THE ROYAL AUSTRALIAN AND NEW ZEALAND
COLLEGE OF PSYCHIATRISTS

MOCK WRITTENS EXAMINATION

AUCKLAND / NEW ZEALAND

DECEMBER 2004

PAPER II

MODEL ANSWERS

Please realise that this is an "amateur" version of the real thing, and that the marking schedules here and for our Paper I are more idiosyncratic and not structured quite as in the real writtens, due to local question writers not being as aware of these. Make sure you do read the exams section of the College website to be clear about how the real thing is in fact marked.
E.g. ½ marks are not allowed in the real writtens, so examiners are forced to stick more strictly to the marking templates with less room for "fudging".
In the real exams all questions are as evidence-based as possible, and we tried to manage this where we could, but some questions are less EBM-rigorous and are based more on extensive clinical experience. You will not agree with all the model answers, but then that very likely parallels the real writtens as well.

Critical Essay Question: (40 marks)

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

"The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant."

- John Stuart Mill

A full sample essay will not be provided here, but rather guidelines as to the type of content expected.
The marking schedule, as you recal, is structured around the 5 parameters:
A total of 40 marks is possible. Each dimension was thus scored out of 8.

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

Points are random or unconnected or listed. **or** Assertions are unsupported or false **or** There is no conclusion	0-2
Points follow logically to support argument/thesis **and** Assertions are supported by correct and relevant knowledge	3-6
Advanced level of argument displayed (and extra points for good references)	7-8

Dimension 2. Flexibility

Only one point of view is considered	0-2
Considers more than one point of view	3-6
Demonstrates more than one point of view at a sophisticated level	7-8

Dimension 3. Ability to Communicate

Spelling, grammar and vocabulary impede communication	0-2
Spelling, grammar and vocabulary adequate for communication of ideas	3-6
High level of skill at written expression	7-8

Dimension 4. Humanity/Experience/Maturity/Judgment

Ideas are naive, superficial, unethical, extreme or poorly thought out	0-2
Ideas are reasonably sophisticated, demonstrate clinical experience and personal maturity, are ethically aware	3-6
Ideas demonstrate high level of sophistication, maturity, experience, ethics	7-8

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

No demonstration of psychiatry or mental illness being placed in broader contexts - scientific, cultural, historical etc.	0-2
Psychiatry or mental illness are placed in broader contexts - scientific, cultural, historical, etc	3-6
Superior understanding of above demonstrated	7-8

The quote's focus is clearly around ethical and philosophical issues which are particularly important to psychiatrists as well as to society in general, and better candidates began by stating this clearly.
Definitions then tended to occur, and these were provided to a varying degree. Those who did better in fact spent a consideable part of the body of the essay discussing some of the terms/concepts in the quote in detail, while other candidates gave a brief and rather simplistic definition of the main terms which then limited them regarding discussion of those issues in more depth.
For example, most candidates defined "power", and many defined "harm". However the issue of what exactly is meant by "harm" is in fact a key point and the better candidates discussed this in some detail, pointing out the differences between actual bodily/physical harm vs more subtle and less visible abuses of various sorts, and vs differing cultural/subcultural notions of "harm" either in present societies or historically. The concept of what "harm" is and what sorts of "harm" we as a society will or will not not tolerate is not a fixed unitary concept and did not in fact lead itself to a simple definition. Another key concept was that of the "civilised community". Again, those who gave a specific and concrete definition of this then failed to discuss the concept, which is important regarding who currently and historically we see as being part of our "civilied community" and who we tend to ostracise and put on the outside, deprived of rights. The mentally ill, in the past, tended to have no rights and to be excluded from the community, so this issue warranted more discussion than a simple definition.

The message overall from this is to be careful of definitions, particularly in quotes which are very much about ethical/philosophical issues, as this one was. Often the meaning of the terms is the core of the essay, not merely a brief "definition" task to be dispen sed with in 3 or 4 sentences at the start. Concepts of interest and worthy of discussion in the quote also included "rightfully", "harm", "physical good" and "moral good".

Various structures were followed to respond to the quote. Most candidates began with a few paragraphs on the use of power to prevent harm to others, and then moved on to 1 or 2 paragraphs on the use of power to prevent harm to self. Pretty much all in the end concluded that they disagreed with J S Mill and did feel that use of power to prevent harm to self was warranted.

Within that overall structure, each section tended to cover support for this exercise of power, then counter-arguments expressing concern about such power being abused. The depth of discussion varied considerably. Issues usefully included were several of the ethical principles in the "Georgetown mantra" - notably in this instance the principle of autonomy, and also that of beneficence and to a lesser degree non-maleficence (not spelled malificence by the way). Various examples were used to illustrate support of the use of power to prevent harm to others (laws, MHActs, parental limit-setting etc.) vs concern about abuses of this exercise of power against autonomous individuals (historical abuses of power too numerous to mention, esp. those related to mental health e.g. Nazi eugenics with imprisonment and killing of mentally ill, abuses in USSR and China, etc. More modern e.g.s included the American invasion of Iraq, and recently proposed UK legislation aimed at detention of those with severe ASPD to prevent them committing future crimes.) Discussions often included how changing views of "harm" have led to e.g.s of altering concepts of what "harm" is and how our laws and MHActs have responded to these.

Candidates then tended to move on to the more vexed issue of intervening to prevent "harm" to the self. Better candidates discussed what such "harm" might entail re the benefits or limits of using power to intervene and prevent it. Again, changing social values and hence legal systems and MHActs across history and cultures were explored. Candidates variably discussed suicidality vs more minor self-harm vs self-damaging behaviour such as substance abuse vs self-neglect due to illness or disability. Again, examples were given regarding support for intervening, using "power" to prevent such harms, or examples of abuses of such powers or instances where apparently beneficent interventions in fact breached the principle of non-maleficence (by causing further harm – e.g. acute admissions traumatising patients, prolonged detention of patients with severe PDs worsening them, etc.). The issue of *competency* was relevant and needed to be discussed. Another issue touched on in the better essays was that of treatability – should we detain and exercise power against those who are not in fact treatable?

Other themes in the body of the essay which were interesting and relevant were of society as a parent – setting limits, but if too over-protective and interventionist (e.g. preventing possible self-harm) the "child" (the individual) cannot grow and learn from mistakes. As well as historical illustations, religious views (prohibitions against murder, sayings of Ghandi and the Buddha etc,) were used as examples, as were changing social attitudes - to suicide (e.g. decriminalisation), to substance abuse, to incest, to abuse of children, women and the elderly. Some touched on the benefit to society in preventing suicide caused by treatable illness (prevents loss of a valuable worker, loss of that person's social value as parent or family member, prevents unravelling of the fabric of social networks, etc.) Issues about use of powers regarding those with intellectual disability arose, as did discussion of euthanasia and whether intervention to prevent this was "rightful" or not.

Clearly there was a great deal of scope for discussion, and the better essays organised these sections well and mentioned a wide range of issues. Some essays were simply too short and with inadequate and rather simplistic content. Some candidates, as ever, appeared to have allowed insufficient time. Some essays displayed a lack of pre-planning, with the writer launching off into the topic energetically but not setting out the arguments clearly or structuring the discussion well. Most completed the essay with a summing-up that in the better essays wove together justifications for the exercise of power both to prevent harm to others but also to prevent self-harm in certain instances, but conveyed the complexity of the issues, the need for context and the readiness with which such powers can be abused. Most candidates sympathised with Mill's reluctance to intervene to protect against self-harm but in the end did not agree that this was never warranted.

More marks were gained if candidates gave any references at all, or even mentioned basic sources such as the Georgetown Medical Ethics princples, the College Code of Ethics, the WHO Helsinki agreement, etc. Candidates who aced this question gave many references from the literature on philosophy and ethics, especially Utilitarianism, the philosophical school within which Mills (an English philosopher) arose in the C19th.

Regarding "breadth", more marks were gained for a wide variety of examples and viewpoints drawn from psychiatry, but also from other fields, and from other cultures and time periods. Essays which focussed purely on the application of the quote to mental health issues and the MHAct scored less well, as did those which barely mentioned its application to psychiatry at all. Remember not to be insular in examples given (e.g. using a purely local illustration which an non-local marker would not comprehend) and similarly, that MHActs differ in NZ and across all Australian states, so avoid specific terminology when discussing the MHAct in such essays.

Critical Analysis Question 1

Use of lithium and the risk of injurious motor vehicle crash in elderly adults: case-control study nested within a cohort

Mahyar Etminan, Brenda Hemmelgarn, J A C Delaney, and Samy Suissa

BMJ, Mar 2004; 328: 558 - 559.

Method

We used a case-control approach on data from a cohort that has been described previously. Briefly, we used the Universal Quebec Automobile Insurance Agency to identify all 224,734 drivers aged between 67 and 84 years in the province of Quebec at 1 June 1990 and followed them up to 31 May 1993. To be included in the cohort subjects needed to have a valid driver's licence and to have lived in Quebec for at least two years before 1 June 1990. Cohort subjects were followed up until they reached the age of 85 or emigrated from Quebec or until 31 May 1993, whichever was the earliest. We defined the study outcome as subjects' involvement, as drivers, in a motor vehicle crash in which at least one person sustained a physical injury. Cases were subjects who had any such crash during the follow up period, and the date of their first crash was taken as the index date. Controls were a 6% random sample of the cohort, and their index dates were randomly selected during the follow up.

Exclusion criteria were the same as in the previous study. We used data from the Quebec Health Insurance Agency to identify subjects' use of prescription drugs and other covariate information. The database on prescription drugs includes information on all outpatient prescriptions of drugs dispensed to people aged 65 years or older. The accuracy and validity of these data have been shown to be high.

Results

A total of 5579 people in the cohort had had an injurious motor vehicle crash during the follow up period. A random sample of 13,300 control subjects was drawn from the cohort. Current use of lithium was higher among subjects who had been involved in an injurious motor vehicle crash than among control subjects (rate ratio 2.08 (95% confidence interval 1.11 to 3.90)). Current use of carbamazepine was not associated with having had an injurious motor vehicle crash (rate ratio 0.83 (0.48 to 1.44)).

Rate ratios for having been involved as a driver in an injurious motor vehicle crash (cases), according to drug use:

Drug use	No of cases (n=5579)	No of controls (n=13 300)	Rate ratio	
			Crude	Adjusted* (95% CI)
Lithium				
Any use in the year before index date†:	20	27	1.77	1.80 (1.00 to 3.24)
1-4 prescriptions	2	8	0.60	0.71 (0.15 to 3.45)
≥5 prescriptions	18	19	2.26	2.18 (1.14 to 4.19)
Current use (within 60 days before index date†)	19	22	2.06	2.08 (1.11 to 3.90)
Carbamazepine				
Any use in the year before index date†:	36	79	1.09	1.04 (0.70 to 1.54)
1-4 prescriptions	18	41	1.05	1.02 (0.58 to 1.79)
≥5 prescriptions	18	38	1.13	1.05 (0.58 to 1.85)
Current use (within 60 days before index date†)	18	48	0.90	0.83 (0.48 to 1.44)

* *Adjusted for age, sex, residence in the country, previous involvement in an injurious motor vehicle crash, chronic disease score, and exposure in the 60 days before the index date to antidepressants, anti-epileptics, benzodiazepines, antipsychotics, antimigraine drugs, muscle relaxants, or narcotic analgesics.*

† *The date of each driver's first crash in the follow up period (for cases) or a random date (for controls).*

Critical Analysis Question 1 (20 marks)

1. Read the method. What type of study is this? (2 marks)

This question is here just to get candidates attuned to what sort of things they are looking for and to remind them that although authors may describe a study as of being a particular design they are sometimes wrong. So don' t always believe what is written!

This study is a case control study.

2. Who are the controls? What do you think about the authors' choice of controls? (3 marks)

The main problem in case control studies is in the selection of controls. In this case the controls are:

- 6% random sample of the cohort of 224, 734 individuals of the Quebec Automobile Insurance Agency
- had not had a motor vehicle crash involving physical injury when they were driving
- aged 67 to 84 years
- had a valid drivers licence
- lived in Quebec for at least two years prior to June 1st 1990

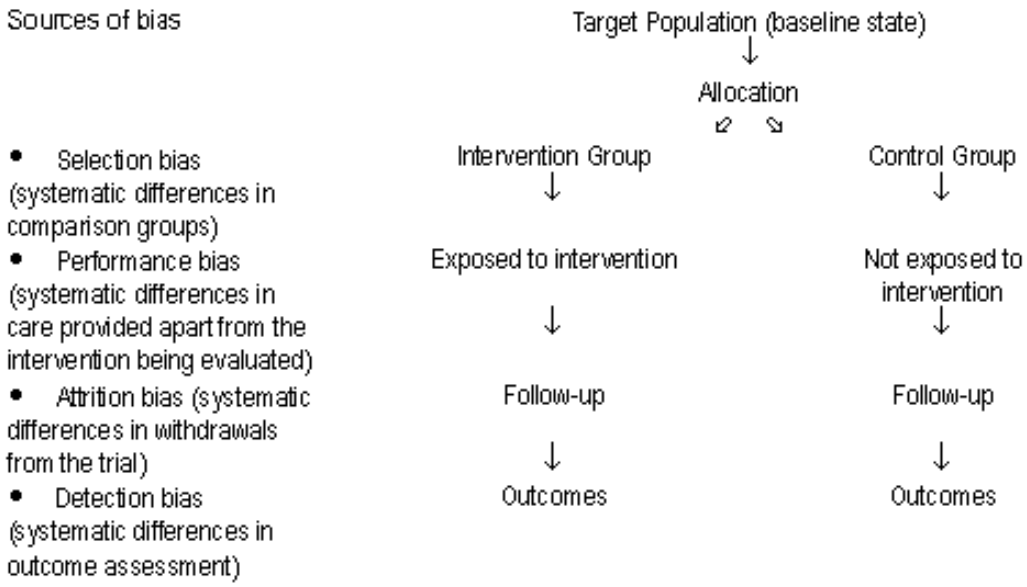
The ideal control population in a case control study is one that differs from the cases only by their experience of the outcome of interest. This seems to be the situation in this study.

3. What are the important sources of bias and confounding factors in this study? (4 marks)

All critical analysis problems ask this question in some way therefore it is important for candidates to be able to define bias and confounding and understand the difference.

Bias - is any systematic error that results in an incorrect estimate of the association between exposure and outcome. As it is a systematic error it is introduced by the researcher and is usually a product of study design.

The diagram below shows one way of describing bias (mnemonic **SPAD**: **S**election, **P**erformance, **A**ttrition (also can mean **A**nalysis) and **D**etection bias)



So in this study are there any important Biases as part of the study design?

- *Selection* bias - no.
- *Performance* bias - Possibly. Individuals who are on medication or unwell may be less likely to be insured. Therefore any association found in this study is likely to underestimate the effect of medication on car crashes.
- *Attrition* bias - Not relevant to this study.
- *Detection* bias – Possibly - might people involved in car accidents who are also on medication be less likely to report them?

Confounding factors - (from the Latin confundere, to mix together) occurs where the effect of exposure to a risk factor (the outcome) is distorted because this risk factor is also associated with other risk factors that affect the outcome. Confounding is a function of the complex interrelationship between exposures and outcomes.

In this study - the important issue here is that people who crash on medication may do so because of their illness rather than their medication. This may be especially relevant in this study if people are taking lithium for bipolar disorder.

4. What does "We used logistic regression to compute the odds ratio as an estimate of the rate ratio of an injurious motor vehicle crash associated with use of lithium or carbamazepine" mean? (3 marks)

Maybe a fairer question would have been - rewrite this sentence to make it understandable!
So to break it down:

- Logistic regression - firstly when authors start writing about logistic regression they are trying to evaluate the role of confounding factors. Logistic regression is a type of multivariate analysis. Multivariate analysis is a way of taking into account simultaneously different factors which may affect the outcome. How this is done should not trouble clinicians. What is important and what clinicians should be looking for is that the authors include in their analysis all those reasonable factors which may be associated with the outcome and the exposure of interest. So in this particular study it is important to take into account age as well as what drugs people are on - older people are more likely to suffer ill health and be on drugs. They are also more likely to have accidents. Multivariate analysis helps to disentangle the effect of drugs and age on crashes. (The authors also tried to take into account sex, residence in the country (presumably because newer residents are more likely to have an accident?), previous involvement in a crash, chronic disease score and exposure to other drugs. They didn' t look at recent acute illness though- which they presumably could have done through hospital discharge statistics - as this would be a marker of current unwellness. This is an important omission).

- Odds ratio - the main outcome of interest in case control studies. Helps answer the question "Is this study important?" Usually in case control studies people only sit up and take notice when the odds ratio is greater than three because of the biases inherent in case control studies.

- Rate ratio - (confusing language) more usually known as the relative risk. It is the ratio of one rate divided by another. It is a more understandable version of the odds ratio and gives more information than the odds ratio. However in most case control studies you can only calculate the odds ratio which is an (over) estimate of the relative risk, (use the two by two table as below to work it out if you don' t understand that last bit).

So what the sentence means is "we tried to take several confounding factors into account when we worked out the likelihood of someone having a crash when they were using lithium or carbamazepine".

(What you as clinicians need to know is *what confounding factors were taken into account* and *how large was the likelihood*.)

5. **Read the results. Draw a two by two table for the risk of having an injurious motor vehicle crash whilst having used lithium in the previous 60 days. What is meant by the rate ratio? What tests of statistical significance did the authors use? Comment on the authors' choice. (5 marks)**

This question carries more marks than others because if you can draw a 2x2 table you have understood the study.

	Crash	No Crash	Total
Lithium	**19**	**22**	**41**
No lithium	**5,560**	**13,278**	**18,838**
Total	**5,579**	**13,300**	

As above, the Rate Ratio is more usually known as the relative risk. It is the ratio of one rate divided by another. It is a more understandable version of the odds ratio and gives more information than the odds ratio. However in most case control studies you can only calculate the odds ratio which is an (over) estimate of the relative risk.

The authors used the ***confidence interval*** a test of statistical significance.
Comment on this: The advantage of the *confidence interval* over conventional *P values* is that it tells you not only whether a particular result was likely to have occurred by chance, it also tells you something about the variability of the estimate of the association between an exposure and an outcome.

6. **Based on this study, what advice would you give to your elderly patients who are taking lithium and driving? (3 marks)**

Personally I don' t think this study would change my advice. Patients still need all the usual advice about taking lithium and early warning signs of relapse of illness.

This question was written by Dr Simon Hatcher. If you don' t understand aspects of it you can contact him on s.hatcher@auckland.ac.nz or you could just read the new book ***Evidence Based Mental Health Care***
- by Simon Hatcher, Mark Oakley-Browne and Robert Butler – available shortly from Amazon.co.uk as in this link:
http://www.amazon.co.uk/exec/obidos/ASIN/0443073066/qid%3D1104373515/202-6034393-6150219

Critical Analysis Question 2 (20 marks)

You are an advanced trainee who has commenced work at a Child and Adolescent Psychiatry service. You encounter several sets of parents who are worried that the prescription of SSRI medication for depression or anxiety disorders may be harmful for their adolescent children. After discussion with your supervisor, you decide to try to locate a good review article to clarify this issue, so that you can advise the parents and young people you are seeing.

1. **How would you identify all the possibly useful Review Articles on this topic so as to screen these? Describe the techniques you would use to search using suitable keywords and what sort of limits might be useful in the search. (4 marks)**

   - Search electronic databases – Medline (Pubmed), Psychlit, Cochrane database, etc. (1 mark)
   - Keywords: *depressive disorders, antidepressive agents, fluoxetine, paroxetine, sertraline, citalopram, fluvoxamine, venlafaxine, child, adolescent (for example*
     Should state that a series of searches would be carried out using suitable keywords successively, not using them all at once. (1 mark)
   - Limits: (2 marks)
     - "review" types of articles
     - articles in English
     - studies on humans
     - articles published since 2000 (older ones wouldn't include recent studies)

2. **What sort of Inclusion Criteria might you want to use in selecting suitable Review Articles from a list located by a search? (apart from those set via search "limits" as above) (2 marks)**

   - Reviews looking at randomised controlled trials of SSRIs in this age group.
   - Reviews looking at safety and efficacy issues in the use of these medications.
     (± Reviews looking at the treatment of depression and anxiety in this age group.)

3. **In analysing the suitable Reviews you have located, how would you evaluate the validity of the Review's conclusions? (5 marks)**

   - the statistical methods used to combine the results of individual studies.
   - the comparability of the studies included in the analysis and the generalizability of the results.
   - the heterogeneity of results across studies.
   - the quality of studies included in the review.
   - the possibility of publication bias.

4. **In considering the validity of individual studies included in the Review, what are the three main methodological features that have been empirically shown to influence the results of studies about therapy? (3 marks)**
   - randomization
   - concealment of randomization
   - blinding

5. **What is "publication bias"? (2 marks)**
   Negative studies are unlikely to be published and are less likely than positive studies to be available for detailed literature reviews or meta-analyses.
   (Studies which duplicate previous studies are also less likely to be published.)

6. **One Review you locate is a meta-analysis. What is a meta-analysis and what are the three main aims of the authors in the analysis of results, in a meta-analysis? (4 marks)**
   The statistical analysis of a large collection of results from individual studies for the purpose of integrating the findings. (1 mark)
   The main aims of the authors in the analysis of results for a meta-analysis are: (3 marks)
   - to understand / clarify the rigor of the studies to be included
   - to uncover reasons for differences among study results
   - to provide readers with sufficient information with which to judge the applicability of the review to their clinical practice

Modified Essay 1 (25 marks)

Sam is a 29 year old man with a diagnosis of schizoaffective disorder who has recently come on to your outpatient clinic caseload. Since initial diagnosis ten years ago Sam has had twelve admissions to psychiatric inpatient units with relapses of his mental illness and his attendance at outpatient clinic is intermittent. His adherence to his medication regime of lithium carbonate 1200mg daily and risperidone 6mg daily is variable. According to his file, Sam has denied use of substances but he now tells you that he has binged on alcohol whenever he can afford it "for years". He had not disclosed this previously as he did not think it was relevant, but his family have been telling him he has an alcohol problem and he 'needs help'. On further questioning you find he meets criteria for alcohol abuse but not alcohol dependence.

Question 1

Outline the possible negative consequences of Sam's alcohol abuse, interacting with his schizoaffective disorder. (8 marks)

SCORING KEY

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

			Mark
A	Increased risk of relapse of symptoms and/or hospitalization.	**1**	
B	Reduced adherence to treatment regime (e.g. medication, clinic attendance)	**1**	
C	Potential interactions with medications (e.g. dehydration and lithium toxicity)	**1**	
D	Increased risk of violence	**1**	
E	Increased risk of suicide	**1**	
F	Further financial problems, on top of any caused by his schizoaffective disorder	**1**	
G	Further impairment of his ability to maintain stable housing, on top of any problems caused by his schizoaffective disorder–	**1**	
H	Further possible social burden to his family/society, on top of any problems caused by his schizoaffective disorder–	**1**	
I	Negative views of patient by mental health treatment providers (e.g. blame for 'self-induced' problems, sense of hopelessness, frustration)	**1**	
J	Risk of 'falling between the gaps" of the services	**1**	
K	Further impairment of his ability to maintain employment, on top of any problems caused by his schizoaffective disorder	**1**	
L	Further impairment of his ability to maintain meaningful relationships, on top of any problems caused by his schizoaffective disorder	**1**	
		Up to a maximum of 8 marks total	

Question 2
What further information about Sam's alcohol use would assist in developing treatment strategies. (9 marks)

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

			Mark
A	Any relationships between alcohol use and symptom relapse (e.g. preceeding or subsequent) and between alcohol use and treatment adherence	**1**	
B	Any relationships between alcohol use and life events, and how these may have interacted with his mental illness	**1**	
C	Previous treatment for alcohol abuse and outcomes	**1**	
D	Previous periods of abstinence and circumstances related to this	**1**	
E	Weekly/monthly pattern of use, amounts	**1**	
F	Context of alcohol use (e.g. alone, with peers, at pub)	**1**	
G	Perceived reasons for alcohol use (eg 'self-medication, socialisation, craving)	**1**	
H	Any negative social or legal consequences of alcohol use (eg financial, relationship, accommodation, employment, forensic)	**1**	
I	Any negative medical consequences of alcohol use or physical side effects (e.g. abnormal LFTs)	**1**	
J	Level of insight regarding potential for alcohol use to impact negatively on mental health	**1**	
K	Level of motivation for wanting to change alcohol use	**1**	
L	Coping strengths/strategies as these relate to his alcohol use	**1**	
M	Collateral information from other sources (e.g. family) regarding his alcohol use	**1**	
N	Level of social support and attitude of family to his alcohol use, and family history of A&D problems	**1**	
		Up to a maximum of 9 marks total	

Integrated treatment is not available in your outpatient clinic. However, Sam is agreeable to attending the local Alcohol and Drugs counselling service and for you to share clinical information with a counsellor.

Question 3
What information and advice relating to Sam's schizoaffective disorder and your management plan would it be important for his A&D counsellor to understand in order to effectively treat his alcohol abuse? (8marks)

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

			Mark
A	Need for assertive engagement in light of intermittent clinic attendance and ambivalence	**1**	
B	Knowledge of Sam's early warning signs and any known precipitants	**1**	
C	Long-term and relapsing nature of schizoaffective disorder and need for long-term treatment	**1**	
D	Need for liaison between mental health and A&D services to reduce possibility of conflicting advice or treatment (eg harm reduction vs abstinence)	**1**	
E	Plans with regards medication regime (eg if there were to be a change of mood stabilizer) and possible side effects of meds	**1**	
F	Any history relating to risk to himself or others	**1**	
G	Possibility of cognitive deficits due to mental illness or medications (eg reduced attention span, poor memory, reduced learning capacity)	**1**	
H	Who to contact and how to contact them, if concerns about mental state arise, including after hours crisis back-up	**1**	
I	Current plan for frequency of review at clinic and frequency of updating A&D counsellor with progress (and vice versa)	**1**	
J	Baseline functioning and mental state (e.g. any ongoing delusions or perceptual disturbances)	**1**	
K	Any physical health problems and relevant lab results	**1**	
L	Sam's history of mental illness, relapse and admissions	**1**	
		Up to a maximum of 8 marks total	

MEQ1 – marker feedback:
Candidates often didn't read the Q properly or answer what was asked, esp. re part 3. You should know about the "integrated treatment" concept in Dual diagnosis services.

Modified Essay 2 (25 marks)

Khalid is a fearful young Kurdish man aged 17 who came to New Zealand at age 10 after spending three years in a refugee camp in Indonesia. He lives with his domineering stepfather and his mother, who appears rather anxious. She had witnessed a number of traumatic events during her time in Iran with a number of her extended family having been killed, including Khalid' s biological father.
Khalid left school 6 months ago after experiencing bullying from students. The family have also experienced graffiti written on their fence and minor vandalism.
His mother is concerned that he appears listless and spends all his time just "lying around the house watching TV" when he should be out working. She is concerned that he may be smoking marijuana.
Khalid tells us that he can' t really be bothered leaving the house and that when he does he feels scared because everybody is looking at him.

Question 1

Outline a formulation regarding Khalid' s presentation. Link risk factors to symptoms and signs of social isolation, anxiety and substance use. (10 marks)

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

			Mark
A	Mother and family' s experience of trauma has resulted in being overprotective to Khalid with heightened sense of danger	**1**	
B	Possible genetic predisposition to anxiety disorder	**1**	
C	Survivor guilt	**1**	
D	Loss of his biological father at an early age	**1**	
E	Sensitive temperament with stressors of being bullied at school contribute to withdrawal, anxiety symptoms and poor self-esteem	**1**	
F	Experience of ethnic minority with discrimination from neighbours resulting in increased fear	**1**	
G	Marijuana use is self medication for anxiety.	**1**	
H	Isolative behaviour is learnt behaviour from Mother' s fearfulness, neighbours vandalism and experiencing the trauma of bullying.	**1**	
I	Substance use is a conflict of cultural values between family and peer group Marijuana use leads to amotivation.	**1**	
J	Substance use as a means of individuation from family, developing sense of autonomy and identity.	**1**	
K	Possible abuse by stepfather contributes to his sense of fear.	**1**	
		Up to a maximum of 10 marks total	

Following your assessment of Khalid you determine that there is no risk to self or others and he does not appear depressed. He is ambivalent about treatment and refuses medication. You see him once a week over a four week period and discover that he is smoking marijuana on a daily basis. The focus of your management is to try and build a therapeutic relationship, to monitor his mental state and provide education about his substance misuse, focusing on a harm minimisation model as Khalid is adamant that he does not wish to stop using marijuana. However he is happy to continue seeing you.
During one of your reviews you are joined by Khalid' s stepfather. He is very angry that you have known that Khalid has been smoking marijuana daily and have not told the family. He says that you are not doing enough to help Khalid, that he needs more therapy and that he should have a change of doctor.

Question 2

How would you address Khalid' s stepfather' s concerns? (10 marks)

SCORING KEY

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

			Mark
A	Acknowledge and recognise family' s concerns and expectations (and that unrealistic aspects likely related to concern about wellbeing of son)	**1**	
B	Acknowledge and recognise family' s anger (and that it is likely related to their experience of discrimination)	**1**	
C	Recognise issues of ignorance of illness and of the effects of marijuana.	**1**	
D	Explain issues of confidentiality and the reasons for these.	**1**	
E	Clarify to the family that you would tell them if you considered Khalid was a risk to himself or others.	**1**	
F	With Khalid' s permission outline your management plan (focus on engagement)	**1**	
G	Outline rationale for harm minimisation.	**1**	
H	Offer the family support (possibly with interpreter or cultural support)	**1**	
I	Recognise the emotions in yourself of a sense of feeling attacked and obtain support for this through peer review or supervision.	**1**	
J	Recognise family' s ignorance of psychiatric system and your role. Clarify what father means by therapy. Explain you are providing supportive therapy which is all Khalid is accepting of.	**1**	
K	Explain that if Khalid also wished for a change of doctor you would try to arrange this but that changing staff can affect his care.	**1**	
L	Clarify what Khalid's stepfather expects of you.	**1**	
M	Explain time-course of recovery.	**1**	
		Up to a maximum of 10 marks total	

You address the family' s concerns and they agree for you to continue working with Khalid. Over the next two months there is an improvement in his functioning and he is able to start work as a butcher' s apprentice. However it also becomes apparent that whenever Khalid uses marijuana he wonders if the police or his family may be trying to monitor his activities. He is not suicidal, has never been violent and does not identify any persecutors.
Khalid tells you that now he is working he does not have time to see you anymore.

Question 3

Outline your management plan at this point. (5 marks)

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

			Mark
A	Consider whether the risks warrant compulsory treatment under the Mental Health Act.	**1**	
B	Explore reasons why he wants to disengage.	**1**	
C	If it is only because he is busy during the day then consider seeing him after hours or negotiate other means of follow-up	**1**	
D	Ensure Khalid and parents know the early warning signs (have a Relapse Prevention /EWS Plan) and ensure parents know how to contact services/Crisis team, and when to do so.	**1**	
E	Consider staying in contact with the family for a number of months even if Khalid will not see you / Involve family	**1**	
F	Again outline to Khalid the dangers of his marijuana use.	**1**	
		Up to a maximum of 5 marks total	

MEQ2 – marker feedback:
Part 1 – A formulation requires a *hypothesis*, linking <u>why</u> or <u>how</u> a risk factor or experience can lead to a Sx or behaviour. Merely listing risk factors then a Differential Dx did not score well.
Part 2 – generally well answered. In "addressing concens" also state your understanding of what could be fuelling father's anger – e.g. possibly past experience of discrimination. Some candidates just did not put *enough* issues/points for marks – it was a 10 mark section after all.

Modified Essay Question 3: (25 marks)

Mr. James, a 60 year old European man, is referred to your consultation-liaison service by a medical team following the consultant's ward round. The referral reads "Please review this man admitted 5 days ago to investigate weight loss (10kg in 3 months). He told one of the night staff that he wants to die. Please assess - ?depression." You see in his medical file that he and his wife have been seen by the ward social worker. He lives with his wife who is well. He retired early following a redundancy and the couple are financially secure. Their only son moved to live overseas six months ago.
The medical team have recently examined Mr James and completed basic medical investigations. As a first step in your assessment you read his medical file. As a second step you see Mr James and take a full history.

Question 1
Outline the other steps involved in your assessment. (10 marks)

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

			Mark
A	Complete a *Mental State Examination specifically assessing him for signs of depression* and to determine its severity – psychomotor slowing or agitation, depressed mood, restricted affect, negative cognitions/ruminations, suicidal ideation, depressive delusions or overvalued ideas, perceptual disturbances due to a psychotic depression, impaired insight and judgement due to depression, etc.	**1**	
B	Complete a *Mental State Examination to assess for/exclude other differential diagnoses* – e.g. organic disorder, anxiety disorder, psychosis, substance abuse such as alcoholism, etc.	**1**	
C	*Cognitive Testing* - Complete a *Mini Mental State Examination* (MMSE) (ideally with additional frontal lobe testing) to screen for organic disorder	**1**	
D	Complete a *Depression Rating Scale* (e.g. Hospital Anxiety and Depression Scale, HADS or Geriatric Depression Scale, GDS)	**1**	
E	*Collateral from GP* - speak to his GP	**1**	
F	*Collateral from medical team* - speak to the medical consultant / registrar / or social worker	**1**	
G	*Collateral from family* - speak to his wife (plus any other family if such exist)	**1**	
H	Develop a *Formulation*	**1**	
I	Come to a *Differential Diagnosis*	**1**	
J	Complete a full *Risk Assessment* (assessing suicidality is not enough, must mention an assessment of risk to self or others and serious impairment of self care)	**1**	
K	Complete an *Outcome Measure* (e.g. the HoNOS)	**1**	
		Up to a maximum of 10 marks total	

Note to Marker: If candidates say they would repeat the physical examination or arrange various medical assessments/investigations this does not attract marks, as is not the psychiatric registrar's role in a C-L setting.

Question 2

Which basic medical investigations, besides a full blood count and chest X-Ray, would be the most important for you to check had been completed. (9 marks)

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

			Mark
A	Urea and electrolytes (U+Es)+/- creatinine	**1**	
B	Liver function tests (LFTs) +/- GGT	**1**	
C	Calcium (Ca++) +/- phosphate	**1**	
D	Thyroid function tests (TFTs)	**1**	
E	Fasting glucose	**1**	
F	C reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)	**1**	
G	Autoimmune screen	**1**	
H	Stool sample tested for infection	**1**	
I	Mid stream urine (MSU)	**1**	
J	Syphilis serology	**1**	
		Up to a maximum of 9 marks total	

The investigations are normal. You diagnose Mr James as having a moderate Major Depressive Episode. He is at a low risk of self harm.

Question 3

Outline the key elements of your management plan. (6 marks)

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

			Mark
A	*Engagement* - engage with Mr James and his wife and establish some rapport so as to persuade him to commence appropriate treatment	**1**	
B	*Education/Information/Consent* - discuss the diagnosis and management options with Mr James and his wife / discuss the need to treat his depression as the cause of his weight loss / agree on an overall treatment plan	**1**	
C	*Medical team liaison* - discuss the diagnosis and management plan with a member of the medical team / liaise with the medical team	**1**	
D	*Psychotherapy* – offer/arrange some form of talking therapy (such as counselling, CBT, IPT)	**1**	
E	*Medication* – if he agrees, prescribe an antidepressant (e.g. paroxetine, citalopram, fluoxetine or nortriptyline) and consider a sleeping tablet if he has significant insomnia (e.g. temazepam or zopiclone)	**1**	
F	*Follow-up* - refer Mr James to his local community mental health team for follow up OR offer an outpatient appointment / outpatient follow-up	**1**	
G	*Crisis back-up* - arrange urgent after-hours back-up support via the local Crisis team/CMHC in case he should worsen after returning home, and ensure Mrs James has their contact number	**1**	
H	*GP Laison* - write to his GP / contact his GP	**1**	
		Up to a maximum of 6 marks total	

MEQ 3 – marker feedback:
Part 1 – only 1 person thought of formulation as part of assessment, and none thought of an outcome measure, so this part was not very well done.
Part 2 – many were not thinking widely enough about basic tests so didn't list the ABC ones and lost points.

Remember that the markers need to be reassured that you DO know the basics. Omitting these in MEQs as you feel they are "too basic" or "too obvious" is a common flaw and <u>will</u> fail you. This exam is to check that you are ready to graduate from basic training so the College needs to be reassured that you DO know the basics.

Modified Essay Question 4: (25 marks)

Andy is a 22 year old European man with social phobia who is referred to your out-patient clinic by his new General Practitioner. You discuss the referral with the GP: Andy has had longstanding difficulties in group situations and has been on a sickness benefit all his adult life but the GP is reluctant to continue this without a specialist assessment. As a child Andy was shy and had difficulty mixing with his peers. His attendance at school deteriorated in his teens and he left without obtaining any qualifications. He lives with his mother and younger sister. He refuses to attend any family social events which is a source of conflict between him and his mother. He avoids leaving the house during daylight hours and she is worried that he is becoming a recluse. His mother is also concerned about his drinking - he pressurizes her to bring beer home from the supermarket for him, and this had led to some arguments.

Question 1

Outline how you would assess Andy' s problems. (9 marks)

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

			Mark
A	*Practicalities of Engagement so as to Assess* – this may be difficult. He may not agree to an appointment as he rarely goes out during daylight hours. Also he is not asking for help but his GP is insisting. A home visit may be required.	**1**	
B	*Take a Comprehensive History from Andy* - a careful history is required with particular attention to: developmental history, family history of anxiety disorder, prescribed medications, physical health, use of nicotine and coffee, family and social relationships, goals for the future.	**1**	
C	*Carry out a Mental State Examination looking for features of social phobia*: typical cognitions (fear of feeling ashamed, fear of scrutiny), anxiety, restlessness, physiological symptoms, degree of insight, effect on judgement.	**1**	
D	On history and MSE - *Screen for co-morbid conditions or differentials* - other anxiety disorder symptoms such as panic, agoraphobia. Exclude co-morbid depression. Exclude OCD, psychosis.	**1**	
E	Assess the severity of his *Substance Abuse* – e.g. history of alcohol abuse, consequences of this, symptoms of abuse vs dependancy, other substance use.	**1**	
F	Consider use of a *Standardized Rating Scale* such as the Social Anxiety Scale.	**1**	
G	Comprehensive *Risk Assessment*	**1**	
H	*Physical evaluation* - to exclude exacerbating factors and in view of alcohol use. Either arrange this with his GP or do physical assessment yourself. Again, if he will not leave home a more limited physical may be all that is possible, but basic laboratory testing can hopefully be managed from home as well.	**1**	
I	*Collateral history from family* – from his mother (possibly sister if old enough) and assessment of family relationships. Meeting with the family together at home may assist with this.	**1**	
J	Develop a *Formulation*	**1**	
K	Come to a *Differential Diagnosis*	**1**	
		Up to a maximum of 9 marks total	

Following your assessment, you feel that the risks of self-harm or to others are low, and that Andy is not depressed or acutely agitated. Andy then tells you that he has used his mother' s diazepam a few times and this made him feel much more relaxed. He says that he would like you to prescribe this for him.

Question 2

Discuss the components of your overall treatment plan for Andy, and how you would try to implement this. Comment on how you would respond to his request that you prescribe diazepam. (10 marks)

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

			Mark
A	*Plan engagement* – arrange appointment or arrange to home visit. Aim to develop therapeutic relationship, try to instill hope, try to encourage him re treatment.	**1**	
B	*Education and Information* – to be provided about social phobia and its treatment.	**1**	
C	*Management of alcohol abuse or dependancy* – depending on degree of the problem and his preparedness to modify his use. Care if is in fact dependant – would need a withdrawal regime. Unlikely to agree to accept an inpatient detoxification. Educate regarding problems, at least try for a harm minimisation approach. Possibly involve a dual diagnosis worker from the A&D services as well.	**1**	
D	*Respond to his request for diazepam* - the dangers associated with taking other' s prescribed medications should be discussed. The chronicity of social phobia, development of tolerance to benzodiazepines and evidence for other more effective treatment options should be covered. Even if the above issues are mentioned, candidates score zero for this section of they would nonetheless prescribe him a benzodiazepine. Diazepam is not appropriate.	**1**	
E	*Management of possible benzodiazepine abuse or dependancy* – depending on the degree of the problem and his preparedness to modify this. Care if is in fact dependant – would need a withdrawal regime. Unlikely to agree to accept an inpatient detoxification. Educate regarding problems. Talk with his mother and ensure that if he is withdrawn from benzodiazepines she prevents further access to her supply. Monitor this in case she finds it hard to manage.	**1**	
A	*Cognitive / Behavioural therapy* - there is evidence from one trial that CBT has a superior effect to fluoxetine. CBT reduces the risk of relapse. Combination of cognitive and behavioral approaches to manage the symptoms of social phobia. May initially need to be done via home visiting.	**1**	
B	*Antidepressant medication – most common choice is the SSRIs* – these are prescribed at similar doses as for depression but may require up to 12 weeks to show an effect. MAOIs have also been shown to be effective.	**1**	
C	*Gradual Titration* - candidates should mention the need to titrate any medication gradually when starting, or anxiety symptoms can be worsened.	**1**	
D	*Longer-term Plan re Medication* – may well need to maintain medication in the longer term, as 50% of patients relapse on cessation.	**1**	
E	*Other medication options* - beta-blockers may have a small role in specific situations.	**1**	
G	*Family Intervention* – education and information for his mother and sister about social phobia. Possibly family therapy if this appears useful after further assessment. Support for the family.	**1**	
H	*Social & Occupational Interventions* – possibly provide support via a community support worker/case manager. Gradual engagement in local activity and social programmes if possible, once he responds to treatment, followed by assistance with occupational rehabilitation. Maintain sickness benefit until he is able to work.	**1**	
I	*Liaison with the GP* – maintain communication with his GP regarding the assessment, ongoing progress of the plan, and need for ongoing sickness benefit.	**1**	
		Up to a maximum of 10 marks total	

Question 3

Discuss the features that indicate a poorer prognosis for Andy. (6 marks)

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

			Mark
A	*Natural history of Social Phobia* - social phobia is often a chronic condition	**1**	
B	*Chronicity* - Andy has had symptoms since early childhood – indicates a poorer prognosis	**1**	
C	*Severity* - he is likely to have an *Avoidant Personality Disorder* which indicates a poor prognosis	**1**	
D	Probable *Alcohol Abuse* indicates a poorer prognosis	**1**	
E	Probable *Benzodiazepine abuse* may indicate a poorer prognosis	**1**	
F	*Conflicted family relationships* indicate a poorer prognosis	**1**	
G	*Isolation/avoidance and reluctance to go out* – indicate likely *engagement problems* and a potentially poor prognosis. Makes provision of cognitive and behavioural therapy more difficult.	**1**	
H	*Poor functioning socially and occupationally* – he has never worked or maintained normal social relationships so rehabilitation is likely to be harder	**1**	
		Up to a maximum of 6 marks total	

MEQ 4 – marker feedback:
Not generally done all that well – candidates *do* need to be au fait with anxiety disorders even if you don't see many clinically in your local services in basic training.
Part 1 - Not all that well done – you needed to exclude other conditions and comorbidity, many did not put what Sx/cognitions they would look for to do so.
Part 2 – Inadequately and v. simplistically done in the main. *Learn* about this.
Part 3 – Many seemed not aware of the generally chronic nature of social phobia and its link (when severe) with avoidant PD (which makes it harder to treat).