THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS

MOCK WRITTENS EXAMINATION

AUCKLAND / NEW ZEALAND

December 2006 / May 2007

PAPER II

MODEL ANSWERS

Note that these Mock Writtens papers are produced by local psychiatrists with no connection to the Examination Committee and are not vetted, test driven and perfected by committee in the way that the real papers are. The main point is not to get fixated about whether the question writers were “right” and you were “wrong” in the model answers, but to practice the marathon of doing 2 full 3-hour papers and practising the technique of the various question types. If you disagree with the factual detail of an answer, research the issue and decide for yourself. However, if you locate a clear typo feel free to email felicity@iprohome.co.nz so that it can be corrected.

Critical Essay Question: (40 marks)

DIRECTIONS:

- **Use as many pages as needed to answer this Critical Essay Question**
- **Write only on the front, lined side of each page**
- **You can request additional spare pages from the invigilator if needed. Interleave these into the booklet at the appropriate place.**
- **Do not use the scrap paper provided to add any additional pages – always ask the invigilator for additional pages.**

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

"The DSM, a largely political piece of work, ...can be seen as a reflection of the "voters" values, biases, social status, privilege and power and as an agent of injustice rather than an empirically supported professional tool used in service of healing."

Dr O. Zur, July 2006 http://www.drzur.com/dsmcritique.html

Reminder about marking process:
There are 5 dimensions. 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.</td><td>0</td><td rowspan="4">Comments:

A 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 that clarifies the quote's issues & a brief definition of what the DSM is
• A mid-section to essay with discussion addressing:
– Arguments/examples/references in support of the quote
– Arguments/examples/references against the quote
• Closing statement that summarises and provides the writer's overall "conclusions"

Points are given for examples and references, and for the overall coherence and flow of the arguments/discussion.

Arguments need to refer to the evidence-base, e.g. there should be some discussion of the validity of DSM system (descriptive validity), and of any research that supports or contributes to its validity and reliability in terms of objective scientific justification.

Note that the essay should not become derailed however purely into a discussion of the pros and cons of the DSM as a diagnostic system, thus missing out other issues in the quote.</td></tr>
<tr><td>Points are random or unconnected or listed or Assertions are unsupported or false or There is no conclusion</td><td>1-2</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.	0	Comments:
The candidate considers only one point of view.	1-2	There needs to be discussion both for and against the quote's statement.
The candidate considers more than one point of view, but the strengths and weaknesses of the views are poorly evaluated.	3-4	Needs (ideally) to be evaluation of the strengths and weaknesses of different examples/arguments, rather than just a series of examples or statements some of which are pretty thin and unconvincing.
The candidate considers more than one point of view and the strengths and weaknesses of each view are well evaluated.	5-6	
The candidate demonstrates highly sophisticated ability to set out and evaluate >1 point of view	7-8	Top points if the arguments to and fro are explained in a sophisticated manner.

Dimension 3. Ability to Communicate

The spelling, grammar or vocabulary renders the essay extremely difficult to understand; **or** totally unintelligible.	0	NB: Also mark down if writing's illegible or if are multiple deletions and insertions
The spelling, grammar or vocabulary significantly impedes communication.	1-2	
The spelling, grammar and vocabulary are acceptable but the candidate demonstrates limited capacity for written expression.	3-4	
The spelling, grammar and vocabulary are acceptable and the candidate demonstrates good capacity for written expression.	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.	0	Comments: Candidate needs to bring ethical arguments and examples into essay – and to have a balanced view, neither totally dismissing quote or strongly supporting it unthinkingly. Cultural differences and need for sensitivity re diagnosing conditions in social groups re power differentials must be mentioned (extremes of age, intellectual disability, men vs women, etc.). Potential for abuse of diagnostic systems must be mentioned. e.g. historical abuses and abuses in various political regimes. Diagnostic systems and psychiatric practice itself in the context of philosophy, sociology and politics needs to be addressed. e.g. evolution of DSM according to social/political pressures needs mention – such as addition of PTSD (? due to pressure for compensation and health insurance coverage), deletion of homosexuality as an "illness", changes to Axis II categories and tendency for some categories not to be gender-neutral (histrionic vs antisocial PD etc.)
Judgments are naïve; **or** superficial; **or** extremely poorly thought through; **or** unethical.	1-2	
The candidate demonstrates some reasoned judgment, maturity of thinking, clinical experience and displays some awareness of the ethical issues raised by the quote.	3-4	
The candidate shows good capacity for reasoned judgment, mature thinking, clinical experience, awareness of ethical issues raised by the quote.	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.

Candidate shows no awareness of the broader scientific, social, cultural or historical context.	0	Comments: Look for discussion of DSM and diagnostic systems in: – Psychiatry and other spheres of life/science. Extra points if other classificatory or division systems are mentioned to compare and contrast – e.g. ICD, zoological taxonomy, social systems like caste system, racial segregation in apartheid, etc. – Past history – history of making diagnoses, of the development of the DSM (fairly flawed and idiosyncratic initially) etc. History of use/misuse of diagnostic classifications in societies and politically. – Cross-cultural similarities/problems with diagnostic systems. WHO etc. studies of ability to diagnose same major illnesses across many nations Examples of DSM's pros and cons should be provided from a range of areas as above.
There is a very limited understanding of the scientific, social, cultural or historical context of psychiatry or mental illness.	1-2	
The candidate demonstrates an ability to understand psychiatry or mental illness in only one of the following contexts: broader scientific, socio-cultural, historical context.	3-4	
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.	5-6	
Highly sophisticated scope, demonstrating a superior understanding of the broader context of psychiatry or mental illness.	7-8	

Some General Brainstorming Ideas re Possible Content of Essay:
"The DSM, a largely political piece of work, ...can be seen as a reflection of the "voters" values, biases, social status, privilege and power and as an agent of injustice rather than an empirically supported professional tool used in service of healing."

Introduction:
The quote is a fairly extreme statement so it would not be unreasonable to note this in the introduction, while at the same time acknowledging that there may be some validity to aspects of this viewpoint. "DSM" should be briefly defined/explained. The quote criticises the DSM and calls it "largely political", "reflection of the voters values" and an "agent of injustice". The quote also states that DSM is not "empirical" and is not a "professional tool used in service of healing". These core statements/issues should be extracted and briefly restated as the basis for the essay's arguments. ***[Note that teasing out the specific statements within the quote in your initial brainstorming session will greatly assist you then to organise arguments so as to write the essay. Practice taking similar quotes and teasing out the core issues/statements which will need to be addressed. Do this in study groups ideally, so as to bounce ideas off each other.]***

Pros:
To argue *for* the quote, candidates need to think in what way the statements as above could be true, or partially true. So to what degree is DSM politically or socially determined, and to what degree is it an unjust system or does it support injustice, and to what degree is it not scientifically supported or evidence-based. Also whether it is in fact used inappropriately or to persecute or stigmatise, i.e. not used to "support healing".

Discussion of deficits of DSM re its historical development (not initially at all scientific or empirically-based, very driven by psychoanalytical concepts, determined "by committee" with clashes in the viewpoints and egos of powerful clinicians, no research to back it up at least initially. All this leading to its being influenced to some degree by the social and political views of the time. Possibly aspects of DSM can be seen as a distillation of the views of the "voters" (i.e. wider society) to some degree, but more so of the psychiatric community's views, as wider society was likely to be much more biased and limited in viewpoint by stigma.

Classifications or divisions as common in human societies but often harmful and limiting of individual rights and potential – e.g. social systems like Indian caste system, racial segregation in apartheid, feudal society roles, the UK social class system, and gender roles.

Evolution of DSM according to social/political pressures – such as addition of PTSD (some say due to pressure for compensation and health insurance coverage), deletion of homosexuality as an "illness", changes to Axis II categories and tendency for some categories not to be gender-neutral (histrionic vs antisocial PD etc.)

Useful to set DSM in context of other similar "scientific" classificatory systems like ICD, zoological taxonomy, etc. Are descriptive not based on aetiology or a more fundamental "truth". Brief mention and definition of 'descriptive validity' useful vs any more empirical validity, and of paucity of research that supports or contributes to overall DSM subcategory validity and reliability in terms of objective scientific justification. References would earn points here.

Past history of use/misuse of diagnostic classifications in societies and politically. e.g. historical abuses (over-diagnosis of schizophrenia and use of ECT, misdiagnosis and incarceration of adolescents with behavioural problems, difficult interfaces with forensic system, and abuses in various political regimes (USSR, Cuba, China, etc.) where authoritarian regimes have invented spurious diagnostic categories as a means of social control. However – note that true DSM tended to be misused or altered, to this end.

Cross-cultural and social problems with diagnostic systems - need for sensitivity when diagnosing conditions in social groups with power differentials (other races and cultures, children, elderly, intellectual disability, men vs women, minority groups such as homosexuals.)

Risk of over-reliance on DSM re power of the APA, health insurance-driven categories (misdiagnosis so patients can receive funded treatments etc.) Unthinking adherence to DSM by clinicians, using it as a "Bible". Stigma from certain diagnoses such as Borderline PD – can be counterproductive re "healing". Stigmatisation and dehumanisation caused by viewing people as "diagnoses" "he's a schizophrenic", "she's a borderline" etc.

Cons:

Although this is not overall the main point, some defence of the DSM (and of all diagnostic systems) is needed here (or these points may be woven into the discussion of "pros" as above, as counter-arguments to each one)

- That there is at least descriptive validity which has been refined over successive editions of DSM so as to be more accurate and specific, and increasingly based on increasing amounts of research into aetiology, epidemiology, treatment-response and course of psychiatric disorders.
- That psychiatrists and society (our referrers, patients, families) need a common language to communicate what the problem is, and a "shorthand" for this re diagnostic terms.
- That we need a structure with clear criteria or else can be too subjective (history of very idiosyncratic and variable diagnosing in USA pre DSM).
- That research needs a clear classification and diagnostic system on which to base studies.
- Cross-cultural validation of psychiatric diagnoses – WHO etc. epidemiological studies did show ability to diagnose the same major psychiatric illnesses across many nations.

Mental illness thus exists in a similar way in all nations and is not merely a misguided construct imposed on people by power-hungry psychiatrists (as claimed by the anti-psychiatry movement). Given this, we need diagnostic systems so as to assess and treat genuine illnesses - so as to heal and support patients in their recovery.

DSM not used in modern psychiatric systems in democratic nations as a tool of state suppression/persecution, nor is it an instrument of social persecution. Categories are not these days socially determined and tend to be adjusted now according to research/epidemiological evidence, not due to political or social pressures. Mentally ill have many rights and protections in law, and not making a diagnosis can deprive them of these, in fact.

Enlightened modern psychiatric systems mean that making a diagnosis need not be stigmatising or persecuting – can be liberating and helpful (e.g. patients with Asperger's, bipolar disorder or borderline PD being able to access websites with support groups and information to assist them).

Conclusions:
Needs a balancing summary (briefly) acknowledging (e.g.) the deficits of classificatory systems such as the DSM but nonetheless defending the need for them at least until we are a lot clearer about aetiology (for example) as an alternative system on which to base diagnoses. A warning about need to be aware of DSM's deficits and not to use it too unthinkingly however, and to be aware that it is to some degree affected by social "norms" and viewpoints.

Reminder of actual CEQ Dimensional Scoring:

Dimension 1. Capacity to produce a logical argument and critical reasoning	
There is no evidence of logical argument or critical reasoning.	0
Points are random or unconnected or listed; **or** assertions are unsupported or false; **or** there is no conclusion.	1 2
The points in this essay follow logically but there is only a weak attempt at supporting the assertions made by correct and relevant knowledge.	3 4
The points in this essay follow logically to demonstrate the argument; **and** assertions are supported by correct and relevant knowledge.	5 6
The candidate demonstrates a highly sophisticated level of reasoning and logical argument.	7 8
Dimension 2. Flexibility	
The candidate restricts him or herself to an extremely narrow and very rigid line of argument.	0
The candidate considers only one point of view.	1 2
The candidate considers more than one point of view, but the strengths and weaknesses of the views are poorly evaluated.	3 4
The candidate considers more than one point of view and the strengths and weaknesses of each view are well evaluated.	5 6
The candidate demonstrates a highly sophisticated capacity to set out and evaluate more than one 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.	0
The spelling, grammar or vocabulary significantly impedes communication.	1 2
The spelling, grammar and vocabulary are acceptable but the candidate demonstrates poor capacity for written expression.	3 4
The spelling, grammar and vocabulary are acceptable and the candidate demonstrates good capacity for written expression.	5 6
The candidate displays a highly sophisticated level of written expression.	7 8
Dimension 4. Judgment, experience and maturity, ethical awareness	
The candidate demonstrates an absence of any capacity for judgment; **or** judgments are grossly unethical.	0
Judgments are naive; **or** superficial; **or** extremely poorly thought through; **or** unethical.	1 2
The candidate demonstrates some reasoned judgment or maturity of thinking or clinical experience or awareness of the ethical issues raised by the quote.	3 4
The candidate shows good capacity for reasoned judgment, mature thinking, clinical experience, awareness of ethical issues raised by the quote.	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	
The candidate shows no awareness whatever of the broader scientific, social, cultural or historical context.	0
There is a very limited understanding of the scientific, social, cultural or historical context of psychiatry or mental illness.	1 2
The candidate demonstrates an ability to understand psychiatry or mental illness in a broader scientific or socio-cultural or historical context.	3 4
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.	5 6
Highly sophisticated scope, demonstrating a superior understanding of the broader context of psychiatry or mental illness.	7 8

Critical Analysis Question 1 (20 marks)

Detection of Alzheimer's disease and dementia in the preclinical phase: population based cohort study

Katie Palmer, PhD student, Lars Bäckman, professor, Bengt Winblad, Professor, Laura Fratiglioni, professor. Aging Research Center, Division of Geriatric Epidemiology and Medicine, Neurotec, Karolinska Institute, and Stockholm Gerontology Research Center, Box 6401, 11382, Stockholm, Sweden

British Medical Journal 2003;326:245 (full article is available free on-line)

Abstract

OBJECTIVES

To evaluate a simple three step procedure to identify people in the general population who are in the preclinical phase of Alzheimer's disease and dementia.

DESIGN Three year population based cohort study.

SETTING Kungsholmen cohort, Stockholm, Sweden.

PARTICIPANTS 1435 people aged 75-95 years without dementia.

ASSESSMENTS Single question asking about memory complaints, assessment by mini-mental state examination, and neuropsychological testing.

MAIN OUTCOME MEASURE Alzheimer's disease and dementia at three year follow up.

RESULTS

None of the three instruments was sufficiently predictive of Alzheimer's disease and dementia when administered separately. After participants had been screened for memory complaints and global cognitive impairment, specific tests of word recall and verbal fluency had positive predictive values for dementia of 85-100% (95% confidence intervals range from 62% to 100%). However, only 18% of future dementia cases were identified in the preclinical phase by this three step procedure. Memory complaints were the most sensitive indicator of Alzheimer's disease and dementia in the whole population, but only half the future dementia cases reported memory problems three years before diagnosis.

CONCLUSION

This three step procedure, which simulates what might occur in clinical practice, has a high positive predictive value for dementia, although only a small number of future cases can be identified.

Method (excerpt)

We assessed memory complaints with a single direct question: “Do you currently have any problems with your memory?” Global cognitive impairment with no dementia was defined as scoring one standard deviation below the age and education specific mean on the mini-mental state examination, an easy to administer test of global cognitive functioning.

Three domains of cognitive functioning were assessed in neurological testing: episodic memory, verbal fluency, and visuospatial skill. Impairment was defined as scoring one standard deviation below the age and education specific means on the following tests:

Recall, episodic memory - A composite score of four significantly correlated ($r=0.54-0.59$, $P<0.01$) word recall tasks were used: free recall of rapidly and slowly presented random words, and free and cued recall of organisable words.

Verbal fluency - Participants were asked to produce as many grocery items as possible during 60 seconds. Scores were based on the number of grocery items produced.

Visuospatial skill - A composite score of three significantly correlated ($r=0.24-0.40$, $P<0.01$) tests was used to assess visuospatial skill: block design, clock setting, and clock reading.

Table 4.
Positive and negative predictive values of memory complaints, global cognitive impairment with no dementia, and impairment on domain specific cognitive tests for Alzheimer' s disease and dementia* at three year follow up with three step screening.

	Step 1: Tests in the general population		Step 2: Testing only people with memory complaints		Step 3: Testing only people with both memory complaints and cognitive impairment	
	Positive predictive value (95% CI)	Negative predictive value (95% CI)	Positive predictive value (95% CI)	Negative predictive value (95% CI)	Positive predictive value (95% CI)	Negative predictive value (95% CI)
Memory complaint	0.25 (0.21 to 0.29)	0.88 (0.86 to 0.90)	—	—	—	—
Global cognitive impairment with no dementia	0.35 (0.28 to 0.42)	0.87 (0.85 to 0.89)	0.45 (0.34 to 0.57)	0.80 (0.75 to 0.84)	—	—
Domain specific cognitive impairment:						
Episodic/recall impairment	0.37 (0.23 to 0.51)	0.87 (0.83 to 0.91)	0.41 (0.22 to 0.60)	0.80 (0.71 to 0.88)	0.75 (0.51 to 0.99)	0.73 (0.56 to 0.89)
Verbal fluency impairment	0.34 (0.21 to 0.46)	0.88 (0.84 to 0.91)	0.44 (0.25 to 0.64)	0.82 (0.74 to 0.90)	0.85 (0.62 to 1)	0.65 (0.47 to 0.82)
Visuospatial impairment	0.33 (0.20 to 0.45)	0.87 (0.83 to 0.91)	0.33 (0.15 to 0.50)	0.79 (0.70 to 0.87)	0.24 (0.01 to 0.47)	0.49 (0.29 to 0.68)

* Progression to dementia versus remaining alive or dying without dementia.

Critical Analysis Question 1 (20 marks)

QUESTION 1.1
What is a population based cohort study? (2 marks)

Population based - means taken from the general population or at least not a clinically defined population. In this particular study the population was a sample of people from a particular suburb of Stockholm, Sweden.
Cohort study - means a group of people who all start together and are followed up for a period of time - re original meaning of 'cohort' from the Roman. Cohort studies are best thought of conceptually like a race where everyone starts together with the same handicap and hopefully everyone crosses the finishing line.

QUESTION 1.2
What is the major advantage and disadvantage of evaluating a 3 step procedure for diagnosis? (2 marks)

Major advantage is that it replicates what happens in clinical practice.
Major disadvantage is that what happens in clinical practice isn't that good and there are better tests available (e.g. the 'paired associate learning' test)

QUESTION 1.3
Give 3 advantages and 3 disadvantages of using the authors' definition of "global cognitive impairment with no dementia" (6 marks)

Advantages
Clearly defined.
Possible pre dementia state.
Probably important for the patient.

Disadvantages
By definition it is normal to have "global cognitive impairment with no dementia" in about one third of the population (think what the standard deviation means).
Hard to know clinically what it means.
Based on mini mental state examination which isn't the best screening instrument.

QUESTION 1.4
Give an advantage and a disadvantage of the study's three year follow-up period. (2 marks)

Advantage – makes the study feasible.
Disadvantage – may not be long enough to detect all the cases of dementia in the population.

QUESTION 1.5
In Table 4 what do positive and negative predictive values mean? (4 marks)

Positive predictive value – the proportion of people who score positive on the screening tests who turn out to have dementia
Negative predictive value – the proportion of people who score negative on the screen who really don't get dementia
NB: Both these measures are dependent on the prevalence of the disease in the population.

QUESTION 1.6

QUESTION 1.6.1

From Table 4, if someone aged 75 or over complains of memory problems, what are their chances of having Alzheimer' s disease 3 years later? (2 marks)

25% i.e. one in four people in the general population over 75 who complain of memory problems go on to get Alzheimer's/dementia three years later. (Or to put it another way, most people who complain of memory problems don't go on to develop dementia after 3 years.)

QUESTION 1.6.2

What happens to their chances if they then score one standard deviation below the age and education specific mean on the MMSE? (2 marks)

Goes up to 35% - or about 1 in 3 people who have "global cognitive impairment without dementia" go on to develop dementia after 3 years.

Critical Analysis Question 2 (20 marks)

As an advanced trainee, exploring which treatments might best protect your patients with bipolar disorder from serious sequelae, you discover the following article:

Lithium in the Prevention of Suicidal Behavior and All-Cause Mortality in Patients With Mood Disorders: (title truncated)

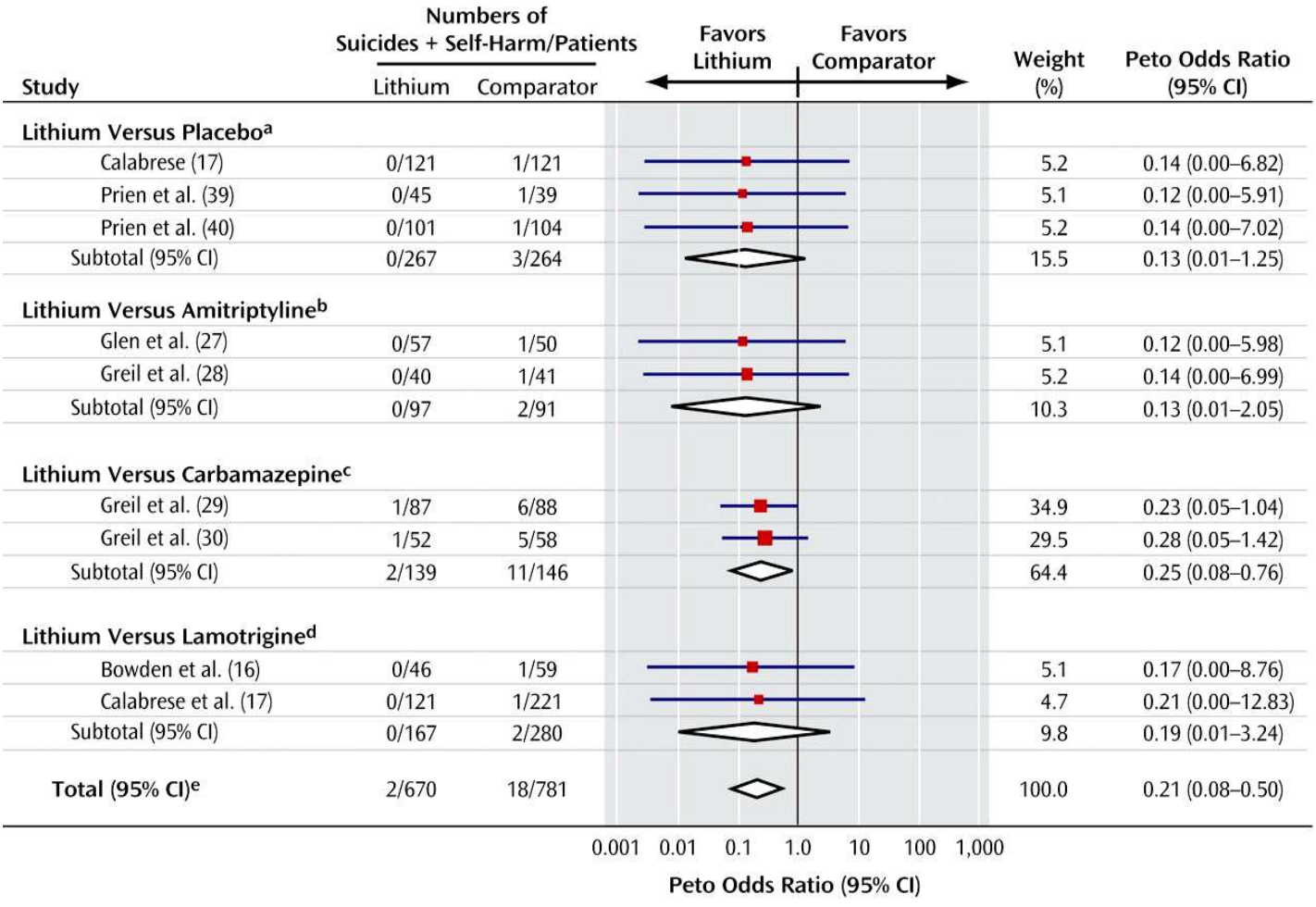
Andrea Cipriani, M.D., Heather Pretty, M.L.I.S., Keith Hawton, D.Sc. and John R. Geddes, M.D.
Am J Psychiatry 162:1805-1819, October 2005

Abstract (excerpt)
OBJECTIVE: Observational studies suggest that long-term lithium treatment has a strong antisuicidal effect in mood disorders, but it is uncertain whether this association is a genuine therapeutic effect or is due to confounding factors in nonrandomized studies.

Results (excerpt)

Suicide and Deliberate Self-Harm
The diagram below shows a Forest Plot (dot and blob) diagram.
Examine the figure and answer the following questions.

Forest Plot of Suicides Plus Deliberate Self-Harm in Randomized Trials Comparing Lithium With Placebo or Active Comparators in mood disorders



Critical Analysis Question 2 (20 marks)

QUESTION 2.1

QUESTION 2.1.1
What sort of studies produce this type of diagram? (2 marks)

Systematic reviews

(give 1 mark for meta analysis – this is not strictly correct. Most meta analyses don't analyse their results in this way but meta analysis is the statistical part of a systematic review. All meta analysis means is the process of using statistical methods to combine the results of different studies – the important part is deciding what studies to include in the first place hence the importance of systematic reviews.)

QUESTION 2.1.2
What are the key characteristics of this type of study? (2 marks)

Systematic search of the literature and
Clear rules for the inclusion/exclusion of studies.

QUESTION 2.2
What is the total number of patients included in this analysis? (2 marks)

1451 (670 + 781)

QUESTION 2.3

QUESTION 2.3.1
What does the odds ratio mean and how is calculated? (4 marks)

The odds ratio is the ratio of two odds. Usually this is the odds in favour of exposure in the cases divided by the odds in favour of exposure in the non-cases.

i.e.	*Cases (suicides and self harm)*	*Non-cases (no suicide or self harm)*
Exposure (lithium)	*a*	*b*
No Exposure (comparator)	*c*	*d*

Odds ratio is a/c divided by b/d

QUESTION 2.3.2
Draw a two by two table for the Total illustrating how you would calculate the odds ratio. (6 marks)

	Cases (suicides and self harm)	*Non-cases (no suicide or self harm)*
Exposure (lithium)	*2*	*670*
No Exposure (comparator)	*18*	*781*

Odds ratio 2/18 (0.11) divided by 670/781 (0.86) = 0.13
(NB: this is the crude odds ratio – peto odds ratio includes some adjustments but the principle is the same)

QUESTION 2.4
What conclusions can you draw from this table? (4 marks)

- *Lithium appears to have a protective effect against suicide and self harm in people with mood disorders.*
- *The risk of self harm and suicide in those taking lithium is roughly one fifth that of people not taking lithium.*
- *However note that most of the evidence for this comes from two studies from the same group who had a high rate of self harm/suicide in their studies.*
- *Note also that these dot and blob diagrams don't tell you information about how long the study was for instance – obviously the longer the study the more likely it is to detect adverse events such as self harm/suicide.*

See: free article available on-line:
BMJ 2001;322:1479-1480 (16 June)
Forest plots: trying to see the wood and the trees
http://www.bmj.com/cgi/content/full/322/7300/1479

and the actual article by Cipriani et al is also available free on-line
Lithium in the Prevention of Suicidal Behavior and All-Cause Mortality in Patients With Mood Disorders: A Systematic Review of Randomized Trials
http://ajp.psychiatryonline.org/cgi/content/full/162/10/1805

Some Resource Texts for CAP questions:

Brown, T. & Wilkinson G. *Critical Reviews in Psychiatry*. 3rd ed. London: Gaskell
http://www.rcpsych.ac.uk/publications/gaskellbooks.aspx

Hatcher, S., Oakley-Browne, M. and Butler R - *Evidence Based Mental Health Care*
Churchill Livingstone, 2004 available via www.amazon.com

Modified Essay Question 1 (25 marks)

Mark is a 38 year old man with depression who is referred to your service, a local community mental health centre, by his General Practitioner (GP) for further assessment and treatment.

The referral letter advises that Mark has been depressed for the past two years, however this has become worse in recent months and the GP feels he is at moderate risk. The referral letter states that Mark is feeling "really down", is anxious and unable to sleep (despite using 5 x 7.5mg zopiclone the previous night) and that he is at a turning point. Mark is prescribed venlafaxine 375mg mane and zopiclone 22.5mg nocte. He has no reported medical history and is on no other medication.

The GP also mentions that Mark is the charge nurse of a medical ward at the local hospital and that there is conflict between Mark's wife and their thirteen year old son after their son was suspended from school due to assaulting a fellow student.

Question 1 (8 marks)

Please outline the potential risk factors for depression that you will be looking for in your assessment of Mark.

SCORING KEY

Use whole marks only, not ½ marks. Allot marks according to how adequately the issues are covered.

		worth	mark
A	Past history of a mood disorder	**1**	
B	Family history of affective disorders	**1**	
C	Presence of physical illness (needs assessment re current health status despite past medical history apparently being negative)	**1**	
D	Cumulative childhood disadvantage / losses / trauma (loss of a parent, lack of parental care, previous trauma)	**1**	
E	Social and cultural supports (marital status, access to a confidant, employment status)	**1**	
F	Personality traits (e.g. anxious, impulsive, obsessional, neuroticism)	**1**	
G	Adverse life events / life stressors	**1**	
H	Chronic sleep disorder	**1**	
I	Substance abuse/dependence (candidates may not bother putting this as this risk factor does not apply to this patient. But if it is listed as a theoretical risk factor it earns a mark.)	**1**	
J	Longer-term use of a sedative/hypnotic, esp. at higher than usual doses	**1**	
		Up to a maximum of 8 marks in total TOTAL:	

Modified Essay Question 1 contd.

During your assessment you confirm the diagnosis of a major depressive episode. Mark gives a two year history of depressive symptoms with symptoms becoming more severe in the previous three months. Symptoms include lowered mood, amotivation, anergia, loss of confidence, impaired memory, insomnia, anorexia and weight loss, and suicidal ideation with no intent. No psychotic symptoms are present.

Mark reports that there have been large periods of time where he has felt grindingly flat, dull and blue. His wife describes Mark as having low self-esteem and being chronically unhappy, and as always lacking confidence, despite being competent.

Mark has had little contact with mental health professionals prior to seeing you (apart from seeing a psychiatrist on one past occasion who prescribed venlafaxine), despite having experienced symptoms over the past two years. His GP has treated him with a variety of medications over the past two years including paroxetine, citalopram, moclobemide and nortriptyline. He has been treated with venlafaxine for the past four weeks.

Mark is physically well - blood tests, ECG, and CT brain scan have been unremarkable. Mark is a non-smoker, and denies using alcohol or illicit drugs.

Question 2 (10 marks)

Discuss the interventions you would consider to manage his resistant depression. Include further options if your first strategies are unsuccessful.

SCORING KEY

Use whole marks only, not ½ marks. Allot marks according to how adequately the issues are covered.

		worth	mark
A	Establishing a good therapeutic relationship (therapeutic alliance, motivation, hopeful expectancy, collaborative decision making).	**1**	
B	Ongoing risk assessment and management of these via reviews, support from his wife, Crisis Team / after-hours support.	**1**	
C	Consider obtaining a second opinion to review the diagnosis and management.	**1**	
D	Psychoeducation for Mark and his wife.	**1**	
E	Psychological therapies - individual therapy (e.g. CBT/ Problem-solving therapy/ IPT/ Psychodynamic). Family therapy should be considered as well.	**1**	
F	Address issues of his competency to work (and if unable to work, organise practical support while unwell (benefit/pension).	**1**	
G	Check and maximise the adequacy of medication he is taking (adherence, adequacy of dose, duration of treatment). Get serum levels if available.	**1**	
H	Re-check his treatment history – dosages and lengths of time treated (although part of assessment, would need review if he continued to be treatment resistant)	**1**	
I	Augmentation strategies e.g. lithium, tri-iodothyronine, atypical antipsychotic.	**1**	
J	ECT (unilateral treatment of non-dominant hemisphere initially followed by maintenance medication).	**1**	
K	Combined antidepressants (requires informed consent and possibly a 2nd opinion).	**1**	
L	Higher than recommended doses of antidepressants (requires informed consent and possibly a 2nd opinion).	**1**	
L	(After unsuccessful trials of treatment). Review case again – esp. diagnosis, past records, ensure no substance abuse.	**1**	
		Up to a maximum of 10 marks in total TOTAL:	

Modified Essay Question 1 contd.

During your assessment, it becomes clear that Mark is struggling to cope at work. He has a good work record and there have been no complaints about his performance. He sees his work environment as increasingly demanding and his manager as exceedingly unsupportive. Mark has taken four weeks of leave because of "stress" but is now feeling pressured to return to work because other senior staff on the ward are away.

Mark reports that his ability to concentrate is diminished and that he needs longer to think through decisions, thus finding it difficult to cope during emergencies. He is normally a conscientious worker, and is concerned about his memory problems, so ensures that any medications administered are checked by his colleagues. His manager is not aware that he suffers from depression and he is reluctant to discuss it with her as he fears that she will not keep this information confidential.

You advise Mark to take further leave but he refuses and says that he thinks he can cope and that his manager will refuse any further leave as they are short-staffed. He says that he has to return to work the following day.

Question 3 (7 marks)

Describe how you would manage this situation.

SCORING KEY

Use whole marks only, not ½ marks. Allot marks according to how adequately the issues are covered.

		worth	mark
A	Identification of the key issue (his right to autonomy and confidentiality versus your duty to advise when practice is impaired by mental illness, thus protecting his patients from harm).	**1**	
B	Discuss the dilemma with him, regarding concerns about safety of patients – try to work collaboratively to find a solution.	**1**	
C	Further identify possible areas of his work where patients are at risk and encourage strategies to minimize or eliminate such risks.	**1**	
D	Discuss alternate ways he could inform his work and arrange more leave - e.g. advise someone other than the manager – occ. health or a professional adviser	**1**	
E	With his permission, involve his wife in the discussion and in weighing up the issues, especially if it's felt his judgement is somewhat impaired by depression.	**1**	
F	See if his GP (who he knows better) can persuade Mark to take further time away from work.	**1**	
G	Discuss with your consultant / your supervisor / in peer review.	**1**	
H	However, if all the above is insufficient to ensure patient safety, inform the nursing council (nursing registration authorities).	**1**	
	Up to a maximum of 7 marks in total **TOTAL:**		

Modified Essay Question 2 (25 marks)

Damien is a 32 year old man who has been referred from the inpatient unit to your Community Mental Health Centre. He has a diagnosis of paranoid schizophrenia.
The brief referral letter from his inpatient psychiatrist requests that you follow him in the community, as a compulsory patient under the mental health act. The letter tells you that Damien has been admitted for four months, and is now stabilized on intramuscular depot risperidone. He was admitted to the inpatient unit after he assaulted a resident at his NGO-run hostel, and during the hospitalisation he also assaulted the psychiatric registrar who had admitted him. He is now to be discharged to your area as he wants to live near to his parents.

Question 1 (6 marks)
Discuss the information that you would seek prior to seeing Damien.

SCORING KEY
Use whole marks only, not ½ marks. Allot marks according to how adequately the issues are covered.

		worth	mark
	From the Inpatient Unit and Prior Psychiatrist		
A	Details about his admission; includes circumstances, seriousness and precipitants of the assaults; circumstances and precipitants of the admission; medications trialled as an inpatient and his response to these; current mental state examination, current level of functioning; current legal status regarding mental health act and regarding the assaults (i.e. does he face any charges regarding these) and the grounds for his ongoing mental health act status.	**2**	
B	Details of past history; including other at-risk behaviours; the course of illness; any comorbidity (Axis II, substance use, medical); forensic history; other background/personal history; treatment history and adherence to treatment; information collected from collateral sources, the course of prior hospitalisations.	**2**	
	From Family		
C	Includes family attitude to and involvement with the discharge planning; Damien's developmental history; any prior dangerousness to family, and their degree of understanding and acceptance of their son' s illness.	**1**	
	From Other Informants		
D	From the NGO staff - including details of his adjustment there and length of stay; precipitants and circumstances of the assault, his ability to form a therapeutic alliance, his adherence to medication and staff direction, any substance abuse.	**1**	
E	Information from GP may also be reasonable, if he has had a regular GP.	**1**	
		Up to a maximum of 6 marks in total TOTAL:	

Modified Essay Question 2 contd.

After a detailed initial assessment of Damien you conclude that he has obvious ongoing psychotic symptoms including persecutory delusions, and that he is withdrawn from others including staff and his parents.

Question 2 (13 marks)

What current and historical clinical parameters would you need to consider so as to assess Damien's risk of violent behaviour in future?

SCORING KEY

Use whole marks only, not ½ marks. Allot marks according to how adequately the issues are covered.

		worth	mark
	Historical Factors Indicating Higher Risk		
A	History of prior violence (details would need to be elicited re type of violence, methods, magnitude or seriousness, and frequency)	**1**	
B	Young age of onset of violence	**1**	
C	Poor occupational history (instability in job history or lack of work skills)	**1**	
D	Problems with intimate relationships (instability or lack of close relationships)	**1**	
E	Psychiatric history of serious mental illness (esp. psychotic disorder/Bipolar Disorder, serious cognitive disorder or organic impairment)	**1**	
F	Presence of personality pathology or disorder (esp. Cluster A and B)	**1**	
G	Established psychopathic disorder (as per the Psychopathy Checklist)	**1**	
H	Substance abuse (significantly greater risk)	**1**	
I	Early maladjustment (e.g. difficulty in a range of domains - home, school, day care. History of bullying, conduct disorder)	**1**	
J	Prior failure of supervision (e.g. violence while under compulsory Mental Health Act treatment or during probation)	**1**	
	Current Clinical Factors Increasing Risk		
K	Poor response to treatment (treatment resistance)	**1**	
L	Active symptoms of psychiatric illness	**1**	
M	Lack of insight	**1**	
N	Impulsivity (from illness, personality, etc.)	**1**	
O	Negative attitude to treatment / poor engagement / poor adherence to treatment	**1**	
	Up to a maximum of 13 marks in total TOTAL:		

Modified Essay Question 2 contd.

You are aware that Damien has a history of heavy cannabis use. He tells you that he wants to live on his brother's farm in the rural outskirts of your district, so that he can grow organic crops for the local market. He has no prior experience of horticulture, but has recidivist convictions for possession of cannabis, with 20 plants having being found in the backyard of his rented flat at one time. Damien says that he plans to get a "Start-Up Grant" from the local Employment Office so as to fund this organic farming venture. He says that he wants to be near his family, who although they deny having been previously victimized, are clearly frightened of him. In addition, there is a split in your community team with disagreement as to Damien's management and considerable concern about his level of risk, poor response to treatment and whether he was really fit for discharge.

Question 3 (6 marks)

Which factors in this situation could possibly lead to Damien reoffending violently?

SCORING KEY

Use whole marks only, not ½ marks. Allot marks according to how adequately the issues are covered.

		worth	mark
A	Likely ready access to drugs such as cannabis which will increase risk.	**1**	
B	Other life stressors that could destabilise Damien (e.g. financial hardship – coping on a benefit/pension, relative social isolation).	**1**	
C	Probable high expressed emotion within his family and lack of emotional support.	**1**	
D	Ongoing active psychotic symptoms likely to worsen if he becomes more stressed, especially if he is poorly adherent to treatment.	**1**	
E	May well be harder to follow him up in a more rural area – could be problems with him receiving assertive care, complying with regular injections and follow-up. Linked to his poor engagement and adherence.	**1**	
F	Stress and frustration from the impracticality of his plans (e.g. fact that it would be unlikely that the Employment Office would give him a "Start-Up Grant"). Linked with his plans indicating poor judgement – another risk factor.	**1**	
G	Conflict in treating team possibly leading to reduced communication and liaison.	**1**	
		Up to a maximum of 6 marks in total TOTAL:	

Modified Essay Question 3 (25 marks)

Sally is a 15 year old indigenous girl who presented to the Emergency Department following an overdose of 30 Paracetamol tablets. She was brought to hospital by her aunt immediately after disclosure of the overdose. She has been seen by the medical team and wants to go home immediately. You are asked to review her as they have concerns about her being discharged without being psychiatrically assessed.

Sally's parents are away visiting relatives in another part of the country and she has been staying with her aunt for the last 10 days. Her aunt reports that the family did not take Sally with them as she "wasn't interested" in the trip and had become very irritable when pressed to go with them.

Sally has no previous psychiatric history and her aunt described her as being a "happy, easy-going kid" until a few weeks ago. Her attendance at school has been more erratic recently and her aunt is not sure how Sally is progressing academically or socially.

Question 1 (9 marks)
Outline how you would proceed with your assessment.

SCORING KEY
Use whole marks only, not ½ marks. Allot marks according to how adequately the issues are covered.

		worth	Mark
A	Detailed history, especially presenting history with reference to the recent deterioration. Also – developmental history as far as possible, to assess possible underlying vulnerabilities or stressors.	**1**	
B	Careful mental state evaluation, especially regarding depressive cognitions, suicidal ideas/plans, and to exclude psychosis.	**1**	
C	Ensure medical assessment and treatment has been completed. Specifically regarding the overdose and serum paracetamol levels, and regarding checking that usual screening blood tests have been completed, and a full physical.	**2**	
D	Attempt to establish engagement / rapport / therapeutic relationship.	**1**	
E	Consider cultural aspects (e.g. use a cultural support worker, consider Sally's and the family's cultural beliefs).	**1**	
F	Exclude possible drug and alcohol issues.	**1**	
G	Attempt to contact or involve Sally's parents. Mention should be made that she in under-age and currently not with her legal guardian.	**1**	
H	Discussion of risk assessment (all aspects should be mentioned but especially suicidality/self-harm and self-care). Discuss the need to assess Sally regarding risks before she leaves hospital.	**1**	
I	Liaison with the school to determine her progress there (e.g. any concerns they might have about her coping).	**1**	
		Up to a maximum of 9 marks in total **TOTAL:**	

Modified Essay Question 3 contd.

After your assessment you decide that Sally is suffering from a Major Depressive Episode of moderate severity. Sally and her family quickly agree that this seems accurate. They then ask you to explain what it means and what could be done to help her.
Sally and her family also ask about using traditional healing as well as "Western" options.

Question 2 (9 marks)
Outline how you would proceed, following this request.

SCORING KEY
Use whole marks only, not ½ marks. Allot marks according to how adequately the issues are covered.

		worth	Mark
A	Psychoeducation regarding the construct of Major Depression utilising a biopsychosocial model. Possible references to natural history, progression and aetiology.	**2**	
B	Ensuring the family understands the given information e.g. asking them questions and provides opportunity for the family to ask questions.	**1**	
C	Recognition of the need to present the information to Sally in a developmentally appropriate way (possibly including youth-focussed reading material).	**1**	
D	Discussion around treatment modalities specifically focusing on SSRIs and CBT. Extra mark for reference to the evidence base in adolescents re most effective treatments (fluoxetine and CBT).	**2**	
E	Discussion about SSRIs and adverse effects especially possible agitation and increased suicidality in adolescents.	**1**	
F	Involvement (or discussion of the need to involve) a cultural support worker (indigenous health worker) in the discussion, especially regarding the wish to use traditional healing methods.	**1**	
G	Mature discussion of the family's request for traditional healing, acknowledging the importance of this. Discussion of possible drug interactions and compatibility of the approaches and need to negotiate this with the family.	**2**	
H	Discussion of the need for ongoing follow-up until remission achieved and how this will be provided (outpatient setting – multidisciplinary team).	**1**	
		Up to a maximum of 9 marks in total TOTAL:	

Modified Essay Question 3 contd.

Sally quickly responds to treatment with medication but her family feel that she "just isn't back to being herself". They ask about increasing the medication but Sally isn't keen to do this. She says she feels much better and finds she is "enjoying life a lot" and feels "super". She believes her family don't want her to get better because they have been able to treat her "like a baby" while she was unwell and don't want her to "grow up".

Question 3 (7 marks)
Discuss how you would deal with this development.

SCORING KEY
Use whole marks only, not ½ marks. Allot marks according to how adequately the issues are covered.

		worth	Mark
A	Explore the possibility of medication induced mania or hypomania. Candidate must also outline how they would then manage Sally.	**2**	
B	Discuss Sally's right to refuse a change in her treatment given that she is a minor. Discussion around Sally's competence for an extra mark.	**2**	
C	Elicit specifically what the family mean by "not being herself"	**1**	
D	Get collateral history from school, friends and family regarding Sally's functioning and presentation.	**1**	
E	Review diagnosis and consider other possibilities e.g. substance abuse.	**1**	
F	Explore the family dynamics and functioning and the impact (positive or negative) of Sally being in the 'sick role' in this family.	**1**	
		Up to a maximum of 7 marks in total **TOTAL:**	

Modified Essay Question 4 (25 marks)

Mr Green is a 62 year old retired boat builder who was brought into the Emergency Department via ambulance following a fall in which he severely bruised his arm. He lives with his wife, who is also retired, in a semi-rural area, and they have three adult children, two of whom live in a nearby city and visit them most weeks.

Mr Green seemed somewhat confused to the ambulance officers, and gave them a vague account of being persecuted by his neighbours and of trying to peer over their fence when he fell. He also complained that his wife did not understand him.

Mrs Green was in tears, saying that she had been very worried about her husband and that she thought there was something wrong with him, but she was reluctant to say more in his presence. She said that he had refused to see their General Practitioner, had been arguing with their neighbours and that she had been staying with their daughter for the past few days before coming home today.

Mr Green has a history of hypertension for which he is on treatment, and was seen in the Emergency Department two months earlier, suffering from an "anxiety attack" after he became stranded on a mud bank while fishing in a dinghy with his son. His wife also mentioned that he had had a "breakdown" in his late teens before she knew him, but said that he had had no mental health problems since that time.

As the Liaison Psychiatry registrar, you are asked to assess Mr Green.

Modified Essay Question 4 contd.

Question 1 (12 marks)
Outline details of how you would assess Mr Green, with particular reference to the key aspects of history and sources of collateral history, the mental state, and medical investigations needed in order to generate a formulation and a differential diagnosis.

SCORING KEY
Use whole marks only, not ½ marks. Allot marks according to how adequately the issues are covered.

	worth	mark
Need to clarify the *reasons for assessment*.	**1**	
Need to establish rapport and therapeutic relationship - e.g. to see Mr Green alone for part of the assessment.	**1**	
Collateral - from Mrs Green - need to see Mrs Green separately at some point. during the assessment. Need collateral from other family members and from GP as well.	**2**	
Obtain presenting history - Gradual or sudden onset? Screening for symptoms of current/past mood disorder, psychotic symptoms, anxiety symptoms. Screening for symptoms of dementia/functional decline - e.g. language difficulties, emotional lability, childish or impulsive behaviour, fatuous affect.	**3**	
Clarify past psychiatric, substance abuse and medical history - history of head injury, exposure to chemicals or toxins, alcohol and drug history. Screening for vascular risk factors.	**2**	
Clarify personal history especially social history and premorbid personality	**1**	
Mental state examination with particular reference to assessing possibility of mood disorder or psychotic symptoms. Cognitive testing: MMSE and "Bedside" frontal and executive testing (several subtests should be mentioned specifically). Look for evidence of focal signs, TIA/CVA symptoms and signs.	**3**	
Investigations - Check what investigations have been done. Ensure full screening blood tests done, ECG, CXR, MSU, careful physical examination. Head CT or MRI scan could be mentioned, but are not essential if the other medical assessments are covered well.	**2**	
Risk Assessment – with particular reference to risk to self, self-care and possible risk to others from his behaviour.	**1**	
Social situation - address issues of supports and carer-stress with his wife.	**1**	
	Up to a maximum of 12 marks in total TOTAL:	

Modified Essay Question 4 contd.

Mr Green is dismissive of his wife' s concerns, but describes vague persecutory delusions about being watched by his neighbours and says that he thinks his wife is involved in some way. He describes possible auditory hallucinations of people talking outside the house, consistent with these beliefs. He scores 27/30 on MMSE with reasonable, though quite concrete, frontal lobe testing responses. He gives a history of having been admitted for a month with a probable depression aged 17, for which he received follow-up and an unknown medication for a short time.

The Emergency Department registrar tells you that Mr Green has been "medically cleared" as his arm is just bruised, and wants to know what you would like to do with him. His wife approaches you and says that she doesn' t feel able to care for him because of his "strange behaviour" over the last few weeks. With some prompting, she admits that she is also very worried about Mr Green returning home as she worries that he might become aggressive towards her. "He looks at me as though I' m evil sometimes", she says.

Question 3 (6 marks)
Please outline the essential elements you would need to consider in your management plan, taking into account the above facts.

SCORING KEY
Use whole marks only, not ½ marks. Allot marks according to how adequately the issues are covered.

		worth	mark
A.	*Need to clarify diagnosis* • Need further investigation and a clear diagnosis, particularly regarding delirium vs dementia vs a psychiatric illness such as psychosis or depression. • Mr Green thus requires further medical assessment, particularly re intracranial lesions or cerebrovascular disease.	**2**	
B.	*Need to carefully consider where best to further assess him* • Consider individual and family and systemic factors in making the decision regarding community management vs medical inpatient vs psychiatric inpatient management. • Importance of Liaison Psychiatry role, need for liaison with medical and inpatient psychiatry teams, patient and family. • Need to advocate for appropriate assessment/treatment	**3**	
C.	*Need to consider symptom and behavioural management* • Environmental management (delirium nursing, level of observation required.) • Pharmacological management (low dose neuroleptics, possibly benzodiazepines). Better answers will include discussion of risks and benefits for this patient, with the options.	**2**	
		Up to a maximum of 6 marks total **Total**:	

Modified Essay Question 4 contd.

Mr Green is transferred to a medical ward for further investigation of his altered mental state. He is on the ward for 2 weeks, where staff notice that he periodically gets lost, and has persecutory ideation. A CT head scan shows diffuse white matter ischaemic changes but no recent CVA.

Mr Green signed an Enduring Power of Attorney (EPOA) two years previously, giving his wife the role of making decisions around his care and welfare should he become incompetent to do so. The multidisciplinary team and his family have concerns about his ability to safely return home, but Mr Green is adamant that he wants to do so. You are asked to assess his competence regarding this issue.

Question 3 (7 marks)
Outline how you would complete such an assessment.

SCORING KEY
Use whole marks only, not ½ marks. Allot marks according to how adequately the issues are covered.

		worth	mark
A	*Recognition of Role, Understanding of Competency Assessment and EPOA* – That this is a medico-legal rather than a clinical assessment. Recognition that the concept of decision-making capacity is regarding a specific question, rather than across all areas of Mr Green's life. Recognition that capacity to activate EPOA is not necessarily linked to cognitive function, MMSE scores or diagnosis. (2 marks if all aspects are covered.)	**2**	
B	*How to Set Up the Assessment Itself* - Ensuring Mr Green understands the reasons for the assessment. "Maximize his capacity" – via choice of setting for the assessment, reducing his anxiety, optimizing vision and hearing, not tiring him out, establishing rapport.	**1**	
C	*Assessment of Competency* - Assessment of his ability to understand the question being asked Assessment of his ability to process information – his ability to think rationally Assessment of his ability to understand the consequences of his decision Assessment of his ability to communicate his wishes.	**4**	
D	*Collateral Information* – Ensure collateral information is obtained regarding his dispositional autonomy (his previous decision-making history). Collateral about the family dynamics. Mention of care being needed regarding issues such as undue influence over Mr Green or abuse of powers, when assessing competency. (2 marks if all aspects are covered.)	**2**	
		Up to a maximum of 7 marks total. **Total:**	