



**THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF  
PSYCHIATRISTS**

# MOCK WRITTENS EXAMINATION

(from the Auckland New Zealand program)

**December 2009 / May 2010**

**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.

## Critical Essay Question (40 marks)

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

*"The biopsychosocial model has become more of a hindrance than a help. It has worsened the misconception that biology and psychology are separate entities. This so-called 'model' also gives no guidance as to which aspect, if any, should take precedence in implementing treatment. Psychiatrists thus tend to follow their own prejudices or the pressures of the system within which they work, and focus excessively on the biological."*

- Prof. R. G. James, 2007

### 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)

There is no evidence of logical argument or critical reasoning.	0	<p><u>Comments:</u> 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:</p> <ul style="list-style-type: none"> <li>Reasonable opening statement clarifying the quote (ideally not just parroting it)</li> </ul>
Points are random or unconnected or listed <b>or</b> Assertions are unsupported or false <b>or</b> There is no conclusion	1-2	<ul style="list-style-type: none"> <li>There may be brief discussion of what a model is, in this context, and whether the Biopsychosocial "so-called model" really is one</li> <li>A mid-section to essay with discussion addressing: <ul style="list-style-type: none"> <li>Arguments/examples/references against the quote (often translates to arguments <i>supporting</i> the BPS model)</li> <li>Arguments/examples/references in support of the quote (often translates to arguments <i>critical of</i> the BPS model)</li> </ul> </li> <li>Closing statement summarising, and providing the writer's overall "conclusions"</li> </ul> <p>Ideally we want relevant examples and (ideally) references, and a good overall coherence and flow in the arguments and discussion.</p>
Points in essay follow logically but there is only a weak attempt at supporting the assertions made by correct and relevant knowledge.	3-4	<p><u>Examples of points that may be included:</u></p> <ul style="list-style-type: none"> <li>The history of the BPS model – <u>Engel</u> as its originator in 1970s and ideally his intentions (i.e. meant to be used to expand viewpoints in medicine rather than its current devoted adherence in psychiatry)</li> <li>Linkage of the model with the move to <u>holistic</u> assessments &amp; interventions – better answers will acknowledge that the BPS model is not itself truly holistic but that it is an early attempt towards a more holistic approach</li> <li><u>Pros</u> of the BPS model – does encourage reasonable breadth of approach, there is an evidence-base to the importance of combining psychological and social interventions with biological treatment (eg.s can be given such as CBT &amp; meds for depression, combining psychosocial intervention and meds in Scz. etc.) Useful to touch on historical problems from use of more rigid medical or psychological models (overly biological or psychoanalytic eras)</li> <li><u>Cons</u> with the BPS model: not truly holistic and overly simplistic – does not necessarily include cultural or spiritual aspects of health or political aspects (eg. post-colonisation/land-loss issues). As quote says, its application may be too rigid and not tailored to individual person (not all people need all 3 approaches - may waste resources or cause side-effects if feel have to use all 3 when only one, such as psychotherapy for milder depression, is really all that's needed.)</li> <li><u>Other arguments supporting the quote:</u> eg. discussion of the pressures acting to force doctors in psychiatry to be too biological – resources; funding based on DSM categories; public perception and risk-aversion; bureaucracy; overwork; inadequate training or aptitude; inability by psychiatrists to tolerate uncertainty; wanting to "do something" (the need to help, to please) so Rxing meds. etc.</li> </ul>
The points in this essay follow logically to demonstrate the argument; <b>and</b> assertions are supported by correct and relevant knowledge.	5-6	
The candidate demonstrates a highly sophisticated level of reasoning and logical argument. (and extra points for good references)	7-8	

**Dimension 2. Flexibility**

The candidate restricts essay to an extremely narrow and very rigid line of argument.	0	<u>Comments:</u> There needs to be discussion both for and against the quote's statement (or the BPS model) as outlined above. Ideally we need a balance of arguments, not mostly pro-BPS model discussion with a tiny amount of agreement with the quote's criticisms at the end as an afterthought.  Needs (ideally) to be evaluation of the strengths and weaknesses of different examples or arguments, rather than just a series of (often sweeping) statements, which are either unsupported, or are thin and unconvincing.  Top marks if the arguments for and against are laid out in a sophisticated manner, without a simplistic assumption that the BPS model is either truly holistic or utterly flawed.
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 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; <b>or</b> 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; <b>or</b> judgments are grossly unethical.	0	<p><u>Comments:</u></p> <p>Candidate needs to have a balanced view, neither totally dismissing the quote's arguments or strongly supporting these unthinkingly.</p> <p>Discussion around ethical issues is expected – e.g. of an overly rigid approach in psychiatry as flawed, using historical examples of a too-biological or too-psychological approach impacting on the well-being and autonomy of patients/families. e.g. the 'treatment' of distressed immigrants in detention camps with diazepam. Or, ethics of pouring scarce resources unthinkingly into too-broad a BPS approach when only one type of intervention has been shown by research to be truly effective. etc.</p> <p>Better answers will show mature appreciation that the perspective of the individual patient or family is more important than the blind application of any "model". eg. mention of the Recovery model as a different type of approach which also advocates a holistic understanding.</p>
Judgments are naïve; <b>or</b> superficial; <b>or</b> extremely poorly thought through; <b>or</b> 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 <b>or</b> 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	<p><u>Comments:</u></p> <p>There is plenty of scope in the quote for arguments and examples adding breadth. The essay should not focus purely on the BPS model in current-day psychiatry. Examples are:</p> <ul style="list-style-type: none"> <li>• Its origins with Engel – intended for use in the general medical setting in fact, not in psychiatry.</li> <li>• Its limitations in that it does not per se cover cultural, spiritual, political etc. factors – especially crucial in the Australian and NZ context with important indigenous and immigrant populations with very different views of what is essential as regards "health".</li> <li>• Historical examples illustrating errors in the past where too-narrow approaches have caused problems.</li> </ul>
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	

## 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)
The points in this essay follow logically but there is only a weak attempt at supporting the assertions made by correct and relevant knowledge.	(2)
The points in this essay follow logically to demonstrate the argument; and assertions are supported by correct and relevant knowledge.	(3)
The candidate demonstrates a highly sophisticated level of reasoning and logical argument.	(4)

### 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)
The candidate considers more than one point of view, but the strengths and weaknesses of the views are poorly evaluated.	(2)
The candidate considers more than one point of view and the strengths and weaknesses of each view are well evaluated.	(3)
The candidate demonstrates a highly sophisticated capacity to set out and evaluate more than one point of view.	(4)

### 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)
The spelling, grammar and vocabulary are acceptable but the candidate demonstrates poor capacity for written expression.	(2)
The spelling, grammar and vocabulary are acceptable and the candidate demonstrates good capacity for written expression.	(3)
The candidate displays a highly sophisticated level of written expression.	(4)

### 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)
The candidate demonstrates some reasoned judgment or maturity of thinking or clinical experience or awareness of the ethical issues raised by the quote.	(2)
The candidate shows good capacity for reasoned judgment, mature thinking, clinical experience, awareness of ethical issues raised by the quote.	(3)
The candidate demonstrates a highly sophisticated level of judgment, maturity, experience or ethical awareness.	(4)

### 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)
The candidate demonstrates an ability to understand psychiatry or mental illness in a broader scientific or socio-cultural or historical context.	(2)
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.	(3)
Highly sophisticated scope, demonstrating a superior understanding of the broader context of psychiatry or mental illness.	(4)

# Critical Analysis Questions

## Critical Analysis Question 1 (20 marks)

Read the abstract and answer the questions that follow.

### Age at onset and cognition in schizophrenia: meta-analysis

T. K. Rajji, MD, FRCPC, Z. Ismail, MD, FRCPC and B. H. Mulsant, MD, MS, FRCPC

Department of Psychiatry, University of Toronto and Geriatric Mental Health Program, Centre for Addiction and Mental Health, Toronto, Canada

*The British Journal of Psychiatry* (2009) 195: 286-293. doi: 10.1192/bjp.bp.108.060723

#### Background

The relationship between cognition and age at onset of schizophrenia is largely unknown.

#### Aims

To compare cognitive deficits in individuals with youth-onset and late-onset schizophrenia with those in adults with first-episode schizophrenia.

#### Method

Twenty-nine databases (including EMBASE, MEDLINE and PsycINFO) were searched from 1980 to 2008. Selected publications had to include healthy controls and analyse separately individuals diagnosed with schizophrenia or a related disorder and individuals with first-episode, youth-onset (maximum age of onset of 19 years) or late-onset schizophrenia (minimum age of onset of 40 years).

#### Results

Individuals with youth-onset and first-episode schizophrenia demonstrate large deficits (mean effect size  $\geq 0.8$ ) on almost all cognitive measures. Individuals with youth-onset schizophrenia demonstrate larger deficits than those with first-episode schizophrenia on arithmetic, executive function, IQ, psychomotor speed of processing and verbal memory. In contrast, those with late-onset schizophrenia demonstrate minimal deficits on arithmetic, digit symbol coding and vocabulary, but larger ones on attention, fluency, global cognition, IQ and visuospatial construction.

#### Conclusions

Individuals with youth-onset schizophrenia have severe cognitive deficits, whereas those with late-onset schizophrenia have some relatively preserved cognitive functions. This finding supports the view that severity of the disease process is associated with different ages at onset. In addition, the cognitive pattern of people with late-onset schizophrenia suggests that their deficits are specific rather than solely as a result of ageing and related factors.

Allot marks depending on the degree to which the candidate has provided the required answer.

Question 1.1

Question 1.11 What is a meta-analysis? (2 marks)

*A meta analysis is a statistical technique for comparing the results of different studies. (Usually it involves some form of meta regression and the combination of effect sizes).*

Question 1.12 How would a systematic review of this topic differ from this meta-analysis? (4 marks)

*A systematic review would clearly describe a comprehensive search strategy and the rules for deciding what papers were included and excluded in the review. The question that the review addresses would be clearly defined. The authors would independently assess the papers for inclusion in the review and extraction of data for the review.*

Question 1.2

Question 1.21 What is effect size? (2 marks)

*Effect size is the difference in means of two groups divided by a measure of the variability of the data, usually the standard deviation. The trouble with effect sizes is that it is hard to bring them into any clinical conversation with patients or colleagues (unlike NNT for example).*

Question 1.22 What does a “mean effect size  $\geq 0.8$ ” mean? (3 marks)

*What an effect size means depends to a large degree on context. Despite this there have been several attempts to describe in words the meaning of different effect sizes. The best known is Cohen's where an effect size of 0.2 to 0.3 might be a "small" effect, around 0.5 a "medium" effect and 0.8 to infinity, a "large" effect. So the simple answer to this question is "large".*

**Question 1.3 What are the differences between Medline, Embase and PsycInfo? (3 marks)**

*Medline contains more than 18 million records from approximately 5,000 publications covering biomedicine and health from 1950 to the present. It is compiled by the United States National Library of Medicine and uses medical subject headings (MeSH terms) to index and search for articles.*

*Embase, is a biomedical and pharmacological database produced by Elsevier (a publishing company based in Amsterdam) that contains over 20 million records from 1947 to the present. Each record is fully indexed and it covers over 7,000 biomedical journals from 70 countries. Embase has wider coverage of non English journals than Medline and has a bias towards pharmacological research.*

*PsycINFO is a database of abstracts of literature in the field of psychology (note it contains books and manuscripts as well as journal articles). It is produced by the American Psychological Association and contains 2.5 million records from about 2,000 journals.*

**Question 1.4 How would you define “age of onset of schizophrenia” for this study? (2 marks)**

*Tricky – need to have a rule and be consistent. Could be age of first presentation to mental health services (although this is clearly affected by how services are organised) or age of first symptoms (which may be more important but harder to assess).*

**Question 1.5 What confounding factors may explain the finding that “severity of the disease process is associated with different ages at onset”? (4 marks)**

*The main one that comes to mind is the effect of treatment. Younger age of onset is associated with longer time on treatment so there may be the cognitive effects of taking medication long term, the effect on cognition of admissions to hospital as well as reduction in educational opportunities.*



## Critical Analysis Question 2 (20 marks)

Read the abstract and answer the questions that follow.

### Structured risk assessment and violence in acute psychiatric wards: randomised controlled trial

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Nursing and Social Education Research Unit, University of Bern Psychiatric Services, Berne, Switzerland

*The British Journal of Psychiatry* (2008) 193: 44-50. doi: 10.1192/bjp.bp.107.045534

#### Background

There is a lack of research on the possible contribution of a structured risk assessment to the reduction of aggression in psychiatric in-patient care.

#### Aims

To assess whether such risk assessments decrease the incidence of violence and coercion.

#### Method

A cluster randomised controlled trial was conducted with 9 acute psychiatric admission wards as the units of randomisation, (with four wards in the intervention arm and five wards in the control arm). The intervention comprised a standardised risk assessment following admission with mandatory evaluation of prevention in high-risk patients.

#### Results

Incidence rates decreased substantially in the intervention wards, whereas little change occurred in the control wards. The adjusted risk ratios suggest a 45% reduction in severe aggressive incidents and a 27% decline in the use of coercive measures. The severity of aggressive incidents did not decrease.

#### Conclusions

Structured risk assessment during the first days of treatment may contribute to reduced violence and coercion in acute psychiatric wards.

Allot marks depending on the degree to which the candidate has provided the required answer.

#### Question 2.1

Question 2.11 What is a cluster randomised controlled trial? (2 marks)

*Cluster randomised trials are generally those trials where the unit of randomisation is not an individual participant but a group of participants. For example general practices or wards (as above) may be randomised. This contrasts with most randomised trials where each subject is individually assigned at random to an intervention group and the intervention is applied directly to the subject.*

**Question 2.12** What sort of problems are best studied using cluster randomised trials? (2 marks)

*The sort of problems generally studied using cluster randomised trials are those which are “educational” (which include quality improvement initiatives such as above or public health interventions) or screening. These are generally where subjects cannot be allocated independently (as the intervention is directed at a cluster), or participants may interact with one another during the treatment period so that those who are not supposed to get the intervention are “contaminated” by those who have received it .*

**Question 2.13** Why are cluster randomised trials always bigger than the equivalent individual randomised controlled trial? (4 marks)

*The price that you pay for doing cluster randomised trials is that you need to take into account the fact that individuals within a cluster may be more alike than the differences between clusters. In other words the variability between clusters needs to be taken into account. For example in the study above patients admitted to one ward may be very low risk of violence compared to another ward where because of short staffing there is an increased risk of violence.*

*(In statistical terms- which I wouldn't expect trainees to know - what this does is to increase the size of standard errors and hence widen confidence intervals and increase P values compared with a study of the same size using simple randomisation. The effective sample size is reduced and power is lost. The larger and fewer the clusters are, the more important and greater the effect becomes. The important part of this answer is understanding the concept in the first paragraph).*

**Question 2.2**

**Question 2.21** What are the ethical issues with this study? (2 marks)

*The individual patients are not asked for their consent to take part in the study. They have no choice (presumably) whether they are admitted to a ward which carries out the intervention or whether the ward is in a control group.*

**Question 2.22** How would you address them? (4 marks)

*Tricky – but not insurmountable. Basic approaches are i) to get a “guardian” or “gatekeeper” to consent to the trial – so for example in this study the CEOs of the hospitals could give consent for the study to take place and/or ii) ask all participants permission to collect outcome data (although this doesn't get over the problem of subjects not having any choice about what intervention they get) or ask their consent to receive the new assessment (although there is still the question of what you ask controls to consent to and the main effect of the intervention may be the “mandatory evaluation” by staff). Some authors divide the problem into consent for randomisation and consent to receive the intervention. (ref Edwards SJ, Braunholtz DA, Lilford RJ, et al. Ethical issues in the design and conduct of cluster randomised controlled trials. BMJ 1999;318:1407–9).*

Table 2

Main outcome measures

	Intervention			Control		
	Patients, <i>n</i> (treatment days)	Incidents	Rate/100 treatment days (95% CI)	Patients, <i>n</i> (treatment days)	Incidents	Rate/100 treatment days (95% CI)
<b>Before intervention</b>	364 (6074)	81	1.33 (1.06-1.66)	515 (8449)	95	1.12 (0.91-1.37)
<b>After intervention</b>	390 (7727)	56	0.73 (0.59-1.00)	583 (10 485)	100	0.95 (0.78-1.16)
<b>Change</b>			-45%			-15%

## Question 2.3

**Question 2.31** Table 2 shows the main outcome measures for this study. What is the absolute risk reduction for the change in incidents per 100 days for the intervention? (2 marks)

*0.6 incidents per 100 treatment days (1.33-0.73). One of the questions about this study is the clinical importance of such a reduction despite it being statistically significant.*

**Question 2.32** From Table 2 what is the relative risk reduction for the change in incidents per 100 days for the intervention? (2 marks)

*Relative risk reduction is 45% ( $1.33/(1.33-0.73)$ ). If the question had been “relative risk reduction for the change in incidents per 100 days for the intervention compared to the controls” the answer would be 3 ( $-45/-15$ ), (in other words a threefold reduction in incidents). For relative risk reduction the question is relative to what?*

**Question 2.33** What other explanations may account for the change in the number of incidents? (2 marks)

*There may have been other changes in the intervention wards over this period of time for example staffing changes or a change to the casemix on the ward.*

# Modified Essay Questions

## Modified Essay Question 1 (25 marks)

Mr Williams is a 72-year-old retired accountant who was referred by his General Practitioner to a community mental health team for older adults. Mr Williams lives with his wife in their own home. Two daughters live locally.

The general practitioner's referral said:

*"Could you please assess Mr Williams, who presents with paranoid beliefs and confusion? These problems have developed over the past 6-12 months. Mr Williams wrongly accuses his wife of having an affair. She has significant heart failure and is 'stressed out'. Mr Williams has been treated for benign prostatic hypertrophy and oesophageal reflux. He is in generally good health otherwise. His regular medications are Terazosin and Omeprazole. Cardiac, respiratory and abdominal examinations were today unremarkable. Basic observations are currently within normal limits, although there have been episodes of hypotension over the past two years."*

As the mental health team's registrar, you have been assigned to review Mr Williams at home.

## Modified Essay Question 1 contd.

### Question 1.1 (12 marks)

Outline details of how you would assess Mr Williams, with particular reference to the key aspects of the history and sources of collateral history, the mental state and medical investigations needed to generate a formulation and differential diagnosis.

#### SCORING KEY

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

		worth	mark
A.	<b>General assessment principles</b> , including: <ul style="list-style-type: none"> <li>• need to establish rapport &amp; therapeutic relationship</li> <li>• importance of collateral information, interviewing Mr &amp; Mrs William separately</li> <li>• confidentiality and its limits</li> <li>• assessment considerations for older adults (i.e. slower pace, optimising vision/hearing, see at home)</li> </ul>	2	
B.	Obtain <b>presenting history</b> , including: <ul style="list-style-type: none"> <li>• longitudinal course of illness: order of symptom appearance, gradual vs stepwise</li> <li>• screen for mood, psychotic, anxiety symptoms</li> <li>• screen for cognitive symptoms: memory, executive dysfunction, agnosia, dyspraxia, dysphasia, personality change</li> <li>• level of functioning</li> </ul>	2	
C.	Clarify <b>past history</b> : <ul style="list-style-type: none"> <li>• previous mental health problems &amp; treatment</li> <li>• medications (esp. those with potential to cause cognitive impairment)</li> <li>• family mental health history, including dementia or neurological conditions/problems</li> <li>• medical problems, including vascular risk factors, features of stroke, head injury, seizures</li> <li>• alcohol &amp; drug use</li> </ul>	2	
D.	Clarify relevant <b>personal &amp; social history</b> , pre-morbid personality, Enduring Power of Attorney (or guardianship) status.	1	
E.	<b>Mental state examination</b> , with particular reference to: <ul style="list-style-type: none"> <li>• any focal neurological features</li> <li>• thought disorder</li> <li>• psychotic symptoms</li> <li>• cognition, including MMSE &amp; tests examining frontal lobe function</li> </ul>	2	
F.	<b>Investigations</b> : Check what investigations have been done already. Ensure full range of appropriate initial investigations done, including bloods (FBC, U&Es, TFTs, B12, folate, Ca, PO4, ESR/CRP, syphilis), MSU, ECG, CXR. Head radioimaging could be mentioned, but is not essential at this stage. Better answers will give reasons for seeking tests (e.g. rule out delirium, identifying any medical disorders contributing to baseline cognitive impairment)	2	
G.	<b>Risk Assessment</b> : Candidates should consider potential risk issues broadly, including aggression towards wife/others, self-cares (personal cares, taking medication, wandering), domestic affairs (wandering, management of finances, burning kettle/pots, leaving door unlocked), and driving.	1	
Up to a maximum of 12 marks in total <b>TOTAL:</b>			

## **Modified Essay Question 1 contd**

During your assessment Mrs Williams tells you her husband's confusion fluctuates significantly over the course of a day. There are also episodes lasting several minutes of diminished level of consciousness. She tells you Mr Williams also reports seeing large animals in their house, sometimes becoming distressed by these. He has vivid nightmares, and thrashes around for some minutes after waking up. At times he's fallen over, but has not sustained any head injury. More recently Mr Williams has needed assistance with dressing. There were no auditory hallucinations or prominent affective symptoms. Mrs Williams confirms her husband's delusional jealousy. At times he will angrily accuse her having an affair with a neighbour, but has not physically threatened or assaulted her.

Mr Williams forcefully tells you his wife is having an affair, but otherwise denies any psychiatric symptomatology or functional impairment.

On mental state examination Mr Williams is alert, guarded, provides a limited account of recent events and symptoms, has mildly irritable mood, flat affect and mildly dysarthric speech. There is no formal thought disorder or responding to non-apparent stimuli. His MMSE is scored 24/30, with marks lost for orientation (-2), recall (-2), repeating a sentence and copying a design. His clock drawing is very poor; numbers are missing and he's completely unable to insert the clock hands. His gait is shuffly. There are no abnormal involuntary movements.

A week after your initial assessment routine investigations have been completed. A full range of blood tests, urinalysis, Chest x-ray and ECG are all unremarkable.

**Question 1.2 (7 marks) contd.**

**Please outline the essential elements you would need to consider in your management plan, taking into account to above facts**

**SCORING KEY**

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

		worth	mark
<b>A.</b>	<p><i>Diagnostic Clarification</i>, including:</p> <ul style="list-style-type: none"> <li>• further medical examination, including checking for neurological symptoms and signs, referral to geriatrician or neurologist for evaluation of parkinsonism</li> <li>• head radioimaging</li> <li>• fuller cognitive testing, with particular attention to frontal lobe and visuospatial impairment</li> <li>• occupational therapy evaluation</li> <li>• sleep diary</li> </ul> <p>Good answers will cover main differentials, including Lewy Body Dementia (likely diagnosis), Parkinsons-type syndromes, delirium, other dementia syndromes</p>	<b>3</b>	
<b>B.</b>	<p><i>Follow-up</i>, including regular reviews, multidisciplinary team, liaison with GP. At this stage further mental health assessment and management could occur at home, but worsening risk may require inpatient care. Risk should be documented, with risk management plans given to relevant people (eg. wife, GP).</p>	<b>2</b>	
<b>C.</b>	<p><i>Symptom and behavioural management</i>, including:</p> <ul style="list-style-type: none"> <li>• additional support for Mrs Williams (eg. other family members, home help, respite care, 'Alzheimers Society' or similar)</li> <li>• optimising vision</li> <li>• medication. Cholinesterase inhibitors and a low dose atypical antipsychotic (eg. Quetiapine, Aripiprazole) could be considered for management of psychotic symptoms, but particular care would be needed because of likely Parkinsonism. Clozapine could be a 2<sup>nd</sup> line option for significant &amp; treatment-refractory psychotic symptoms. The likely REM sleep disorder could be managed with Quetiapine or Clonazepam. Good answers will include comments about medication risks/benefits, limiting exposure to antipsychotics (time-limited trials, minimum dose necessary, use for significant/distressing symptoms only), potential for psychosis to worsen with any dopaminergic medication used to treat apparent Parkinsonism.</li> <li>• driving tests, or limitations on driving</li> <li>• clarifying decision-making capacity, with view to possibly activating any EPOA or making application to Family Court under PPPR Act (or similar Guardianship legislation in Australia).</li> </ul>	<b>4</b>	
Up to a maximum of 7 marks in total <b>TOTAL:</b>			

## Modified Essay Question 1 contd

Mrs Williams phones you several weeks after your initial assessment, asking if it's safe for Mr Williams to drive. He is apparently adamantly opposed to stopping driving, stating he will continue to do so, even if told not to by a doctor or the police.

### Question 1.3 (6 marks)

Outline how you would approach this problem

#### SCORING KEY

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

	worth	mark
<p><b>A. Further assessment of driving, including:</b></p> <ul style="list-style-type: none"> <li>History – particularly from collateral informants – of any motor vehicle accidents, near-misses, dents in car, negative reactions from other motorists, whether family are prepared to travel in car driven by Mr Williams, traffic infringements, etc.</li> <li>Office-based cognitive tests with some evidence in predicting ability to drive (eg. Clock drawing, trail-making tests)</li> <li>Medical evaluation: visual testing, neurological testing (NB: looking for movement disorders, muscle stiffness, incoordination)</li> <li>Recognition of road signs (using local Transport Authority's information on fitness to drive)</li> <li>On-road tests, ranging from basic tests (e.g. conducted by AA) to more expensive driving tests administered by an Occ Therapist. A good answer will note on-road tests are the gold standard and will need to be repeated at regular intervals for someone with a neurodegenerative disorder such as dementia.</li> </ul>	3	
<p><b>B. Appropriate management:</b> Good answers will predict that Mr Williams should at least have limitations placed on his driving, pending further information becoming available. Management might include:</p> <ul style="list-style-type: none"> <li>Placing restrictions on times of day &amp; area in which Mr Williams can drive, having someone accompany him in car. More severe problems should be dealt with by instructing Mr Williams not to drive</li> <li>Notifying the appropriate Transport Authority</li> <li>Notifying police if Mr Williams is in act of driving when directed not to do so</li> <li>Removing keys or car, using authority of Enduring Power of Attorney or Guardian/Property Manager appointed under local Guardianship laws.</li> <li>Provide support for other transport options (eg. subsidised public transport and taxis, shopping assistance).</li> </ul>	3	
Up to a maximum of 6 marks in total <b>TOTAL:</b>		



## Modified Essay Question 2 (25 marks)

James is a 14 year old European boy who has been admitted for flexor tendon repair after he thrust his arm through a window during a family argument. He lives with his parents and two younger siblings, but is brought to hospital by a neighbour who says his parents were too drunk to drive him in for medical attention. His parents have not come to the hospital to see him and consent for the surgery was obtained over the phone. James' serum alcohol was high on admission: he says he drank about 10 cans of beer on the night he hurt himself, supplied by his parents.

James is healthy and has no significant medical history.

His mother phoned the charge nurse the day after admission to say that she "couldn't handle him anymore" and that he had been regularly staying out at night, smoking marijuana, and had been suspended from school because of angry interactions with teachers. She says he has not been seen by any services in regards to this problem.

James is referred to you two days post surgery as he is "fit for discharge" according to the surgical team. They want you to organise a follow-up plan for his "anger problem".

### Question 2.1 (10 marks)

**Outline details of how you would assess James, with reference to key aspects of the history, sources and content of collateral history, James' mental state and other investigations which may be necessary to develop a formulation and management plan.**

#### SCORING KEY

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

	worth	mark
<b>A. History around the events leading to admission:</b> history will need to cover: antecedents to injury, his viewpoint about it and whether it was a self-harm attempt. Current or past suicidal ideation. History from James, and collateral history is also needed – from parents, extended family, maybe from neighbour.	2	
<b>B. History and symptoms suggestive of mental illness,</b> especially: depression or psychosis, low mood, vegetative symptoms, psychotic symptoms. Need collateral about all this, and about his moods and coping – i.e. his problems with emotional management (esp. anger, frustration).	2	
<b>C. History of alcohol and other drug use:</b> substances used, frequency, age of starting, effects on his health, school and on relationships, whether he ever drives even though underage, etc.	2	
<b>D. History regarding family:</b> Who is at home? Nature of his significant relationships. Exposure to family violence. Family attitudes to the problems. Family approaches to help-seeking and prior treatment contacts. Previous contact with Child Welfare Services.	2	
<b>E. Collateral from school:</b> Behaviour, academic functioning, AOD use, any further information about the family situation.	1	
<b>F. Relevant developmental and past history:</b> e.g. of abuse, head injury, medical insults, trauma. Collateral from his GP.	2	
<b>G. Mental State Examination:</b> focus on rapport, mood, psychosis, insight.	2	
<b>H. Physical findings:</b> examination, toxicology, other investigations.	2	
Up to a maximum of 10 marks in total		
TOTAL:		

## Modified Essay Question 2

You discover that James was seen by the school nurse last year after saying he was going to kill himself: she referred him to local youth mental health services but he didn't go to the appointment. James's mother says she is worried that he will kill himself "like his cousin did last year." She says that she is so upset by this situation that she is leaving town to stay with relatives, and says that she wants James "held in hospital so that he won't hurt himself."

The ward social worker has found that James was referred to Youth Social Services last year because he was picked up by police after being found in a park, intoxicated. However, the family moved and he was not seen by either service. When you contact the Youth Social Services social worker you are told that the case was closed.

James has a history of contact with the police for vandalism, usually when intoxicated. He has also been found in a stolen car with friends but no charges were laid.

### Question 2.2 (5 marks)

**Outline the strategies you might use with James and his family to engage them with mental health follow-up services.**

#### SCORING KEY

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

	worth	mark
<b>A. Adolescent-friendly approaches:</b> venue, activities, games, eye contact, calm, non-judgemental, see with a friend/supporter, clarify confidentiality.	2	
<b>B. Statutory approaches:</b> Could compel family follow-up if the risks justify this. e.g. via Youth Social Welfare Services, possibly Youth Justice system, Mental Health Act.	2	
<b>C. Family engagement:</b> Arrange a wider family meeting to better assess and engage parents - and extended family as appropriate.	2	
<b>D. Engage other services/professionals:</b> Teacher(s), youth worker, school nurse, etc.	2	
Up to a maximum of 5 marks in total <b>TOTAL:</b>		

## Modified Essay Question 2

You meet with James and complete a standard psychiatric assessment.

As you discover more about James you uncover a picture of serious and prolonged alcohol and marijuana use. James uses marijuana, several joints daily, obtained from his cousin, and drinks alcohol at least twice a week, up to 10 cans of beer at a time, usually obtained in the family home. You do not identify any other Axis I disorder.

### Question 2.3 (10 marks)

Describe in detail your immediate and medium-term interventions for James' alcohol and other drug use.

#### SCORING KEY

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

	worth	mark
<b>Immediate:</b>		
<b>A. Motivational approaches:</b> advantages, disadvantages, where he is in desire for change	<b>2</b>	
<b>B. Physical assessment</b> and toxicology	<b>2</b>	
<b>C. Attempt to engage parents</b> with parenting support and Alcohol and Drug service assistance for themselves	<b>2</b>	
<b>Medium-term:</b>		
<b>D. Harm reduction</b> - and strategies targeting binge drinking.	<b>2</b>	
<b>E. CBT</b> strategies targeting reasons for drinking.	<b>2</b>	
<b>F. Family therapy</b> targeting reduction of substance use, negotiating boundaries. Encourage attendance at a parenting course regarding teenagers.	<b>2</b>	
<b>G. Pharmacological interventions</b> are not recommended in this age group.	<b>2</b>	
<b>Up to a maximum of 10 marks in total</b>		
<b>TOTAL:</b>		

### Modified Essay Question 3 (25 marks)

Ismail is the 24 year old son of an immigrant Middle Eastern family. He has three younger sisters. His family immigrated when he was a teenager in order to achieve a better standard of life. His family were affluent professionals back home.

Employment opportunities have been scarce for his parents as new residents and there have been financial difficulties. Ismail easily learned English and attended the local high school. There he was bullied but achieved well academically. He completed two degrees at University before being employed by a corporate multinational company initially as a system analyst, but latterly as a project leader.

Ismail has been referred by fax from his GP, who saw him with his parents. Ismail had been expressing concerns that the other staff at work were controlling his thinking and that he was worthless and powerless. His family are distressed and seeking help.

You are rostered as the Crisis Dr on duty for your community team for Ismail's assessment.

#### Question 3.1 (9 marks)

The triage nurse has arranged for you to see Ismail and his family at 1600hrs.  
Explain your initial course of action up to and including your assessment.

#### SCORING KEY

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

	worth	mark
<b>A. Speak with Crisis triage nurse</b> <ul style="list-style-type: none"><li>a. Ascertain risk issues [urgency; how to conduct assessment: necessity of Police involvement?]</li><li>b. Consider service issues [see with evening staff vs day staff]</li><li>c. Consider requirement of translator for family for collateral history</li><li>d. Any obvious cultural input available at short notice</li><li>e. Consider where to conduct assessment</li><li>f. Consider gender issues of staff</li></ul>	<b>2</b>	
<b>B. Speak with General Practitioner</b> <ul style="list-style-type: none"><li>g. Any other history, relevant past medical hx; any investigations conducted</li><li>h. Pertinent knowledge of family and social issues</li></ul>	<b>1</b>	
<b>C. Consult with Early Intervention team</b> [if there is one] if they wish to become involved immediately	<b>1</b>	
<b>D. Contact family</b> to offer home visit or arrange clinic visit	<b>1</b>	

## Modified Essay Question 1

### Question 3.1 contd.

<b>E.</b>	<b>Conduct assessment</b> i. Ascertain Ismail's concerns if any j. Establish rapport / alliance k. Explain purpose of interview / confidentiality	<b>1</b>	
<b>F.</b>	l. History of the presenting complaint [how long, what context; what distress, impact or dysfunction; consider precipitants /triggers]	<b>1</b>	
<b>G.</b>	m. Past Psych hx n. Past Medical Hx o. Recreational drug use p. Personal history including trauma hx q. Family hx mental illness	<b>2</b>	
<b>H.</b>	r. Collateral hx from family	<b>1</b>	
<b>I.</b>	s. Assess for risk issues	<b>1</b>	
<b>J.</b>	t. Attitude to medications generally	<b>1</b>	
<b>K.</b>	u. Degree of psychological-mindedness; his explanatory model.	<b>1</b>	
<b>L.</b>	v. <b>Mental State Examination</b> [Including: explore his beliefs about others at work; other passivity phenomena; do others eg family control him also?; assess for other psychotic symptoms; assess for mood symptoms; insight]	<b>3</b>	
Up to a maximum of 9 marks in total <b>TOTAL:</b>			

### Modified Essay Question 3 contd.

During the assessment, with his parents in the room, Ismail discloses that he had in the past sexually abused one of his sisters and that he is feeling much guilt and sadness about this.

#### Question 3.2 (7 marks)

Describe how you would proceed.

#### SCORING KEY

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

	worth	mark
A. Conduct part of the assessment without parents present.	1	
B. Conduct interview in neutral style [neither judgemental nor condoning] Remind of limits of confidentiality	1	
C. Ascertain details of offending [what occurred; when; for how long; how often; up until when; against whom; who is aware; why he is disclosing now]  Ascertain current age of victim or other potential victims, and his access to them	3	
D. Assess for depression and for depressive psychosis [e.g. delusions]	1	
E. Enquire about his own sexual abuse history.	1	
F. Formulate a safety plan if any potential victims are still at risk	1	
G. Manage family's distress; family's questions	1	
H. Consider arranging consultation or assessment with expert sexual offending services i.e. SAFE or the local equivalent. [Ideally should mention that the timing of this needs care.]	1	
I. Consider child protection agencies as appropriate	1	
J. Consider what services available / appropriate for victim	1	
K. Careful accurate documentation	1	
Up to a maximum of 7 marks in total TOTAL:		

### Modified Essay Question 3 contd.

Ismail ends up in your ongoing care in the community. He experiences frank psychotic symptoms for approximately a month but has a full resolution of symptoms with the use of antipsychotic medication and weekly psychological input.

Although sad in his mood in response to his experience he is not clinically depressed. He develops good insight and returns to work, although he struggles with his concentration and the rigours of the job and the expectations of his seniors.

Three months after the full resolution of his symptoms Ismail announces that he, his now adult siblings and his parents wish to go on Hajj, a pilgrimage to Mecca in Saudi Arabia, in two months time. They seek your opinion regarding this.

#### Question 3.3 (9 marks)

**Outline the issues you would raise in discussion with Ismail and his family and how you would manage the process.**

#### SCORING KEY

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

	worth	mark
A. Clarify that your role is as mental health expert not spiritual leader/advisor	1	
B. Gather specific information about trip [how long it will be, how arduous, specific stressors involved like fasting, will he be with family all the time for support, etc.]	3	
C. Interview Ismail alone also [any evidence of family pressure to go on Hajj, what are his real wishes, are there any difficult family dynamics/power issues?]	1	
D. Discuss his current mental state	1	
E. Discuss acceptability of medication treatment during that time vs risk of a relapse if he does not continue this. [may be wish for spiritual healing ; practical concerns re fasting or risk of dehydration, etc.]	1	
F. Discuss recommendations regarding duration of treatment [ideally he needs one year of Rx and psychotic symptom free if Dx is schizophrenia. ]	1	
G. Discuss relevant factors known to lead to relapse [sleeplessness; stress]	1	
H. Cover his family's views & wishes	1	
I. Collaborative decision making but expert opinion. [recovery paradigm]	1	
J. Discuss Relapse Plan. Ensure knowledge of Early Warning Signs [? use of EWS Scale]	2	
K. Discuss letter to take while travelling [for health professional in case needed; for Customs re medications]; practicalities to organise the prescription.	1	
L. Discuss availability of PRN contact whilst away [phone; email]	1	
Up to a maximum of 9 marks in total <b>TOTAL:</b>		

#### Modified Essay Question 4 (25 marks)

Mr Green is a 63 year old man who is currently an inpatient in the Coronary Care Unit following an acute inferior myocardial infarction. He has been in hospital for the past three days and there have been no post-infarct complications.

He has been referred to the liaison psychiatry team because he appears to be low in mood. The nurses have noticed that he looks flat and his interactions with them are minimal. He is eating and drinking normally.

When you review him, he presents exactly as described in the referral letter. While not actually telling you to leave, his responses to your questions are monosyllabic. He does not appear to be confused. You carry out a full assessment as best you can, taking as much history from him as possible and assessing his mental state and cognitive functioning.

When you ask for permission to telephone his wife (who is listed as his next of kin) for some collateral history, he refuses. There are no other family members living locally.

#### Question 4.1 (6 marks)

Outline how your assessment would proceed from this point.

#### SCORING KEY

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

	worth	mark
A. Talk to nurses, doctors, other involved staff on his treating team.	1	
B. Review his medical case notes and investigations.	1	
C. Search for any past psychiatric records or contacts in case he is already in the system (even if he said he had no past psychiatric history).	1	
D. Talk to his General Practitioner (GP).	1	
E. Weigh up the ethical issues as to whether the situation is of sufficient severity to countermand his instruction not to phone his wife. (It does not sound to be).	2	
F. Arrange another review in the fairly near future – aims being further assessment, risk assessment and to try again to persuade him to let you contact his wife.	3	
Up to a maximum of 6 marks in total TOTAL:		



## Modified Essay Question 4

Two days later, you review Mr Green again. He talks a little more this time, but it becomes clear that he is depressed. He is having thoughts of killing himself. He is also having thoughts of harming staff and has made some plans as to how to do this, for example, by grabbing a needle. These thoughts appear to be due to irritability and desperation, rather than any psychosis.

It appears that Mr Green's depressive symptoms predate his myocardial infarction. Things have not been going well at work and his mood has been declining for the last two months. This heart attack is the final straw. He now feels completely hopeless and helpless about himself and his future.

You managed to contact his GP, but the GP was unaware of Mr Green's current depression and had not seen him for several months. The GP had not been prescribing any medication. You have also confirmed that there is no other past psychiatric history.

Mr Green agrees to start an antidepressant. However, he still does not want you to phone his wife or any other family members.

### Question 4.2 (13 marks)

**What is your plan of action based on this second assessment?**

#### SCORING KEY

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

	worth	mark
<b>A.</b> Talk to his treating team about your assessment and suggested treatment.	2	
<b>B.</b> Warn staff about the risks – i.e. his suicidal thoughts and his thoughts of harming them. With the staff, consider the pros and cons of instituting a "watch".	3	
<b>C.</b> Override Mr Green's refusal to phone his wife, given the safety concerns. Gather collateral from her and discuss his diagnosis and the risks and treatment plan with her.	3	
<b>D.</b> Consider use of the Mental Health Act if Mr Green will not cooperate or remain in hospital. Leave instructions for regular and on-call staff about this.	2	
<b>E.</b> Decide on the safest antidepressant, given his recent MI. An SSRI is the safest choice.	2	
<b>F.</b> Talk with Mr Green about your concerns and the action plan – explain the need to talk to his wife despite his concerns. Explain about the preferred treatment. Try to instill hope and encourage him not to harm himself or others.	4	
<b>G.</b> Review Mr Green daily.	1	
<b>Up to a maximum of 13 marks in total</b>		
<b>TOTAL:</b>		

### Modified Essay Question 4

A further two days later, things are not going well for Mr Green. He has refused to take his prescribed antidepressant, despite having agreed to this initially. He remains very withdrawn and has ongoing suicidal ideation and thoughts of harming the staff, although he has not acted on these. He is still eating and drinking adequately.

In addition, he has had some episodes of arrhythmia and his cardiac medication has been adjusted.

#### Question 4.3 (6 marks)

**What is your plan of action based on this second assessment, particularly regarding the role of Mental Health Services in Mr Green's care from this point on?**

#### SCORING KEY

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

	worth	mark
A. Consider the best place of treatment, although with the arrhythmias he is likely to need to stay in CCU.	1	
B. With the ward staff, set up regular safety checks or a "watch".	1	
C. Consider again the use of the Mental Health Act if Mr Green will not cooperate or remain in hospital, no matter which ward he is on. Leave instructions for regular and on-call staff about this.	2	
D. Close liaison with medical and nursing staff regarding his state and to ensure his mental and physical needs are addressed.	1	
E. A risk/benefit analysis of antidepressant prescribing and ensuring this would not worsen his cardiac problems.	1	
F. Consider ECT if he continues to refuse oral antidepressants and the risks continue to be high. Risk/benefit analysis of ECT re his medical condition, together with treating team. Probably would not talk to his wife as yet about this option.	2	
G. Continue to review Mr Green to try to persuade him to accept antidepressant treatment and to review his mental state and risk status.	1	
H. Meet with Mr Green's wife again to continue to discuss the situation and treatment options. See if she or any other family member or friend can persuade Mr Green to accept antidepressant treatment.	2	
Up to a maximum of 6 marks in total TOTAL:		