Committee for Examinations
Objective Structured Clinical Examination

Station 10
Brisbane September 2016

The Royal Australian & New Zealand College of Psychiatrists

1.0 Descriptive summary of station:

The candidate is required to take a focussed drug and alcohol history from Lisa, a 25-year-old woman who took an accidental overdose of over the counter opioids, in order to establish codeine dependence. The candidate is then expected to outline options for the management of codeine dependence. The history should be comprehensive and include enquiring about the use of substances other than codeine.

1.1 The main assessment aims are:

- To evaluate the candidate's ability to take a focussed drug and alcohol history, and establish opioid dependence (codeine) based on the findings.
- To evaluate the candidate's ability to outline management options for opioid dependence.

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

- Elicit sufficient criteria to clearly establish an opioid use disorder.
- Explain the diagnosis of an opioid misuse disorder in a non-judgemental manner.
- Highlight the importance of involvement of the partner in treatment planning.
- Include the benefits of opioid substitution.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Substance Used Disorders
- **Area of Practice:** Addictions
- **CanMEDS Domains:** Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Content; Formulation – Communication; Management – Initial Plan, Management – Long-term, Preventative)

References:

- 'Policy for maintenance pharmacotherapy for opioid dependence' Victorian government department of health 2013. (PDF on the internet http://www.health.vic.gov.au/dpcs/pharm.htm)
- 'National clinical guidelines and procedures for the use of buprenorphine in the maintenance treatment of opioid dependence' Commonwealth of Australia 2006.
- 'Clinical guidelines and procedures for the use of Methadone in the maintenance treatment of opioid dependence' Commonwealth of Australia 2003.

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: female in her mid-twenties, slightly dishevelled.
- 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.

As a junior consultant psychiatrist in the emergency department (ED) you have been asked to see Lisa, a 25-year-old woman, brought in the previous night. Her partner found Lisa drowsy and barely responsive and called an ambulance. ED staff diagnosed opiate intoxication and she is now medically cleared.

The on-call psychiatry registrar had assessed Lisa and documented:

- *Lives in a rental house with Jake (her partner for the past 7 years); in a loving relationship but no children.*
- *No relevant medical history or regular prescribed medications.*
- *No history of developmental trauma; grew up in a loving, supportive family.*
- *Works full time as an events company promoter for the past 5 years and loves her job.*
- *Denied any psychiatric history - first presentation to the ED. Overdose was unintentional - accidentally took too much medication to help her sleep.*
- *Mental state examination: denied symptoms of depression, mania and psychosis. Did admit to anxiety relating to insomnia but none at other times. She was cognitively intact.*

Lisa refused to answer questions about her drug and alcohol history until she sees you.

Your tasks are to:

- To take a focussed drug and alcohol history.
- To explain the diagnosis to the patient.
- To explain management options to the patient.

You will not receive any time prompts.

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' and any other candidate material specific to the station e.g. investigation results.
  - Pens.
  - Water and tissues are 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 - there are no cues or time prompts for you to give.
- DO NOT redirect or prompt the candidate – 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 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.

You have no opening statement or any prompts.

The role player opens with the following statement:

'Thanks for seeing me, this is a bit embarrassing.'

3.2 Background information for examiners

The aims of this station are to test the candidate's ability to take a focussed drug and alcohol history, establish a diagnosis of opioid dependence/opioid use disorder and establish dependence on codeine. The history should be comprehensive and include enquiring about the use of substances other than codeine, including alcohol, prescription medication and illicit drugs. The candidate must explain the diagnosis to the patient and outline initial and longer-term management options which must include substitution therapies, detoxification, antagonist treatments, residential treatments and 'medication free' options.

In this scenario the candidate is expected to discuss the risks and benefits of different options in the management of opiate dependence - this must include a discussion of different options that include abstinence and substitution therapy. They may prefer a short course of buprenorphine through the withdrawal period.

In order to 'Achieve' in this station the candidate **must**:

- Elicit sufficient criteria to clearly establish an opioid use disorder.
- Explain the diagnosis of an opioid misuse disorder in a non-judgemental manner.
- Highlight the importance of involvement of the partner in treatment planning.
- Include the benefits of opioid substitution.

A better candidate may:

- not only take a comprehensive drug and alcohol history but may enquire about gambling as well. They will clearly establish criteria for both physiological and psychological dependence on codeine, and identify that this case is severe.
- describe the severity of the dependence when explaining the diagnosis to the patient.
- also discuss the pros and cons of the different treatment options to the patient.

Substance Misuse Screening

1. Conduct a simple initial screening by asking about tobacco, alcohol, and drug use during the patient interview. Use a non-judgmental approach when asking these questions.
2. Should start with open-ended questions. May use statements like 'Tell me about your alcohol use?' instead of 'Do you drink alcohol?' assuming that all patients consume some alcohol may yield more forthright answers. Confirm responses by asking about frequency (how many days per week on average) and quantity (how many drinks on a typical day).
3. Alternatively, incorporate a short substance abuse screening instrument, like the 4-item CAGE or CAGE-AID (adapted version that also includes drug misuse). When substance abuse is indicated, follow-up with additional interview questions to learn more.
4. Patients may be less honest about drug use, but many signs and symptoms of drug use can be identified through the physical exam, laboratory, or toxicological testing. In this scenario the patient has been screened physically.

Identifying substance use may be made based on self-report data, objective analysis of specimens of urine, blood, etc. or other evidence (drug in the patient's possession, clinical signs and symptoms, or reports from informed third parties). It is always advisable to get corroboration from more than one source of evidence relating to substance use.

Diagnosis of Opioid Use Disorder:

According to the DSM-5 a minimum of 2 criteria are required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6-7 is severe (APA, 2013). Opioid Use Disorder is specified if opioids are the drug of abuse, with a problematic pattern of use leading to clinically significant impairment or distress occurring in the last 12 months:

1. Taking the opioid in larger amounts or for longer than intended
2. Persistent desire or attempts to cut down or quit but not being able to do it
3. Spending a lot of time obtaining, using or recovering from the opioid and its effects
4. Craving or a strong desire to use opioids
5. Repeatedly unable to carry out major obligations at work, school, or home due to opioid use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use
7. Stopping or reducing important social, occupational, or recreational activities due to opioid use
8. Recurrent use of opioids in physically hazardous situations
9. Consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids
10. *Tolerance as defined by *either* a need for markedly increased amounts to achieve intoxication or desired effect *or* markedly diminished effect with continued use of the same amount
11. *Withdrawal manifesting as *either* the characteristic withdrawal syndrome *or* opioids or something similar is used to avoid withdrawal.

**These criteria are not considered to be met for those individuals taking opioids solely under appropriate medical supervision.*

Dependence Syndrome (ICD-10) is similarly defined as a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.

According to the ICD-10, an essential part of the dependence syndrome is the presence of either psychoactive substance taking or a desire to take a particular substance and that the subjective awareness of compulsion to use drugs is most commonly seen during attempts to stop or control substance use. This diagnostic requirement is therefore expected to exclude situations like surgical patients who are given opioids for pain relief who may show signs of an opioid withdrawal state when drugs are not given but who have no desire to continue taking drugs.

Opioid Intoxication in the context of recent use, leads to clinically significant problematic behavioural or psychological changes (e.g. initial euphoria followed by apathy, dysphoria, psychomotor agitation or retardation, impaired judgement). It is manifested by the following transient signs and symptoms:

- Drowsiness or coma; slurred speech; impairment in attention or memory that are not attributable to other causes. In rare instances perceptual disturbances like hallucinations with intact reality testing or auditory, visual or tactile illusions in the absence of delirium can occur.

Opioid Withdrawal can manifest after cessation or reduction of opioids after heavy prolonged use, or when an opioid antagonist is administered after a period of opioid use. Withdrawal is a time limited set of symptoms that develop within minutes to days. The person can experience dysphoric mood, nausea/vomiting, muscle aches, lacrimation or rhinorrhoea, pupillary dilatation/piloerection or sweating, diarrhoea, yawning, fever and insomnia. These symptoms occur at a level that causes significant distress or impairment in functioning and no other cause can be found.

Management of Opioid Dependence/Opioid Use Disorder

- **This exert was taken from '**Policy for maintenance pharmacotherapy for opioid dependence' Victorian government department of health 2013. (PDF on the internet http://www.health.vic.gov.au/dpcs/pharm.htm)

The candidate must outline management options. The views of the patient regarding treatment should include their motivation to enter treatment, clarity on the trigger for seeking treatment, what their goals are for the treatment episode and an opinion of their stage of change.

As in other areas of chronic disease management, addiction treatment planning should:

- be a continuous process;
- involve the patient and reflect the patient's circumstances and case complexity;
- be based on coordinated care across service providers to address multiple domains;
- be documented so as to be meaningful to the patient, their carers and other service providers.

People presenting in crisis often seek short-term treatment, without necessarily having considered all their treatment options. All types of available treatment for opioid dependence should be considered in consultation with the patient, taking into account the patient's treatment preferences, and be based upon the evidence of effectiveness and safety of available options. The principles of informed consent should be observed in selecting and referring patients to treatment services.

The use of buprenorphine for several days following a crisis generally alleviates withdrawal symptoms without significant sedation, thereby allowing patients and clinicians to examine post-withdrawal issues relatively early on in the withdrawal episode. Patients who are not interested in ongoing pharmacotherapy treatment can stop a short course of buprenorphine with minimal rebound discomfort. However, if a patient wants to extend the duration of their withdrawal program, or decide on maintenance treatment they can continue buprenorphine treatment over a longer period of time (and switch to methadone if necessary).

The table below lists key factors for the different treatment approaches that are relevant to selection of the type of treatment, but is not an exhaustive summary of evidence for the effectiveness of the different approaches.

TYPE OF TREATMENT	ADVANTAGES	DISADVANTAGES
Substitution treatment	• Strong evidence of capacity to reduce opioid use, decrease mortality and improve quality of life • Avoids withdrawal in people who are ill or unstable • Capacity to retain patients in treatment • Widespread availability	• Expense to patient (daily travel dispensing fees) • Side effects • Stigma • Restrictions of supervised dosing (lifestyle travel etc.) • Prolonged withdrawal on cessation
Detoxification	• Short-term commitment • Attractive to consumer • Low threshold easy access • Entry point to treatment	• Poor long-term outcomes if stand-alone treatment • Increased overdose risk following withdrawal (loss of tolerance) • Can lead to destabilisation of other health conditions (chronic pain, mental health)
Antagonist treatment (naltrexone)	• Effective in decreasing opioid use in highly motivated well-supported people • 'Opioid-free' medication	• Poor retention for most people • Limited acceptance • Side effects • Complicates pain management • Cost to patient • Requires detoxification before initiating naltrexone • Increased overdose risk following cessation due to loss of tolerance

Residential Treatment and Rehabilitation

- Effective for those with complex social problems and poor living skills
- Usually 'medication-free'
- Requires commitment of time and separation from home and community
- Long-term outcomes depend on aftercare
- Completion of detoxification usually a requirement for entry
- Expensive to provide
- Often waiting lists
- High variability in quality of counselling services

Outpatient Counselling (no medication)

Some effectiveness in substance misuse problems of lesser severity and early stages.

A stepped care approach to treatment delivery suggests using less restrictive treatment approaches for those with low severity dependence (e.g. detoxification, counselling), increasing to more intensive treatment options (substitution treatment, residential) for those with more severe and entrenched problems.

Factors that indicate particular treatment directions:

- certain medical and psychiatric conditions (e.g. chronic pain, psychotic disorders, acute medical conditions such as infective endocarditis, HIV) can be destabilised during detoxification and attempts at sustaining an opioid-free lifestyle; such patients are often better directed to opioid substitution treatment.
- women who are opioid-dependent and pregnant should usually be directed to opioid substitution treatment due to the risk of antenatal complications associated with detoxification, and high rates of relapse to heroin or other opioid use with other treatment approaches.
- people with a preference for abstinence-based interventions who are well supported and well-motivated are more likely to respond to counselling with or without naltrexone.
- people with poor living skills and unstable social circumstances may benefit from residential treatment.

Opioid Substitution Treatment

Substitution treatment has specific requirements that need to be addressed in the treatment plan, including jurisdictional approval to prescribe methadone or buprenorphine, and dispensing arrangements.

Once diagnosis, consent to treatment and choice of modality is established, treatment should be commenced without delay. If there are concerns about initiating treatment safely and effectively, specialist referral is recommended.

At commencement of treatment a plan should be developed, and should then be actively reviewed over the course of the treatment episode. The treatment plan should involve appropriate referral to relevant services where the selected treatment approach cannot be delivered by the assessing service.

Evidence indicates poor outcomes in more severely dependent populations in substitution treatment.

Methadone is generally prescribed for opioid dependent patients 18 years or older. It is contraindicated in people with severe hepatic impairment or respiratory insufficiency, or those with a hypersensitivity to methadone or other ingredients in the formulation. Caution is needed when assessing individuals with high risk polysubstance use, co-occurring alcohol dependence, a history of naltrexone use, comorbid psychiatric illness, chronic pain or relevant concomitant medical problems.

A starting dose of below 20mg for a 70kg patient can be presumed to be safe, as this is the lowest dose at which toxicity has been observed. Patients should be observed daily prior to dosing and an assessment made of intoxication. In the first two weeks, with daily dispensing, any concerns should be referred to a doctor before a dose is administered. Because of the pharmacology of methadone, it is preferable that patients are reviewed at least once, and preferably twice by an experienced clinician (doctor or nurse) in the first week with a view to assessing intoxication from methadone. It is recommended that the methadone dose is not increased for at least the first 3 days of treatment unless there are clear signs of withdrawal at the time of peak effect, i.e. 3-4 hours after dose. Dose increments should be of 5-10mg every 3 days, subject to assessment with a total weekly increase not exceeding 20mg. Effective doses should be determined for individual patients but in general are 60-100mg per day.

Buprenorphine is an increasingly popular alternative to methadone. Until recently the only buprenorphine preparation available in Australia for the treatment of opioid dependence was Subutex®, a sublingual tablet containing only buprenorphine. Buprenorphine is a partial opioid agonist at the mu (μ) opioid receptors. Methadone is a full opioid agonist, and its effect is primarily due to the induction of cross-tolerance, which is dose dependent. In contrast buprenorphine achieves its effect primarily by prolonged occupancy of a high proportion of opioid receptors, blocking the action of the illicit or uncontrolled drug.

The sublingual tablet contains buprenorphine hydrochloride in 0.4, 2, and 8mg strengths and is safer than full agonists at higher doses. It has similar indications, contraindications and precautions to methadone, but can be prescribed for age 16 years and up. The other product, sublingual Suboxone® contains a 4:1 ratio of buprenorphine/naloxone. As naloxone is an opiate antagonist that reverses the effects of opiates it is expected to reduce the likelihood of intravenous abuse of the drug.

Methadone and buprenorphine are more likely to be successful if they are part of a comprehensive treatment program, addressing the physical, psychological and social/environment issues. For example, treatment may include a combination of medication, counselling and the development of a positive support network of peers, friends and a support group.

3.3 The Standard Required

In order to:

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 Lisa, a 25-year-old woman, currently living with your boyfriend, Jake, in a rental property about 5km from the hospital. You have been in this relationship for 7 years and are planning on getting married next year and starting a family. You have not had children before. You have been working as a promoter for an events management company for the past 5 years and love your job.

You cannot remember much about the previous night; you do remember being worried you may not be able to sleep and taking '*Nurofen plus*' as the codeine in it helps to make you drowsy. You think you probably took more than usual and that was why Jake found you very drowsy and called an ambulance. If asked by the candidate, you are adamant you did not intend to overdose and have never felt suicidal. You now feel very remorseful about what happened and would like to get some help. You were a little better by the time the ambulance arrived and they did not need any injection or medication at the time, but they decided to bring you in to make sure you were ok.

You have had problems with your sleep for as long as you can remember. Your sleep pattern has varied a bit over the years but you often would take 2 - 4 hours to get to sleep and you struggle to get up in the mornings. While it did have some impact on you when you were at school it really only caused significant problems when you started work. You found that you were constantly late for work and would often feel exhausted when you got there. When you started your current job you were fearful that you could lose it if this continued.

You had realised that when taking any medication for pain (like period pain or a headache), you would feel drowsy after taking medications that contained CODEINE and so started taking these to help with your sleep. Initially you found this helped with your sleep but after a few months, they didn't seem to be as effective. You were not sure why, maybe you were just more stressed and so you decided you would need to take more tablets to get to sleep. You have used these for years, unsure exactly how long.

In the beginning you would only take codeine containing medications on days before you had something important on at work, but for the past 2 years it has been every night in increasing amounts. Currently you need to take 30 to 40 tablets of codeine containing medications to get to sleep every night, and even then you sometimes struggle to get to sleep.

You have not been aware of any physical complications from taking the codeine, although if asked, you have noticed that you are very constipated. You actually hadn't really thought it was directly linked to taking codeine but put it down to poor diet and lack of exercise. You have had blood tests and physical examinations with your GP which have been normal, and the staff at the emergency department have told you that your blood tests are all normal.

With regard to the pattern of your codeine use, if you do not take codeine you now cannot sleep at all and you start to feel anxious. You also notice some physical symptoms including nausea, sweating, yawning, abdominal and leg cramps if you don't take codeine. You know that if you can just get some tablets you will be fine. If asked, you could consider that these ideas of getting medications could be cravings for codeine.

You are frightened that you may lose your job if you experience all these symptoms on days of work and have tried not to miss work for more than a day. You are aware that the increasing doses of codeine have started to affect your performance at work, especially when you decide to try to take less; you feel achy all over and like you might be coming down with a cold on these occasions, and need to take codeine during the day to get rid of the pain. However, this means you are often drowsy and find it hard to concentrate, resulting in your co-workers and boss making comments.

In order to get codeine containing medications you tend to visit several pharmacies on your way home from work, this can take you a few hours. Your preference is for *Nurofen plus* as you know how it works for you. You are not sure how much it all costs you but think it would be at about $100 a week. Your boyfriend, Jake, is not aware of the amounts you are taking but is concerned as he has noticed you don't seem to be yourself. The other day, at a family function your mother also commented on the change in you and your best friend, Judy, asked you whether you are OK as you seem more tired and distracted. You have started to avoid going out and have to admit this all seems to be impacting on multiple areas of your life.

Despite all this, you and Jake are still on track to get married in January and start a family. After what happened last night you realise that you have to do something about this before it gets out of control and before you start trying for a baby.

If the candidate asks, you are a social drinker, you are not a big fan of alcohol, you only drink when out with friends usually on Friday and Saturday nights, when you would only have 2 to 3 glasses of white wine. You have never had a problem with alcohol in the past. When you were between the ages of 18 and 22, you did take illicit drugs mostly on weekends at parties: you used ecstasy, speed, cocaine and marijuana, you have never used these drugs daily and are certain you never became dependant on them. You are uncertain about the exact amounts used. You have not used these drugs at all for over 3 years. You have never injected any drugs and you have never used any other prescribed drugs (particularly drugs called benzodiazepines like Valium).

You have never had any drug or alcohol counselling or treatment of any kind – you would never previously have even thought that you might need this, although you have felt very embarrassed by what you have been doing and are reluctant to tell anyone including your GP and Jake. You are keen to know what your treatment options are, you are frightened that if you go '*cold turkey*' you won't cope and you may lose your job. Thus you not only would like to know about how to '*detox*' but also if the codeine could be replaced with something else to make sure you can sleep.

With regard to past history, you have no past psychiatric history; you are fit and well and don't take any regular medications. You have never been allergic to a prescribed medication.

If asked about your early life, you come from a close and loving family. There is no history of developmental trauma. You did fine at school. You have always been able to make and keep friends. There is no history of you having behavioural problems or getting into trouble with police or driving offences. You have a wide circle of friends, and over the years you have lost contact with the friends whom you used to use drugs with.

4.2 How to play the role:

Casually attired, you were brought into hospital the previous night so will probably be a bit dishevelled and look tired. You are initially a little reluctant to talk about your codeine use as you have been keeping it a secret and are ashamed of what happened last night.

During the discussion you accept that you are addicted to codeine, and that is the only issue you have. You are keen to hear what can be done to manage your addiction.

On occasion you will yawn and also be restless in your chair and may act as if you are feeling a bit nauseous.

4.3 Opening statement:

'Thanks for seeing me, this is a bit embarrassing.'

4.4 What to expect from the candidate:

The candidate is likely to start by introducing themselves and asking about the reasons for you not wanting to give a drug and alcohol history to the assessing registrar the night before. You will explain you felt embarrassed about talking about it then, but have now thought about it and you want help to deal with the problem. You will answer the questions asked of you freely but will not elaborate too much. You will accept the candidate's diagnosis without question and listen to the treatment options outlined without interrupting except to clarify anything you do not understand. At the conclusion you will thank the candidate and will ask to be given some time to think about it.

4.5 Responses you MUST make:

When the candidate advises you of the diagnosis of opioid dependence/codeine dependence/opioid use disorder:

'Are you saying that I am a drug addict?'

4.6 Responses you MIGHT make:

'I am really worried if I stop the codeine, I won't cope, I won't sleep.'

If asked: Your mood is 'OK', your appetite, concentration, memory, energy levels and motivation are normal. You have never had periods of having an elevated mood or feeling high.

You get anxious about not being able to sleep but otherwise deny anxiety.

You are able to enjoy usual activities and have hope for the future. You deny suicidal thoughts or thoughts of self-harm.

You have never had any unusual experiences or psychotic symptoms like hearing voices that others do not hear or feeling like you are being watched or monitored.

4.7 Medication and dosage that you need to remember:

Nurofen plus: contains 200milligrams of ibuprofen and 12.5milligrams of codeine.

Recommended dosage is 2 tablets followed by 1-2 tablets every 4-6 hours (with a recommendation not to take more than 6 tablets in 24 hours).

You have not been given any medication since coming into hospital.

STATION 10 – MARKING DOMAINS

The Main Assessment Aims are:

- To evaluate the candidate's ability to take a focussed drug and alcohol history, and establish opioid dependence (codeine) based on the findings.
- To evaluate the candidate's ability to outline management options for opioid dependence.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed history of the patient's drug and alcohol history? (Proportionate value – 35%)

Surpasses the Standard (scores 5) if:
clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication; excludes other addictions like gambling; elicits the severity of the condition from the history taken.

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 substance use with appropriate depth and breadth; history taking is hypothesis-driven; clarifying important positive and negative features; enquiring about other substances of abuse including alcohol, prescription medication and illicit drugs.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Elicit sufficient criteria to clearly establish an opioid use disorder.

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:
omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in history including a failure to enquire about criteria for a codeine use disorder; failure to enquire about other substance misuse.

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 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

1.12 Did the candidate communicate their findings to the patient sensitively, appropriately and accurately? (Proportionate value - 15%)

Surpasses the Standard (scores 5) if:
communicates findings in a sophisticated manner; explains the severity of the opioid use disorder.

Achieves the Standard by:
correctly communicating findings of an opioid misuse disorder in suitable language, with appropriate detail and sensitivity; reflecting on limitations of the ED setting; being responsive to the patient's embarrassment.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Explain the diagnosis of an opioid misuse disorder in a non-judgemental manner.

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:
unable to synthesise information in a cohesive manner; fails to explain a diagnosis of an opioid use disorder to the patient; incorrectly interprets the information provided by the patient.

1.12. FORMULATION - Communication	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

1.13 Did the candidate formulate and describe a relevant initial management plan? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:
provides a sophisticated link between the plan and key issues identified; clearly addresses difficulties in the application of the plan; succinctly covers generally accepted treatment options; provides the pros and cons of the different treatment options to the patient.

Achieves the Standard by:
demonstrating the ability to prioritise and implement evidence based treatment for an opioid use disorder; explaining initial management options including detoxification with and without medication aids, antagonist treatments, counselling.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Highlight the importance of involvement of the partner in treatment planning.

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. The candidate mentions all 4 of the treatment options in some detail.

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 adversely impact on patient care; only mentions one or none of the treatment options outlined above.

1.13. Category: MANAGEMENT - Initial Plan	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

1.16 Did the candidate formulate an appropriate longer term management plan, including preventative treatment? (Proportionate value – 25 %)

Surpasses the Standard (scores 5) if:
overall plan is sophisticated, tailored yet comprehensive; incorporates a sophisticated psychosocial approach into plan; succinctly covers generally accepted treatment options including some psychological and social therapies promulgated in the literature; provides the pros and cons of the different treatment options to the patient. May address the issue of the sleep problem.

Achieves the Standard by:
demonstrating the ability to prioritise and implement evidence based care; explaining options including substitution therapies, residential treatments and 'medication free' options; giving priority to continuity of care; demonstrating awareness of possible complications of treatment and available interventions/monitoring; acknowledging appropriately realistic possibility of treatment failure; considering interface between medication vs no medication; counselling vs no counselling, community vs residential.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Include the benefits of opioid substitution.

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 adversely affect outcomes; candidate has difficulty with most of the skills above.

1.16. Category: MANAGEMENT - Long-term, Preventative	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
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 defined tasks?

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