



Modified Essay Questions

SCORING KEY

AUGUST 2017

INSTRUCTIONS:

- Please use pencil ONLY, preferably 2B
- Do not fold or bend
- Erase mistakes fully
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- Completely fill in the oval

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Modified Essay 1

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You are a visiting psychiatrist working in a community mental health team three days each month, in a small rural town of 3000 people. The town is located in the lands of the Wiradjuri people of Australia.

You see Donna, a 56-year-old Wiradjuri woman for urgent review.

Donna was last seen two years earlier for problems with anxiety, depression and social avoidance but she did not follow-up and was lost to care. The Aboriginal mental health worker had no concerns and she was discharged back to her general practitioner (GP).

However, the GP has now referred Donna for review as her anxiety has escalated. This follows the release from jail three weeks ago, of the man who sexually assaulted Donna twenty-two years ago.

He returned to town after his release and since then she has found it impossible to leave her home, she is not sleeping, and she wonders how she will cope if she sees this man. She has contacted the police to ask them what to do but has found their response unhelpful.

While recognizing the patient is not suicidal, nor psychotic and has no history of such, she is extremely distressed. The GP requests your urgent advice.

Question 1.1

Outline (list and justify) the cultural considerations relevant to your interaction with Donna.

(10 marks)

A.	Considering and offering the involvement of a culturally appropriate support person subject with Donna's approval. Preparedness to defer to their advice (eg relevance of social relationship to Donna and her assailant). Donna may wish for confidentiality.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
B.	Establishing engagement in a culturally appropriate manner. Understanding the impact of culture on verbal and nonverbal communication and the impact of bilateral cultural factors in the interaction.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
C.	Gender aspects that may be relevant ("women's business") in Indigenous culture, cultural chaperone (if appropriate), and other aspects that a clinician may need to know.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
D.	Clarification of indigenous Elder status – recognising social status of both Donna and her assailant and/or her assailant's family.	<input type="radio"/> 0 <input type="radio"/> 1
E.	Awareness of cross cultural and intergenerational trauma, and elevated rates of community violence and sexual assault.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
F.	Recognising the local community's experience of mental health services and government agencies.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
G.	Spare (only to be used after approval from Co-Chairs, Writtens Subcommittee)	<input type="radio"/> 1
H.	Did not attempt	<input type="radio"/>
I.	Did handwriting affect marking?	<input type="radio"/>

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While recognizing the patient is not suicidal, nor psychotic and has no history of such, she is extremely distressed. The GP requests your urgent advice.

Question 1.2

List the most important issues you wish to clarify in your review of this patient.
(8 marks)

A.	Clarification of current stressor	<input type="radio"/>	<input type="radio"/>
B.	Clarification of previous trauma	<input type="radio"/>	<input type="radio"/>
C.	Role of the trauma, especially with regard to the indigenous person	<input type="radio"/>	<input type="radio"/>
D.	Risks of re-traumatization, especially trigger of trauma symptoms	<input type="radio"/>	<input type="radio"/>
E.	Current symptoms, mental state	<input type="radio"/>	<input type="radio"/>
F.	Personality style, resilience, coping strategies	<input type="radio"/>	<input type="radio"/>
G.	Current supports and social situation	<input type="radio"/>	<input type="radio"/>
H.	Current treatment	<input type="radio"/>	<input type="radio"/>
I.	Review of current risk	<input type="radio"/>	<input type="radio"/>
J.	Drug and alcohol use	<input type="radio"/>	<input type="radio"/>
K.	Spare (only to be used after approval from Co-Chairs, Writtens Subcommittee)	<input type="radio"/>	<input type="radio"/>
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You diagnose Donna with PTSD and would like to engage her in treatment.

Question 1.3

Describe (list and explain) the challenges treatment may entail. (11 marks)

A.	Fragmented resources and its implications: medical, psychological, psychiatric, supportive agencies, continuity of care, less specialised care for PTSD, etc.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
B.	Considering the role of traditional healing practises as part of treatment. Collaboration and difficulties.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
C.	Confidentiality, small community, multiple roles of community members. Conflict of interest. Exposure to stigma associated with mental illness.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
D.	Acceptability as a visiting practitioner. The interplay of your own cultural background and the role in the therapeutic alliance. Cultural, gender, and your role as an outsider.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
E.	Her supports. Implications of treating Donna within her community – familiar supports, difficulties and need for broader consultation, community status.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
F.	Containment of resources within rural contexts: one emergency department; one pharmacy etc. Possible interaction with assailant in health care facility.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
G.	Historical cultural issues eg the historical experiences of Invasion and “Stolen Generations” that may affect engagement with a health service.	<input type="radio"/> 0 <input type="radio"/> 1
H.	Spare (only to be used after approval from Co-Chairs, Writtens Subcommittee)	<input type="radio"/> 1
I.	Did not attempt	<input type="radio"/>
J.	Did handwriting affect marking?	<input type="radio"/>

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While recognizing the patient is not suicidal, nor psychotic and has no history of such, she is extremely distressed. The GP requests your urgent advice.

You diagnose Donna with PTSD and would like to engage her in treatment.

Towards the conclusion of your clinical interview, Donna asks for a prescription for diazepam. The GP did not mention anything in the referral but Donna says she has been using up to 40mg daily for several years.

Question 1.4

Outline (list and justify) your approach to this new information. (4 marks)

A.	Obtain the history of benzodiazepine use – clarify dependency diagnosis including consequences including falls, withdrawal, including other drug use. Medical history, any drug interactions.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
B.	Collateral: liaising with the GP and the local pharmacy, if needed. Pharmaceutical access registration services (doctor shopping). Diversion. Also falls, seizures, driving accidents, exploitation.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
C.	Spare (only to be used after approval from Co-Chairs, Writtens Subcommittee)	<input type="radio"/> 1
D.	Did not attempt	<input type="radio"/>
E.	Did handwriting affect marking?	<input type="radio"/>

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Question 1.5

Outline (list and justify) the implications of this new information. (8 marks)

A.	Implications of benzodiazepine use in treatment of PTSD – changes to treatment plans. Use of alternative strategies (including pharmacological) and psychological methods in the future.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
B.	Role of the psychiatrist in framing an ongoing plan in managing possible benzodiazepine dependence. Appropriate reference to benzodiazepine prescribing guidelines, eg NICE etc.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
C.	Consideration of the medical risks in the context of high dose benzodiazepine prescribing in older Indigenous women. Dangers of withdrawal including psychiatric symptoms, especially suicidality. Also falls, seizures, driving accidents, exploitation.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
D.	GP related issues, isolation, community pressure, boundaries. Prescribing outside guidelines. Registration issues.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
E.	Possible threat to treatment alliance if psychiatrist takes rigid view about management of benzodiazepine use. Explore Donna's view of her need for benzodiazepines. Discussion of a future plan and development of a shared understanding around ongoing prescribing.	<input type="radio"/> 0 <input type="radio"/> 1
F.	Spare (only to be used after approval from Co-Chairs, Writtens Subcommittee)	<input type="radio"/> 1
G.	Did not attempt	<input type="radio"/> 0
H.	Did handwriting affect marking?	<input type="radio"/> 0

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Modified Essay 2

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You are a community based junior psychiatrist and you have recently assessed Norman, aged 84 years, who lives in an aged residential care facility for people with dementia. Norman suffers from moderately severe Alzheimer's disease.

The staff are concerned that he is verbally aggressive towards staff and other residents, and occasionally he lashes out and hits staff. Some of the untrained staff in the centre feel that Norman is deliberately "playing up" and are annoyed with him.

When you examine Norman he is calm but severely cognitively impaired. He has no major apparent physical problems. Recent routine laboratory investigations including mid-stream urine culture are unremarkable. Norman is on no medication. The staff are giving him lorazepam 0.5mg daily on an as required (PRN) basis for his verbal aggression but it has not been effective. You plan to review him in two weeks.

Question 2.1

Describe (list and explain) the information you would ask the residential care staff to collect regarding Norman's difficult behaviour. (10 marks)

A.	BEHAVIOUR CHART – incorporating: i. FEATURES OF HIS GENERAL BEHAVIOUR How he behaves with any family and friends, daily activity and routine, sleep pattern, appetite, confusion, different response to different staff normally, etc. ii. ANTECEDENTS TO AGGRESSIVE BEHAVIOUR What is usually happening prior to outbursts, obvious triggers, ways of avoiding or diverting. iii. DESCRIPTION OF ACTUAL DIFFICULT BEHAVIOURS Frequency, time of day, what actually happens, how long episode last, particular staff or residents who get targeted. iv. CONSEQUENCES OF BEHAVIOUR What staff do in response to outbursts, consistency of response, PRN medications given, effectiveness of interventions.	0 1 2 3 4 5 6 7 8
B.	PAIN Assessment of current experience of pain; twice a day.	0 1
C.	MOOD CHART Assess anxiety, depression, and fluctuations during the day.	0 1
D.	COLLATERAL INFORMATION/HISTORY FROM STAFF, FAMILY Pre morbid personality, hobbies, habits, routines, interest, history of violence; history of alcohol or drug use. Repeat urine analysis.	0 1 2 3
E.	Spare (only to be used after approval from Co-Chairs, Writtens Subcommittee)	1
F.	Did not attempt	0
G.	Did handwriting affect marking?	0

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When you return to the centre two weeks later, you find that the staff have not collected any information for you.

Question 2.2

Describe (list and explain) the barriers to care staff collecting such information.
(7 marks)

A.	STAFF BELIEFS <ul style="list-style-type: none"> • Lack of knowledge about dementia. • Dislike of the patient. • Cultural beliefs about care of the elderly, role of family. 	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
B.	STAFFING ORGANISATION <ul style="list-style-type: none"> • Shift work and continuity of care poor. • Lack of care plans or documentation. • Staff too busy/workload too heavy. • Clinical leadership. • Lack of supervision and support. 	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
C.	ENGAGEMENT WITH PROCESS <ul style="list-style-type: none"> • Primary care workers often unskilled and poorly paid, increased workload, feel disempowered. • Cannot see point of process. • Feel blamed for any difficulties. • May not speak English. • Instructions not clear. • Suspicious of the psychiatrist. 	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
D.	FAMILY ISSUES <ul style="list-style-type: none"> • Lack of interest from family. • Obstruction. 	<input type="radio"/> 0 <input type="radio"/> 1
E.	Spare (only to be used after approval from Co-Chairs, Writtens Subcommittee)	<input type="radio"/> 1
F.	Did not attempt	<input type="radio"/>
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When you return to the centre two weeks later, you find that the staff have not collected any information for you.

The management of the care facility asks for a case discussion for the staff on modifying this patient's behaviour.

Question 2.3

Describe (list and explain) how you would use the case discussion to increase staff engagement in the management of this patient's behavior.

(10 marks)

A.	APPROACH/ATTITUDE Respectful and open. Acknowledge staff challenges. Develop collaborative approach.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
B.	SHARED FORMULATION OF THE PROBLEM Development of an explicit common understanding within the team of the patient's situation. Importance of hand over and communication between the shifts and staff. eg Biopsychosocial model, spiritual, cultural issues.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
C.	BENEFITS OF BETTER BEHAVIOUR MANAGEMENT Less tension, job satisfaction. Benefits other patients. Increase staff and patient safety.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
D.	EMPOWERMENT OF STAFF Opportunities for staff, building confidence, skills and resources. Benefits for other patients.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
E.	INFORMATION ABOUT DEMENTIA Nature of dementia and BPSD, role of medication, use of behavioural chart.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
F.	Spare (only to be used after approval from Co-Chairs, Writtens Subcommittee)	<input type="radio"/> 1
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Duncan, a 30-year-old male, works as an accountant with an international accounting firm. He is well regarded by his colleagues and is expected to become a partner of the firm.

You are a junior psychiatrist in the outpatient clinic of the hospital where Duncan attended following a paracetamol overdose one week ago. He made a full medical recovery.

The overdose occurred after Duncan's wife, Maxine, discovered him looking at adult pornographic images on the internet. Duncan and Maxine have been married for six years and have two children aged five years and three years. Maxine is 30 years old and she no longer works outside of the home.

Duncan is active in local community events and is involved in a program to help disadvantaged teenagers.

Duncan attends for a follow up appointment at the insistence of his wife, who is concerned about his viewing of pornography.

Question 3.1

Outline (list and justify) the possible explanations for Duncan's viewing of pornography. (8 marks)

A.	Sexual dysfunction eg disturbance of libido, sexual orientation, sexual fantasies.	<input type="radio"/> 0 <input type="radio"/> 1
B.	Drug and alcohol misuse eg disinhibition due to intoxication.	<input type="radio"/> 0 <input type="radio"/> 1
C.	Response to stress in his life eg financial, work pressures, marital issues.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
D.	Marital dysfunction – eg substitute for lack of intimacy.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
E.	Non pathological behaviour - participating in viewing adult pornography is not illegal.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
F.	Compulsive Behaviour/Impulse Control problem - concealing more deviant underlying sexual fantasies.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
G.	Spare (only to be used after approval from Co-Chairs, Writtens Subcommittee)	<input type="radio"/> 1
H.	Did not attempt	<input type="radio"/>
I.	Did handwriting affect marking?	<input type="radio"/>

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Note to NDS: Please set the maximum mark to 8.

Marker ID

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Modified Essay Questions

SCORING KEY

AUGUST 2017

INSTRUCTIONS: 

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Modified Essay 3

The information that is presented in italics in this question is a repetition of the earlier sections of the case vignette.

Duncan, a 30-year-old male, works as an accountant with an international accounting firm. He is well regarded by his colleagues and is expected to become a partner of the firm.

You are a junior psychiatrist in the outpatient clinic of the hospital where Duncan attended following a paracetamol overdose one week ago. He made a full medical recovery.

The overdose occurred after Duncan's wife, Maxine, discovered him looking at adult pornographic images on the internet. Duncan and Maxine have been married for six years and have two children aged five years and three years. Maxine is 30 years old and she no longer works outside of the home.

Duncan is active in local community events and is involved in a program to help disadvantaged teenagers.

Duncan attends for a follow up appointment at the insistence of his wife, who is concerned about his viewing of pornography.

Duncan and Maxine request couples' therapy because of marital disharmony and a mismatch in sexual interest.

Question 3.2

Describe (list and explain) the issues to be explored in couples' therapy with Duncan and Maxine. (9 marks)

A.	Marriage - Goals and expectations for the marriage eg future of the marriage.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
B.	Intimacy - Emotional intimacy eg confiding relationship, trust, shared responsibilities.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
C.	Sex - Sexual expectations eg differing views about timing and nature of sexual relationship.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
D.	Communication style - Mismatch, depth, expectations, listening skills.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
E.	Core Values - individual and shared eg social, religious, financial, child rearing, protection of children from accidental exposure to pornography.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
F.	Spare (only to be used after approval from Co-Chairs, Writtens Subcommittee)	<input type="radio"/> 1
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Modified Essay 3

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You are a junior psychiatrist in the outpatient clinic of the hospital where Duncan attended following a paracetamol overdose one week ago. He made a full medical recovery.

The overdose occurred after Duncan's wife, Maxine, discovered him looking at adult pornographic images on the internet. Duncan and Maxine have been married for six years and have two children aged five years and three years. Maxine is 30 years old and she no longer works outside of the home.

Duncan is active in local community events and is involved in a program to help disadvantaged teenagers.

Duncan attends for a follow up appointment at the insistence of his wife, who is concerned about his viewing of pornography.

Duncan and Maxine request couples' therapy because of marital disharmony and a mismatch in sexual interest.

Duncan denies any paedophilic sexual attraction and is adamant that he has a heterosexual orientation. He says that he finds the images sexually arousing and distracting from his day to day life. He is spending increasing amounts of time searching for and looking at these images.

Question 3.3

Describe (list and explain) the possible barriers to engaging with Duncan. (7 marks)

A.	CONFIDENTIALITY ISSUES Concerns about confidentiality eg work, wife, community work; Potential legal implications, potential loss of relationship, or loss of employment etc.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
B.	THERAPEUTIC ALLIANCE Transference issues with you; Countertransference issues. Therapist's bias/cross cultural issues and gender issues.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
C.	PRAGMATIC ISSUES Access barriers eg time and geographical availability, cost.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
D.	PERSONALITY/SOCIOCULTURAL ISSUES Related to the underlying cause for the behaviour. Lack of motivation to change. Ambivalence, denial, narcissism. He may not see his behaviour as a problem.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
E.	Spare (only to be used after approval from Co-Chairs, Writtens Subcommittee)	<input type="radio"/> 1
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The overdose occurred after Duncan's wife, Maxine, discovered him looking at adult pornographic images on the internet. Duncan and Maxine have been married for six years and have two children aged five years and three years. Maxine is 30 years old and she no longer works outside of the home.

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Duncan and Maxine request couples' therapy because of marital disharmony and a mismatch in sexual interest.

Duncan denies any paedophilic sexual attraction and is adamant that he has a heterosexual orientation. He says that he finds the images sexually arousing and distracting from his day to day life. He is spending increasing amounts of time searching for and looking at these images.

During the third session, Duncan reveals that he is facing disciplinary action at work for viewing pornography on work computers. He is requesting a report to his employer.

Question 3.4

Describe (list and explain) your approach to this request. (7 marks)

A.	PROCESS ISSUES Clarify who requests the report. Clarify the reasons for the report. Clarify Duncan's expectations from the report.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
B.	THERAPEUTIC RELATIONSHIP ISSUES Consider the implications of providing the report for ongoing therapy. Define your role with Duncan as treating vs independent doctor. Implications of releasing confidential information; information to the employer.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
C.	THERAPIST RELATED ISSUES Supervision from peer. Consider countertransference issues.	<input type="radio"/> 0 <input type="radio"/> 1
D.	ETHICAL ISSUES Confidentiality, discussing your boundaries if the employer or wife contacts you. Resource use, significant time to write report/secretarial support. Role conflict, patient advocacy vs responsible care.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
E.	Spare (only to be used after approval from Co-Chairs, Writtens Subcommittee)	<input type="radio"/> 1
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Modified Essay 4

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You are the on call psychiatrist within the Emergency Department and are contacted by the psychiatry registrar about Mr Morris. He is an 80-year-old widower, who has been medically cleared after a serious suicide attempt by hanging. Mr Morris believes that his suicide attempt was rational.

He has no past history of suicidal behaviours or psychiatric illness and has been physically well. Mr Morris is disappointed that his suicide attempt did not work. He still believes that he should end his life. No collateral information is available.

The psychiatry registrar seeks your advice on an involuntary admission to keep him safe.

Question 4.1

Describe (list and explain) the issues relevant when responding to the registrar's request. (7 marks)

A.	Content and clinical reasoning – Formulation: includes patient's reasons for believing suicide is rational and registrar's assessment of the basis for this, rationale for admission (what would be accomplished by it, is it for assessment, what is the proposed treatment plan); assessment of cognitive capacity.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
B.	Adequacy and reliability of assessment – adequacy of registrar's assessment, limited amount of information reduces confidence in risk assessment. High probability of mental illness given serious suicide attempt. Other factors eg anxiety about institutional responses.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
C.	Medico-legal – role of compulsory treatment, boundaries of treatment, need for adequate information to meet medico-legal oversight. Alternative treatments, less restrictive alternatives.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
D.	Spare (only to be used after approval from Co-Chairs, Writtens Subcommittee)	<input type="radio"/> 1
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He has no past history of suicidal behaviours or psychiatric illness and has been physically well. Mr Morris is disappointed that his suicide attempt did not work. He still believes that he should end his life. No collateral information is available.

The psychiatry registrar seeks your advice on an involuntary admission to keep him safe.

Mr Morris has been admitted involuntarily to your in-patient team. His only son returns from overseas a few days later. The team is of the view that Mr Morris does not have a mental illness.

Mr Morris states that he has achieved everything in life he wanted and has lived long enough.

His son says his father should remain in hospital because his father will kill himself if he is allowed home.

Question 4.2

Describe (list and explain) how you would manage the situation.

(9 marks)

A.	Family meeting – including Mr Morris and son to facilitate communication. Encourage carers support. Ongoing psychological supports for Mr Morris and son.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
B.	Confirm capacity, mental and physical health status, exclude grief; consider second opinion from colleague.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
C.	Medico-legal - unable to detain in absence of mental disorder, risks of illegal detention, legal advice, contact medical defence and hospital governance. Inform patient and son of their rights.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
D.	Documentation - decisions made and justification.	<input type="radio"/> 0 <input type="radio"/> 1
E.	Professional support for all staff.	<input type="radio"/> 0 <input type="radio"/> 1
F.	Spare (only to be used after approval from Co-Chairs, Writtens Subcommittee)	<input type="radio"/> 1
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The psychiatry registrar seeks your advice on an involuntary admission to keep him safe.

Mr Morris has been admitted involuntarily to your in-patient team. His only son returns from overseas a few days later. The team is of the view that Mr Morris does not have a mental illness.

Mr Morris states that he has achieved everything in life he wanted and has lived long enough.

His son says his father should remain in hospital because his father will kill himself if he is allowed home.

Mr Morris is released from involuntary care and discharged home to follow-up from community team. However, he completes suicide within a week after discharge from hospital.

In reviewing Mr Morris's case, you realize that your registrar did not notify the out-patient team of Mr Morris' discharge as planned and the out-patient team were unaware of his discharge.

Question 4.3

Describe (list and explain) the relevant issues raised by this situation. (8 marks)

A.	Son's grief and quite possibly anger and blaming – recognizing & acknowledging the son's reactions, face-to-face meeting, open disclosure, and apology, debrief and offer of assistance to access ongoing support.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
B.	Registrar welfare - welfare issues, undue self-blame, anxiety around consequences, performance issues. Informing medical defence organisation.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
C.	Self - recognizing many roles, self-care. Medicolegal repercussions.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
D.	System response to critical incident – no fault review process of the incident like Root Cause Analysis. Review of processes to prevent system errors.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
E.	Closer follow-up might not have changed outcome.	<input type="radio"/> 0 <input type="radio"/> 1
F.	Spare (only to be used after approval from Co-Chairs, Writtens Subcommittee)	<input type="radio"/> 1
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Modified Essay 5

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Amanda, aged 35 years, has had bipolar disorder since she was 24-years-old. She is married and has two pre-school aged children. Amanda had frequent manic episodes in her late 20s, and had a severe postnatal psychotic depression followed by a period of hypomania after the birth of her daughter, who is now 18 months old.

She is taking Sodium Valproate 1600mg and Olanzapine 20mg daily, and is currently asymptomatic. She says other mood stabilisers have not been effective in preventing relapse of her bipolar disorder in the past.

You are Amanda's usual psychiatrist at the community mental health service outpatient clinic. At a routine appointment Amanda tells you that she has gained over 20 kilograms on her current medication, despite her attempts to diet. She would like to stop her medication as she feels it is making her look fat and disgusting.

Question 5.1

Outline (list and justify) your management of this request. (9 marks)

A.	ASSESSMENT OF HER PSYCHIATRIC HISTORY Review with Amanda and old files her medication history especially relapse signature and risks.	0 1 2
B.	ASSESSMENT OF CURRENT CAPACITY AND COMPETENCY TO MAKE THESE DECISIONS Her understanding of risks of relapse and consequences (capacity).	0 1 2
C.	ASSESSMENT OF WEIGHT GAIN, METABOLIC ISSUES Her weight history to check which drugs were effective in preventing relapse and which were associated with weight gain (query role of Olanzapine vs Valproate). Check current weight and BMI Check that Amanda's current perception of being overweight is valid. Check other medical causes for weight gain, query pregnancy, TFTs, Polycystic ovaries etc. Weight related adverse effects of medication eg diabetes.	0 1 2
D.	MANAGEMENT OF HER WEIGHT Attempt to engage Amanda in planned approach to weight loss looking at a range of strategies that may include changes in medication under close supervision. Information on life style interventions eg exercise, diet.	0 1 2 3
E.	MANAGEMENT OF HER ILLNESS Explore with her possible consequences of abrupt cessation of medication with regard to her mental health, husband and children's well-being. If Amanda insists on stopping medication, attempt to persuade her to reduce the Olanzapine first, offer alternatives, check Valproate level to query reduce dosage. Institute close monitoring by Amanda, her husband, her case manager for early warning signs of relapse. Consider/offer alternative antipsychotics less associated with weight gain. (Note to marker – other relevant management strategies can be considered).	0 1 2 3

F.	Spare (only to be used after approval from Co-Chairs, Writtens Subcommittee)	1
G.	Did not attempt	0

H.	Did handwriting affect marking?	0
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She is taking Sodium Valproate 1600mg and Olanzapine 20mg daily, and is currently asymptomatic. She says other mood stabilisers have not been effective in preventing relapse of her bipolar disorder in the past.

You are Amanda's usual psychiatrist at the community mental health service outpatient clinic. At a routine appointment Amanda tells you that she has gained over 20 kilograms on her current medication, despite her attempts to diet. She would like to stop her medication as she feels it is making her look fat and disgusting.

She manages to lose 6 kg in weight and is pleased with her success. She now informs you that she and her husband want to have the third child that they had always planned.

Amanda asks your advice regarding what to do with her medication when she gets pregnant.

Question 5.2

Discuss (list and debate) your response to this situation.

(8 marks)

A.	<p>INFORMATION GATHERING. Explore option of not having a third child in a non-judgmental way – motivations, pros, cons. Ascertain whether already pregnant as this alters emphasis of discussion. Check that still using contraception. Check what happened with medication in Amanda's previous pregnancies including outcomes for the babies and for Amanda's mental health. Encourage Amanda to bring her husband in to an appointment so that all of the risks and benefits of the various options can be discussed with both of them.</p>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
B.	<p>MANAGEMENT STRATEGIES Importance of instituting plan before getting pregnant, close monitoring of mental state if changing medications to lower risk mood stabilizers. Outline current knowledge of potential risks with Valproate use during pregnancy, especially risks of foetal malformations in first trimester and recommend to cease it during pregnancy. Outline risks to family and to Amanda of severe manic or depressive episode including long term outcome to mother and baby. Possible strategies of switching to anti-psychotic alone for early pregnancy, folate supplementation.</p>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4
C.	<p>Arrange early follow-up discussion time to review decisions and arrange next stage plus or minus referral to antenatal clinic if available. (Don't leave until next routine clinic visit).</p>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2
D.	Spare (only to be used after approval from Co-Chairs, Writtens Subcommittee)	<input type="radio"/> 1
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