THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS

MOCK WRITTENS MODIFIED ESSAY PAPER 2023 – MODEL ANSWERS

Paper written Nov 2022 by the NSW Branch Training Committee and the Health, Education and Training Institute for Higher Education, and **adapted for use in NZ by the NZ Training Committee**

Note that these Mock Writtens papers are produced by local psychiatrists and academics 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 2.5 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 the MEQs, 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/essay-style/meq-instructions-to-examiners.aspx (login to college site first)

NB: In the real exam there's a more complex system to calculate the final marks which we can't replicate in a Mock exam. It's best to aim for well above 50% (60-65% is safer), to allow for that in the actual exam.

MODIFIED ESSAY QUESTION 1 (25 marks)

You are a junior consultant psychiatrist providing after hours cover to the Emergency Department. Your registrar calls you to discuss Mrs Smith, a 69-year-old retired receptionist, who was asked to come to the Emergency Department by her family doctor. She has presented with her husband and has requested that he join her in the assessment. Mrs Smith reports she has been her husband's primary carer for the last 3 years (he has dementia). Mrs Smith reports that she has not been feeling her usual self – she feels more irritable and gets flustered easily. She says her sleep is disturbed.

Question 1.1 (8 marks)
Describe (list and explain) the salient features of history and examination you would like your psychiatric registrar to focus on when assessing Mrs Smith. (*a list with no explanation will not receive any marks)*

		Mark (circle)
A	Risk Assessment – she & her husband are vulnerable, under stress & her coping's chaged: - Risk to self – plan, intent, imminence, past history, means. Risk of suicide/self-harm - Others – threats to others, intent, plan, past history. Specific risk of harm to husband - Other risks – finance, reputation, risk of falls	0 1 2
B	Assessment of Depressive Symptoms esp. occurring in older adults – important to screen for this, common Dx: - Sleep disturbance and sleep pattern - Fatigue - Psychomotor retardation - Loss of interest in living & anhedonia - Hopelessness - Memory and concentration problems - Weight and appetite changes	0 1 2
C	Past Psychiatric History: Earlier exposure of depression increases risk of depression later in life – again, screening for depression	0 1
D	Recent and Past Medical History – screening for contributors to depression or change in coping: check for hypothyroidism, medication use, pain, other recent illness associated with increased risk of depression in older people	0 1
E	Current Functioning – essential to evaluate this as her coping's changed, & as part of Risk Assessment: - ADL/IADL functioning - Social functioning - Impairment in functioning as a consequence and/or cause of depressive symptoms	0 1
F	External Supports – need to determine level of stressors, mitigating factors: - Nature and quality of supports e.g. family, friends, neighbours - Loneliness, degree of isolation - Other social supports e.g. any other carers for her husband	0 1
G	Mental State Examination – essential to diagnose cause of changed coping: - Level of engagement and rapport, appropriateness, any current intoxication - Look for signs of depression, mania, anxiety (mood and affect) - Look for delusions or other psychotic Sx linked with depression e.g. poverty, nihilistic delusions, guilt, etc.	0 1 2
H	Cognitive function – essential to diagnose cause of changed coping, effects of depression: - Cognitive screening results & features of any cognitive changes	0 1
	Did handwriting affect marking?	
	Up to a maximum of 8 marks in total **TOTAL**	

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

Modified Essay Question 1 contd.

You are a junior consultant psychiatrist providing after hours cover to the Emergency Department. Your registrar calls you to discuss Mrs Smith, a 69-year-old retired receptionist, who was asked to come to the Emergency Department by her family doctor. She has presented with her husband and has requested that he join her in the assessment. Mrs Smith reports she has been her husband's primary carer for the last 3 years (he has dementia). Mrs Smith reports that she has not been feeling her usual self – she feels more irritable and gets flustered easily. She says her sleep is disturbed.

Question 1.2 (3 marks)
Describe (list and explain) the key areas of concern in regard to risk.
(a list with no explanation will not receive any marks)

		Mark (circle)
A	Suicide risk (possible if Mrs Smith is stressed and depressed)	0 1
B	Elder abuse (if she's depressed she might neglect her husband, she might consider homicide or suicide/homicide if despairing and hopeless, there might be coercion or abuse of Mrs Smith &/or her husband by another party)	0 1 2
C	Self neglect/functional decline (a risk if she's becoming depressed and unable to care for herself & husband)	0 1
	Did handwriting affect marking?	
	Up to a maximum of 3 marks in total **TOTAL**	

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

Modified Essay Question 1 contd.

You are a junior consultant psychiatrist providing after hours cover to the Emergency Department. Your registrar calls you to discuss Mrs Smith, a 69-year-old retired receptionist, who was asked to come to the Emergency Department by her family doctor. She has presented with her husband and has requested that he join her in the assessment. Mrs Smith reports she has been her husband's primary carer for the last 3 years (he has dementia). Mrs Smith reports that she has not been feeling her usual self – she feels more irritable and gets flustered easily. She says her sleep is disturbed.

During the assessment, Mrs Smith reports feeling listless and fatigued, having problems concentrating, and worrying about how she can continue to care for Mr Smith. She expresses the view that the both of them are a burden to their children and says she thinks they'd both be better off dead. After the assessment, you and your registrar make a provisional diagnosis of major depressive disorder.

Question 1.3 (6 marks)
Describe (list and explain) the issues your registrar should consider to determine if Mrs Smith requires admission under the Mental Health Act. *(a list with no explanation will not receive any marks)*

		Mark (circle)
A	Her decision-making capacity and level of insight	0 1
B	Evidence of any cognitive decline, pychosis, or delirium on mental state examination	0 1
C	Risk assessment – suicidality, safety & care of husband, self-care, vulnerability (exploitation/abuse by others)	0 1 2
D	Attitude towards accepting treatment in the community (and any past Hx of this, if it exists)	0 1
E	Ability of the local community mental health services to provide assertive follow-up	0 1
F	Degree of community support – family, friends, other supports, would alternate arrangements for the care of her husband assist?	0 1
G	Ethical considerations i.e. beneficence vs non-maleficence, autonomy, justice	0 1
H	Current physical health – not in itself a criterion for use of the MHAct, but might add additional risk factors	0 1
	Did handwriting affect marking?	
	Up to a maximum of 6 marks in total **TOTAL**	

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

Modified Essay Question 1 contd.

You are a junior consultant psychiatrist providing after hours cover to the Emergency Department. Your registrar calls you to discuss Mrs Smith, a 69-year-old retired receptionist, who was asked to come to the Emergency Department by her family doctor. She has presented with her husband and has requested that he join her in the assessment. Mrs Smith reports she has been her husband's primary carer for the last 3 years (he has dementia). Mrs Smith reports that she has not been feeling her usual self – she feels more irritable and gets flustered easily. She says her sleep is disturbed.

During the assessment, Mrs Smith reports feeling listless and fatigued, having problems concentrating, and worrying about how she can continue to care for Mr Smith. She expresses the view that the both of them are a burden to their children and says she thinks they'd both be better off dead. After the assessment, you and your registrar make a provisional diagnosis of major depressive disorder.

Mrs. Smith tells you she does not want to be admitted to hospital for treatment because she has to look after her husband.

Question 1.4 (8 marks)
Discuss (list and debate) the pertinent ethical considerations in any decision to admit Mrs Smith.
(a list with no debate will not receive any marks)

		Mark (circle)
A	Beneficence and non-maleficence: - the risk of treatment – e.g. medication risks, and psychological distress from coercive treatment vs the benefits of treatment – e.g., restoration of her individual autonomy from treatment and vs the risk of harm due to her <u>not</u> getting treatment – Mrs Smith could harm herself or Mr Smith - the risk of harming family relationships vs the benefit of protecting family relationships	0 1 2 3
B	Autonomy, insight and capacity to consent: - Mrs Smith has a right to give informed consent – important not to undermine her autonomy & functioning - However if her capacity is impaired she may not be able to give informed consent - Her capacity to consent is related to specific decisions so Mrs Smith may have ethical capacity if she is able understand relevant information, relate that information to her personal situation, and make a balanced decision about a specific treatment	0 1 2
C	Justice: - If Mrs Smith refused treatment or was not admitted to hospital it could be a violation of the principle of justice if a person with severe illness were left untreated - However, it would be unjust to require Mrs Smith to be treated as an inpatient because of a lack of community resources to manage her illness at home, if that were otherwise feasible and safe	0 1 2
D	Pros and Cons: - The issues above need to be weighed up alongside the risk factors to determine which is most important, based on appropriate risk management while avoiding non-maleficence (i.e. not making things worse) - Prevention of harm is the key ethical basis to justify involuntary treatment	0 1 2
E	Psychiatrist's role and responsibilities: - The responsible psychiatrist & treating team need to consider their ongoing clinical and therapeutic relationship with Mrs Smith as well - The psychiatrist has a leadership role within the team in this debate and eventual decisions - If Mrs Smith is admitted, it will be important to determine who will care for Mr Smith, and where.	0 1 2
	Did handwriting affect marking?	
	Up to a maximum of 8 marks in total **TOTAL**	

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

Modified Essay Question 2 (23 marks)

You are a junior consultant psychiatrist working in the CL team in a busy general hospital. You are called to review a patient in the Emergency Department (ED) admitted under the Toxicology team. The patient, Hugo, is a 19-year-old man studying Veterinary Science. He normally lives with his mother. He has a difficult relationship with his father following his parents' separation when he was aged six. Their separation was acrimonious and was due to his father's excessive alcohol use and violence towards Hugo and his mother.

Hugo has a history of self-harm and has made a couple of previous suicide attempts by overdose requiring brief hospitalisation. The first overdose was in the context of his father remarrying when he was aged 16 and the second after an argument with an ex-girlfriend one year ago. Following his first suicide attempt his GP started him on fluoxetine which he took for 3 months before stopping because he didn't feel that it helped.

Hugo has a recent history of recreational drug use, mostly MDMA at university parties. He also occasionally binge drinks alcohol.

On this occasion, Hugo has been brought to hospital by ambulance following an overdose of promethazine. The ambulance report states that his girlfriend had called emergency services after he sent her a text message with a photograph of several empty pill packets. This was in the context of their relationship ending a few days earlier.

In ED, Hugo appears to be drowsy, disorientated and he is picking at the air as though something is there. He is awaiting transfer to the Toxicology ward. However, they have requested your input prior to this.

Question 2.1 (8 marks)

Describe (list and explain) your approach to the situation and the advice you would provide regarding short term management while Hugo is in hospital. *(a list without any explanation will not receive any marks)*

		Mark (circle)
A	Get information from records: - Review the medical history and investigations - Past psychiatric history – other episodes of depression, mania, psychosis - Substance use history – overdoses, treatment attempts, sequelae	0 1 2
B	Mental state examination: - emphasis on assessing his mood, thought form and content, insight - Cognitive assessment: bedside assessment by the psychiatrist, expect candidate to name a suitable instrument to assess his cognition. Delirium assessment - orientation, hallucinations, short term memory	0 1 2
C	Collateral: nursing staff caring for him since admission, toxicology team, GP, mother, ambulance service	0 1
D	Risk assessment & management: - Assess ongoing risk to Hugo, any risk to his girlfriend - Advise about the level of care, need for own room & special observations, falls risk, mgmt of disorientation - Possible use of MHA if he can't otherwise be kept safe	0 1 2
E	Ensure drug screening is done (urinary and bloods)	0 1
F	Symptomatic Mx advice: avoid anticholinergics, Diazepam PRN, cease any antidepressants in the short-term	0 1
G	Ensure follow-up: - Ongoing reviews & history, MSE clarification by CL team - Support and psychoeduction for nursing staff looking after him - Assessment pre discharge to decide if he needs inpatient care under psychiatry team vs community follow-up	0 1 2
H	Arrange initial liaison with university if Hugo consents to this once competent	0 1
	Did handwriting affect marking?	
	Up to a maximum of 8 marks in total **TOTAL**	

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

Modified Essay Question 2 contd.

You are a junior consultant psychiatrist working in a busy general hospital. You are called to review a patient in the Emergency Department (ED) admitted under the Toxicology team. The patient, Hugo, is a 19-year-old man studying Veterinary Science. He normally lives with his mother. He has a difficult relationship with his father following his parents' separation when he was aged six. Their separation was acrimonious and was due to his father's excessive alcohol use and violence towards Hugo and his mother.

Hugo has a history of self-harm and has made a couple of previous suicide attempts by overdose requiring brief hospitalisation. The first overdose was in the context of his father remarrying when he was aged 16 and the second after an argument with an ex-girlfriend one year ago. Following his first suicide attempt his GP started him on fluoxetine which he took for 3 months before stopping because he didn't feel that it helped.

Hugo has a recent history of recreational drug use, mostly MDMA at university parties. He also occasionally binge drinks alcohol.

On this occasion, Hugo has been brought to hospital by ambulance following an overdose of promethazine. The ambulance report states that his girlfriend had called emergency services after he sent her a text message with a photograph of several empty pill packets. This was in the context of their relationship ending a few days earlier.

In ED, Hugo appears to be drowsy, disorientated and he is picking at the air as though something is there. He is awaiting transfer to the Toxicology ward. However, they've requested your input prior to this.

You return to see Hugo 48 hours after admission. He's alert, orientated and Toxicology are requesting his transfer to a mental health unit. He tells you that he felt distressed by the relationship breakup. He is also stressed about disagreements with a supervisor at his clinical placement. He expresses remorse over his suicide attempt and assures you that he would not harm himself again if discharged. He describes impulsive behaviour like reckless driving and binge eating, saying his mood is 'always up and down'. His relationship history is characterised by intense, short-lived relationships that he finds intense and overwhelming. Hugo wants to know why he feels this way.

Question 2.2 (7 Marks)
Outline (list and justify) the primary diagnosis and differential diagnoses you would discuss with Hugo.
(a list without any justification will not receive any marks)

		Mark (circle)
A	Borderline personality disorder (due to presence of: affective instability, interpersonal difficulties, substance use, self-harm, impulsivity)	0 1 2 3
B	Persistent depressive disorder (history of suicidality, binge drinking, prescription of SSRI by GP)	0 1
C	Bipolar affective disorder type 2 (due to affective instability, lack of history of manic episodes but some evidence for depression)	0 1
D	Adjustment disorder (his self-harm was soon after a stressful rejection)	0 1
E	Substance induced mood disorder (alcohol is likely to cause lowered mood, and MDMA could elevate his mood)	0 1
F	Substance Use Disorder (due to the frequency & quantity of use, physical & psychological dependence, periods of abstaining, effects in other domains of his life – school, social, family)	0 1
G	Chronic Posttraumatic Stress Disorder (due to unresolved grief & trauma from the abuse in his childhood)	0 1
H	Cyclothymic disorder (due to affective instability, lack of history of manic episodes but some evidence for depression)	0 1
	Did handwriting affect marking?	
	Up to a maximum of 7 marks in total TOTAL	

Note to Examiner: Final mark is set at not more than 7 (i.e., if they score more, final mark is still 7)

Modified Essay Question 2 contd.

You are a junior consultant psychiatrist working in a busy general hospital. You are called to review a patient in the Emergency Department (ED) admitted under the Toxicology team. The patient, Hugo, is a 19-year-old man studying Veterinary Science. He normally lives with his mother. He has a difficult relationship with his father following his parents' separation when he was aged six. Their separation was acrimonious and was due to his father's excessive alcohol use and violence towards Hugo and his mother.

Hugo has a history of self-harm and has made a couple of previous suicide attempts by overdose requiring brief hospitalisation. The first overdose was in the context of his father remarrying when he was aged 16 and the second after an argument with an ex-girlfriend one year ago. Following his first suicide attempt his GP started him on fluoxetine which he took for 3 months before stopping because he didn't feel that it helped.

Hugo has a recent history of recreational drug use, mostly MDMA at university parties. He also occasionally binge drinks alcohol.

On this occasion, Hugo has been brought to hospital by ambulance following an overdose of promethazine. The ambulance report states that his girlfriend had called emergency services after he sent her a text message with a photograph of several empty pill packets. This was in the context of their relationship ending a few days earlier.

In ED, Hugo appears to be drowsy, disorientated and he is picking at the air as though something is there. He is awaiting transfer to the Toxicology ward. However, they've requested your input prior to this.

You return to see Hugo 48 hours after admission. He's alert, orientated and Toxicology are requesting his transfer to a mental health unit. He tells you that he felt distressed by the relationship breakup. He is also stressed about disagreements with a supervisor at his clinical placement. He expresses remorse over his suicide attempt and assures you that he would not harm himself again if discharged. He describes impulsive behaviour like reckless driving and binge eating, saying his mood is 'always up and down'. His relationship history is characterised by intense, short-lived relationships that he finds intense and overwhelming. Hugo wants to know why he feels this way.

Hugo says he wants to go home rather than continue being admitted. When you call his mother to discuss a discharge plan she expresses concerns about Hugo trying to self-harm again and wants to know why you won't keep him in hospital longer. You arrange a family meeting.

Question 2.3 (4 marks)
Describe (list and explain) the key task needed so as to arrange this family meeting, and the issues you will raise at the meeting.
(a list without any explanation will not receive any marks)

		Mark (circle)
	Before the meeting:	
A	Consent from Hugo is needed to meet with him and his mother and discuss her concerns. If he refuses, need to explain the impact this may have on his relationship with her and whether he can continue living with her	0 1
	At the meeting:	
B	Explain Hugo's diagnosis and any differential diagnoses	0 1
C	Explain the negatives of keeping Hugo in hospital – the minimal benefits of hospital admission for people with Borderline PD, limited role of pharmacotherapy, need for community-based therapy primarily, risk of Hugo's coping worsening in hospital, impact of hospitalisation on his studies	0 1
D	Discuss a safety plan: Provide information on how to access help 24/7 if he's at risk of self-harm, regular follow up & support with the community team, pharmacotherapy if any is appropriate, possible use of planned respite periods, involvement of his GP	0 1
E	Psychological treatment options: use of psychotherapy as the mainstay of his longer-term management	0 1
F	Offer liaison with the university – e.g. medical certificate/letter for the time missed and requesting extra time, if needed, for assessments	0 1
	Did handwriting affect marking?	
	Up to a maximum of 4 marks in total TOTAL	

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

Modified Essay Question 2 contd.

You are a junior consultant psychiatrist working in a busy general hospital. You are called to review a patient in the Emergency Department (ED) admitted under the Toxicology team. The patient, Hugo, is a 19-year-old man studying Veterinary Science. He normally lives with his mother. He has a difficult relationship with his father following his parents' separation when he was aged six. Their separation was acrimonious and was due to his father's excessive alcohol use and violence towards Hugo and his mother.

Hugo has a history of self-harm and has made a couple of previous suicide attempts by overdose requiring brief hospitalisation. The first overdose was in the context of his father remarrying when he was aged 16 and the second after an argument with an ex-girlfriend one year ago. Following his first suicide attempt his GP started him on fluoxetine which he took for 3 months before stopping because he didn't feel that it helped.

Hugo has a recent history of recreational drug use, mostly MDMA at university parties. He also occasionally binge drinks alcohol.

On this occasion, Hugo has been brought to hospital by ambulance following an overdose of promethazine. The ambulance report states that his girlfriend had called emergency services after he sent her a text message with a photograph of several empty pill packets. This was in the context of their relationship ending a few days earlier.

In ED, Hugo appears to be drowsy, disorientated and he is picking at the air as though something is there. He is awaiting transfer to the Toxicology ward. However, they have requested your input prior to this.

You return to see Hugo 48 hours after admission. He's alert, orientated and Toxicology are requesting his transfer to a mental health unit. He tells you that he felt distressed by the relationship breakup. He is also stressed about disagreements with a supervisor at his clinical placement. He expresses remorse over his suicide attempt and assures you that he would not harm himself again if discharged. He describes impulsive behaviour like reckless driving and binge eating, saying his mood is 'always up and down'. His relationship history is characterised by intense, short-lived relationships that he finds intense and overwhelming. Hugo wants to know why he feels this way.

Hugo says he wants to go home rather than continue being admitted. When you call his mother to discuss a discharge plan she expresses concerns about Hugo trying to self-harm again and wants to know why you won't keep him in hospital longer. You arrange a family meeting.

Hugo mentions that he has been thinking about 'doing therapy'.

Question 2.4 (4 marks)
Describe (list and explain) the types of psychotherapy that may be suitable for Hugo.
(a list without any explanation will not receive any marks)

		Mark (circle)
A	Dialectical behaviour therapy – evidence-based intervention for Borderline PD	0 1 2
B	Psychodynamic psychotherapy – often used in conjunction with DBT in patients with Borderline PD	0 1 2
C	Cognitive behavioural therapy – a possibility, but less strong evidence for its efficacy in DBT. Might be useful if he were also depressed	0 1
D	Family therapy/relationship counselling – Hugo and his mother might need more sessions, or he and his girlfriend might request this if they continue their relationship	0 1
E	Mentalization-based therapy – evidence-based intervention for Borderline PD	0 1
F	Motivational Interviewing for substance use – likely to be needed alongside DBT for harm reduction	0 1
	Did handwriting affect marking?	
	Up to a maximum of 4 marks in total TOTAL	

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

Modified Essay Question 3 (25 marks)

You are a junior consultant working in private practice in the community. A 32-year-old recently married woman, Kylie, comes to see you. She was diagnosed with ADHD in high school and has been intermittently followed up by other doctors over the last 15 years, sometimes with stimulant medication which does help her.

Question 3.1 (6 Marks)
List the symptoms and signs of ADHD you would be looking for, to clarify whether Kylie has ADHD.

		Mark (circle)
A	**Min. 5 symptoms of inattention and/or min. 5 symptoms of hyperactivity/impulsivity** must have persisted for **at least 6 months** to a degree that's inconsistent with the developmental level and which negatively impacts social and academic/occupational activities. (1 mark if these criteria are explained) Symptoms of inattention are: (up to 3 marks depending how many of these are given) • Often fails to give close attention to details or makes careless mistakes at work, or in other activities • Often has trouble holding attention on tasks or activities • Often does not seem to listen when spoken to directly • Often does not follow through and fails to finish work tasks, chores, or duties in the home (side-tracked) • Often has trouble organizing tasks and activities • Often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time • Often loses things necessary for tasks and activities (e.g. pens, keys, glasses, mobile phone) • Is easily distracted • Is often forgetful in daily activities Symptoms of hyperactivity and impulsivity are: (up to 3 marks depending how many of these are given) • Often fidgets or taps hands or feet, or squirms in seat • Has difficulty staying seated, or complains of restlessness • Often described as disruptive or rowdy • Is often "on the go" as if "driven by a motor" • Often talks excessively • Often blurts out an answer before a question has been completed • Often has trouble waiting their turn • Often interrupts or intrudes on others (e.g. butts into conversations)	0 1 2 3 4
B	Several symptoms (inattentive or hyperactive/impulsive) were present before age 12	0 1
C	Several symptoms (inattentive or hyperactive/impulsive) must be present in at least 2 settings (e.g. at home or work, with friends or relatives, other settings)	0 1
D	Her symptoms interfere with or reduce her social or occupational functioning	0 1
E	Symptoms don't occur exclusively due to schizophrenia or another psychotic disorder and are not better explained by another mental disorder (eg., mood, anxiety, dissociative or personality disorder, or substance intoxication or withdrawal)	0 1
	Did handwriting affect marking?	
	Up to a maximum of 6 marks in total **TOTAL**	

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

Modified Essay Question 3 contd.

You are a junior consultant working in private practice in the community. A 32-year-old recently married woman, Kylie, comes to see you. She was diagnosed with ADHD in high school and has been intermittently followed up by other doctors over the last 15 years, sometimes with stimulant medication which does help her.

Kylie is a school teacher and is having difficulty organising herself at work. She's behind on her paperwork and says school reports are due soon but she hasn't started writing them. She's been off stimulant medication for the last 3 years. At home, she's having difficulty managing to look after her 4-year-old stepson by marriage. She wants to try and get pregnant this year.

Question 3.2 (8 marks)
Describe (list and explain) what further issues you would explore with Kylie.
(a list without explanation will not receive any marks)

		Mark (circle)
A	**Explore the current difficulties to clarify the issues:** e.g. her functioning at work (and any work-place stressors). Her coping as a parent – can she prioritise her step-son's needs? Are there behavioural difficulties with her step-son – if so what and why? Have any concerns been raised by his day care? Has there been any involvement of Oranga Tamariki? How's the relationship with her husband?	0 1 2 3
B	**Explore any other psychiatric co-morbid conditions**: (need to clarify all the stressors/issues) e.g. substance use disorder, anxiety, depression, complex developmental trauma/PTSD	0 1 2
C	**Explore Kylie's attitudes to pregnancy:** (important given that she's already struggling) Why does she wants to get pregnant this year? Has she discussed this with her husband? Has she considered the impacts of pregnancy and early motherhood on her wellbeing and coping? Has she considered the welfare of the baby and her step-son? Is she prepared for a shift in roles?	0 1 2
D	**Explore her supports:** (crucial if she's to cope with her current situation, let alone a pregnancy) Have she/her husband got family locally who could help? Close friends or neighbours? Financial ability to cope with her not working/extra child/funding additional care etc.? Might she need mothercraft or similar social support?	0 1
E	**Discuss the safety of stimulant medications in pregnancy**: (esential that she understands the risks) Check her understanding and give psychoeducation: generally dexamphetamine is safer than methylphenidate in pregnancy. All stimulants have the potential to reduce placental functioning, to increase risk of premature labour, to restrict foetal growth and to cause neonatal abstinence syndrome. In the 1st trimester there's a marginally raised risk of cardiac defects. Lactation is contraindicated (milk concentration can be 2.5 x plasma level)	0 1 2
F	**Check her past response to non-pharmacological management:** (need a full history re the ADHD) e.g. has she tried ADHD coaching, neurofeedback, psychotherapy of any sort? How did it go, if so?	0 1
	Did handwriting affect marking?	
	Up to a maximum of 8 marks in total **TOTAL**	

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

Modified Essay Question 3 contd.

You are a junior consultant working in private practice in the community. A 32-year-old recently married woman, Kylie, comes to see you. She was diagnosed with ADHD in high school and has been intermittently followed up by other doctors over the last 15 years, sometimes with stimulant medication which does help her.

Kylie is a school teacher and is having difficulty organising herself at work. She's behind on her paperwork and says school reports are due soon but she hasn't started writing them. She's been off stimulant medication for the last 3 years. At home, she's having difficulty managing to look after her 4-year-old stepson by marriage. She wants to try and get pregnant this year.

Kylie is not functioning well and wants to consider starting medication for ADHD.

Question 3.3 (4 marks)
Describe (list and explain) your approach to management. *(a list without explanation will not receive any marks)*

How would you access the most recent information on this?

		Mark (circle)
A	**Need to include her husband** in this, as any problems would affect them both, esp. if she becomes pregnant. If she refuses, explore why and try to persuade her. She may need his help remembering details, as well as support	0 1
B	**1st line: Stimulants** (with pregnancy safety category) • Dexamphetamine (B3) • Lisdexamfetamine (Vyvanse) (B3) • Methylphenidate (Ritalin) (D) • Methylphenidate long-acting (D) • Methylphenidate modified release (Concerta) (D) Should be some explanation of what the pregnancy categories mean and which options are safer. Note that there's some uncertainty with the categorical classification of drugs and most drugs recommended during gestation are either category B or C. The key is careful risk-benefit analysis and a well-informed patient decision	0 1 2 3
C	**Give written information** – as she may not be attending all that well and the details are complicated. e.g. write her and her husband a summary of the issues, and give pharmacological handouts	0 1
D	**Non-stimulants** (with pregnancy safety category) **2nd line:** • Atomoxetine (B3) • Clonidine (B3) • Guanfacine (B3) **3rd line:** • Modafinil (D) • Buproprion (B2) • Reboxetine (B1) • Venlafaxine (B2)	0 1 2
E	**Accessing information:** via MIMS or similar, do a literature review, consult a perinatal psychiatrist, discuss at peer review group, get supervision from an experienced colleague, etc.	0 1
	Did handwriting affect marking?	
	Up to a maximum of 4 marks in total **TOTAL**	

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

Modified Essay Question 3 contd.

You are a junior consultant working in private practice in the community. A 32-year-old recently married woman, Kylie, comes to see you. She was diagnosed with ADHD in high school and has been intermittently followed up by other doctors over the last 15 years, sometimes with stimulant medication which does help her.

Kylie is a school teacher and is having difficulty organising herself at work. She's behind on her paperwork and says school reports are due soon but she hasn't started writing them. She's been off stimulant medication for the last 3 years. At home, she's having difficulty managing to look after her 4-year-old stepson by marriage. She wants to try and get pregnant this year.

Kylie is not functioning well and wants to consider starting medication for ADHD.

Kylie has her baby, and a year later consults with you when the newborn is 12 weeks old and breastfeeding. Kylie has not been on any psychiatric medications in her postnatal period. Her ADHD is significantly impairing her functioning, her marriage is under strain, and she wants help.

Question 3.4 (7 marks)
Outline (list and justify) the management strategies you would consider implementing.
(a list without justification will not receive any marks)

		Mark (circle)
A	**General approach (essential for a good therapeutic alliance):** Need to be empathic, non-judgmental, have a practical & holistic biopsychosocial approach	0 1
B	**Include her key supports (important as they need to know the issues to support her and to cope as well):** Include her husband or arrange a family meeting as next step, etc.	0 1
C	**Exclude other conditions (essential to assess the issues and provide effective advice/intervention):** e.g. post-natal depression/puerperal psychosis/mania. Check for sleep deprivation (exhaustion)	0 1
D	**Biological management (as she's requesting assistance, and it's helped in the past):** - Consider medications for ADHD. Discuss risks of these in breastfeeding (they're not esp. safe), the pros/cons of taking medication at this point, might she stop breastfeeding? – how much longer might she want to continue this, benefits and risks of continuing breastfeeding if she's on meds - Maximise her sleep – consider use of an hypnotic (but also consider safety of these in breastfeeding)	0 1 2
E	**Psychological management (as she's asking for assistance and breastfeeding):** ADHD coaching, breast feeding advice if needed, marital counselling if needed, sleep hygiene education, psychotherapy at a later stage when she can manage this. Consider mothercraft support including admission to a specialised facility for technique and coaching. Other interventions – refer to local perinatal service or community support worker, to a parenting programme to enhance mentalisation of baby, build her capacity & facilitate a secure attachment environment.	0 1 2
F	**Social management (as she's asking for assistance and isn't coping):** Consider ways to assist her with meals, shopping, housework, childcare (e.g. relatives, friends, paid external help). Could she share feeds with husband (e.g. express breastmilk and he can give a bottle overnight, or husband/mother/etc. can give an overnight formula bottle as expressing is laborious and can take too much time/energy – she may need to be given permission to use formula and not feel guilty), Could she link in with mothers' groups (playgroups/library baby groups/early childhood centre etc.) Could she get out for 30min daily without baby (i.e. can childcare be arranged) to walk in fresh air & sunshine Any child protection concerns need to be addressed	0 1 2
G	**Follow-up and liaison (essential to continue monitoring & communicate with all professionals involved):** Arrange follow-up, liase with her GP, Plunket nurse, any other services or supports involved	0 1
	Did handwriting affect marking?	
	Up to a maximum of 7 marks in total **TOTAL**	

Note to Examiner: Final mark is set at not more than 7 (i.e. if they score more, final mark is still 7)

Modified Essay Question 4 (22 marks)

You are a generalist junior consultant psychiatrist on duty for the Emergency Department. You have been asked to assess a 14-year-old boy, Jake, brought by the police and ambulance to the ED.

The police documentation indicates “domestic dispute with his mother Mary. Has punched holes in the wall and set furniture on fire. According to his mother, he has also been threatening to kill the family cat and has tried to poison it in the past.”

The ED psychiatry registrar has seen Jake and described him as sullen and sitting with his arms crossed, refusing to speak. His mother was seen in the ED yelling at him "if you keep doing this, you’ll never be allowed to come home. I’ve had enough!”

Question 4.1 (3 marks)
Describe (list and explain) how you would approach the interview with Jake as part of a comprehensive psychiatric assessment. *(a list without any explanation will not receive any marks)*

		Mark (circle)
A	**Safety** - Ensure Jake seen in a quiet, low stimulus setting - Consider impacts upon rapport/whether it is appropriate for security/police to remain outside	0 1
B	**Direct assessment of Jake** - Offer to see Jake alone. - attempts to build rapport. - Explicitly discuss confidentiality and limits of confidentiality. - Observe for signs of substance intoxication, overt psychosis or mood disorder.	0 1 2
C	**Collateral Information** - Explains need to seek collateral information from his mother and other sources (e.g., emergency services). - Considers Gillick competence to give or refuse consent to interview and seeking collateral information.	0 1 2
	Did handwriting affect marking?	
	Up to a maximum of 3 marks in total **TOTAL**	

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

Modified Essay Question 4 contd.

You are a generalist junior consultant psychiatrist on duty for the Emergency Department. You have been asked to assess a 14-year-old boy, Jake, brought by the police and ambulance to the ED.

The police documentation indicates “domestic dispute with his mother Mary. Has punched holes in the wall and set furniture on fire. According to his mother, he has also been threatening to kill the family cat and has tried to poison it in the past.”

The ED psychiatry registrar has seen Jake and described him as sullen and sitting with his arms crossed, refusing to speak. His mother was seen in the ED yelling at him "if you keep doing this, you’ll never be allowed to come home. I’ve had enough!”

Jake eventually agrees to speak and says that he has had enough of his mother who keeps asking him to stop hurting the cat. He points to himself and says, “This is Jake, and the mother is always giving Jake shit for not going to school. The mother doesn’t care about Jake and is only nice to her feline. The felines don’t know the rules and don’t care about rules. Jake tried to poison the new feline because it wouldn’t listen to Jake, when he told the feline to piss in its litter box. The stupid feline keeps pissing in Jake’s room.”

When asked about drug use, he said: “Jake smokes ‘fortified tetrahydrocannabidiol’, because the ‘diol’ is twice the strength and makes Jake’s mind chill twice as hard. It’s a legal mind medicine in parts of the world.” He denied using alcohol or other drugs.

Question 4.2 (8 marks)
Describe (list and explain) the aspects of history that you need to explore with Jake.
(a list without any explanation will not receive any marks)

		Mark (circle)
A	History of relationship with mother and other adult carers: (assessing current situation, Jake’s POV & stressors) - Family context and structure – e.g. members of family, who lives at home - Duration of difficulties with his mother - Role of his father or other significant adults in his life - Abuse and trauma - physical, emotional or sexual abuse by adult carers	0 1 2
B	History of school attendance: (assessing functioning) Last regular attendance & what does he do when not at school. Behavioural problems, suspensions or expulsions	0 1
C	Assess for Autism Spectrum Disorder: (his speech and manner make this a possibility) Due to Jake’s unusual syntax – refers to Mary as ‘the mother’ and not ‘Mum’, himself as ‘Jake’ & cats as ‘felines’	0 1 2
D	Assess for ADHD (which can cause disturbed behaviour): inattention, hyperactivity/restlessness, past diagnosis?	0 1
E	Psychiatric symptom screening for differentials and comorbidities: - Any psychotic symptoms, especially hallucinations &/or persecutory beliefs (his ideas are very odd) - Any co-occurring anxiety/OCD symptoms - Any symptoms of mood disorder, especially hypomania or mania	0 1
F	Screen for Intellectual Disability or learning problems (re comorbidities)	0 1
G	Screen for Conduct disorder symptoms (re comorbidities), & involvement with youth justice services or police	0 1
H	Risk assessment – must get history to assess risks of harm to self, others and of impaired self-care (safety)	0 1 2
I	Drug and alcohol assessment including motivation to change: (re comorbidities) - Frequency/quantity of use, physical/psychological dependence, periods of abstaining, effects in other domains of life like school, family, friends	0 1
J	Any involvement with care and protection services? (re his disturbed behaviour)	0 1
	Did handwriting affect marking?	
	Up to a maximum of 8 marks in total **TOTAL**	

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

Modified Question 4 contd.

You are a generalist junior consultant psychiatrist on duty for the Emergency Department. You have been asked to assess a 14-year-old boy, Jake, brought by the police and ambulance to the ED.

The police documentation indicates “domestic dispute with his mother Mary. Has punched holes in the wall and set furniture on fire. According to his mother, he has also been threatening to kill the family cat and has tried to poison it in the past.”

The ED psychiatry registrar has seen Jake and described him as sullen and sitting with his arms crossed, refusing to speak. His mother was seen in the ED yelling at him "if you keep doing this, you’ll never be allowed to come home. I’ve had enough!”

Jake eventually agrees to speak and says that he has had enough of his mother who keeps asking him to stop hurting the cat. He points to himself and says, “This is Jake, and the mother is always giving Jake shit for not going to school. The mother doesn’t care about Jake and is only nice to her feline. The felines don’t know the rules and don’t care about rules. Jake tried to poison the new feline because it wouldn’t listen to Jake, when he told the feline to piss in its litter box. The stupid feline keeps pissing in Jake’s room.”

When asked about drug use, he said: “Jake smokes ‘fortified tetrahydrocannabidiol’, because the ‘diol’ is twice the strength and makes Jake’s mind chill twice as hard. It’s a legal mind medicine in parts of the world.” He denied using alcohol or other drugs.

Jake’s mother says that Jake has always been a bit odd, and that he can’t make or keep friends. She says he’s hated the cats forever, is always trying to teach them ‘human rules’, and then yells at them when they don’t do what he wants. He’s refused to see a paediatrician or psychologist because he doesn’t think that he has a problem. She says he can be calm one minute and then ‘lose it’ if she asks him to stop obsessing over rules. His mother explains that he only ever refers to himself by his first name.

Question 4.3 (4 marks)
Describe (list and explain) the main information you need to obtain from Jake’s mother or from any other sources. *(a list without any explanation will not receive any marks)*

		Mark (circle)
A	**From his mother** - Developmental history (e.g. milestones, childhood anxiety) - Social development, especially re social reciprocity - Family psychiatric history, esp. screening for anxiety, ASD, OCD, learning difficulties - History suggesting psychotic or mood disorder - Any other substance use history - Any knowledge of significant traumas/stressors	0 1 2 3
B	**From the Emergency Services & ED** - Behaviour when apprehended by police/ambulance - Behaviour in the ED	0 1
C	**From his GP** - Any additional medical history, history of any investigations, referrals, etc.	0 1
D	**From his school** - Any stressors at school - Any known learning difficulties – was he ever in a special/remedial class - His friends and type of friends (e.g. odd peers, disruptive or antisocial peers) - Distractibility, impulsivity, disruptiveness in class - Behaviour with peers vs behaviour alone - Whether his behaviour tends to violate the rights of others	0 1 2
	Did handwriting affect marking?	
	Up to a maximum of 4 marks in total **TOTAL**	

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

Modified Question 4 contd.

You are a generalist junior consultant psychiatrist on duty for the Emergency Department. You have been asked to assess a 14-year-old boy, Jake, brought by the police and ambulance to the ED.

The police documentation indicates “domestic dispute with his mother Mary. Has punched holes in the wall and set furniture on fire. According to his mother, he has also been threatening to kill the family cat and has tried to poison it in the past.”

The ED psychiatry registrar has seen Jake and described him as sullen and sitting with his arms crossed, refusing to speak. His mother was seen in the ED yelling at him "if you keep doing this, you’ll never be allowed to come home. I’ve had enough!”

Jake eventually agrees to speak and says that he has had enough of his mother who keeps asking him to stop hurting the cat. He points to himself and says, “This is Jake, and the mother is always giving Jake shit for not going to school. The mother doesn’t care about Jake and is only nice to her feline. The felines don’t know the rules and don’t care about rules. Jake tried to poison the new feline because it wouldn’t listen to Jake, when he told the feline to piss in its litter box. The stupid feline keeps pissing in Jake’s room.”

When asked about drug use, he said: “Jake smokes ‘fortified tetrahydrocannabidiol’, because the ‘diol’ is twice the strength and makes Jake’s mind chill twice as hard. It’s a legal mind medicine in parts of the world.” He denied using alcohol or other drugs.

Jake’s mother says that Jake has always been a bit odd, and that he can’t make or keep friends. She says he’s hated the cats forever, is always trying to teach them ‘human rules’, and then yells at them when they don’t do what he wants. He’s refused to see a paediatrician or psychologist because he doesn’t think that he has a problem. She says he can be calm one minute and then ‘lose it’ if she asks him to stop obsessing over rules. His mother explains that he only ever refers to himself by his first name.

After your assessment, Jake appears to be calmer, and his mother is open to taking him home.

Question 4.4 (2 marks)

Outline (list and justify) the main differentials of your principal diagnosis.

(*a list without any justification will not receive any marks)*

		Mark (circle)
A	**Autism Spectrum Disorder** – possible due to his odd syntax and use of names/epithets, his rigidity of viewpoint, the long-term nature of the problems, his fixation on and odd beliefs about the drug he uses, his problems socialising. *Note to markers: this differential is the most likely and uness included, this question scores zero.*	0 1 2
B	**Anxiety Disorder or Obsessive Compulsive Disorder** – possible due to his agitation and distress about the cats, his use of the drug to feel “chill” (self-medication?), his possible obsessions about the cats, his rigidity about “rules”. Regular cannabis use could be making it worse and be a partial cause.	0 1 2
C	**Schizotypal Personality Disorder** – possible due to his long-term bizarre beliefs which sound fixed – about the cats, and about the effects of the drug he uses, and his social isolation. Regular cannabis use could be making it worse and be a partial cause.	0 1 2
D	**Schizophrenia** (not Schizopheniform Disorder as it’s been going on too long) – possible due to his bizarre, fixed beliefs which might be delusional if explored further, and the long-term nature of his ideation. Regular cannabis use could be making it worse and be a partial cause.	0 1 2
	Did handwriting affect marking?	
	Up to a maximum of 2 marks in total **TOTAL**	

Note to Examiner: Final mark is set at not more than 2 (i.e. if they score more than 2, final mark is still 2)

Modified Question 4 contd.

You are a generalist junior consultant psychiatrist on duty for the Emergency Department. You have been asked to assess a 14-year-old boy, Jake, brought by the police and ambulance to the ED.

The police documentation indicates “domestic dispute with his mother Mary. Has punched holes in the wall and set furniture on fire. According to his mother, he has also been threatening to kill the family cat and has tried to poison it in the past.”

The ED psychiatry registrar has seen Jake and described him as sullen and sitting with his arms crossed, refusing to speak. His mother was seen in the ED yelling at him "if you keep doing this, you’ll never be allowed to come home. I’ve had enough!”

Jake eventually agrees to speak and says that he has had enough of his mother who keeps asking him to stop hurting the cat. He points to himself and says, “This is Jake, and the mother is always giving Jake shit for not going to school. The mother doesn’t care about Jake and is only nice to her feline. The felines don’t know the rules and don’t care about rules. Jake tried to poison the new feline because it wouldn’t listen to Jake, when he told the feline to piss in its litter box. The stupid feline keeps pissing in Jake’s room.”

When asked about drug use, he said: “Jake smokes ‘fortified tetrahydrocannabidiol’, because the ‘diol’ is twice the strength and makes Jake’s mind chill twice as hard. It’s a legal mind medicine in parts of the world.” He denied using alcohol or other drugs.

Jake’s mother says that Jake has always been a bit odd, and that he can’t make or keep friends. She says he’s hated the cats forever, is always trying to teach them ‘human rules’, and then yells at them when they don’t do what he wants. He’s refused to see a paediatrician or psychologist because he doesn’t think that he has a problem. She says he can be calm one minute and then ‘lose it’ if she asks him to stop obsessing over rules. His mother explains that he only ever refers to himself by his first name.

After your assessment, Jake appears to be calmer, and his mother is open to taking him home.

Question 4.5 (5 marks)
Outline (list and justify) your initial management plan, including which services you would refer Jake to.
(a list without any justification will not receive any marks)

		Mark (circle)
A	*Safety (crucial to base risk management on risk assessment – safety is paramount)* - Re-assess his risk to others, especially mother and pets, before discharge home - Set up a crisis management plan & give his mother 24/7 contact numbers for the local crisis team	0 1 2
B	*Referrals* - CAMHS (due to his age and the need for specialist CAP assessment and teatment) - Psychologist (needed for expert assessment and to rule out Intellectual Disability as an extra factor: ideally organised via the CAMHS team) - Paediatrician (due to his age and the need to rule out any organic cause – & in some areas paediatricians do ASD assessment/treatment) - Family therapist (due to the conflict and high expresed emotion at home, ideally organised via the CAMHS team) - Speech therapy (for his unusual syntax and speech: ideally organised via the CAMHS team) - Occupational therapy (functional assessment & social skills training: ideally organised via the CAMHS team) - Youth Drug and Alcohol Services (due to his regular cannabis use) - Care and protection services (if required – e.g. if his mother cannot care for him, or if child abuse exists) - Social worker/WINZ (to help his mother arrange a Disability Allowance)	0 1 2 3
C	*ASD Treatment* - Non-pharmacological – psychological and behavioural strategies at home and school, such as CBT, modelling, peer training, cartooning, self-management techniques, social skills training. NB: enlisting allied health workers, teachers, etc. is important to assist with behavioural targets - Pharmacological – aim to treat any comorbidities e.g. anxiety, OCD, ADHD, psychosis	0 1 2 3
	Did handwriting affect marking?	
	Up to a maximum of 5 marks in total **TOTAL**	

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

Modified Essay Question 5 (30 marks)

You are working as a junior consultant psychiatrist in a Youth Community Public Mental Health Centre. You have received a referral letter from a GP (with input from the school counsellor) regarding Marcie, an 18-year-old student who is in year 12 at the local co-ed high school. Marcie lives with her mother – her father died when she was two and she has no siblings.

The GP's letter states that Marcie started at her current school in year 9 – she was previously in an all-girls school. Marcie was previously well, engaged in a range of sports and had no academic concerns. However, her grades for the last term have been very poor. Lately, teachers have raised concerns about her lack of engagement with other students, and reported that she has suffered panic attacks when asked to speak in front of others.

They say she has been reluctant to come to any sports or swimming events this year. She prefers to wear her loose-fitting sports uniform to school every day. In addition, Marcie recently cut her hair very short. There has also been a steady decline in her body weight from 70 kg to 60 kg and to a BMI of 20 from a previous 23.

Marcie appears reluctant to mix with her previous friends. A brief same-sex relationship earlier this year did not go well.

Staff have not witnessed any bullying at school. The school counsellor has raised possible concerns about alcohol use and use of diuretics but was unsure and said this could just be school gossip. Marcie has recently been referring to herself as "Marc" rather than Marcie.

Marc/Marcie has asked to see you on their own today.

Question 5.1 (9 marks)
Describe (list and explain) the details of your assessment. (*a list without explanation will not receive any marks*)

		Mark (circle)
A	**Establish rapport**. Allow a safe space for Marc to feel heard, validated and accepted. Ask if Marc would like a support person present. Enquire about current concerns, about reason for presentation from Marc's perspective.	0 1
B	**Ask about Marc's gender identity once some rapport's established** – try to set Marc at ease if possible. Discuss in a non-judgmental, sensitive manner. Ask how Marc likes to be addressed and then stick to Marc's preference for name & pronouns. Try to clarify whether Marc's attracted to same-sex as gay, or from gender dysphoria thus identifies as male – only important in terms of how Marc feels about the issue and whether it causes confusion/shame etc.	0 1
C	**Personal history:** birth order, childhood attachments, family structure, home life/ living situation, financial status/part time work, relationships/peers/supports. Ask about isolation from peers, prior relationship with same-sex partner, poor grades this year.	0 1 2
D	**Psychiatric history**: check for recent onset or pre-existing symptoms, evidence of specific psychiatric syndromes (e.g. mood, anxiety, eating, dissociative, or psychotic disorders; and gender dysphoria). Check for any link with alcohol use. Check for any history of deliberate self-harm, co-morbid substance use disorder incl. tobacco use e.g. to lose weight. Ask about medication abuse: e.g. laxative/diuretic use, appetite suppressants/stimulants for weight loss. Try to assess whether wearing loose clothing is to de-accentuate female curves & hide breasts or to hide an eating disorder. Check the family and past psychiatric history.	0 1 2
E	**Medical history & (with Marc's permission and done sensitively) physical exam**: Check for physical health symptoms & signs related to weight loss. Check for sequelae of alcohol use – e.g. Sx & signs of pancreatitis, liver disease, peripheral signs. Look for sequelae of bingeing/purging. Assess genital & breast development – rule out an intersex state. Note any body shape changes and whether Marc adopts male postures/stances. Does Marc breast-bind?	0 1 2
F	**Mental state examination**: **Appearance**: assess whether Marc establishes rapprt and engages, alertness. Evaluate if Marc dresses androgynously – e.g. loose clothing, binding/hiding breasts. Look for female vs male self-care re: hairstyle, fingernails, makeup, any jewellery. **Behaviour:** Look for any psychomotor agitation or retardation, withdrawal/anxiety/shyness. Any signs of substance intoxication or withdrawal. **Thought content.** Assess risk-related concerns – safety, e.g. self-harm ideation, low self-esteem, self-loathing, feelings of isolation and alienation. Any clash between biologic sex & self-assigned gender. Marc's views on that, how does Marc feel? **Mood**: Assess mood state and affective reactions. Appropriate affect? Depressed? Anxious? **Perception:** check for dissociative experiences, feelings of being the wrong sex. Ask about distress re weight or sex - eg. about body shape/size/appendages. Rule out Sx of psychosis or substance induced experiences.	0 1 2
G	**Investigations**: Arrange FBC (checking MCV – re EtOH/nutritional deficits), Electrolytes/Renal fn/TFT/LFT (GGT re EtOH abuse, low albumin re poor nutritional state). Check Lipase, CMP, HbA1C, LH/FSH, Testosterone, Estradiol, Prolactin levels. Get an ECG – rule out arrhythmia in context of EtOH use or eating disorder.	0 1
H	**Further Assessment:** With Marc's consent, organize a meeting with the teacher/school counsellor and Marc's mother.	0 1
	Did handwriting affect marking?	
	Up to a maximum of 9 marks in total **TOTAL**	

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

Modified Essay Question 5 contd.

You are working as a junior consultant psychiatrist in a Youth Community Public Mental Health Centre. You have received a referral letter from a GP (with input from the school counsellor) regarding Marcie, an 18-year-old student who is in year 12 at the local co-ed high school. Marcie lives with her mother – her father died when she was two and she has no siblings.

The GP's letter states that Marcie started at her current school in year 9 – she was previously in an all-girls school. Marcie was previously well, engaged in a range of sports and had no academic concerns. However, her grades for the last term have been very poor. Lately, teachers have raised concerns about her lack of engagement with other students, and reported that she has suffered panic attacks when asked to speak in front of others.

They say she has been reluctant to come to any sports or swimming events this year. She prefers to wear her loose-fitting sports uniform to school every day. In addition, Marcie recently cut her hair very short. There has also been a steady decline in her body weight from 70 kg to 60 kg and to a BMI of 20 from a previous 23.

Marcie appears reluctant to mix with her previous friends. A brief same-sex relationship earlier this year did not go well.

Staff have not witnessed any bullying at school. The school counsellor has raised possible concerns about alcohol use and use of diuretics but was unsure and said this could just be school gossip. Marcie has recently been referring to herself as "Marc" rather than Marcie.

Marc/Marcie has asked to see you on their own today.

Question 5.2 (5 marks)
Based on the information provided, outline (list and justify) the differential diagnoses you would consider.
(a list with no justification will not receive any marks)

		Mark (circle)
A	**Gender Dysphoria:** Possible due to Marc's probable dysphoria from perceived incongruence between biological sex and gender identity – this is indicated by preference for the name Marc, transfer from an all-girls school, the more masculine haircut, wearing concealing clothing and sports gear, avoiding change rooms. The weight loss might be to reduce breast size and curves, and poor grades, anxiety Sx, social isolation and possible alcohol use might be from distress and confusion about these issues	0 1 2
B	**Intersex Condition:** Much less likely to present so late but it could cause gender confusion and needs to be ruled out via assessment, examination and tests	0 1
D	**Body Dysmorphia:** Also need to rule out any perceived defect or unacceptability of body shape/size/breasts which is not due to any gender dysphoria or eating disorder	0 1
E	**Social Anxiety Disorder:** Possible, due to the Hx of panic attacks at school when asked to speak in public, and Hx of social avoidance and isolation	0 1
F	**Major Depressive Disorder:** Possible due to the indication in the Hx that Marc might have low mood – distress, isolation, poor coping, poor grades, and weight loss	0 1
G	**Eating Disorder NOS:** Possible due to Marc's weight loss and preference for baggy clothes. Also the school gossip that Marc might use a diuretic	0 1
H	**Alcohol Use Disorder:** The only indicator of this is the school gossip nonetheless it needs to be assessed and ruled out as it's a common problem in distressed young people and often co-morbid with anxiety & mood disorders	0 1
	Did handwriting affect marking?	
	Up to a maximum of 5 marks in total **TOTAL**	

Note to Examiner: 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.

You are working as a junior consultant psychiatrist in a Youth Community Public Mental Health Centre. You have received a referral letter from a GP (with input from the school counsellor) regarding Marcie, an 18-year-old student who is in year 12 at the local co-ed high school. Marcie lives with her mother – her father died when she was two and she has no siblings.
The GP's letter states that Marcie started at her current school in year 9 – she was previously in an all-girls school. Marcie was previously well, engaged in a range of sports and had no academic concerns. However, her grades for the last term have been near failing. Lately, teachers have raised concerns about her lack of engagement with other students, and reported that she has suffered panic attacks when asked to speak in front of others.

They say she has been reluctant to come to any sports or swimming events this year. She prefers to wear her loose-fitting sports uniform to school every day. In addition, Marcie recently cut her hair very short. There has also been a steady decline in body weight from 70 kg to 60 kg and to a BMI of 20 from a previous 23.

Marcie appears reluctant to mix with her previous friends. A brief same-sex relationship earlier this year did not go well.

Staff have not witnessed any bullying at school. The school counsellor has raised possible concerns about alcohol use and use of diuretics but was unsure and said this could just be school gossip. Marcie has recently been referring to herself as "Marc" rather than Marcie.

Marc/Marcie has asked to see you on their own today.

After a thorough assessment, including collateral information from Marc's mother (who is concerned and supportive), teachers, the counsellor and GP, and subsequent review, Marc has been diagnosed with Gender Dysphoria and Social Anxiety Disorder.

Question 5.3 (8 marks)
Outline (list and justify) treatment options that you would consider and discuss with Marc, his mother, and the GP. *(a list without any justification will not receive any marks)*

		Mark (circle)
A	Assess readiness for transitioning and refer: Psychosocial readiness – safety, supports, to what extent he's been living his desired gender role already. Evaluate his transition goals and readiness for change – how reasonable is his grasp of the timeline. Provide him with all the key information about next steps including info on gender role change. Explore him living in his preferred gender role for up to a year – not essential unless considering sex reassignment surgery, but experience in his preferred gender role may help Marc with the decision. Refer Marc to a specialist gender dysphoria service that can provide psychological, psychiatric and medical care during the transition.	0 1 2
B	Get baseline measures: height, weight, waist circumference, and BP. Arrange tests including for blood-borne viruses and STIs, & specific tests - Testosterone-Oestradiol ratio, & if not already done, LH/FSH/Prolactin levels; lipid profile; HbA1C; LFT; TFT; FBC, Electrolytes, Renal fn; rule out pregnancy with B-hCG.	0 1 2
C	Biological Interventions for transitioning: Testosterone therapy to be organised via referral to an Endocrinologist. Discuss hormonal therapy with depot Testosterone (weekly, or monthly) and its risks/limitations. Assess his awareness and readiness to accept a deeper voice, increased skin thickness, body/facial hair, possibility of androgenic alopecia. Ensure he's on contraception during transition period and afterwards if no surgical transition's done.	0 1 2 3
D	Modified CBT and gender-affirming therapy for transitioning: should be used alongside biological treatment	0 1
E	Psychosocial aspects: Provide guidance on social transition and refer to special interest groups – in NZ: Ministry of Health site, Gender Minorities Aotearoa, NZPOTC, etc. In Australia: Transcend Australia, Zoe Belle Gender Collective and TGV (Transgender Victoria). Ensure support and psychoeducation for Marc's mother.	0 1
F	Alcohol/drug use: if problem exists – refer to Youth CADS, AA, NA, consider naltrexone, antabuse or detox referral	0 1
G	Anxiety: Consider use of an SSRI for Social Anxiety Disorder if still needed despite psychotherapy as above	0 1
H	Long-term Treatment: Plan follow-up to review his coping & quality of life in preferred gender role. Practical discussion about any changes needed at school (incl. teacher/counsellor) and monitor success of this. Asses the success and stability of any transitioning eg. use of new name/pronouns, living as preferred gender etc. If any concerns, consider re-referral to counselling/psychotherapy to help address underlying issues, and manage any problems. May need intervention following school with higher education provider/workplace, etc. Continued liaison re testosterone therapy via specialist gender dysphoria service & endocrinologist – might need to monitor hormone levels; lipid profile, BP and ongoing physiological and physical changes. Depending on the ongoing role of a specialist gender dysphoria service, may need to discuss gender affirming surgery and give info on accessing this in public system, i.e. risks and permanence of procedures like bilateral mastectomy and phalloplasty. Also need to refer Marc to Adult MH Services at some point.	0 1 2 3
	Did handwriting affect marking?	
	Up to a maximum of 8 marks in total. **TOTAL**	

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

Modified Essay Question 5 contd.

You are working as a junior consultant psychiatrist in a Youth Community Public Mental Health Centre. You have received a referral letter from a GP (with input from the school counsellor) regarding Marcie, an 18-year-old student who is in year 12 at the local co-ed high school. Marcie lives with her mother – her father died when she was two and she has no siblings.

The GP's letter states that Marcie started at her current school in year 9 – she was previously in an all-girls school. Marcie was previously well, engaged in a range of sports and had no academic concerns. However, her grades for the last term have been near failing. Lately, teachers have raised concerns about her lack of engagement with other students, and reported that she has suffered panic attacks when asked to speak in front of others.

They say she has been reluctant to come to any sports or swimming events this year. She prefers to wear her loose-fitting sports uniform to school every day. In addition, Marcie recently cut her hair very short. There has also been a steady decline in body weight from 70 kg to 60 kg and to a BMI of 20 from a previous 23.

Marcie appears reluctant to mix with her previous friends. A brief same-sex relationship earlier this year did not go well.

Staff have not witnessed any bullying at school. The school counsellor has raised possible concerns about alcohol use and use of diuretics but was unsure and said this could just be school gossip. Marcie has recently been referring to herself as "Marc" rather than Marcie.

Marc/Marcie has asked to see you on their own today.

After a thorough assessment, including collateral information from Marc's mother (who is concerned and supportive), teachers, the counsellor and GP, and subsequent review, Marc has been diagnosed with Gender Dysphoria and Social Anxiety Disorder.

The service you refer Marc to requests a capacity assessment prior to accepting him in their care.

Question 5.4 (4 marks)
Describe (list and explain) what this process of capacity assessment would involve.
(a list without any explanation will not receive any marks)

		Mark (circle)
A	Does Marc **understand information relevant to the decision and the effect of the decision** – i.e. the risks and benefits of treatment versus no treatment (Examples of issues that might be given in explanation: • that testosterone therapy could cause permanent changes, e.g. a deeper voice and clitoral hypertrophy • on the other hand, helping Marc better fit his preferred gender could be very beneficial to his overall wellness • if he has no treatment he could experience more dysphoria, worsening anxiety and potential depression • has he considered trying options for a while that have no permanent effects, e.g. male clothes, breast-binding)	0 1
B	Is Marc able to **retain the information** as above so as to make the decision (as he can't make a clear decision if unable to remember the information)	0 1
C	Does he have **decision-making ability and consistency** (this means, is he able to weigh up the necessary information so as to make the decision. Is there consistency in his decision over time, esp. as some of the treatment choices are irreversible.)	0 1
D	Is Marc **free of undue influence or coercion** in making the decision (as if coerced in some way he wouldn't be making his own decision freely)	0 1
E	Can Marc **communicate his decision**, views and needs clearly (as unless he can clearly communicate these we can't know what his decision really is)	0 1
F	Candidates may note that **capacity assessments are cross-sectional** (means they're of the moment and might need repeating in future if Marc's mental state changed, esp. if he were deciding about an irreversible procedure)	0 1
	Did handwriting affect marking?	
	Up to a maximum of 4 marks in total **TOTAL**	

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

Modified Essay Question 5 contd.

You are working as a junior consultant psychiatrist in a Youth Community Public Mental Health Centre. You have received a referral letter from a GP (with input from the school counsellor) regarding Marcie, an 18-year-old student who is in year 12 at the local co-ed high school. Marcie lives with her mother – her father died when she was two and she has no siblings.

The GP's letter states that Marcie started at her current school in year 9 – she was previously in an all-girls school. Marcie was previously well, engaged in a range of sports and had no academic concerns. However, her grades for the last term have been near failing. Lately, teachers have raised concerns about her lack of engagement with other students, and reported that she has suffered panic attacks when asked to speak in front of others.

They say she has been reluctant to come to any sports or swimming events this year. She prefers to wear her loose-fitting sports uniform to school every day. In addition, Marcie recently cut her hair very short. There has also been a steady decline in body weight from 70 kg to 60 kg and to a BMI of 20 from a previous 23.

Marcie appears reluctant to mix with her previous friends. A brief same-sex relationship earlier this year did not go well.

Staff have not witnessed any bullying at school. The school counsellor has raised possible concerns about alcohol use and use of diuretics but was unsure and said this could just be school gossip. Marcie has recently been referring to herself as "Marc" rather than Marcie.

Marc/Marcie has asked to see you on their own today.

After a thorough assessment, including collateral information from Marc's mother (who is concerned and supportive), teachers, the counsellor and GP, and subsequent review, Marc has been diagnosed with Gender Dysphoria and Social Anxiety Disorder.

The service you refer Marc to requests a capacity assessment prior to accepting him in their care.

Marc wants to know how easy and quick it will be for him to start gender-transitioning treatment.

Question 5.5 (4 marks)
List possible barriers to treatment for people with gender dysphoria.

		Mark (circle)
A	**Patient and family factors:** • Patient might have diminished capacity • Patient might be influenced by stigma/shame/bias and be unsure about the decision • There might be high expressed emotion in the family – family might object (esp. relevant in younger patients) • There might be cultural barriers/viewpoints • Patient's personal/religious beliefs might be a barrier • Demogaphic features that create barriers in a patient are younger age, lower income, and poor health literacy causing problems navigating gender transition services	0 1 2
B	**Systemic Factors:** • Access to specialist gender transition services – e.g. if live rurally or in a small town • Bias and lack of knowledge in healthcare professionals such as GPs, psychiatrists • Waiting lists, esp. with external factors such as the Covid pandemic • Financial barriers e.g. possible unemployment if there's discrimination at work or from required sick leave • Might be lack of social support or community support groups – e.g. if live rurally or in a small town	0 1 2
C	**Treatment factors - medication/surgical:** • Adverse effects – e.g. from hormone therapy • Perceived lack of efficacy of medication • Fear of surgical complications and of surgery's irreversibility • Actual surgical complications and poor outcomes might delay completion of the process • The mandatory waiting period living as the preferred gender might be too obstructive/difficult for some patients	0 1 2
D	**Illness factors – the impact of any co-morbid illness, such as:** • Significant anxiety disorder • Significant depression • Development/worsening of an eating disorder • Development/worsening of an alcohol/drug use disorder • development of a medical illness complicating the transition	0 1
	Did handwriting affect marking?	
	Up to a maximum of 4 marks in total **TOTAL**	

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