# Committee for Examinations
# Objective Structured Clinical Examination

## Station 4
## Gold Coast April 2019

The Royal Australian & New Zealand College of Psychiatrists

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**1.0 Descriptive summary of station:**

John Baker is a 25-year-old Occupational Therapist who works as an occupational rehabilitation provider in a multidisciplinary private practice where the candidate (the junior consultant) is based. He raises a case questioning the diagnosis of PTSD provided by the GP. The candidate is to engage in secondary consultation focussing on the diagnosis, and identify that the PTSD is secondary to vicarious trauma. During the interaction, the colleague makes a number of prejudicial comments regarding mental illness, and the sufferers of mental illness. The candidate is to address the challenging situation that occurs, and constructively address the issue of stigma.

**1.1 The main assessment aims are to:**

- Take a focussed history for the diagnosis of post-traumatic stress disorder in the context of a colleague seeking advice.
- Effectively manage a challenging communication to promote a positive patient outcome.
- Demonstrate the capacity to constructively address stigma in the workplace.

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

- Explore the patient's current risk factors including use of substances when clarifying the history.
- Relate the diagnostic criteria to the patient learning of violent fatal incident of close colleagues.
- Specifically comment on the stigmatising attitude of the OT.
- Demonstrate how psychoeducation / feedback can be used to tackle stigma.

**1.3 Station covers the:**

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category**: Other Disorders - Trauma and Stressor Related Disorders
- **Area of Practice**: Adult Psychiatry
- **CanMEDS Domains**: Medical Expert, Collaborator, Health Advocate
- **RANZCP 2012 Fellowship Program Learning Outcomes**: Medical Expert (Assessment – Data Gathering Content; Diagnosis), Collaborator (External Relationships), Health Advocate (Addressing Stigma)

***References:***


- Australian guidelines for the treatment of acute stress disorder and post traumatic stress disorder. 2013. Phoenix Australia – Centre for Posttraumatic Mental Health, Melbourne Victoria, https://phoenixaustralia.org/wp-content/uploads/2015/03/Phoenix-ASD-PTSD-Guidelines.pdf.
- Corrigan PW, O'Shaugnessy JR Challenging mental illness stigma as it exists in the real world. *Australian Psychologist, June 2007; 42(2): 90-97.*
- Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013).
- Henderson et al. Mental health-related stigma in health care and mental health-care settings. *Lancet, Psychiatry 2014, November: 467-482.*
- Thornicroft et al, Evidence for effective interventions to reduce mental-health-related stigma and discrimination. *Lancet 2016; 387: 1123–32.*


**1.4 Station requirements:**

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: confident professional male (25 – 30 years).
- Pen for candidate.
- Timer and batteries for examiner.

## 2.0 Instructions to Candidate

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

You have recently started working as a junior psychiatrist in a private a multidisciplinary practice. John Baker, a relatively junior occupational therapist, asks to see you to discuss a patient he has seen in his role as an occupational rehabilitation provider.

John wishes to discuss Clark Keogh; a veteran who was medically discharged from the army with a hand injury. He has been seeing Clark for two months to develop a vocational training plan as a route for future employment. Clark was recently diagnosed as having PTSD by his General Practitioner, and John is questioning the diagnosis and wants your assistance to clarify the diagnosis.

Your tasks are to:

- Obtain information pertinent to the case from John to assist in clarifying the diagnosis.
- Explain the criteria for the diagnosis to John.
- Address John's understanding of the presentation.

**You will not receive any time prompts.**

**Station 4 - 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' and any other candidate material specific to the station.
  - Pens.
  - Water and tissues (available for candidate use).
- Do a final rehearsal with your role player.

**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 there are no cues / time prompts for you to give.
- DO NOT redirect or prompt the candidate – the role player 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 after the <u>final task</u>:**

- You are to state the following:

  ***'Are you satisfied you have completed the task(s)?***
  ***If so, you <u>must</u> remain in the room and <u>NOT</u> 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.

There is no opening statement or prompt for you to give.

The role player opens with the following statement:

***'Doctor, I'm glad you're here. I wanted to discuss a patient, if you are free?'***

### 3.2 Background information for examiners

In this station, the candidate will be approached by an allied health professional to discuss diagnostic issues, as the OT is questioning the diagnosis made by a GP. The candidate is expected to demonstrate the ability to gather information from a professional colleague to assist in making a diagnosis of PTSD, and discuss the diagnosis with John.

John makes a number of prejudicial comments regarding the diagnosis. The candidate is to effectively manage the challenging communication to reach a positive outcome. In this way the candidate is expected to address the matter of stigma in mental illness through an educational opportunity.

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

- Explore the patient's current risk factors including use of substances when clarifying the history.
- Relate the diagnostic criteria to the patient learning of violent fatal incident of close colleagues.
- Specifically comment on the stigmatising attitude of the OT.
- Demonstrate how psychoeducation / feedback can be used to tackle stigma.

**Post-traumatic stress disorder (PTSD):**

PTSD symptoms can develop in a person who has been through a traumatic event which threatened their life or safety, or that of others around them. These events can be in the form of a serious accident, physical or sexual assault, war or torture, or disasters such as earthquakes or floods. As a result of the traumatic experience, the person tends to develop feelings of intense fear, helplessness or horror.
In diagnosing PTSD, the DSM-IV outlined three major symptom clusters: re-experiencing, avoidance and numbing, and hyperarousal. Several revisions to the PTSD diagnostic criteria have been introduced into DSM-5. Firstly, PTSD has been moved from the Anxiety Disorders section to a new category – Trauma- and Stressor-Related Disorders. All of the conditions included in this classification require exposure to a traumatic or stressful event as a diagnostic criterion.

The definition of 'traumatic event' has been narrowed, and the person's response to the stressor as 'fear, helplessness or horror' has been removed as there is little empirical support for its utility. The other main change includes having four rather than three symptom clusters by dividing the avoidance and numbing symptom cluster. This is based on research showing active and passive avoidance to be independent phenomena. The passive avoidance cluster has become a more general set of dysphoric symptoms.

**ICD-10 Diagnostic Criteria for PTSD**

The patient must have been exposed to a stressful event or situation (either brief or long-lasting) of exceptionally threatening or catastrophic nature, which would be likely to cause pervasive distress in almost anyone.

A. There must be persistent remembering or "reliving" of the stressor in intrusive "flashbacks," vivid memories, or recurring dreams, or in experiencing distress when exposed to circumstances resembling or associated with the stressor.

B. The patient must exhibit an actual or preferred avoidance of circumstances resembling or associated with the stressor, which was not present before exposure to the stressor.

C. Either of the following must be present:

1. Inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor.
2. Persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor), shown by any two of the following:
   a. Difficulty in falling or staying asleep.
   b. Irritability or outbursts of anger.
   c. Difficulty in concentrating.
   d. Exaggerated startle response.

D. Criteria B, C, and D must all be met within six months of the stressful event or at the end of a period of stress. (For some purposes, onset delayed more than six months can be included, but this should be clearly specified.)

[Source: WHO, 1992].

**DSM-5:**

All of the diagnostic criteria are required for the diagnosis of PTSD, the following summarises the criteria:

**Criterion A: stressor (one required)**

Exposure to actual or threatened death, serious injury, or sexual violence, in one or more of the following ways:

- Direct exposure / experiencing.
- Witnessing the event(s).
- Learning that the traumatic event(s) occurred to a relative or close friend. Actual or threatened death must be traumatic or accidental.
- Experiencing repeated or extreme exposure to aversive details of the traumatic event(s), usually in the course of professional duties (e.g., first responders, medics).

**Criterion B: intrusion symptoms (one required)**

The traumatic event is persistently re-experienced in the one or more of the following intrusion symptom ways:

- Recurrent, involuntary and intrusive memories of the traumatic event(s).
- Recurrent distressing dreams related to the traumatic event(s).
- Dissociative reaction – flashbacks.
- Intense or prolonged psychological distress at exposure to internal or external cues that symbolise / resemble an aspect of the traumatic event(s).
- Marked physiological reaction to internal or external cues that symbolise / resemble an aspect of the traumatic event(s).

**Criterion C: avoidance (one required)**

Persistent avoidance of trauma-related stimuli after the trauma, in one or more of the following ways:

- Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
- Avoidance of or efforts to avoid external reminders that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

**Criterion D: negative alterations in cognitions and mood (two required)**

Negative thoughts or feelings that began or worsened after the trauma, in the following ways:

- Inability to remember an important aspect of the traumatic event(s).
- Persistent and exaggerated negative beliefs or expectations about oneself, others or the world.
- Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead to blaming themselves or others.
- Persistent, negative emotional state (shame, guilt, fear, anger, horror).
- Markedly diminished interest or participation in significant activities.
- Feelings of detachment or estrangement from others.
- Persistent inability to experience positive emotions.

**Criterion E: alterations in arousal and reactivity (two required)**

Trauma-related arousal and reactivity that began or worsened after the trauma, in at least two of the following ways:

- Irritable behaviour and angry outbursts typically expressed as verbal or physical aggression towards people or objects.
- Reckless or self-destructive behaviour.
- Hypervigilance.
- Exaggerated startle reaction.
- Difficulty concentrating.
- Difficulty sleeping.

**Criterion F: duration (required)**

Symptoms last for more than one month.

**Criterion G: functional significance (required)**

Symptoms create distress or functional impairment (e.g., social, occupational).

**Criterion H: exclusion (required)**

Symptoms are not due to medication, substance use, or other illness.

**Two specifications:**

**Dissociative Specification** - In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:

- **Depersonalisation -** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as if 'this is not happening to me' or one were in a dream, time moving slowly).
- **Derealisation -** Persistent or recurrent experiences of unreality of surroundings (e.g., world around the individual is experienced as unreal, dreamlike, distant, distorted).

**Delayed Specification** - Full diagnostic criteria are not met until at least six months after the trauma(s), although onset of some of the symptoms may occur immediately.The re-experiencing or 'intrusive' symptoms are often regarded as the hallmark feature of traumatic stress. Re-experiencing symptoms include intrusive and unwanted thoughts, and images of the event, and distressing dreams or nightmares. Re-experiencing symptoms can also include 'flashbacks' where people may lose awareness of their surroundings, and become immersed in the memory of the event. These flashbacks may be so vivid that people feel as if they are experiencing the traumatic event again. People can become upset or distressed when reminded of what happened, and have intense physical reactions like sweating and rapid heartbeat.

Avoidance and numbing symptoms are generally understood to result from different underlying mechanisms. Avoidance symptoms are characterised by active, deliberate attempts to keep memories of the traumatic event out of mind by actively avoiding any possible reminders. It can result in a person going to extreme lengths to avoid people, places, and activities that trigger distressing memories, or internal triggers like thoughts and feelings.

The numbing symptoms are more passive and less under voluntary control. They are expressed as a loss of interest in activities that previously brought enjoyment, as detachment or estrangement from others, restricted emotional responses (e.g., being unable to experience joy or love), and a sense of a foreshortened future. These numbing symptoms are thought to particularly characterise more chronic and severe forms of the disorder. As such, they are usually considered to be a poor prognostic indicator.

The arousal symptoms of PTSD are associated with a sustained increase in sympathetic nervous system activity, well beyond its adaptive function in response to the traumatic event. The individual experiences ongoing increased arousal. Increased arousal is evident in a range of symptoms, such as poor concentration and memory, irritability and anger, difficulty in falling and staying asleep, being easily startled, and being constantly alert to signs of danger (hypervigilance). In DSM-5, an additional symptom of 'reckless or self-destructive behaviour' has been included in this cluster.

**Stigma:**

The second part of this station expects the candidate to address stigma in the workplace.

Several theoretical approaches to mental-health-related stigma and discrimination have been developed including models defining stereotypes (negative beliefs about a group), prejudice (agreement with stereotyped beliefs, or negative emotional reactions such as fear or anger, or both), and discrimination (behavioural consequence of prejudice, such as exclusion from social and economic opportunities). The behavioural consequences of stigma (i.e. discrimination) can compound the disabilities related to the primary symptoms of mental illness, and lead to disadvantages in many aspects of life, such as personal relationships, education, and work.

Many people with mental illness report that health personnel, providing both mental and physical health services, are an important source of stigma and discrimination.

Education and the provision of factual data help to produce short-term to medium-term knowledge, and attitudinal improvements in groups where stigma is evident. Social contact and first-person narratives are noted to be more effective in reducing aspects of stigma in individuals and groups. Successful Interventions that are most often used include mental health education or informational approaches - such as social contact or first-person narratives. Overall, these interventions mostly result in short-term improvements in awareness and positive behaviour changes, which are sustained at medium-term follow-up in about half of the studies. Recent findings suggest that filmed versions of social contact might be as effective as direct contact with people with mental illness.

### 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.

**Domain Not Addressed** – the candidate demonstrates significant defects in all 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 a 25-year-old man, John Baker, a newly qualified Occupational Therapist (OT), who has recently started working in a shared clinical practice with other health professionals. One of your jobs is as an 'occupational rehabilitation service provider'. Occupational rehabilitation services are also called 'return to work professionals', and are experienced in dealing with workplace injuries, and helping people get back to work.

In this station, you are going to meet a psychiatrist to discuss the following patient you have been working with. Clark Keogh is a 38-year-old army veteran whose GP has recently diagnosed as having Post Traumatic Stress Disorder (PTSD). Clark spent a substantial time of his last appointment with you discussing his mental health issues. You have been seeing Clark for two months, and have been developing a vocational training plan to identify Clark's strengths and wishes, and subsequently pursue appropriate training opportunities to help him regain employment.

You are keen to discuss Clark's presentation with the psychiatrist as you are questioning the diagnosis of PTSD. You express disbelief to the psychiatrist as you find it hard to understand that a person can suffer a disorder, such as PTSD without actually being present at the time of the traumatic event. You also express your overall frustration with working with patients with mental illnesses as an occupational rehabilitation professional, as you feel most of them are probably just cheating the system.

**About Clark Keogh's injury:**

Clark had a crush injury to the right hand when deployed overseas. There was tendon damage which was surgically repaired. Clark was medically discharged from the army following this hand injury three years ago. He has poor movement of his 4th and 5th fingers, and chronic pain in his hand - '*a dull ach*e'. The injuries were formally assessed as not causing sufficient impairment for a veteran's pension. He has struggled to maintain any sustained employment since then.

**Clark has told you the following psychiatric history:**

Clark describes ongoing problems with anxiety and low mood. He described these problems becoming more severe over the last year, and that this followed a reunion of servicemen. He was particularly upset at the time when recalling a number of close friends who had died during an incident overseas, and so they were absent from the reunion.

The incident occurred in the Middle East. Clark was not actively involved in the incident as he had suffered the hand injury (when a crate slid on a truck and pinned his hand against the inside of the truck), and was receiving care in base hospital at the time. His platoon was on patrol when an explosive device was thrown into an Armoured Personnel Carrier (APC). Those in the APC were either killed or severely injured. Clark heard the explosion and knew that there was something wrong as it was nearby, and the base was locked down immediately afterwards.

It did not take long before Clark discovered that it was friends and colleagues involved in the attack on the APC. He was not only upset about the loss of his friends, but felt guilty about being in hospital and not with his platoon.

The guilt has often recurred, and he has experienced other symptoms over the years. He tended to minimise these especially when he was still in the army. He would sometimes experience nightmares involving his platoon being ambushed, caught in explosions, and he was trapped and kept at a distance away from them. He would feel helpless and distressed during such nightmares, and would wake in a sweat.

He had also started to find that commemorations such as ANZAC Day or news of military action on the TV had started to make him feel uneasy. Since the reunion, the nightmares have become more frequent. He has also noticed that he has become more sensitive to things that remind him of his military service and overseas deployment. Clark describes feeling anxious, *'sick in his stomach'* and helpless when particular things remind him of the incident such as loud bangs, the smell of hospitals and disinfectants, and even the sight of military trucks and vehicles (especially APCs) that he sees driving around his town - there is an Australian Defence Force driver training school nearby. He has also started to go out less often, and stopped watching the news to avoid feeling that way.

Clark has noticed that he is drinking more alcohol: he is now drinking 4–6 bottles of beer each night. He finds this helps him sleep.

**If the candidate asks you:**

- You are not aware of Clark having any history of mental illness prior to his military service.
- Clark is able to focus on other things when he needs to.
- He is able to enjoy being with his two children, taking them to school sports activities and playing at home. He has found that he can be more irritable at times, and can be easily angry with the children (Katy and Jake) or his wife Stella '*over little things'*. He feels guilty about the way he acts, and can feel that he is not a good father / partner.
- He can also feel guilty about being alive whilst his friends (some who were parents too) are now dead.
- Clark does not have any thoughts about suicide.
- Clark has recently started taking an antidepressant medication called sertraline (100 milligrams in the morning). He was already taking Panadeine, prescribed by his GP, for the hand injury. Clark says he does not overuse these tablets, taking a maximum of six a day even though the GP has said he can take up to eight if the pain is severe.
- He has a couple of days each week when he does not use the Panadeine.
- He is otherwise well and does not have any other medical problems.

### 4.2 How to play the role:

You are to dress smart but casual. You are well groomed. Your manner is confident. You are not expected to know a lot about being an OT.

### 4.3 Opening statement:

***'Dr, I'm glad you're here. I wanted to discuss a patient, if you are free?'***

### 4.4 What to expect from the candidate:

The candidate will initially explore the information that you have about Clark Keogh to help them arrive at a diagnosis. They will then explain their diagnosis to you as the role player. After you have made the scripted comments, the candidate will then look to engage you in a professional manner to address the issue of stigma.

### 4.5 Responses you MUST make:

Early in the presentation, soon after mentioning the GP's diagnosis, say:

***'I think he's just faking it.'***

After the candidate has completed the explanation of the diagnosis, say:

***'I still find it hard to believe you can get PTSD when you were never there.'***

***'I'm sure a lot of mental patients try to get off easy, not like those with real disabilities.'***

### 4.6 Responses you MIGHT make:

If the candidate does not really respond to your negative comments above:
Scripted statement: ***'Complaining of a mental illness makes it so easy to make it up as a problem.'***

### 4.7 Medication and dosage that you need to remember:

Sertraline – 100 milligrams once daily.

Panadeine – two tablets if required for pain.

## STATION 4 – MARKING DOMAINS

**The main assessment aims are to:**

- Take a focussed history for the diagnosis of post-traumatic stress disorder in the context of a colleague seeking advice.
- Effectively manage a challenging communication to promote a positive patient outcome.
- Demonstrate the capacity to constructively address stigma in the workplace.

**Level of Observed Competence:**

**1.0 MEDICAL EXPERT**

**1.2 Did the candidate take appropriately detailed and focussed collateral 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.

***Achieves the Standard by:***
demonstrating use of a tailored biopsychosocial approach; conducting a detailed but targeted assessment; obtaining a history relevant to the patient's problems and circumstances with appropriate depth and breadth; hypothesis-driven history taking; integrating key sociocultural issues relevant to the assessment; demonstrating ability to prioritise; eliciting the key issues; clarifying important positive and negative features; assessing for typical and atypical features.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Explore the patient's current risk factors including use of substances when clarifying the history.

***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):***
scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response.

***Below the Standard (scores 1):***
scores 1 if there are significant omissions affecting quality.

***Does Not Address the Task of This Domain (scores 0).***

| 1.2 Category: ASSESSMENT – Data Gathering Content | Surpasses Standard | Achieves Standard | | Below the Standard | | Domain Not Addressed |
|---|---|---|---|---|---|---|
| ENTER GRADE (X) IN ONE BOX ONLY | 5 ☐ | 4 ☐ | 3 ☐ | 2 ☐ | 1 ☐ | 0 ☐ |

**1.9 Did the candidate describe the relevant criteria to explain the diagnosis of PTSD? (Proportionate value - 25%)**

***Surpasses the Standard (scores 5) if:***
demonstrates a superior performance; appropriately identifies the limitations of diagnostic classification systems to guide treatment.

***Achieves the Standard by:***
demonstrating capacity to integrate available information in order to formulate a diagnosis / differential diagnosis; demonstrating detailed understanding of diagnostic systems to provide justification for diagnosis and differential diagnosis; adequate prioritising of conditions relevant to the obtained history and findings, utilising a biopsychosocial approach, and / or identifying relevant predisposing, precipitating perpetuating and protective factors; including communication in appropriate language and detail.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Relate the diagnostic criteria to the patient learning of violent fatal incident of close colleagues.

***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):***
scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response.

***Below the Standard (scores 1):***
scores 1 if there are significant omissions affecting quality.

***Does Not Address the Task of This Domain (scores 0).***

| 1.9. Category: DIAGNOSIS | Surpasses Standard | Achieves Standard | | Below the Standard | | Domain Not Addressed |
|---|---|---|---|---|---|---|
| ENTER GRADE (X) IN ONE BOX ONLY | 5 ☐ | 4 ☐ | 3 ☐ | 2 ☐ | 1 ☐ | 0 ☐ |

**3.0 COLLABORATOR**

**3.3 Did the candidate demonstrate an appropriately skilled approach to the Occupational Therapist? (Proportionate value - 20%)**

***Surpasses the Standard (scores 5) if:***
recognises complexity of liaison; manages potential conflicts of interest; readily contributes to interagency activities.

***Achieves the Standard by:***
liaising with relevant stakeholders / agencies; demonstrating respect, acknowledging and understanding roles, listening to differing views, identifying appropriate techniques to enhance engagement; building therapeutic relationships to improve patient outcomes; maintaining an effective working alliance.

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

a. Specifically comment on the stigmatising attitude of the OT.

***Below the Standard (scores 2):***
scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response.

***Below the Standard (scores 1):***
scores 1 if there are significant omissions affecting quality.

***Does Not Address the Task of This Domain (scores 0).***

| **3.3. Category: EXTERNAL RELATIONSHIPS** | **Surpasses Standard** | **Achieves Standard** | | **Below the Standard** | | **Domain Not Addressed** |
|---|---|---|---|---|---|---|
| **ENTER GRADE (X) IN ONE BOX ONLY** | **5** ☐ | **4** ☐ | **3** ☐ | **2** ☐ | **1** ☐ | **0** ☐ |

**5.0 HEALTH ADVOCATE**

**5.2 Did the candidate appropriately seek to address stigma? (Proportionate value - 25%)**

***Surpasses the Standard (scores 5) if:***
recognises the important role of psychiatrists in addressing stigma; reflects on personal behaviours that increase stigma; is aware that social contact and first-person narratives are effective at reducing stigma.

***Achieves the Standard by:***
demonstrating the capacity to: identify the impact of cultural beliefs and stigma of mental illness on patients, families and carers; apply principles of prevention, promotion, early intervention and recovery to clinical practice; recognise the role of staff in the generation and maintenance of stigma; constructively address competing attitudes towards mental health.

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

a. Demonstrate how psychoeducation / feedback can be used to tackle stigma.

***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):***
scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response.

***Below the Standard (scores 1):***
scores 1 if there are significant omissions affecting quality.

***Does Not Address the Task of This Domain (scores 0).***

| **5.2. Category: ADDRESSING STIGMA** | **Surpasses Standard** | **Achieves Standard** | | **Below the Standard** | | **Domain Not Addressed** |
|---|---|---|---|---|---|---|
| **ENTER GRADE (X) IN ONE BOX ONLY** | **5** ☐ | **4** ☐ | **3** ☐ | **2** ☐ | **1** ☐ | **0** ☐ |

## GLOBAL PROFICIENCY RATING

Did the candidate demonstrate adequate overall knowledge and performance at the level of a junior consultant psychiatrist?

| **Circle One Grade to Score** | **Definite Pass** | **Marginal Performance** | **Definite Fail** |
|---|---|---|---|