THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS

MOCK WRITTENS EXAMINATION

AUCKLAND / NEW ZEALAND

December 2005 / May 2006

PAPER II

MODEL ANSWERS

Note that the Writtens Sub-Committee samples of recent past questions and scoring guides came out in January 2006, after this Mocks paper was written. It has not been possible to adapt the MEQ scoring guides in this Mocks paper to conform to the structure shown in real scoring guides (i.e. fewer "correct" answers often scoring 2 marks not 1 mark each). This will be corrected in future Mocks papers.

Critical Essay Question: (40 marks)

In essay form, critically discuss the following statement from different points of view and provide your conclusion.

"Understanding and using humour is essential in mental health work – but humour can be a two-edged sword, and its role is not taught in most training programs."

- Martin D. Perez, 2002

Reminder about marking process:
There are 5 dimensions. All are weighted equally. Each dimension scores up to 8 marks.
A total of 40 marks is possible.

Marking Guide:

Dimension 1. Capacity to produce a logical argument (critical reasoning)

<table>
<tr><td>There is no evidence of logical argument or critical reasoning. Points are random or unconnected or listed or Assertions are unsupported or false or There is no conclusion</td><td>0-2</td><td rowspan="3"><u>Comments:</u>
Some logical structure needs to be demonstrated, rather than the writer seeming to have launched into the topic with no forethought, in a random or impulsive manner.
Look for:
• A reasonable opening statement & a definition of humour
• A mid-section to essay with discussion addressing:
– Why people use/need humour (individually and in society) and its causes. Better candidates will also cover neurobiology as well as psychological mechanisms
– The use of humour in assessment and diagnosis (recognising defences, manic symptoms, etc.)
– The use of humour therapeutically, esp. in psychiatry/therapy
– The pros and cons of using humour in psychiatry and other contexts.
– Whether appropriate/ therapeutic use of humour is taught, or can be taught and if so, ideas how.
• Closing statement that summarises and provides the writer's overall "conclusions"

Points for good examples (for this topic, examples are more likely than formal references, as supporting evidence).
Overall coherence and flow of the arguments/discussion.</td></tr>
<tr><td>Points in essay follow logically but there is only a weak attempt at supporting the assertions made by correct and relevant knowledge.

The points in this essay follow logically to demonstrate the argument; and assertions are supported by correct and relevant knowledge.</td><td>3-4

5-6</td></tr>
<tr><td>The candidate demonstrates a highly sophisticated level of reasoning and logical argument. (and extra points for good references)</td><td>7-8</td></tr>
</table>

Dimension 2. Flexibility

The candidate restricts essay to an extremely narrow and very rigid line of argument. The candidate considers only one point of view.	0-2	Comments: Ability to discuss positive uses of humour by individuals and society, as well as more negative implications. Ability to set out and discuss both pros and cons in use of humour therapeutically, in some detail. Ideally some sophistication in discussion of the pros and cons, rather than just brief statements with no evaluation of the accuracy or evidence for these views. Ability to briefly discuss why this issue may not be formally taught but how it is conveyed by less didactic means (modelling, in apprenticeship-style or psychotherapy supervision, etc.), and whether it should be more fully covered within training.
The candidate considers more than one point of view, but the strengths and weaknesses of the views are poorly evaluated. The candidate considers more than one point of view and the strengths and weaknesses of each view are well evaluated.	3-4 5-6	
The candidate demonstrates highly sophisticated ability to set out and evaluate >1 point of view	7-8	

Dimension 3. Ability to Communicate

The spelling, grammar or vocabulary renders the essay extremely difficult to understand; **or** totally unintelligible. The spelling, grammar or vocabulary significantly impedes communication.	0-2	Mark down if writing's illegible or if are multiple deletns and inserts.
The spelling, grammar and vocabulary are acceptable but the candidate demonstrates limited capacity for written expression. The spelling, grammar and vocabulary are acceptable and the candidate demonstrates good capacity for written expression.	3-4 5-6	
The candidate displays a highly sophisticated level of written expression.	7-8	

Dimension 4. Humanity/Experience/Maturity/Judgment

The candidate demonstrates an absence of any capacity for judgment; **or** judgments are grossly unethical. Judgments are naïve; **or** superficial; **or** extremely poorly thought through; **or** unethical.	0-2	Comments: Look for reasonable grasp of potential to make empathic connections via humour, but also its potential to harm and distress. More negative expressions such as sarcasm, irony, "black humour", etc. Cultural differences and need for sensitivity must be mentioned, also sensitivity with abused/traumatised patients. Ethical issues re care with professional boundaries also need to be addressed – over-familiarity, etc. Better candidates will also address the ethics of staff teams using humour to release tensions, especially in high-stress psychiatric work. Ethically dubious, but is it avoidable? Is it necessary for team cohesion and coping? Issues of "laughing at" vs "laughing with". Timing and judgement in use of humour should ideally be mentioned – need to get to know patient/family, context. Use and misuse of humour due to expression of aggression, transference and countertransference (& not just in formal therapy settings). Ideally, mention of racist jokes, use of humour to reduce or increase stigma and bigotry, excessive/inappropriate use as marker of staff inexperience or burnout.
The candidate demonstrates some reasoned judgment ,maturity of thinking, clinical experience and displays some awareness of the ethical issues raised by the quote. The candidate shows good capacity for reasoned judgment, mature thinking, clinical experience, awareness of ethical issues raised by the quote.	3-4 5-6	
The candidate demonstrates a highly sophisticated level of judgment, maturity, experience **or** ethical awareness.	7-8	

Dimension 5. Breadth - ability to set psychiatry in a broader context.

<table>
<tr><td>Candidate shows no awareness of the broader scientific, social, cultural or historical context. There is a very limited understanding of the scientific, social, cultural or historical context of psychiatry or mental illness.</td><td>0-2</td><td rowspan="3">Comments:
Look for discussion of the use of humour in:
– Individual defences
– Society as a whole
– Across cultures – variations vs universality, humorous plays conveying AIDS info in Africa/India, wry proverbs.
– Spiritually (laughing yogis in India)
– Across time/history (e.g. court jesters in past, jokes circulating after historical disasters, avoidance re opaqueness in psychoanalysis in past vs greater interaction now between therapists and clients, etc.)

Essay should not just focus on use of humour in psychiatry/therapy, but include wider human contexts

Examples of its use and misuse should be provided from a range of areas as above.

Essay should ideally look not only at use of humour with patients/clients, but also within staff teams and systems, hospital settings, and in training and supervision.</td></tr>
<tr><td>The candidate demonstrates an ability to understand psychiatry or mental illness in only one of the following contexts: broader scientific, socio-cultural, historical context.

The candidate demonstrates an ability to understand psychiatry or mental illness in two or more of the following contexts: broader scientific, socio-cultural, historical context.</td><td>3-4

5-6</td></tr>
<tr><td>Highly sophisticated scope, demonstrating a superior understanding of the broader context of psychiatry or mental illness.</td><td>7-8</td></tr>
</table>

Some General Brainstorming Ideas re Possible Content:
Definition Humour – comedic or pleasurable effect, sometimes laughter, caused by lateral, symbolic, ambiguous or unexpected connections or progressions of thinking or of imagery.

Why humour is used

- as a means of communicating between individuals which deepens empathy and rapport in relationships and create bonds (in-jokes, family jokes)
- links with laughter as an expression of pleasure/happiness
- as a psychological defence (a mature defence in Vaillant's category, but can be over-used or used dysfunctionally)
- as a safer expression of anxiety, pain (black humour, gallows humour) or defence against distress. Wry proverbs and witty sayings about "scary big issues" in life ("nothing is certain in life except death and taxes") etc.
- as an oblique or passive way of expressing anger and aggression when direct expression is unsafe (between individuals e.g. sarcasm, undermining jokes, or societally e.g. political comedians in apartheid regime, cartoons against the enemy in wartime)
- all the above in a wider social context – to cope with tragedies and disasters (post 9/11 jokes) to deal with unacceptable or repressed thoughts and feelings (racist jokes, sexual innuendoes, double entendres.)

Biology of humour/research into it

- neurophysiology – research (e.g. Kandell's work) shows changes in thinking and behaviour are reflected in structural and functional brain changes. Encouragement of laughter/humour alters limbic and cortical areas via facial expression pathways and can improve mood
- Links with brain pleasure centres and dopaminergic motivational brain systems
- Some research exists into +ve effects of laughter and humour on general health. Candidates are unlikely to be able to quote actual references, but may correctly refer to existence of such studies. A few e.g.s (there are many more re the use of humour):

Perceived attributes of health-promoting laughter: a cross-generational comparison. J Psychol. 2002 Mar;136(2):171-81.
Make them laugh. Therapeutic humor for patients with grief-related stress or anxiety. Adv Nurse Pract. 2000 Aug;8(8):34-7. Review. No abstract available.
Inverse association between sense of humor and coronary heart disease. Int J Cardiol. 2001 Aug;80(1):87-8.

- Widely written about in psychotherapy literature including psychotherapeutic texts, research in this field is often qualitative
- One e.g. is J Ellard's ANZJP article spoofing types of therapy, to comment on poorly done research (educational use of humour in training)

Pros: - positive uses

Use in assessment and diagnosis
- to detect defences and psychological issues, underlying anxieties
- to detect hypomanic symptoms (patient jovial, often makes interviewer laugh)
- incongruous laughter and fatuous jokes as a frontal/schizophrenic symptom
- lack of any humour/pleasure as a marker of depression and severe negative symptoms

Use therapeutically
- in general clinical work to develop therapeutic relationship and address difficult issues
- in psychotherapy similarly, and to confront defences and address unacceptable feelings. Also to detect defences, anxiety and transference reactions.
- in rehabilitation – social and communication skills groups, psychoeducation, etc.
- effective and judicious use is part of the "art" of psychiatry

Use in teams and work contexts
- to cement and bond teams
- to release stress when work is painful and frustrating
- to enable teams to cope and to release tension in case of conflicts

Use in training and supervision
- modelling interventions and attitudes (e.g. with trainees from overseas medical systems)
- detection of countertransference issues
- identification and development of empathy, general support in general supervision
- education and conveying important messages (cartoons in presentations and talks, etc.)

Cons: - negative uses

- to express anger, aggression, increase stigma, cause splitting and rifts
- angry nihilistic humour as a marker of staff burnout
- as a defensive resistance to therapeutic work
- as an inappropriate countertransference reaction
- as a collusion with patient in their defence and to trivialise therapeutic relationship
- causing splitting within teams and services (jokes against management, against other team members) – scapegoating by jokes, sarcasm (also in group therapy)
- can be misused by inexperienced staff
- if used insensitively with patients / families who are too unwell, vulnerable, traumatised, etc. – and especially with very depressed patients.
- if used inappropriately/insensitively re cultural differences, age gaps, too soon in therapeutic relationship, when patient not sufficiently known.
- As a boundary breach re over-friendliness and inappropriate intimacy in therapeutic relationship
- Ethical issues as above – can be abusive, destructive: beneficence, "first do no harm". Refer College Code of Ethics principles (respect, dignity, beneficence, professionalism, boundaries)

Critical Analysis Question 1

DUP Study (excerpts)

ABSTRACT:
BACKGROUND: It is unclear what determines **Duration of Untreated Psychosis** (DUP) in schizophrenia and why long DUP predicts poor outcome.
AIMS: First, to test the hypothesis that specific patterns of symptoms and social functioning acting before treatment prolong DUP. Second, to clarify the mechanisms linking DUP with recovery after treatment.
METHOD: Two hundred and forty-eight consecutive first admissions with schizophrenia were interviewed to assess DUP, symptoms and social functioning at admission, and symptoms were re-assessed after 6-12 weeks.
RESULTS: Median DUP was 12 weeks. Long DUP was predicted by poor insight, social isolation and preserved coping skills, but not by demographic factors. Even allowing for all these variables, long DUP predicted poor outcome.

METHOD:
Sample: Patients were recruited from consecutive day-patient and in-patient admissions for first episodes of psychosis over a 26-month period, as part of a randomised, controlled psychological treatment study (the Study of Cognitive Reality Alignment Therapy in Early Schizophrenia - SOCRATES). They were aged 16-64 and admitted from Manchester, Liverpool and North Nottinghamshire.

Eligible patients met criteria for DSM-IV schizophreniform disorder, schizophrenia, schizoaffective disorder, delusional disorder and psychosis NOS. Patients were excluded if substance misuse was judged to be the major cause of the psychosis. Patients were randomised to one of three treatment conditions on top of routine care: cognitive-behavioural therapy (CBT), supportive counselling and 'no extra treatment'.

Analysis: Using SPSS 6.1 for Windows, we examined associations between DUP and demographic, symptomatic and social functioning variables at baseline using correlation measures. After initial data analysis, DUP was normalised by taking the logarithm to base 10 ($_{log10}$DUP) to allow the use of parametric statistics (i.e. Pearson' s r, **-t**ests), and these results are presented…. We performed a general factorial analysis of variance (ANOVA) with $_{log10}$DUP as the dependent variable (this let us include categorical confounders like ethnicity more easily than a multiple regression)…. To test the second hypothesis, about recovery after treatment, we first correlated $_{log10}$DUP with change in PANSS total score over the follow-up period. Then we used baseline variables (including $_{log10}$DUP and determinants of $_{log10}$DUP) to predict change in PANSS as the dependent variable in an ANOVA, as for the analysis of determinants of DUP. This would reveal whether $_{log10}$DUP still had a significant association with the outcome of initial treatment after correcting for confounders. We included the treatment group in the SOCRATES trial as an independent variable.

Results:
At baseline, $_{log10}$DUP correlated positively with the PANSS total score (r=0.13, P=0.04): the longer the DUP the more severe the symptoms at admission. Pearson correlations with the positive symptom and general psychopathology sub-scale scores were 0.14 (P=0.03) and 0.15 (P=0.02), respectively, but with the negative sub-scale r was 0.05 (P=0.49).

Although DUP did not correlate significantly with SFS total score (for $_{log10}$DUP r=0.04, NS), this masked correlations with component sub-scales in opposite directions. DUP correlated negatively with the social integration index (r=-0.14, P=0.05), and positively with the coping index (r=0.16, P=0.03); thus, long DUP was predicted by worse social integration on the one hand, but by better coping with daily activities on the other.

Poor insight, poor integration and avolition predicted longer DUP.
Shorter DUP was predicted by poor coping and the presence of preoccupation or hostility.

Better social integration predicted more improvement in PANSS score (i.e. a greater decrease in score over treatment). Surprisingly, better coping predicted less improvement. Insight, the strongest predictor of long DUP, was not significantly associated with change in the PANSS. Male gender predicted less improvement. Other demographic variables were not strongly associated with PANSS change (all P>0.30); nor was treatment condition (P=0.52).

Critical Analysis Question 1 (20 marks)

1.1 What type of study is the DUP study?
Select any correct options from the list below (2 marks)

❑	Randomised controlled treatment study	No – the SOCRATES study was, but not this DUP study.
yes	**Causation study** (1 mark)	Whether specific Sx or social functioning changes caused longer DUP (see Aims)
❑	Critical Review	No
❑	Diagnostic instrument evaluation	No
yes	**Prognostic study** (1 mark)	Whether longer DUP was indicative of poorer treatment outcome (see Aims)

1.2.1 In the analysis, the authors mention the use of parametric statistical tests. What are parametric tests as opposed to non-parametric tests? (4 marks)

1) Nonparametric methods are used when we know nothing about the distribution of the variable in the population (hence the name nonparametric). There is no *assumption* of a normal distribution. (2 marks)
2) Parametric tests are used where there is a normal distribution. (2 marks)

(NB: if answer given is Parametric = normally distributed data vs Nonparametric = non-normally distributed data this is not quite correct so only gets 3 marks max.)

1.2.2 In the analysis of variance, the authors had DUP as the "dependent variable". What does this mean and what is a dependant variable? (2 marks)

1) The dependant variable is also called the 'outcome variable'. The value of a dependent variable is dependent on other independent variables and its value will change as the independent variable (causative or intervention factor) changes. (1 mark)
2) In the DUP Study, DUP was analysed statistically as being affected (varying) due to other "independent" variables such as SFS or PANSS scores. (1 mark)

1.2.3 The authors state that they included the treatment group as in the SOCRATES trial as an independent variable. They also state "Other demographic variables were not strongly associated with PANSS change (all P>0.30); nor was treatment condition (P=0.52)." **What does this tell us about the effect of the SOCRATES treatment groups on the DUP results? (2 marks)**

1) An independent variable is one which 'causes' the dependent variable. In the DUP study the authors analysed the results statistically so that the type of SOCRATES treatment group was treated as an independent variable – i.e. whether patients had CBT, supportive therapy or "no extra treatment" was looked at re whether this affected the PANSS scores after treatment at 12 weeks. (1 mark)
2) "Treatment condition" did not affect the PANSS scores significantly (p=0.52 so not quite significant) – i.e. the SOCRATES treatment group didn't really make a difference to PANSS scores so is unlikely to have been a confounding factor in the DUP results. (1 mark)

Table 2 Correlation of baseline variables with duration of untreated psychosis

Variable	Correlation	P
PANSS lack of insight	0.35[1]	<0.001
SFS integration	−0.23[1]	0.004
SFS coping	0.17[1]	0.04
PANSS poor volition	0.19[1]	0.02
PANSS preoccupation	−0.18[1]	0.02
PANSS hostility	−0.15[2]	0.03

1. Values of beta for independent variables in analysis of variance with $\log_{10}$ duration of untreated psychosis as dependent variable.
2. Point biserial correlation; P7 was transformed to a binary variable for the analysis.
PANNS, Positive and Negative Syndrome Scale;
SFS, Social Functioning Scale.

1.3.1 In Table 2, poor insight, poor social integration and poor volition predicted longer DUP, and shorter DUP was predicted by poor coping and by preoccupation or hostility.
In what way might these factors be linked with the DUP? (4 marks)

1) Poor insight would be likely to cause a patient not to seek treatment or even to actively avoid treatment, so prolong DUP (1 mark)
2) Poor volition could make a patient less organised and less motivated to seek treatment or go to see a GP etc., so prolong DUP (1 mark)
3) Poor social integration would mean that the person was less likely to have family and friends close to them to become concerned and help them to arrange assessment or treatment, so prolong DUP. (1 mark)
4) Preoccupation (e.g. with delusions or hallucinations) indicates more active positive Sx which would be more likely to bring someone to attention and result in their being assessed, so shorten DUP. (1 mark)
   Hostility, similarly, would be more likely to bring someone to attention and result in their being assessed, so shorten DUP. (1 mark)
5) Better coping could cause longer DUP as the person would be less likely to cause concern and come to attention early. (1 mark)

(any of the above, or similar reasoning, to a max. of 4 marks. A few details on the respective factors are needed for full maks, rather than a brief general comment.)

Table 3 Predicted impact of duration of untreated psychosis on the amount of improvement in Positive and Negative Syndrome Scale (PANSS) score after 12 weeks of treatment

DUP[1]	Mean improvement in PANSS score[2]	95% CI[3]
1 month	−44%	−50 to −39
6 months	−38%	−41 to −34
1 year	−35%	−40 to −30
6 years	−29%	−40 to −18

1. DUP, duration of untreated psychosis.
2. Change in total score divided by (baseline total score −30), since minimum score=30.
3. CI, confidence interval for the mean.

1.4.1 In Table 3, explain how sure we can be about the mean improvement in PANSS result where DUP was 6 years as compared to 6 months. (2 marks)

1) Not as sure about the DUP=6 years PANSS result, as the Confidence Interval is wider. (1 mark)
2) Explanation: For the DUP=6 years result the CI range is wider (-40 to -18). This means we can be 95% sure that the true value of the mean PANSS score where DUP was 6 years lies somewhere in this range. Whereas the mean PANSS score for those with DUP of 6 months is in the range -34 to -41 so the actual result of -38% is more likely to be accurate. (1 mark)
3) Cannot be certain there is a real statistical difference between the 2 means as the 2 sets of CIs overlap. (1 mark)

(key issues wanted are: awareness that it's the CIs that give us this information, understanding of what CIs are and what they mean, ability to apply this knowledge to the Table.)

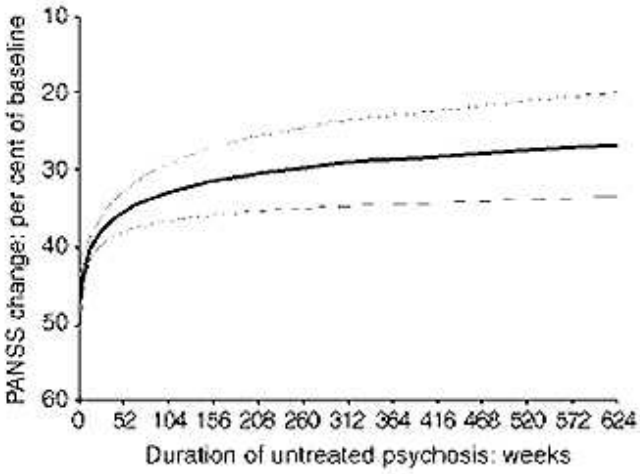

Fig. 1 Predicted change in Positive and Negative Syndrome Scale (PANSS) against duration of untreated psychosis (with 95% CIs).

1.5.1 From Figure 1, what are the implications for early psychosis intervention services about channelling their efforts to reduce DUP? (4 marks)

1) Depends whether there is a causal link between long DUP and poorer response to treatment (i.e. less PANSS change after treatment). From the brief excerpts of the DUP paper provided, candidates could not be sure that there is a definite causal link on which to base service planning e.g. Could be other confounding factors such as the symptom-pattern of the illness causing *both* longer DUP and poorer response to Rx once treated. (2 marks)

2) After the first few months to a year of DUP this effect levels out so that a DUP of 1-2 years has a similar effect to a DUP of 6 years on responsiveness to treatment. (2 marks)

3) This means that it would be more effective for EPI-type services (and mental health planners in general) to focus on reducing DUP as much as is possible). (2 marks)

In the full paper the researchers make a case from their statistical analyses and from other research that there is in fact a causal link between longer DUP and poorer response to Rx.

(any of the above, to max. of 4 marks)

See: Medline
Drake RJ, Haley CJ, Akhtar S, Lewis SW.
Causes and consequences of duration of untreated psychosis in schizophrenia.
Br J Psychiatry. 2000 Dec;177:511-5. (free fulltext article)

Critical Analysis Question 2 (20 marks)

You are an advanced trainee working in a community team which often commences previously untreated patients with psychosis on antipsychotic medication. Most of your patients are on a voluntary basis. Medical staff on the team are confident doing clinical assessments for extrapyramidal side effects (EPSE) or using the AIMS or GATES instruments - but other team members are unable to do these assessments. You feel that the team's patients are not being adequately monitored for development of extra-pyramidal side-effects, and want to locate a screening tool that all the team's staff can use. You locate a test called the "Sentence Length Test" (SLT). Patients write the same dictated sentence before and during treatment, and micrographia changes in their handwriting affecting the overall length of the sentence they write are measured by ruler and are used to detect early development of Parkinsonian symptoms. It appears to be a simple test that requires little training and can be done in any setting. There is however only one study validating the SLT that you can locate, which compares it with a clinical evaluation of EPSE by psychiatrists, looking specifically at Parkinsonian symptoms. This study found that a 5-10% reduction in sentence length correlated to mild clinically diagnosed EPSE, and a 15-25% reduction in sentence length to moderate EPSE. Your supervisor encourages you to set up a study to assess the SLT and determine if it would in fact be a useful screening test for the team.

2.1 Your source population are to be drawn from patients followed up by your team. What inclusion or exclusion criteria might you need to consider? (4 marks)

i. Both genders. (1 mark)
ii. ? Limit age-range. The very young or old might be better excluded. (but team sounds likely to be adults aged 18 – 65 which would be OK). (1 mark)
iii. Patients need to be starting on antipsychotic Rx. Inclusion only of patients recently commenced antipsychotic medication for the 1st time vs those well established on this is probably simpler. (1 mark)
iv. Need to include only patients competent to give informed consent. (1 mark)
v. Whether only those treated on a voluntary basis, or if could include consenting/competent patients having M.H.Act treatment. The latter would be ethically more fraught. (1 mark)
vi. Need to exclude patients with complicating organic conditions e.g. Parkinson's disease per se. (any condition which could mimic EPSE effects on handwriting.) (1 mark)
vii. Whether to exclude patients with significant substance abuse – if you keep them in test is more useful in real world even with those using substances, but might cause errors in results. (1 mark)
viii. Patients need to be able to write (1 mark)
- no serious physical disability affecting writing arm/hand.
- problem for patients with poor grasp of English unless you use their own language
- illiterate or intellectually disabled patients would have difficulties.

(any of the above, if reasonably discussed, to a max. of 4 marks)

2.2 State the two main types of reliability of the SLT you would want to assess, and briefly describe how these would be assessed. (2 marks)

i. Inter-rater reliability - Different raters would assess the same patient at the same time. Their scores should be closely comparable. (1 mark)
ii. Test-retest reliability - The same rater assesses the same patient more than once (at a time when the patient's symptoms are stable). The scores on the 2 occasions should be closely comparable. (1 mark)

2.3 What level of reliability would you want? (using a reliability coefficient) (1 mark)
> 0.7 (1 mark) using Pearson or an intra-class correlation.

2.4 What sort of blinding would you need to have in the study, and how would you organise this? (2 marks)

i The raters using the SLT would need to be blind to the results of the clinical assessment of EPSE (and vice versa). (1 mark)

ii If medical staff were administering the SLT they might well form a clinical judgement of EPSE during their contact with the patients, which could bias their SLT measurements. It would thus be preferable to have team staff unused to clinical assessment of EPSE administering the SLT, with medical staff on the team doing the clincial assessment of EPSE, and both groups being blinded to the ratings of the other. (1 mark)

iii If it was hard to find raters with no ability at all to assess EPSE clinically (likely) then SLT assessors should collect the sentence from patient and a separate rater, blinded to the clinical assessment of EPSE result, measures the sentence length. (1 mark)

(any of the above to max. 2 marks)

2.5 You have results from 50 patients for your study regarding the group with mild EPSE on clincial evaluation, and have arranged them in a 2x2 table as below. (4 marks)

	Clinical EPSE		
	Mild EPSE	**No EPSE**	**Totals**
5-10% reduction in sentence length on antipsychotic	**20**	**10**	**30**
No change in sentence length on antipsychotic	**5**	**15**	**20**
Totals	**25**	**25**	**50**

Calculate the Positive Predictive Value of your SLT test (PPV), and what does this figure actually mean?

PPV = 20/30 = 67% (1 mark)

This means that 2/3 of patients with a 5-10% reduction in sentence length actually *will* have mild EPSE on clinical evaluation. (1 mark)

(if correct "working out" is shown, give the mark even if they then get the arithmetic wrong in calculation and draw slightly incorrect conclusions from this.)

Calculate the Negative Predictive Value of your SLT test (NPV), and what does this figure actually mean?

NPV = 15/20 = 75% (1 mark)

This means that ¾ of patients with no change in sentence length actually will *not* have mild EPSE on clincial evaluation. (1 mark)

2.6 Describe three ethical issues you would need to consider in the study. (3 marks)

- The need for informed consent. Who should obtain their consent – their keyworker? Or someone they rely on less for support? How would you inform them? Need written information as well as verbal discussion. (1 mark)

- The need for patients to be competent to give informed consent, even if voluntary patients. (1 mark)
- Patients need to be able to withdraw consent at any time. (1 mark)
- Right to privacy - need to maintain confidentiality of patient details. (1 mark)
- Whether patients treated under the M.H.Act might also be competent and able to participate – or would this be an abuse of their compulsory status? (1 mark)
- Need to minimise any negative outcomes for patients, from the study. This seems unlikely given the simple non-invasive nature of the test, although merely being asked to participate in any study could cause stress to certain patients. And all patients enrolled would need the 2 assessments, with some undergoing test-retest repeats etc. However, this is balanced by the benefits of all subjects having a proper clinical assessment for EPSE. (1 mark)
- That all treatment of EPSE (or lack of this) would be based on the clincial assessments not just on the SLT, to avoid unnecessary treatment or missing EPSE which needed intervention. (1 mark)
- That participation in the study should not determine whether patients followed-up by your team have their EPSE assessed. Normal clinical care should not be dependant on taking part in the study. (1 mark)
- That patients in study who have EPSE identified have access to treatment/interventions for this. (1 mark)
- Whether there might be any negative outcomes for your team and hence for patient care, from the study. e.g. if assisting you with it took too much staff time and kept them from normal clinical duties. Maybe more likely to affect the medical staff performing EPSE clinical assessments – but against this is again the potential benefit to team patients of having these EPSE assessments done. (1 mark)

(1 mark for each of the above, to a max. of 3 marks)

2.7 Discuss likely limitations of this study. (4 marks)

- The SLT only assesses Parkinsonian symptoms. It would not help as a screening test for akathisia or TD. (1 mark)
- More detailed clinical assessments of EPSE are still needed if the SLT is positive – it is not an adequate evaluation by itself. (1 mark)
- It would in fact be hard to get a pre-medication baseline for the SLT in real clinical practice, where separate teams often provide initial acute care, compared with community follow-up. Might possibly be workable in EPI settings. (1 mark)
- Are the PPV and NPV good enough to warrant the SLT being used as a screening test? Are we happy that only 2/3 of those scoring positively will in fact turn out to have EPSE (e.g. re time wasted by medical staff doing full clincial assessments for EPSE on them all). The SLT misses 25% of patients who score negatively on it yet do have mild EPSE. If the team adopted it, these patients might not get clinical evaluations of EPSE, so their EPSE might go untreated. (1 mark)
- Hard to maintain proper blinding within a relatively small clinical team. (1 mark)
- Relatively small numbers so low power. (1 mark)
- Can the clinical evaluation of EPSE really be considered a “gold standard”? But there are flaws with the AIMS as well, and the GATES requires a lot of time and training to administer. (1 mark)
- The exclusion factors would mean that you’d be unsure how useful the test would be in the real world – e.g. with substance-abusing patients. (1 mark)
- “the Hawthorne effect” – falsely improved scores as subjects are aware they are being studied. Possibly a wish to write well to please the assessor. (1 mark)

(1 mark for any of the above to max. 4 marks)

(PS: don’t go looking for the SLT – it doesn’t exist!)

Modified Essay 1 (25 marks)

Jane is a 35 year old Caucasian woman, currently in a de facto relationship, unemployed and receiving welfare payments. She lives with her three children, all sons, aged fifteen, eleven and four, from two previous relationships. Her main supports are her current male partner, and an aunt. She, her partner and her case manager report that she is currently caring well for her children.

Jane has a history of drug and alcohol misuse from the age of nineteen when she was a heavy user of morphine (taken intravenously), cannabis and alcohol. She is believed to have stopped all opiates over ten years ago, but was diagnosed with hepatitis C three years ago.

Jane currently uses alcohol, cannabis and benzodiazepines, which she buys "off the streets". For the last four months she has been attending the out patient Drug and Alcohol Centre where you work, and seems motivated to change her drug use. Jane has a family history of alcohol problems: her mother is currently in recovery after years of heavy drinking and Jane has been told that her father was a "chronic alcoholic". Jane has a poor relationship with her mother, who lives in another town, and Jane has never had contact with her father who left when she was a baby. Jane's Drug and Alcohol Centre counsellor is concerned that Jane may be depressed and asks you for a psychiatric opinion.

Question 1 (10 marks)

Indicate areas you would focus on in your assessment of Jane, in order to clarify her diagnosis.

SCORING KEY

Use whole marks only, not ½ marks. 1 mark per item if it adequately covers the content indicated.

		worth	mark
A.	Symptoms of depression (whether she meets criteria for MDE, dysthymia, BPAD, adjustment disorder) and in the latter case exploration of plausible stressors from personal family circumstances/ life events that might impact on presentation & mood. Past history, family history and mental state could usefully be mentioned.	**2**	
B.	Symptoms of drug dependence/abuse/harmful use. Clarification if the patient is intoxicated or in withdrawal. An assessment of the quantities of drugs used (contexts of drug use could also be usefully discussed).	**2**	
C.	Exploration of any link, and in particular the temporal link between substance use and depressive symptoms.	**2**	
D.	Clarification of physical health, including history, physical examination and tests (e.g. what is the status of her Hep C, whether she is on interferon, does she have HIV, other common problems related to alcohol use.)	**1**	
E.	Plausible links between any physical problems or their treatments and the psychiatric symptoms the candidate uncovers.	**1**	
F.	Clarification whether personality factors could be contributing to any mood symptoms.	**1**	
G.	A plausible systems enquiry into other diagnoses, particularly those common in people with substance use problems: anxiety disorders, psychotic disorders etc.	**1**	
H.	Matters not directly bearing on diagnosis, but rather management: a good risk assessment including that of risk to her children, clarification of motivation to change, history of previous treatment, assessment of function.	**1**	
I.	Discussion of collateral information: family, friends, other professionals etc.	**1**	
		Up to a maximum of 10 marks in total **TOTAL:**	

Discussion: *the most important elements in clarification are the first five and they have therefore been awarded the bulk of the marks. Management matters are not really a 'clarification' but are nonetheless given 1 mark.*

Modified Essay Question 1

You decide that despite some symptoms of depression, treatment should initially concentrate on her substance use and in particular alcohol. Jane has attended nine counselling sessions before the assessment with you. Her initial goal had been to reduce her alcohol use. She feels, however, that she has made little progress in cutting down her substance use, rather, whenever she tries reducing her alcohol consumption she finds herself using more benzodiazepines and vice versa.

Question 2 (6 marks)
Outline the advantages and disadvantages of using naltrexone to assist Jane in her goal of reducing her alcohol consumption.

SCORING KEY
Use whole marks only, not ½ marks. 1 mark per item if it adequately covers the content indicated.

		worth	mark
A	Disadvantage: most research looks at using this drug to achieve abstinence, rather than reduction	**1**	
B	Disadvantage: it has a high relapse rate when if it is stopped	**1**	
C	Disadvantage: it has a number of side effects (at least two well-know or common ones to get a mark e.g. nausea, raised LFTs at high doses)	**1**	
D	Disadvantage: it could cause a withdrawal syndrome if she is secretly using opioids	**1**	
E	Disadvantage: drug interactions (almost exclusively with opioids, so for example makes severe pain relief and anaesthesia difficult)	**1**	
F	Disadvantage: can only be prescribed by a specialist service and only for a limited time	**1**	
G	Disadvantage: may be seen by patient as 'quick fix' or 'magic bullet'.	**1**	
H	Advantage: easy to use, once a day drug, needing minimal titration	**1**	
I	Advantage: good evidence it is effective for alcohol dependence. Its effects specifically are - reducing relapses, reducing standard drinks consumed and reducing craving	**1**	
J	Advantage: not a drug of abuse	**1**	
K	Advantage: does not interact with most commonly used psychotropic drugs e.g. anti-depressants or other anti-alcohol medications such as disulfiram and acamprosate	**1**	
L	Advantage: No major problems with stopping the drug	**1**	
M	Advantage: minimal side-effects	**1**	
N	Advantage/Disadvantage: does not cause severe physical reaction when combined with alcohol	**1**	
O	Disadvantage: safety of drug unknown in pregnancy	**1**	
		Up to a maximum of 6 marks in total TOTAL:	

Discussion: *the candidate should be able to discuss with the patient the pros and cons. Can only score a maximum of four for either pros or cons (i.e. must give balanced discussion).*
Only exceptional candidates are likely to know everything about this medication.

Modified Essay Question 1

During a follow up appointment, mainly aimed at assessing her response to naltrexone, Jane mentions that she wants to become pregnant to her current partner, in the belief that he will take their relationship more seriously if they have a child together. She asks you for your opinion on this idea.

Question 3 (9 marks)

Outline your approach to this request, and describe the clinical and risk issues that you would focus on.

SCORING KEY

Use whole marks only, not ½ marks. 1 mark per item if it adequately covers the content indicated.

		worth	mark
A	Some discussion about how appropriate this request is. While the candidate clearly has a role in talking about medical and psychiatric risks, it may be inappropriate to talk in depth about the merits of this as a relationship building device. Exploration of relationship, other reasons for pregnancy, simple advice around this issue, and discussion over appropriate referral to say relationship counselling or family planning could all be mentioned. Discussion of counter-transference issues, esp. if candidate plans taking on role of relationship advisor.	**2**	
C	Discussion of possible harm to foetus of continued drug and alcohol use. Candidate must advise patient of known risk of foetal damage caused by alcohol or fail this section of the MEQ. Neonatal withdrawal from benzodiazepines could also usefully be mentioned.	**2**	
D	Effect of naltrexone not known in pregnancy or breast-feeding and therefore not recommended by the manufacturer/or – that she may therefore need to cease naltrexone if she became pregnant.	**1**	
E	Sensible discussion of effect of other medications e.g. antidepressants on pregnancy.	**1**	
F	Discussion of effect of pregnancy on any mood problems and substance use.	**1**	
G	Discussion of her ability to care for a 4th child - the pros and cons of involving social services, and confidentiality issues could be usefully discussed.	**1**	
H	Discussion of general health status (including hepatitis C, its possible transmission to the foetus, and other problems in vignette) and how this might effect pregnancy.	**1**	
I	A discussion about who she would plan to have monitor the pregnancy (her physical care during pregnancy is not a role for the candidate), appropriate advice on this issue and getting her agreement to allow liaison with them.	**1**	
J	Discussion of how instability in drug or psychiatric problems could lead to risks to the foetus (self harm, homicide, malnutrition).	**1**	
K	Discussion of what happened in past pregnancies (with her relationships, mood, substance use, care for other children) - and what previously helped.	**1**	
L	Attempt to bring partner (or indeed other support e.g. the Aunt) into the discussion while maintaining patient's confidentiality.	**1**	
		Up to a maximum of 9 marks in total TOTAL:	

Discussion: *quite a broad question. The key points are the skill in appropriately answering a difficult question from the patient (a process issue), and giving clear information about the risks and particularly the risk of foetal alcohol syndrome (content).*

Modified Essay Question 2 (25 marks)

Thim Phu is a 27 year old Asian man who has been discharged from the local inpatient unit to an NGO accommodation provider in the area of your community mental health clinic. He is not previously known to you but there is a brief discharge summary from the unit.

He has a known diagnosis of schizophrenia, paranoid type and recently moved to the district although had been itinerant before his admission. He speaks only limited English and his family live in a different city and have been reluctant to become involved. His hospital admission was caused by some bizarre behaviour when he was also intoxicated.

Thim Phu has been living in the supported NGO accommodation now for two weeks and the staff there already have concerns about him. They say he acts oddly with the other residents and is not really fitting in. They are also concerned that he is not sleeping well at night.

Question 1 (8 marks)
Discuss the information you would seek prior to seeing Thim Phu.

SCORING KEY
Use whole marks only, not ½ marks. 1 mark per item if it adequately covers the content indicated.

		worth	mark
A	**From the inpatient unit**		
A1	More details about admission: circumstances of admission, recent degree of risk to self or others, course of admission and of medication tried, current Mental Health Act status, mental state/functioning on discharge.	**1**	
A2	More details of past history: past risk history to self or others, accommodation tried previously, past medication Hx and adherence, any other collateral sources you could locate (other past admissions and old notes, any GP, etc.)	**1**	
A3	Cultural issues: what attempted involvement of family was there, what component of stigma, was any cultural worker or service previously involved, need for interpreter in assessments.	**1**	
B	**From the NGO staff the current situation including:**		
B1	Details of odd/worrying behaviour - since when, in what circumstances.	**1**	
B2	Specifically any details of behaviour that might indicate dangerousness/risks.	**1**	
B3	Details of NGO residence: e.g. what mix of residents, values and attitudes of other residents, any other current conflicts or issues affecting the NGO, recreational drug prevalence, how much supervision is there, specific philosophies of this NGO.	**1**	
B4	How difficult is the situation - is his remaining at the NGO residence still an option?	**1**	
B5	Medication issues: What are his current meds, any changed route e.g. oral vs IMI, impression of adherence, are his meds supervised at all and if so how, when and by whom. Any signs of side-effects such as akathisia.	**1**	
B6	Substance use issues: Is he using recreational drugs or alcohol currently, how much if so, what impact is that having, attitudes of NGO to substance use (e.g. zero tolerance vs OK to use off-site as long as no problems within NGO)	**1**	
B7	Issues with sleep: Nature of sleep disturbance. Contributing factors (other residents' behaviour, shared room, location). What time he is taking antipsychotics. Any hypnosedatives tried to date?	**1**	
C	**Other Possible but less likely Informants:** e.g. contact GP if there is one (doesn't sound likely), possibly contact family although again it sounds as though he is estranged from them, and there might well be language barriers with telephone contact.	**1**	
		Up to a maximum of 8 marks in total TOTAL:	

Modified Essay Question 2

You see Thim Phu at the NGO house in the company of the care provider and an interpreter. During some of the interview Thim Phu speaks in quite reasonable English, but generally he sits in a dejected and sad manner. He brightens during longer exchanges with the interpreter.
You find out that Thim Phu has stopped his oral antipsychotic medication since leaving hospital.

Question 2 (11 marks)
What factors are likely contributors to Thim Phu's adherence to medication treatment?

SCORING KEY
Use whole marks only, not ½ marks. 1 mark per item if it adequately covers the content indicated.

		worth	mark
A	**Factors linked to Thim Phu himself**		
A1	Attitudes to biological treatments generally	**1**	
A2	Past experience and beliefs	**1**	
A3	Cultural, family, values and prejudices	**1**	
A4	Support network and milieu (attitudes of the other residents & NGO staff)	**1**	
A5	Personality	**1**	
A6	Insight into illness	**1**	
B	**Factors linked to Thim Phu's treatment**		
B1	Response to treatment (its effectiveness)	**1**	
B2	Side effects of any medications used – their severity and his understanding of them	**1**	
B3	Stigma associated with taking treatment	**1**	
B4	Treatment alliance (alliance with treating staff to date, change of teams from inpatient to community)	**1**	
B5	Treatment setting (e.g. whether any supervision or prompting to take meds)	**1**	
B6	Complexity (e.g. no. of medications, need for blister packs, multiple vs once daily regime)	**1**	
C	**Factors linked to Thim Phu's illness**		
C1	Psychosis-specific symptoms (e.g. delusions about drug treatment, delusions of grandeur, persecutory beliefs, hallucinations telling him not to take it, passivity phenomena, marked thought disorder.)	**1**	
C2	Depression with reduced motivation or nihilism	**1**	
C3	Anxiety Sx due to psychosis or depression which interfere with his coping	**1**	
C4	Cognitive impairment (e.g. due to psychosis or depression such as impaired attention and concentration, frontal impairment re memory & new learning, etc.)	**1**	
C5	Negative Symptoms such as amotivation	**1**	
	Up to a maximum of 11 marks in total TOTAL:		

NB:
candidates must give some answers from A, B and C – each category can only score max. 4 marks each.

Modified Essay Question 2

You decide that working with Thim Phu using an Adherence Therapy (Compliance therapy) model would be beneficial.

Question 3 (6 marks)
Outline your approach describing the phases and principles of Adherence therapy, and key techniques involved.

SCORING KEY
Use whole marks only, not ½ marks. 1 mark per item if it adequately covers the content indicated.

		worth	mark
A	**Phases**		
A1	Eliciting patient's stance or attitudes to treatment	**1**	
A2	Exploring ambivalence towards treatment	**1**	
A3	Highlighting need for maintenance treatment	**1**	
B	**Key principles of Adherence therapy**		
B1	Non-blaming atmosphere	**1**	
B2	Focus on eliciting the patient's concerns	**1**	
B3	Express empathy with patient	**1**	
B4	Support self-efficacy (knowledge on which to base choices, autonomy, self-care etc.)	**1**	
C	**Key techniques of Adherence therapy**		
C1	Reflective listening	**1**	
C2	Regular summarizing	**1**	
C3	Inductive questioning (using specific examples to help patient grasp overall principles)	**1**	
C4	Explore ambivalence, exploration of pros and cons of alternatives	**1**	
C5	Discussion of the discrepancy between present behaviour and broader goals	**1**	
C6	Use of normalizing rationales (e.g. Giving examples of how unusual symptoms can be caused by various things such as Sleep deprivation, Post-traumatic stress disorder, Sensory deprivation, Hostage situations, Sexual abuse, etc. - so as to help the patient feel more ' normal' and less alienated by the concept of "schizophrenia", and to catastrophize less about the term – is combined with sensible, accurate psychoeducation and explanations of symptoms.)	**1**	
C7	Techniques drawn from Cognitive Therapy	**1**	
C8	Techniques drawn from Motivational Interviewing	**1**	
C9	Techniques drawn from Psychoeducation principles	**1**	
	Up to a maximum of 6 marks in total **TOTAL:**		

Modified Essay Question 3: (25 marks)

David is a single 34 year old European account executive living alone in an apartment, who presents with a seven year history of panic attacks. His first panic attacks occurred following a minor motor vehicle accident which happened while driving home from work. On that day he had been passed over for promotion for a job that he believed was rightfully his. Over the following years, the panic attacks have become increasingly frequent and are now occurring spontaneously. As a result, David has become increasingly reluctant to leave his house, and has had to cease work in the last six months. He has however been living off his investments and is not in financial difficulties. David denies any substance abuse and is physically well. He is currently between GPs, as his last GP retired and he has decided to change to a practice closer to his apartment.

Question 1 (9 marks)
Outline your management plan.

SCORING KEY
Use whole marks only, not ½ marks. 1 mark per item if it adequately covers the content indicated.

		worth	Mark
A	Establish rapport and a therapeutic relationship	**1**	
B	Establish baseline for frequency and severity of symptoms (both panic attacks and avoidance behaviour)	**1**	
C	Psychoeducation	**1**	
D	Distress tolerance skills	**1**	
E	Hyperventilation control	**1**	
F	Cognitive behavioural therapy	**1**	
G	Exposure to panic-inducing stimuli in office (e.g. visualisation)	**1**	
H	In vivo exposure to phobic situations	**1**	
I	Pharmacological interventions (TCA / SSRI / benzodiazepines)	**1**	
J	Advice on lifestyle modifications e.g. reducing caffeine	**1**	
		Up to a maximum of 9 marks in total TOTAL:	

Modified Essay Question 3

David describes a fear of losing control when he panics and wants to know how to avoid this. You feel that further information about panic attacks and agoraphobia and the treatment of these conditions will be useful.

Question 2 (7 marks)
What are the essential points that you will cover in psychoeducation?

SCORING KEY
Use whole marks only, not ½ marks. 1 mark per item if it adequately covers the content indicated.

		worth	Mark
A	Describe the nature and course of panic disorder and agoraphobia	**1**	
B	Explain the basis of anxiety and how the anxiety response is distorted in those with panic disorder (cognitive model of anxiety)	**1**	
D	Describe how lifestyle factors can contribute to anxiety e.g. coffee, stimulants	**1**	
E	Explain the importance of needing to experience anxiety to overcome it	**1**	
F	Provide a rationale for treatment, the likelihood of a positive response and the time-frame for this	**1**	
G	Be realistic about the likelihood of experiencing anxiety in the course of treatment and still having some residual anxiety when treatment is finished	**1**	
H	Describe CBT - how this therapy works and what it involves	**1**	
I	Describe use of antidepressants or anti-anxiety medication as an adjunct to CBT	**1**	
J	Describe the use of relaxation training and similar techniques to manage anxiety	**1**	
		Up to a maximum of 7 marks in total TOTAL:	

Modified Essay Question 3

David responds well to psychoeducation and has been considering other treatment options while you were away on a month's leave. In the interim he has been making good progress, with a reduction in both the frequency and severity of his panic attacks and a lessening of avoidance behaviour. However, at your six week appointment with him, David admits that his brother Neil, a GP, has been prescribing lorazepam 1mg bd for him which he has been taking since first seeing you.

Question 3 (9 marks)
Discuss how you would deal with this issue, including the information that you would provide to David.

SCORING KEY
Use whole marks only, not ½ marks. 1 mark per item if it adequately covers the content indicated.

		worth	Mark
A	Explore the rationale behind the use of benzodiazepines	**1**	
B	Discuss the relative merits of CBT/antidepressants/benzodiazepines	**1**	
C	Discuss the risk of dependence and other adverse effects associated with benzodiazepine use (e.g. effects on driving)	**1**	
D	Discuss the possibility of rebound anxiety occurring when using short-acting benzodiazepines	**1**	
E	Discuss the possibility of benzodiazepine use reducing the effectiveness of a trial of CBT	**1**	
F	Discuss the need for clarity regarding Neil's respective roles i.e. treatment provider vs brother	**1**	
G	Communicate with Neil and reach agreement about who the prescribing doctor will be – namely, you	**1**	
H	Firmly encourage David to arrange a proper GP	**1**	
I	Reach agreement about a strategy for withdrawing the benzodiazepine	**1**	
J	Recheck whether David is using any other substances	**1**	
		Up to a maximum of 9 marks in total TOTAL:	

Modified Essay Question 4 (25 marks)

Mr James Taylor is a 67 year old retired school teacher who is referred by his GP to your Older Person's Community Mental Health team. Mr Taylor lives with his wife Mary who is 61 yrs old and still working part time as a hairdresser. They have two adult children who live in another city and keep in touch by phone, but visit infrequently.

Mrs Taylor approached the GP for advice. She is distressed that their relationship is "falling apart" after 40 years of a happy marriage. Since his retirement Mr Taylor appears to have changed and she does not understand why. He has become irritable and no longer seems to be able to talk things through like they used to. He has become sarcastic and rude, and does not appear to care if he upsets her. He appears to have difficulty controlling his temper and on two occasions Mary has felt threatened. He often does not shave and occasionally she has noticed a body odour that he never used to have. He embarrassed her at her work Christmas party by flirting with her junior assistant and has joined a charismatic church after a lifetime of little church attendance. Last month the electricity was cut off as Mr Taylor failed to pay the bill. Mary has tried for some time to get Mr Taylor to see the GP but he has refused saying that he has never felt better and that she is the one with the problem. Mrs Taylor has tried to discuss her concerns with her children but they think she is over-reacting and that "Dad is just loosening up" after retiring.

Mr Taylor has no previous history of contact with mental health services. He has hypertension which is well controlled.

Following her visit, the GP asked Mr Taylor to attend the surgery for a check-up prior to a repeat prescription for anti-hypertensives. Mr Taylor scored 28/30 on an MMSE. During that visit the GP persuaded him to see a specialist "to see if there is anything wrong or if the two of you may need a bit of marriage guidance." Mr Taylor reluctantly agrees, "just to get everyone off my back".

Modified Essay Question 4

Question 1 (10 marks)

Please outline details of how you would assess this man, with reference to the setting-up of the interview and the key aspects of history, collateral and mental state needed in order to generate a formulation and differential diagnosis.

SCORING KEY

Use whole marks only, not ½ marks. 1 mark per item if it adequately covers the content indicated.

		worth	mark
A	Some discussion of the delicacy of such an assessment. Need to establish rapport. Possible settings, and issues around seeing Mr and Mrs Taylor together or separately.	**2**	
B	Presenting history - Gradual or sudden onset? Screening for Sx of current/past mood disorder - especially consideration of manic symptoms.	**2**	
C	Alcohol/Drug history. Better candidates may mention looking for physical stigmata of abuse/dependence.	**1**	
D	Screening for other symptoms of dementia/functional decline – e.g. language difficulties, emotional lability, childish or impulsive behaviour, fatuous affect.	**1**	
E	Screening for any possibility of head injury.	**1**	
F	Personal history, especially premorbid personality.	**1**	
G	Mental state examination with particular reference to excluding possibility of mood disorder or psychotic Sx.	**1**	
H	Cognitive testing: Repeat MMSE. Clarify deficits with GP. "Bedside" frontal and executive testing (ideally several should be mentioned specifically)	**1**	
I	Medical history, including medications and any recent changes.	**1**	
J	Screening for vascular risk factors and for evidence of focal signs or TIA/CVA Sx and signs.	**1**	
K	Check what investigations GP has already done. Ensure full usual screening blood tests, careful physical a CT or MRI scan (mention of scan not needed for the mark if other medical assessments covered).	**1**	
L	Addressing issues of safety, risk, supports and carer-stress with his wife.	**1**	
		Up to a maximum of 10 marks total **Total:**	

Modified Essay Question 4

At a family meeting, one of Mr Taylor's sons says he has been reading on the internet about the cholinesterase inhibitor medications. He wonders whether his father should be on these drugs.

Question 2 (5 marks)
How would you respond to this question?

SCORING KEY
Use whole marks only, not ½ marks. 1 mark per item if it adequately covers the content indicated.

		worth	mark
A	Explanation of the dementia syndrome and possible subtypes/differential diagnosis.	**1**	
B	Some explanation of mode of action of cholinesterase inhibitors and effects on disease progression vs symptom delay	**1**	
C	Some mention of prescribing guidelines of what ever country you're in/ Issues of funding/use outside of an Alzheimer's diagnosis.	**1**	
D	Evidence for use in vascular dementias increasing, therefore need for diagnostic clarification	**1**	
E	Little evidence for efficacy in Fronto-Temporal Dementia (a possible diagnosis with his presenting Sx) – could even possibly worsen his Sx.	**1**	
F	Issues around how efficacy would be monitored and decisions around end point	**1**	
G	Specific discussion of side-effects	**1**	
H	Some reference to other medication options available – e.g. memantine, antipsychotics, etc.	**1**	
I	Discussion of the non-medication approaches to treatment.	**1**	
		Up to a maximum of 5 marks total	
		Total:	

Modified Essay Question 4

Three months later, the GP phones you again for advice. Mrs Taylor and her son have been to see a solicitor who recommended that Mr Taylor nominates his son to hold his Enduring Power of Attorney. The GP is unsure whether Mr Taylor has the capacity to do so and wants you to carry out an assessment.

Question 3 (10 marks)
Please outline how you would complete such an assessment.

SCORING KEY
Use whole marks only, not ½ marks. 1 mark per item if it adequately covers the content indicated.

		worth	mark
	General Issues		
A	Recognition of role – is a medico-legal vs a clinical assessment.	**1**	
B	Better candidates will expand on whether this is within the routine scope of public system practice vs being done privately.	**1**	
C	Recognition of the concept of decision-making capacity being specific, not global	**1**	
D	Recognition that capacity to nominate EPOA is not necessarily linked to cognitive function/MMSE scores/diagnosis	**1**	
	With the Patient		
E	Ensuring Mr Taylor understands the reasons for the assessment.	**1**	
F	'Maximize his capacity' – via choice of setting for the assessment, reducing anxiety, optimizing vision and hearing, not tiring the patient, establishing rapport	**1**	
G	Assessment of his understanding of the concept and the consequences of nominating a certain person. (i.e. the powers of the EPOA)	**1**	
H	Assessment of his understanding of the possible people who could hold EPOA and reasons why he might choose one person over another/his options	**1**	
I	Assessment of his understanding of the extent of his estate/assets (He should demonstrate at least an approximate understanding)	**1**	
J	Screening for reversible factors that may effect decision-making capacity such as delirium or psychosis or depression	**1**	
K	Some assessment of previous decision-making style	**1**	
L	Assessment of his ability to communicate wishes, and the consistency of this.	**1**	
M	Assessment of his ability to process information – his ability rationally to think his way through and make a decision.	**1**	
	Collateral / Family		
N	Obtain any clinical records and other information. Assessment is based on interview and information from other sources	**1**	
O	Consideration of the family dynamics and consideration of issues such as undue influence or abuse of powers	**1**	
		Up to a maximum of 10 marks total. Total:	