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1.0 Descriptive summary of station:

The candidate is required to assess a 58-year-old man, presenting with significant anxiety in the context of a deteriorating, agitated, major depressive episode with somatic delusions. This presentation is on the background of longstanding generalised anxiety disorder. The candidate is then to present a preferred diagnosis with a short-term management plan.

1.1 The main assessment aims are to:

- Assess the interplay between anxiety and agitation, and identify those features as manifestations of a severe major depressive episode with psychotic features.
- Manage the immediate risks arising out of assessment of severe and deteriorating depression with psychotic symptoms.

1.2 The candidate MUST demonstrate the following to achieve the required standard:

- Reassure that help is available.
- Explore at least 2 risks associated with his somatic delusion, e.g., reduced oral intake, medication compliance, reduced urine output.
- Justify a preferred diagnosis of a major depressive episode with psychotic features.
- Recommend one of the following: hospital admission or the benefit of electroconvulsive therapy.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Mood Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Domains:** Communicator, Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – data gathering content; Diagnosis; Management – initial plan), Communicator (Patient communication – to patient)

References:

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- Akiskal, HS., Benazzi, F., Perugi, G., et al. Agitated unipolar depression re-conceptualised as a depressive mixed state: Implications for the antidepressants-suicide controversy. J Affect Disord. 2005; 85: 245-58.
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- Schatzberg, AF., Rothschild, AJ. Psychotic (delusional) major depression: should it be included as a distinct syndrome in DSM-IV? Am. J Psychiatry. 1992; 149: 733-45.
- Swann, AC., Secunda, SK., Katz, MM., et al. Specificity of mixed affective states: clinical comparison of dysphoric mania and agitated depression. J Affect Disord. 1993; 28: 81-89.

1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiners x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: male in his 50s, untidily dressed as if having difficulty dressing neatly.
- Pen for candidate.
- Timer and batteries for examiners.

2.0 Instructions to Candidate

You have **eight (8) minutes** to complete this station after **two (2) minutes** of reading time.

You are working as a junior consultant psychiatrist in an adult community mental health clinic. Mr Patterson has been brought in by his wife for an urgent appointment on the request of his GP.

The GP letter for this patient states:

Dear Doctor,

Thank you for seeing Paul Patterson, a 58-year-old man who has a long history of excessive anxiety. Until recently this was quite well controlled by sertraline 200mg daily. For the past 1-2 months he has become increasingly anxious. I added quetiapine 50mg nocte but his mental condition seems to have deteriorated further. Can you please assess him and manage his condition?

Your opinion will be highly appreciated.

Kind regards

*Dr David Deakins
Riverside Medical Clinic*

Your tasks are to:

- Assess the presenting symptoms **in the patient**.
- Justify your preferred diagnosis and outline your short-term management **to the examiner**.

No physical examination is required.

You will receive a prompt at **six (6) minutes** if you have not commenced the second task.

Station 10 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
 - A copy of 'Instructions to Candidate'.
 - Pens.
 - Water and tissues (available for candidate use).
- Do a final rehearsal with your simulated patient.

During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- TAKE NOTE that there is a scripted prompt for you to give at **six (6)** minutes.
- DO NOT redirect or prompt the candidate unless scripted – the simulated patient has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:
'Your information is in front of you – you are to do the best you can'.
- At **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your mark sheet in an envelope by / under the door for collection (**do not seal envelope**).
- Ensure room is set up again for next candidate. (See 'Prior to examination' above.)

If a candidate elects to finish early:

- You are to state the following:
*'Are you satisfied you have completed the task(s)?
If so, you must remain in the room and NOT proceed to the next station until the bell rings'.*
- If the candidate asks if you think they should finish or have done enough etc., refer them back to their instructions and ask them to decide whether they believe they have completed the task(s).

3.0 Instructions to Examiner

3.1 In this station, your role is to:

Observe the activity undertaken in the station, and judge it according to the station assessment aims and defined tasks as outlined in 1.1 and 1.2.

When the candidate enters the room briefly check ID number.

You have no opening statement.

The role player opens with the following statement:

'I don't know what is happening to me.'

If the candidate has not commenced the second task please provide the following prompt at **six (6) minutes**:

'Please proceed to the final task.'

3.2 Background information for examiners

Detailed Assessment Aims

This station is intended to assess the competency of candidates to diagnose and acutely manage agitated depression with somatic delusions. The candidate is asked to assess a 58-year-old agitated man originally referred by a general practitioner (GP) with history of anxiety and identify that the worsening anxiety is actually part of agitated depression with somatic delusions.

The GP started quetiapine 50 mg daily, but the patient lately refused to take the medications as he is worried about bowel rupture. The depressive syndrome is superimposed on comorbid long-standing generalised anxiety disorder for which the patient has already been taking sertraline 200 mg prescribed by the GP.

In order to 'Achieve' this station the candidate **MUST**:

- Reassure that help is available.
- Explore at least 2 risks associated with his somatic delusion, e.g., reduced oral intake, medication compliance, reduced urine output.
- Justify a preferred diagnosis of a major depressive episode with psychotic features.
- Recommend one of the following: hospital admission or the benefit of electroconvulsive therapy.

Therefore, candidates are to take a history related to anxiety and agitation and identify those features as manifestations of a severe depressive episode with psychotic features – mainly somatic delusions. Identification of concerns of bowel rupture / soap in meals is crucial in this patient as they are associated with food refusal and acute fluid and nutritional depletion. The candidates should identify this as a very serious risk and the basis for immediate management considerations.

Better candidates will very clearly distinguish the emergence of a distinct depressive syndrome against the background of long-term anxiety. The patient in this scenario had a depressive episode approximately 20 years ago following job loss, but it did not present with psychotic features. The candidate may also acknowledge that the patient's added anxiety occurred because depressive symptoms are deteriorating despite adequate dose of antidepressant.

Following this assessment, the candidate is to address the immediate risks for a 58-year-old man who is not drinking or eating adequately in the past few days and make plans to admit the patient. This initial treatment plan is to be outlined by the candidate to the examiner.

Assessment details to consider:

Because of the distressing beliefs of bowel rupture and that the patient's condition is deteriorating with potentially fatal consequences from metabolic derangements and azotaemia, hospitalisation is the most appropriate response in this scenario.

Treatment details to consider:

Candidates are expected to articulate an immediate plan that should cover hospitalisation, need for urgent physical review, options for emergency psychiatric treatment, capacity to consent to treatment, and need or otherwise for compulsory treatment. Liaison with the family, local mental health services and GP is also relevant.

Candidates are not required to outline specific choices of medication management for depressive symptoms but should mention electroconvulsive therapy (ECT) as a frequently preferred option in such circumstances, ECT is likely to be a lifesaving treatment in this instance and typically administered following hospital admission for a severe major depressive episode.

A surpassing candidate may elaborate on the urgency of treatment interventions and other possible specific physical complications, namely azotaemia and metabolic derangements from reduced fluid and food intake. They could identify the need for physical review in light of these possible consequences.

A surpassing candidate will interact in a highly sensitive way to foster the therapeutic alliance and pick up very early that this is likely a psychotic depression. They may address the relevance of the Mental Health Act in a nuanced way and may show experience of the practical difficulties involved in getting this patient to hospital.

Agitated depression is a subtype of depression in which depressed and anxious mood along with inner psychic restlessness dominate the clinical picture (Koukopoulos, et al 2007). Its prevalence in mood disorder community clinics has been estimated as 16.5-26% (Maj, et al 2006; Spitzer, et al 1978). In contrast to typical retardation of activity, agitated depression manifests with increased activity with loss of purpose.

While anxiety in typical depression can be interpreted as an emotional reaction to painful arousal, anxiety in agitated depression appears to be a form of excitation or arousal and inherent in agitation. Agitation is often tormenting to patients. Anhedonia and initial and intermittent insomnia rather than terminal insomnia tend to be marked in agitated depression. Various delusions often accompany this type of presentation.

Delusional depression that develops for the first time after 50 years of age often presents with severe agitation (Akiskal 2017). Agitation signifies a high risk of suicide (Angst, et al 1999). Many patients suffering from agitated depression reported a train of thought called 'crowded' or 'racing thoughts'. It may be difficult to differentiate the clinical presentation of agitated depression from mania and sometimes clinicians consider a diagnosis of Mixed Affective State.

The nosological status of agitated depression is debatable; some authors consider it as part of bipolar mixed state (Schatzberg & Rothschild 1992), and others disagree (Swann, et al 1993) placing it in the affective spectrum (Akiskal, et al 2005). Increased activity in mania is goal directed and triggered by external cues, whereas agitation in depression is internal and purposeless. Unlike in mania agitated depression does not present with pleasurable activities, grandiosity, external distractibility or decreased need for sleep.

Antidepressants particularly Serotonin Specific Reuptake Inhibitors (SSRIs) may make agitated depression worse. The patient in this scenario is taking sertraline 200 mg. It poses enormous challenge to psychiatrists in view of the acuteness of symptoms, severe agitation and serious risks of both deliberate and accidental self-harm (in this case severe fluid and nutritional depletion). Antipsychotics and benzodiazepines are often beneficial in the treatment of agitated depression. Electroconvulsive therapy (ECT) is usually rapidly effective.

DSM-5 criteria for Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful).
Note: In children and adolescents, can be irritable mood.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month) or decrease or increase in appetite nearly every day.
Note: In children, consider failure to make expected weight gain.
4. Insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
 6. Fatigue or loss of energy nearly every day.
 7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
 8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
 9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Note: Criteria A-C represent a major depressive episode.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode.

Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

- D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
- E. There has never been a manic episode or a hypomanic episode.

Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

ICD-10 criteria for a depressive episode

Diagnostic criteria for depression ICD-10 uses an agreed list of ten depressive symptoms.

Key symptoms:

At least one of the following, most days, most of the time for at least 2 weeks:

- persistent sadness or low mood; and / or
- loss of interests or pleasure; and / or
- fatigue or low energy.

If any of above present, ask about associated symptoms:

- disturbed sleep.
- poor concentration or indecisiveness.
- low self-confidence.
- poor or increased appetite.
- suicidal thoughts or acts.
- agitation or slowing of movements.
- guilt or self-blame.

The 10 symptoms then define the degree of depression, and management is based on the particular degree:

- **not depressed** (fewer than four symptoms)
- **mild depression** (four symptoms)
- **moderate depression** (five to six symptoms)
- **severe depression** (seven or more symptoms, with or without psychotic symptoms)

Symptoms should be present for a month or more, and every symptom should be present for most of every day.

3.3 The Standard Required

Surpasses the Standard – the candidate demonstrates competence above the level of a junior consultant psychiatrist in several of the domains described below.

Achieves the Standard – the candidate demonstrates competence expected of a junior consultant psychiatrist. That is the candidate is able to demonstrate, *taking their performance in the examination overall*, that

- i. they have competence as a **medical expert** who can apply psychiatric knowledge including medicolegal expertise, clinical skills and professional attitudes in the care of patients (such attitudes may include an ability to tolerate uncertainty, balance, open-mindedness, curiosity, 'common sense' and a scientific approach).
- ii. they can act as a **communicator** who effectively facilitates the doctor patient relationship.
- iii. they can **collaborate** effectively within a healthcare team to optimise patient care.
- iv. they can act as **managers** in healthcare organisations who contribute to the effectiveness of the healthcare system, organise sustainable practices and make decisions about allocating resources.
- v. they can act as **health advocates** to advance the health and wellbeing of individual patients, communities and populations.
- vi. they can act as **scholars** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.
- vii. they can act as **professionals** who are committed to ethical practice and high personal standards of behaviour.

Below the Standard – the candidate demonstrates significant defects in several of the domains listed above.

Does Not Achieve the Standard – the candidate demonstrates significant defects in most of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

4.0 Instructions to the Role Player

4.1 This is the information you need to memorise for your role:

You are Paul Patterson, a 58-year-old married man living with your wife, Mary, in your own home. You are a carpenter and have worked in this trade for the past 38 years.

Today you are going to be assessed by a psychiatrist at a community mental health clinic. You are very unwell at the moment. Your mood is very low, and you are feeling very agitated and anxious. You are also feeling so tired today, although you have just managed to attend the clinic as your wife is insisting for this consultation.

Recent anxiety symptoms:

While you have suffered from increased feelings of anxiety and body tension for a long time, approximately 35 years, in the past 2-3 weeks, your anxiety has gone sky high. You have noticed that you can't settle. This is associated with a terrible inner sense of '*not being stable*', and not feeling at ease or at peace. Since last weekend, your restlessness has worsened. You are very worried that something bad is happening.

You feel exhausted, but that does not offer any relief for your restlessness or agitation. It is an awful state for someone to have to experience.

Recent mood symptoms:

In the past 1-2 months you have felt down, as you experienced during your previous episode of depression 20 years ago, but not as bad as this. Your mood has been low almost every day. You also find it difficult to concentrate and you move around with inner turmoil. You have lost interest in things you habitually did before these symptoms developed (like walking, meeting friends, camping with your wife, reading).

If asked about these symptoms: Your sleep has been disturbed; taking longer than before to get to sleep. You go to bed by around 9pm but can't go to sleep as you are worrying all the time, '*tossing and turning*', until about midnight. Then you wake several times through the night until you wake up for good by 7am, which is your usual time. You don't feel well rested. You have also noticed that lately you are not hungry. You believe you have lost a bit of weight, but you are unsure how much.

Patients with depression often have negative views of the world and themselves. You have recently started viewing the world as an unsafe place for reasons that you can't explain. You feel like there is a dark hole in front of you; nothing appeals to you. You don't see a future; an experience which is terrifying. You occasionally get thoughts of '*what is the point of life, not just mine, everyone's life*', but you have never thought of actually committing suicide.

Other recent symptoms:

You have terrible feeling that your intestines (bowel) are bursting / rupturing inside, and your other organs are degenerating / disintegrating. You believe this has led to bad gas being released from your gut. You are worried and ashamed that the bad gas is emitting from your intestine because it is rupturing, and it is making other people sick. You feel really bad about this, and this is actually your worst worry at the moment.

You decided to stop eating four days ago and have been only drinking a small amount of orange juice, altogether approximately a small cup in a day (200ml). You don't feel the need for food anyway. In the last one week, you have felt there has been something unusual in your meals which you cannot explain. You wonder if it may be soap in your meals, and you think this could be the reason why your bowel is rupturing. You do not have concerns that anyone is trying to poison you but are unsure why the food tastes strange.

If specifically asked, your urine output is much less than what was usual for you, and it seems to be concentrated (dark in colour), but your urine does not have any strange smell.

Recent medications:

You feel as if the above symptoms are getting worse day by day. Your wife is particularly worried that your mood continues to drop even though you have been on a high dose of antidepressant medication (called sertraline) for the last 20 years. You don't see the point of continuing medication because you believe your bowel is rupturing. What is worse, you have no clue what brought on these symptoms or changes. They appear to have come from nowhere as you have not noticed any recent stressors, or changes in your life like any losses, and this is perplexing.

As your symptoms have been worsening your general practitioner (GP) started another medication called quetiapine 50 mg at night, two weeks ago, but you don't feel that it helped.

Your mental health history:

Approximately 20 years ago a GP started sertraline for your anxiety, and the dose was gradually increased to 200 milligrams in the morning. If asked about the history of your symptoms, your response can initially be vague as it started a long time ago; but your anxiety started in your 20s. You worry too much about many things for no clear reasons. For example, you worry whether you might have accidents when you travel; whether you will be ridiculed by others in social settings; whether you will get an infectious disease; and whether robbers will break in to your house with weapons. You know that these are unreasonable worries, and the probability of them occurring are remote. Despite this you are still worried, and sometimes you feel tense and unable to relax. It is of course, an unpleasant experience. Long ago you have learned to live with this, and the sertraline really did help for a long time. You know that your condition is called Generalised Anxiety Disorder.

You do not experience panic attacks: which are described as sudden onset intense brief anxiety spells which often have physical symptoms like shortness of breath and rapid heartbeat. You never had recurrent, intrusive distressing thoughts, other than described above, or any need to have to complete repetitive behaviours, like cleaning things excessively or checking things over and over (these are symptoms of a disorder known as Obsessive Compulsive Disorder, which you do not have). You are usually an emotionally stable person.

Except for taste of soap in your meals, you do not have any strange perceptions (e.g. hearing voices without seeing people or seeing things, which others cannot see). You did not experience any unusual smells (taste of soap in meals is something new). You do not have any paranoia or unusual / strange beliefs other than your belief that your bowel is rupturing.

You do not blame yourself for your situation, but do feel guilty about possibly making others sick from the bad gas emitting from your intestine. You do not have any other unusual beliefs, for instance, the world is going to end.

You never experienced periods of mania (mood state opposite to depression) which often involves excessive happiness, increased energy levels, thoughts of having special powers, big unrealistic plans or strange behaviour (for e.g. increased unnecessary spending) or no need for sleep.

You do not drink alcohol or use any other intoxicating or recreational substances / drugs. You do not smoke cigarettes.

There has been no problem with your memory, although you are currently feeling a bit dull.

Your general health:

You have regular health checks with your GP, Dr David Deakins. Your physical health is unremarkable.

About your personal life:

You have taken time off from work for the past one month. If asked about any of these: you haven't had problems driving; you have never got into any physical fights or violence; you have no legal charges against you. You have been living with Mary for the past 26 years. It is mutually supportive and stable relation. You have no children.

Over the last few weeks you have been unable to go to work due to these distressing symptoms.

There is no history of mental illness in your family.

4.2 How to play the role:

Overall you appear distressed, mostly restless in your seat and occasionally turning, or getting up and walking around, but easily redirected by the candidate. If the candidate asks you about your anxiety symptoms, then go on to describe your symptoms of anxiety but do not volunteer mood symptoms. When the candidate asks you for mood symptoms then you freely volunteer them as scripted above under 'Recent mood symptoms'. You answer all questions by the candidate as best as you know.

Although your bowel concerns, and your belief that they are rupturing, are very important, DO NOT volunteer information of changes in your bowel, urine or eating pattern unless asked.

4.3 Opening statement:

'I don't know what is happening to me.'

4.4 What to expect from the candidate:

The candidate needs to learn about your symptoms so that they can establish a diagnosis to guide treatment. To do this, they may ask about a range of symptoms, and the details of what medications you have been taking.

They should also ask you about your mental wellbeing like thoughts of suicide. The candidate may also ask you about your personal life like your relationships, and work history (answer as per previous page). If the candidate asks you about your early life, personal history or any other information then you may say *'that was all fine'*.

4.5 Responses you MUST make:

'I can't rest; I am rotten.'

Within first two (2) minutes *'There just seems to be no hope at all.'*

"It's not safe for me to eat anything."

4.6 Responses you MIGHT make:

If the candidate asks you what makes you worried or anxious or is there anything else troubling you then Scripted Response: *'I think my bowel is rupturing.'*

If the candidate asks about your wife you may say:

Scripted Response: *'I don't want to worry her with this.'*

4.7 Medication and dosage that you need to remember:

- Sertraline (SIR-TRA-LEEN) 200 milligram (2 tablets) in the morning
- Quetiapine (KWE-TI-APEEN) 50 milligrams at night.

STATION 10 – MARKING DOMAINS

The main assessment aims are to

- Assess the interplay between anxiety and agitation, and identify those features as manifestations of a severe major depressive episode with psychotic features.
- Manage the immediate risks arising out of assessment of severe and deteriorating depression with psychotic symptoms.

Level of Observed Competence:

2.0 COMMUNICATOR

2.1 Did the candidate demonstrate an appropriate professional approach to gathering information from the patient? (Proportionate value – 20%)

Surpasses the Standard (scores 5) if:

able to generate a complete and sophisticated understanding of complexity; rapidly tailors interactions to establish and maintain rapport; recognises patient's views of possible admission; genuinely acknowledges patient's dilemma of experiencing deterioration despite antidepressant and anti-anxiety treatment.

Achieves the Standard by:

demonstrating empathy and ability to establish rapport; acknowledging the patient's anxiety and agitation; listening to patient's concerns and forming a partnership using language and explanations tailored to the patient's capacity; effectively using open ended questions rather than leading questions; validating the patient's experiences; acknowledging the impact of anxiety and depression on concentration and rational thinking; encouraging a conversation related to capacity to consent.

To achieve the standard (**scores 3**) the candidate **MUST**:

- Reassure that help is available.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

Below the Standard (scores 2 or 1):

scores 2 if the candidate does not meet (a) above or has omissions that would detract from the overall quality response; significant omissions affecting quality scores 1.

Does Not Achieve the Standard (scores 0) if:

errors or omissions materially adversely impact on alliance and information gathered; inadequately reflects on relevant information obtained; unable to maintain rapport; disengages the patient by premature conclusions.

2.1 Category: PATIENT COMMUNICATION – To Patient	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

1.0 MEDICAL EXPERT

1.2 Did candidate take appropriately detailed and focussed history? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:

clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication in assessing physical and psychological symptoms.

Achieves the Standard by:

demonstrated use of tailored biopsychosocial approach; prioritising a history relevant to the patient's problems and circumstances; exploring the range of symptoms required to make a diagnosis; conducting a focussed assessment to establish a diagnosis of major depressive episode; eliciting key issues including agitation; assessing for typical and atypical features; completing a risk assessment relevant to the individual case.

To achieve the standard (**scores 3**) the candidate **MUST**:

- Explore at least 2 risks associated with his somatic delusion, e.g., reduced oral intake, medication compliance, reduced urine output.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

Below the Standard (scores 2 or 1):

scores 2 if the candidate does not meet (a) above or has omissions that would detract from the overall quality response; significant omissions affecting quality scores 1 (e.g. does not exclude manic symptoms).

Does Not Achieve the Standard (scores 0) if:

omissions adversely impact on obtained content; significant deficiencies in exploring depressive and psychotic symptoms; does not rule out risk of suicide; does not specifically enquire the risk of medical complications from reduced food and fluid intake.

1.2 Category: ASSESSMENT – Data Gathering Content	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

1.0 MEDICAL EXPERT

1.9 Did the candidate formulate and describe relevant diagnosis? (Proportionate value – 20%)

Surpasses the Standard (scores 5) if:

explicitly identifies recent emergence of a new syndrome against the background of long-term anxiety; includes differential diagnoses like organic mood disorder or akathisia; provides accurate detail of potential physical complications of nutritional depletion (azotemia, metabolic derangements).

Achieves the Standard by:

demonstrating capacity to integrate available information in order to formulate a diagnosis; demonstrating detailed understanding of diagnostic systems to justify a diagnosis; identifying agitation and delusions as part of a major depressive disorder; indicating severity of depression; acknowledging lack of a clear precipitating factor and overt predisposing factors; considering high risk of suicide in the context of agitation; offering a differential diagnosis of akathisia or mixed affective state.

To achieve the standard (score of 3) the candidate **MUST:**

a. Justify a preferred diagnosis of a major depressive episode with psychotic features.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

Below the Standard (scores 2 or 1):

scores 2 if the candidate does not meet (a) above or has omissions that would detract from the overall quality response; significant omissions affecting quality scores 1.

Does Not Achieve the Standard (scores 0) if:

inaccurate or inadequate diagnostic formulation; diagnosis is not supported by presenting symptoms elicited; errors or omissions are significant and adversely affect conclusions.

1.9 Category: DIAGNOSIS	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

1.13 Did the candidate formulate and describe a relevant initial management plan? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:

provides a sophisticated link between the plan and key issues identified; addresses difficulties in the application of the plan; clearly balances compulsory care with capacity to consent; identifies barriers in implementing care including resistance to admission, stigma of ECT, medical clearance.

Achieves the Standard by:

demonstrating the ability to prioritise and implement evidence-based acute care; planning for risk management; considering the patient's capacity to consent in the context of severe agitation and delusional beliefs; considering alternative medication options; outlining physical and psychiatric treatment needs; communicating with local mental health service and GP; incorporating the wife in the treatment planning; having realistic time frames for plan review.

To achieve the standard (scores 3) the candidate **MUST:**

a. Recommend one of the following: hospital admission or the benefit of electroconvulsive therapy.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered; if the candidate includes most or all correct elements.

Below the Standard (scores 2 or 1):

scores 2 if the candidate does not meet (a) above or has omissions that would detract from the overall quality response; significant omissions affecting quality scores 1.

Does Not Achieve the Standard (scores 0) if:

errors or omissions will impact adversely on patient care; plan lacks structure or is inaccurate; plan is not tailored to patient's immediate needs or circumstances.

1.13. Category: MANAGEMENT - Initial Plan	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

GLOBAL PROFICIENCY RATING

Did the candidate demonstrate adequate overall knowledge and performance at the defined tasks?

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail
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