The Royal Australian & New Zealand College of Psychiatrists

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THE MEQ EXAMINATION

Dr Song Chan
Chair,
Writtens Subcommittee

A/Prof Kane Vellar
Chair
Committee for Examinations

ACKNOWLEDGEMENT

The Royal Australian & New Zealand College of Psychiatrists

We acknowledge Aboriginal and Torres Strait Islander Peoples as the First Nations and the traditional custodians of the lands and waters now known as Australia, and Māori as tangata whenua in Aotearoa, also known as New Zealand.

We recognise and value the traditional knowledge held by Aboriginal and Torres Strait Islander Peoples and Māori. We honour and respect the Elders past and present, who weave their wisdom into all realms of life— spiritual, cultural, social, emotional, and physical.

ACKNOWLEDGEMENT

The Royal Australian & New Zealand College of Psychiatrists

We recognise those with lived and living experience of a mental health condition, including community members and College members. We affirm their ongoing contribution to the improvement of mental healthcare for all people.

OVERVIEW

The Royal Australian & New Zealand College of Psychiatrists

- Examinations Committee
- The MEQ
- Question Generation
- Standard setting & results analyses
- Tips & Strategies, Preparation
- Small-group work – how to approach questions?
- Q&A session

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ORGANISATIONAL STRUCTURE

ASSESSMENTS ORG STRUCTURE

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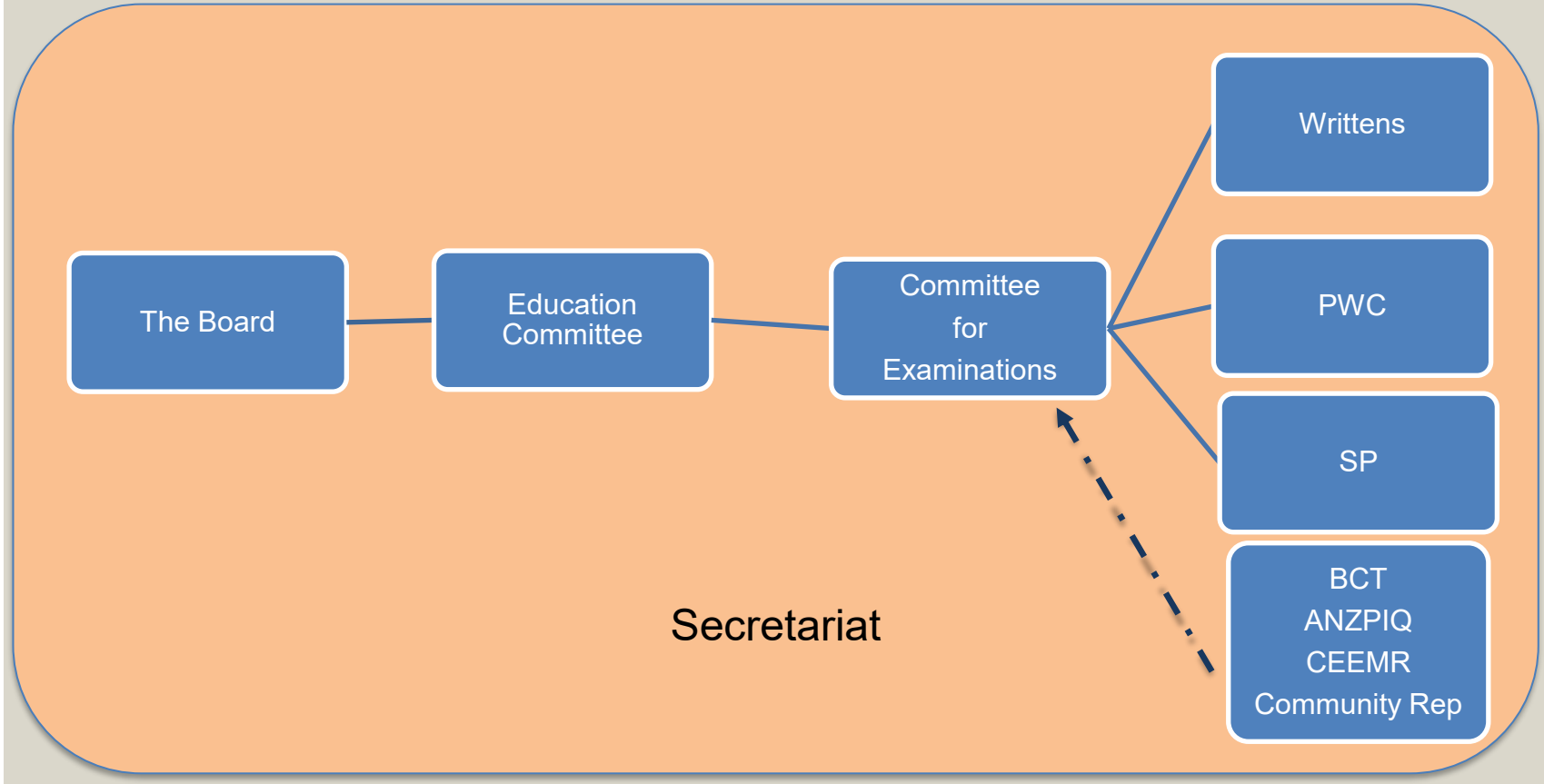

MEMBERSHIP OF THE CFE* & WRITTENS SUBCOMMITTEE

The Royal Australian & New Zealand College of Psychiatrists

- Chair, Deputy Chair, & Co-chairs of the Subcommittees.
- Nominations of Fellows by Fellows
- To be Subcommittee member, Fellows must have three years post nominals.
- 3-year terms (max of 2).
- Volunteers

* CFE: Committee For Examinations

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THE MEQ

THE MEQ

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"The MEQ will have a clinical focus and will assess capacity for critical thinking about clinical practice and the application of clinical knowledge, as well as the capacity for critical thinking about issues relevant to the practice of psychiatry including sociocultural, models of illness, ethical and complex service issues."

www.ranczp.org

MEQ VS MCQ VS I-OCA

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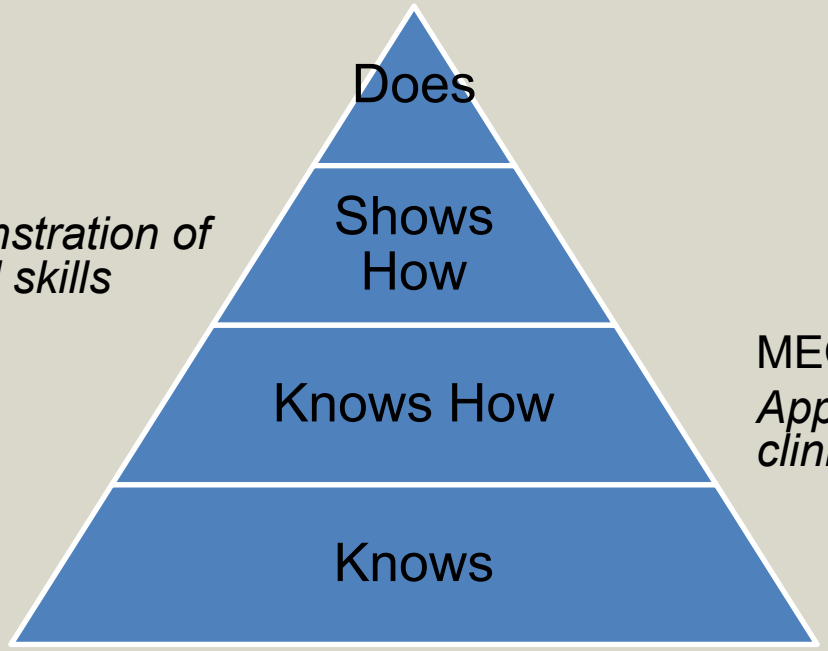
I-OCA
Demonstration of clinical skills



MEQ Examination
Application of clinical knowledge

MCQ Examination
- Factual Recall

PURPOSE OF THE MEQ

The Royal Australian & New Zealand College of Psychiatrists

- Paper-based examination assesses knowledge application.
- 125 marks in 150 marks (September 2026) then 150 marks in 150 minutes (February 2027)*
- A series of vignettes of situations psychiatrists will face in their day-to-day practice.
- Capacity for critical thinking including sociocultural, models of illness, ethical, and complex service issues.

*The change in total marks will not increase the total number of MEQ questions, but rather adjusting for the online marking system which is unable to handle ‘extra’ marks within a question

PURPOSE OF THE MEQ

The Royal Australian & New Zealand College of Psychiatrists

- Assessment of clinical competence and problem solving.
- Understanding and describing the management of complex but common psychiatric situations.
- Capacity to think broadly and include biopsychosocial aspects in assessment and treatment planning.
- Requires some clinical maturity.

PUT IN ANOTHER WAY – THE MEQ EXPLORES….

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- Clinical assessment,
- Management & treatment,
- Staff & professionalism issues,
- Ethics, &
- Some of the areas previously examined in consultancy vivas.

- Start with an area of clinical practice that is relevant to trainees at *this stage of training and is included in the curriculum.

**Trainees must have completed Stage 1 and minimum of 6 months in Stage 2 (18 months+ of training) to undertake the MEQs and the CEQs.*

IN SHORT

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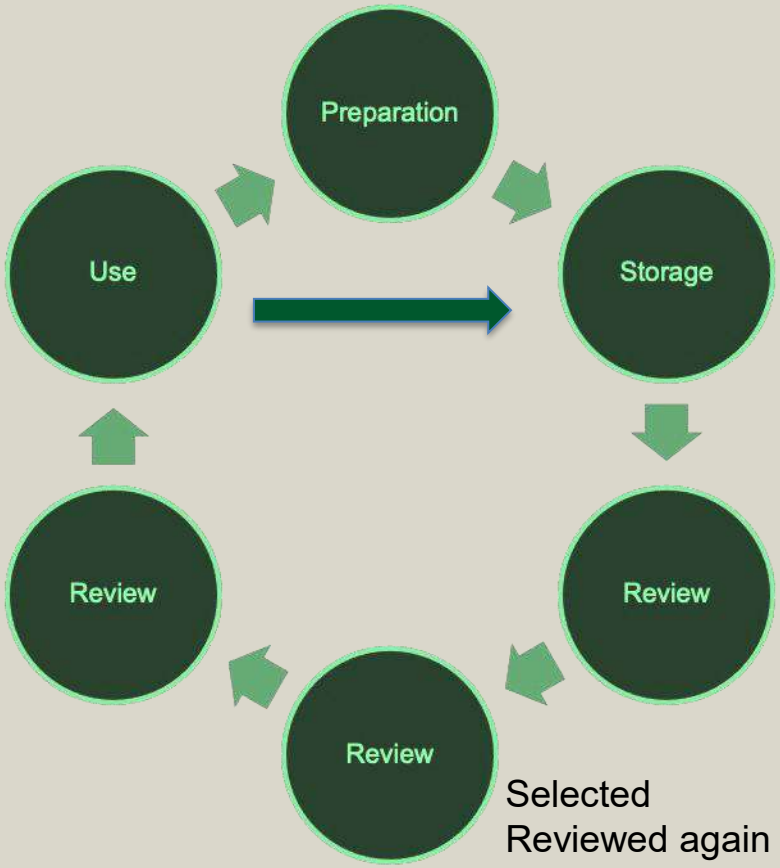
QUESTION SETTING & VETTING

THE LIFECYCLE OF THE MEQ

The Royal Australian & New Zealand College of Psychiatrists

Performance review
Analyses:
- Quantative & qualitative
- Placement in the paper
- Judgement about the quality of the question
- Feedback from markers

Published or stored



Inspiration
Dreams
Researched
Drafted

Content vetting
Checking
Blueprinting
Storage

Selected
Reviewed again
Edited
Standard setting

WHO ARE THE QUESTION WRITERS AND MARKERS?

The Royal Australian & New Zealand College of Psychiatrists

- RANZCP Fellows
- Binational representation
- Passionate about training and teaching in psychiatry
- Question Writing Workshop (annually in October)
- Vetting, a continual process
- To be a marker, Fellows are to have two years post nominals

QUESTION GENERATION & VETTING PROCESS

The Royal Australian & New Zealand College of Psychiatrists

- A range of sources, most commonly from real-life experiences of Fellows in the workplace, from journal articles / guidelines / peer review.
- All are relevant to the practice of psychiatry
- Strong face validity,
  - situations likely to be seen as a trainee or a consultant.
- Syllabus / blueprinting matched
- Repeat reviews

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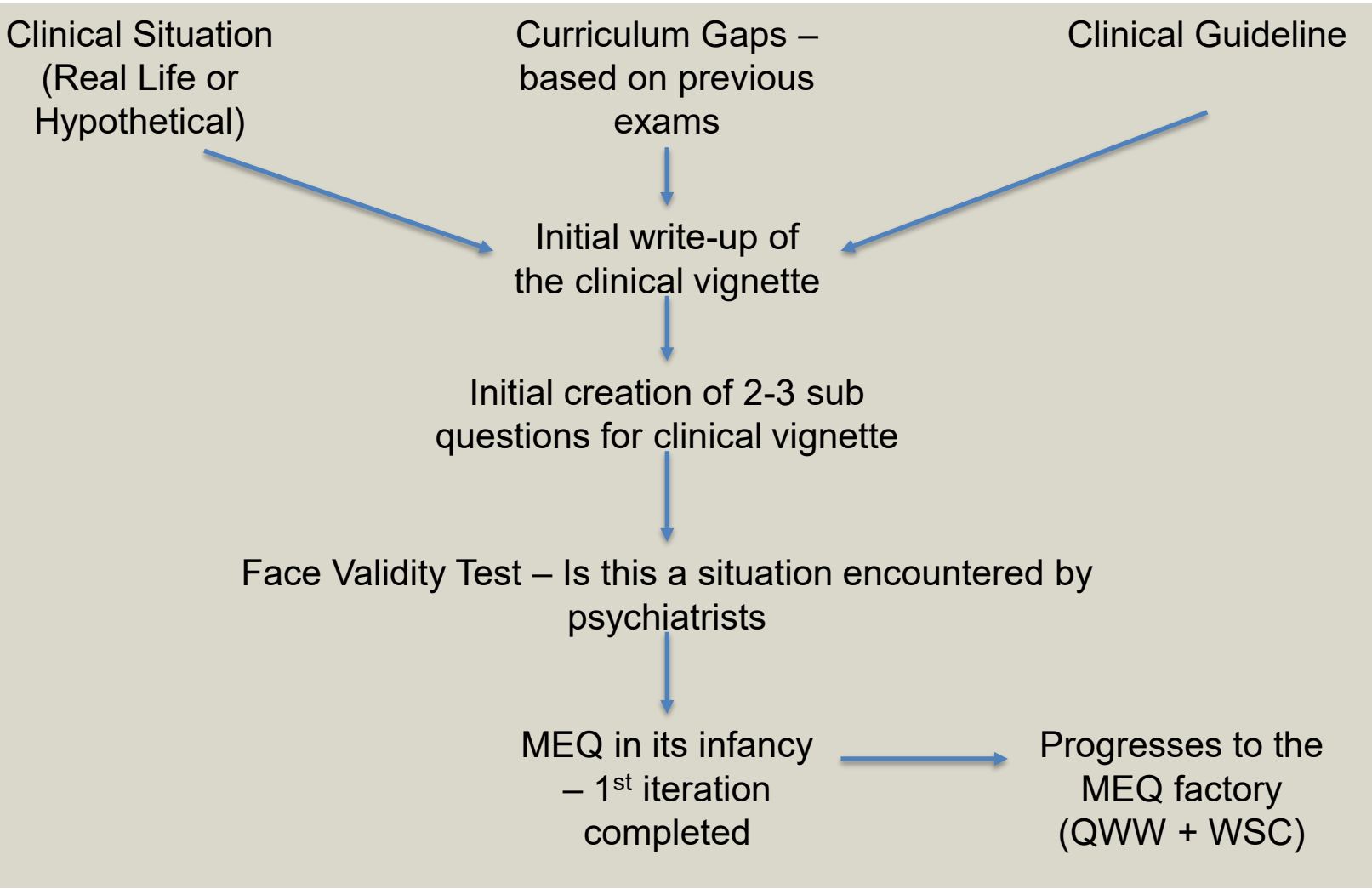

CURRICULUM CONSIDERATIONS – WHAT IS COVERED IN THE MEQ EXAMINATION

The Royal Australian & New Zealand College of Psychiatrists

Advocacy	Leadership, Governance and relevant legal frameworks	Specific Areas of Practice (e.g. C&A, POA, C-L)
Assessment	Phenomenology	Specific Disorders
Basic Sciences & Medical Knowledge	Professional Communication & Liaison	Treatments in Psychiatry
Epidemiology, Diagnosis & Classification , Public Health	Psychology, Philosophy and Psychodynamic Principles	
Ethic/Professionalism	Scholarship	
History of Psychiatry	Sociocultural Awareness	

All questions in the MEQ fall under 1 or more of the above curriculum areas

THE ANATOMY OF AN MEQ

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There are five parts to the Modified Essay Question:

1. Theme
2. Main vignette
3. A series of between 2 to 4 questions
4. Additional vignettes may precede subsequent questions.
5. Marking Guide

THE MEQ

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- **List …**

Means you want a list without anything extra, the list doesn't have to be explained or justified.

- **Outline (list and justify) …**

Means a list with something extra that indicates a reason for its inclusion.

- **Describe (list and explain) …**

Provides more detail than Outline and might resemble the Short Answer format of past written exams, i.e. some elaboration for the answer's inclusion.

- **Discuss (list and debate) …**

Means a substantial answer, covering a number of points with some analysis about its inclusion in the answer.

EXPLANATION VS JUSTIFICATION

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Explanation

- Understanding HOW something has happened, or WHY it occurred.
- Focus is on the what and how.
- Primarily informative.

Justification

- Providing a reason something should be done or believed, or to defend a particular stance.
- Focus is on why something is right, valid, or acceptable.
- Primarily persuasive or argumentative.

THE MEQ

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- Expected answers in a rubric are divided into 'domains' and each domain of knowledge could be worth any number of marks - candidates can score any number of marks within that range depending on depth and breadth of cover.

Domains

A.	**RECENT HISTORY** • Precipitant for current presentation. • Issues around primary or secondary gain: is he genuinely worried, suicidal or is he trying to avoid court and consequences. • Explore possible symptoms of current mental illness: depression; mania. • Current functioning, coping style/personality. • History of substance use and current intoxication. • Some details re charge.	⓪ ① ② ③ ④ ⑤ ⑥ ⑦
B.	**RISK ASSESSMENT** • TO SELF - plan, intent, imminent, past history, means. • OTHERS - threats to victim, others, intent, plan, past history. • REPUTATION - possible impact of alleged offence (suspended from work; family and friends' reactions; publicity; content about him on social media).	⓪ ① ② ③
C.	**MENTAL STATE EXAMINATION** • Level of engagement and rapport. • Looking for signs of depression, mania and current intoxication. • Shame and anger.	⓪ ① ②
D.	**EXTERNAL SUPPORTS** • Nature and quality of supports; family, friends, colleagues. • Living alone? • Fear of consequences for employment. • Legal support and cost.	⓪ ① ②
E.	**COLLATERAL INFORMATION** • GP, family, next-of-kin.	⓪ ①

Modified Essay 1

Each question within this modified essay question will be marked by a different examiner. The examiner marking one question will not have access to your answers to the other questions. Therefore, please ensure that you address each question separately and specifically. Answer this question fully, even if you believe that you have partly covered its content in your answers to other questions.

You are a junior consultant psychiatrist working on a Consultation Liaison team in a metropolitan hospital. Adil is a 32-year-old single Afghan refugee with a diagnosis of schizophrenia and intravenous heroin misuse. He is under a community mental health team and is prescribed depot antipsychotic medication. Adil initially agreed to be admitted to the medical ward for suspected infective endocarditis. However, he has since refused to have any tests done, and has tried to leave the medical ward. You have been asked to assess Adil as his medical team is concerned about his treatment refusal.

Question 1.1

Outline (list and justify) the factors that might be contributing to Adil's treatment refusal.

Please note: a list without any justification will not be awarded any marks.

(10 marks)

A.	**Patient factors:** • Language barriers: understanding of his current condition; is there a need for an interpreter? • Cognitive impairment related to schizophrenia or substance dependence. • Cultural factors: non-western explanatory models of illness, including spiritual explanation for his illness. • Health literacy. • Insight: how informed is he about his medical condition? • Fears of implications of having another illness such as the uncertainty of his residency status. • Trauma-related triggers - being kept in hospital; mistrust of authorities (treating team); personality. • External commitments or obligations, including financial concerns with being in hospital.	0 1 2 3 4 5 6
B.	**Illness factors (may or may not impair Adil's capacity for consenting):** • Depression - reluctance, hopelessness for prospects for treatment. • Psychosis - inadequately treated; substance induced. • Delirium - infection, etc. • Physical illness (non-delirium causes) e.g. malnourishment, pain, drug intoxication/withdrawal/craving. • Cognitive impairment secondary to schizophrenia. • Opiate withdrawal (acute symptoms including agitation, restlessness and confusion given history of intravenous heroin use).	0 1 2 3 4
C.	**Systems factors:** • Paternalistic approach - medical teams may present as paternalistic in their approach to patient care (consider person-centered care, collaborative approach). • Family factors - social isolation; visiting policies. • Cultural awareness with respect to the treating team lacking awareness of culturally safe care • Stigma about patients with mental illness or those who abuse substances; blame attribution. Refugee stigma. • Negative countertransference.	0 1 2 3 4

Breadth

Depth

MINIMISING CONFUSION/AMBIGUITY

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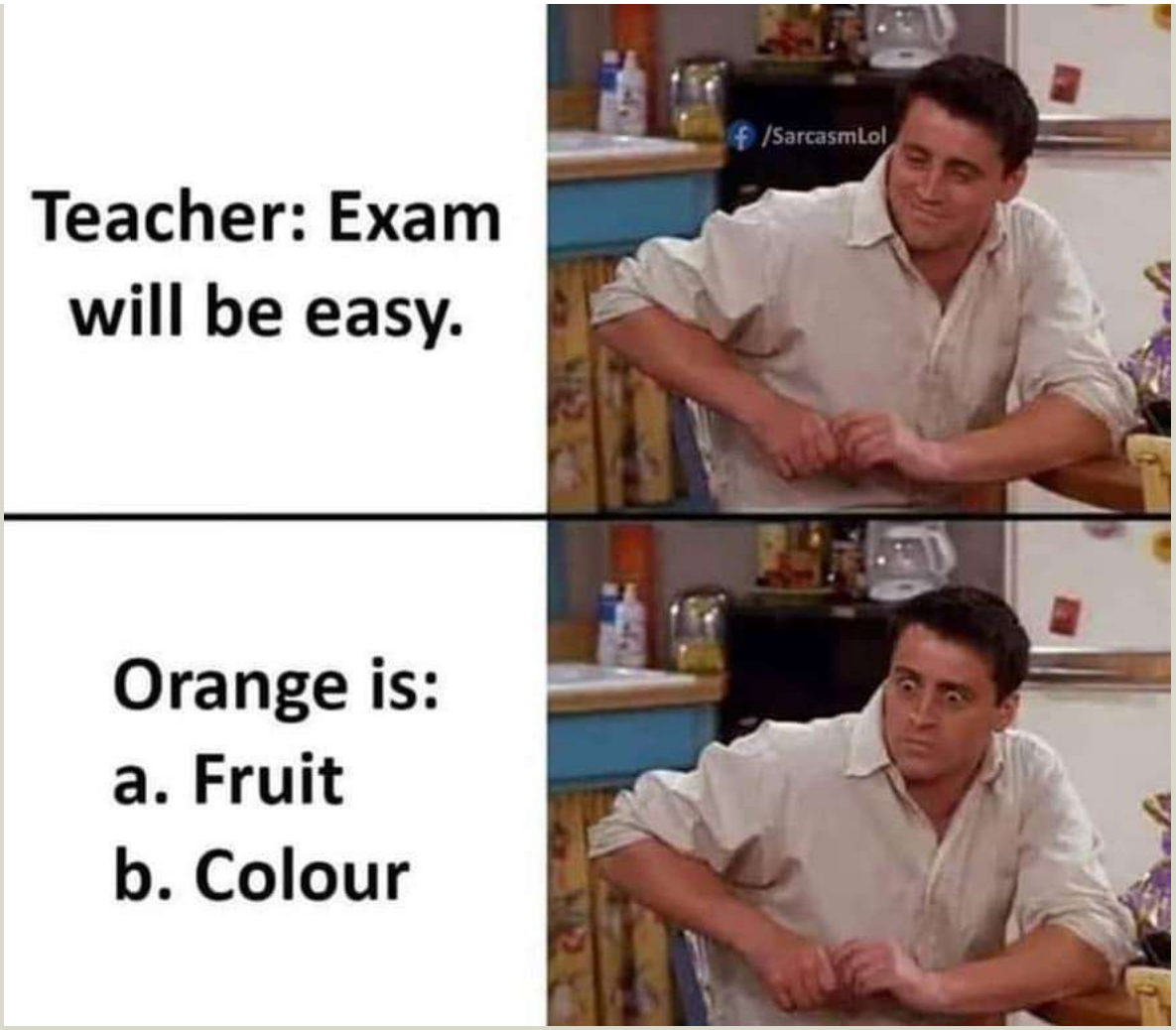

THE LIFECYCLE OF THE MEQ

The Royal Australian & New Zealand College of Psychiatrists

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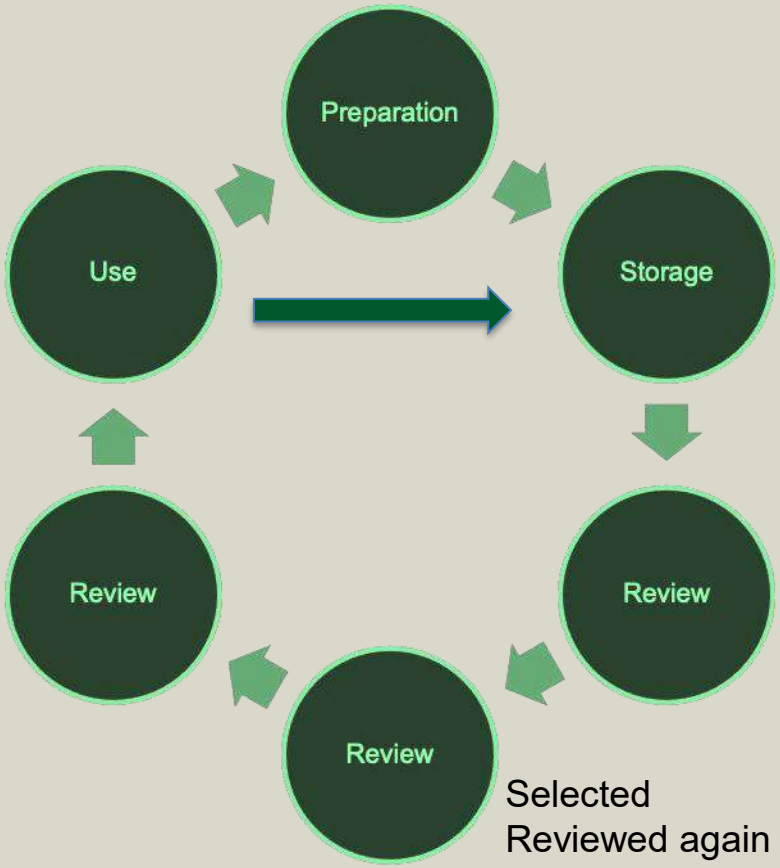

Inspiration
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Reviewed again
Edited
Standard setting

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STANDARD SETTING
POST-EXAM ANALYSES

STANDARD SETTING: FINDING THE PASS MARK

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- Options:
  - **Norm referenced:** Used when a pre-determined proportion of examinees are required to pass e.g. 55% – not what we do
  - **Criterion referenced:** Used when a desirable competency level is required which each candidate should achieve
- RANZCP uses “modified Angoff method”

THE "MINIMALLY COMPETENT END-OF-STAGE-3 TRAINEE"

The Royal Australian & New Zealand College of Psychiatrists

A trainee at the end of their training who:

- Has some knowledge gaps
- Has some difficulty applying knowledge to more complex clinical situations
- Seeks advice more often than a senior colleague
- Can lack sophistication

But…

- A good grasp of basic knowledge
- Able to practice independently or in private practice
- Is "safe" enough to be on an after-hours roster or to cover a colleague's leave
- "Forgivable errors"

MINIMALLY-COMPETENT END-OF-STAGE 3 STANDARD SETTING

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- The standard is set to the minimally-competent End-of-Stage-3 trainee.
- Represents the point at which a candidate is ‘good enough’ = pass mark.
- Fairness

STANDARD SETTING:
OVERALL CONSIDERATIONS TO KEEP IN MIND

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- Candidates are under examination conditions and under time pressure.

- Candidates will not structure their responses in the way that the marking guide is set up.

- Often minimally competent candidates may write a lot about a couple of points therefore missing out on rest of the points expected in the answer.

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POST-EXAM ANALYSES

POST-EXAM RESULTS ANALYSIS

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- All results are analysed and validated from the raw data
  - Multiple methods; independent checking
  - This gives us the confidence that the results being used are as accurate as possible.
- Analyses are performed to identify inconsistencies
  - Candidate performance
  - Response options
  - Marker feedback
  - Marker performance
- Any unexpected result is reviewed.
- Cohort comparisons
- Within-cohort comparisons (e.g SIMG & Trainees)

ANY QUESTIONS SO FAR?

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HOW DO I PREPARE FOR THE MEQ?

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ELIGIBILITY

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Eligibility

You are eligible to apply for the MEQ exam after you have completed 18 months FTE training.

The RANZCP recommends that you take the exam in Stage 3, as it is set at the standard expected at the end of Stage 3.

You should have successfully completed the exam by 60 months FTE training.

Most data suggests that candidates are more likely to pass with 30-36 months FTE training under their belt.

RECENT CHANGES TO BE MINDFUL OF

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- Computer Based Examination – this is the standard and the norm.

- MEQ: 125 marks in September 2026, increasing to 150 marks in February 2027

GENERAL STRATEGIES

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- Reading extensively and broadly
- Podcasts which are broad in topic.
- Practice, practice, practice
- MEQs: PRETEND to be a consultant; walk like a duck, talk like a duck, look like a duck; ask your supervisor to d/w as if you are a consultant. Ask to lead the team meeting/ward round – ask for feedback.
- Podcasts
  - Preparation for the CEQ and MEQ papers.
  - Hosted by current examiners and trainees who have recently sat the exams.

RESPONDING TO THE MEQ – ONION PEELS

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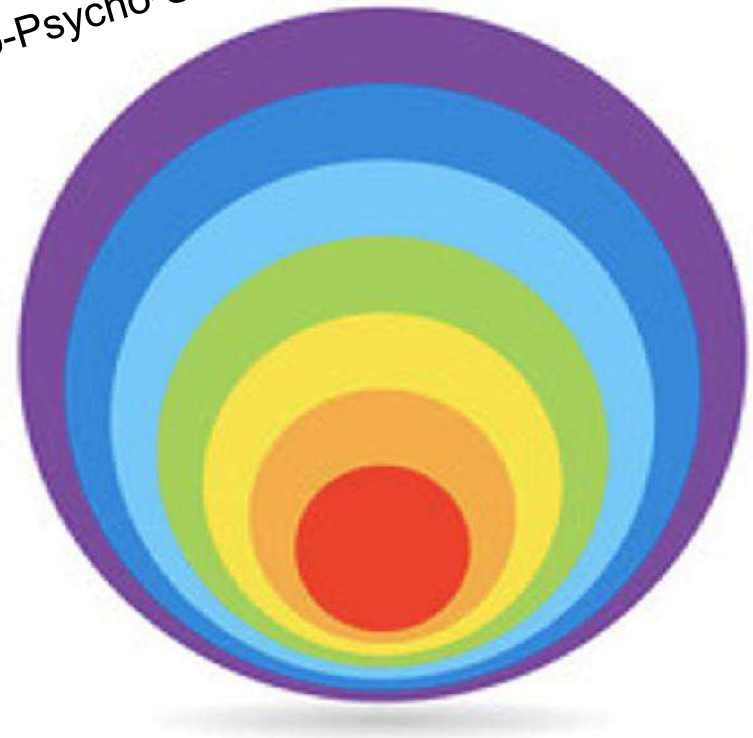
Bio-Psycho-Socio-Cultural Framework



- The patient
- The family
- Occupation, Social, Educ
- The care system
- Institutions, Covenants,
- The HCP
- Etc

Interconnected with the CANMEDS Competencies

With thanks to Dr Dom Baetens

Image By dzm1try

TIPS FOR THE MEQ I

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- College website – some previous MEQs
- Read College Feedback
  - Often, there are recurring themes
- Commonly, marker feedback is about a failure to follow the instruction.
- Follow the instruction. Provide a list if that is the direction.
- Use supervision to think like a psychiatrist
- EVERY piece of information is useful and there for a reason

TIPS FOR THE MEQ II

The Royal Australian & New Zealand College of Psychiatrists

- Use bullet points if that works for you.
- Ensure you provide a justification/description/for-&-against arguments.
- Draw on your clinical experience when responding to the MEQ.
- Use the bio-psycho-socio-cultural approach when considering an assessment or management question if you can't think of anything else.
- Avoid generic responses; make them specific to THIS scenario.

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PREPARATION

PREPARING FOR THE MEQ - GENERAL

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- Don’t underestimate the time required for preparation.
- Consider your commitments e.g. family, children, placement, etc.
- Don’t sit too early
- Sitting at the right time
  - This is very individual
  - More experience under your belt esp CAP, CL

PREPARING FOR THE MEQ – TIMING & TECHNIQUE

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- Practice, practice, practice
- Develop a mind map / grid / onion layers
- Stick to the timing from the get-go. Time management is a problem for many. Allow 10 min for a 10-mark question.
- Technique
  - Be succinct in your responses
  - Consider using bullet points vs narrative style
  - Use headings e.g. risk assessment

PREPARING FOR THE MEQ – WHAT TO CONSIDER?

The Royal Australian & New Zealand College of Psychiatrists

- Practice typing – consider a typing course if you are slow
- Use double line spacing – makes for better legibility even in the electronic examination
- Group practice vs solo practice vs study buddy
- Mark each other's submissions
- Be kind but not nice when marking; be critical.

PREPARING FOR THE MEQ - KNOWLEDGE

The Royal Australian & New Zealand College of Psychiatrists

- Know the basics – ethical principles, recovery, patient centered care, BPS model of care, position statements, CANMEDS

- CANMEDS
  - The College website provides tips on how broad the consultant's roles are
  - Not all the CANMED roles will be applicable in each MEQ.

- Use your experience, cultural background

PREPARING FOR THE MEQ - EXPERIENCES

The Royal Australian & New Zealand College of Psychiatrists

- Ask for feedback from consultants
- Think out loud; demonstrate clinical reasoning
- All cases should be formulated and view from an MEQ lens if possible
- Listen to those with a lived experience and your multidisciplinary team – understand what they do.
- Talk to your colleagues and ask for feedback; give feedback

MEREDITH'S HOUSEKEEPING CEQ & MEQ

The Royal Australian & New Zealand College of Psychiatrists

- Application dates – NO LATE APPLICATIONS
- Online ONLY applications
- Special consideration
  - At the time of application
  - Long term ailments, learning difficulties
  - Acute (usually medical issues)
  - Adequate documentation, recency
- Incident reports
- Results release
- Review requests
- Contingency planning
- etc

MEQ 1 – MARKING THE MEQ – HOW DO THESE ANSWERS DIFFER?

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- A taster in the MEQ through marking

- Work in groups
  - Step 1 - Without the marking guide, what are the differences between these answers?
  - Step 2 – Using the marking guide, how would you score the answer?
  - Step 3 – How would we score the answer and why?

QUESTION A

The Royal Australian & New Zealand College of Psychiatrists

Modified Essay 5

Each question within this modified essay will be marked by a different examiner. The examiner marking this question will not have access to your answers to the other questions. Therefore, please ensure that you address each question separately and specifically. Answer this question fully, even if you believe that you have partly covered its content in your answers to other questions.

You are a junior consultant psychiatrist working in a community mental health centre. A general practitioner refers Stan, a 37-year old unemployed electrician to you.

Stan has a 20-year history of obsessive compulsive disorder. He is unable to leave the house because of checking rituals. He lives with his elderly parents who shop and cook for him. He has a long history of intermittent contact with mental health services but has never attended for longer than a few months at a time. He has tried many different medications but has stopped them because he could not tolerate the side-effects.

Question 5.1

Describe (list and explain) the factors that may have contributed to Stan's poor engagement with mental health services in the past.
Please note: a list with no explanation will not receive any marks. ***(10 marks)***

HOW WOULD YOU APPROACH THIS QUESTION?

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- Think of a model for your answer
  - Bio-psycho-social-cultural?
  - The layers of the onion as before?
  - Another model?
- What would be the key points you would put into your answer?
- WHY are they in your answer?
- Share with your table

EXAMPLE A

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- Poorly Written Answer
- The candidate does not follow the instruction to ‘list and explain’. In fact there are no explanations. While quite a few points are valid, the lack of explanation will be detrimental in the examination
- The candidate does demonstrate some breadth in their thinking using a biopsychosocial approach to the question.
  - However, there is not a lot of depth to score the marks within a domain.
- Does make some assumptions
  - e.g.no car because he is unemployed

EXAMPLE B

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- This answer demonstrates breadth and depth using the same bio-psycho-social model
- Answers are often explained – we know what the point has been raised
- However, slightly long answer and may run out of time if the candidate takes too long (remember 10 marks = 10 minutes).

MARKING GUIDE FOR QUESTION

The Royal Australian & New Zealand College of Psychiatrists

A.	**INDIVIDUAL/ILLNESS FACTORS:** • Treatment Pessimism. Pessimistic attitude towards treatment, including stigma, poor insight, stage of change, lack of treatment understanding and previous treatment failures. Can include frustration and hopelessness. • The OCD itself. Severe OCD may have made it difficult to leave the house and attend appointments. This may be related to overwhelming anxiety and the time consuming nature of the rituals. • Comorbidities: psychosis; personality factors, such as passive aggressive, avoidant, paranoid personality traits. substance abuse. • Impact of OCD on Stan's developmental trajectory.	0 1 2 3 4
B.	**FAMILY FACTORS:** • Parents tolerate and accommodate OCD symptoms, so no impetus to change. • Family attitudes about mental illness and mental health services. • Parents' lack of awareness of treatment options which could improve his level of functioning and the illness. • Family violence – dynamic of avoidance and fear of Stan becoming violent. • Stigma – self, parental, community. • Relational dynamics between Stan and his parents may contribute to his poor engagement by his acting out (punishing his parents, for example). • Parental health including frailty.	0 1 2
C.	**TREATMENT FACTORS:** • Inadequate or inappropriate treatment e.g. benzodiazepines or only one treatment modality e.g. never offered CBT. • Medication side-effects, poor understanding of expected response times and duration of treatment. • Failure to address comorbidities, e.g. substance dependence, depression, other anxiety disorders. • Failure to address systemic barriers to treatment e.g. failure to address possible parental factors. • ERP/CBT may cause Stan to become distressed or anxious.	0 1 2 3
D.	**MENTAL HEALTH SERVICES FACTORS:** • Difficulty following up an ambivalent patient. • Service capacity and lower prioritisation as Stan may be perceived as not being at high risk. • Lack of staff trained in relevant psychotherapy e.g. CBT. • Failure to develop a therapeutic alliance e.g. through failure to personalise treatment. • Lack of continuity of treatment staff. • Poor attunement between staff and Stan. • Accessibility – distance, transport.	0 1 2 3

MARKING OF EXAMPLE A

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Example A

Medication/Biological

- Stan has been on the wrong type of medication in the past for his OCD
- Stan has treatment resistant OCD
- Stan does not trust the clinic team because of side effects
- Stan might be depressed from his OCD

A1

Broad coverage of domain but no explanations

Psychology

- He does not appear to have had any psychological treatment in the past, only medications
- No one has been able to engage with stan
- Maybe there is no psychologist in the clinic
- Stan does not want to get better as he likes his parents doing everything for him

relevant point, but no explanation, so no marks

if this is the case, how does it explain non-engagement?
Should be .. unable to offer psychotherapy

Very softly could be awarded a mark in B
but explanation is exceptionally poor

Social

- Stan is unemployed so cannot afford to travel to clinic
- Stan might have no car
- Stan may drink a lot and has an alcohol or drug problem
- The clinics might not see OCD due to workload pressure or discharges him being he is low acuity.

D1 - accessibility, so cannot attend, soft explanation

If this is the case, how does it impact non-engagement?

While relevant for domain D, there is a lack of breadth overall for it to be a second mark.

if lack of psychology + clinic pressures were explained potentially could score second mark in D

MARKING OF EXAMPLE B

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Medication/Biological

- While Stan has tried many medications in the past, he may have experienced side effects because they were not monitored appropriately, leading to non-compliance. — C1 - explained
- There may have been a misunderstanding around duration of treatment required with OCD, often longer than depression, to ger maximum benefit from medications. — C2 - explained
- Stan may have psychiatric co-morbidities such as a depressive disorder or other anxiety disorder common with OCD. This means may reduce his engagement with services especially if anhedonic or avolitional. — A1 - explained
- Stan's OCD in fact might be so severe that the disorder itself stops him from leaving the home to engage with the community team. It is possible that the service does not have resources to do home visits so he ends up often being labelled as 'disengaged'. — A2 - explained

Social

- Stan is currently unemployed so may not be able to get to the clinic because he doesn't have money or a car to take himself there — D3 - explained
- He might not want to go with his parents who would be the obvious people to take him to clinic
- Stan may feel ongoing stigma with his obsessive-compulsive disorder, which means that it would be easier to stay at home.
- OCD in public adult community clinics may be seen as lower acuity compared with suicide and psychosis, so when Stan improves a little, he may be discharged quickly with no long term treatment plan leading to repeat presentations.

B - but not broad enough for 2nd mar

MARKING OF EXAMPLE B

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Psychological

- Due to the short periods of engagement, Stan may never have completed a structured course of cognitive behavioural therapy / ERP, recommended for individuals who have obsessive compulsive disorder and only been treated with medications. This could lead to feelings of failure and no progress — D1 - explained
- There may be no psychology resources at the local community clinic similar to many places in New Zealand which meant that he felt hopeless and things didn't not improve, so left the clinic.
- Stan may have tried psychotherapy, but could not find a psychologist he clicked with, leading to treatment resistance and disengagement. — D2- explained
- Stan may not be psychologically minded and this could be due to personality traits or past experiences. This would impact any longer term treatment plan. Might not gel with psychiatrist as well. — A3 - explained
- Stan's parents have looked after him for so many years so he may have developed dependency, so might not actually want to get better. — B1 - explained

MEQ 2 – HOW DO THESE ANSWERS DIFFER? QUESTION B

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Modified Essay 5

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

You are a junior consultant psychiatrist working in a community mental health centre. A general practitioner refers Stan, a 37-year old unemployed electrician to you.

Stan has a 20-year history of obsessive compulsive disorder. He is unable to leave the house because of checking rituals. He lives with his elderly parents who shop and cook for him. He has a long history of intermittent contact with mental health services but has never attended for longer than a few months at a time. He has tried many different medications but has stopped them because he could not tolerate the side-effects.

You assess Stan in his home and confirm that he has no other major psychiatric disorder. Stan tells you that he has to check switches and power sockets constantly because he fears he will leave an electrical appliance on and cause harm to his parents. Similar fears have prevented him from working outside of the home. Stan reports that he does not drink nor take drugs. He would like treatment for his problems as long as it does not involve admission to hospital. He consents to treatment.

Question 5.2

Describe (list and explain) the key features of your psychological treatment plan for Stan.

Please note: a list with no explanation will not receive any marks. ***(8 marks)***

HOW WOULD YOU APPROACH THIS QUESTION?

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- Think of a model for your answer
  - Bio-psycho-social-cultural?
  - The layers of the onion as before?
  - Another model?
- What would be the key points you would put into your answer?
- WHY are they in your answer?
- Share with your table

EXAMPLE C

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- Well written answer
- Demonstrates a balance of depth and breadth, particularly when explaining CBT. The question talks about your plan for Stan, so ideally it should be tailored as such
- Not a perfect answer as very few if any candidates get a perfect answer, however, still very solid.
- Can miss out an entire domain but still perform very well.

EXAMPLE D

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- Poorly Written Answer
- Covers a lot of material superficially and the treatment plan doesn't seem to relate specifically to Stan
  - A bunch of specific concepts with no explanation for its inclusion beyond just explaining what ERP is.
  - E.g. what is the purpose of a thought diary? What would Stan use it for?
- Medications part of answer is irrelevant as question is about psychological treatment plan.
- Similarly asking for a psychologist is irrelevant as the question asks for your plan

MARKING GUIDE FOR QUESTION

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A.	**PSYCHOEDUCATION:** • Provide information to the patient and family about the condition in a way that has personal relevance. • Provide information that exposure and response prevention, and cognitive therapy have the best evidence base. • Explain rationale of chosen psychological treatment.	0 1 2
B.	**COGNITIVE BEHAVIOUR THERAPY:** • Initial assessment and formulation, assess preparedness to change; identify maintaining factors: triggers, avoidance and safety behaviours. • Development of exposure hierarchy. Use of a measurable monitor of change, e.g. Subjective Units of Distress Scale, YBOCS, or other. • Choose goals to work on and set specific homework tasks. • Confront each chosen situation, refrain from engaging in compulsive ritual and stay in situation until anxiety subsides. • Monitor using an appropriate outcome measurement e.g. role of Goal Attainment Scale.	0 1 2 3 4 5
C.	**FAMILY INTERVENTION:** • Family therapy to support understanding of and responses to enduring patterns. • Negotiate role for parents; practical advice for parents assisting them not to inadvertently do things for him instead of with him e.g. by completing tasks for him. • Identify the dynamics/parental responses which may be reinforcing the illness, e.g. conflict avoidance.	0 1 2
D.	**LONG TERM RECOVERY:** • Maximising quality of life even in the context of chronic disorder, including vocational and functional rehabilitation. • Learning to live with OCD. • Identifying and encouraging realistic goals. • Note to Markers: mentioning recovery without contextualising or justifying its use here is not acceptable.	0 1 2

Effective treatment of Stan's obsessive compulsive disorder should start with psychoeducation.

The psychoeducation should give Stan an understanding of his OCD, how it impacts his life and what the treatment plan will be to help with his symptoms. In particular, education should be given around realistic timeframes and the treatment process to ensure that Stan has a shared understanding with you to reduce the risk of disengagement.

A1 - Psychoeducation Explained
Depth in answer

Psychoeducation should also be given to his family so they can support Stan to attend psychological treatment. It is possible given that his parents do his shopping and cooking, they may have also lost hope in Stan getting better. Family may need to know how to push and support Stan with engaging in psychotherapy.

A2 - involving family and explained

As Stan has obsessive compulsive disorder, the gold standard psychological treatment will be cognitive behavioural therapy, with exposure response prevention.

The initial sessions should focus on teaching Stan the 5-part model, to understand the concepts and relationships between his thoughts, feelings and actions, particularly when he feels the urge to check on something. This would include identifying triggers. Psychoeducation should be rolled into this too.

B1 - explained

This would then progress to establish an exposure hierarchy. Stan should be encouraged to do experiments starting from least provoking situations, record his thoughts and emotions, and practice slowly challenging them as he tolerates. There should also be regularly set homework to encourage practicing of skills.

B2 - explained

This would also involve teaching skills such as relaxation and grounding as Stan will feel anxious when challenging his ritualistic behaviours.

B3 - explained

Progress should be monitored using a scale like Y-BOCS, to allow you as the psychiatrist to monitor progress but also for Stan to track his own progress. This may improve compliance.

B4 - explained

Treatment plan should also build hope as Stan has lived with OCD for 20 years and unemployed. It may also need a supportive framework to help Stan back into vocational employment which would be paired with his psychotherapy.

D1 - explained

MARKING FOR EXAMPLE D

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Example D

Stan has OCD so the best treatment is cognitive behavioural therapy with exposure response prevention.

A1 - explained around evidence based and rationale

This starts with a 5-part model and a hierarchy of events. Sessions should focus on gradual exposure and response prevention.

Should be taught relaxation skills to use during exposure response prevention.

Should keep a thought diary as it is part of ERP.

B1 - B2
Here we have a series of concepts
Not tailored to Stan
Why is a thought diary used?
Relaxation skills explained
why is the 5 part model used?

If he is depressed also, he might need extra CBT.

Psychoeducation around OCD to ensure compliance with treatment. Should be told what OCD it, and what to do when he feels a need to act on his thoughts.

A2 - explaination and education around OCD

Should be done by a psychologist with experience, refer to psychology team. If none available, should consider referring to private.

question is around YOUR psychological plan as if you are delivering it!

Need to make sure that medications continue to be optimized or else he might relapse.

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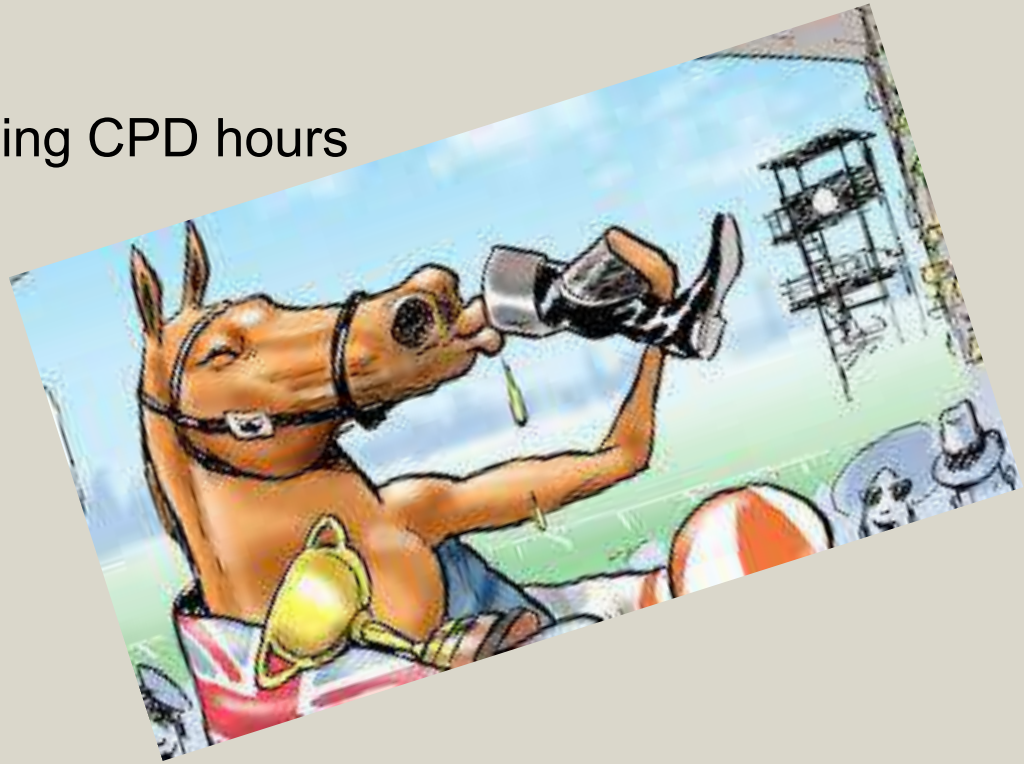

MEQ FEEDBACK SURVEY

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Q&A