THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS

MOCK WRITTENS ESSAY PAPER 2016

(Produced by the New Zealand Training Programmes)

Model Answers

Note that these Mock Writtens papers are produced by local NZ psychiatrists rather than by the Examination Committee so they're not vetted, test driven and perfected by committee in the way that the real papers are. The main point is not to get fixated about whether the question writers were "right" and you were "wrong" in the model answers, but to practice the marathon of doing 2 full 3-hour papers and practising the technique of the various question types. If you disagree with the factual detail of an answer, research the issue and decide for yourself.

Critical Essay Question (40 marks)

In essay form, critically discuss this quotation from different points of view and provide your conclusion.

"...much of the frustration and existential anxiety that confronts clinicians working with high-risk clinical populations arises from the notion that suicide and serious self-injury are conceptualised as predictable and preventable complications of treatable mental illnesses."
- Michael Robertson, Australasian Psychiatry, August 2014

Reminder about marking process:
These are from the new CEQ scoring domains – I've selected the ones that seemed appropriate for the quote topic.

1. Communication/SPAG (Competency: Communicator)

The candidate demonstrates the ability to communicate clearly: Spelling, grammar and vocabulary adequate to the task; able to convey ideas clearly.	Proficiency level	No additional explanation needed. Illegible handwriting isn't counted here but a largely-illegible essay will lose a lot of points in other areas, as the marker won't be able to understand the content.
The spelling, grammar or vocabulary significantly impedes communication.	0	
The spelling, grammar and vocabulary are acceptable but the candidate demonstrates below average capacity for clear written expression.	1	
The spelling, grammar and vocabulary are acceptable and the candidate demonstrates good capacity for written expression.	2	
The candidate displays a highly sophisticated level of written expression.	3	

2. Critical Evaluation and Grasp (Competency: Scholar)

The candidate demonstrates the ability to critically evaluate the statement/question: Includes the ability to describe a valid interpretation of the statement/question.	Proficiency level	Requires a brief re-stating or summing-up of the core concepts and issues in the quote in the essay's introduction – *not* just an exact repetition of the quote with no interpretation. The key issue is the perception that suicide and serious self-harm can be prevented. The quote does not say whose perception this is, and that would be a good topic to discuss in the essay. The quote asserts that this perception causes clinicians working in the field frustration and 'existential anxiety'. Any potentially unclear terms should be defined. Here I think 'high-risk clinical populations' is one (people at high risk of suicide or serious self-harm). This also reminds the candidate that the essay should *not* be about preventing risk to *others*). 'Existential anxiety' should be as well. I don't think there's one right way to define this—philosophers differ—but in my view it's the individual clinician's anxiety about not doing the right thing or fulfilling what society expects, and what they expect of themselves. Thinking through what this means helps the candidate focus their essay. As well as covering the above in the essay's introduction—and there should be an introduction, not just a series of arguments with no intro or conclusion—look for the candidate's grasp of the issues in the quote throughout the whole essay in the way the arguments are set out and explained.
The candidate takes the statement/questions completely at face value with no attempt to explore deeper or alternative meanings.	0	
One or more interpretations are made, but may be invalid, superficial or not fully capture the meaning of the statement/question.	1	
The candidate demonstrates an understanding of the statement/question's meaning at superficial as well as deeper or more abstract levels.	2	
One or more valid interpretations are offered that display depth and breadth of understanding around the statement/question as well as background knowledge.	3	

3. Critical Reasoning/Evidence/POVs (Competency: ME, Communicator, Scholar)

The candidate is able to identify and develop a number of lines of argument that are relevant to the proposition. The candidate makes reference to the research literature where this usefully informs their arguments. Includes the ability to consider counter arguments and/or argue against the proposition.	Proficiency level	Evaluated from the arguments in the body of the essay. Explanation to the left is re the overall requirements for content and structure. In this essay, points that could usefully be addressed include: • Robertson's assertion that there's a <u>perception</u> that suicide and serious self-harm can be predicted and prevented. Whose perception? The general population? The media? Patients' families and carers? Politicians and government bodies? Service leaders? Clinicians themselves? All of the above? –> Discussion of this, examples and evidence *for* this, strength of that evidence. Then, arguments and evidence *against* this and the strength of those examples/evidence. • That there's a conflict between the <u>perception</u> as above and the <u>reality</u> – i.e. Robertson's implication is that suicide and serious self-injury are NOT necessarily predictable and preventable complications of treatable mental illnesses. –> Discussion of this, examples and evidence *for* this, strength of that evidence. Then, arguments and evidence *against* this and the strength of those examples/evidence. • Robertson talks specifically of <u>treatable</u> mental illnesses. This could either have been defined in the Introduction, or could be discussed here. The main disorder likely to be assumed is Mood Disorder, which is usually seen as being 'treatable' by most of the stakeholders above, but which, as clinicians know, may in some cases be resistant, or depressed mood may not be due to an "illness" but to personality disorder. Discussion as to whether in the modern age PDs should be classed as "treatable" or not – compared to historical problems when patients with severe PDs were not managed well in MHS. Discussion of curative concepts of "treatment" vs the long-term management of 'resistant' illness or PD-related disability to improve functioning and reduce risk. • Robertson's assertion that clinicians working with high-risk clinical populations experience frustration and (existential) anxiety. –> Discussion of this, examples and evidence *for* this, strength of that evidence. Then, arguments and evidence *against* this and the strength of those examples/evidence. e.g. suicide rates in psychiatrists themselves, research re burnout, etc.
There is no evidence of logical argument or critical reasoning; points are random or unconnected, or simply listed.	0	
There is only a weak attempt at supporting the assertions made by correct and relevant knowledge OR there is only one argument OR the arguments are not well linked.	1	
The points in this essay follow logically to demonstrate the argument and are adequately developed.	2	
The candidate demonstrates a sophisticated level of reasoning and logical argument, and most or all the arguments are relevant.	3	

4. Maturity/Breadth/Sensitivity/Advocacy (Competency: ME, Advocate, Professional)

The candidate demonstrates a mature understanding of broader models of health and illness, cultural sensitivity and the cultural context of psychiatry historically and in the present time, and the role of the psychiatrist as advocate and can use this understanding to critically discuss the essay question.	Proficiency level	Requires evidence and examples to be given from outside a narrow concept of modern psychiatry. e.g. <u>Examples/Arguments From History</u> (past issues of the "treatability" of various disorders that might lead to suicide, for example). Changing historical perceptions of mental disorders as the fault of the patient (possession by demons, sin, suicide a crime, etc.) to patients being victims of an illness and the onus thus falling on clinicians to "cure" and treat this. <u>Cultural Issues</u> might include discussion of the culture of psychiatry itself – seen as 'the caring profession', so we expect to be able to empathise, to help people, and of course, to prevent suicide and serious self-harm. Causes existential anxiety if we can't – the difficult balance for clinicians in managing the wish to 'save everyone' and the reality that not all self-harm is predictable or preventable. <u>Broader Models of Health And Illness</u> could include sociological viewpoints – the 'sick role', i.e. the social contract society has with people with a 'genuine mental disorder' – if they have this (and does a PD count?) then clinicians have an obligation to treat such people and to prevent serious harm. But that's not always possible.
The candidate limits themselves inappropriately rigidly to the medical model OR does not demonstrate cultural awareness or sensitivity where this was clearly required OR fails to demonstrate an appropriate awareness of a relevant cultural/historical context OR fails to consider a role for psychiatrist as advocate.	0	
The candidate touches on the expected areas but their ideas lack depth or breadth or are inaccurate or irrelevant to the question/statement.	1	
The candidate demonstrates an acceptable level of cultural sensitivity and/or historical contextand/or broader models of health and illness and/or the role of psychiatrist as advocate relevant to the question/statement.	2	
The candidate demonstrates a superior level of awareness and knowledge in these areas relevant to the statement/question.	3	

5. Ethical Awareness (Competency: Professional)

The candidate demonstrates appropriate ethical awareness	Proficiency level	Key Principle-based ethical concepts are: Beneficence – doing good, providing effective treatment and risk-management for mental illnesses. Society expects this of us and we expect it of ourselves as a profession. Reference = College Code of Ethics. 'Principle 3: Psychiatrists shall provide the best attainable psychiatric care for their patients' (re clinicians providing appropriate treatment and risk management to patients) 'Principle 9: Psychiatrists have a duty to attend to the health and well-being of their colleagues, including trainees and students.' (re detecting burnout and 'frustration and existential anxiety' in colleagues and esp. in juniors, and supporting them) 'Principle 11: Psychiatrists shall work to improve mental health services and promote community awareness of mental illness and its treatment and prevention, and reduce the effects of stigma and discrimination.' (re overall service provision to manage risk and reduce serious self harm in patient populations) Other issues arising from the Ethical Principles which could be discussed: The need to do no harm (non-maleficence) with our interventions in people self-harming due to PDs. Also the difficult balance between supporting patients' autonomy vs risk management when they are unwell and thus unsafe.
The candidate fails to address ethical issues where this was clearly required, or produces material that is unethical in content.	0	
The candidate raises ethical issues that are not relevant or are simply listed without elaboration or are described incorrectly or so unclearly as to cloud the meaning.	1	
The candidate demonstrates an appropriate awareness of relevant ethical issues.	2	
The candidate demonstrates a superior level of knowledge or awareness of relevant ethical issues.	3	

6. Clinical Context & Application (Competency; Medical Expert, Collaborator, Manager)

The candidate is able to apply the arguments and conclusions to the clinical context, and/or apply clinical experience in their arguments.	Proficiency level	This should have been easy to manage, as the quote is about clinical risk-management and the treatment of patients. I would expect clinical issues to be covered in the body of the essay arguments, so that this can be graded as on the left.
Arguments and conclusions appear uninformed by clinical experience (no clinical link) or are contrary or inappropriate to the clinical context.	0	
There is an attempt to link to the clinical context, but it is tenuous or the links made are unrealistic.	1	
The candidate is able to apply the arguments and conclusions to the clinical context, and/or apply clinical experience in their arguments.	2	
The candidate makes links to the clinical context that appear very well-informed and show an above average level of insight.	3	

7. Conclusion (Competency: Medical Expert, Communicator, Scholar)

The candidate is able to draw a conclusion that is justified by the arguments they have raised.	Proficiency level	A conclusion at the essay's end is required, and is graded here. As per the details at the left, it needs to be justified by the arguments in the body of the essay.
There is no conclusion.	0	
Any conclusion is poorly justified or not supported by the arguments that have been raised.	1	
The candidate is able to draw a conclusion/s that is justified by the arguments they have raised.	2	
The candidate demonstrates an above average level of sophistication in the conclusion/s drawn, and they are well supported by the arguments raised.	3	

OK, so - first time trying the new CEQ scoring and it actually adds up to 21.
So score it, then double the mark to get the final mark out of 40.

If anally retentive, multiply the score by 1.91 rather than by 2.0, for precision!

MODIFIED ESSAY QUESTION 1

Modified Essay Question 1: (23 marks)

You are a Consultant Psychiatrist working in a rural area, responsible for assessments of all acute patients. You are able to seek phone guidance from a Child and Adolescent Specialist in a neighbouring city.

A distressed mother presents to your service with her 15 year old son (Bradley) and 7 year old son (Stephen). They have just come from the emergency room, where the seven year old has had his broken arm set and plastered. Bradley's mother states that Bradley broke Stephen's arm, as Stephen had broken his Xbox. She says that Bradley seems remorseless, stating repetitively "he broke my Xbox, I broke his arm. Fair is fair", and that she can't live with "a psychopath". She has told the triage staff that he has always been short of empathy, that he seems more attached to his Xbox than his family, and she worries he will be involved in something awful like a high school shooting. Her fears have increased lately as he has been more irritable and withdrawn, and regarding Stephen's injury she said: "I should have seen it coming".

Question 1.1 (12 marks)

Outline the key information you will seek in your assessment of Bradley and his family.

		worth	mark (circle)
	History of the Index Event and Risk History		
A	Account of the index event including Bradley's thinking around the event, remorse, understanding that behaviour was not okay and why family is distressed.	2	0 1 2
B	Previous violence or risk to Stephen specifically and others generally. Any further intent to act towards Stephen or others at school and home. Any other forensic events or concerns, and a screen for conduct issues.	2	0 1 2
	Psychiatric Symptoms and Behaviour Screening		
C	Review for possible superimposed depressive symptoms and regarding the presence or otherwise of other psychopathology, including: any affective symptoms, agitation, cognitive symptoms/signs, or psychotic symptoms. Substance use history should be checked, given his age.	2	0 1 2
D	Internet/gaming use. How many hours online, and whether many offline activities are given up for online time, interest in antisocial video games, family limit-setting around technology/conflict when asked to come out of virtual world.	1	0 1
	Home Situation		
E	His interactions in the home environment – whether he shows warmth to his family, whether he can establish when they are unhappy/sad, usual relationships with parents and brother. What supports are there for him and mother – single mother? Or is father somewhere, are there extended family, etc.	2	0 1 2
	Developmental History & Autism spectrum screening		
F	A good developmental history; regarding early eye-gaze, early behaviour, social development. History of capacity to make friends, not just parallel play. Any perseverative interests or difficulties with speech and understanding body language, pointing and others' emotions from an early age.	2	0 1 2
	Social and School Situation		
G	Circumstances at school, friendships and their quality of any friendships (warmth and interconnection rather than just a shared interest in gaming), stresses re learning or bullying would be useful. Any evidence of concrete thinking or possible low intellectual function. (Collateral from school would be excellent re learning, empathy, social skills, but this is usually not practical in an acute setting.)	2	0 1 2
	Up to a maximum of 12 marks in total	**TOTAL:**	

<u>Note to Examiners:</u> Final mark is set at not more than 12. (i.e. if they score more, final mark is still 12)

Modified Essay Question 1

His mother tells you that Bradley struggled socially from an early age, seldom making friends prior to finding some boys he was able to talk to about computer games – she has never heard them discuss anything else. Kindergarten teachers described his interests as "quirky". He is attending school each day, and the school have described him as "quiet" and have not raised any concerns with her recently.

Question 1.2 (4 marks)

List the key mental state features you will look for in your assessment of Bradley, and explain why each is important.

		worth	mark (circle)
A.	Screening – for low mood, dysphoria, unusual thoughts/perceptions. His self care, general coping, depressive symptoms, etc. – screening for mood and psychotic disorders, (thought form and content).	2	0 1 2
B.	Developmental disorder symptoms – Speech prosody, repetitive speech, eye contact/lack of. Reciprocity/lack of in social interaction. Signs of a socially awkward youth or clumsy, stereotypical movements, etc. – screening for developmental disorders e.g. ASD.	2	0 1 2
C.	Preoccupations, plans, his own interests, point of view and intentions and the degree to which he can develop rapport. His subjective perspective and immediate plans – for risk assessment and diagnostic screen.	1	0 1
D.	Rough gauge of his cognitive capacity i.e. intellectual functioning. Degree of understanding and concreteness – for risk assessment and diagnostic screen.	1	0 1
	Up to a maximum of 4 marks in total TOTAL:		

<u>Note to Examiners:</u> Final mark is set at not more than 4. (i.e. if they score more, final mark is still 4)

Modified Essay Question 1

Bradley tells you during your assessment that from his point of view the situation is "sorted" and he wants to go home. He can't see why people would be concerned about the risk to his younger brother: "Unless I got another Xbox and he broke that". There is no prior history of violence or aggression. You are concerned about his excessive use of the Xbox (around 40 hours per week – it intrudes on his sleep, and leads to irritable responses when he's asked to spend time off it). However you have not elicited any convincing symptoms of a mental illness, nor are there concerns about substance use.

Question 1.3 (7 marks)

Discuss your initial management plan, following this assessment, focussing especially on risk management.

		worth	mark (circle)
A.	**Risk to brother – notification of authorities -** immediate management plan needs to consider the risk to his sibling. Stephen has a serious injury which wasn't accidental and Child Welfare services should be notified. Alternatively, esp. given this is a rural area, notifying the Police would be acceptable. Issues are regarding consequences of high risk-to-others behaviour, and about setting appropriate risk-management in place.	2	0 1 2
B.	**Admission vs outpatient follow-up** - no acute indication for admission to a child and adolescent ward as Bradley is not acutely ill. Stating he could be admitted for "assessment" if there were no other alternatives would be acceptable but not the preferred management as not an ideal use of a busy acute unit and likely to mean removing Bradley a considerable distance from home (rural area).	2	0 1 2
C.	**Immediate placement tonight** – needs to be mention of the need for discussion and negotiation of the options: • home if everyone including Child Welfare are happy with this (see below) • possibly placement with a family friend or extended family • Child Welfare service might place him if they chose • family might elect to have Bradley home and their younger son placed with extended family temporarily, etc.	2	0 1 2
D.	**Management of risk to brother - immediate behavioural management and family education** • talk with family about the need to monitor their younger son's safety closely (e.g. Bradley is not to "babysit" whilst assessment is being done) • clarify the family's understanding of at-risk situations, limit-setting, and set immediate follow-up in place, and crisis intervention plan/contacts.	2	0 1 2
	Up to a maximum of 7 marks in total	**TOTAL:**	

<u>Note to Examiners:</u> Final mark is set at not more than 7. (i.e. if they score more, final mark is still 7)

MODIFIED ESSAY QUESTION 2

Modified Essay Question 2 (24 marks)

You are working in a community based child and adolescent team and are meeting with Matt and his parents for the first time.

The referral states “Can you please assess Matt, an 18 year old schoolboy, who presents with a four month history of weight loss. Six months ago he began to eat more healthily in order to get in shape for the competitive rowing season, but began losing weight once rowing training started.

Recently, despite encouragement by his parents to eat, he has increasingly cut down on food because of constipation, bloating, and pain in his stomach. He denies vomiting. Up until recently Matt has had excellent health. His symptoms and weight loss have been extensively checked by a gastroenterologist who has not found any underlying physical cause.

Matt was very distressed when a month ago his coach banned him from rowing because he was losing condition. Since then he has been quite withdrawn and uncommunicative. “

On examination: Height 180 cm , weight 50 kg, pulse good volume and regular (lying 40 bpm, standing 65 bpm), BP lying 90/55 and standing 85/ 55 . Normal examination of heart, lungs & abdomen.

Question 2.1 (6 marks)

What additional information would you need to assess the risks and determine Matt’s initial management?

		worth	mark (circle)
A	**Information needed to determine place of care –** Community treatment is preferable. Inpatient treatment would be required however, if there was significant medical instability, or risk of developing re-feeding syndrome, or risk of suicide.	1	0 1
B	**Information needed re the medical instability and medical risk –** e.g. • Symptoms such as: syncope, seizures, chest pain, increasing shortness of breath, muscle weakness/camps, confusion, delirium, low urine output • ECG – dysarrthymias, QTC>450 msec, ST and T-wave changes • Hypothermia • Hypoglycaemia • Significantly raised liver enzymes, high amylase or abnormalities in renal function with ketones in urine as sign of severe dehydration • FBC with neutropenia < 1	2	0 1 2
C	**Information needed re the degree of re-feeding risk –** e.g. • History of rapid weight loss–e.g. > 1 kg/week or more than 10% body weight over 3-6 months • Little or no nutritional intake for > 5 days • Abnormal biochemistry: low potassium, magnesium, calcium	2	0 1 2
D	**Information needed re suicide risk –** • current hopelessness, ideas, urges or plans to harm or kill himself, access to lethal means (necessary to get any marks at all here) • Past history of DSH or emotional dysregulation • history of suicide in family or friends • substance misuse history re added risk factors	2	0 1 2
	Up to a maximum of 6 marks in total	**TOTAL:**	

<u>Note to Examiners:</u> Final mark is set at not more than 6. (i.e. if they score more, final mark is still 6)

Modified Essay Question 2

You think it possible that Matt has Anorexia Nervosa.

Question 2.2 (9 marks)
Describe the additional information you would need, to clarify this diagnosis and other differentials?

		worth	mark (circle)
A	Details of eating behaviour and restriction – eating pattern and levels of eating-related anxiety e.g. only eating alone, extremely slow eating, cutting food into small pieces, subjective or objective bingeing, food hiding/hoarding.	2	0 1 2
B	Compensatory behaviours – e.g. excessive exercise, purging, chewing and spitting, use of medications to lose or maintain low weight (laxatives, diuretic, appetite suppressants).	2	0 1 2
C	Body image disturbance (overestimating current body size) and/or fears about weight or becoming fat.	1	0 1
D	Cognition and thought content – obsessive thinking about food, poor concentration and attention, impaired short term memory and reduced cognitive flexibility. Degree of insight – minimizing symptoms and seriousness of symptoms. Willingness to change behaviours.	2	0 1 2
E	Past history of abnormal eating, of weight - prior history of perceived or actual obesity and timeline of weight loss. History of any other mental disorders.	2	0 1 2
F	Screening for differentials or additional disorders – review symptoms of anxiety disorders (OCD, panic disorder, social phobia, PTSD, GAD) as well as mood disorders (particularly depression), substance use disorders, personality disorders and psychotic disorder.	2	0 1 2
	Up to a maximum of 9 marks in total TOTAL:		

<u>Note to Examiners:</u> Final mark is set at not more than 9. (i.e. if they score more, final mark is still 9)

Modified Essay Question 2

Matt is admitted to the medical ward. The next day you receive a call from the registrar asking for assistance, as Matt is very wound up and is threatening to pull out the naso-gastric tube inserted for feeding, saying he needs to go for a run.

Question 2.3 (6 marks)
How would you manage this situation? Outline the ethical and medicolegal issues as well.

		worth	mark
A	Gather background information from nursing staff, referring registrar, consultant physician and dietician – about proposed treatment plan and current difficulties.	1	0 1
B	Interventions with Matt and his parents. • Review his mental state and coping – talk with parents • Provide Matt and parents with psycho-education • Externalize the eating disorder, and aim to enhance Matt's autonomy as far as possible without compromising treatment • Continue to assess relationship between Matt and his parents and assist them to support Matt's compliance with treatment	2	0 1 2
C	Develop a distress tolerance plan in conjunction with Matt, the family and MDT for anxiety management – e.g. distractions like music, computer games, chatting, soothing statements, abdominal breathing, visualization, etc.	1	0 1
D	Consider medication for short term anxiety management – benzodiazepines as first line or low dose antipsychotic e.g. quetiapine or olanzapine if no cardiac or other contraindications.	1	0 1
E	Arrange a meeting of treating team to allow expression of views and agree on a united MDT approach. May include family and Matt in latter part of meeting.	1	0 1
F	Ethical and medicolegal issues: • Need for informed consent – re the risks he faces and consequences of treatment and of refusing treatment. • Beneficence – duty of care – to provide treatment for a potentially fatal condition in a timely manner to minimize long-term consequences • Matt's age and dependent status with regard to parents. As a last resort the option of involuntary treatment under MHA remains if he is unable or unwilling to consent to treatment. • Non-maleficence – potential of traumatising him and of poor engagement with services, with long term consequences.	2	0 1 2
	Up to a maximum of 6 marks in total **TOTAL:**		

Note to Examiners: Final mark is set at not more than 6. (i.e. if they score more, final mark is still 6)

Modified Essay Question 2

Matt has been in hospital for 10 days and is due to be discharged home in three days time. His parents are concerned that Matt is still underweight and ask you to recommend the best treatment for Matt once he is discharged.

Question 2.4 (3 marks)
Give your recommendation, your rationale for this choice, and briefly outline what you would tell his parents about the recommended treatment.

		worth	mark
A	**Treatment recommendation:** Family Based Treatment (as developed by Lock (2011).) *Unless this type of treatment is correctly specified no marks can be awarded for this question.* Generic terms such as "family therapy" are not sufficient.	1	0 1
B	**Rationale:** this has the most substantial evidence base and is considered treatment of choice for people aged less than 19 with anorexia nervosa with a duration of illness of less than 3 years.	1	0 1
C	**Information to discuss with his parents:** • It's an intensive outpatient treatment of about 15- 20 sessions where the entire family support the adolescent with anorexia to restore weight. • Anorexia is a life threatening condition and can become chronic. This is a condition where food is medicine and the people in the best position to manage this are the parents. • Beginning with a family meal, parents are coached to take control of their child's eating and other eating disordered behaviours to allow weight restoration. Siblings also support the adolescent patient. • Once weight is restored, parents gradually return control back to the adolescent and encourage normal adolescent development,	2	0 1 2
	Up to a maximum of 3 marks in total **TOTAL:**		

Note to Examiners: Final mark is set at not more than 3. (i.e. if they score more, final mark is still 3)

MODIFIED ESSAY QUESTION 3

Modified Essay Question 3: (20 marks)

You are the Psychiatric Registrar working in an inpatient Psychiatry of Old Age Unit. Paul, aged 68 and a retired accountant, is admitted under your team. He has an established seven year history of early onset Alzheimer's Dementia and lives at home with his wife, Mabel. His admission has been precipitated by a recent deterioration in his behavior and a delirium is suspected. Paul is so agitated and aggressive that he initially needs to be restrained and managed in seclusion.

Question 3.1 (10 marks)

Describe your initial approach to the assessment and care of Paul's physical health.

		worth	Mark (circle)
A	Comprehensive medical assessment and investigations – to identify likely organic causes of delirium. • full physical examination and ongoing reviews • blood/urine work-up and physical assessments – X-rays, ECG etc. • Possible consultation with physician/geriatrician • Ideally mention difficulties doing investigations such as ECG and CT in a grossly disturbed patient	3	0 1 2 3
B	Information gathering to guide treatment • on admission, signs of neglect, poor nutrition status, bruising • collateral history from family, community team, GP – including past medical illnesses, medications, dementia history, substance use • ongoing information re vital signs and oral intake, urinary output • ongoing assessment of level of disturbance, use of seclusion, risks to patient (injuries and poor intake) and to staff caring for him	3	0 1 2 3
C	Non-pharmacological strategies to manage his acute confusional state (family and familiar staff to stay with him once this is safe, cease use of seclusion as soon as possible, orientation and environmental management, etc.)	2	0 1 2
D	Pharmacological options for management of acute confusional state (low dose antipsychotic).	1	0 1
E	Consider suitability for treatment on POA inpatient unit vs an adult acute unit - relatively young age, physically able, level of agitation and risk, skill set of staff, vulnerability of older, more infirm patients on the Unit – or consider a medical ward with a watch if his physical frailty outweighs risk from aggression.	1	0 1
F	Medicolegal framework for his assessment and detainment for the treatment of delirium and of his physical state. Duty of care, Mental Health Act, Guardianship order, etc.	1	0 1
	Up to a maximum of 10 marks in total TOTAL:		

Note to Examiners: Final mark is set at not more than 10. (i.e. if they score more, final mark is still 10)

Modified Essay Question 3

A family meeting with Mabel is organised by the ward social worker.

Question 3.2 (6 marks)

Outline the key information you would seek from Mabel.

		worth	Mark (circle)
A.	Acknowledgement of Mabel's distress and assess her current coping and her physical state. Consider carer burden, burnout, what supports she has available and is using. Mention need for an empathic, supportive attitude.	2	0 1 2
B.	Collateral history of the acute presentation and recent deterioration, his symptoms, fluctuating levels of confusion, diurnal variation, sleep pattern.	2	0 1 2
C.	History of his premorbid state in context of the AD diagnosis and his functional impairment. Especially safety issues such as risks to Mabel/others. e.g. violence, sexual assault. Risks to himself re poor self-care – intake, wandering, self-injury or accidental injury. Medication history and compliance.	2	0 1 2
D.	Elicit his past medical history, his family history, personal history re his coping and personality before development of AD, substance use history.	2	0 1 2
	Up to a maximum of 6 marks in total TOTAL:		

<u>Note to Examiners:</u> Final mark is set at not more than 6. (i.e. if they score more, final mark is still 6)

Modified Essay Question 3

Paul recovers from his acute confusional state.

Question 3.3 (4 marks)

Discuss the medicolegal issues that are likely to arise regarding Paul's future care needs.

		worth	Mark (circle)
A	Assessment of competency and his ability to consent once he's no longer acutely confused.	1	0 1
B	Medicolegal provisions – potential enactment or role for Enduring Power of Attorney or the need for a Guardianship Order if EPOA not already in place. • Principal of the least restrictive order possible, under Guardianship law • Identification of a suitable Welfare Guardian &/or Property Manager • Consider the need for a specific Guardianship order regarding compulsory placement in a Dementia Care Facility • Social worker to ensure independent legal advice for patient and family, e.g. regarding future provisions such as his will, estate, bequests.	3	0 1 2 3
C	Driving issues – may need reporting, notification of licensing authorities.	1	0 1
D	Ongoing treatment of mental disorder – possible role of Mental Health Act.	1	0 1
	Up to a maximum of 4 marks in total TOTAL:		

<u>Note to Examiners:</u> Final mark is set at not more than 4. (i.e. if they score more, final mark is still 4)

MODIFIED ESSAY QUESTION 4

Modified Essay Question 4: (21 marks)

You are working as a junior consultant in a community mental health team and have been referred a patient, George. His GP mentions concerns about an increase in anxiety and distress, and concern from his workplace that he is not leaving work until 9.00pm most nights due to him having to check what he has done repeatedly including checking all the doors and windows are locked, rattling the door handles for several minutes. He is under a final review at work and likely to lose his job.

The GP referral letter tells you George is a 24 year old man with a past history of Obsessive Compulsive Disorder (treated from age 17 by his GP with medication). At that time he had obsessions of contamination and compulsive rituals with excessive hand washing. Since then, he has generally been functioning well until the last year. The GP's letter indicates that his fears of contamination are not currently prominent but had been replaced by other obsessions. He lives at home with his partner and they have just had their first child.

Question 4.1 (6 marks)

Outline the key aspects of your assessment.

		worth	mark (circle)
A	Review of George's presentation • Symptoms of OCD – now apparently obsessional doubt and checking compulsions – clarify time period over which the Sx have worsened, & exact nature of the obsessions and compulsions at work and home. • Review for other anxiety disorders • Review for comorbid mood problems • Assessment of risk because of his distress and the impact on his job • Current and past medication and its efficacy/problems • Substance abuse history – re self treatment • Recent stressors – birth of first child and job under threat	3	0 1 2 3
B	Review his records • Details of past treatment for OCD under youth services and what was beneficial at that time	1	0 1
C	Get collateral history from partner • His recent level of functioning and impact of his symptoms • Current stressors • Her concerns re his risk of self-harm	2	0 1 2
	Up to a maximum of 6 marks in total **TOTAL:**		

<u>Note to Examiners:</u> Final mark is set at not more than 6. (i.e. if they score more, final mark is still 6)

Modified Essay Question 4

George's partner reports concern about his long hours at work and that he constantly seeks reassurance from her regarding his obsessions at home, e.g. checking things are switched off and whether he has knocked someone over on the way to work. She also reports that she thinks George is avoiding involvement with the baby, which worries her.

George says his partner has become increasingly frustrated by his behaviour and he is worried that he may lose his job and his relationship. He is consumed by his obsessional thinking and avoids touching their baby saying he's concerned he might harm her. He reports thinking he may be becoming a paedophile because he has thoughts of touching his baby which he finds abhorrent. He is thus avoiding touching her. He reports feeling increasingly hopeless that things will ever stop.

He reports feeling very distressed by his obsessions and that although he sees the stress they are causing his wife he cannot stop the checking or reassurance-seeking. He has been drinking increasing amounts of wine over the last few months, which he reports is the only thing that helps.

Question 4.2 (6 marks)

Outline the key aspects of your Risk Assessment.

		worth	mark (circle)
A	<u>Risk of suicide</u> • Intent, plans, whether has been close to acting on his ideas • Timeline of feeling more hopeless and distressed by his symptoms • Hope for improvement and future-orientation • Protective factors – moral or religious beliefs, family support etc. • Ongoing stressors that add risk • Presence of comorbid depression – check History and Symptoms • Past history of suicidal ideation, esp. when OCD was worse in the past	3	0 1 2 3
B	<u>Risk to his daughter and family</u> • Careful assessment of egodystonic nature of obsessional thoughts regarding his daughter (re OCD vs paedophilia) • Whether he has ever acted on these thoughts • History of any past similar obsessional thoughts, and consequences • Collateral from partner re her concerns about her daughter • Consideration of informing appropriate Child Welfare services (consider this if diagnosis is *not* OCD or if OCD is so severe and unresponsive to treatment that his wife and daughter are adversely affected)	2	0 1 2
C	<u>Risks from his alcohol use</u> • His level of functioning and the impact of drinking on his life – when does he drink? Is he ever drunk when with his child? Amount drunk & time course of worsening? Sx of dependency vs abuse, etc. • Any medical sequelae (falls, injuries, GI Sx, blackouts etc.) • Any social/legal sequelae (drunk driving, work impairment, etc.)	2	0 1 2
	Up to a maximum of 6 marks in total **TOTAL:**		

<u>Note to Examiners:</u> Final mark is set at not more than 6. (i.e. if they score more, final mark is still 6)

Modified Essay Question 4

From your assessment you make a diagnosis of Obsessive Compulsive Disorder (OCD) with obsessional thoughts of doubt and compulsive checking. He also has obsessions about sexually interfering with his daughter with avoidance of touching her or repeated reassurance-seeking if he does. You also diagnose a single episode of depression which started after the OCD worsened. The suicide risk you assess as low to moderate (in that it could increase if he were to feel more hopeless but currently does not involve suicidal planning or intent).

George reports he had previously been on 40mg/day Fluoxetine from age 17 and had found it helpful. He came off this after discussion with his GP about four years ago because he was managing reasonably. Since then, things have become increasingly difficult and about a year ago he recommenced Fluoxetine and again increased this to 40mg. However in view of the lack of effect, he had recently changed this to Sertraline, currently at a dose of 100mg. George reports little benefit from this and is feeling increasingly hopeless that things will improve.

Question 4.3 (9 marks)

Outline your overall management plan. Cover the psychological and pharmacological interventions in detail.

		worth	mark (circle)
A	<u>Psychological treatment – Exposure and response prevention</u> • Psychoeducation • Develop graded hierarchy of rituals, safety behaviours and avoidance • Exposure and response prevention – in vivo and as homework • Avoid reassurance and check for patient's use of cognitive rituals	3	0 1 2 3
B	<u>Psychological treatment – Metacognitive treatment</u> • Psychoeducation and explanation of model and duration - 10-20 sessions, need for a therapeutic contract • Metabeliefs – inflated responsibility, over importance of thoughts (thought/action fusion), overestimation of threat, importance of controlling thoughts, intolerance of uncertainty, perfectionism • Thought challenging for meta-beliefs • Detached mindfulness • Behavioural experiments aimed at reducing rituals, safety behaviours and avoidance	2	0 1 2
C	<u>Medication</u> • Increase Sertraline to maximum of 200mg (do an ECG at that time) • Duration – at least 10-12 weeks • Trial of a further SSRI also at high dose if Sertraline ineffective • Consideration of change to Clomipramine or augmentation with Risperidone or Aripiprazole.	3	0 1 2 3
D	<u>Involvement of family</u> • Psychoeducation for spouse/family about OCD and the model of treatment • Ongoing support – involvement of his wife in some treatment sessions	2	0 1 2
	Up to a maximum of 9 marks in total	**TOTAL:**	

<u>Note to Examiners:</u> Final mark is set at not more than 9. (i.e. if they score more, final mark is still 9)

MODIFIED ESSAY QUESTION 5

Modified Essay Question 5: (26 marks)

You are a consultant psychiatrist who is on duty for the day. You take a phone call from a General Practitioner. He just seen a 30 year old woman called Anna who has presented at his surgery today for the result of a pregnancy test. He is concerned as she is talking quickly, is irritable and difficult to interrupt. She says she has had difficulty sleeping but otherwise she feels 'fine', and is unhappy he is ringing the hospital. He has only seen her a few times before for routine medical issues, and she was nothing like this. She lives with her husband, and has one child aged two.

The GP is able to tell you that she has had a history of depression including a postnatal depression after her two year old child was born, but as she moved to this country from across the Tasman in the past year he has only a little information available.

Anna then insists that you phone her husband so that he can tell you that she is 'fine'.

Question 5.1 (5 marks)

Outline the key information you would want to obtain from these two phone calls, so as to make an initial safety plan.

		worth	Mark (circle)
A	Further history from GP – • Any additional information – e.g. is she on medication / was she admitted to hospital in the past / what treatment did she have? • What is the result of the pregnancy test? • Any relevant physical history	2	0 1 2
B	Collateral history from husband – • Her recent level of functioning • Timeline of this deterioration • Impact on her care of their 2 year old child • His understanding of her past episodes of depression and what treatment was involved – as per history from GP • Any risk to self, risk to their child, any impaired self-care • Current medication? • History of substance abuse • Are there any other close supports you should get collateral from?	3	0 1 2 3
	Up to a maximum of 5 marks in total TOTAL:		

<u>Note to Examiners:</u> Final mark is set at not more than 5. (i.e. if they score more, final mark is still 5)

Modified Essay Question 5

The GP says Anna is 6 weeks pregnant, and recently restarted citalopram 20mg from a supply she had 'left over' at home, as she had 'not been feeling quite right'.

Anna's husband says that she was severely depressed in the past on three occasions since age 17, and was treated successfully with antidepressants in the community with mental health team follow up. She had an episode 2 weeks after the birth of her first child where she was sleepless and very irritable. Her husband says the clinicians discussed Bipolar Disorder, but he and Anna thought she was exhausted after a difficult labour. She was given sodium valproate at that time, but stopped it after 3 months because she did not think she needed it any more.

Her husband has been very worried about Anna for the past week as she has not been sleeping at all, and has been extremely irritated by their two year old. He heard her yelling and swearing at the child yesterday. He stayed home from work due to his concerns and is exhausted, and unable to care for her at home any more. He says he can bring her to the hospital for assessment.

Question 5.2 (9 marks)

Outline your approach to Anna's assessment, especially regarding the risk assessment.

		worth	mark (circle)
A	Setting up the assessment – practicalities: • Need for an involuntary assessment if in fact Anna refuses to attend • Interview Anna's husband independently	2	0 1 2
B	Interview with Anna – mental state aspects to assess: • Mood and affect • Level of agitation and distress • Any psychosis (particularly delusions centred on her child) • Insight re the impact of illness on her family and her attitude to treatment	2	0 1 2
C	Risk Assessment (from Anna and collateral from husband): • Thoughts and feelings towards 2 year old child • Reasons for the outburst - whether irritability or psychosis-driven • What is the worst thing she has done? Has she ever hit her child? • Relationship with her 2 year old historically? (ideally also whether the child was planned/wanted and any difficulty with the pregnancy and birth)	3	0 1 2 3
D	Background History for Context: • How does she feel about being pregnant – was it planned and does her husband know ? • Does she have feelings about the baby in utero? • What's Anna's own experience of being parented? Any history of trauma or abuse? • What are her supportive relationships like? Adequate supports? • Has she been angry or aggressive towards her husband or others – coping with anger and her premorbid personality.	3	0 1 2 3
	Up to a maximum of 9 marks in total	**TOTAL:**	

Note to Examiners: Final mark is set at not more than 9. (i.e. if they score more, final mark is still 9)

Modified Essay Question 5

You decide to admit Anna to inpatient care under the Mental Health Act due the severity of her manic state, which includes psychotic thoughts about her daughter. She is very distressed and you consider her a high AWOL risk.

Question 5.3 (6 marks)

Outline your initial ward management plan for Anna including medication. How does her pregnancy impact on your prescribing?

		worth	mark (circle)
A	Nursing Care • Set in place required level of nursing observations • Low stimulus, safe environment (likely to be a closed HDU/ICU type of setting initially)	1	0 1
B	Medication • Consider stopping the antidepressant • Consider starting anti-manic medication such as an atypical antipsychotic • Consult specialist perinatal service if available (or pharmacist/drug information services) regarding risk profiles of medications in pregnancy • Avoid use of sodium valproate, carbamazepine and to a lesser extent lithium, due to risk of teratogenesis • Carefully document the rationale and issues, for all medications used.	3	0 1 2 3
C	Interactions with Anna and her husband • Education and reassurance • Fully discuss any medications prescribed and any possible effect on the foetus with Anna's husband, and with Anna herself as she gets better • Fully document all discussions with the family regarding management and medication	2	0 1 2
D	Social Interventions • Inpatient social worker to assess home situation esp. care of the 2 year old • Consider potential Care and Protection issues.	1	0 1
	Up to a maximum of 6 marks in total	**TOTAL:**	

Note to Examiners: Final mark is set at not more than 6. (i.e. if they score more, final mark is still 6)

Modified Essay Question 5

Anna recovers quickly from her psychotic manic episode on Olanzapine 10mg daily, and is discharged home two weeks later. You are treating her as an out-patient and she is now six months pregnant.

Question 5.4 (6 marks)

Outline your management plan in the lead up to the birth, regarding risk management and the birth period management plan.

		worth	mark (circle)
A	Risk Management Plan • Thorough psychoeducation and support (possibly use motivational interviewing principles) to improve her and husband's insight. Aim to improve acceptance of diagnosis of Bipolar 1 Disorder, and her medication adherence. • Relapse-Prevention and Early Warning Signs plan. Discuss risk of relapse: with a Bipolar 1 diagnosis, Anna's risk of relapse post-partum is up to 50% (very high). Include her husband, GP and other key supports in an early warning network. Ensure they have 24/7 Crisis contact numbers. • Close follow-up from your community team – keyworker, see very regularly, check medication adherence, adverse effects, overall coping and improve engagement. • Involve midwife, obstetrician, GP and any other relevant clinicians in the management plan. • Consider interventions such as 'Interpersonal and Social Rhythm Therapy' for self-management. • Consider need for support via extended family or funded caregiver assistance, to assist with 2 year old child's care.	3	0 1 2 3
B	• Case conference to set in place the Birth Management Plan • Written Birth Management Plan copy held by all involved parties • Plan to include: ▪ Medication plan across this time (e.g. may be complex if lithium is used in later trimesters, then ceased across birth, then restarted) ▪ Early warning signs and crisis contact plan (how to access the relevant clinicians and crisis services) ▪ Reminder of other supports available to Anna and how to access these ▪ Plan for care of older child if Anna does become unwell ▪ Plan to maximise sleep in early postpartum period including expressing milk, use of hypnotic medication, etc.	3	0 1 2 3
	Up to a maximum of 6 marks in total	**TOTAL:**	

<u>Note to Examiners:</u> Final mark is set at not more than 6. (i.e. if they score more, final mark is still 6)

MODIFIED ESSAY QUESTION 6

Modified Essay Question 6: (26 marks)

You are a consultant psychiatrist working after hours in the Emergency Department. Fred is a 19 year old indigenous man bought in by his parents after he made threats to assault a 7 year old boy – the neighbour's child – who was playing with his younger brother.

Fred had been noted to be increasingly agitated and pacing around the house, and a kitchen knife was found underneath his bed. His parents report a 3-4 month decline in functioning due to his increasingly odd behaviour and say he has been spending increasing time in his bedroom with the curtains drawn. They strongly suspect that he is again using cannabis.

Fred has had one prior brief admission to a psychiatric hospital at the age of 17 after he assaulted a classmate at his school during a period of heavy cannabis use. He spent a short period of time in hospital and was discharged without treatment or follow-up as he was not then presenting with features of mental illness.

Question 6.1 (8 marks)

Outline the key aspects to your assessment, including your approach to the interview and the sources of information, in order to make an initial risk assessment.

		worth	mark (circle)
A	<u>Approach to interview</u> • Need to arrange for a cultural support worker if possible • Safety – determine need for Security staff as back-up, physical layout (escape points), carry a duress alarm, etc. • Arrange to talk with parents independent of Fred	2	0 1 2
B	<u>Review Fred's records</u> • Details of past psychiatric history esp. the admission, including mental state findings when last unwell • Details of past assault (seriousness, what drove his actions)	2	0 1 2
C	<u>Detailed history from Fred and his parents</u> • Recent level of functioning • Any evidence of psychotic symptoms (paranoia / other odd thoughts, hallucinations, concerns re the neighbour's boy / other symptoms) • Drug and alcohol use • History of violence (including the past known assault) • Recent irritability, anger, threats of violence • Self harm/suicidality	3	0 1 2 3
D	<u>Mental State Examination</u> • Evidence of psychosis (delusions—e.g. paranoia, passivity, hallucinations, thought disorder) • Why did he threaten the neighbour's boy – and his ongoing intent, plus any other thoughts of harm to others or himself • Mood and affect (arousal, intensity) • Insight or lack of it, judgement, etc.	2	0 1 2
	Up to a maximum of 8 marks in total **TOTAL:**		

<u>Note to Examiners:</u> Final mark is set at not more than 8. (i.e. if they score more, final mark is still 8)

Modified Essay Question 6

Background information regarding Fred's admission at age 17 indicated that he presented as perplexed, guarded, and acutely paranoid. He reported that the victim of the assault was a classmate who had been "messing with my thoughts". He was treated with PRN benzodiazepines and discharged after 5 days having failed to engage with the treating team, with a diagnosis of a drug induced psychosis.

His parents report that Fred had been "not his usual self" for a few months after discharge. They report no history of violence or conduct problems. They say he had seemed confused and fearful for the past few weeks and that they were away from the house a lot through this time due to Fred's grandfather being sick in hospital.

Fred presents with a perplexed and fearful demeanour and is preoccupied with the intentions of the neighbour's boy.

Question 6.2 (8 marks)

Give a risk formulation for Fred (with consideration of the key mental state and environmental factors).

		worth	mark (circle)
A	Risk Behaviours • Past manual assault • threats to assault the neighbour's 7 year old boy • keeping a knife under his bed	2	0 1 2
B	Internal / Mental state factors *Past violence:* • Possible passivity phenomena driving past assault • Acute paranoia, perplexed affect at that time *Current mental state risk factors:* • Perplexed and fearful • Pre-occupied with 7 year old boy (? paranoid and/or passivity phenomena)	2	0 1 2
C	External / environmental factors • Cannabis use • Access to victim (neighbour's boy) • Access to weapons (knives) • Reduced level of parental supervision (sick grandfather) • Stress due to his grandfather being unwell	2	0 1 2
D	Answer demonstrates the ability to formulate these risk factors coherently and at a sophisticated level. (i.e. to synthesise the information, not just list it).	2	0 1 2
	Up to a maximum of 8 marks in total	**TOTAL:**	

Note to Examiners: Final mark is set at not more than 8. (i.e. if they score more, final mark is still 8)

Modified Essay Question 6

Fred is admitted for an inpatient assessment under the Mental Health Act. He presents with features of a psychotic episode characterized by passivity phenomena (thought insertion), concerns that he is being watched by cameras, and disordered thinking. After one week Fred reports that the neighbour's 7 year old boy is putting thoughts into his head and that he wants to "take him out". Later that day, Fred goes absent from the ward.

Question 6.3 (4 marks)

Outline your management of this situation with regards to immediate risk management and the ethical and legal issues.

		worth	mark (circle)
A	Immediate Risk Management • Need to contact police. • Need to contact parents/family and the neighbour family where the boy lives (ask them to call the police and the inpatient unit if he turns up).	2	0 1 2
B	Legal & Ethical considerations • Issues relating to duty to warn the neighbours. • Mental Health Act issues – that the nature of Fred's illness and severity of the risk warrants use of the MHAct and Fred's retrieval/police assistance to return him to hospital and continue his treatment there. • Ethical issues related to the decision to breach Fred's privacy (autonomy, beneficence, non-maleficence).	2	0 1 2
	Up to a maximum of 4 marks in total	**TOTAL:**	

Note to Examiners: Final mark is set at not more than 4. (i.e. if they score more, final mark is still 4)

Modified Essay Question 6

Fred is safely returned to the ward without incident. Four weeks later you are considering his discharge from hospital to his parents' home under the care of an Early Intervention community mental health team. His mental state has stabilised on treatment with an oral atypical antipsychotic. His insight into his illness remains limited.

Question 6.4 (6 marks)

Outline the key aspects to his Risk Management plan, with regard to the risk formulation, which you would want to implement with the follow-up team.

		worth	mark (circle)
C	<u>Management of Mental State factors</u> • Need for close medication monitoring • Consideration of depot medication • Consideration of need for ongoing Mental Health Act • Comprehensive monitoring of mental state in community including a careful handover from ward to community team. Discussion of 'duty to warn' issues with follow-up team • Psychoeducation and other possible psychological interventions • Close monitoring of his thoughts about the neighbour's boy	3	0 1 2 3
D	<u>Management of environmental / external factors</u> • Family engagement and education with assistance from cultural support workers, as part of his support and monitoring network • Ensure adequate supervision and support at home with consideration of supported accommodation options if Fred and family prefer this • Address his cannabis use (education, motivational interviewing, refer to A&D service) • Ensure no access to controlled weapons (e.g. firearms)	2	0 1 2
E	<u>Crisis Management</u> • Fred and family to be aware of emergency contacts (24/7 access) • Ensure a Crisis Management Plan is formulated with Fred and his family including Early Warning Signs, and actions to take if these arise.	2	0 1 2
	Up to a maximum of 6 marks in total	**TOTAL:**	

<u>Note to Examiners:</u> Final mark is set at not more than 6. (i.e. if they score more, final mark is still 6)