

A drawback of the BRM, as with all standard setting techniques, is that it is ultimately reliant on the examiners' judgment in regard to what they collectively define as a passing performance; indeed, De Champlain (2014) says it is this factor that 'can make or break a standard setting exercise.'

Barriers to Implementation of BRM

Due to the statistical analysis involved in the BRM, faculty expertise may pose a barrier to implementation initially (Yousuf et al., 2015); however, given the links between Glenfield Hospital and University of Leicester, liaison with the statistics department would hopefully address this, with them providing education on how to execute such calculations on basic spreadsheet programs (McKinley & Norcini, 2014).

Almost any assessment procedure changes will be initially met with resistance by faculty and students (Bloom, 1989), but the high face validity of the BRM will likely lead to its longer-term acceptance (Yousuf et al., 2015). Perhaps most importantly, the BRM is the technique now used to standard set in the actual CASC examination (Royal College of Psychiatrists Examination Unit, 2015), and candidates may favour being subjected to the same technique for the mock CASC as the exam proper.

An additional barrier could be difficulties of bringing a sufficiently-sized group of examiners together with the necessary familiarity and expertise with the CASC assessment to make well-informed judgments on competency (McKinley & Norcini, 2014). Of course, there are financial implications in assembling such a panel, and a balance needs to be struck between sample size and expertise and what is affordable for the faculty; however the risk of a small group is that the cut-score could be unduly affected by the idiosyncrasies of a single examiner (De Champlain, 2014).

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