THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS

MOCK WRITTENS ESSAY PAPER 2017

(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 a full 3-hour paper and practising the technique of the different question types. If you disagree with the factual detail of an answer, research the issue and decide for yourself.

For the MEQs in particular, it's suggested that you refer to this guide when marking: https://www.ranzcp.org/Files/PreFellowship/2012-Fellowship-Program/Exam-Centre/Essay-style/MEQ-Instructions-to-Examiners-1501209.aspx

Critical Essay Question (40 marks)

In essay form, critically discuss this quotation from different points of view relevant to the practice of psychiatry and provide your conclusion.

"Meditation and Mindfulness skills are now a 'must have' if you wish to be healthy, happy and thrive in your work and life."

(from a website advertising Mindfulness training)

Reminder about marking process:
These are from the newest 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	**Proficiency level**	This part's pretty self-evident. NB: Illegible handwriting isn't specifically scored here, although if a significant problem it's likely to reduce the marks elsewhere. It won't be an issue from 2017 when this paper switches to being done on computer.
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 2	
The spelling, grammar and vocabulary are acceptable and the candidate demonstrates good capacity for written expression.	3 4	
The candidate displays a highly sophisticated level of written expression.	5	

2. Critical Evaluation and Grasp of the Quote (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**	This is about understanding the actual quote – in this case it's a pretty simple one so that shouldn't be difficult. Ideally, candidates will note the quote is from an advertisement thus may comment that it makes an exaggerated and sweeping statement. The concepts of meditation and especially Mindfulness MUST be defined here. The meaning of "must have" might also usefully be explained, in popular culture slang terms. Skepticism regarding the statement in the quote or at least a mention that it's a one-sided or extreme POV should be mentioned, and that the candidate intends to examine the pros and cons in their essay.
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 2	
The candidate demonstrates an understanding of the statement/question's meaning at superficial as well as deeper or more abstract levels.	3 4	
One or more valid interpretations are offered that display depth and breadth of understanding around the statement/question as well as background knowledge.	5	

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	This, and 4. below are the body of the central arguments of the essay.
		The quote is an extreme statement so the candidate needs to explore both POVs – that meditation and Mindfulness are essential and extremely valuable, versus the opposing POV that they're not all they're cracked up to be, or indeed, can actually be harmful.
		Points for critical thinking and an organised approach, laying out the various points. Expect to see:
		• Points about the benefits of meditation/Mindfulness
		  ○ In life generally, for individuals
		  ○ In mental health work
		  ○ In the workplace generally
		• Need some evidence-base ideally, with mention of research into it and links back to Marsha Linehan re-introducing old meditation techniques that have been around 1000s of years, into DBT as Rx for Borderline patients.
		  ○ Linehan's research
		  ○ Other DBT research
		  ○ Broader studies into benefits of Mindfulness as a technique for emotional stability and stress-management
		  ○ Examples of the history & culture of meditation as a long tradition of spiritual practice, more recently used more for stress reduction (Buddhism, Zen, Hinduism, prayer, association with yoga, etc.)
		• Opposing POV, regarding the "faddishness" of everyone adopting and touting Mindfulness and meditation as always good and good for all (the 'must have' aspect). Ideally, mention of the psychology of fads and fashions.
		• Opposing POV about the adverse effects of Mindfulness and meditation
		  ○ Known to cause serious adverse reactions in some trying it – e.g. anxiety, panic Sx, psychotic breaks, relapses of serious mental illness like BPAD, etc. Not common but not unknown.
		  ○ Recent research about Mindfulness practice impeding learning as it interferes with automatic habit-formation
		  ○ Historically, was a serious spiritual practice and spiritual leaders acknowledged that it wasn't for everyone and could have adverse affects esp. if practiced intensely. Need for a teacher/guide, which is often overlooked in the modern world where people can get the basic skills on-line with little or no guidance.
		• Mention that the ad's POV is bound to be extreme as they're selling a product for financial gain. Other leaders in the field may at times "oversell" the techniques due to being psychologically/narcissistically invested in it
		• Mention that these are psychological interventions, and as ever, important to take a balanced approach to interventions – e.g. some conditions require medication and could not be managed with this approach alone.
		• etc. 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 2	
The points in this essay follow logically to demonstrate the argument and are adequately developed.	3 4	
The candidate demonstrates a sophisticated level of reasoning and logical argument, and most or all the arguments are relevant.	5	

4. Critical reasoning - accuracy (Competency: ME, Scholar)

Information cited in the essay is factually correct.	**Proficiency level**	Closely linked to 3. above, so this is the place to score for accuracy of arguments and for an accurate evidence base being provided – or not.
There are significant errors of fact that, if used as a basis for treatment planning, could pose a risk to patients.	0	
There are errors of fact that are multiple and/or substantial, but without the element of significant risk to patients.	1 2	
Assertions made are generally correct, with no major errors of fact.	3 4	
There are no major errors of fact and the level of relevant factual knowledge is higher than average (e.g. accurately quoted literature).	5	

5. Breadth/Maturity/Advocacy/Culture (Competency: Medical Expert, Health 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**	Clearly plenty of opportunity to link back to the history of meditation and Mindfulness practices, and to the more recent history of its resurgence with DBT etc. This also gives cultural connections and depth – influences from Asian cultures, and from all religions which involve prayer and meditation. Should be mention of the psychiatrist's advocacy role in this – understanding this intervention and being able to incorporate it into treatment where appropriate, and, as with many more intensive psychological interventions, where to avoid it as too risky. Ideally, some mention of the need for holistic approaches to treatment and to the mind-body continuum would be good – i.e. the need for balance.
As relevant to the question or statement: 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 the 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 2	
The candidate demonstrates an acceptable level of cultural sensitivity and/or historical context and/or broader models of health and illness and/or the role of psychiatrist as advocate relevant to the question/statement.	3 4	
The candidate demonstrates a superior level of awareness and knowledge in these areas relevant to the statement/question.	5	

6. Ethical Awareness (Competency: Professional)

The candidate demonstrates appropriate ethical awareness	**Proficiency level**	Note should be made that quote is from an advertisement and we don't have the rest of the page – but the ad may be ethically dubious as it's an extreme statement designed to attract customers and make money, so the risks of this practice may be underplayed or not even mentioned. More importantly, there needs to be mention of our work as psychiatrists and our ethical responsibility to read up and understand these techniques so we can advocate responsibly for or against them with individual patients, and can provide appropriate and accurate information. Issues of beneficence – these techniques may help our patients, ourselves, and our colleagues. versus non-maleficence – the need to avoid adverse effects from recommending these techniques to our patients, or using them ourselves or with work colleagues.
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 2	
The candidate demonstrates an appropriate awareness of relevant ethicalissues.	3 4	
The candidate demonstrates a superior level of knowledge or awareness of relevant ethical issues.	5	

7. Clinical Context (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**	These techniques are largely used in a clinical context in the mental health sphere so the links are clear and should be touched on in the body of the essay. The ad also advocates for them in the workplace, and mention could be made of them as stress-management methods for staff working in a challenging field. May usefully be a brief mention of other stress-management techniques used clinically, with which these share features – like visualisation, breathing techniques, and progressive muscle relaxation in anxiety management.
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 itis tenuous or the links made are unrealistic.	1 2	
The candidate is able to apply the arguments and conclusions to the clinical context, and/or apply clinical experience in their arguments.	3 4	
The candidate makes links to the clinical context that appear very well-informed and show an above average level of insight.	5	

8. 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 2	
The candidate is able to draw a conclusion/s that is justified by the arguments they have raised.	3 4	
The candidate demonstrates an above average level of sophistication in the conclusion/s drawn, and they are well supported by the arguments raised.	5	

These domains for the CEQ scoring add up to exactly 40. Score = /40.

MODIFIED ESSAY QUESTION 1

Modified Essay Question 1: (24 marks)

You are a junior consultant working in the community and have received a referral for Jacob, aged 25, from the inpatient psychiatric unit. He has recently been discharged from hospital and is on risperidone 1 mg nocte. He remains under compulsory treatment.

Jacob attends an initial interview with his parents. He reports that his symptoms have improved over the last fortnight, but mentioned seeing special meaning in road signs and billboards on the way to his appointment with you. The discharge note from the inpatient unit indicates that he reported bizarre beliefs on admission and expressed fears that his father was going to kill him with a chainsaw. He also had grandiose thoughts such as that he had superpowers.

Question 1.1 (8 marks)

Outline the key aspects of your initial risk assessment for Jacob.

		worth	mark (circle)
A	Assessment of current psychotic symptoms, including a mental status examination and the degree of improvement since admission.	1	0 1
B	Review current pharmacotherapy, including the appropriateness of the medication and the dosage for Jacob's condition. Also review adherence to treatment and screen for side effects.	2	0 1 2
C	Current alcohol and drug use.	1	0 1
D	Assess specific risks, including any thoughts related to father wanting to kill him, any steps taken to defend himself, any past history of violence and the likelihood Jacob would act on apparent illness-related beliefs.	2	0 1
E	Assess engagement in treatment and follow up, including the capacity to establish a therapeutic alliance and level of insight. Evaluate his willingness to follow through with treatment recommendations.	2	0 1 2
F	Get collateral information about risk. Obtain information from parents around: • initial presentation • progress since admission • behaviour, including aggression • how comfortable are his parents to have Jacob at home	2	0 1 2
G	Review discharge documents and discuss case with inpatient clinicians. Review the admission notes and initial risk assessment. Review diagnosis, progress on unit and symptomatic improvement.	1	0 1
	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 1

Jacob is unemployed and living with his parents. He has not been in employment since leaving school five years earlier and is spending most of his time studying topics of special interest to him, which include numerology, psychology, theories on the illuminati and other conspiracies. He mentions using cannabis consistently for two years in his early twenties but says he has not smoked for the previous three years.

Collateral history from his mother confirms that Jacob was under mental health services as a child, at which time he was given diagnoses of ADHD, Specific Learning Disabilities, and Dyspraxia. She mentions that he seemed to be directionless over the previous five years and was isolating himself in his room while researching his special interest topics. She asks whether his functioning will improve, with follow-up.

Question 1.2 (8 marks)

Discuss the key information you will seek in your assessment of Jacob's functioning (both current and historic).

		worth	mark (circle)
A.	Get a developmental history including milestones and scholastic performance (review school reports if available). Estimate his past likely IQ.	2	0 1 2
B.	Clarify the past Child & Adolescent Mental Health Service care and outcome. Review past diagnoses, including extent of learning disabilities and dyspraxia and any contribution from underlying neurological difficulties. Review the past diagnosis of ADHD, treatments recommended and responses to these. Review his old notes for evidence of depression or low self-esteem.	2	0 1 2
C.	Review his history of social relationships, including with peers and any intimate relationships.	1	0 1
D.	Clarify the nature and extent of past and present substance use. Consider a urinary drug screen if not already done.	1	0 1
E.	Obtain a detailed picture of his current activities of daily living and what he does with his time.	1	0 1
F.	Clarify the nature and extent of any decline in functioning over time.	1	0 1
G.	From his records and collateral, estimate the Duration of Untreated Psychosis (DUP) as an important prognostic factor.	1	0 1
H.	Clarify his parents' expectations of treatment and their management of any problems at home.	1	0 1
	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 1

It is two months later and Jacob's case manager reports that he has not made much progress. Jacob's continues to spend most of his time at home. His case manager is concerned that he is depressed but he does not seem suicidal.

She also mentioned that he has disclosed to her that he has been accessing objectionable sites on the internet, which include pornographic material. Closer questioning has revealed a fascination with images of minors. She further mentioned that he has expressed guilt at this behaviour but noted that he has been unable to cease accessing the sites.

Question 1.3 (8 marks)

In light of this development, discuss your plan to assess and manage Jacob's current risks to children, including his accessing of child pornography.

		worth	mark (circle)
A.	Obtain a psychosexual history, including any history of sexual abuse.	1	0 1
B.	Explore the extent and content of internet access.	1	0 1
C.	Clarify whether there is a history of offending, particularly sexual offending.	1	0 1
D.	Clarify the reported feelings of guilt relating to Jacob's internet use and evaluate his capacity to make changes.	1	0 1
E.	Clarify access to children in his current environment.	1	0 1
F.	Consider disclosure to family or statutory agencies (usually mandatory if significant risks to children are uncovered).	1	0 1
G.	Consider referral to forensic services for another opinion.	1	0 1
H.	Consider referral to appropriate agencies (such as those working with young males with a potential for sexual offending) for further (usually psychological) treatment.	1	0 1
I.	Consider helping him find acceptable alternatives to internet use to occupy his time, or restricting his access to the internet.	1	0 1
J.	Explore symptoms of depression and consider treatment.	1	0 1
	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 2

Modified Essay Question 2 (25 marks)

You are phoned by a junior registrar in the early hours of the morning about Damien, aged 32, who is being restrained in the Emergency Department because of aggression and threatening to punch staff. Damien had been brought to the ED by police, having climbed onto the bridge railings of a pedestrian motorway overpass, and having threatened to kill himself by jumping off.

There is a history of poly-substance abuse and intermittent intravenous use of illicit substances. Damien has an established diagnosis of antisocial personality disorder with an extensive criminal history dating back to age 16, including violent offences.

Due to Damien's aggression and lack of co-operation the registrar has been unable to interview him. However, similar presentations in the past have resulted in brief involuntary admissions, with Damien having been released after several days 'without evidence of a mental disorder'. The registrar suggests this presentation is 'bad behaviour' rather than 'mental illness' and is asking your opinion on discharging Damien.

Question 2.1 (7 marks)
Outline what would need to be assessed before Damien could be safely discharged.

		worth	mark (circle)
A	Risk assessment to ensure he's safe for discharge. Especially: • Details of recent dangerous behaviour. Planning, and intent regarding climbing bridge rails. Precipitants, thought processes, emotional state • Attitude to potential harm to others from jumping onto busy motorway • Attitude to the suicide attempt (remorse vs intent to repeat it) • Current suicidal, aggressive or homicidal ideas and intent • Clarify the risk history from his records (self and others) • Disposition and environment – where would he go, degree of support, would risks be worsened there? etc.	3	0 1 2 3
B	Check for psychiatric disorders (co-morbid or substance-induced) that might require treatment • Depression: co-occurs in 25% with ASPD, or depression due to stimulant withdrawal. • Elevated mood/aggression, e.g. from stimulant intoxication • Psychotic disorder (comorbid or caused by drug use) • Anxiety disorder: co-occurs in 50% with ASPD, or from opiate withdrawal	3	0 1 2 3
C	Rule out organicity – delirium due to an acute medical condition that would require treatment • Medical complications of IV drug use – haemorrhagic &/or ischemic strokes; infections – septicaemia, infective endocarditis, infectious meningitis or encephalopathy; embolization - infective or street drug contaminants • Medical complications of intoxication or withdrawal e.g. encephalitis (solvents), DTs or seizure activity (alcohol, benzodiazepines), electrolytes and water (MDMA), etc. • Injury – as a result of accident, violence from others, deliberate self harm or police restraint (e.g. head injury, wounds, fractures, overdose)	3	0 1 2 3
	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

Damien is admitted under the Mental Health Act to the acute psychiatric unit.
The police request a copy of the psychiatric assessment, and ask to be informed when Damien is released so that they can arrest him.

Question 2.2 (5 marks)
Outline the ethical and legal issues arising from the police requests, and how you might address these.

		worth	mark (circle)
A	Key Ethical issues: • *Autonomy* – regarding Damien's right for confidentiality of health information • *Non-maleficence* – the need not to cause harm to Damien by our actions How you might address these: • Need to fully disclose the need to share information with the police prior to assessment/treatment commencing, and you should only inform the police with Damien's written informed consent if he's competent. • BUT (non-maleficence) – need to weigh up the above against Damien's mental state to ensure you don't increase his risks by full disclosure if he's not competent to take part in decisions. • Need to weigh up the various risks – the need to respect Damien's autonomy must be balanced against autonomy of others. i.e. degree of risk from Damien to the safety of others. This could outweigh the need to maintain his confidentiality. NB: there are of course issues of *Beneficence* in the need to treat Damien, but these are not relevant to the exact question above so they gain no marks if mentioned. NB: also, candidates may mention *Justice* as there are legal issues, but 'justice' in Ethical Principles terms is a different matter and if mentioned, gains no marks.	3	0 1 2 3
B	Relevant Legislation includes: • Privacy Act • Mental Health Act • Criminal Justice Act (Damien might be on parole or bail, which could place clinician under obligation to advise the police of his whereabouts)	2	0 1 2
C	Challenging nature of case – how you might address this: • Discuss the case with respected peer(s) and get legal advice. Options could include lawyer with medical defence union, Hospital/Service/DHB lawyer, etc. (e.g. in NZ, the DAHMS or DI)	1	0 1
	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 2

After four days of assessment and treatment Damien is considered ready for discharge. He has stable vital signs, and physical examination (including neurological examination) and bloods are unremarkable. Urine screen was positive for opiates. His threatening behaviour stopped once his anger subsided, although he remains somewhat irritable. He is sleeping well but states he feels 'wired' much of the time. Accompanying somatic symptoms are strongly suggestive of anxiety. There are no psychotic symptoms and no ongoing suicidal or homicidal ideas. His partner of five years is keen that he returns home as she is expecting their first child.

Question 2.3 (7 marks)
Outline (list and justify) further areas for assessment not already covered, that would help clarify Damien's prognosis.

		worth	mark
A	Determine the degree of psychopathy – the greater the degree of psychopathy, the worse his prognosis. Might mention use of a checklist like PCL-R	1	0 1
B	Clarify the presence of comorbid psychiatric conditions such as whether his anxiety symptoms constitute an anxiety disorder, mood or psychotic disorders, attention deficit disorder	1	0 1
C	Clarify his IQ and developmental history – if he has co-morbid intellectual disability or learning disabilities that would worsen the prognosis	1	0 1
D	Assess his ability to develop rapport, empathy and form bonds with others (as suggested by his close relationship) – e.g. via collateral from his partner. This is likely to vary inversely to his psychopathy score	1	0 1
E	Clarify the nature of his defences – more primitive defences (e.g. projection, devaluation, denial, projective identification, omnipotence and splitting) indicate a worse prognosis than more neurotic defences (e.g. idealization, intellectualization, isolation, sublimation and repression)	2	0 1 2
F	Assess his substance use (severe abuse/dependency worsens his prognosis) • wheel of change evaluation • severity and details of the substance abuse and its impact on his life	2	0 1 2
G	Assess his ability to engage with services and his insight and willingness to collaborate in a treatment plan	1	0 1
	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

[Vignette repeated from 2.3]
After four days of assessment and treatment Damien is considered ready for discharge. He has stable vital signs, and physical examination (including neurological examination) and bloods are unremarkable. Urine screen was positive for opiates. His threatening behaviour stopped once his anger subsided, although he remains somewhat irritable. He is sleeping well but states he feels 'wired' much of the time. Accompanying somatic symptoms are strongly suggestive of anxiety. There are no psychotic symptoms and no ongoing suicidal or homicidal ideas. His partner of five years is keen that he returns home as she is expecting their first child.

Question 2.4 (6 marks)
Outline and justify the longer-term treatments that might be appropriate for Damien's diagnosis of Antisocial Personality Disorder, if he returns home and has out-patient follow-up.

		worth	mark
A	Main treatment for his ASPD is psychological	1	0 1
B	Develop a therapeutic relationship characterised by caring, fairness, trust, non-punitive and non-authoritarian attitudes	1	0 1
C	Pragmatic out-patient psychological interventions would be: • Psychoeducation and relapse prevention • Skill-based: e.g. social skills, problem-solving skills, anger management	2	0 1 2
D	Psychotherapy options as an out-patient would be: • CBT • DBT for his emotional dysregulation • Motivational interviewing for substance abuse, also for criminal behaviour/attitudes • Psychodynamic approach using mentalization-based therapy (Bateman & Fonagy)	2	0 1 2
E	Try to address social/environmental issues that might be worsening his ASPD • Generally pragmatic problem-solving approach • Address financial stressors if appropriate (e.g. benefit/pension) • Engage partner, address possible concerns related to her pregnancy	1	0 1
F	Avoid psychotropic medications for ASPD – no evidence that medication is effective to reduce core symptoms of ASPD as such. (Might be used with care for co-morbidities.)	1	0 1
	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

Modified Essay Question 3: (24 marks)

You are a junior consultant working in a child and adolescent team. You are asked to see Ella, aged 16, who has just been medically cleared. She was admitted overnight to a medical ward for treatment after a paracetamol overdose, and this is her first contact with mental health services. Ella's mother Sarah is present, but Ella says she will not speak with her mother in the room.

Question 3.1 (10 marks)

Outline how you would approach assessing Ella and the key information you would want to gather.

		worth	Mark (circle)
A	Interview Ella alone – she refuses to talk to you otherwise. Also promotes trust, autonomy and protects her privacy	1	0 1
B	Also talk with her mother. Essential to get mother's collateral history and perspective	1	0 1
C	History of depressive symptoms and any prior depressive episodes or self-harm	1	0 1
D	Risk assessment: • Her thinking around the overdose (expectation of lethality, degree of planning, etc.) • Thinking post-overdose (reaction to survival, current self-harm ideation and intent, access to means, plans, etc.) • Mitigating/protective factors and degree of support at home vs stressors there • Willingness to engage in follow-up and possible treatment	3	0 1 2 3
E	Personal, family, social and developmental history. Clarify the family structure and Ella's personal/social history and circumstances (family, school, friends, interests)	2	0 1 2
F	History of any other mental illness – screen for mood disorder, anxiety disorders, eating disorder, psychotic disorder, etc.	1	0 1
G	History of trauma or abuse (screen for PTSD)	1	0 1
H	Medical history and medication used, if relevant	1	0 1
I	Substance abuse history if relevant	1	0 1
	Up to a maximum of 10 marks in total TOTAL:		

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

Modified Essay Question 3

You learn that Ella has been feeling empty and low since starting high school at age 13. She took the overdose when distressed about the break up of a 3 week relationship with a 17 year old boy who she thought she would eventually marry. At the time of the overdose she wished to die, but she also texted him and several friends to "show them what he'd done to me". She has previously taken two other overdoses, both in the context of stressors. She cuts herself about twice-weekly and has previously also burnt herself with matches so as to "feel something". Her GP has prescribed fluoxetine to a maximum dose of 40mg which she reports being compliant with but says doesn't help. Her sleep and appetite are intact. She has supportive parents who have been concerned about her for some time. Her mother reports she was sexually abused by a neighbour between ages 7 – 9 (for which the neighbour has been incarcerated) and that she was bullied at primary school for being slightly overweight and wearing glasses.

Question 3.2 (4 marks)

Outline (list and justify) the most likely differential diagnoses at this point.

		worth	**Mark (circle)**
A.	Major Depressive Episode (On the basis of persistent low mood, empty feelings, suicidality)	2	0 1 2
B.	Posttraumatic Stress Disorder. (On the basis of problems coping since the abuse history and bullying, numbing, possible dissociation)	2	0 1 2
C.	Borderline personality disorder (on basis of dysthymic mood, emptiness, self-harm).	2	0 1 2
	Up to a maximum of 4 marks in total TOTAL:		

1 mark for the differential diagnosis, 2nd mark for the justification

<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 3

Ella's mother Sarah reports that she and her husband have been researching online and they wonder whether Ella has features of a borderline personality disorder. She tells you she is aware that the criteria say that diagnosis is made after age 18, but they would like to know whether this should be considered in planning treatment as she thinks it describes her daughter's experiences so well.

Question 3.3 (4 marks)

Discuss the pros and cons you would raise with Sarah as to whether emergent borderline personality disorder should be considered in someone under age 18.

		worth	Mark (circle)
Reasons to consider Borderline PD as the main differential			
A	If BPD is in fact the main diagnosis then trying to treat her depression will in the end be unproductive.	1	0 1
B	DSM-V says it's possible to diagnose it before age 18 if the symptoms have persisted for at least 1 year – which they have with Ella.	1	0 1
C	Diagnostic formulation of Ella's history of abuse and bullying explains the onset and persistence of her dysfunctional coping and personality traits.	1	0 1
Reasons to be cautious about Borderline PD as the main differential			
D	There's evidence that adults with borderline traits exhibited these as teens, but some adolescents do "grow out" of the most challenging personality features.	1	0 1
E	Might be foreclosing on a potentially stigmatising diagnosis at too early a stage.	1	0 1
F	If in fact the diagnosis is depression then she hasn't had a full trial of effective medication, and she deserves to have this.	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 3

After discussion, it is decided to include management of Borderline Personality Disorder in Ella's management plan.

Question 3.4 (6 marks)

Discuss the key aspects of your short-term and longer-term management plan for Ella.

		worth	Mark (circle)
A	Plan for her immediate safety • Discharge plan – community care with Ella at home with parents • Parents to keep her medication safe • Close support and follow-up via mental health services/Crisis Team, etc.	2	0 1 2
B	Continue community follow-up and assess further to clarify her diagnosis and response to treatments	1	0 1
C	Consider alternative medications/alternative antidepressant/changing her medication	1	0 1
D	Refer Ella for psychotherapy, based on her psychological formulation: • For a therapy with proven efficacy in Borderline PD (Cognitive Analytical Therapy, DBT or Mentalization-Based Therapy) (mention of one of these gets the 2nd mark) • No marks if CBT or IPT are suggested	2	0 1 2
E	Structured Clinical Management (as described for Borderline PD) https://www.ucl.ac.uk/psychoanalysis/people/pages/Anthony/structured_clinical_management	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 4

Modified Essay Question 4: (23 marks)

You are a junior consultant in the Consultation Liaison service of a large general hospital. You have been asked to urgently review Mr Edmonds, a 79 year old widower who normally lives alone. The surgical team are requesting a transfer to the Psychiatric Unit for Mr Edwards who is one of their post-operative patients, as he assaulted one of the nursing staff.

Question 4.1 (10 marks)

Outline your assessment in terms of your approach and the history you would seek.

		worth	mark (circle)
Approach			
A	Need to carry out a comprehensive assessment using all available sources of information. The patient might not be able to give much himself, or not accurately, if he's delirious.	1	0 1
B	Specifically, need additional information from the hospital records and staff. Need to liaise with the nursing and surgical team, regarding: • His medical and surgical past records, medical history, investigations etc. • His medical state and any complications from the surgery • The impact of the assault on staff caring for him and any countertransference • Any need for staff support and education around managing a challenging situation	3	0 1 2 3
C	Specifically, need collateral history from his family about level of support, any stressors, his living situation, his legal status (e.g. the guardianship situation).	1	0 1
D	Specifically, need collateral history from his General Practitioner (GP) about his medical background, usual medications, lead up to the admission, longer-term coping	1	0 1
Comprehensive History from all these sources			
E	Need to mention/list the most relevant headings, e.g.: • Current presentation, nature of surgery and recovery from this • Medications currently, including analgesia • Delirium-oriented history – presence and potential causes of delirium e.g. History of fluctuating levels of consciousness, disorientation, any likely medical cause • History of decline over time, emerging dementia or cognitive impairment • Past history of any other medical/psychiatric conditions and treatment • Substance use history • Risk and forensic history • Social/family history – social circumstances, level of independence and functioning • Guardianship issues – Power of Attorney assigned? Guardianship Order in place? (3 = well covered, 2 = reasonably covered, 1 = partly covered, 0 = poorly covered)	3	0 1 2 3
F	Mental State Examination – careful MSE is required esp. if he cannot give an accurate history. Checking: orientation, attention and concentration, memory, abnormal perceptions commonly seen in delirium, etc.	2	0 1 2
G	From all the above, a Risk Assessment needs to be carried out, especially regarding risk to others from aggression (e.g. if confused) and risk to self from impaired self-care	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 4

On arrival at the surgical ward you find that it's very busy and beds are urgently needed to manage the acute intake for the day. The surgical charge nurse approaches you and is verbally hostile, demanding that this "mad man" is taken to the Psychiatric Unit immediately, or that he is arrested by the police for assaulting one of her nurses.

Question 4.2 (5 marks)

Describe your response to these demands.

		worth	mark (circle)
A	Attitude: Maintain a professional and calm manner despite any provocation. Attempt to defuse. Acknowledge that the situation is stressful. Maintain focus on providing safe and appropriate care for the patient	1	0 1
B	Explain what you *can and will* do: Explain you'll assess the patient and gather necessary history and medical input then communicate with the surgical team asap. Explain that this may well be a delirium, but you need to assess the patient to be sure	1	0 1
C	Explanation what you *can't* do: Explain about patient's likely non-suitability for transfer to a psychiatric unit or for police arrest	1	0 1
D	Ensure assaulted staff member receives appropriate help: check on their wellbeing and that hospital policies are being followed e.g. incident reporting. Offer support for the staff member who was hit (either personally or via Liaison Psychiatry nursing staff if available) or check that staff member had appropriate support, EAP referral, etc.	2	0 1 2
E	Use own support structures/peer review: Attempt to defuse the hostile situation, but if this persists, consider reporting Charge Nurse for bullying/unprofessional behaviour. Use a mentoring or supervision relationship, or peer group discussion, to review the situation and your reactions, and handling of it.	1	0 1
	Up to a maximum of 5 marks in total TOTAL:		

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

Modified Essay Question 4

When you meet Mr Edmonds it is rapidly evident that he is confused and most likely delirious. Your assessment and a review of the pre-anaesthetic work-up reveals that Mr Edmonds has a history of daily alcohol intake. A provisional diagnosis of alcohol withdrawal delirium (delirium tremens) is made.

Question 4.3 (8 marks)

Outline your short-term management plan.

		worth	mark (circle)
A	Oversight of the acute management of severe alcohol withdrawal: • Use of a monitoring scale e.g. CIWA (Clinical Institute Withdrawal Assessment for Alcohol) • Physical observations needed including pulse, BP, temp, sweating, tremor, etc. • Benzodiazepines IV to be charted to manage alcohol withdrawal – lorazepam preferentially in the elderly to avoid accumulation. Consider dexmedetomidine if too sedated for adequate benzo dosage • IV fluids for dehydration, possible hypoglycaemia, etc. • Thiamine parenterally • Multivitamins to be charted • Low-dose haloperidol for behavioural disturbance *only* if patient is well-covered with benzodiazepine and has no history of dementia • Education of staff about signs of withdrawal/DTs including visual hallucinations • Alert staff to the risk of seizures • Monitoring for signs of Wernicke's (ophthalmoplegia, ataxia, confusion) • Monitor for any other medical complications (cardiac, electrolytes, liver, renal, etc.) • Encourage a medical consult especially if patient's health is additionally compromised as above. *(Better answers would note that a medical registrar would be expected to manage all of this competently, but this is a surgical ward so they may be less skilled at the medical management of the DTs and more Liaison oversight might be needed)*	3	0 1 2 3
B	Oversight of the general management of delirium: reorientation and reassurance, low stimulus environment e.g. single room, use of watch or support staff, bed rails, support with ADLs/toileting. Medical reviews and vigilance for any other causes of delirium	2	0 1 2
C	Ongoing reviews and communication with treating team: Encourage the steps as above, educate about delirium and alcohol withdrawal. Monitor patient for hallucinations/delusions, assist team with his behavioural management, reassure and support surgical team in their management of the patient	2	0 1 2
D	Ongoing communication with his family: Inform, explain, check collateral. If impaired capacity is prolonged, consider need to activate Enduring Power of Attorney, etc.	2	0 1 2
E	Consult with the addictions service: regarding his management – or at least alert them about a likely referral one he's recovered from alcohol withdrawal	1	0 1
	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 5

Modified Essay Question 5: (23 marks)

You are a junior consultant working in an outpatient assertive engagement service. Stephen is a 46 year old unemployed man with a 15 year history of psychotic illness, including seven inpatient admissions. He normally lives with 2 flatmates in a complex of social housing units. He is treated compulsorily via the Mental Health Act, on a long-term community treatment order. He has a history of assault and of assault with a weapon, which occurred 13 years earlier.

Since his last inpatient admission 3 years ago, Stephen has been under the care of the assertive engagement community mental health team. For much of this time his mental state has been at baseline, which includes a chronic but vague sense of paranoia plus auditory hallucinations characterised as voices that talk to him. The content of his auditory hallucinations has been generally persecutory, occasionally giving him instructions. Generally he has not been overly troubled by these symptoms, and has had no difficulty resisting the hallucinatory instructions.

Over the course of his illness, Stephen has had a number of diagnoses, but most consistently schizophrenia plus an underlying antisocial personality disorder. He also has a past history of cannabis dependence (says he last used this five years earlier) and sporadic polysubstance abuse. Over the previous three years there has been no evidence of mood disorder. Since his last inpatient admission he has been prescribed olanzapine 20mg and risperidone 2mg at night.

Over the four weeks before you see Stephen, his female case manager has reported that Stephen has become gradually more paranoid than usual. In addition, Stephen has become harder for his case manager to locate in the previous two weeks and he appears not to have been staying at his unit. Stephen has also isolated himself from friends. The night before you see Stephen, he was arrested for trespassing on private property after a member of the public reported seeing somebody with a flashlight inside a half-built house at midnight. The police say he's been irritable and uncooperative, and has not given a coherent account of his actions.

P.T.O.
for Question 5.1

Modified Essay Question 5 (contd.)

Question 5.1 (10 marks)

Outline (list and elaborate) the most likely psychiatric and psychosocial factors that could contribute to Stephen's presentation and discuss how each factor might potentially be managed.

		worth	Mark (circle)
For answers below, 1 mark for the factor itself, and up to 2 marks for the management.			
A	Psychiatric factor: A *relapse of Stephen's substance use*, causing him to behave uncharacteristically (due to intoxication or withdrawal or because it's precipitated a relapse of psychosis). His substance use might also lead him to commit crime to fund this. How this could be managed: A motivational interviewing approach towards his substance use. Offer support for detoxification if required (e.g. a supervised setting for drug withdrawal or the use of medications to aid withdrawal symptoms). Consider referral to a specialised alcohol and drug service.	3	0 1 2 3
B	Psychiatric factor: A *psychotic relapse*, possibly in the context of medication non-compliance, maybe exacerbated by psychosocial stressors or resumption of substance use. How this could be managed: Assess medication compliance with Stephen and by collateral from others. Ensure poor compliance isn't due to adverse effects. Get blood levels of antipsychotic medications if practicable. Assess his psychotic symptoms and risks. Consider whether admission is needed and whether if so, whether compulsory. Options also include closer supervision of oral medication or a switch to depot antipsychotic. Consider clozapine if psychosis is treatment resistant. Consider psychological treatment for residual positive symptoms.	3	0 1 2 3
C	Psychosocial factor: Conflict or problems with flatmates, family or friends leading Stephen to lose or to avoid his accommodation and to become stressed. How this could be managed: Support and liaise with his social supports, NGO or other agency to try to help resolve any conflicts, ensure adequate housing, finances, and increased social support (e.g. a support worker). (1 mark)	2	0 1 2
D	Psychosocial factor: *Criminal activity* related to poverty and/or his antisocial personality traits. How this could be managed: Clarify the contribution of Stephen's mental illness to his offending, including a careful mental state examination. Liaise with law enforcement around how best to manage Stephen's behaviour. Consider requesting an opinion from a forensic psychiatrist.	3	0 1 2 3
	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 5

After assessing Stephen, you decide to continue to treat him in the community. It transpires that non-adherence to his oral antipsychotic medication has been a significant contributor to Stephen's worsening and his case manager is advocating for Stephen to be changed to a depot antipsychotic.

Question 5.2 (6 marks)

Outline (list and elaborate) the factors you would consider in deciding whether or not a depot antipsychotic was the best psychopharmacological option for Stephen.

		worth	mark (circle)
A	Check Stephen's preference for depot or oral medications. He might prefer an injection every few weeks to taking tablets daily. Or he might be strongly opposed to a depot.	1	0 1
B	Clarify reason(s) for non-adherence to oral antipsychotic treatment. Might include adverse effects or lack of efficacy (in which case you could try another oral agent) or could be lack of insight into need for treatment. Supervised administration of oral medication may be another option.	2	0 1 2
C	Consider the role of compulsory treatment. As Stephen is subject to compulsory treatment, treatment with depot antipsychotic may be enforced if he declines this and if it is considered to be in Stephen's best interests. However, consider the practicalities of trying to legally compel treatment if he's determined not to comply – he can be hard to locate. When unwell, he's also likely to present a risk of violence towards staff trying to give injections. Consider day-stay treatment or an admission to monitor depot treatment, if needed. Admission either to acute unit or a rehab facility if one's available.	2	0 1 2
D	Consider practical issues relating to administration of depot antipsychotic. What facilities and staff are available to administer injections? If he won't attend the clinic is it safe to give in his home? Deltoid administration might be preferable to buttock administration for injections in his home. Facilities to watch for post-injection sedation syndrome may be needed if olanzapine's used (e.g. consider admission or day-stay).	2	0 1 2
E	Weigh up the risks vs benefits overall. Evaluate the above factors, especially his likely degree of cooperation and the administration risks and practicalities, versus the risk if he remains non-compliant with oral medication and relapses more seriously.	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

Having decided to continue oral antipsychotic treatment for Stephen, you go away on holiday for six weeks. On your return you discover that one of your colleagues has started Stephen on depot fluphenazine, and he is now receiving 40mg every two weeks. Stephen now presents with a tremor in both hands, decreased variability in facial expression, appears to move more slowly, and you notice a (new) increased latency in his responses to your questions to him.

Question 5.3 (3 marks)

Outline (list and elaborate) your management.

		worth	mark (circle)
A	Reduce fluphenazine depot antipsychotic dose or increase interval between doses to reduce total exposure to fluphenazine and reduce treatment-emergent EPSE.	1	0 1
B	Add an anticholinergic drug to manage EPSE.	1	0 1
C	Consider changing him to a depot less likely to cause pseudo-parkinsonism (i.e. a second generation depot antipsychotic).	1	0 1
	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 5

Following your treatment intervention, the symptoms outlined above resolve.

Around 12 months later Stephen presents with his mother, who complains about the recent appearance of unusual facial movements, which she says cause people to look at Stephen when out in public. You observe constant, repetitive and rhythmic chewing movements with an associated slight, repetitive tongue protrusion. Stephen himself had not been aware of the movements.

Question 5.4 (4 marks)

Outline (list and elaborate) your management regarding the tardive dyskinesia (TD).

		worth	mark (circle)
A	Stop any anticholinergic if prescribed, as this may exacerbate TD	1	0 1
B	Reduce antipsychotic dose or increase dosing intervals as much as possible to minimise antipsychotic exposure	1	0 1
C	Change to another antipsychotic with lower propensity for TD. Clozapine's the most likely to be effective and it prevents rebound worsening, but also consider other second generation medications (e.g. olanzapine or aripiprazole which have depot forms.)	2	0 1 2
D	Consider other treatments to reduce tardive dyskinesia, e.g. tetrabenazine, clonazepam, ginko biloba, propranolol. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3899488/)	1	0 1
E	If Stephen isn't bothered by these movements and refuses to change medications or cannot be changed to anything else due to adverse effects, continue, but titrate carefully down to the lowest possible dose that maintains wellness (as in B above) and monitor the TD regularly using AIMS or similar, to see if it's worsening.	1	0 1
	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

Modified Essay Question 6: (21 marks)

You are a junior consultant on-call in the evening and are asked to assess Rebecca, a 24 year old woman who's presented to the Emergency Department (ED) following an overdose of 28 tablets of Paracetamol 500mg and 21 tablets of Clonazepam 0.5mg. Six hours have passed since the overdose. She does not need treatment with N-acetylcysteine and has been "medically cleared for discharge" by the ED.

Rebecca is 28 weeks pregnant with her first child. She has a history of intravenous drug use and is followed-up by the local Addictions service. She's prescribed Methadone 60mg daily which is dispensed by her pharmacy each day.

On interview, Rebecca describes a four month history of depressive symptoms consistent with a diagnosis of major depressive disorder. She has not been treated in the past for depression and there is no previous history of deliberate self harm or attempted suicide. Rebecca is unable to give a clear account of the overdose but denies continuing suicidal ideation. She claims to have little memory of taking the overdose. She appears somewhat drowsy, there is some slurring of her speech, and nursing staff report that she is a little unsteady on her feet. Her manner is cooperative and she says she will follow your recommendations.

Question 6.1 (13 marks)
Discuss (and justify) your initial overnight management plan for Rebecca.

	(In general, 1 mark for the issue and 1 for the justification)	**worth**	**mark (circle)**
A	<u>Immediate disposition decision – Rebecca should remain in hospital</u> She hasn't recovered sufficiently from the overdose to be discharged home or for the risk of suicide to be adequately assessed (candidate should note the residual features of intoxication: drowsy, slurred speech, unsteady on feet, impaired memory). Other reasons to keep her in: she could have taken other substances not seen on tox. screen (will be positive for opiates). Observation needed for withdrawal symptoms.	3	0 1 2 3
B	<u>Immediate disposition – negotiation</u> Need to liaise with ED/medical/psych staff. Rebecca either to stay in ED overnight, or might need transfer elsewhere, e.g. a medical/ED acute stay ward or psychiatric ward.	1	0 1
C	<u>Review Rebecca once she recovers from overdose – complete Risk Assessment</u> Need to assess Rebecca again after the effects of the overdose have resolved. To do risk assessment, clarify diagnosis, determine place/nature of further treatment.	3	0 1 2 3
D	<u>Clarify available supports – get collateral</u> • Family and/or friends – check the range and nature of supports available • Negotiate who she prefers to get support from and involvement of next of kin • Make contact with them, also to get collateral history	3	0 1 2 3
E	<u>Clarify social circumstances</u> Get a clearer picture of these – e.g. maternity care, housing, financial stressors, any close relationship, nature of this if so, screen for domestic violence/abuse, etc.	2	0 1 2
F	<u>Complex case – consult with relevant experts and services</u> Risk issues affect her own safety and wellbeing, and that of her child. Liaise as soon as possible – e.g. the next day. • Careful follow-up needed with collaboration between services/health professionals • Liaise with GP and with any midwife/pre-natal staff • Involve a social worker or contact them if one's already involved • Liaise with the Addictions service	3	0 1 2 3
	Up to a maximum of 13 marks in total **TOTAL:**		

<u>Note to Examiners:</u> Final mark is set at not more than 13. (i.e. if they score more, final mark is still 13)

Modified Essay Question 6

The next morning Rebecca reports that she has injected heroin intravenously on a number of occasions during the pregnancy. Some of the needles she used had been shared with others. This is not information she has disclosed previously to the Addictions service.

Question 6.2 (8 marks)

What additional aspects of Rebecca's management plan after recovery from the overdose are needed in light of this information. Justify these management recommendations.

		worth	mark (circle)
A	Risk of blood-borne viruses, need for screening • Rebecca should be offered screening for blood-borne viruses, which could also have been transmitted to her child • Educate regarding these risks • Need to mention specific viruses: HIV, hepatitis B, hepatitis C	3	0 1 2 3
B	Need to liaise with other services/professionals regarding this information • Those providing Rebecca's maternity care need to be informed • The Addictions service needs to be informed • Involvement of a social worker – referral to Child Protection Services needs consideration	3	0 1 2 3
C	Need to manage the increased risk to Rebecca and her child This is also the justification for sharing this information. • Screening for blood-borne viruses might need repeating • Increased monitoring of pregnancy might be needed • Increased social support likely to be needed • Methadone dose might need adjustment • If she's contracted a blood-borne virus, might be treatment needed and available	3	0 1 2 3
	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)