THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS

MOCK WRITTENS ESSAY PAPER 2020

(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 mastering the technique required for the different question types. If you disagree with the factual detail of an answer, research the issue and decide for yourself.

When marking, and for the MEQs in particular, it's suggested that markers also refer to the 'MEQ Instructions to Examiners' from the Essay paper page of the college website: https://www.ranzcp.org/Files/PreFellowship/2012-Fellowship-Program/Exam-Centre/MEQ-Instructions-to-Examiners-1501209.aspx

This is a shorter version of the Essay Paper, in line with changes made in 2019.
The CEQ is worth 40 marks and is marked out of 40 (final % mark for CEQ is result/40).
The MEQs in this paper are worth 126 (final % mark for the MEQs is result/126).
To get the overall score, add the final % for CEQ to final % for MEQs, and divide by 2.
NB: The CEQ must be passed, to pass this Mock Exam.
In the real exam there's a more complex system to calculate the final marks which we can't replicate in a Mock exam. Candidates are advised to aim for well above 50% (60-65% is safer), to allow for that in the actual exam.

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.

"Where there is no hope, it is incumbent on us to invent it."

– Albert Camus, *The Stranger,* 1942

Reminder about marking process:
These are from the CEQ scoring domains – I've selected the ones most 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 scored here, although if it's a significant problem it's likely to reduce the marks elsewhere. Illegibility won't be an issue if this paper ever switches to being done on computer, but spelling and grammatical errors will be even more evident, so being able to type *accurately* as well as quickly will matter a lot if that eventually happens.
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**	Ideally, the first paragraph would be devoted to the trainee's understanding of the meaning of the quote, but this will also come across in the rest of the essay. Although the quote has deceptively simple wording, it would be worth giving a definition of the concept of hope. Hope refers to a positive, future orientated attitude, with the expectation of attaining personally valued goals. It is the opposite of hopelessness, a concept which trainees will want to address in the essay. Exceptional trainees may be familiar with models of hope, such as Snyder's hope theory. This comes from the positive psychology movement and describes a cognitive and emotional model of hope that requires goals, pathways (to their achievement) and agency (or motivation) to achieve these goals. Camus asserts that in the absence of hope (hopelessness), it should be engendered. The quote doesn't specify whether that should be done by the hopeless individual themselves or by others, but it emphasises the importance of providing hope. The word 'invent' suggests that hope should be made up, even if it isn't there (or at least doesn't seem to be from the hopeless individual's perspective). It would be worth noting that the sense of hopelessness an individual may feel for their situation may not be shared by those around them, particularly when this is the result of mental disorder in the individual. To effect positive change, hope needs to be linked to motivation to change and to strategies to implement this (as per Snyder's model), which could also be addressed in the 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

<table>
<tr><td>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.</td><td>Proficiency level</td><td rowspan="4">Exceptional trainees may be aware that Albert Camus was a French philosopher and writer. The Stranger was published in 1942, a time of global upheaval, destruction and loss. The quote may be particularly relevant to periods of crisis and change, including the 2020 Covid-19 pandemic.
This section, and (4) below, form much of the body of the essay.
The quote is open to broad interpretation and there are many topics that could be addressed. These include:
- Hope as a mechanism for resilience or coping with stress. The presence of hope can buffer against adversity and stress, leading to a reduced risk of psychopathology and the potential for personal growth in a crisis.
- Where might a situation without hope arise? The absence of hope is a core phenomenon of many psychiatric disorders, including depression (especially if severe), schizophrenia, and addictions. In depression, a lack of hope features in some conceptualisations of the disorder (Beck's depressive triad, with negative views about the future).
- The importance of hopelessness, such as is measured through the Beck Hopelessness Scale, in predicting suicide risk (i.e. there are strong links between a lack of hope and suicide).
- The 'downward drift' in socioeconomic status of many patients with severe mental illness into poverty, isolation, homelessness and poor physical health which predisposes to a lack of hope for the future.
- The centrality of clinicians (and others) in maintaining a sense of hope and modelling their own hope for a good outcome. This goes to the heart of the argument in the quote – that where people lack hope, we need to provide it. So where a patient subjectively has no hope, clinicians and others around them need to be hopeful for them (based not on lying to the person but on greater knowledge of treatment options and the illness's course) and strive to instil this (hence to 'invent it').
The instillation of hope is a key task for treating clinicians. It's part of the therapeutic relationship, and is a non-specific positive effect in psychotherapies. This is a key argument to make.
- Hope is particularly important in psychotherapy of all forms, being critical in initiating any psychotherapeutic change. There are specific short term psychotherapies designed to instil or improve hope, which have been shown to have some benefits in reducing suicidality. Motivational Enhancement Therapy (based on the model of Prochaska and DiClemente) is a commonly used, manualised psychotherapy that enhances agency to achieve goals and so fits within the broad concept of instilling hope.
- In terms of covering different Points of View, one way is to look at different stakeholders. Providing hope features prominently in nursing literature, but is also crucial to all disciplines (including psychiatrists, psychologists, and social workers). It's particularly important in the work of peer support workers (see (7) below). You could also consider the importance of hope for families of sufferers of mental illness, and for their GPs and others, through</td></tr>
<tr><td>There is no evidence of logical argument or critical reasoning; points are random or unconnected, or simply listed.</td><td>0</td></tr>
<tr><td>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.</td><td>1
2</td></tr>
<tr><td>The points in this essay follow logically to demonstrate the argument and are adequately developed.</td><td>3
4</td></tr>
</table>

The candidate demonstrates a sophisticated level of reasoning and logical argument, and most or all the arguments are relevant.	**5**	to society at its broadest – including politicians and funding agencies. Things we're hopeless about are unlikely to get funded. - Re counter-arguments to the quote, 'inventing' hope when it isn't there can be dishonest and harmful if not based on something real. In medicine, lack of clarity about a terminal illness diagnosis can cause harm. Marx called religion "the opium of the masses", meaning belief in an afterlife led to the poor being oppressed by the rich. Cult leaders like Jim Jones have falsely instilled hope of salvation, causing tragedy. In psychotherapy, collusion with false hope linked to a patient's denial could be harmful. Similarly, colluding with a patient's false hope that they could safely cease crucial psychotropic medication yet stay well could be disastrous. - Are there situations where there is genuinely no hope, i.e. where a clinician has no hope (either as they lose it or never had it) for a patient? The problem of 'heartsink' patients could be raised, where the clinical situation has exhausted a team or a clinician's resources. Alternatively, this could arise due to clinician burnout and would have a negative impact on patient outcomes. These could be managed by bringing in more people with a fresh perspective, support from service leaders, and by the clinician getting personal help. Similarly, a family having no hope would have a similar negative impact on an individual, and this could potentially be addressed through psychoeducation or family therapy. 'Existential crises' can arise where a clinician encounters a person whose situation genuinely appears hopeless and whose decision to attempt suicide initially seems justified. We tend to manage these by providing support and allowing time to pass (e.g. with a short crisis admission) and by broadening the people involved in instilling hope by including our wider teams and the person's friends and family. Usually, in a few days, matters seem less dire, after the provision of support. And there are many more arguments. The above are just some examples.

4. Critical Reasoning/Accuracy (Competency: Medical Expert, Scholar)

Information cited in the essay is factually correct.	**Proficiency level**	Closely linked to (3) above, this is the place to score for the accuracy of arguments made and for supportive evidence to back up any assertions, such as examples, or ideally references.
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**	The arguments in the body of the quote need to demonstrate this breadth and maturity. References to history and culture would be useful to place the quote in context. The concept of hope goes back to at least Greek mythology (hope was the last thing released from Pandora's box, after all the evils had escaped). It's central to some religions – e.g. the concept of the resurrection in Christianity. Many other religions have a positive focus as well – the hope/goal of attaining nirvana in Buddhism, the hope of accumulating positive karma and spiritual enlightenment via reincarnation in Hinduism, etc. For breadth, it would be useful to think about the importance of hope in other areas of medicine. Trainees could consider other challenging areas such as palliative care, where instillation of hope in possible treatments, or in achieving peace and acceptance may apply. Staff working in other challenging fields may be expert at maintaining hope, an essential role in Spinal Units and Burns Services. The importance of maintaining a sense of hope via leadership applies in medicine and psychiatry, but also through national leaders modelling or instilling it at times of crisis. Comparisons between Jacinda Ardern and Donald Trump or Jair Bolsonaro in the Covid-19 pandemic spring to mind. Another example might be Winston Churchill instilling hope of victory in the UK in WWII, at the time the quote was published.
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**	It should be possible to discuss ethical issues regarding any quote, and trainees should assume that this will be a marking dimension in all essays. Here, one could consider the ethics of 'inventing hope' (apparently contravening the principle of honesty and thus damaging an individual's autonomy) with the importance of acting in the person's best interests (beneficence). As covered in (3) above, this may be a matter of perspective, as where the instillation of hope is based on the clinician's wider knowledge and more accurate judgement (than, say, a seriously depressed person's perspective), there may be no dishonesty and thus, no ethical breach but in fact an example of beneficence. However, also as in (3) above, the instillation of hope based on a falsehood where a clinician is knowingly lying is likely to be an ethical breach (contravening respect, autonomy and potentially resulting in the patient being harmed and abused). There is a strong ethical imperative for clinicians to maintain hope for those under their care and to keep caring for them even in difficult circumstances (fidelity and the duty of care).
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 ethical issues.	3 4	
The candidate demonstrates a superior level of knowledge or awareness of relevant ethical issues.	5	

7. Patient-centred Care (Competency: Medical Expert, Collaborator)

The candidate demonstrates understanding of patient-centred care, the recovery model in psychiatry, and the role of carers.	**Proficiency level**	This is an important marking domain for this quote. There are a number of points that could be made here, including: - Most people with severe mental illness have had many negative experiences such as stigmatisation, discrimination, rejection, and loss. These can make it hard to hope and lead to demoralisation. - A sense of hope is the starting point in the recovery process. Integral to this is the shift from a focus on symptoms and deficits to one on strengths and solutions to the person's problems. With hope that things can change, people can put in the effort to make changes that show positive progress is possible. - The importance of clinicians engendering and maintaining hope as part of the recovery process. "You believed in me…even when I didn't believe in myself" - Peer support workers focus on engendering hope and optimism, often working with people who feel they have lost all hope in and for themselves. This can be done by modelling their own recovery attitudes, essentially 'inventing' hope as per the quote.
The candidate fails to consider patient-centred care, carers, and/or recovery principles where these are relevant OR merely mentions them.	0	
The candidate mentions these concepts but does not demonstrate an accurate understanding of them or is unable to do so clearly.	1 2	
The candidate demonstrates understanding of patient-centred care, the recovery model in psychiatry, and the role of carers.	3 4	
The candidate demonstrates a superior depth or breadth of understanding of patient-centred care, the recovery model in psychiatry, and the role of carers.	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**	The essay needs to wrap up with a defined conclusion. This should be justified by the arguments already made and must *not* introduce new information. The quote is intrinsically difficult to disagree with, unless trainees take the view that it is dishonest to invent hope when it isn't there – and, as above, this would need to be discussed carefully, regarding the ethics and the basis for instilling hope. Most essays will likely support the quote's assertion, but the critical thinking component comes in understanding the breadth of the issues raised by the quote and their importance to psychiatric practice. If the conclusion is not clearly announced and the last paragraph does not seem to be a conclusion at all (just a point where the trainee ran out of time), score zero for this domain.
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	

In the real CEQ they tend to only have about 6 marking domains, and to weight them each differently. That's too complex a system for a Mock exam, so these 8 domains for the CEQ scoring add up to exactly 40 marks. Final Mark % = score / 40

MODIFIED ESSAY QUESTION 1

Each question within this modified essay will be marked by a different examiner. The examiner marking one question will not have access to your answers to the other questions. Therefore, please ensure you address each question separately and specifically. For example, answer question 1.4 fully, even if you believe you have partly covered its content in your answers to questions 1.2 and 1.3.

Modified Essay Question 1: (22 marks)

You are a junior consultant working in the consultation-liaison service at a large general hospital. You have been asked by your general medical colleagues to urgently see John, a 41 year old Samoan man under their care. John was transferred back 3 days ago from the regional neurosurgical unit and has a peripherally inserted central cannula (PICC) in situ as he requires four weeks of treatment with intravenous antibiotics. The treating physician reported that John repeatedly stated that morning that he didn't need antibiotics because he was 'cured' and that "the bandage on my head proves it". He is increasingly irritable with nursing staff trying to give him medication and has attempted to leave on two occasions today. On his second attempt to leave, he required security to contain him. John is 6' 2" and strongly built.

Question 1.1 (9 marks)
Outline (list and explain) the specific information you need to gather in your assessment of John to safely manage the escalating situation.

		worth	mark (circle)
A.	Risk: • Immediate risk to others given his presentation – access to 'weapons', risk of accidental harm to others, threats, level of aggression. • Immediate risk of harm to self – is his treatment refusal any sort of self-harm? Risks of accidental harm to self (inability to keep himself safe).	2	0 1 2
B.	Capacity: His current capacity to make decisions about his treatment options. • Does he retain information long enough to make a rational decision, understand the current situation and consequences, assess the situation rationally to make a decision, and communicate a consistent choice?	2	0 1 2
C.	Medical Status: • Why was he in the regional neurosurgical unit & what treatment did he receive there? • Current medical status including vital signs and screening for delirium. • Past medical history.	2	0 1 2
D.	Mental State Examination and Past Psychiatric History: • Establish if there's any evidence for a primary psychiatric disorder as opposed to an organic condition at this point in time. • Particular focus on tests of attention, symptoms of psychosis & symptoms of mood disorder.	2	0 1 2
E.	Medications: Any medications that might precipitate acute behavioural change.	1	0 1
F.	Alcohol and Substance use history: Especially around possible substance withdrawal.	1	0 1
G.	Collateral information: From family and medical staff/services regarding his recent presentation, and his usual coping and behaviour.	1	0 1
H.	Cultural Assessment: Clarify any cultural issues with the family. Ideally, involve an appropriate cultural team/cultural worker in the assessment.	1	0 1
	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 1 contd.

As part of your assessment, you ascertain that John has a delirium and lacks the decision-making capacity to self-discharge from the hospital at this point in time. He continues to be periodically agitated, despite his wife and sister visiting daily to help calm him down.

Question 1.2 (9 marks)
Outline (list and explain) how you would manage the situation, given that John still requires life-saving care.

		worth	mark (circle)
A.	Medico-legal Issues The delivery of care needs to be done under a legal framework for people lacking decision-making capacity ('duty of care'): - Decisions should be taken as required for life-preserving treatment. - Family should be involved in treatment decisions (his wife and sister), with the principle that they make decisions on his behalf based on his wishes if he had decision-making capacity. Use any EPOA if this exists. - Discuss with the hospital legal team about the need to keep John in hospital against his will for treatment and the rationale behind this. - Discuss the delivery of care in these conditions with a peer/peer group.	3	0 1 2 3
B.	Management of John's Delirium - Arrange a 1:1 watch, taking into account his size and the safety of John and the watch - Move John to a single room ideally, avoiding bright lights and darkness - Low dose antipsychotics as needed (e.g. haloperidol), with intramuscular options if required. - Benzodiazepines may be used cautiously (but can exacerbate confusion). - Frequent re-orientation as with any cognitively impaired person. - Distraction techniques may assist if he persistently attempts to leave. - Encourage staff to use a delirium rating scale e.g. 4-AT or CAM.	3	0 1 2 3
C.	Management of the Ward/Staff - Explain to the ward nursing team the issues around treatment when an individual lacks decision-making capacity. - Discuss with the ward nursing team how to manage his difficult behaviour. - Write a clear plan in the notes. - Ask the Charge Nurse to ensure nurses across all shifts know the plan. - Reassure ward staff that this is difficult, and you will review John daily.	3	0 1 2 3
D.	Family Interventions - Discuss with family the delivery of care given that John lacks capacity. - Psychoeducation about his cognitive impairment. - If the family become significantly distressed, arrange additional support – regular discussions, extended family support, social work, counselling, etc.	2	0 1 2
E.	Cultural Intervention - Ideally, involve a cultural advisor/cultural team for John & family.	1	0 1
	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 1 contd.

Three days later, you receive an email from the Charge Nurse about John, who demands that you 'drug him up' or move him to another ward because her nurses are refusing to care for him any more, as he remains verbally abusive when prevented from leaving the hospital.

Question 1.3 (4 marks)

Outline (list and explain) the potential factors that may have led to the charge nurse's request.

		worth	mark (circle)
A.	Lack of understanding about John's delirium: His cognitive impairment and behavioural change may be interpreted as deliberately disruptive behaviour.	1	0 1
B.	Nursing staff may be struggling to manage his behavioural disturbance: Staff may be avoiding John, causing his behaviour to escalate due to neglect.	1	0 1
C.	Management strategies implemented may be inadequate: He may not have enough PRN charted, or the watches may not be able to contain him.	1	0 1
D.	Hospital systemic issues: The Charge Nurse may be under significant pressure to move John, e.g. due to staff or bed shortages.	1	0 1
E.	Racism: The Charge Nurse and/or other staff might be racially biased and responding to prejudice, increasing their fear and reluctance to care for him (he's a large man and verbally aggressive).	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 2

Each question within this modified essay will be marked by a different examiner. The examiner marking one question will not have access to your answers to the other questions. Therefore, please ensure you address each question separately and specifically. For example, answer question 1.4 fully, even if you believe you have partly covered its content in your answers to questions 1.2 and 1.3.

Modified Essay Question 2 (22 marks)

You are a junior consultant working in a community mental health clinic and have been asked to review Joanne, an unemployed 28 year old woman who lives with her parents. Joanne was referred to your team one month ago by her GP, and was diagnosed with Obsessive Compulsive Disorder (OCD) by the psychologist on your service and a locum psychiatrist. She recently commenced psychological treatment.

The psychologist has asked you to see Joanne because she has stopped medication (fluoxetine 40mg mane, previously prescribed by her GP), and is now doing poorly. She has also lost weight in the past month.

Question 2.1 (10 marks)
Outline (list and explain) what you will include in Joanne's assessment.

		worth	mark (circle)
A.	Interact with Joanne so as to develop the therapeutic alliance	1	0 1
B.	Assess the risks, especially risk to self (self-harm risk, impaired self-care)	1	0 1
C.	Re-evaluate her history and symptoms. Clarify the history of obsessions and compulsions. Clarify why she stopped medication	2	0 1 2
D.	In what ways is she doing poorly? Clarify the reasons for and rapidity of her weight loss	1	0 1
E.	Re-evaluate her diagnosis. Specifically, screen for differentials such as psychosis or mood disorder	2	0 1 2
F.	Get collateral history from parents, with her permission	1	0 1
G.	Liaise with her GP	1	0 1
H.	Physical examination to assess her weight/BMI, lying/sitting/standing BP and heartrate, neurological exam	2	0 1 2
I.	Arrange blood tests, including electrolytes	1	0 1
J.	Consider neuroimaging to exclude organic brain disease, esp. if any abnormalities on neurological examination.	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 2 contd.

Joanne reports the obsessional thought that she has done something wrong. She relates this to accidentally viewing pornography when on the internet six months earlier. This obsessional thinking leads to her constantly questioning her actions and being unable to make decisions. There is no other compulsive behaviour. After a thorough assessment, you conclude that Joanne has severe OCD. This has deteriorated since she stopped fluoxetine two weeks earlier due to her obsessional anxiety about doing something wrong. She has lost some weight but is not physically compromised.

Question 2.2 (6 marks)
Outline (list and explain) the key elements of your treatment plan for Joanne at this point.

		worth	mark (circle)
A.	Consolidate the therapeutic alliance, see her regularly	1	0 1
B.	Pharmacotherapy – restart medication (e.g. fluoxetine, alternative SSRI, clomipramine) to control obsessional symptoms. Aim for a high dose of antidepressant, consider antipsychotic augmentation	3	0 1 2 3
C.	Psychotherapy – regular follow up with the psychologist and Cognitive Behavioural Therapy (CBT) for her OCD symptoms	1	0 1
D.	GP/medical follow up to monitor her weight and physical wellbeing. Continued liaison with her GP	2	0 1 2
E.	Continued involvement of her parents/family, with her consent	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 2 contd.

Joanne deteriorates further. She takes medications for three days then stops again. She is nearly paralysed by indecision related to her obsessions, fearing that any behaviour she completes will confirm her fear that she's done something terribly wrong. She attends psychotherapy but is not able to make use of therapeutic techniques outside sessions. Her BMI is now 15.5 and her food intake has been minimal for the last week.

Question 2.3 (6 marks)
Outline (list and explain) the key elements of your treatment plan for Joanne at this point.

		worth	mark (circle)
A.	Continue to communicate often and clearly with Joanne and her family	1	0 1
B.	Manage the risks, particularly her risk from poor self care. Consider admission to a psychiatric unit, vs intensive home treatment	2	0 1 2
C.	Consider use of the Mental Health Act to admit her, if needed	1	0 1
D.	Either as an inpatient, or (if safe and feasible) at home: supervise and encourage her medication adherence, food and fluid intake, and monitor her weight and physical health.	2	0 1 2
E.	Involve a dietitian and monitor Joanne for re-feeding syndrome	1	0 1
F.	Re-evaluate the diagnosis – consider a second opinion	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

Each question within this modified essay will be marked by a different examiner. The examiner marking one question will not have access to your answers to the other questions. Therefore, please ensure you address each question separately and specifically. For example, answer question 1.4 fully, even if you believe you have partly covered its content in your answers to questions 1.2 and 1.3.

Modified Essay Question 3: (23 marks)

You are a junior consultant psychiatrist working in a Community Mental Health Team. Anton is a 42-year-old man of European descent under your care. He has an 18 year history of paranoid schizophrenia and is currently on clozapine. He is treated compulsorily via the Mental Health Act. He lives alone in rental accommodation, receives long-term social services income due to his illness and is supported by his elderly parents who are retired and live locally. He has no other close family

Anton attends your clinic complaining that his neighbours have organised with the police to have him monitored and have installed an internet tracking device on the lamppost outside his flat. Anton reports they did this a year ago under the pretence of having fibre internet installed. He has been isolating himself at home and reports that he has no interest in going out and has lost weight because he is not eating. Anton says he has been more worried about the surveillance devices in the last three months and he can no longer sleep because of the fear. He wants zopiclone to help him sleep and a letter to the council to have the lamppost removed, as otherwise he will have to “take matters into my own hands".

Question 3.1 (5 marks)
List the potential reasons for Anton’s presentation at this point.

		worth	mark (circle)
A.	Use of alcohol or illicit drugs.	1	0 1
B.	Poor medication adherence.	1	0 1
C.	He has a treatment resistant illness.	1	0 1
D.	His psychotic illness is relapsing.	1	0 1
E.	His serum clozapine has dropped due to a cytochrome P450 system interaction – e.g. from him resuming cigarette smoking.	1	0 1
F.	Another unidentified stressor, e.g. financial difficulties.	1	0 1
G.	He has a comorbid depression.	1	0 1
H.	An undisclosed or as yet unidentified comorbid medical condition.	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 3 contd.

As part of your management plan you need to address Anton's medication.

Question 3.2 (7 marks)
Outline (list and explain) the key points of your medication management for Anton.

		worth	mark (circle)
A.	Assess the adequacy of his clozapine dose and increase this if levels are low (check serum levels, clozapine:norclozapine ratio, check medication dispensing records.)	2	0 1 2
B.	Investigate and manage any reasons for his serum clozapine being low (e.g. poor adherence - try blister packs, a medication delivery service; or smoking resumption which might mean a larger dose is needed; or side-effects of clozapine like sedation, dribbling, constipation, hating blood tests, might need management.)	2	0 1 2
C.	Consider a change in his antipsychotic regime (e.g. to a depot medication if oral adherence isn't possible or he prefers a depot; or augment with a second antipsychotic e.g. by adding aripiprazole which is non-sedating.)	2	0 1 2
D.	Assist with his insomnia (prescribing zopiclone to aid sleep accedes to his request and increases therapeutic engagement. But it's ineffective for his psychosis, and there's risk of dependence. Consider alternative medications e.g. melatonin, or non-medication strategies such as sleep hygiene education, but this might be difficult during a psychotic relapse.)	2	0 1 2
E.	Consider augmentation to treat a comorbid mood disorder (a mood stabiliser if any history of symptoms of mania/hypomania; or an antidepressant if he's depressed - e.g. an SSRI as first line option.)	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 3 contd.

At your next review Anton says he wants to regain his Driver's License. He thinks resuming driving would make it easier for him to find work and he could drive his parents to the supermarket. His parents used to drive their own car but his father's eyesight has deteriorated and his mother is anxious about driving.

Question 3.3 (7 marks)
Outline (list and explain) your response to Anton's request.

		worth	mark (circle)
A.	Maintain a supportive and realistic manner, recognising his plan as a positive recovery goal regarding work and supporting his family, while balancing it against any risks from Anton driving.	1	0 1
B.	Take a driving history including any risky driving behaviour such as traffic offences, past convictions, DUIs and his history/current use of substances.	2	0 1 2
C.	Consider his current degree of recovery – are there symptoms likely to affect his driving e.g. poor attention/concentration, mood abnormalities, suicidal ideation, delusions about the monitoring device on the lamppost and any risk of him using the car to remove the lamppost.	2	0 1 2
D.	Get collateral information from Anton's parents – his driving history, their views on him driving and their need for driving support.	2	0 1 2
E.	Consider any medico-legal issues with Anton driving while on compulsory treatment, e.g. local Driving Authority rules in relation to any history of psychosis or any history of sedation from medication.	2	0 1 2
F.	Refer Anton for a specialist assessment of his driving skills – as part of the risk assessment to determine if he'd be safe to drive.	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 3 contd.

Anton then says that he has in fact bought a second-hand car and he drove it to the clinic today. The car is unregistered and has no warrant of fitness. Anton admits that he had a drink before driving to the clinic. "Just a beer, though."

Question 3.4 (4 marks)
Outline (list and explain) your immediate response to this situation.

		worth	mark (circle)
A.	Raise your concerns about his driving with Anton, especially his driving after drinking.	1	0 1
B.	Explain to Anton any driving restrictions due to him being treated under the Mental Health Act.	1	0 1
C.	Try to get Anton to agree not to drive.	1	0 1
D.	Try to persuade Anton to hand over the car keys to you or other staff.	1	0 1
E.	Contact the police if he won't relinquish the keys and drives away, i.e. you need to breach his privacy to support public safety.	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)

- Note that any medium-term or longer-term plan to address his alcohol use attracts no marks as it's not part of an 'immediate response' to the situation.

MODIFIED ESSAY QUESTION 4

Each question within this modified essay will be marked by a different examiner. The examiner marking one question will not have access to your answers to the other questions. Therefore, please ensure you address each question separately and specifically. For example, answer question 1.4 fully, even if you believe you have partly covered its content in your answers to questions 1.2 and 1.3.

Modified Essay Question 4: (18 marks)

You are a junior consultant psychiatrist in an urban area and have been referred a new patient, Mrs Chin, to be assessed in your outpatient clinic. She is a 75 year old Chinese woman, married and living with her husband in their own home. She and her family emigrated from Hong Kong 30 years ago when she was in her mid-forties. Her son (her only child) lives locally with his family, in the same suburb. Her family are concerned that she has become unwell over the past four months. She is reported to be sad and to have lost interest in her usual hobbies (Mah Jong with friends, and calligraphy). Her sleep is poor and she can be disoriented at times. Her husband says that her memory is not as good as it used to be. Mrs Chin was prescribed an antidepressant by her GP but without any improvement so far.

Question 4.1 (6 marks)
Outline (list and justify) your differential diagnoses at this point.

		worth	mark (circle)
A.	Major Depressive Episode – due to her low mood, loss of interest, poor sleep.	2	0 1 2
B.	Dementia – due to her poor memory and disorientation. Her low mood and disorientation point to a Fronto-Temporal Dementia and the most likely types are Alzheimer's disease or a Vascular Dementia.	2	0 1 2
C.	Organic Mood disorder – should always be a differential, given her age. Could be due to hypothyroidism, low B12 or folate, a CVA, etc.	2	0 1 2
D.	Alcohol abuse – should be ruled out as she has low mood not responding to an antidepressant, and disorientation.	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 4 contd.

In the referral, the GP explains that Mrs Chin speaks Cantonese and cannot speak or understand English well, and that an interpreter will be needed for the assessment. The GP says that Mrs Chin's son always attends and interprets when the GP sees her, as his father's English is also limited.

Question 4.2 (4 marks)
Discuss your approach to communicating with Mrs Chin and her family.

		worth	mark (circle)
A.	Pros and cons of using a trained interpreter need discussion: • Advantages – Interpreter will have had proper training in interpreting technique and is less likely to translate inaccurately or with bias. • Disadvantages – Mrs Chin and her family may be ashamed to have another Chinese person knowing their problems, so may refuse. They may fear the interpreter will gossip within their community.	2	0 1 2
B.	Pros and cons of using Mrs Chin's son to interpret need discussion: • Advantages – may be much more acceptable to Mrs Chin and family. He needs to be included anyway, in family meetings and reviews. • Disadvantages – son may be reluctant to translate accurately if he's embarrassed by her replies. Mrs Chin may withhold information so as not to upset her son.	2	0 1 2
C.	Practicalities of using an interpreter (or Mrs Chin's son) need discussion: • Need to discuss the process with the interpreter first, especially if untrained (her son), and explain what will be covered. • Need to face Mrs Chin and husband with the interpreter beside you and address them, not face and talk to the interpreter. • Need to decide whether it will be sequential (most likely) or simultaneous translation. • Need to explain to interpreter that accuracy is important and they need to translate verbatim and not censor even if her speech is disorganised or they feel what she's saying is embarrassing.	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)

NB: saying that it would be difficult to locate an interpreter attracts no marks, as it should not be hard to arrange a Cantonese interpreter in an urban setting.

Modified Essay Question 4 contd.

From the assessment, Mrs Chin's cognitive function is moderately impaired and she has a past medical history indicating vascular risk factors. She does not drink alcohol or smoke cigarettes, and she has mild hypertension (untreated, to date). Her husband says that her memory has been getting slowly worse for more than two years. Her sadness now appears to be more frustration at being unable to manage usual activities. She needs to be reminded frequently when doing housework and often loses objects in the house. The likely diagnosis is now felt to be a vascular dementia with moderate cognitive impairment. Mrs Chin and her family want to know what this means and what treatment is available.

Question 4.3 (8 marks)
Outline (list and explain) your approach, and the information and medium-term treatment plan you would discuss with them.

		worth	mark (circle)
A.	Approach: Maintain an empathic, supportive and practical approach, and ideally continue using an interpreter. If a full assessment has been carried out and Mrs Chin and the family want her son to attend and interpret, that may be reasonable as long as he's able to accurately convey the information.	1	0 1
B.	Biological Interventions: • Medication to improve cardiac risk factors e.g. liaise with her GP to treat hypertension, taking care not to worsen her low mood with a beta blocker. • Avoid medications that can increase confusion like anticholinergics or sedatives – educate her and the family about sleep hygiene instead • Consider antidepressant medication depending on the degree of low mood. Avoid anticholinergic antidepressants.	3	0 1 2 3
C.	Psychological Interventions: • Psychoeducation and support regarding the diagnosis for Mrs Chin and her family. Her family members may well need separate sessions. • Practical advice for her family about managing her disorientation and forgetfulness – how to interact with her using distraction, reminiscence, reorientation, avoiding confrontation, etc. • Discuss with the family and Mrs Chin the need for a stable daily routine and cues like a clock, calendar, lists and written reminders, etc. • Occupational therapist input to support her resuming hobbies and any cognitively stimulating activities.	3	0 1 2 3
D.	Social and Cultural Interventions: • Social work input to refer Mrs Chin and her family to local Dementia Support organisations, and any suitable support groups – e.g. any groups for older Asian people at local community centres. • Social work assistance in setting up an Enduring Power of Attorney if she still has the capacity to consent. • Involve the local Asian Mental Health Cultural service if such exists.	2	0 1 2
E.	Follow-up: Arrange regular follow-up with the Old Age Mental Health team – e.g. yourself, a keyworker, a social worker, ideally an OT &/or psychologist.	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

Each question within this modified essay will be marked by a different examiner. The examiner marking one question will not have access to your answers to the other questions. Therefore, please ensure you address each question separately and specifically. For example, answer question 1.4 fully, even if you believe you have partly covered its content in your answers to questions 1.2 and 1.3.

Modified Essay Question 5: (23 marks)

You are a junior consultant psychiatrist and have been asked to see Davey, a 9-year-old boy referred by his school with concerns about his irritability, poor academic performance and restlessness in the classroom. You see him with his mother, Shannon, who has raised him as a solo parent after his biological father absconded on hearing of her pregnancy. She has had no further contact with the father, and Davey is her only child. Shannon works full-time in a supermarket and Davey attends after-school care. Davey spends Saturday with his maternal grandmother while Shannon does a second job as a cleaner, to supplement their income.

Question 5.1 (6 marks)
List the key areas you need to assess in your initial work-up.

		worth	mark (circle)
A.	ADHD symptom screening	1	0 1
B.	Assess him for a Learning Disorder / assess his cognition or IQ	1	0 1
C.	Security of his relationship with mother	1	0 1
D.	Developmental history	1	0 1
E.	Family psychiatric history, especially of ADHD	1	0 1
F.	Oppositional Defiant Disorder screening	1	0 1
G.	Collateral history about Davey's behaviour in each setting – home, the school, and with grandmother	1	0 1
H.	Assess his sleep, appetite, general health and coping	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 5 contd.

You arrange for Connors ADHD Rating Scales to be done at school and at home, for Davey. The results show high scores across all domains (Inattention, Hyperactivity/Impulsivity, Learning problems, Executive function, Aggression and Peer Relations), with *t* scores above 70 for Inattention, Learning Problems and Executive Function.

You talk with Shannon and suggest treating Davey with stimulant medication. Shannon says: "I'm worried he might be a bit slow, what with not doing too good at school. Shouldn't he have his IQ checked first in case that's the problem?"

Question 5.2 (1 mark)
State why Davey should not have IQ testing first, before treatment for ADHD.

		worth	mark (circle)
A.	Need to ensure that his ADHD is treated first, so as to get valid IQ testing results.	1	0 1
		Up to a maximum of 1 mark in total TOTAL:	

Modified Essay Question 5 contd.

Question 5.3 (5 marks)
Outline (list and explain) a) the key additional things you would need to assess prior to Davey starting stimulant treatment and b) your approach, and what you would need to discuss, to gain consent for Davey to start stimulant treatment for ADHD.

		worth	mark (circle)
A.	Maintain a supportive and empathic manner with Shannon and Davey and tailor explanations appropriately for Shannon's level of understanding.	1	0 1
B.	Check Davey's guardianship arrangements with Shannon – make sure his father's not entitled to have a say in his treatment as well.	1	0 1
C.	Explain to Shannon why you think Davey has ADHD and the potential benefits of stimulant treatment (based on the evidence).	1	0 1
D.	Explain to Shannon the potential side effects, especially possible effects on Davey's growth, height, and weight.	1	0 1
E.	Check with Shannon that there's no family or medical history of sudden cardiac death or cardiac arrhythmias.	1	0 1
F.	Ensure Davey has a physical examination including heart auscultation, blood pressure and pulse, baseline weight and height. Consider an ECG if there are any cardiac abnormalities on the physical, or any medical/family cardiac illness history.	2	0 1 2
	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 contd.

Davey is between the 25th and 50th centile for his height and between the 50th and 75th centile for his weight on commencing stimulant treatment.

His school reports a significant improvement on treatment with 0.9 mg/kg Methylphenidate LA (long-acting) with good coverage of the school day, a significant improvement towards normal in Davey's reading ability and improved classroom behaviour. You discharge Davey back to his GP.

Six months later, Davey's GP contacts you, concerned that Davey has gained no weight or height in the last six months.

Question 5.4 (5 marks)
Outline (list and explain) your management suggestions to Davey's GP.

		worth	mark (circle)
A.	Check the centiles, as Davey was at a slightly greater weight for height at the start of treatment so he may still be in an acceptable centile.	1	0 1
B.	Review with the GP the time and amounts of his doses and meals. (e.g. check he's having a dose after, not before breakfast, and suggest a change in his meals at home – e.g. having more for dinner, having a supper.)	1	0 1
C.	Suggest that the GP gives Shannon dietary advice for Davey – practical and in writing.	1	0 1
D.	Check with the GP that Davey has no other medical problems – e.g. check his bowel function, other GI and physical symptoms.	1	0 1
E.	Discuss with the GP the possibility of medication holidays during weekends or over school holidays, if the concerns persist.	1	0 1
F.	Discuss with the GP the possibility of referring Shannon and Davey to a dietitian.	1	0 1
G.	Maintain a professional and supportive manner with the GP and advise GP to refer Davey back to you if his growth remains poor.	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 5 contd.

One year later Davey's GP asks you to review Davey as he has only gained 2 cm of height in the past year (the 50th centile for growth at this age is 5-6 cm per year and the 2nd centile is 4 cm per year). Davey has gained 1 kg in weight. Shannon has persuaded Davey's GP to increase the methylphenidate LA to a daily dosing of 1.4mg/kg to manage Davey's symptoms in his after-school programme. This was because the programme staff threatened to ban Davey from the programme due to his behaviour, which in turn jeopardised Shannon's job.

Question 5.5 (6 marks)
Outline (list and explain) your approach and what you would need to cover in your next review of Davey with Shannon.

		worth	mark (circle)
A.	Maintain a supportive and empathic manner with Shannon and Davey and tailor your interactions appropriately for Shannon's level of understanding.	1	0 1
B.	Clarify with Shannon the reasons for Davey's problematic behaviour (and the nature of this), in the after-school programme.	1	0 1
C.	Discuss with Shannon her stress levels and need for additional support (e.g. any need for respite, any changes in family support or circumstances.)	1	0 1
D.	Repeat Davey's height and weight measurements and check that his measurements are plotted accurately on the centile chart.	1	0 1
E.	Discuss with Shannon the growth problems being caused by the increased dose and that the dose of Davey's methylphenidate needs to be reduced.	1	0 1
F.	Consider a mix of long-acting and short-acting medication at the start of the after-school program, or other modifications to the timing of doses.	1	0 1
G.	Discuss with Shannon the need for dietary interventions – dietitian referral and/or high density food snacks for Davey.	1	0 1
H.	Discuss the need for medication holidays – at weekends and across school holidays, to reduce stimulant exposure for Davey.	1	0 1
I.	Consider atomoxetine or clonidine instead of stimulant medication – discuss these as alternatives.	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 6

Each question within this modified essay will be marked by a different examiner. The examiner marking one question will not have access to your answers to the other questions. Therefore, please ensure you address each question separately and specifically. For example, answer question 1.4 fully, even if you believe you have partly covered its content in your answers to questions 1.2 and 1.3.

Modified Essay Question 6: (18 marks)

You are an on-call consultant psychiatrist called to assess Abigail (aged 23) in the Emergency Department (ED) on a Saturday. You are assisting with cover as the registrar was overloaded with other assessments. Abigail has presented to ED twice within the past 3 days, each time with overdoses of 10 paracetamol tablets. Abigail is well known to the ED with multiple past presentations of self harm including lacerating her wrists, intoxication and overdose. She has now been medically cleared for discharge from ED. The house officer's notes say that her current presentation was triggered by conflict with her father with whom she lives, as Abigail says he does not believe her report of childhood sexual abuse by a neighbour who was a friend of her father. Her father says Abagail has intense mood swings which are difficult to control or predict.

Question 6.1 (4 marks)

List the most likely differential diagnoses which might account for her presentation at this point, based on the above information.

		worth	mark (circle)
A.	Adjustment disorder	1	0 1
B.	Bipolar Spectrum Disorder	1	0 1
C.	Borderline Personality Disorder	1	0 1
D.	Major Depressive episode	1	0 1
E.	Post Traumatic Stress Disorder	1	0 1
F.	Substance Use Disorder	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 6 contd.

Question 6.2 (8 marks)
Outline (list and explain) the history you would take to confirm a diagnosis of Borderline Personality Disorder and how you would undertake this assessment.

		worth	mark (circle)
A.	Screening for features of Borderline Personality Disorder: (from the History and Mental State examination) e.g. unstable/intense relationship history, unstable self image, efforts to avoid real or imagined abandonment, impulsivity, recurrent suicidal behaviour, affective instability, chronic feelings of emptiness, inappropriate or intense anger, transient and stress-related paranoid ideation.	3	0 1 2 3
B.	Clarify the recent triggers/stressors.	1	0 1
C.	Check there are no symptoms better explained by another diagnosis e.g. bipolar disorder, psychosis or a substance use disorder.	1	0 1
D.	Get collateral history from her family or friends, if she agrees.	1	0 1
E.	Get history from her clinical records.	1	0 1
F.	Practicalities of undertaking the assessment: • Arrange privacy for the review – confidentiality issues • Therapeutic engagement – be non-confrontational, non-judgemental • Validate her distress while encouraging safe behaviour • See her with a crisis team staff member or nurse chaperone. If crisis team staff are available to assist, consider who should lead the interview (taking into account experience level and who will be best able to develop rapport.)	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)

Modified Essay Question 6 contd.

A comprehensive management plan which actively discourages admission for Abigail due to a past history of prolonged, difficult admissions with regression, angry acting out, and escalating self-harm, is located in Abigail's records. Abigail's regular follow-up is from a community mental health centre and a private psychotherapist. Abigail is now somewhat calmer and has started talking of staying with a friend overnight, as she's still angry with her father.

The private psychotherapist then arrives at the ED and talks with you before seeing Abigail. She offers to take Abagail home with her and to ensure her safety. The therapist lives with her partner and two small children at home.

Question 6.3 (6 marks)
Discuss your response to the psychotherapist's request.

		worth	mark (circle)
A.	History taking opportunity – gather collateral.	1	0 1
B.	Check the therapist's current formulation and treatment strategy, and whether this aligns with the community team's treatment plan.	2	0 1 2
C.	Discuss with the therapist your concerns about the inappropriate nature of her suggestion to take Abigail home: • Boundary breach • Damages the therapeutic relationship • After hours contact from the therapist in a crisis rewards and encourages future acting out • Inability of the therapist actually to ensure Abigail's safety • Possible risk to the therapist/her family	3	0 1 2 3
D.	Negotiate an agreement for a more appropriate place of discharge with the therapist and Abigail (e.g. to the friend) Arrange crisis team/community team follow-up and resumption of Abigail's usual psychotherapy appointments. Aim for a plan which is safe and preserves the therapeutic relationship.	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)