Committee for Examinations
Objective Structured Clinical Examination

Station 1
Gold Coast April 2019

The Royal Australian & New Zealand College of Psychiatrists

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DO NOT REMOVE FROM ROOM

ACTIVE BYE STATION 1 NOTES

The following information is provided for you. These same 'Instructions to Candidate' will be available in Station 1.

You may make notations on your notepad, which you will take with you into Station 1.

- You have **twenty (20) minutes** in this Active Bye Station to watch a DVD of an interview with a patient, and work on the responses to the tasks based on the DVD.
- After you leave the bye station, you have a further **five (5) minutes outside the examination room** to continue working on the responses you will present to the examiners.

Instructions to Candidate

This is a VIVA station: there is no role-player in the examination room.

Your tasks are to:

- Explain how you would have managed that situation if you were the doctor conducting the interview, after it was temporarily halted at 7.12 minutes, when the patient experienced difficulties.
- Present your mental state examination of the patient.
- Present your formulation of the patient's situation.
- Discuss the risks and benefits of the patient's current choice of treatment.
- Outline your management plan for this patient.

You will not receive any time prompts.

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1.0 Descriptive summary of station:

This is a viva station following an active bye in which the candidate will watch the DVD of an interview of a patient with panic disorder. During the course of the interview, the patient has a panic attack. The interview halts at this time and resumes at a time a few minutes later, when the patient has recovered from the panic attack. The candidates are expected to present a mental state examination, formulation and management plan for the patient.

The candidate is also expected to describe how they would have managed the panic attack, if they were the doctor conducting the interview. The patient asks the doctor to let them to keep using clonazepam, which they get from 'a friend'. The candidate is to present the issues pertaining to this request.

1.1 The main assessment aims are to:

- Identify and present important features of a mental state examination, formulate and provide a management plan.
- Describe the risks associated with long term benzodiazepine use, and acquiring medication from unlicensed sources.
- Outline how to manage a panic attack.

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

- Describe the use of controlled breathing, and at least one more technique to control the panic attack.
- Identify anticipatory anxiety and avoidance or ruminations as part of the patient's anxiety.
- Link the premorbid personality and childhood adversity to the development of panic disorder.
- Explain the risk of self-medicating with unprescribed medication from an unlicensed source.
- Address the patient's low self-esteem as part of the management.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category**: Anxiety Disorders, Core clinical skills
- **Area of Practice**: Adult Psychiatry
- **CanMEDS Marking Domains Covered:** Medical Expert, Collaborator, Professional
- **RANZCP 2012 Fellowship Program Learning Outcomes**: Medical Expert (Assessment – Mental State Examination, Formulation, Management – Treatment Contract, Management – Therapy), Collaborator (Patient Relationships), Professional (Ethics)

References:

- Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of panic disorder, social anxiety disorder and generalised anxiety disorder, Gavin Andrews, Caroline Bell, Philip Boyce, Christopher Gale, Lisa Lampe, Omar Marwat, Ronald Rape and Gregory Wilkins
- Textbook of Anxiety Disorders: Author: Dan J. Stein (ed.); Eric Hollander (ed.); Barbara O. Rothbaum (ed.)
- Ment Health Clin. 2016 Jun; 6(3): 120–126. Published online 2016 May 6. doi: 10.9740/mhc.2016.05.120 Benzodiazepine use, misuse, and abuse: A review Allison Schmitz, PharmD
- Diagnostic and Statistical Manual of Mental Disorders (DSM-5), Fifth edition. American Psychiatric Association. 2013
- World Health Organization. (1992). The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines (Vol. 1). World Health Organization.
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- Broocks, A, Bandelow, B, Pekrun, G. (1998) Comparison of aerobic exercise, clomipramine, and placebo in the treatment of panic disorder. The American Journal of Psychiatry 155: 603–609.
- Milrod, B, Leon, AC, Busch, F. (2007) A randomized controlled clinical trial of psychoanalytic psychotherapy for panic disorder. The American Journal of Psychiatry 164: 265–272.
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- Depping, AM, Komossa, K, Kissling, W. (2010) Second-generation antipsychotics for anxiety disorders. The Cochrane Database of Systematic Reviews 8: CD008120.
- CNCPS Second Phase Investigators (1992) Drug treatment of panic disorder: Comparative efficacy of alprazolam, imipramine, and placebo: Cross-national collaborative panic study, second phase investigators. The British Journal of Psychiatry 160: 191–202.
- Katzman, MA, Bleau, P, Blier, P. (2014) Canadian clinical practice guidelines for the management of anxiety, posttraumatic stress and obsessive-compulsive disorders. BMC Psychiatry 14(Suppl. 1): S1.
- Stein, MB, Goin, MK, Pollack, MH. (2009) Practice Guideline for the Treatment of Patients With Panic Disorder, 2nd Edition. Arlington, VA: American Psychiatric Association
- Baldwin, DS, Anderson, IM, Nutt, DJ. (2014) Evidence-based pharmacological treatment of anxiety disorders, post-traumatic stress disorder and obsessive-compulsive disorder: A revision of the 2005 guidelines from the British Association for Psychopharmacology. Journal of Psychopharmacology 28: 403–439.

Acknowledgements:

- RANZCP Auckland Training Programme Mock Objective Structured Clinical Examination Station No. 2, April 2008.

1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiners x 2, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- DVD player.
- Role players for the DVD: doctor should be a professionally dressed male; role player for the patient is a male in his mid 30s, polite, well dressed, worried looking.
- Pen for candidate.
- Timer and batteries for examiners.

2.0 Instructions to Candidate

You have **fifteen (15) minutes** to complete this station after **five (5) minutes** of reading time.

This is a VIVA station: there is no role-player in the examination room.

You have viewed a DVD recording of an interview in the active bye station.

Your tasks are to:

- Explain how you would have managed that situation if you were the doctor conducting the interview, after it was temporarily halted at 7.12 minutes, when the patient experienced difficulties.
- Present your mental state examination of the patient.
- Present your formulation of the patient's situation.
- Discuss the risks and benefits of the patient's current choice of treatment.
- Outline your management plan for this patient.

You will not receive any time prompts.

Station 1 - 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).

During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- TAKE NOTE that there are no cues / time prompts for you to give.
- DO NOT redirect or prompt the candidate unless scripted.
- 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 **fifteen (15) 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 co-examiner's and your mark sheet in **one** 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 final task:

- You are to state the following:

  'Are you satisfied you have completed the task(s)?

  If so, you must remain in the room and NOT proceed to the next station until the bell rings.'

- If the candidate asks if you think they should finish or have done enough etc., refer them back to their instructions and ask them to decide whether they believe they have completed the task(s).

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room, briefly check ID number.

This is a VIVA station**.** There are no opening statements or prompts.

3.2 Background information for examiners

In this viva station, the candidate is to watch the DVD of an interview of a patient with a panic disorder. Candidates are expected to present a mental state examination, formulation and management plan for the patient.

During the course of the interview the patient has a panic attack. The interview halts at this time, and resumes at a time a few minutes later when the patient has recovered from the panic attack. The candidate is expected to describe how they would have managed the panic attack if they were the doctor conducting the interview. The patient requests the doctor to permit them to keep using clonazepam which they acquire from 'a friend', and the candidate is to present the issues pertaining to this request.

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

- Describe the use of controlled breathing, and at least one more technique to control the panic attack.
- Identify anticipatory anxiety and avoidance or ruminations as part of the patient's anxiety.
- Link the premorbid personality and childhood adversity to the development of panic disorder.
- Explain the risk of self-medicating with unprescribed medication from an unlicensed source.
- Address the patient's low self-esteem as part of the management.

A surpassing candidate may:

- present a sophisticated mental state examination and formulation
- consider legal and ethical aspects of self-medicating
- be aware of countertransference issues in regard to this
- present levels of evidence in their outline of the management plan.

DSM 5 defines a **panic attack** as a discrete period of intense fear or discomfort in which four or more of the following symptoms developed abruptly, and reached a peak within 10 minutes:

1. Palpitations, pounding heart, or accelerated heart rate
2. Sweating
3. Trembling or shaking
4. Sensation of shortness of breath or smothering
5. Feeling of choking
6. Chest pain or discomfort
7. Nausea or abdominal distress
8. Feeling dizzy, unsteady, light-headed, or faint
9. Derealisation or depersonalisation
10. Fear of losing control or going crazy
11. Fear of dying
12. Paraesthesia (numbing or tingling)
13. Chills or hot flushes.

Panic disorder is a common distressing and often disabling condition in which patients experience recurrent unexpected panic attacks followed by at least one month of persistent concerns about having additional attacks (i.e., anticipatory anxiety), worry about implications of the attack, or a significant change in behaviour (e.g., avoidance) related to the attacks.

According to DSM 5, to diagnose panic disorder, one needs:

- One or more of the attacks followed by a month (or longer) of one or both of the following:
- Persistent worry about having more panic attacks and / or their consequences (e.g., having a heart attack).
- A significant abnormal change in behaviour in response to the attacks, such as avoiding unfamiliar situations.
- The disturbance cannot be attributed to the physiological effects of a substance, such as a drug or medication, or another medical condition.
- The disturbance cannot be better explained by another mental disorder, such as social anxiety disorder or specific phobia, which may involve panic attacks.

ICD 10 criteria

According to ICD-10, for a definite diagnosis of panic disorder, several severe attacks of autonomic anxiety should have occurred within a period of about one month:

a. In circumstances where there is no objective danger;
b. Without being confined to known or predictable situations; and
c. With comparative freedom from anxiety symptoms between attacks.

ICD-10 further clarifies that panic disorder must be distinguished from panic attacks occurring as a part of established phobic disorders. When secondary to depressive disorders fulfilling the criteria, panic disorder should not be given as the main diagnosis.

Management of a panic attack

While there is plenty of information on how to manage panic disorder, scant literature is available about how to stop a panic attack. The management should include:

1. Clear reassurance about the nature of attack, and the fact that these attacks are not lethal and will resolve spontaneously.
2. Directing the patient to loosen the tight clothes.
3. Allow room and space for breathing, allow fresh air to come in.
4. Encourage to do controlled breathing: try to relax by taking slow, deep and complete breaths.
5. Encourage to use positive statements to oneself like: '*I know this is just an anxiety attack', 'I am not going to die', 'This is going to finish soon'.*
6. If the attack continues, a fast-acting benzodiazepine like clonazepam may be offered but is best avoided.
7. The therapist / clinician must remain calm and in control throughout the process.

Risks of Benzodiazepine misuse and using medication from an unlicensed source

Although the addiction potential of benzodiazepines (BZDs) became widely known decades ago, much remains unknown about identifying individuals at risk for developing addiction and how to treat individuals abusing BZDs. Prescription drug abuse has received more attention in recent years, but most of the research has focussed on prescription opioid abuse. Despite the risk of abuse and the introduction of safer alternatives, BZDs are one of the most prescribed classes of medications.

BZD misuse can be divided into two patterns:
1) deliberate or recreational abuse with the intention of getting high and
2) unintentional misuse that begins as legitimate use but later develops into inappropriate use.

Young adults ages 18 to 35 years comprise the largest portion of BZD abusers. BZD use and misuse have a strong association with comorbid psychiatric disorders, and personal or family history of substance use disorders. Comorbid psychiatric disorders are more common in BZD abusers than in other substance misuse populations. Approximately 40% of BZD abusers report a comorbid psychiatric disorder, highlighting the importance for clinicians to address both the underlying psychiatric disorder, as well as the BZD misuse. Nevertheless, alprazolam and clonazepam are the two BZDs associated with the most misuse-related ED visits; the rate of alprazolam involvement is more than double that of clonazepam.

Sources of prescription drug diversion are numerous, and can include both health care-related and non-health care-related sources. The most frequently reported health care source of BZD diversion was a regular prescriber, followed by a script doctor (i.e. a provider that sells prescriptions), doctor shopping (i.e. an individual receives care from multiple providers for multiple prescriptions), and pharmacy diversion (i.e. undercounting pills by pharmacy staff, employee theft). Recommendations for identifying high-risk individuals and reducing BZD abuse include obtaining a thorough personal and family substance use history, obtaining a urine drug screen, monitoring frequently for signs of abuse, reassessing the risks and benefits of ongoing therapy, prescribing a limited number of as-needed doses to reduce physiologic dependence, and differentiating carefully between physiologic dependence and addiction.

Some clinicians argue the medical community has overreacted to the risks of BZD misuse, stating it may result in under-prescribing of a safe and efficacious class of medications, and they argue for responsible but continued benzodiazepine prescribing. Although benzodiazepines possess abuse potential, particularly in substance misuse populations, it is crucial that risks be balanced with benefits. Prescribers must also weigh the risks of untreated illnesses. Poorly controlled or untreated anxiety or insomnia may increase the risk of alcohol relapse. Evidence-based pharmacotherapy and use of agents without abuse potential should be prescribed first-line and when appropriate, but BZDs may be indicated for some patients at elevated risk for misuse. When this occurs, provide thorough education on the risk of combining these drugs with alcohol or other substances, discuss diversion, prescribe a BZD with lower abuse potential, monitor for adverse effects, and monitor for inappropriate use.

Despite risks of misuse and diversion, BZDs are a safe and efficacious class of medications and continue to have a place in therapy. Lawmakers and health care professionals will be tasked with reducing misuse while maintaining accessibility for appropriate patients. Reductions in inappropriate prescribing rather than all prescribing should be emphasised and encouraged. Education is vital. Health care professionals must be knowledgeable about abuse patterns and diversion trends. It is imperative that prescribers and pharmacists educate patients not only on the risks to themselves, but also the risks to others, to reduce medication sharing. It is critical to identify BZD misuse risk factors prior to prescribing, use safer alternatives, and make appropriate interventions to combat ongoing abuse.

Outline of the evidence base for panic disorder that should be part of the management plan

A collaborative, pragmatic approach is recommended, beginning with psychoeducation and advice on life-style factors followed by specific treatment. In addition to efficacy, selection of initial treatment should take into account severity, patient preference, accessibility, cost, tolerability and safety.

A large body of level I evidence demonstrates the efficacy of CBT, antidepressant pharmacotherapy with SSRIs, SNRIs or TCAs and benzodiazepines for the treatment of panic disorder. There is limited or lower quality evidence for other psychological therapies, other antidepressant classes and other medication classes.

Initial treatment options are CBT, medication with an SSRI (or an SNRI if SSRIs are ineffective or are not tolerated) in combination with graded exposure to anxiety triggers, or a combination of CBT plus medication. Initial treatment should be selected in collaboration with the patient, based on the severity of the disorder, previous response to treatment, availability and the person's preference.

NICE guidelines recommend the use of CBT over first-line pharmacotherapy, and that pharmacological interventions should only be routinely offered to people who have not benefitted from psychological interventions (National Institute for Health and Care Excellence, 2011b, 2012).

Other guidelines, including Canadian clinical practice guidelines (Katzman et al., 2014), those by the American Psychiatric Association (Stein et al., 2009) and the British Association of Psychopharmacology (Baldwin et al., 2014), suggest that the choice of treatment (between CBT and pharmacotherapy) should be based on the person's preferences, previous response to treatment, comorbidity and availability of treatment options.

CBT for panic disorder

CBT has been shown to be efficacious in the treatment of panic disorder. It has been extensively studied in studies comparing CBT with a control, pharmacotherapy, and the combination of CBT and pharmacotherapy.

Typical CBT programs address the physical, cognitive and behavioural symptoms of panic disorder, and aim to prevent relapse in three stages.

The first stage includes psychoeducation (explaining about anxiety and the symptoms of panic disorder), formulation, treatment rationale, symptom monitoring and addressing factors that facilitate or hinder therapy. Motivational interviewing and education of the person's family or members of their social support network should also be considered, and written information or links to reliable online information should be provided.

The second stage includes identifying and reducing cognitive symptoms through challenging unhelpful thinking, particularly about catastrophic cognitions, using behavioural experiments and in vivo exposure to test hypotheses, with the aim of reducing safety behaviours and avoidance, and interoceptive exposure to feared physical sensations.

The final stage is relapse prevention that includes identifying potential precipitants for setbacks, identifying the patient's early warning signs and developing a plan to manage setbacks and prevent relapse.

The optimal duration of CBT for panic disorder is 7–14 hours, usually delivered in weekly sessions.

CBT can be delivered face-to-face (individual or group), accessed by computer, tablet or smartphone application (dCBT), or through self-help books. CBT delivered face to face (particularly individual) is the most traditional form of delivery and the most widely available, hence has been the most extensively studied.

dCBT has been an area of rapid development and study over recent years. There have been 12 RCTs of automated guided dCBT, which show a mean effect size of 1.31 (95% CI = [0.85, 1.76]) at a mean follow-up of 7.8 months post intervention, and an average adherence of 74%. Three of the studies included a comparison with face-to-face CBT and showed no difference in efficacy.

Other psychological therapies and interventions

There is currently much interest in other potentially useful therapies such as mindfulness, and Acceptance and Commitment Therapy (ACT). However, there is insufficient evidence from meta-analyses specific to panic disorder to make conclusions at this time.

Exercise as a form of treatment has been reported to be less effective than medication and no more effective than relaxation (Broocks et al., 1998; Wedekind et al., 2010). Exercise is, nevertheless, recommended by National Institute for Health and Care Excellence (NICE) as part of general health care for people with panic disorder (National Institute for Health and Care Excellence, 2011a). Often, patients with panic disorder have stopped exercising because they catastrophically misinterpret the bodily sensations produced such as increased heart rate, shortness of breath and sweating. This can be managed by careful explanation and encouraging gradual introduction of exercise.

Panic-focussed psychodynamic psychotherapy delivered twice a week in a 12-week manualised treatment program has been shown to be effective in one RCT (Milrod et al., 2007).

Emotion-Focussed Therapy (EFT) developed by Shear and Colleagues, specifically targets emotional regulation as it related to interpersonal control and to fears of being abandoned or trapped. However, in a randomised comparison, EFT was found no better than a pill-placebo and was less effective than both CBT and imipramine.

Two studies of Eye Movement Desensitisation and Reprocessing (EMDR) have reported equivocal or unsustained benefits, and do not support the use of EMDR for panic disorder (Feske and Goldstein, 1997; Goldstein et al., 2000).

Relaxation Therapies such as progressive muscle relaxation have been regarded as weak treatments for panic disorder.

Pharmacotherapy for panic disorder

Medication with SSRIs, SNRIs, TCAs and benzodiazepines has been shown to be efficacious in the treatment of panic disorder. These medications have been extensively studied in RCTs comparing medicines with pill placebo control, CBT, and the combination of CBT and pharmacotherapy.

On average, rates of response to medication are 50–70%. Meta-analyses report equivalent efficacy for SSRIs, TCAs and benzodiazepines. These studies also report no differences in attrition and dropout rates for the different medications (SSRIs 23.1%, TCAs 23.5% and benzodiazepines 17.7%). MAOIs are effective in managing the symptoms of panic disorder, but their use is limited by their safety and tolerability profile.

Medications with less supportive evidence include Mirtazapine, Duloxetine, Milnacipran, Moclobemide, Bupropion, Divalproex, levetiracetam and Gabapentin.

A Cochrane review of second-generation antipsychotic agents (Depping et al., 2010) reported no clear benefits for their use in panic disorder.

Although there is lack of clear evidence for what constitutes an adequate trial of medication, consensus expert recommendation is to wait for at least six weeks with at least two weeks at the full dose, however the recently updated British Association of Psychopharmacology guidelines recommend 12 weeks.

The optimal duration of treatment has not been well studied. Most guidelines refer to expert consensus recommendations and suggest continuation for at least six months (National Institute for Health and Care Excellence, 2011a) to a year.

When medication is discontinued, consensus advice is to taper medication down over weeks to months to reduce the risk of discontinuation symptoms.

Role of Benzodiazepines

Benzodiazepines (alprazolam, clonazepam, diazepam, lorazepam) have been shown to be efficacious for the treatment of panic disorder, approximately equal to that of SSRIs and TCAs. Benzodiazepines have a rapid onset of action. Alprazolam is the most extensively studied of the benzodiazepines, and was the benzodiazepine used in the Cross National Collaborative Panic Study (CNCPS Second Phase Investigators, 1992). It is effective in the treatment of panic disorder but is no longer recommended due to safety concerns, mainly a high risk of dependency, and difficulty discontinuing.

Despite their efficacy, benzodiazepines are not recommended as first-line treatment options, largely because of the risk of side effects (particularly sedation and cognitive impairment), tolerance and dependence (especially with alprazolam). Their use in combination with CBT also has potentially detrimental effects. Because of these concerns, recommendations are for benzodiazepines to be used short term, and to be dosed regularly rather than 'as required' (Katzman et al., 2014; Stein et al., 2009).

Occasionally, benzodiazepines may be useful in an emergency setting for short-term management of severe agitation or anxiety, and for the management of an acute panic attack. They should not be used as a treatment for panic disorder in people with a history of substance use disorder.

A possible formulation

Anthony is a 36-year-old male who was referred by his GP for psychiatric assessment due to the presence of panic symptoms.

These panic symptoms were closely correlated to Anthony commencing his own accounting business. One might hypothesise that Anthony's fear of failure, and somewhat dependent nature made it difficult for him to work in a more autonomous role.

From a cognitive persepective, Anthony is experiencing a vicious cycle of anxiety and avoidance. His physical symptoms of anxiety lead to the cognition that he is suffering from a medical illness (e.g. heart attack), which fuels his physical symptoms further resulting in avoidance of areas he deems unsafe. His anticipatory anxiety regarding the fear of further attacks reinforces his avoidance which ultimately leads to greater dysfunction.

Anthony is currently managing his anxiety symptoms with benzodiazepines which, in the short term, alleviates his anxiety. He is at risk of benzodiazpine dependence with tolerance to the effects of his clonazepam, as well as the risk associated with acquiring an ongoing supply of medications in an illicit manner which may lead to forensic related issues. This is of particular concern, given his past history of alcohol misuse, and a similar history in his father which may indicate a biological predisposition towards substance abuse or dependence.

It would seem that Anthony has adpoted a physical explanatory model for his symptoms. He believes that he has a 'medical illness' which shifts the focus away from psychological strategies, and other ways of dealing with his anxiety. The possibility of a medical explanation for his symptoms (e.g. arrythmia) merits consideration, and this is, potentially, a driving factor for his anxiety.

Anthony's developmental history may shed some light on his current difficulties. He has a childhood history of anxiety with fears of separation. As a small child he utilised periods of distress to obtain care from his mother which may have led to more entrenched dependence. His current panic symptoms may, from a psychodynamic perspective, be an unconscious expression of distress which has the aim of eliciting care from those around him. Anthony seems to have had an ingrained sense of poor self worth, perhaps dating back to the invalidation and violence he witnessed from his father, as well as the feeling of disappointing his mother. His feelings of being unable to manage his anxiety may be compounding his low sense of self-worth, and a feeling of helplessness.

Looking to the future, Anthony has a number of challenges. His ongoing stress at work may continue to fuel his anxiety, and his misuse of benzodiazepines may lead to dependence, as well as rejection of psychological therapies for his panic disorder. Despite these, Anthony seems to have a number of protective factors. He has engaged well with his psychiatrist, and his family seems to be a source of support for him.

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.

STATION 1 – MARKING DOMAINS

The main assessment aims are:

- Identify and present important features of a mental state examination, formulate and provide a management plan.
- Describe the risks associated with long term benzodiazepine use, and acquiring medication from unlicensed sources.
- Demonstrate the ability to manage a panic attack.

Level of Observed Competence:

3.0 COLLABORATOR

3.4 Did the candidate develop an appropriate therapeutic relationship with the patient? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:
Recognises the complexity of the situation; prioritises use of specific additional resources to meet the specific needs of the patient; positively promotes safety for all involved.

Achieves the Standard by:
Demonstrating ability to develop therapeutic relationship in a stressful situation; responding quickly to concerns raised; maintaining open communication; appropriately informing patient of useful techniques; describing options like providing reassurance and plenty of space, loosening tight clothes, remaining calm, using positive statements and offering a fast acting benzodiazepine as a last resort.

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

a. Describe the use of controlled breathing, and at least one more method to manage the panic attack.

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

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

1.0 MEDICAL EXPERT

1.3 Did the candidate demonstrate adequate proficiency in presenting a mental state examination? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:
the mental state examination is relevant to the patient's problems and circumstances; it is presented at a sophisticated level.

Achieves the Standard by:
demonstrating capacity to present a thorough, organised and accurate mental state examination; assessing key aspects of observation of appearance, behaviour, conversation and rapport, mood and affect, thought (stream, form, content, control), perception, insight and judgement; deciding on the importance of a cognitive assessment; providing a succinct presentation with accurate use of phenomenological terms; including appropriate positive and negative findings.

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

a. Identify anticipatory anxiety and avoidance or ruminations as part of the patient's anxiety.

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).

1.3. Category: ASSESSMENT – Mental State Examination	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

1.11 Did the candidate generate an adequate formulation to make sense of the presentation? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:
provides a superior performance in a number of areas; demonstrates prioritisation and sophistication; applies a sophisticated sociocultural formulation.

Achieves the Standard by:
identifying and succinctly summarising important aspects of the history; synthesising information using a biopsychosocial framework; integrating medical, developmental, psychological and social information; developing hypotheses to make sense of the patient's predicament; accurately describing recognised theories and evidence; commenting on missing or unexpected data; accurately linking formulated elements to any diagnostic statement; analysing vulnerability and resilience factors.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Link the premorbid personality and childhood adversity to the development of panic 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):
scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality respons

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

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

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

7.0 PROFESSIONAL

7.1 Did the candidate appropriately adhere to principles of ethical conduct and practice? (Proportionate value – 15%)

Surpasses the Standard (scores 5) if:
sensitively explains the risks of using benzodiazepines when not properly prescribed and monitored; seeks peer review in difficult countertransference situations; comprehensively considers all major aspects of ethical conduct and practice.

Achieves the Standard by:
demonstrating the capacity to: identify and adhere to professional standards of practice in accordance with College Code of Conduct / Code of Ethics and institutional guidelines; apply ethical principles to resolve conflicting priorities; demonstrate the ability to clearly communicate indications for treatment with clonazepam; work within patient treatment goals, and negotiate targeted outcomes; adequately inform regarding treatment risks / benefits and complications, including potential adverse outcomes; provide psychoeducational material; employ a psychologically informed approach, especially to risky behaviours.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Explain the risk of self-medicating with unprescribed medication from an unlicensed source.

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).

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

1.0 MEDICAL EXPERT

1.14 Did the candidate demonstrate an adequate knowledge and application of relevant biological and psychosocial therapies? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:
includes a clear understanding of levels of evidence to support treatment options.

Achieves the Standard by:
demonstrating awareness of the efficacy of CBT, antidepressant pharmacotherapy with SSRIs, SNRIs or TCAs and benzodiazepines for the treatment of panic disorder; demonstrating the understanding of these treatments; identifying specific treatment outcomes and prognosis; appropriate selection, benefits / risks, application, adherence, monitoring of specific interventions; medication(s) choice, dosing and monitoring; application of psychoeducation; sensitive consideration of barriers to implementation; identifying the role of other health professionals.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Address the patient's low self-esteem as part of the management.

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

1.14. Category: MANAGEMENT - Therapy	**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**

Committee for Examinations
Objective Structured Clinical Examination

Station 2
Gold Coast April 2019

The Royal Australian & New Zealand College of Psychiatrists

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1.0 Descriptive summary of station:

The RANZCP is committed to redress the inequities in mental health experienced by Aboriginal and Torres Strait Islander and Māori communities (Indigenous mental health). In this station, the candidate is expected to develop a comprehensive formulation of an Aboriginal woman in a culturally sensitive manner that indicates Indigenous cultural awareness. The candidate is expected to recognise illness in the midst of cultural and spiritual complexity, and then attempt to make sense of it in their formulation. The candidate is to take a history including important cultural and spiritual information from Jacinta, who is recovering from a manic episode. As a demonstration of engaging Jacinta, the candidate is asked to read aloud the Acknowledgement of Country document. The candidate will present a formulation that explains why this woman is suffering from these problems at this point in time.

1.1 The main assessment aims are to:

- Develop rapport with an Indigenous woman who has a mental illness.
- Clarify the history in respect of culture, spirituality and mental illness.
- Make sense of the history gathered by presenting their formulation for an Indigenous woman with a mental illness, taking into account cultural and spiritual factors.

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

- Read aloud the Acknowledgement of Country in a manner that exhibits cultural sensitivity.
- Specifically explore Jacinta's cultural beliefs.
- Take time to clarify experiences and meaning related to Jacinta's deceased sister.
- Identify the core components of a comprehensive formulation specifically including cultural and spiritual dimensions.
- Succinctly link Jacinta's cultural and spiritual factors into the formulation.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category**: Mood Disorders, Other Skills – Indigenous
- **Area of Practice**: Adult Psychiatry
- **Can MEDS Marking Domains Covered**: Medical Expert, Communicator, Scholar
- **RANZCP 2012 Fellowship Program Learning Outcomes**: Medical Expert (Assessment – Data Gathering Process, Assessment – Data Gathering Content, Formulation), Communicator (Cultural Diversity), Scholar (Application of Knowledge)

References:

- Malhi, G.S., Bassett, D., Boyce, P., Bryant, R., Fitzgerald, P.B., Fritz, K., Hopwood, M., Lyndon, B., Mulder, R., Murray, G., Porter, Singh, A.B Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders. Australian and New Zealand Journal of Psychiatry 2015, Vol. 49(12) 1-185.
- Sperry, L., Gudeman, J.E., Blackwell, B., Faulkner, L.R. Psychiatric Case formulations. American Psychiatric Press, Washington. 1992.
- RANZCP Clinical Examinations Formulation Guidelines for Trainees 2004.
- RANZCP Entrustable Professional Activity (EPA) https://www.ranzcp.org/Files/PreFellowship/2012-Fellowship-Program/EPA-forms/EPA-table.aspx
- RANZCP https://www.ranzcp.org/About-us/About-the-College/Reconciliation-Action-Plan
- RANZCP https://www.ranzcp.org/Publications/Indigenous-mental-health/Aboriginal-Torres-Strait-Islander-mental-health
- RANZCP https://www.ranzcp.org/Publications/Indigenous-mental-health/Aboriginal-Torres-Strait-Islander-mental-health/The-Dance-of-Life
- RANZCP Understanding the Dance of Life https://www.ranzcp.org/Files/Resources/The-Dance-of-Life-Helen-Milroy.aspx

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1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Five chairs (examiners x 2, role player x 1, candidate x 1, and observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: Aboriginal woman 30–40 years of age
- Pen for candidate.
- Timer and batteries for examiners.

2.0 Instructions to Candidate

You have **fifteen (15) minutes** to complete this station after **five (5) minutes** of reading time.

You are working as a junior consultant psychiatrist in an adult in-patient unit. You have just returned to work after a holiday. You are meeting Jacinta, a 35-year-old Indigenous lady, for the first time. Jacinta was admitted four days ago under the Mental Health Act with symptoms of mania and psychosis. She was initially unhappy about admission but is now more settled. Unfortunately, the Aboriginal and Torres Strait Islander mental health worker is in the community today, so you will be meeting Jacinta alone.

Her family reported Jacinta began worrying about them after her twin sister died two months ago. Jacinta was not sleeping, was behaving erratically, and had driven from Alice Springs to Gold Coast in just a few days. When she arrived, her family tried to take her to hospital, but she had fought with her brother, and would not get into the car.

Jacinta is a well-known Aboriginal woman who has actively advocated for the traditional owners' land rights and cultural integrity. She is strongly connected to her culture, heritage and beliefs, and is passionate about her people and the impact of colonisation. She was born in Alice Springs, raised in the traditional culture, language and spiritual realms of her people.

Jacinta will hand you a document.

An Acknowledgement of Country

An Acknowledgement of Country is a way of showing awareness of and respect for the Traditional Custodians of the land on which a meeting or event is being held, and of recognising the continuing connection of the Custodians to their Country. Unlike Welcome to Country, An Acknowledgement of Country can be performed by anyone.

Acknowledgement of Country

I would like to acknowledge the Traditional Custodians of the lands we are meeting on today and pay respects to the Elders past, present and future.

Your tasks are to:

- Take a history from Jacinta to help you understand her background and her illness.
- Describe the components generally included in a comprehensive formulation **to the examiners**.
- Then present your comprehensive formulation for Jacinta **to the examiners**.

You will not receive any time prompts.

Station 2 - 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 are available for candidate use.
- Do a final rehearsal with your role player and co-examiner.

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 unless scripted – 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 **fifteen (15) 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 co-examiner's and your mark sheet in **one** 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 final task:

- You are to state the following:

  'Are you satisfied you have completed the task(s)?
  If so, you must remain in the room and NOT proceed to the next station until the bell rings'.

- If the candidate asks if you think they should finish or have done enough etc., refer them back to their instructions and ask them to decide whether they believe they have completed the task(s).

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room, briefly check ID number.

The role player opens with the following statement:

***(*Role player hands the candidate a card with Acknowledgement of Country)**

'Before we talk…read this aloud!'

The card will read:

> **Acknowledgement of Country**
>
> **I would like to acknowledge the Traditional Custodians of the lands we are meeting on today and pay respects to the Elders past, present and future.**

3.2 Background information for examiners

The RANZCP is committed to addressing the inequities in health experienced by Aboriginal and Torres Strait Islander and Māori communities (Indigenous Mental Health). In the long OSCE station, the successful candidate will need to give careful attention to rapport, and ease into the history gathering which may take some time.

Of key importance in a station involving Indigenous patients is the expectation that candidates respect the patient's dignity and demonstrate awareness of culture. Candidates need to show a willingness **to listen to the story**, to modify their interview style, to cope with uncertainty, and to manage any significant differences with the patient. Indigenous patients may well differ depending on their connection to culture, their life experiences, and the personal, lived impact of assimilation. The patient in this station is competent in both Aboriginal and Western culture, having been raised in a traditional setting and having a university education.

In this station, the main focus is on history taking and formulation. The candidate is expected to develop an understanding and present a formulation that displays a cultural awareness of Indigenous peoples. The candidate is expected to tease out and recognise the features of mania in the midst of cultural and spiritual complexity and ambiguity, and attempt to make sense of it in their formulation.

The material provided below is available on the RANZCP website for all candidates to access.

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

- Read aloud the Acknowledgement of Country in a manner that exhibits cultural sensitivity.
- Specifically explore Jacinta's cultural beliefs.
- Take time to clarify experiences and meaning related to Jacinta's deceased sister.
- Identify the core components of a comprehensive formulation, specifically including cultural and spiritual dimensions.
- Succinctly link Jacinta's cultural and spiritual factors into the formulation.

Acknowledgement of Country

The Instructions to Candidate explicitly states that an Acknowledgement of Country is '***a way of showing awareness of and respect for the Traditional Custodians of the land***'. Having been given this explanation, it would be expected that candidates demonstrate respect for the patient by reading this acknowledgement.

If the candidate fails to read aloud the Acknowledgement of Country as requested by the role player, it will impact on engagement, rapport and the quality of the information gathered. It might well signal a lack of sensitivity and failure to appreciate the importance of acknowledging the cultural origin of the patient. Furthermore, it may indicate a lack of the capacity to begin to engage with an Indigenous person in a culturally sensitive manner.

Outline for Indigenous cultural cases:

As part of the examination process across the two countries, the RANZCP aims to assess candidates' competence to engage, interview and manage people of Indigenous culture. There are three Indigenous nations to consider: Aboriginal and Torres Strait Islander (ATSI) peoples and Māori peoples. Each has its own unique cultural, psychological, social, spiritual and religious parameters. To examine culture is complicated, but some issues overlap, and may be useful as parameters to assess candidates' cultural awareness. These include cultural concepts of health, wellbeing and illness, as well as social determinants of wellbeing such as rituals, histories, ancestral beliefs, and access to Country, lands, waterways, cultural sites.

The Indigenous nations of the two countries have different histories. The Aboriginal and Torres Strait Islander people have an ancient history dating back over 60,000 years, at first contact were sophisticated hunter gatherers, cultivators and seafarers. Māori history in New Zealand dates back 1000 to 2000 years. The Maori people were agricultural and hunter-gatherer with a history of seafaring across the Pacific Ocean from an older period. The impact of Western contact on the Indigenous nations of both countries was immense and is ongoing. They were dispossessed of their lands, traditional lifestyles, customary roles and kinship relations. The Indigenous people of Australia and New Zealand were confronted with violent conflicts, massacres, inequitable pacts, religious conversion, and attempts at cultural annihilation. Memories of this assaulting history remain vivid in the minds of many today, and needs to be acknowledged in attempting to understand Indigenous wellbeing and mental health.

Surviving Indigenous people have accommodated to European cultural in a variety of ways. Some have been able to assimilate, but at the cost of cultural identity. Some have been able to create a cultural identity and fluency in the western world, and to build resilience. For some, the need to forge identity and belonging has been compromised by disadvantage, deprivation and discrimination. This disadvantage may be economic, social, occupational, environmental, psychological, educational, cultural and / or spiritual. Colonisation continues to be less than kind to the Indigenous nations, and may negatively impact on mental and physical health. The loss of spiritual connection may have deep effects on identity and belonging, and thus the psyche with the potential to cause demoralisation.

Rapport and approach:

When interviewing Indigenous people, candidates need to adopt a different approach from standard western medical practice, especially when explaining roles. Indigenous people may expect to hear some personal information from the health professional. This will foster personal connection, build rapport and pave the way for the professional to ask personal questions in return.

Typically, Indigenous peoples are more interested in how person interacts and reacts rather than that person's role (doctor, specialist). In this station, relatedness is tested by the way the candidate manages the interaction. In developing rapport, it is helpful to establish family connections, and find out if the family is concerned about the patient's behaviour. Enquiring about cultural activities, family expectations, where Jacinta was raised, and her family relationships / genealogy will give context to her presentation. Specifically exploring Jacinta's own explanations for the current situation, and her concepts of illness and wellness is important in the cultural context, as well as inquiring about spiritual upbringing and beliefs.

In an Indigenous clinical setting, an interrogating approach will not foster rapport or elicit useful responses. Clinicians generally need to proceed at a slower, measured pace, expecting and tolerating silence periods and allowing ample opportunity for the patient to consider and answer direct inquiries. By asking multiple, closed question, unaware interviewers may cause unnecessary distress and engender feelings of shame. An indigenous person may feel negatively judged when they cannot answer questions, they may feel rushed to answer or may not understand what is being asked of them. As with all interviews, it is important to explain medical or technical jargon so it is understandable to the person and their family. The interview should be a careful balance between limiting closed-ended questions, and avoiding the use of open-ended questions too soon. Appropriate use of language can help the person relax, encourage disclosure, and reduce shame. Equally, it is important to seek clarification about the cultural or spiritual significance of matters raised. Similarly, clarifying language used is important to enhance mutual understanding. Sometimes the use of storytelling about people with similar symptoms can help the person to overcome feelings of shame or shyness.

With regard to non-verbal communication, a downward gaze may be to show respect for the interviewer, rather than indicate mental illness or display the overused MSE phrase 'avoids of eye contact'. With Indigenous patients, it may be appropriate to shake hands or to engage in some other ritual, with guidance either from the person or a cultural mental health worker in an interview.

Deep listening / Dadirri:

Miriam-Rose Ungunmerr-Baumann has articulated **Dadirri, a technique** of inner, deep listening and quiet, still awareness which is important to understand in relating to Indigenous people. She emphasises the importance of listening to **the story** carefully, and allowing the person adequate time to tell their story. **Dadirri** also accommodates long silences that can occur when developing rapport or when issues are difficult to verbalise. It acknowledges that, at times, there may be no need for words. It requires the listener to listen deeply; to listen over and over again; '***for to listen is to learn***'.

In many Indigenous cultures, one learns by watching, following and listening, not by asking questions; learning involves observing, waiting and then acting. It is useful to have some comprehension of this way of being for Indigenous Australians. '*We don't mind waiting, because we want things to be done with care. We don't like to hurry. There is nothing more important than what we are attending to; there is nothing more urgent that we must hurry away for*.' While useful in the clinical setting, this technique may prove difficult for candidates to adopt with an aroused, hypomanic patient, such as with Jacinta in the examination situation.

In summary the candidates are to:

- Manage potentially challenging communication, and put this woman at ease by adapting an accepting communication and interview style.
- Balance her giving her story within the time-frame available; responding to concerns raised and maintaining open communication whilst gathering information.

Culture and spirituality

It is not expected that the candidate will have an in-depth knowledge of the cultural ramifications. In the examination setting it may be difficult to demonstrate, but the formulation of a superior candidate may show an awareness of the cultural traditions, spiritual beliefs of meaning and belonging, history of colonisation, an understanding of impact of cultural violation, and disposition of values. The value of this understanding is the ability to explore other underlying cultural issues that may influence the presentation of mental illness.

Often there are expectations for Indigenous people to return *'to their families'* because of the belief that all Indigenous people have intact communities and families. Recent times have seen a breakdown in some of the traditional structures that could have absorbed and comforted people in need.

In summary the candidate is expected to:

- Demonstrate an ability to remain non-judgmental.
- Be aware that limited views of wellbeing and predetermined ideas of pathology can result in distress being attributed to mental illness rather than to cultural expectations, norm and beliefs. Such misinterpretations may cause further suffering and anguish for the person and those who support them.
- Demonstrate an ability to explore Jacinta's cultural beliefs by allowing her to tell her story, and by listening with an open mind to her lived experience.
- Demonstrate an ability to explore Jacinta's spiritual beliefs regarding her ability to connect with and to hear her sister, and recognising this as a cultural norm not a sign of psychosis.

Background for Indigenous Formulation: The Dance of Life

To best understand Aboriginal and Torres Strait Islander peoples, a holistic approach is needed. To assist conceptualising Indigenous culture, Professor Helen Milroy has developed **The Dance of Life**; a multi-dimensional model derived from narrative, theory, paintings and existing evidence. This framework was specifically designed to assist practitioners in understanding health and wellbeing from an Aboriginal perspective. It could well prove useful to assist candidates develop a formulation of Jacinta's issues.

In using the 'Dance of Life' to understand Indigenous people, culture and spirituality are viewed as **primary** to achieving wellbeing. The biological, psychological and social aspects of life are considered next. This is different from the Western bio-psycho-social model in which culture and spirituality are viewed almost as add-ons. This may be due to the complexity of describing and understanding both culture and spirituality. Often the dominant culture is less aware of its own cultural practices, only looking at other groups as '*having a culture'*. In a similar vein, Western cultures have recently come to view spirituality only in terms of religious practices. Some view the Western World's declining interest in spiritual matters as leading individuals to feel a loss of attachment or connection with the earth, the universe, and something greater than ourselves. Western loss of connection to spirit and community may lead to a more materialistic and self-preoccupied perspective, which is counter to the Indigenous sense of community and spiritual connectness. The Dance of Life framework aims to bridge this divide for the western mind.

Indigenous nations traditionally are firmly grounded and supported by community and spirituality. They tend to reflect back on culture to grow, and reach forward to the experiences life has waiting. The stories of ancestors, the collective grief, as well as healing, begin from knowing one's origins.This perspective then gives direction to the future endeavours.

Formulation for RANZCP Clinical Examinations:

There are as many ways to formulate a case as there are practising psychiatrists. However, for the present purposes, it is useful to revisit briefly the College Guidelines for Trainees provided by the RANZCP.
In essence, formulation involves the ability to postulate or propose a set of explanatory hypotheses or speculations that link the findings on history and mental state examination with the putative diagnosis, and as such should precede the diagnostic statement.

What is a Formulation?

'Why does this patient suffer from this (these) problem(s) at this point in time?'
Formulation is an integrated synthesis of the data, demonstrating an understanding of this unique individual, with their vulnerabilities and resources, and how they come to be in the current predicament. Essentially, formulation highlights possible linkages or connections between different aspects of the patient's history, and adds something new to what has already been presented.

Formulation Framework – three sections

Both section I & II involve exercising of judgement as to which aspects of the history are selected, and to convey an appropriate sense of emphasis and priority. This choice will be dictated to some extent by Section III.

Section I - brief introductory statement

That places the patient and their problems in context.

A. Succinctly states demographics and history of diagnosis / presentation

B. Succinctly states the current context leading to presentation – *precipitating factors*

Section II - highlights the important biological, psychological and social, cultural and spiritual factors

These factors of the history have potential explanatory power - 'longitudinal' perspective.

The concept of 'vulnerability' (or predisposing factors) is to make sense of the presentation; highlighting recurring themes in the history; the impact of genetics and the environment, with the environment seen as modify genes via epigenetic mechanisms.

C. Succinctly states bio-psycho-social cultural & spiritual vulnerabilities; *predisposing and perpetuating factors*

Section III - makes linkages between Section I and Section II using hypotheses derived from acceptable models or frameworks

Patient's vulnerabilities are juxtaposed with current stressors (and / or environment) to provide a plausible explanatory statement. The candidate will select and give priority to the most plausible linkages between the material of Section I and Section II. Given the candidate's limited knowledge of the patient (and our limited knowledge of cause / effect in psychiatry) the formulation will invariably be hypothetical; a set of 'educated guesses'; the plausibility of these speculations makes the difference between a good and a poor formulation.

Additional information

D. Comment on current psychosocial setting

E. Incorporate a statement about the patient's strengths (or protective factors) in the formulation.

Formulation – including culture, spirituality

Indigenous spiritual and cultural understandings are important, but often difficult to assess or make sense of in a traditional Western clinical perspective. The formulation prioritises the history gathered into a sophisticated bio-psycho-socio-cultural spiritual explanation. The current case involves a woman who is highly educated both within her own cultural and in the Western modern world who presents in a state of distress with a history of recent manic features. The candidate is expected to develop a formulation that works with the patient's expectations. They will achieve this by listening carefully to Jacinta's history; developing understanding of her social, cultural, spiritual, family and personal history, and then proposing a plausible explanation of the causes for her presentation.

In summary the candidate is expected to:

- Demonstrate a broad approach that allows for the complexity of Indigenous culture, and utilises a bio-psycho-socio-cultural spiritual model in formulation and planning management.
- Arrive at an understanding of this woman's spiritual connection with her deceased twin sister (that is not indicative of psychosis), her strong cultural beliefs that drive her to fulfil her role for her people, and the impact of her grief for the loss of her sister causing her to travel to see family, losing sleep and missing medication, likely precipitating her current manic episode and admission.

Combination of 'The Dance of Life' and RANZCP formulation framework

The following table combines Professor Milroy's **Dance of Live** with the RANZCP Guidelines on formulation. Each cell of the table summarises issues from Jacinta's history that may be relevant to understanding her predicament, and might be useful in formulating her case.

	Predisposing / Vulnerabilities	**Precipitating / Triggers**	**Perpetuating / Maintaining**	**Protective / Strengths / Resilience factors**
Cultural	Her culture might have an impact on how she communicates feelings and deals with adversity	Death of twin sister Increasing fear for safety of family Impaired ability to make realistic plans and take steps to carry them out	Continuum of cultural identity; Diversity of practice and experience; Cultural clash, two worlds; Cultural knowledge; Cultural grief;	Strong family connections Culture - customs and traditions, and the beliefs of the family and community Lore / Law; Language; Healing Beliefs, Expression, Experiences
Spiritual	Dreaming; Belonging, connectivity; Philosophical views; Beliefs; Experiences	Death of twin sister Struggling to cope with her strong feelings and impulses	Spirituality and Health; Existential Despair	A positive view of herself and confidence in her strengths and abilities
Social / Lifestyle factors	Employed by Charles Darwin University Does talk at conferences about the land and cultural issues Single, recently long-term relationship ended Community centred; Kinship system; Obligation and reciprocity	Death of twin sister Currently on leave from work for three months following the death of her sister Was living with her sister, her home has too many memories and has been living with other family, moving from place to place Loss of buffering	Missing her twin sister Fearful of another family member dying suddenly Travelling to visit family members, driving great distances and not sleeping or eating properly	No alcohol, nicotine or other substance abuse Generally active and physically well Well educated Very supportive family
Psychological / Emotional	Did not access mental health services with level of distress Instead sought support of family and travelling long distances to see them and check on them Profound trauma; Loss and grief; Re-traumatisation Sense of self; Identity and role; bereavement	Struggling to cope with death of twin sister This level of distress having negative impact on resilience and ability to cope with life's stressors Increasing levels of distress impacting on sleep and appetite and mood Place in society; Present trauma, loss, grief; Psychological morbidity, illness	Variable compliance with medication More episodes of mania and / or depression increased risk of loss of functional achievements and increased risk of further episodes of mania and / or depression Impact of discrimination; cultural and spiritual phenomenology	Willing to take medication Belief in what twin sister was trying to do for her in reminding her to take medication and to ensure sleep hygiene maintained to keep well and reduce frequency of episodes of mania and / or depression Grief and trauma

	Predisposing / Vulnerabilities	Precipitating / Triggers	Perpetuating / Maintaining	Protective / Strengths / Resilience factors
Physical / Biological	Family history of mood disorders Maternal family history of mood disorders Variable compliance with medication Connection of genes and environment epigenetics Presence of mania sufficient to qualify for the diagnosis of BPAD	Poor sleep Poor self-care Had low mood when parents separated, not a major depressive episode, which preceded the onset of mania by several years Present morbidity, burden of chronic illness; Land-rights and treaty; Holistic view; Urban, rural and remote differences	Stress; Grief and mortality; Transgenerational trauma; Chronic mental health; Complimentary healing and practices	Generally, functions well despite two previous episodes of mania. Has understood importance of compliance with medication to reduce risk of functional impairment and episodes Connection to country, source of renewal

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 Jacinta, a 35-year-old Indigenous woman. You are an Arrernte (pronounced Arunda) woman from Alice Springs, Central Australia in the Northern Territory. You were admitted four days ago to the inpatient psychiatric unit at Gold Coast Hospital. You are meeting this psychiatrist for the first time. You want to test the doctor out because you are tired of the way people show lack of respect to your culture. Over the past few days, you have refused to speak to people on the ward until they have read aloud *An Acknowledgement of Country* document. This is to get them to understand and acknowledge your cultural heritage.

Most people have read it with no problems, but there have been some patients on the ward who have thrown it back at you or told you to go away, and this has made you very upset and angry.

It reads:

> An Acknowledgement of Country
> An Acknowledgement of Country is a way of showing awareness of and respect for the Traditional Custodians of the land on which a meeting or event is being held, and of recognising the continuing connection of the Custodians to their Country. Unlike Welcome to Country, An Acknowledgement of Country can be performed by anyone.
>
> Acknowledgement of Country
> I would like to acknowledge the Traditional Custodians of the lands we are meeting on today and pay respects to the Elders past, present and future.

You have spoken with the Aboriginal and Torres Strait Islander mental health worker about the responses you have experienced, and how to cope with the distress this is causing you. You have also spoken with local Elders who have come to the ward to help you. They have done ceremony with you, and you are feeling better.

Yesterday, you had an argument with a patient as they were rude when they refused to read it. The doctors moved you into the more secure part of the ward for several hours to settle down. The Aboriginal and Torres Strait Islander mental health worker brought the Elders in again today, and you feel calmer in yourself. It is upsetting as you really believe that most people disregard your culture, and so you want to teach everyone respect. You are adamant that the best way to start is to get them to read out loud the Acknowledgement of Country. No one can dissuade you because you believe this is the only way for mutual understanding to begin. To you, the reading out loud is a demonstration of the truth of the person's intent to open up to your culture. You want to hear the commitment in their voice.

The doctors, nurses and the Elders have been trying to explain to you that part of the way you are feeling and behaving, is because you are unwell. You disagree; you don't feel sick at all. In fact, you feel very well; better than you have ever felt. You do accept that the medication is helping you sleep better, and your mood is not as high as it was, but you do still get irritated with others pretty easily. You know you are right, because you just are! You know that you respect the nurses and doctors, but you mostly respect the Aboriginal and Torres Strait Islander mental health worker and the Elders, because they listen to you and they know what you need to get better.

History of presenting issues

You can accept that before coming into hospital you were pretty unwell, and you did not mean to fight with your little brother, Jake. You did not think you needed to come into the hospital, you just needed to sleep. Your family just got into your business, you knew what you were doing. You admit you did not sleep much in almost three days, and drove from Alice Springs to Gold Coast. It is your business that you went via the top of Adelaide. Deep down, you know you almost drove off the road, and okay, you almost drove into another vehicle, but nothing happened! You needed to check the family. It is your right to know they are safe and well. Look your twin sister, she is dead.

Things had been going well until your twin sister passed away two months ago from pneumonia. You do not tell the doctor her name because that is not the way. (In your culture, you do not speak the name of departed people). You miss her terribly, she understood you, she could calm you especially when you got too excited. She made sure you took your medication and had sleep. You always listened to her. She knew how to talk to you. She did not have your illness. Other members of your mother's family have schizophrenia or depression or bipolar.

Sometimes you can hear your sister calling to you. She says your name, but you know she is not singing you to join her. You know she loves you and is watching over you, and your family. Sometimes you see her but when you look closer, she disappears. She looks happy. She is checking up on you… especially now you have been sick. You miss her so much. You know your sister is good and has moved on. This fits with your spiritual beliefs. From a cultural and spiritual perspective this is normal.

After your sister died, you had trouble sleeping, and have not been taking your medications properly. Since her death, you have become worried about the family. You decided to visit them although they live far away. You enjoyed visiting the family and at the time, you could not understand why they kept telling you to sleep, you felt on top of the world. You were talking a lot. You became convinced that by visiting them, you were protecting them from dying suddenly like your sister.

Last week, you drove six hours to Uluru to check on your brother who works as an artist out there. Of course, he was okay, so then you drove down to Coober Pedy to your sister cousin's place and checked on her. She told you to stop and sleep, but you had to get to your little sister in Gold Coast to check on her. You know your sister cousin rang your brother. He told your father and the family were prepared for your arrival. You had fallen asleep while driving, but lucky there was a rut in the road it woke you up. You pulled over to sleep for a short time. In Port Augusta, South Australia you stopped for a sleep. You knew you were getting elevated. You drove faster to get to your family. You forgot your medication when you left home. When you got to your family, you almost collapsed. You were talking and talking, you did not pause, and they said they could not understand you because you were talking so fast. The family wanted you to see the doctor, but you did not want to go, you just needed sleep. They wanted to take you to hospital. You became really irritated with them, your younger brother tried to talk to you, but you fought him and refused to get you in the car. They called the police who took you to hospital. You have been on the inpatient psychiatric unit at Gold Coast Hospital for four days. You were on this unit a year ago, with a similar episode. You feel a little better, maybe your family were right, but you got so angry with them.

When you feel high or elevated mood or manic, it is like being really powerful, energised. You do not need sleep or food. You have many racing ideas, and talk a lot and often fast. Just like now, during the car trip you talked to yourself, played loud music, cried loudly or laughed really loudly. You had stopped the car to yell out loud how you felt. At fuel stations or shops, you noticed people looking at you, but you did not care. You knew that they recognised that you were important and special. The doctors said you were '*grandiose and paranoid*'. But you knew the public were going to vote you in as next prime minister of Australia. You were going to right all the wrongs against your people. You would demand recognition and apology from the government.

Past psychiatric history

When you were 17 years old your parents separated. You were sad wanting to join your ancestors, but it settled with the support of family.

You were diagnosed with a mental illness called Bipolar Disorder when you were 20 years old, and experienced your first manic episode. At that time, you had started a movement to get white fellas to take your people seriously. You believed the government would send you to the United Nations as their representative. You went to the Tent Embassy at Parliament. They called the Police. You were in Canberra Hospital inpatient psychiatric unit for five weeks.

Your second admission under the Mental Health Act was at the Gold Coast. You stopped medication after three years of being well. You were in a manic state, and recommenced on medication to balance out your mood and to help calm your thinking, Lithium 750 milligrams at night. You were in hospital for six weeks.

You have had issues with the police because of your erratic driving when unwell. You believe they have not charged you with a fine because they know how important you are.

You see your GP regularly and get your prescriptions from him. If you are asked, you do not use cannabis or drink alcohol, and you do not smoke cigarettes.

Personal History

You live with your mum in Alice Springs, and your extended family lives locally and remotely back in community. Your mother is Arrernte and your father is a white fella, Anglo-Australian from Queensland. They separated when you were 17 years old. It was hard for you because you wanted your family to stay together. You had your twin sister and you supported each other. You grew up with three brothers and three sisters, one of whom was your twin sister. You have always looked out for each other. You grew up listening to stories and dreaming. You were raised in the culture, the language and the lore. Your grandma and grandpa were highly respected elders, and together always tried to work with government, and were influential in getting recognition for your people, the traditional owners. You come from a long line of *knowledge holders*, and know it is important to uplift people and be proud of who you are. Your people observe the lore and look after country, and teach the children the Arrernte language and culture. You know your dreaming stories and your own dreaming. You went to school in Alice Springs. You have a Degree in Indigenous Studies from Charles Darwin University in Alice Springs and Gold Coast. Your father moved to Queensland from Alice Springs. Your siblings visit with him from time to time.

Cultural history

You know some of the locals in Gold Coast. You spoke at local meetings from time to time about your work with land and culture. You are a well-known Aboriginal woman. You actively advocate for the traditional owners' land rights and cultural integrity. You are passionate about your people, your culture and the impact of colonisation. Being raised in the traditional culture, language and spiritual realms of your people, you know how important Country is and your need to protect it and teach others about it. Your elders have supported you in promoting and teaching others the necessary cultural knowledge to protect Country. You have met many other mobs from around Australia including white fellas who support the call to protect Country. The mining companies and the Northern Territory and federal governments have wanted to mine for uranium. Over and over, you have fought against this with your people, with the elders due to the risk to the artesian basin that holds two hundred years of water becoming contaminated by mining.

4.2 How to play the role:

You are well dressed, and proud of who you are and where you come from. You talk straight and direct. You might become annoyed with the candidate if you feel they are not taking you seriously or disregard what you are trying to tell them. You expect them to listen to you and to engage with you.

When the candidate enters the room, you gesture with the card in your hand, for them to sit down in the chair provided for them.

Do not answer any questions or speak with the candidate until they are seated and have the card. Then make your opening statement '***Before we talk…read this aloud*!'**

4.3 Opening statement:

***(*Role player hands the candidate a card with Acknowledgement of Country)**

'Before we talk…read this aloud!'

4.4 What to expect from the candidate:

You can expect the candidate to do as you request, and read the document you hand them aloud. They should behave in a respectful manner, and have some knowledge of how to approach your cultural history.

If the candidate does not seem to have knowledge of Aboriginal and Torres Strait Islanders cultures (some may be from New Zealand), you expect them to be respectful and to try to understand what your concerns are.

The candidate may ask you a range of questions, only answer from the information you have been given.

If you do not have answers for what they ask, say **'*I don't know'*** or **'*Why don't you ask someone else.*'**

4.5 Responses you MUST make:

If the candidate reads it aloud respectfully (you feel respected by the candidate), then acknowledge and say: ***'Thanks'***

If the candidate reads it aloud in an off-hand manner (you feel uncomfortable about the way the candidate has spoken to you), then say:
'Read it again…show my culture respect.'

If the candidate does not read it aloud (reads it silently or quietly to themselves) then say:
'Read it aloud, then we can talk.'

If the candidate has not read it aloud and keeps trying to engage you in conversation after one (1) minute, then say:
'Show my culture respect, read it aloud.'

During the rest of the assessment:

'I am an Arrernte (Arrernte pronounced Arunda) woman.'

'I can see and hear my sister…but it's different to those other things I was thinking about...it's our way.'

'I know I gotta take my medication to stay well.'

4.6 Responses you MIGHT make:

If the candidate asks whether you have felt like dying or suicidal.
Scripted response: ***'No, never.'***

4.7 Medication and dosage that you need to remember

You take Lithium 750 milligrams at night for your Bipolar Disorder.

STATION 2 – MARKING DOMAINS

The main assessment aims are to:

- Develop rapport with an Indigenous woman who has a mental illness.
- Clarify the history in respect of culture, spirituality and mental illness.
- Make sense of the history gathered by way of a formulation for an Indigenous woman with a mental illness.

Level of Observed Competence:

2.0 COMMUNICATOR

2.4 Did the candidate demonstrate a culturally sensitive approach to patient? (Proportionate value - 10%)

Surpasses the Standard (scores 5) if:
demonstrates a sophisticated and knowledgeable approach to cultural aspects of patient.

Achieves the Standard by:
recognising and incorporating cultural needs / expectations; adapting assessment and management to the specific cultural needs; considering when to use interpreters or cultural health workers.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Read aloud the Acknowledgement of Country in a manner that exhibits culturally sensitivity.

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).

2.4. Category: CULTURAL DIVERSITY	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Domain Not Addressed**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

1.0 MEDICAL EXPERT

1.1 Did the candidate adequately conduct an assessment of the patient? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:
clearly achieves the standard overall with a superior performance in a number of areas; demonstrates competency in overall management of the interview; demonstrates superior technical competence in eliciting information.

Achieves the Standard by:
managing the interview environment; integrating generalist and sub-specialist assessment skills; engaging the patient as well as can be expected; demonstrating flexibility to adapt the interview style to the patient, problem or special needs; prioritising information to be gathered; appropriate balance of open and closed questions; summarising; being attuned to patient disclosures, including non-verbal communication; recognising emotional significance of the patient's material and responding empathically; sensitively evaluating quality and accuracy of information; clarifying inconsistent information efficiently.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Specifically explore Jacinta's cultural beliefs.

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).

1.1. Category: ASSESSMENT – Data Gathering Process	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Domain Not Addressed**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

1.2 Did the candidate take appropriately detailed and focussed history that includes the spiritual aspects of Jacinta's history? (Proportionate value - 20%)

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; demonstrating cultural awareness by gathering the important cultural and spiritual history; hypothesis-driven history taking; integrating key sociocultural issues relevant to the assessment; demonstrating ability to prioritise; eliciting the key issues; completing a risk assessment relevant to the individual case; demonstrating phenomenology; clarifying important positive and negative features; assessing for typical and atypical features.

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

a. Take time to clarify experiences and meaning related to Jacinta's deceased sister.

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 scores 1; omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in history.

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** ☐

6.0 SCHOLAR

6.4 Did the candidate prioritise and describe the core components of formulation based on available literature and clinical experience? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:
candidate acknowledges the documented evidence of recognising cultural diversity and Indigenous culture; incorporates the impact of environment, people and new knowledge on current understanding; acknowledges their own gaps in knowledge.

Achieves the Standard by:
identifying key aspects of the available literature on health in Indigenous people; commenting on the development of psychiatric formulation based on history and presentation in the context of culture; discussing major strengths and limitations of available clinical experience; describing the relevant applicability of medicine and culture to the scenario; referring to relevant RANZCP guidance on formulation; incorporating literature and government resources into their framework of understanding.

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

a. Identify the core components of a comprehensive formulation specifically including cultural and spiritual dimensions.

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 scores 1; omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in history.

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

6.4. Category: APPLICATION OF KNOWLEDGE	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Domain Not Addressed**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

1.0 MEDICAL EXPERT

1.11 Did the candidate generate an adequate formulation to make sense of the presentation? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:
provides a superior performance in a number of areas; demonstrates prioritisation and sophistication; applies a sophisticated sociocultural spiritual formulation.

Achieves the Standard by:
identifying and succinctly summarising important aspects of the history, and observation; synthesising information using a biopsychosocial cultural spiritual framework; integrating medical, developmental, psychological and sociological, cultural and spiritual information; developing hypotheses to make sense of the patient's predicament; accurately describing recognised theories and evidence; demonstrating the links between culture, spirituality and mental illness in this woman; incorporating cultural and Indigenous theories and understandings; commenting on missing or unexpected data; accurately linking formulated elements to any diagnostic statement; including a sociocultural spiritual formulation; analysing vulnerability and resilience factors.

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

a. Succinctly link Jacinta's cultural and spiritual factors into the formulation.

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 scores 1; omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in history.

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

1.11. Category: FORMULATION	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

Committee for Examinations
Objective Structured Clinical Examination

Station 3
Gold Coast April 2019

The Royal Australian & New Zealand College of Psychiatrists

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1.0 Descriptive summary of station:

In this station, the candidate is seeing a 49-year-old lady who has been prescribed escitalopram for anxiety, and has more recently started taking tramadol for pain, and St John's Wort for insomnia resulting in a mild serotonin syndrome.

She has presented with worsening anxiety and a request to increase her medication. The candidate is required to recognise serotonin syndrome in an outpatient setting, examine a patient experiencing serotonin syndrome, and to make appropriate treatment decisions around medication changes.

1.1 The main assessment aims are to:

- Take a focussed history related to medication use.
- Recognise and interpret the pharmacology causing serotonin syndrome.
- Identify and diagnose symptoms of mild to moderate serotonin syndrome from the history and signs on examination.
- Plan appropriate treatment and outline an acute management plan.

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

- Include details on pain relief medication, including over the counter medication, when taking the medication history.
- Specifically demonstrate examination for hypertension, tachycardia, tremor and abnormal reflexes.
- Link the interaction of serotonergic agents to the patient's symptoms when providing an explanation on this diagnosis.
- Prioritise the importance of decreasing doses of serotonergic medication as a first step in treatment.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category**: Anxiety Disorders, Medical Disorders in Psychiatry
- **Area of Practice**: Consultation Liaison
- **CanMEDS Marking Domains Covered**: Medical Expert

  RANZCP 2012 Fellowship Program Learning Outcomes: Medical Expert (Assessment – Data Gathering Content; Assessment – Physical – Selection; Diagnosis; Management – Initial Plan)

References:

- NPS Medicine Wise; https://www.nps.org.au/australian-prescriber/articles/serotonin-syndrome-3.
- Ochsner J. (The Oschner Journal) 2013 Winter; 13(4): 533–540. Serotonin Syndrome; Jacqueline Volpi-Abadie, MD, Adam M. Kaye, PharmD, FASCP, FCPhA, and Alan David Kaye, MD, PhD, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3865832/.
- Edward W Boyer, MD, PhD, March 2018; Serotonin Syndrome (Serotonin Toxicity) https://www.uptodate.com/contents/serotonin-syndrome-serotonin-toxicity.

1.4 Station requirements:

- Standard consulting room; needs a bed that can lay flat, blood pressure cuff, tendon hammer, tuning fork, stethoscope, and Evian spray bottle.
- Five chairs (examiners x 2, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: middle-aged Caucasian woman, neatly dressed in casual clothing.
- Pen for candidate.
- Timer and batteries for examiners.

2.0 Instructions to Candidate

You have **fifteen (15) minutes** to complete this station after **five (5) minutes** of reading time.

You are a visiting junior consultant psychiatrist to a rural country practice. You are about to see Martha Moore, a 49-year-old woman, who has been seeing her GP for treatment. She has been doing well managing her anxiety symptoms, particularly following a short CBT based therapy program with a private psychologist by telehealth, and had been seeing the GP regularly.

Over the past week, the psychologist has become concerned that some of Martha's symptoms were worsening despite her treatment, and a lack of identifiable triggers. The psychologist has asked her to see you to provide a review of her medication treatment, and see if an increase in dose would be helpful.

Martha told the psychologist that she has had symptoms of agitation, and difficulty going to sleep at night. She said her GP gave her medication for pain after a recent shoulder injury, and although this has helped the pain, she has noted loose bowels at times, and she feels worse overall.

Your tasks are to:

- Take a history relevant to Martha's current symptoms and treatment.
- Perform a focussed physical examination to assess her symptoms, and comment on your findings while doing so **to the examiners**.
- Provide an explanation on how you arrived at your preferred diagnosis related to Martha's symptoms, and outline a short-term plan for the next week **to the examiners**.

You will not receive any time prompts.

Station 3 - 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 and co-examiner.

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 unless scripted – 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 **fifteen (15) 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 co-examiner's and your mark sheet in **one** 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 final task:

- You are to state the following:

  'Are you satisfied you have completed the task(s)?
  If so, you must remain in the room and NOT proceed to the next station until the bell rings'.

- If the candidate asks if you think they should finish or have done enough etc., refer them back to their instructions and ask them to decide whether they believe they have completed the task(s).

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room, briefly check ID number.

The role player opens with the following statement:

'Thank you for seeing me, I'm feeling really odd.'

3.2 Background information for examiners

In this station, the candidate is expected to demonstrate that they can take a relevant history pertaining to an increase in anxiety symptoms, and assess effectiveness of medical and psychological treatment including consideration of pharmacological interactions. In particular, they are expected to diagnose serotonin syndrome, ascribe symptoms that are being experienced by the patient to that syndrome, and develop an appropriate management plan with regards to her medication and psychological management.

They are expected to provide an examination that is appropriate for assessing serotonin syndrome including comment on aspects like:

- Pulse, Blood Pressure, Reflexes, Tremor.

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

- Include details on pain relief medication, including over the counter medication, when taking the medication history.
- Specifically demonstrate examination for hypertension, tachycardia, tremor and abnormal reflexes.
- Link the interaction of serotonergic agents to the patient's symptoms when providing an explanation on this diagnosis.
- Prioritise the importance of decreasing doses of serotonergic medication as a first step in treatment.

A surpassing candidate may:

- Assess for Orientation, Registration and Recall
- Suggest non-SSRI treatments for anxiety
- Offer alternative treatment for her chronic pain symptoms that is not a serotonergic agent
- Identify the features of serotonin syndrome and in detail, explain the level of severity of the syndrome and correctly explain this to the examiner
- Provide tapering and management plan of medication to the examiner.

Background information related to Serotonin Syndrome

Physical presentation

Serotonin syndrome is a wide ranging syndrome that has a range of symptoms and toxicity. It is caused by an increase amount of a serotonergic agent, an overdose of one of these agents like SSRI's and SNRI's, as well as adding serotonergic agents together. There are a range of mild to severe symptoms with patients presenting with subacute to chronic presentations. There are common features of serotonin syndrome that include:

- Tachycardia
- Mydriasis
- Diaphoresis
- Shivering
- Tremor
- Myoclonus
- Hyperreflexia (common)
- Akathisia
- Dilated pupils.

Those with mild symptoms are often afebrile, moderate symptoms can be associated with hyperthermia, hyperactive bowel sounds as well as agitation and hypervigilance. Severe cases can have significant hyperthermia (temp over 41.1C) with the patient having significant hypertension, tachycardia, diarrhoea, confusion, delirium, muscle rigidity, and this can lead to rhabdomyolosis, Adult Respiratory Distress Syndrome (ARDS), renal failure and death.

Laboratory evaluation – Serotonin syndrome is a clinical diagnosis; serum serotonin concentrations do not correlate with clinical findings, and no laboratory test confirms the diagnosis.

Differential diagnosis – The differential diagnosis of serotonin syndrome includes neuroleptic malignant syndrome (NMS), anticholinergic toxicity, malignant hyperthermia, intoxication from sympathomimetic agents, sedative-hypnotic withdrawal, meningitis, and encephalitis.

Taking a history – History taking should include doses of medications, over the counter and prescribed as well as other herbal or alternative medications. Doses, dose overlap and changes must be considered. Most symptoms occur within 24 hours of taking the combination of serotonin medication or increase in serotonin based medications. Therefore the timeline of ingestion is important.

Serotonin Syndrome and NMS

Serotonin syndrome is often misdiagnosed as NMS, but the two can readily be distinguished on the basis of history, examination findings, and clinical course NMS develops over days to weeks, whereas serotonin syndrome develops over 24 hours Serotonin syndrome is characterised by neuromuscular hyperreactivity (tremor, hyperreflexia, myoclonus), while NMS involves sluggish neuromuscular responses (rigidity, bradyreflexia). Hyperreflexia and myoclonus are rare in NMS. In addition, resolution of NMS typically requires an average of nine days, compared with less than 24 hours (usually) for resolution of serotonin syndrome. Hyperthermia, altered mental status, muscle rigidity, leukocytosis, elevated creatine phosphokinase, elevated hepatic transaminases, and metabolic acidosis are seen in severe cases of both conditions, which highlight the necessity of a thorough history and physical examination.

Pathophysiology of Serotonin Syndrome

It is thought to result from stimulation of the 5-HT1A and5-HT2 receptors, and the drug classes implicated in serotonin syndrome reflect this theory. These include serotonin precursors, serotonin agonists, serotonin releasers, serotonin reuptake inhibitors, monoamineoxidase inhibitors (MAOIs) and some herbal medicines (Table 1).

Table 1

Drugs implicated in severe serotonin syndrome*

Drug	*Mechanism*
L-Tryptophan	Serotonin precursor
Selective serotonin reuptake inhibitors	Inhibit serotonin reuptake
Tricyclic antidepressants	Inhibit serotonin reuptake
Monoamine oxidase inhibitors (A>B)	Inhibit metabolism of 5-HT
Pethidine	Serotonin agonist
Tramadol	Inhibits serotonin reuptake
LSD	Partial serotonin agonist
Buspirone	Partial serotonin agonist
Amphetamines and anorectics	↑5-HT release & ↓reuptake
Atypical antidepressants	Various
St John's wort	All of the above?
Lithium	Unknown

* Note: Interactions are more severe between drugs with different mechanisms of increasing serotonin.

Table 1 source: *https://www.nps.org.au/australian-prescriber/articles/serotonin-syndrome-3*

Management

Key principles – Five principles are central to the management of serotonin syndrome:

- Discontinuation of all serotonergic agents.
- Supportive care aimed at normalisation of vital signs.
- Sedation with benzodiazepines.
- Administration of serotonin antagonists.
- Assessment of the need to resume use of causative serotonergic agents after resolution of symptoms.

Application of these principles varies with the severity of illness. In mild cases, discontinuation of inciting medications, supportive care, and sedation with benzodiazepines are generally sufficient. Moderately ill patients require more aggressive treatment of autonomic instability, and possibly treatment with a serotonin antagonist such as cyproheptadine. Hyperthermic patients (>41.1°C) are critically ill, and often require neuromuscular paralysis and tracheal intubation.

Common management pitfalls include failure to recognise serotonin syndrome, misdiagnosis, and failure to understand serotonin syndrome's potentially rapid rate of progression. Even if the diagnosis remains unclear, the clinician should withhold serotonergic agents, and provide aggressive supportive care, anticipating the need for interventions before the patient's condition deteriorates.

Serotonin syndrome often resolves within 24 hours of discontinuing the serotonergic agent, and initiating care, but drugs with long half-lives or active metabolites may cause symptoms to persist.

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 Martha Moore, a 49-year-old woman, who lives in a rural town of 15,000 people. You live with your husband Martin, who is 53 years old, on a small property where you raise goats.

You have been receiving treatment for anxiety from your GP, and a psychologist, and you are coming to see a psychiatrist today because your psychologist has become concerned about your worsening feelings of agitation, and poor sleep over the last week. The psychologist thinks it would be helpful for a psychiatrist to review your medication as you had been doing well up until this week.

You have felt like this for around two weeks, with current symptoms of agitation, forgetfulness, sweatiness, and in particular, the agitation and periodic diarrhoea are the most concerning for you. You are keen to be better and get on with working.

You also hurt your shoulder a while back and it is sore today, but not particularly worse than recently. You have regularly been taking a pain medication for the last two weeks (described below), and took one this morning as it has been helpful.

Background to your concerns

You had no worries about your mental health until about a year ago when you noticed that you were much more nervous, you were reluctant to go out to dinner with your family, got worried about choosing the right clothes to wear, and in general, felt stressed about everything.

You are close to your sister, Jenny, who had an anxiety disorder diagnosed two years ago, and you spoke to her about your concerns. You realised that your symptoms were similar to hers, and she got a lot better taking a medication called escitalopram, so you went to your GP, Dr Helen Ferguson, and asked about it. She started you on medication, 20 milligrams escitalopram, at that appointment six months ago, but also recommended you see a psychologist, Leanne Huxley.

There was a bit of a wait to get sessions with the psychologist, but you got in two months later, and more recently have been doing therapy called 'CBT' (cognitive behavioural therapy), with Leanne for the last four months. You have kept these appointments regularly, and have done the 'homework'. You believe that the time spent with your psychologist was very helpful, and that you were getting better. You know this because your sleep had improved, you no longer spent long periods worrying about trivial matters, and felt more relaxed overall. However, this recently changed.

Adding to your worries, you injured your arm at around the same time (four months ago) on the property while fencing a paddock. You pulled your shoulder while picking up a very heavy load of wire, and it has been painful, stiff, hard to lift your arm over your head, and sore a lot of the day since then. You had physiotherapy and hydrotherapy for a short while, but need to travel some distance to get there. Consequently, you were not very regular, and the pain has persisted. You know that your shoulder will gradually get better, and you are not looking for surgery, pain clinic, time off work etc., you want recovery.

Six weeks ago, Dr Ferguson talked to you about the pain when you went for a review, and a repeat prescription for escitalopram. She suggested that you could use medication to help with pain if needed, and started you on a tablet called tramadol at a dose of 50 milligrams – it was to be used just occasionally, but over the last two weeks you have used it every day because this is a very busy time on the farm, and you need to get things ready for winter.

You are aware that tramadol is a very strong pain killer, and that people can get addicted to it. You are very aware that you should not be taking it every day for a long period of time, but at present you are concerned because you are feeling so bad overall that you did not stop it - but you have never taken more than one tablet per day.

Your pain in your shoulder has improved but you have begun to feel very agitated, restless and thought your anxiety was returning. You also began to have trouble sleeping so you went to the pharmacy, and decided to try something called St John's Wort, which you have taken every night for the past two weeks.

Last week you made an appointment to see the psychologist, and you talked about increasing your CBT sessions, and ran through some strategies. Although they had worked well before they weren't working anymore, and at your last appointment you asked if something else would help. That is when she suggested you see the psychiatrist who visits the area. She thought that you may need to increase your dose of medication. She was also going away for two weeks, and was keen for you to have support while she was gone. Your psychologist has been away previously, and this does not worry you as you know your GP is there, and is a very good doctor.

If you are asked by the candidate, you have no other medical conditions, but have had:

- some loose bowel motions – no blood or mucus, but frequent and runny over the last few days.
- you have not vomited, you have had some nausea for the last four days.
- you feel agitated as though you can't calm down, and seem to be pacing when you are stressed.
- you feel a bit more forgetful over the last two days, and can't recall the date of your last psychology appointment, but you know it was 'a few days ago'.
- yesterday you spend an hour looking for your car keys which you have never done before.
- you feel 'trembly' like you might drop something.
- at times you get sweaty and feel warm.

About you:

You have two adult children, Geoff (25) and Gordon (24) who live nearby, and you get along with them quite well. You grew up a few towns away, met your husband when you were 22 at university studying business, and moved back to run a business together. Your business is successful, and your marriage, friendships and relationships are all going along OK. You keep in touch with your sister, Jenny, whom you are very close to.

The candidate may also ask you about the following issues:

- You don't smoke or drink alcohol and never have.
- You don't use illicit drugs and never have.
- You don't hear voices or have any odd thinking like people watching or following you or the TV referring to you.
- You don't have suicidal or depressive thoughts.
- You don't feel yourself, but can't quite work out why you feel like this as your anxiety was getting better.
- You are a physically healthy person, and do not have problems like high blood pressure, asthma, diabetes or epilepsy.
- You have not been on any other medications long term.

4.2 How to play the role:

You are dressed casually in jeans / casual pants and a blouse, you are well spoken. You are mildly anxious today, and have difficulty sitting comfortably in the chair, and move slightly during the appointment as though adjusting yourself in the seat, you feel hot and have mild sweat on your face (from the Evian spray that we will provide, please spray on just before each candidate enters – light mist on face). You have a mild tremor in your hands, and have been nauseous for a few days, you jiggle your leg throughout the session. You feel that you are forgetful, and thinking clearly is a lot harder than it had been about two weeks ago.

You are polite to the candidate, and want to know if you need more of your escitalopram to feel better. You are keen to answer questions, but you do not associate any of your medications with your symptoms at all, and you do not link the two together.

4.3 Opening statement:

'Thank you for seeing me, I'm feeling really odd.'

4.4 What to expect from the candidate:

The candidate should be interested, empathic and want to enquire about your symptoms, and will want to examine you. They should be interested in your medication, and what you take and when you take it.

The examination should involve pulse, blood pressure, questions around memory, and likely an examination of reflexes and coordination. The candidate should ask you questions about the timeline of your symptoms, in summary:

1. You have anxiety.
2. You saw the GP, and started the medication escitalopram six months ago.
3. You started seeing a psychologist four months ago.
4. That psychologist used CBT which made things better.
5. You are on other medication, and they should ask what it is, why you take it, and for how long.
6. Even though you feel your memory is affected, you will pass all the memory questions you are asked.

The candidate is expected to link together your symptoms with a clinical syndrome, called 'Serotonin Syndrome', often caused by medication. They should explain to the examiner how that occurs, and then talk about management of your anxiety and pain while also modifying your medication. At this time you can just sit quietly.

4.5 Responses you MUST make:

'So why do I feel like this?'

'Can I take more of my escitalopram? My sister went on a higher dose and felt a lot better.'

4.6 Responses you MIGHT make:

If the candidate asks about a family history of illness like dementia, Alzheimer's Disease, or other memory problems.
Scripted response: ***'No, everyone in my family is pretty sharp and all lived to their 90's.'***

If the candidate asks whether you taken an overdose / excessive amounts of your medication.
Scripted response: ***'No, I have been taking my tramadol every day as well as my other tablets, but that is OK, isn't it?'***

4.7 Medication and dosage that you need to remember:

Escitalopram 20 milligrams a day in the morning (also can be called Lexapro).

Tramadol 50 milligrams as required but every morning for the last two weeks.

St John's Wort (two teaspoons at night) for the last two weeks – you are not sure of the dose as it was from the pharmacy without a prescription (over the counter). On the back of the bottle, it said it would help with nerves and sleep.

STATION 3 – MARKING DOMAINS

The main assessment aims are to:

- Take a focussed history related to medication use.
- Recognise and interpret the pharmacology causing serotonin syndrome.
- Identify and diagnose symptoms of mild to moderate serotonin syndrome from the history and signs on examination.
- Plan appropriate treatment and outline an acute management plan.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed history related to anxiety and associated medication management? (Proportionate value – 20%)

Surpasses the Standard (scores 5) if:
clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication; includes the timeline of treatment for both psychological and medication treatment; delineates the initial use of non-medication treatment for pain and the recent inclusion of medication.

Achieves the Standard by:
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; completing a risk assessment relevant to the individual case; clarifying important positive and negative features; assessing for typical and atypical features.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Include details on pain relief medication, including over the counter medication, when taking the medication 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 ☐

1.4 Did the candidate carry out an appropriately focussed and relevant examination as per instructions? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:
the examination is relevant to the patient's problem; conducted at a sophisticated level; all relevant areas are considered; no superfluous assessment is undertaken including review of orientation, registration and recall.

Achieves the Standard by:
completing an organised physical, covering all essential aspects; excluding delirium by completing an assessment of orientation, registration and recall; demonstrating adequate facilitation, attention to privacy for physical examination, and boundary recognition.

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

a. Specifically demonstrate examination for hypertension, tachycardia, tremor and abnormal reflexes.

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).

1.4. Category: ASSESSMENT – Physical – Selection	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 diagnosis of serotonin syndrome caused by pharmacological interactions? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:
demonstrates a superior performance; outlines the presenting symptoms of serotonin syndrome from medication; explains the cause for the symptoms from a physiological point of view; justifies level of severity.

Achieves the Standard by:
demonstrating the capacity to identify features of serotonin related side effects and identifying features of a serotonin syndrome; naming the serotonin agents causing the symptoms; explaining the linkage to an increase in pain treatment medication as well as antidepressants; utilising the timeline of events and relationship to emerging symptoms in explanation.

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

a. Link the interaction of serotonergic agents to the patient's symptoms when providing an explanation on this diagnosis.

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** ☐

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

Surpasses the Standard (scores 5) if:
provides a sophisticated plan that outlines the tapering and changing of tramadol for pain as well as considering alternative medications for anxiety; provides a rationale and plan that outlines other treatments for pain as well as alternative antidepressants that are less likely to cause serotonin syndrome; clearly addresses difficulties in the application of the plan including potential worsening of pain or anxiety and access to close monitoring and support.

Achieves the Standard by:
explaining the risk of ongoing use of the three medications; advising on the gradual cessation of medication and explaining how to do this; discussing the potential role of benzodiazepines in alleviating any symptoms and the need for regular medical reviews during the process; considering further psychological assistance for pain and anxiety management as well as ongoing review of serotonin symptoms; clarifying roles and responsibilities of others in the plan and recognition of their role in the follow up.

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

a. Prioritise the importance of decreasing doses of serotonergic medication as a first step in treatment.

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).

1.13. Category: MANAGEMENT – Initial Plan	**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**

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**

Committee for Examinations
Objective Structured Clinical Examination

Station 5
Gold Coast April 2019

The Royal Australian & New Zealand College of Psychiatrists

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1.0 Descriptive summary of station:

In this station, the candidate is to assess Glen, a 65-year-old man, referred to the outpatient clinic by his GP due to concerns that Glen is depressed, but unwilling to trial antidepressant medication. The candidate is expected to establish that Glen's depression is mild to moderate, that non-pharmacological management is the more appropriate option, and to discuss the appropriate treatment options with Glen. Better candidates will utilise shared decision making to work with Glen in creating a management plan.

1.1 The main assessment aims are to:

- Evaluate the candidate's knowledge of non-pharmacological management options for treating mild to moderate depression.
- Assess the candidate's collaborative approach to working with a patient in development of a management plan.

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

- Explore current and past risk of suicide.
- Discuss at least one psychological treatment, one social treatment and one lifestyle treatment.
- Recommend non-pharmacological management only.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category**: Mood Disorders
- **Area of Practice**: Old Age Psychiatry
- **CanMEDS Domains**: Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes**: Medical Expert (Assessment – Data Gathering Content; Management – Therapy; Management – Treatment Contract)

References:

- American Psychiatric Association (APA) (2013) *Diagnostic and Statistical Manual of Mental Disorders* 5th Edition, Washington DC: American Psychiatric Publishing.
- Australian Commission on Safety and Quality in Health Care - https://www.safetyandquality.gov.au/our-work/shared-decision-making/.
- Bridle C, Spanjers K, Patel S, et al. (2012) Effect of exercise on depression severity in older people: Systematic review and meta-analysis of randomised controlled trials. *The British Journal of Psychiatry* 201: 180–185.
- Calati R, Salvina Signorelli M, Balestri M, et al. (2013) Antidepressants in elderly: Metaregression of double-blind, randomized clinical trials. *Journal of Affective Disorders* 147: 1–8.
- Gin S Malhi 1, 2, Darryl Bassett 3, 4, Philip Boyce 5, Richard Bryant 6, Paul B Fitzgerald 7, Kristina Fritz 8, Malcolm Hopwood 9, Bill Lyndon 10, 11, 12, Roger Mulder 13, Greg Murray 14, Richard Porter 13 and Ajeet B Singh 15 *Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders* (First published in Australian and New Zealand Journal of Psychiatry 2015, Vol. 49(12) 1-185).
- World Health Organisation (1992), International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10). Geneva: WHO.

1.4 Station requirements:

- Standard consulting room; no physical examination facilities.

a. Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
b. Laminated copy of 'Instructions to Candidate'.
c. Role player – early 60's male, casually dressed.
d. Pen for candidate.
e. 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 are working as a junior consultant psychiatrist in an outpatient setting. You are about to see Glen Hobbins, a 65-year-old retired engineer, who has been referred by his GP, Dr White, for your opinion.

Glen had a myocardial infarction six months ago. He underwent coronary artery bypass grafting, and has made a good recovery. His cardiovascular risk factors are now well controlled.

Dr White has referred Glen for an opinion on management as in the last six weeks Dr White has been concerned that has been unwilling to trial an antidepressant for depression. Dr White reports that Glen had a CT Head and MRI Head, and no abnormalities were detected. Glen's MMSE was 30/30, and Glen's MOCA score was 30. Dr White is worried that Glen's reluctance to take an antidepressant may be due to his low mood.

Your tasks are to:

- Obtain a relevant focussed history from Glen.
- Discuss treatment options with Glen.

You are not required to examine Glen physically or to test his cognition.

You will not receive any time prompts.

Station 5 - 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 unless scripted – 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 are no prompts.

The role player opens with the following statement:

'I'm not going to take anymore new medication.'

3.2 Background information for examiners

In this station, the candidate is required to assess a 65-year-old man referred to the outpatient clinic by his GP due to concerns over low mood, and reluctance to trial antidepressant medication. The candidate is expected to establish a diagnosis of depression of mild to moderate depression, and that therefore the patient's request for non-pharmacological management, is an appropriate option.

The candidate should display a knowledge of non-pharmacological management options for treating depression, and the ability to work collaboratively with a patient in development of a management plan.

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

- Explore current and past risk of suicide.
- Discuss at least one psychological treatment, one social treatment and one lifestyle treatment.
- Recommend non-pharmacological management only.

A surpassing candidate may recognise the opportunity for shared decision making, and potential barriers to this in older patients.

Depression is the most common mental illness among older people, and is associated with increased morbidity, premature mortality and greater healthcare utilisation. However, for the majority of older people, treatment of depression is inadequate / suboptimal due to complications of poor recognition, increased prevalence of medication side-effects, polypharmacy and poor adherence to treatment (Bridle C, Spanjers K, Patel S, et al.).

Diagnosing primary depressive episodes on the background of poor physical health also requires more consideration.

DMS-5 Criteria for Depression

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

(1) depressed mood or

(2) loss of interest or pleasure.

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

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

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

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

Note: Responses to a significant loss (e.g. bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history, and the cultural norms for the expression of distress in the context of loss.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum, and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.

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

Specify:
With anxious distress
With mixed features
With melancholic features
With atypical features
With mood-congruent psychotic features
With mood-incongruent psychotic features
With catatonia
With peripartum onset
With seasonal pattern (recurrent episode only).

ICD-10 Criteria for a Depressive Episode

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

Key symptoms:

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

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

If any of the above present, ask about associated symptoms:

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

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

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

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

The international literature supports non-pharmacological (biological) over pharmacological interventions for more mild to moderate depressive episodes.

There is evidence to suggest that response to antidepressant medication may be less in older people than younger cohorts. Calati R, Salvina Signorelli M, Balestri M, et al. found that there is a lower rate of response to antidepressants of all classes in patients of male gender, of older age, and with a longer mean duration of the current episode.

The Royal Australian and New Zealand College of Psychiatrists' Clinical Practice Guidelines on mood disorders divides the non-biological management of mood disorders into the subcategories of psychological treatments, social treatments, and lifestyle treatments -

Psychological Treatments

- *Brief Cognitive Behavioural Therapy* – 4–8 sessions, focussed on a targeted and limited number of cognitions and behaviours felt to be the most likely to maintaining depression.
- *Formal Cognitive Behavioural Therapy* – usually 12–10 sessions, aims to modify dysfunctional cognitions and associated behaviours that are presumed to maintain depression.
- *Interpersonal Therapy* – based on the fact that the onset of depression is usually associated with something going on in the person's current personal life, focusses on the problems in personal relationships and the skills needed to deal with these.
- *Mindfulness* – emphasis on cultivating awareness and acceptance of the present moment, and decreasing rumination and mind wondering, which are both implicated in maintaining depression.
- *Acceptance and Commitment Therapy* – approximately 12 sessions, focusses on three areas – accept reactions and be present, choose a valued direction, take action.
- *Schema Therapy* – used for chronic depression, aims to help change from early maladaptive schemas to more adaptive schemas and coping strategies.
- Low intensity interventions (e.g. internet education) are also recognised as beneficial.

Social Treatments

- *Family Psychoeducation* – has been shown to decrease duration of episode and to reduce relapse rates of depression.
- *Family / Friends* – decreased isolation is associated with recovery from depressive episodes.
- *Formal Support Groups* – teach skills, encourage healthy activities and provide social support.
- *Community Groups* – increase social connectivity, social support and activity.
- *Caregivers* – primary supports being aware of depression is associated with earlier intervention and increased likelihood of accessing of treatment.
- *Employment* – depression rates are elevated in the unemployed population (especially long-term unemployed), maintaining employment or work attendance during an episode of depression is associated with improved recovery rates, difficult or unsupportive work environments can contribute to the development of depression.
- *Housing* – housing problems are associated with a greater risk of depression, depression risks are over ten times greater in the homeless population.

Lifestyle Treatments

- *Exercise* – inactivity is a risk factor for the development of depression, exercise is highly effective treatment intervention for depression.
- *Diet* – adherence to a 'healthy' diet pattern is associated with reduced likelihood of depression.
- *Smoking cessation* – associated with reduced depression, anxiety and stress, and improved mood and quality of life.

- *Alcohol cessation* – alcohol is a depressant, there is an increased incidence of self-harm and completed suicide in people with alcohol problems.
- *Ceasing drugs* – identifying and, if possible, ceasing medications associated with depression (e.g. beta-blockers, corticosteroids, benzodiazepines, anti-Parkinson medication, statins).
- *Managing substance misuse* – depression and substance use are common co-morbidities, ongoing substance misuse increases duration of illness and chance of relapse.
- *Sleep* – although there is no strong evidence that targeting sleep aids in the treatment of depression, there is evidence of a causal link between poor sleep and negative mood, and therefore sleep should be assessed, and behavioural intervention for improving sleep implemented if required.

The guideline advises that in mild to moderate episodes of depression, psychological management alone may be adequate, especially early in the course of illness, and reports that psychological therapies (particularly CBT and related approaches, and IPT) are as effective in reducing mild to moderate depression as pharmacological treatments.

Shared Decision Making

The Australian Character of Healthcare Rights states that consumers should be informed about services, treatments options and costs, and included in decisions and choices regarding care.

The New Zealand Code of Health and Disability Services Consumers' Rights states consumers have the right to effective communication, to be fully informed, and to make an informed choice and give informed consent.

The Australian Commission for Safety and Quality in Health Care advised that shared decision making requires more than providing information regarding evidence-based treatments. It involves integration of a patient's values, goals and concerns along with providing evidence about benefits, risks and uncertainties of treatment, in order to achieve collaborative health care decisions. In partnership with their clinician, patients are encouraged to express their treatment preferences, and to consider the available management options to help select the course of action that best fits their preferences. It differs from other types of decision making – paternalistic and informative – and that decision is made in partnership, and involves an exchange of knowledge and opinions.

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 Glen, a 65-year-old, retired engineer. You have been happily married to Faith for 45 years. You have two grown children, Michael (43) and Emily (41), and five grandchildren. Your children live locally and you see them regularly – there is a family lunch every Sunday.

Your GP has referred you to see a psychiatrist as he wants you to start a course of antidepressants, as he thinks you are depressed, but you do not want to.

The candidate should ask you about the features of depression

You should not volunteer this information without being asked, but these are the responses you should make about the following features:

Symptom	Response
Mood	*You have been feeling down for a month or so, you feel like this every day.*
Do you feel better or worse at any time of day?	*You have not noticed any difference.*
Changes to sleep	*In the last few weeks, you have been waking earlier than you used to (at 4 am when you previously woke after 6 am).*
Changes to appetite	*In the last one to two months, you have not been very interested in food and your clothes are getting big on you. Faith has been trying to get you to eat.*
Motivation / Drive	*This is lower than usual in the last few weeks, but you can be encouraged to do things.*
Energy	*This is decreased and you tire easily. The last three Sundays, you've needed to have a sleep after the family left and this is unusual for you.*
Concentration	*You haven't noticed a problem, you are still able to read and watch TV.*
Enjoyment	*Although you are less interested in doing things, but you are still able to enjoy them, you particularly enjoy time with your grandchildren.*
Libido/sex-drive	*Not brilliant to start with, but this is decreased.*
Negative thoughts	*You do not feel guilty, helpless or worthless.*
Hopelessness	*You do worry that your health issues may prevent you from doing things you want to do.*
Agitation / restlessness	*You have not noticed or felt this.*
Suicide or thoughts of harming yourself	*You have not experienced any of these thoughts, you are still planning on travelling with Faith.*

You had enjoyed working as an engineer, and had planned to work until you were 70. You had been looking forward to retirement, and in particular, to travelling with Faith. But retirement occurred earlier than anticipated when you had a heart attack six months ago. You were at work when suddenly you had a terrible pain in your chest and arm, and you were taken to the hospital in an ambulance, and told that you would need open-heart surgery.

Despite being a huge shock, you feel that you managed all of this well, and remained positive during and after the surgery. You decided to retire as the heart attack made you feel like you needed to make the most of the rest of your life. However retirement has not been quite as you'd hoped, and you now feel frustrated and like the decision of when to retire has been taken out of your hands.

When you were still in hospital, you planned to make some life changes, and to prioritise your health. You had always worked long hours, and didn't exercise often. When you were at work, you had tended to eat a lot of takeaway, and had a particular weakness for fried foods. You had smoked 20 a day since you were 16.

After your heart attack you made plans to exercise more, eat better, and to stop smoking. You did stop smoking and had been proud of this, but now you sometimes wonder if it was worth it. Your wife, Faith, has been providing you with more healthy food, but you're less interested in food than you used to be. You did initially start exercising, and joined a walking group with Faith, but you haven't really done any in the last few weeks.

You felt hopeful when you left hospital, but you have found the treatment required to try and prevent another heart attack difficult. Prior to the heart attack, you had never had any health problems, and had never been on any medication. You had significant problems with some of the medications that you were started on after the heart attack (please see section below of medication). Things are better on the medications that you are on now, but you do not want to change any of your medications or add in any new medication in case you have problems.

<u>If you are asked about any of these unusual experiences</u>

- You have not heard voices.
- You are not worried that you are dying or that your organs are rotting.
- You do not feel that you have done something terrible.
- You do not feel that anyone wants to harm you or hurt you.
- You do not feel that you are destitute or that you or your family have no money.

<u>If you are asked about alcohol or drug use</u>

- You smoked 20 a day from age 16 but stopped after the heart attack.
- You drink 2–3 beers a night – this has been unchanged for many years.
- You have never used any other drugs.

<u>If you are asked about your family</u>

- Your father had a stroke in his 80s. Your mother, Dorrie, is still alive and in nursing home. You visit her once a week.
- There are no other significant health issues in your family.
- As far as you know, no one in your family has ever had problem with depression or their nerves, and you have never had problems with your mood or nerves in the past. You've never tried to harm yourself or attempted suicide.

4.2 How to play the role:

To be dressed in casual attire. You are to be firm about the fact that you do not want to take medication, but otherwise polite and willing to work with the candidate. You are open to treatment that does not involve taking tablets. If the candidate insists on you taking medication, you are to become irritated / annoyed.

4.3 Opening statement:

'I'm not going to take anymore new medication.'

4.4 What to expect from the candidate:

The candidate should discuss your recent medical problems, and also ask questions about mood (this would include asking about things, such as your sleep and appetite as per the table under **4.1**). The candidate should respect your preference not to take medication, and discuss other treatment options with you.

4.5 Responses you MUST make:

'***I don't want to feel the way I'm feeling now.'***

'***I'm not against help, is there anything else?'***

4.6 Responses you MIGHT make:

If asked why you don't want to take medication -
Scripted response: ***'I'm on so much already. I don't want any more.'***

If asked about the heart attack or your general health –
Scripted response: ***'The heart attack was the least of my problems, the medications were much worse.'***

If the candidate recommends no medication – **(NOTE: this is the correct recommendation)**
Scripted response: ***'What am I going to say to Dr White – he won't be happy!'***

4.7 Medication and dosage that you need to remember

You were started on several medications after your heart attack – most of them caused you problems. You can write them on a piece of paper if you wish.

Medication	**Side Effects / Problems**
Clopidogrel 75 milligrams daily	You can't really remember what it is for – but it replaced the aspirin.
Candesartan 8 milligrams daily (current blood pressure medication)	You've had several medications for blood pressure - you were on two to start with. These both had to be stopped as one of them gave you a cough and the other made you dizzy. The doctors then gave you different medication and you had terrible nightmares on it.
Regular *Aspirin*	Made you feel ill – you had pains in your stomach, itchy skin and headaches and so this was stopped.
Cholesterol medication	You can't remember its name, but made your legs weak. You couldn't walk up the stairs. You are no longer on medication for cholesterol.

STATION 5 – MARKING DOMAINS

The main assessment aims are to:

f. Evaluate the candidate's knowledge of non-pharmacological management options for treating mild to moderate depression.

g. Assess the candidate's collaborative approach to working with a patient in development of a management plan.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed history for depressive symptoms? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:
clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication; explores features of agitation and melancholia.

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; completing a risk assessment relevant to the individual case; demonstrating phenomenology; clarifying important positive and negative features to address level of severity (e.g. psychosis); assessing for typical and atypical features.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Explore current and past risk of suicide.

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 (e.g. not exploring risk in any way).

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 ☐

1.14 Did the candidate demonstrate an adequate knowledge and application of relevant psychological / social therapies and lifestyle interventions? (Proportionate value - 35%)

Surpasses the Standard (scores 5) if:
includes a clear understanding of levels of evidence to support treatment options.

Achieves the Standard by:
demonstrating the understanding of these (station specific) treatments; identifying specific treatment outcomes and prognosis; appropriate selection (benefits / risks, application, adherence, monitoring of specific interventions); application of psychoeducation, choice and rationale for specific psychotherapies, social / occupational / family therapies; considering sensitively barriers to implementation.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Discuss at least one psychological treatment, one social treatment and one lifestyle treatment.

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).

1.14. Category: MANAGEMENT – Therapy	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

1.15 Did the candidate adequately engage, inform and discuss the treatment plan with the patient including suitably incorporating the patient's treatment preferences? (Proportionate value - 40%)

Surpasses the Standard (scores 5) if:
clearly achieves the overall standard with presentation of a plan that is comprehensive and sophisticated; incorporates shared decision making and clearly highlighting or referencing the patient's goals for treatment, or discusses potential barriers to shared decision making in older patents.

Achieves the Standard by:
demonstrating the ability to clearly communicate indications for treatment, range of options, and recommendations; working within patient treatment goals, and negotiating targeted outcomes; informing in relation to treatment risks / benefits and complications, including potential adverse outcomes, not recommending other biological treatments (ECT, TMS) as first line treatment.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Recommend non-pharmacological management only.

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).

1.15. Category: MANAGEMENT - Treatment Contract	**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**

Committee for Examinations
Objective Structured Clinical Examination

Station 6
Gold Coast April 2019

The Royal Australian & New Zealand College of Psychiatrists

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1.0 Descriptive summary of station:

The candidate is to undertake an assessment, with the spouse, of a 71-year-old man suffering from Alzheimer's disease. The patient has displayed a recent episode of verbal aggression triggered by delusions of jealousy. The candidate will then present their understanding of the situation and outline the general principles of early management to the spouse.

1.1 The main assessment aims are to:

- Assess an episode of verbal aggression in a patient with dementia by demonstrating skill in undertaking a biopsychosocial and a focussed risk assessment with the spouse.
- Outline the general principles of early management that advocate for multi-disciplinary team involvement utilising non-pharmacological strategies, and not recommending psychotropic medication as first line treatment.

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

- Identify the delusions of infidelity as a specific risk concern of BPSD.
- Establish alcohol as a precipitant to aggressive behaviour.
- Prioritise further assessment involving a Multi-Disciplinary Team approach.
- Sensitively communicate all key aspects of BPSD in dementia.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Other Disorders - Neuropsychiatric Disorders
- **Area of Practice:** Psychiatry of Old Age
- **CanMEDS Domains of:** Medical Expert, Collaborator
- **RANZCP 2012 Fellowship Program Learning Outcomes of:** Medical Expert (Assessment – Data Gathering Content; Formulation), Collaborator (Teamwork - Treatment Planning; External Relationships)

References:

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  1. 'Behaviour management: a guide to good practice'
  2. 'A clinician's field guide to good practice'
  3. 'A guide for family carers'

  http://www.dementiaresearch.org.au/images/dcrc/pdf/A_Clinicians_Field_Guide_to_Good_Practice_Managing_Behavioural_and_Psychological_Symptoms_of_Dementia_2014.pdf.
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- Beck, A.T., Ward, C.H., Mendelson, M., Mock, J., & Erbaugh, J. (1961), An inventory for measuring depression. *Archives of general psychiatry, 4,* 561-571.

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 – woman in her 60s, in semi-smart dress.
- 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 are working as a junior consultant psychiatrist in a community mental health clinic. You are about to interview Vicky, a 69-year-old woman, who lives with her 71-year-old husband, Kon. Kon was diagnosed with mild to moderate Alzheimer's disease by a neurologist one year ago.

Kon has been referred to you by his local general practitioner after a concerning episode last week when Kon became very angry at Vicky, and smashed their wedding photograph on the wall. He shouted at her for the first time in their marriage, and loudly threatened her with divorce. The GP noted that when reviewed the following day, Kon's mental state was stable and unchanged from his previous assessment, he dismissed the incident as a 'private matter between me and my wife', but the GP continued to have concerns for Vicky.

Vicky felt it best to come and see you alone due to not wanting to upset Kon.

Your tasks are to:

- Gather collateral from Vicky to complete a focussed assessment of the aggressive incident.
- Feedback to Vicky how you have formulated your understanding of the situation.
- Present your management plan to Vicky.

You will not receive any time prompts.

Station 6 - 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.

You have no opening statement or prompts.

The role player opens with the following statement:

'I'm at my wits' end, but I don't know how you can help.'

3.2 Background information for examiners

In this station, the candidate is to complete a biopsychosocial and risk assessment with Vicky, the spouse of Kon, a 71-year-old man suffering from Alzheimer's disease. This is in the specific context of an incident, when he displayed a recent episode of verbal aggression in response to delusions of jealousy aggravated by alcohol use. The candidate is then expected to present their understanding of the situation, and explain the general principles of early management to the spouse.

The candidate needs to demonstrate their skill in undertaking an assessment of agitation, and verbal aggression in a patient with dementia. When specifically assessing the aggressive behaviour, the candidate could work through a problem-solving process to define the seriousness of Kon's behaviour. A review of how much of a problem the aggression is, including assessment of whether other behaviours are also a problem, and whether any of them are related to the environment or interactions with others.

The candidate is then to consider the situation, and look at the circumstances contributing to the aggression; when and where the behaviour occurred or did not occur, and if he has possibly behaved in the same way in the same place. Finally, assessment needs to be made of Kon in the situation, and whether he seemed to be in pain or discomfort, or unwell; if he was possibly drinking alcohol at the time; if he was tired, overstimulated, bored, lacking in social contact or anxious, embarrassed, ignored or misunderstood. He could also have been responding to an unpleasant incident, a change or a provocation or even been hallucinating, delusional or depressed. Through their history taking, the candidate should demonstrate their ability to assess risk in this setting, and to apply their knowledge of the potential contributions of concurrent psychiatric illness, alcohol use and medical factors.

The candidate is expected to accurately communicate their findings which should include identifying underlying delusional jealousy, as well as identifying the specific risk this poses to his wife. The candidate should also identify the additional impact of alcohol use as an aggravating factor in this context.

The candidate should then demonstrate skill in formulating and negotiating an initial management plan which should involve multidisciplinary community team assessment in the home, and an awareness that psychotropic medications are NOT recommended as a first line management strategy.

It is important that while the candidate provides options and suggestions to Vicky, they do not give a false sense that interventions can prevent the symptoms of dementia from progressing.

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

- Identify the delusions of infidelity as a specific risk concern of BPSD.
- Establish alcohol as a precipitant to aggressive behaviour.
- Prioritise further assessment involving a Multi-Disciplinary Team approach.
- Sensitively communicate all key aspects of BPSD in dementia.

A better candidate may:

- Show an ability to apply literature and College guidelines in their management of BPSD;
- Make mention of scales and rating instruments for BPSD: agitation, aggression, wandering;
- Involve a bicultural clinician or consider involving a language and cultural interpreter.

Assessment and Diagnosis

Alzheimer's disease typically presents with two overlapping syndromes, one cognitive, the other behavioural. Almost all patients experience the behavioural syndrome which is characterised by psychosis, aggression, depression, anxiety, agitation, and other common but less well-defined symptoms included in the term 'behavioural and psychological symptoms of dementia' (BPSD); like circadian rhythm (sleep / wake) disturbance. BPSD impacts on care providers, and tends to ultimately precipitate the chain of events resulting in long-term institutional care.

Symptoms of Moderate Alzheimer's disease: As a progressively degenerative condition, Alzheimer's disease affects each person differently and symptoms do not appear suddenly. There are three major stages (mild, moderate and severe) even though there is no specific timeframe of progression. People can have both good, clear days and bad days (where they can become agitated, confused or angry).

The moderate (confused) phase of Alzheimer's disease often lasts the longest (between 2 to 10 years) and presents with severe memory and cognitive decline, motor skill changes and behavioural changes. Noticeable gaps in memory and thinking and, while they tend to be able to distinguish familiar from unfamiliar faces, people with Alzheimer's disease can have trouble remembering the name of their spouse. People can become disoriented to time and place. They also lose awareness of recent experiences, and may not be able to express themselves effectively because of a reduction or confusion of words.

Behavioural and Psychological Symptoms of Dementia (BPSD) are also known as neuropsychiatric symptoms. They are a heterogeneous group of non-cognitive symptoms and behaviours that form a major component of the dementia syndrome irrespective of its subtype. They are as important as cognitive symptoms because they strongly correlate with the degree of functional and cognitive impairment. Symptoms include agitation, abnormal motor behaviour, anxiety, elation, irritability, depression, apathy, disinhibition, suspiciousness / delusions, and hallucinations. People can become easily frustrated, especially as their skills decline or in response to demands of carers and the environment.

Delusional jealousy (or Othello syndrome) is the fixed held belief in the infidelity of one's spouse or partner. Present rarely in a wide variety of psychiatric disorders, it has been more commonly associated with organic psychoses including post stroke and in Parkinson's disorder. In dementia, it has been associated in about 8 to 16% of cases and tends to be even more common in Lewy Body Dementia (up to 26%). Delusional jealousy has been identified as a risk factor for aggression and homicide, especially against domestic partners. It has been postulated that developing feelings of insecurity and inferiority in context of partial awareness to failing cognition underpins the evolution of delusions of infidelity. Disparities in health between patients and their spouses have also been associated as a risk factor for developing delusional jealousy.

As part of BPSD, people can have trouble with losing bladder or bowel control, as well as experiencing changes in sleep patterns or appetite. It is estimated that BPSD affects up to 90% of all dementia patients over the course of their illness.

BPSD is thought to be independently associated with poor outcomes, including distress among patients and caregivers, long-term hospitalisation and misuse of medication.

These symptoms most commonly present simultaneously in the patient. A high degree of clinical expertise is crucial to appropriately recognise and manage the neuropsychiatric symptoms in a patient with dementia. Combination of non-pharmacological and careful use of pharmacological interventions is the recommended therapeutic for managing BPSD.

Tests / Instruments:

There are more than 75 different instruments that have been used in the assessment of BPSD, of which the following are a few.

- Brief Psychiatric Rating Scale (Overall and Gorham, 1962),
- Sandoz Clinical Assessment Geriatric (Shader et al., 1974),
- Alzheimer's Disease Assessment Scale (Mohs et al., 1983),
- Cambridge Examination for Mental Disorders (Roth et al., 1986),
- Behavioural Pathology in Alzheimer's Disease Scale (BEHAVE-AD) (Reisberg et al., 1987).

Tools for assessing BPSD include the clinician-administered Neuropsychiatric Inventory (NPI) which assesses ten behaviours, as well as appetite and sleep in the person with dementia. It can help to distinguish between the different types of dementia. Recent versions also include a Caregiver Distress Scale.

The Behavioural Pathology in Alzheimer's Disease (BEHAVE-AD) measures BPSD, and is generally clinician rated in Acute, Primary, Community and Residential Care settings, and can be used to measure change as a result of interventions.

There are also tools to assess particular BPSD areas and pain:

1. Aggression (RAGE = Rating Scale for Aggressive Behaviour in the Elderly)
2. Agitation (CMAI = Cohen-Mansfield Agitation Inventory; PAS=Pittsburgh Agitation Scale)
3. Depression (CSDD = Cornell Scale for Depression in Dementia; GDS=Geriatric Depression Scale)
4. Pain (PAINAD = Pain Assessment in Advanced Dementia; the Abbey Pain Scale; PACSLAC = Pain Assessment Checklist for Seniors with Limited Ability to Communicate).

In addition, psychiatric instruments initially developed for use in adults or to measure single BPSD have been used in demented and older populations, include the Hamilton Depression Rating Scale (Hamilton,1960) and the Beck Depression Inventory (Beck et al., 1961).

The diagnosis of BPSD is based on obtaining a clinical history, direct observation, psychiatric and physical examinations, and reports from care providers. Exclusion of physical problems (e.g. an infection, pain, constipation or poor eyesight or hearing) or mental illnesses such as depression are critical.

Laboratory tests can assess for the presence of medical conditions that can trigger or exacerbate the clinical presentation of BPSD. It is important to exclude unmet medical needs, consider medication that could aggravate confusion or cognitive issues like anticholinergic drugs or benzodiazepines, and consider whether alcohol could be an aggravating factor given that a brain affected by neurodegenerative changes tend to be more susceptible to the adverse effects of alcohol.

Management

Generic approaches of management include engaging the person in enjoyable and meaningful activities, which could range from making music to exercising, spending quality time with the person, like chatting or sharing a task together, developing a structured daily routine, trying to ensure continued social relationships, encouraging the person to engage in past pleasurable activities, reducing unnecessary noise and clutter, providing people with familiar personal items and maintaining a comfortable sleeping environment.

The key principle of management in caring for a person with dementia is the involvement of a multidisciplinary team using a 'person-centred care' approach which aims to develop an understanding of the person as an individual (RANZCP & NSW Health, 2013). This focusses on identifying and meeting the specific needs of the individual. Forming a working partnership between the person, the carer and the clinical team assists in developing shared goals based on the person's values and experience. Clinicians need to focus on establishing rapport with both the carer and person to properly assess and prioritise physical, psychological and social goals.

Factors guiding assessment and treatment include:

1. the person's response to their past and current environments;
2. their personal history, culture and religious background;
3. personal likes and dislikes;
4. interpretation of precipitants to behaviours; and
5. unmet needs (RANZCP & NSW Health, 2013).

Priorities should include:

1. managing physical care needs (investigating physical problems such as pain, infection, constipation, poor eyesight or hearing and possible mental disorders such as delirium or depression);
2. behavioural and environmental strategies including, in this case, restricting access to alcohol;
3. psychological engagement;
4. maximising residual strengths in the person; and
5. caring for the carer.

Cautious consideration of psychotropic medication is only indicated if there are risk issues or psychosocial strategies have not relieved the situation (e.g. not as a first line choice in the present case but to be considered if the symptoms continue to cause concern).

Communication is critical when working with a person with dementia, including attention to body language and tone of voice. Strategies to improve verbal communication include:

1. minimising background noise;
2. speaking in a gentle voice;
3. using simple, calm hand gestures and facial expressions;
4. explaining tasks slowly in simple terms;
5. allowing time to be understood;
6. clarifying by repeating or rewording; and
7. using personal reference where available (person's or relative's name).

The 'Top 5 Strategies' that carers have found useful in BPSD management to reassure the person with cognitive impairment (RANZCP & NSW Health) include listing:

1. things that cause distress;
2. things that settle distress;
3. established reassuring routines;
4. repeated anxieties or questions; and
5. triggers indicating an unmet need.

Composing such a list acknowledges the expertise of the carer, and may assist them to take a step back from troublesome behavioural interactions.

Non-pharmacologic interventions are now considered the foundation of BPSD treatment. Problem behaviours can be seen as meaningful responses to unmet needs in the therapeutic milieu. Because the progression and impact of BPSD varies between patients, interventions must be designed, implemented, and reviewed on an individual basis with a focus on person centred care approaches. They include: family support and education, psychotherapy reality orientation, validation therapy, reminiscence and life review, behavioural interventions, therapeutic activities and creative arts therapies, environmental considerations (including restraint-free facilities), behavioural intensive care units, and workplace design and practices that aid the ongoing management of caregiver stress. Evidence based approaches include possible dementia care mapping to establish patterns of behaviour and identifying underlying potential triggers which also include the use of ABC charts (identification of Antecedent events, Behaviour and Consequences).

Although pharmacological management is a commonly used option, it is often limited in its effects and can be associated with a substantial risk of side-effects.

Social supports need to be put in place for both the person with Alzheimer's disease and the carers. This includes home help, day care and access to other community services. There is a wide range of literature and web-based information about Alzheimer's disease. Consideration of a nursing home has to be approached at some time.

Working with the carer is a basic intervention that should be mentioned by candidates. Acknowledging Vicky's experience and knowledge of Kon is an important step in establishing rapport and gaining her cooperation. She needs specific information / education about Alzheimer's disease and the common occurrence of otherwise inexplicable behaviours (BPSD). Alzheimer's Australia / NZ are important sources of information and education. It is important to emphasise that BPSD behaviours are due to the disorder, are often transient and can be understood and managed with a calm, reassuring presence.

Carer support

Candidates should mention the need to assess Vicky's stress levels, mental wellbeing and current coping, as well as to screen for the development of a treatable mental disorder. Providing her with practical support may improve her ability to continue caring for Kon at home. Specific attention should be paid to:

1. mobilising and engaging established social network;
2. arranging domestic assistance, home maintenance, in-home respite and home care;
3. referral to community services;
4. financial, legal, and guardianship matters; and
5. encouraging contact with Alzheimer's organisations for information and social support.

Any intervention should be positive and incorporate person-centred principles:

- Valuing the person with dementia and treating them as individuals.
- Looking from the perspective of the person with dementia.
- Creating a positive social environment to foster a sense of wellbeing.
- Trying to ensure continued social relationships, encouraging the person to engage in meaningful activities and maintaining a comfortable sleeping environment.
- Reducing unnecessary noise and clutter, providing people with familiar personal items.

It is important to obtain a comprehensive understanding of the behaviour by assessing:

- behaviour: onset, triggers, frequency, occurrence of the behaviour and when does it not occur. It is usually best to record the behaviour, what happened before and afterwards.
- person: characteristics, life history, dementia diagnosis and severity, mood, support needs.

  caregiver(s): characteristics, carer's own health, communication approach, relationship factors, stress threshold.
- environment: physical, social, cultural, emotional, spiritual.

Resources:

Books, DVDs, Help sheets

Online – www.alzheimers.org.au

www.dementiacareaustralia.com

www.dasinternational.org (Dementia Advocacy and Support Network for people with dementia)

www.careraustralia.com.au

www.dbmas.org.au (Dementia Behaviour Management Advisory Services)

www.alzheimers.org.nz

ilearn.careerforce.org.nz/mod/book/view

3.3 The Standard Required

In order to:

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

Achieve 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 medico-legal 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 well-being 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 Vicky, a 69-year-old woman, married to Kon, age 71. You live in the home Kon built for the family 40 years ago. Kon has been diagnosed with Alzheimer's disease.

You are coming to see the psychiatrist today at the request of your GP, Dr Jones, as he is concerned about the distressing incident with Kon last week. You are not sure how the psychiatrist can help.

Incident leading to GP referral

Last week you briefly left Kon at home in the afternoon to take some lemons from your garden to your long term neighbours. Upon your return, Kon was waiting for you at the door. He yelled at you, accusing you of having an affair. He then grabbed your wedding photo hanging next to the front door, and smashed it into pieces against the wall.

You got frightened but also lost your temper, and told him he was crazy and tried to reason with him that you only went to the neighbours, but then he started crying and accused you of not loving him anymore. He maintained that he knew you went to see your '*boyfriend*', and said that the marriage is now finished, although he wanted to go and sort the bloke out (the neighbour). He only settled once your daughter, Maria, arrived after you called her.

This is the first time Kon has behaved like this, although you have noticed that he started to make nasty and derogatory comments about the neighbours in recent months, especially the husband; despite having been friendly with them for many years. He has made fleeting comments referring to him as '*your boyfriend*' when you waved at them as they got home in the car, but you told him not to talk such nonsense and did not think more about it. Now that you recall it, he seems to be more focussed on the neighbour after a glass of ouzo. However, he has not confronted the neighbour or made specific threats.

Background information

Kon was a builder until he sold the business and retired five years ago. Since then he has been keeping himself busy by tending his vegetable garden or enjoying his Greek music.

You met each other in a small village in Greece where you grew up and after you got married, you emigrated to Australia 50 years ago in 1969. You have been married for 51 years and have three grown children (Maria age 50 living nearby, Nick age 48 living in Greece, and Helen age 45 living interstate). You stayed home to raise the children and remained a housewife.

It was a happy marriage with '*normal ups and downs like most couples*', but there was never any conflict and you were devoted to each other and your family. But Kon has become unwell recently, and his behaviour has changed.

In this station, you are about to see a psychiatrist on the recommendation of your GP. You are not sure what they can do for you and your husband Kon.

Diagnosis of dementia

About two years ago, you noticed Kon's memory was slipping. Then he had trouble paying the bills and you took over responsibility for this. When he turned into a one-way street nearly causing an accident a year ago, you decided to do all the driving and Kon reluctantly agreed. His loss of independence was difficult for him given that he loved to go for a drive. Following that incident, Dr Jones did tests and scans. He said Kon was suffering from dementia and referred you to a private nerve specialist. After two appointments, the neurologist said Kon had Alzheimer's disease. He prescribed a memory tablet called Aricept, but Kon just seemed to get worse. After four months, you stopped the tablets and have not seen the neurologist since.

Kon has no other medical problems. He takes no medications, and does not like tablets or going to the doctor.

Alcohol use

Kon never had issues with excessive alcohol use, but used to drink a glass or two of ouzo with friends when they met up at the Greek club or on a weekend whilst watching sport. This never caused concern or problems. More recently, he has taken to pouring himself some ouzo from the cabinet some afternoons, but you did not think much of it, given it did not seem excessive and never more than one or two glasses. If asked, you noticed though on the day of the incident that he seemed to have drunk more than usual, and a bottle was empty that you thought had been half full.

Living with dementia

You sometimes argue with Kon when he does not remember things as it frustrates you. You get particularly frustrated when Kon just sits in his lounge chair for hours, staring at the television. If you shout at him to say something, he just replies that he is okay and asks you to leave him alone.

At other times, Kon follows you wherever you go, and does not let you out of his sight. He even stands by the door when you go to the toilet. He still goes shopping with you, but reluctantly so and tries to convince you not to go either. You do leave him at home sometimes when you are in a hurry, and often finds him waiting just inside the door upon your return, and being quite agitated at you, sharply questioning you about where you went, and what you did and whom you saw. He also gets agitated when you are on the phone, and this has led to arguments and you avoiding calling your friends. He often repeats the same question which is frustrating to you, like '*When are we going to eat?'*. He repeatedly washes any dishes found in the kitchen, and gets under your feet when you try to cook or clean. You have yelled at him in frustration, but never been violent to him.

While he seems to understand everything you say, he never starts a conversation anymore. You feel like his head is empty and miss being able to talk about things with him. Because of his condition, you never visit friends, and no one, other than your daughter Maria, comes to visit you at home.

You do not have any home help. You have never been offered any community services. You have not read anything about Alzheimer's disease because it might make you cry. You live day by day, fearing what will happen as Kon's illness gets worse. You feel it is your duty to care for Kon, and would never consider him going into a nursing home. That is the way both of you have been raised.

Concerning symptoms

Risk: Kon is a gentle man and has never abused you or the children. You do not think Kon could ever hurt himself or anyone else. You have not been afraid of him and he has never threatened to harm you or himself. You do worry how he would cope if anything ever happened to you. He does not tend to wander off or leave the house on his own, and the yard is secure.

Agitation: Late in the afternoon, Kon gets restless and walks about the house from room to room. At night, he will go to the front or back door and rattle the doorknob, trying to get outside. You can easily distract him from the door, and reassure him with comforting words or a hug.

You help Kon in the shower every morning otherwise he would just not shower. For 10 minutes before showering, he is irritable, restless and fidgets at the breakfast table. He can resist washing and does complain when you wet his hair, occasionally pushing you away. You do not feel there is any danger when he is in the shower. Once showered, Kon calmly sits at the table reading the paper. When you ask him what he is reading, he just says '*the news*', but never makes any other comment.

Aggression: Kon raised his voice to you last week for the first time in your marriage, when he made the accusations. There has been no further conflict although he remains somewhat brooding and irritable. When you told Dr Jones about this incident, he immediately referred you to the Community Mental Health Clinic.

Delirium (acute change in alertness): Kon has NOT seemed more confused or disorientated in the past month. He is able to focus his attention on a task (like having breakfast), concentrate on it for a short time and is not easily distracted. His awareness of his surroundings does not change rapidly throughout the day. He does not see things or hear voices that others cannot.

Depression: Kon does not appear to be down, sad or depressed. He never had mental health difficulties or seen a psychiatrist in the past. He does not generally dwell on negative thoughts or express guilt. His sleep is undisturbed, retiring at 9 pm, arising to toilet once but returning to sleep readily, and awakens at 7 am.

He is often muddled and uncertain where he is on awakening, but this settles with reassurance. His appetite is good and weight steady. He has few interests, and spends much of the day sitting in the lounge room staring blankly at the television. He does potter about the back garden in good weather, moving pot plants from place to place on the patio in an aimless manner, and his vegetables have become neglected. He has never spoken of wishing to die. You do not think he would contemplate suicide as he always considered it a sin.

Psychosis: Other than for the above beliefs about your infidelity, Kon has never expressed any ideas of being persecuted, followed, spied upon or interfered with in any way. He does not seem to be responding to unseen things or talk to others when no one is present. He does not speak of hearing voices, and does not appear to see things or have visions of unshared occurrences.

Attitude to future management

Further assessment: You are happy to go along with seeing anyone the doctor / candidate suggests.

Home help: You are willing to accept help in the home, but are not keen on anything like 'day care' for Kon.

Medications: You do not want Kon to be drugged or sedated.

4.2 How to play the role:

You are feeling the strain of caring single-hand for your husband over the past year. You feel isolated, yet unable to ask for assistance believing that it is your fate to care for Kon. You have mixed feelings about getting help. You find it hard to see the man you love, your life partner, disappear before your eyes. You are stressed by the worry and constant care needs, but reluctant to let others do any caring. You are lonely, but are too embarrassed to talk to friends and worry that Kon might say something silly. You do not want to burden your daughter, Maria, whom you believe has enough of her own problems.

4.3 Opening statement:

'I'm at my wits' end, but I don't know how you can help.'

4.4 What to expect from the candidate:

After asking for some background about you and Kon, candidates may explore how the diagnosis of Alzheimer's disease was made, what you know about Alzheimer's and whether you have received any education, assistance or home help.

Candidates should explore the incident leading to the referral, and in particular the ideas about infidelity; past psychiatric issues and specific concerns about your own or Kon's safety, as well as threats to the neighbour. They should explore whether Kon experiences depression, unusual experiences, other unusual fixed but false beliefs or sudden changes in alertness, awareness and attention. They should also ask about his alcohol use as an aggravating trigger.

The candidates should tell you about something called the 'behaviour and psychiatric symptoms of dementia' (if they say 'BPSD', ask them what that means).

They should then propose an action plan involving further assessment in your home with members of a multidisciplinary community team (social worker, community nurse, occupational therapist, and psychologist). They may discuss further interventions to assist you in caring for Kon. They may suggest contacting community help, elder care support services or support groups such as the Alzheimer's Association (Australia) or Alzheimer's New Zealand. They might suggest restricting his access to alcohol.

4.5 Responses you MUST make:

'Do I need to worry about his jealousy?'

'Can he still have his glass of ouzo doctor?'

4.6 Responses you MIGHT make:

If the candidate recommends medication;

Scripted statement: '***I don't want Kon drugged or sedated.***'

If the candidate suggests that others might help care for Kon;

Scripted statement***: 'No one loves Kon like I do … Nobody could care for him as I do...he won't like that.***'

4.7 Medications:

Currently not on regular medication.

The GP prescribed a medication called ARICEPT for four months last year (one tablet twice a day), but it was stopped as Kon seemed to be getting worse.

You are not keen for him to have any tablets like this again.

STATION 6 – MARKING DOMAINS

The main assessment aims are to:

- Assess an episode of verbal aggression in a patient with dementia by demonstrating skill in undertaking a biopsychosocial and a focussed risk assessment with the spouse.
- Outline the general principles of early management that advocate for multi-disciplinary team involvement utilising non-pharmacological strategies and not recommending psychotropic medication as first line treatment.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed history including an assessment of risk? (Proportionate value – 40%)

***Surpasses the Standard (scores 5) if**:*
achieves a score of at least 4 *and* clearly achieves the overall standard with a superior performance in a range of assessment areas; demonstrates prioritisation and sophistication.

Achieves the Standard by:
demonstrating use of a tailored biopsychosocial approach; obtaining a history relevant to the patient's circumstances with appropriate depth and breadth; integrating key sociocultural issues relevant to the assessment; clarifying important positive and negative features.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Identify the delusions of infidelity as a specific risk concern of BPSD.

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 ☐

1.11 Did the candidate generate an adequate formulation to make sense of the presentation? (Proportionate value - 30%)

***Surpasses the Standard (scores 5) if**:*
achieves a score of at least 4 *and* provides a superior performance in a number of areas; demonstrates prioritisation and sophistication; applies a sophisticated sociocultural formulation.

Achieves the Standard by:
identifying and succinctly summarising important aspects of the history and observations; integrating medical, psychological and sociological information including possible contributions of delirium or other psychiatric conditions (depression, psychosis); developing hypotheses to make sense of the patient's predicament using a biopsychosocial framework.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Establish alcohol as a precipitant to aggressive behaviour.

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).

1.11. Category: FORMULATION	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

3.2 Did the candidate appropriately involve treatment teams in developing management plans? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* takes a leadership role in treatment planning; provides a sophisticated link between the plan and key issues identified; addresses difficulties in the application of the plan.

Achieves the Standard by:
Discussing the need to assess psychological issues relevant to patient; offering strategies to deal with problematic behaviours; acknowledging carer's expert knowledge of patient; outlining roles of: social worker to explore social referral or interventions, psychologist to assess capacities and retain of functions, occupational therapist to assess home safety and functional capacity, community nurse to provide practical support, GP to oversee management plan; counselling about the importance of a referral to community support services and / or Alzheimer's Association / Alzheimer's NZ.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Prioritise further assessment involving a Multi-Disciplinary Team approach.

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 or if the candidate *only* offers medication as a way to manage the situation. Significant omissions affecting quality scores 1.

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

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

3.2. Category: TEAMWORK – Treatment Planning	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Domain Not Addressed**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

3.3 Did the candidate demonstrate an appropriately skilled approach to carer? (Proportionate value - 10%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* recognises the complexity of liaison; readily contributes to engagement of other agencies.

Achieves the Standard by:
offering to liaise directly with relevant agencies; identifying appropriate techniques to enhance engagement; outlining plans to maintain an effective working alliance.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Sensitively communicate all key aspects of BPSD in dementia.

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).

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** ☐

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**

Committee for Examinations
Objective Structured Clinical Examination

Station 7
Gold Coast April 2019

The Royal Australian & New Zealand College of Psychiatrists

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1.0 Descriptive summary of station:

Jodie is a 29-year-old patient who has been under the care of a junior consultant psychiatrist for a few months. She suffers from chronic schizophrenia, and is stable on a dose of 15mg olanzapine daily. She is planning to go on a 'holiday of a lifetime' – a three-month round-the-world cruise, with her parents. She is scheduled to leave in six weeks. Jodie is a heavy smoker, and wishes to stop smoking before she goes on holiday. The candidate is to assess Jodie's level of nicotine dependence, and advise her on options she can use to quit smoking.

1.1 The main assessment aims are to:

- Assess a patient's level of nicotine dependence.
- Offer different treatment options and outline their limitations.
- Rationalise their preferred treatment for the patient.

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

- Explore reasons for previous unsuccessful attempts to stop smoking.
- Discuss NRT, one other medication and one non-pharmacological method.
- Explain the need to decrease dose of olanzapine once she has stopped smoking.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category**: Substance Use Disorders
- **Area of Practice**: Addictions, Adult Psychiatry
- **CanMEDS Domains**: Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes**: Medical Expert (Assessment – Data Gathering Content, Management – Therapy, Management Treatment Contract)

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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: woman in late 20s.
- 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 are a junior consultant psychiatrist working in private practice.

Jodie is a 29-year-old woman whom you have seen once previously. She has chronic schizophrenia, and is stable, and symptom free on 15 mg olanzapine daily.

Jodie and her parents have been planning for a three-month round-the-world cruise, and she wants to quit smoking before she leaves for her holiday. She wishes to discuss her treatment options with you.

Your tasks are to:

- Take a focussed history from Jodie that will assist in planning smoking cessation interventions.
- Explain the management options available to Jodie.
- Negotiate a management plan with Jodie.

You will not receive any time prompts.

Station 7 - 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 unless scripted – 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.

The role player opens with:

'Doctor I'm so excited. Just six weeks to go before my big holiday!'

3.2 Background information for examiners

The aims of this station are to assess the candidate's ability to help a woman with well controlled schizophrenia overcome her nicotine dependence over a six-week period. The patient is ready to make plans to quit, so does not require interventions that specifically deal with ambivalence about stopping, rather a focussed discussion on the most suitable options and the potential risks.

As advice-based help and pharmacotherapy can both increase the rate of success of quit attempts, the candidate should offer cessation treatment, either counselling (individual or group) or medication, or both, to Jodie, and is expected to individualise and customise this to Jodie's own personal situation and experience.

The candidate is expected to take an encouraging approach, and provide smoking cessation advice that includes addressing the perception that it is ineffective or that they lack proficiency in managing smoking cessation. The candidate should demonstrate their knowledge and skill in providing evidence-based advice.

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

- Explore reasons for previous unsuccessful attempts to stop smoking.
- Discuss NRT, one other medication and one non-pharmacological method.
- Explain the need to decrease dose of olanzapine once she has stopped smoking.

A better candidate may:

- explore reinforcers for smoking behaviour and / or identify triggers or high risk smoking situations.
- demonstrate a detailed understanding of management options for nicotine dependence.
- provide a succinct overview of all major pharmacological and non-pharmacological options and side effects.
- recognise the limitations of agents used in smoking cessation.

There are higher rates of smoking and nicotine dependence in people with mental illness. Over 30% of Australians with mental illness smoke compared to 15-16% of those without mental illness. For people with schizophrenia, the rate is up to 66%. There is a greater health and financial burden amongst smokers than the general population. Most of the excess morbidity and mortality is due to smoking related illness - cardiovascular disease, respiratory disease or cancer. Despite the decline in prevalence, smoking remains the behavioural risk factor responsible for the highest levels of preventable disease and premature death. The criteria for diagnosing nicotine dependence is outlined in the table below.

Nicotine stimulates nicotinic acetylcholine receptors in the mesolimbic pathway to release dopamine in the nucleus accumbens. This leads to positive reinforcement of rewarding behaviour - smoking. Negative reinforcement - relief from withdrawal symptoms - also perpetuates smoking behaviour in those addicted to nicotine. Following repeated exposure, certain situations and activities become associated with the rewards and develop as cues to smoking.

Smoking is often reported by people as being beneficial as it 'reduces stress'. This is a paradox as multiple studies have identified that cessation of smoking reduces stress, depression, anxiety and improves quality of life. The perceived positive effect of smoking is due to the alleviation of nicotine withdrawal symptoms. Stopping smoking has repeatedly been shown not to exacerbate pre-existing mental illness such as schizophrenia and depression. It is also interesting to note that suicide risk decreases with smoking cessation.

A range of evidence-based strategies have been shown to improve the implementation of effective smoking cessation interventions, and providing a systematic approach to smoking cessation is associated with higher levels of success. Even brief interventions for smoking cessation (involving opportunistic advice, encouragement and referral) can have positive outcomes, and include one or more of the following: brief advice to stop smoking; an assessment of interest in quitting; offering pharmacotherapy where appropriate; providing self-help material; and offering counselling or referral to external support such as Quitline, an accredited tobacco treatment specialist or other local programs. The optimal treatment for smoking is combination of counselling, pharmacotherapy and ongoing support. Multiple attempts are not unusual, and when interventions are put in place, the benefits are cumulative with each attempt.

Assessing Nicotine Dependence

The 5As approach (five components of effective tobacco cessation counselling) was originally proposed by the US Clinical Practice Guideline (Fiore, 2011). It was designed to provide clinicians with an evidence-based framework for structuring smoking cessation by identifying all smokers, and offering support to help them quit. The approach has been adopted in modified forms in a number of international guidelines, and is a suggested pathway to address smoking in patients.

- **ASK** all patients if they smoke.
- **ADVISE** all smokers to quit in a clear, non-confrontational, personalised way.
- **ASSESS** dependence and readiness to quit.
- **ASSIST** with quitting.
- **ARRANGE** follow up.

Motivation for change and readiness to quit can be assessed by using key questions:

- 'How do you feel about your smoking at the moment?' and
- 'Are you ready to quit now?'

There are some simple tools that can be used to help identify dependence.
In a modified CAGE questionnaire, two 'yes' answers identify a positive screen:

1. Have you ever felt a need to **cut down** or **control** your smoking, but had difficulty doing so?
2. Do you ever get **annoyed or angry** with people who criticise your smoking or tell you that you ought to quit smoking?
3. Have you ever felt **guilty** about your smoking or about something you did while smoking?
4. Do you ever smoke within half an hour of waking up (**eye-opener**)?

The 'Four Cs' Test:

Compulsion:

- Do you ever smoke more than you intend?
- Have you ever neglected a responsibility because you were smoking, or so you could smoke?

Control:

- Have you felt the need to control how much you smoke, but were unable to do so easily?
- Have you ever promised that you would quit smoking, and bought a pack of cigarettes that same day?

Cutting Down (and withdrawal symptoms):

- Have you ever tried to stop smoking? How many times?
- For how long?
- Have you ever had any of the following symptoms when you went for a while without a cigarette: agitation, difficulty concentrating, irritability, mood swings? If so, did the symptom go away after you smoked a cigarette?

Consequences:

- How long have you known that smoking was hurting your body?
- If you continue to smoke, how long do you expect to live? If you were able to quit smoking today and never start again, how long do you think you might live?

Other questions that are frequently used include ‘How soon after waking would you smoke?’ - within 30 minutes is a very strong indicator of addiction, and ‘How many cigarettes do you smoke?’ - greater than 20 indicates a higher-level addiction.

It can be helpful to advise patients that when people cease smoking, almost all nicotine is out of the system by 12 hours. After 24 hours, the blood levels of carbon monoxide drop dramatically which enables increased oxygenation in the bloodstream. On the other hand, assessing for withdrawal is an important part of questioning for dependence. It is important to be aware that the withdrawal of nicotine can lead to craving and other symptoms like irritability. Methods to manage these symptoms need to be considered in order to reduce the risk of failure.

Tobacco Withdrawal (American Psychiatric Association, DSM-5) is defined as abrupt cessation of tobacco use, or reduction in the amount of tobacco used, followed within 24 hours by four (or more) of the following signs or symptoms:

- irritability, frustration, anger
- anxiety
- difficulty in concentration
- increased appetite
- restlessness
- depressed mood
- insomnia.

To meet the DSM-5 definition, these symptoms need to cause clinically significant distress or impairment in social, occupational or other important areas of functioning, with the signs or symptoms not attributable to another medical condition and not better explained by another mental disorder, including intoxication or withdrawal from another substance.

Other general withdrawal symptoms that have been identified include craving for sweet / sugary foods, constipation, coughing, dizziness, dreaming / nightmares, nausea and sore throat.

Situations likely to discourage quit attempts or lead to unsuccessful attempts at quitting should be explored. These include:

- high dependence on nicotine and heavy smoking (more than 20 cigarettes per day, short time to first cigarette)
- lack of knowledge of the benefits of quitting or belief that action is not necessary
- enjoyment of nicotine or smoking behaviour
- psychological or emotional concerns (stress, depression, anxiety, psychiatric disorders)
- fear of weight gain
- fear that quit attempt will be unsuccessful
- other substance use (alcohol and other drugs)
- living with other smokers
- circumstances that result in the smoker giving quitting a low priority, such as poverty and social isolation.

Candidates should take opportunities to reinforce certain situations relevant to the individual scenario that can build a sense of hope.

The smoking cessation guidelines for Australian General Practice recommend the following simple actions for clinicians to suggest to patients who are ready to quit:

- Provide assistance – to develop a quit plan
- Suggest coping strategies
- Delay, deep breathe, drink water, do something else
- Assist with pharmacotherapy where indicated
- Encourage social support.

Diagnostic Criteria for Nicotine Dependence:

DSM-5	ICD-10
A problematic pattern of tobacco use leading to clinically significant impairment or distress. Endorsement of at least two criteria in the past 12-months:	**A cluster of behavioural, cognitive and physiological phenomena in which the use of tobacco takes on a much higher priority than other behaviours that once had a greater value. Endorsement of three or more criteria present at some time during the past 12-months:**
Tobacco is often taken in larger amounts or over a longer period than intended	
Persistent desire or unsuccessful efforts to cut down or control tobacco use	Difficulty in controlling tobacco use
A great deal of time is spent in activities necessary to obtain or use tobacco	
Craving, or a strong desire or urge to use tobacco	A strong desire to consume tobacco
Recurrent tobacco use resulting in a failure to fulfil major role obligations at work, school, or home (e.g., interference with work)	
Continued tobacco use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of tobacco (e.g., argument with others about tobacco use)	
Important social, occupational or recreational activities given up or reduced because of substance use	Progressive neglect of alternative pleasures or interests because of tobacco use, increased amount of time necessary to obtain or take tobacco or to recover from its effects
Recurrent tobacco use in situations in which it is physically hazardous (e.g., smoking in bed)	
Tobacco use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by tobacco	Persistent tobacco use despite clear evidence of harmful consequences.
Tolerance: need for markedly increased amounts of tobacco to achieve the desired effect or markedly diminished effect with continued use of the same amount of tobacco	Evidence of tolerance, where greater tobacco use is needed to achieve the same effects originally produced by lower doses
Withdrawal: the characteristic withdrawal syndrome for tobacco or tobacco (or a closely related substance, such as nicotine) is taken to relieve or avoid withdrawal symptoms	A physiological withdrawal state when tobacco use has ceased or been reduced, demonstrated by withdrawal or use of the same (or closely related) substance to avoid withdrawal symptoms

Interventions

Psychological interventions such as motivational interviewing, and counselling are essential components of therapy. Assessing and understanding reinforcers to smoking behaviour, such as sensory rewards, rituals, images and emotional relief help to reduce the risk of relapse. Identifying triggers and high risk smoking situations, and developing plans to cope with them increases long-term cessation rates. Motivational interviewing is a counselling philosophy that values patient autonomy and mutual respect, and uses open-ended questions, affirmations, reflection and summarising.

Both individual counselling and group counselling increase quit rates over approaches where there is minimal support. Individual counselling usually involves four weeks of weekly face-to-face meetings, with a counsellor trained in smoking cessation, following the quit date. It is normally combined with pharmacotherapy.

Group behaviour therapy involves scheduled meetings (typically four to eight) to provide information, advice and encouragement, and some form of behavioural intervention. Advice tends to consist of problem solving and skills training, and social support as part of the treatment.

Telephone counselling (e.g. Quitline) provides advice, encouragement and support by specialist counsellors to smokers who want to quit, or who have recently quit. There is stronger evidence that proactive support is more effective, in part because most smokers will not call Quitline often enough to get the full benefit but will readily accept proactive calls. A review in New Zealand (Shearer et al) of the cost effectiveness of a variety of interventions found Quitlines, especially when combined with pharmacotherapy, to be among the highest rated. Adding Quitline counselling to pharmacotherapy and minimal intervention increases abstinence rates.

Pharmacological interventions including Nicotine Replacement Therapy (NRT), varenicline, bupropion and nortriptyline are recommended for nicotine addiction. Pharmacotherapy should be recommended to all dependent smokers who express an interest in quitting, except where contraindicated. Pharmacotherapy may not be as effective for people smoking less than 10 cigarettes per day, as there is a lack of evidence for effectiveness below this level of smoking.

Both combination NRT (patches plus short-acting preparation) and varenicline are the most efficacious pharmacotherapies, and are of similar efficacy. Patients with mental illness often require higher doses of NRT for longer duration due to higher levels of nicotine dependence.

All forms of NRT are similarly effective, and NRT increases quit rates by 50-70%. The addition of an oral form of NRT significantly increases success as it gives flexible relief to breakthrough cravings. Patients should use enough oral NRT to eliminate cravings. Starting patches two weeks before the quit date significantly increases cessation rates. NRT should be continued for 8–12 weeks. The risk of addiction is low as the nicotine is released slower and at lower doses compared to smoking. There are relatively few significant health effects but should be used with care during pregnancy where intermittent, short-acting oral doses are preferred. Side effects can include insomnia, disturbed dreams, skin irritation (with patch), nausea, heartburn and mouth irritation (with oral preparation). Either a 21mg / 24-hour patch or a 25mg / 16-hour patch for two weeks before quitting is approved by the Therapeutic Goods Administration (TGA).

Oral preparations are available as strips, gum, lozenges, or inhaled cartridges. Some oral forms of NRT are available in two strengths: 2mg and 4mg (gum and lozenge), and 1.5mg and 4mg (mini lozenge). The 4mg version is recommended for more-dependent smokers (those who smoke within 30 minutes of waking) and should also be considered for lighter smokers who continue to report cravings on the lower dose.
It is generally not recommended to regularly use NRT beyond 12 months. However, long-term use of some forms of NRT have not caused ill health effects and may assist some people to remain abstinent, and it is much safer than smoking.

Varenicline is the most effective mono therapy for smoking cessation. Varenicline binds with high affinity at the α4β2 nicotinic acetylcholine receptors, where it acts as a partial agonist to alleviate symptoms of craving and withdrawal. If a cigarette is smoked, the drug prevents inhaled nicotine from activating the α4β2 receptor sufficiently to cause the pleasure and reward response.

It should be commenced one week before the quit date and continued for 12 weeks. The initial dose is Varenicline 0.5mg daily increasing gradually to 1mg twice daily after one week. Nausea occurs in 30% of users. Other side effects include insomnia, disturbed dreams, headache and drowsiness. Meta-analyses have not supported the reports that varenicline has a causal link to reported disturbances of mood, depression or suicidal ideation in those stopping smoking. However, MIMS Australia lists hallucinations, behaviour change and suicidality as side effects of Varenicline and depression, and other serious psychiatric conditions as precautions for this product. It is still recommended that patients are educated about potential side effects and should be monitored during treatment. Varenicline can be used safely with other psychotropic medication.

Bupropion is as efficacious as NRT monotherapy. As a non-nicotine oral therapy, it reduces the urge to smoke and reduces symptoms from nicotine withdrawal. It should be commenced one week before the quit date, and should be continued for at least nine weeks. Side effects include insomnia, headache, dry mouth, and seizure (1/1000). It is contraindicated in patients with a history of seizure disorder, eating disorder, head trauma and alcohol dependence. It should be used in caution with other psychotropic medication that can lower the seizure threshold. Bupropion inhibits the metabolism of tricyclic antidepressants, SSRIs, mirtazapine and antipsychotics. Dose reduction of these agents may be required if bupropion is used in combination with such treatment.

Nortriptyline is a tricyclic antidepressant. It is as efficacious as NRT monotherapy. It should be commenced one week before the quit date, and maintained for about 12 weeks. The dose can be tapered toward the end of therapy. Side effects are common and include dry mouth, constipation, blurred vision and sedation. It should be used with caution in seizure disorders as it can decrease the seizure threshold.

E-Cigarettes (ECs) and 'Vaping'

Electronic nicotine delivery systems (ENDS) are devices that include e-cigarettes which heat a liquid to produce a vapour that is inhaled ('vaped'). The liquid heated to produce the vapour comes in different flavours and usually contains propylene glycol or vegetable glycerine. The liquid may also have nicotine in it. The benefits and risks of ECs are highly contested, and the health risks of vaping long term are still not known, but vaping is less harmful than smoking because of the health problems related to inhaling tobacco smoke. Overall, they appear safer than smoking, though not entirely safe. It is recommended that if smokers do use vaping to help quit smoking, it is important to stop tobacco smoking completely because even low rates of tobacco smoking are harmful.

The 2018 National Academies of Sciences, Engineering and Medicine Committee (NASEM) Review of the Health Effects of Electronic Nicotine Delivery Systems reported that the strength of evidence to support vaping as an effective aid in quitting smoking is "limited," but this is largely due to a lack of randomised clinical trials and varying results reported in longitudinal studies. The Committee found moderate evidence that e-cigarettes with nicotine are more effective for smoking cessation than those without, and that more frequent use of e-cigarettes is more effective.

Even though some people use vaping to help quit smoking, it has not been until recently a proven smoking cessation method. Most evidence has shown that approved aids to quit smoking, such as nicotine-replacement patches, gum or lozenges, in combination with support such as Quitline, helped the highest percentage of smokers to quit. Evidence supports that smokers who switch to vaping with nicotine-containing liquids are more likely to quit than those who vape with non-nicotine-containing liquids. However, a recent study by Hajek et al (2019) concluded that e-cigarettes are more effective for smoking cessation than NRT when both are accompanied by behavioural support; with doubled quit rates at 12 months compared with NRT.

However, e-cigarettes are not likely to be risk free and may expose users to chemicals and toxins at levels that have the potential to cause health effects. These include solvents such as propylene glycol, glycerol or ethylene glycol, which may form toxic or cancer-causing compounds when vaporised. Although these chemicals are typically found in lower concentrations than in tobacco cigarettes, in some studies e-cigarettes and tobacco cigarettes were found to produce similar levels of formaldehyde which is classified as a cancer-causing agent. E-cigarette liquids or vapour may also contain potentially harmful chemicals which are not present in smoke from tobacco cigarettes. Some people experience shortness of breath, coughing and wheezing.

Selling e-cigarettes or e-liquids that contain nicotine is illegal as nicotine is considered a dangerous poison. The Therapeutic Goods Administration (TGA) registered it as a S4 therapeutic product (It can however be purchased online from Nicopharm.com.au). As e-cigarettes usually constitute multiple chemical and ingredients, and therefore it is hard to determine if they are defined as medicinal products.

Nicotine inhalers that are often supplied to patients in smoke-free wards only have one active ingredient – nicotine. They are medicinal products registered under TGA and are not considered to be e-cigarettes. E-cigarettes do not need to be obtained by prescription. They are sold in tobacco shops without scripts, or in vape shops which are being set up and can sell non-nicotine containing e-liquids with the abundant range of flavourings as long as they are not marketed as therapeutic products. However, as vaping becomes more popular there is increasing evidence that a number of 'nicotine-free' liquids actually do contain nicotine.

People cannot vape in non-smoking environments (in NSW a Vape shop can apply for a special licence to be excluded from this provision). Compliance and oversight of quality of e-cigarettes is very difficult as over 32,000 e-cigarette and nicotine containing e-liquid products have been notified. Over time the nicotine delivery in e-cigarettes has improved so their addiction potential may have increased but may also make them a more attractive replacement for smoking.

In New Zealand the Medicines Act 1981 and the Smoke-free Environments Act 1990 (SFEA) regulate the sale, advertising and use of vaping products, including nicotine liquids. A District Court decision ruled these products can be lawfully sold under the Smoke-free Environments Act 1990. All the requirements of the Act also apply to vaping and heated tobacco products, including banning advertising of these products and making it illegal to sell them to young people under the age of 18. The smoking ban in indoor workplaces only applies to smoking and does not apply to vaping or the use of other products that are not smoked.

It is illegal to sell a 'smoking cessation' product that contains nicotine unless the product has been approved by Medsafe for use as a medicine. Nicotine gum, lozenges and patches to help people stop smoking have been assessed and approved by Medsafe for sale in New Zealand. Manufacturers of nicotine-containing e-cigarettes can apply to Medsafe for an assessment of their e-cigarettes as medicines for sale in New Zealand. Although they are available, ECs are not subsidised in New Zealand.

Using a phone app

Apps like My QuitBuddy are designed to support and encourage the individual to becoming smoke free. The personalised application provides a countdown to the quit attempt, tracks quitting progress and checks in to ensure that they are staying smoke free. They can record personalised goals in pictures, words or audio messages and a savings calculator shows savings each day from not smoking. There is also a community message board allowing them to gain motivation and support from thousands of other people quitting.

Hypnotherapy

The aim of hypnotherapy for supporting quitting may be to:

- put suggestions in people's non-conscious mind to weaken the desire to smoke
- strengthen someone's will to stop
- improve their ability to carry through a treatment program.

The usefulness of hypnosis for quitting smoking has not been thoroughly studied, with research producing conflicting results. It has not been shown that hypnotherapy increases the likelihood of quitting in the long term, although counselling or other treatments that may be offered with it can be helpful to some smokers.

Acupuncture

Acupuncture involves treatment by applying needles or surgical staples to different parts of the body. Related treatments include acupressure, laser therapy, and electrostimulation. There is no clear evidence to support the use of acupuncture or related treatments as a quitting aid by themselves. Acupuncture may be more effective when combined with counselling or skills training.

Pharmacological impact on other medications from smoking cessation

Smoking induces the activity of cytochrome P450 enzymes 1A2 and 2B6 which impacts on medications metabolised by them. CYP1A2 is important for a range of medications including psychotropics like clozapine, olanzapine, duloxetine, fluvoxamine, amitriptyline and imipramine. So abrupt cessation of smoking in this case can affect the metabolism of olanzapine, and nicotine replacement therapy does not influence CYP1A2 activity. It is recommended that the olanzapine dose is reduced by 30% within a few days of cessation, and certainly by one week. The dose will need to be increased if smoking recommences.

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 Jodie, a 29-year-old woman, living with your parents on the Gold Coast. You have a diagnosis of schizophrenia which is why you see a psychiatrist.

You are coming to see the psychiatrist today because you want to discuss quitting smoking. The reason for this is that you and your parents have been planning a three month round-the-world cruise on a luxury liner, and you do not want to be smoking when you leave Australia. When you were recovering from your last relapse of schizophrenia, your parents had decided that you would all go on a family holiday together. They have now booked the 'holiday of a lifetime.' The trip is due to start in six weeks' time, and you are very excited.

About your smoking

You have smoked from an early age – about 15 years old. You roll and smoke about 30 cigarettes per day. This can increase to about 40 cigarettes daily at times of stress, but this has not happened recently. You feel that smoking helps you feel calm, and manage the day better than if you were 'smoke free'. You would even 'feel naked' without a cigarette in social situations, and find that it helps you 'connect' with others. Every day starts with a cigarette, but you do not wake up at night to smoke.

You have tried to quit before, but have never had any success - you have generally not made it through the day without smoking. You found that 'break time' at work and drinking a coffee were 'not complete' without a cigarette. The most recent attempt at quitting followed the death of your uncle Eddy from lung cancer last year. He too had schizophrenia, and smoked heavily for most of his life. His death really frightened you and you managed to quit for a few days that time.

You have not previously taken medications to stop but did so on your own, without any planning. These attempts were further complicated by the fact that your parents were both smokers at the time, but they have both stopped smoking in the last year (they saw their doctor and got a mediation called something like '*BUPE'* which helped them quit).

You drink alcohol a couple of times per month - a couple glasses of wine when you go out with people from work. You have never used marijuana or any other illicit drugs and you do not gamble.

You leave for your holiday in six weeks and want to stop smoking before that. You are now willing to listen to what the doctor has to say about potential treatment options for you. You feel it is time to try to quit for good this time. You have had a look on the internet, and this medication '*BUPE'* has appealed to you. You have read positive comments about its success and tolerability from people who have used it, including your parents. You would prefer to use this if possible.

If you are asked about the following situations that are likely to discourage you from quitting or could lead to you making an unsuccessful attempt at quitting please answer as per the table:

Situation	Response
• Your knowledge about how to quit.	As you have had previous attempts you think your understanding is okay.
• Enjoyment of nicotine or smoking behaviour.	You are really going to miss smoking – especially for the social reasons described above and how it makes you feel.
• Fear of weight gain.	You are worried about more weight gain as the schizophrenia medication (see below) has made you put on weight.
• Fear that quit attempt will be unsuccessful.	You hope this time will be better – but still doubt yourself about quitting long term.
• Living with other smokers.	Neither of your parents smoke – they would be so happy if you managed to quit for good. Work will be harder.
• Circumstances that result in you giving quitting a low priority, such as poverty and social isolation.	This is not important at the moment as you have a clear goal for quitting.

About your schizophrenia

You have history of schizophrenia and have recently (about 3-4 months) been referred from the public mental health services to the private psychiatrist who you are meeting today for the second time.

You had two admissions to mental health units in your mid 20s when you first developed psychotic symptoms: where you were out of touch with your usual reality - including that you believed the government was spying on you, that the radio was giving you special messages, and you could somehow intercept secret radio messages about you with your mind. These symptoms made you really scared, and you would not leave home and neglected to care for yourself. So you needed to go to hospital for six weeks the first time and two weeks the second time, both as an involuntary patient under the Mental Health Act.

These symptoms responded well to treatment and once you managed to get into a regular treatment routine, they no longer caused you any difficulties. You initially saw the mental health professionals in the public hospital, but asked to start seeing the private practitioner around three months ago as you were told that you have been stable for a while and only need to be monitored for symptoms and side effects of medicines every three to four months. You had the option of seeing your GP but given that your family can afford private health care, have opted to remain under the care of a specialist for at least one year, just to be completely sure that things will not get worse.

You currently take a medication called OLANZAPINE at a dose of 15 milligrams at night. You are not troubled by side effects besides being a few kilos heavier (maybe 3kg - 4kg) than you were before starting the OLANZAPINE. If asked, you do not feel unduly tired, you exercise regularly, and your blood sugar and cholesterol levels are normal.

When you first became unwell three years ago, you were trialled on a medication called RISPERIDONE, but this made your periods irregular and your breasts feel strange and so it was stopped. You were then tried on ARIPIPRAZOLE, but it did not seem to work. OLANZAPINE was then started, and the dose increased to 20 milligrams. You gradually felt better and were discharged home from hospital. You stopped the medicines of your own in six months because you thought you were better, but got unwell again.

During the second admission, you were re-started on OLANZAPINE right away and got better quickly. You are now aware that you need to take the medicines for a long time and have been very regular with your tablets and visits to the doctor. Your dose was decreased from 20 milligrams to 15 milligrams around nine months ago without any recurrence of your symptoms.

About you

You have been working as a receptionist at a dental practice for the past year. You are good at your job, and your employer and his patients like you.

You are the only child of successful business people. Your parents have a chain of luxury car dealerships. They are wonderful caring people and you have had a happy life. You were a good student and did a degree in business at university. You love the work you do and have no desire to get involved in your parents' business yet.

You are physically healthy. You are single and have had a couple of boyfriends, but nothing serious.

You have never been depressed or suicidal, and have had no other issues with your mental health.

4.2 How to play the role:

You will be dressed in casual clothes.

You will be co-operative with the candidate unless their approach is confrontational or judgemental.

You are willing to take steps to quit smoking.

You will be willing to listen to options suggested and may raise questions about them.

You will prefer to use that medication 'BUPE' as a treatment, but will be willing to opt for an alternative treatment if the risks are made clear to you.

Answer all questions as scripted. Answer any other questions negatively.

4.3 Opening statement:

'Doctor I'm so excited. Just six weeks to go before my big holiday!'

4.4 What to expect from the candidate:

The candidate will introduce themselves, explain their role and may summarise the information that they have been given. They should limit further inquiry to explore the extent of your smoking habit by checking on your pattern of smoking, including the depth of motivation to stop now and any past attempts to quit.

They may also briefly discuss other diagnoses including use of other substances, your treatment for schizophrenia and any hospitalisations.

The candidate should then explain the various treatment options available highlighting risks and benefits.

They should discuss a plan to start these interventions before a designated quit date and should do this in an encouraging manner.

The candidate may also discuss altering the dose of OLANZAPINE because of your stopping smoking.

4.5 Responses you MUST make:

'I am afraid I won't be able to quit this time without help.'

'Mum and dad both used 'BUPE' when they quit, so I think that is the right tablet for me.'

'So I can just take the new meds with my olanzapine?'

'Could vaping be a better choice than meds?'

'Should I try hypnotherapy or acupuncture?'

4.6 Responses you MIGHT make:

If asked:

- You are keen to take this opportunity to quit smoking.
- You do not feel guilty about smoking.
- You do not feel annoyed or angry if anyone criticises you for smoking.
- You are aware that smoking is bad for your health.

4.7 Medication and dosage that you need to remember:

OLANZAPINE 15 milligrams

STATION 7 – MARKING DOMAINS

The main assessment aims are to:

- Assess a patient's level of nicotine dependence.
- Offer different treatment options and outline their limitations.
- Rationalise their preferred treatment for the patient.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed history? (Proportionate value - 40%)

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; demonstrating ability to prioritise; eliciting the key issues; identifying triggers and reinforcers: exploring other substance use.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Explore reasons for previous unsuccessful attempts to stop smoking.

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** ☐

1.14 Did the candidate demonstrate an adequate knowledge and application of relevant biological, psychological and social therapies? (Proportionate value - 40%)

Surpasses the Standard (scores 5) if:
includes a clear understanding of levels of evidence to support treatment options; has a broad approach to treatment, and is able to explain advantages and disadvantages.

Achieves the Standard by:
providing sensitive consideration of barriers to implementation; identifying roles of other health professionals; discussing the possibility of a lapse and the need to try again; explaining the setup of a quit date; talking about triggers from smoking and avoiding these; removing cigarettes and paraphernalia from around the house; attending support groups; using distractors like counselling and execise.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Discuss NRT, one other medication and one non-pharmacological method.

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).

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

1.15 Did the candidate adequately engage, inform and discuss the treatment plan with the patient including suitably incorporating patient preferences? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:
clearly achieves the overall standard with presentation of a plan that is comprehensive and sophisticated; incorporates individual vulnerabilities and resilience factors into a carefully tailored plan.

Achieves the Standard by:
Discusses pros and cons of stopping suddenly and tapering use; demonstrating the ability to communicate the treatment plan; clearly communicate indications for treatment, range of options, and recommendations; work within patient treatment goals, and negotiate targeted outcomes; provide psychoeducational material; arrange or commit to ongoing management; employ a psychologically informed approach; being aware of the lack of evidence for hypnotherapy and acupuncture.

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

a. Explain the need to decrease dose of olanzapine once she has stopped smoking.

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).

1.15. Category: MANAGEMENT - Treatment Contract	**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**

Committee for Examinations
Objective Structured Clinical Examination

Station 8
Gold Coast April 2019

The Royal Australian & New Zealand College of Psychiatrists

Committee for Examinations
Objective Structured Clinical Examination

Station 8
Gold Coast April 2019

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1.0 Descriptive summary of station:

In this station, the candidate is to address the concerns of Maryanne relating to her daughter, Talia, who has recently been diagnosed with Borderline Personality Disorder / emotionally unstable personality disorder (EUPD). Tahlia is 22 years old, and has been frequently cutting, and has visible scars on both arms and both legs. She has been offered a place in a Dialectical Behaviour Therapy Programme (DBT). Her mother does not accept or believe that her daughter has this condition, and has her own ideas on how to manage the situation which the candidate needs to address.

1.1 The main assessment aims are to:

- Outline the main features of borderline personality disorder to the mother.
- Explain to the mother that her daughter self-harms as a way to manage her feelings, and that feelings of being rejected are frequently a trigger.
- Describe the main features and components of DBT.
- Address the mother's concerns empathically.

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

- Demonstrate knowledge of DSM or ICD criteria for Borderline Personality Disorder.
- Explain that self-harm is usually a way of managing strong feelings and that perceived rejection is often the trigger.
- Include the four (4) skills modules in the description of DBT.
- De-escalate the mother's hostility around her perception that her daughter should lose weight and go to the gym.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category**: Personality Disorders
- **Area of Practice**: Adult Psychiatry
- **CanMEDS Domains**: Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes**: Medical Expert (Diagnosis, Formulation, Management – Therapy), Communicator (Conflict Management)

References:

- Bateman and Fonagy. Mentalisation-based treatment for Borderline Personality Disorder. Oxford 2006.
- Linehan M. DBT Skills Training Manual. Guildford Press 2014.
- Linehan M. Understanding Borderline Personality Disorder. The Dialectical approach. Guildford Press 2006.
- National Health and Medical Research Council. Clinical Practice Guideline for the Management of Borderline Personality Disorder. Melbourne: National Health and Medical Research Council; 2012.
- National Institute for Clinical Excellence (2009). Borderline personality disorder - treatment and management. NICE clinical guideline 78. London, UK. Available at http://guidance.nice.org.uk/CG78.
- Borderline personality disorder: Towards Effective Treatment. J Beatson, S Rao and C Watson, 2010.

1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: woman mid 40's; dressed in smart active wear and well made up – makeup is on the heavy side.
- 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 are working as a junior consultant psychiatrist in the adult community mental health team. Today you are meeting Maryanne, who is the mother of your patient Tahlia. Tahlia is a 22-year-old single woman recently diagnosed with Borderline Personality Disorder. Tahlia is cutting herself frequently, mostly superficial, but Tahlia has scars all over her arms and legs. She is looking forward to starting the Dialectical Behaviour Therapy (DBT) programme into which she has been accepted, and Tahlia has asked you to meet her mother to explain her diagnosis and the recommended treatment.

Your tasks are to:

- Outline the main features of Borderline Personality Disorder to Maryanne.
- Help Maryanne to better understand why her daughter self-harms.
- Explain the main features of DBT to Maryanne.

You will not receive any time prompts.

Station 8 - 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 / scripted prompt for you to give.
- DO NOT redirect or prompt the candidate unless scripted – 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.

The role player opens with the following statement:

'I want to help Tahlia, but I really can't understand why she does these terrible things to herself.'

3.2 Background information for examiners

In this station, the candidate is expected to engage with Maryanne, the mother of a young woman with Borderline Personality Disorder, and empathically address her concerns. Tahlia, her daughter, has a history of cutting her own limbs on several occasions. The lacerations have been frequent, required surgical treatment, and have resulted in marked scarring. The scarring concerns her mother who is very conscious of physical appearance, and will express her perception that her daughter should just lose weight and go to the gym. This will lead Maryanne to react in a hostile manner towards the candidate if they do not address this in a sensitive manner with alternate evidence.

Maryanne wants to know the diagnosis of her daughter, as well as what triggers the self-harm. Tahlia has been offered a position in a Dialectical Behaviour Therapy Programme (DBT). Maryanne would also like to know what this is and how it will help.

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

- Demonstrate knowledge of DSM or ICD criteria for Borderline Personality Disorder.
- Explain that self-harm is usually a way of managing strong feelings and that perceived rejection is often the trigger.
- Include the four (4) skills modules in the description of DBT.
- De-escalate the mother's hostility around her perception that her daughter should lose weight and go to the gym.

A surpassing candidate may rapidly identify the mother's ideas about the importance of appearance and pre-empt any hostility in a sensitive manner. They may be able to demonstrate a very comprehensive understanding of how DBT will specifically address Tahlia's presentation.

Borderline Personality Disorder (BPD) is characterised by instability in affect and mood, resulting in impulsiveness and unstable relationships. People with BPD often have an associated instability in their sense of identity and there is often, but not always, a history of neglect or abuse in childhood.

BPD is associated with disorganised attachment styles. Alternately idealising and denigrating within relationships can contribute to splitting that can occur between the patient and clinical team members, between the family and the team, or within the team. Keeping this in mind, Maryanne could be seen as wanting to help her daughter, but is finding it difficult to understand her daughter's struggle. Her hostile feelings towards her daughter can easily be split off and directed towards the treating team. The candidate is expected to recognise this, and respond in a way that deescalates the split using active listening, and empathising with the situation Maryanne finds herself in.

<u>DSM 5 criteria for borderline personality disorder:</u>

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)

5. Recurrent suicidal behaviour, gestures, or threats or self-mutilating behaviour.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

ICD-10 diagnostic criteria for emotionally unstable personality disorder, borderline type:

Emotionally unstable personality disorder is characterised by:

- a definite tendency to act impulsively and without consideration of the consequence
- unpredictable and capricious mood
- liability to outbursts of emotion and an incapacity to control the behavioural explosions
- tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or censored.

Two types may be distinguished: impulsive type and borderline type.

The borderline type is characterised by disturbances in self-image, aims, and internal preferences, by chronic feelings of emptiness, by intense and unstable interpersonal relationships, and by a tendency to self-destructive behaviour, including suicidal gestures and suicide attempts.

Treatment Options

Borderline personality disorder has been shown to benefit from several types of semi structured psychotherapy. DBT, Mentalisation Based Psychotherapy and Schema therapy have all been studied and shown to be helpful.

DBT is a cognitive behavioural treatment developed by Marsha Linehan for BPD, which has now been shown to be helpful for a range of other problems, including substance misuse, eating disorders, depression and PTSD. DBT is not a suicide prevention programme, but there is a strong focus on teaching the patient skills to assist them to lead more meaningful lives.

According to Marsha Linehan (*http://depts.washington.edu/uwbrtc/about-us/dialectical-behavior-therapy/*)

> ‘The term *‘dialectical’ means the synthesis or integration of opposites. The primary dialectic is between acceptance and change. In DBT the patient is helped both to accept their feelings, as well as build skills to change how they respond to things. The goal is to help the patient achieve a life worth living.’*
>
> *DBT can be delivered in a comprehensive format over six to twelve months, or can be used as part of an individual psychotherapy.*
>
> *There are four components of comprehensive DBT:*
>
> - *SKILLS TRAINING weekly group, usually 2 1/2 hours where the skills are introduced.*
> - *INDIVIDUAL THERAPY, looking specifically at how each individual can apply the skills in their life.*
> - *DBT PHONE COACHING, the therapist is available to coach the client in the skills when problems arise.*
> - *DBT CONSULTATION TEAM, where the therapists receive supervision and peer support.*
>
> *There are four behavioural skill modules. Mindfulness, and Distress Tolerance are acceptance oriented skills, whereas Interpersonal Effectiveness, and Emotional Regulation are change oriented skills.*

Acceptance oriented skills

- MINDFULNESS the practice of being fully aware and present in this one moment. This is a foundational skill, to pay attention to the present moment, including strong emotions, without judgement, and with acceptance.

- DISTRESS TOLERANCE how to tolerate pain, not change it. Skills taught in this module will include:
  - Distraction (acronym ACCEPTS Activities, Contribute, Comparisons, Emotions, Push away, Thoughts, Sensations)
  - Self-soothing
  - Improve the moment (acronym IMPROVE Imagery, Meaning, Prayer, Relaxation, One thing, Vacation (brief), Encouragement)
  - Change oriented skills.

- INTERPERSONAL EFFECTIVENESS how to ask for what you want, and say no while maintaining self-respect and relationship with others. Modules include how to communicate your needs (acronym DEAR MAN Describe, Express, Assert, Reinforce, Mindful focus, Appear assertive, Negotiate).

- EMOTIONAL REGULATION how to decrease vulnerability to painful emotions, and change emotions you want to change. Skills taught in this module will include identifying and naming emotions, identifying obstacles to changing emotions, increasing positive emotions, to experience current emotions mindfully, take opposite action, and apply distress tolerance techniques.

Groups are usually led by two trained leaders. After a session start up, and review of the previous week's homework and practise, the new material is presented with the homework task. The group ends with a wind down exercise.

The duration of the comprehensive treatment is usually one year. To remain in the programme, the patient must comply with rules about attendance. Usually if a patient misses four consecutive groups, they will not be permitted to continue. They must agree to not entering into intimate relationships with other group members. Patients are able to contact their therapist by phone or email, although each centre will determine the hours of phone contact that are possible.

The hierarchy of treatment targets guides the therapist's priorities:

- life threatening behaviour
- therapy interfering behaviour
- quality of life behaviours
- skills acquisition.

There are four (4) stages of treatment that give a framework for identifying priorities, as summarised below.

Stage 1	Getting control over own behavioural responses. To reduce dangerous and life threatening behaviours, e.g., suicidality, self-harm, impulsivity, reducing crises.
Stage 2	Focussing on emotional experiences, including shame, self-doubt, blaming. Goal is to reduce the symptoms of PTSD whilst focussing on past trauma.
Stage 3	Daily problem solving. Goal is to feel in control of life with joy; includes goal setting, asking for help, exploring happiness.
Stage 4	Self-actualisation, self-fulfilment, integration, adaptation and acceptance of the self.

(tabulated from www.depts.washington.edu)

Tools

A. CHAIN ANALYSIS (Behavioural Analysis), is the step by step assessment of a problem behaviour, including the triggers and the consequences.

1. Describe the PROBLEM (thoughts, feelings, behaviour).

2. Describe the PRECIPITANTS.

3. Identify VULNERABILITY factors.

4. Describe the CHAIN OF EVENTS that have lead up to the problem behaviour in great detail.

5. Describe the CONSEQUENCES of the behaviour, including reinforcers.

6. Describe different SOLUTIONS.

7. Describe in detail PREVENTION strategies.

8. Describe REPAIRS.

B. DIARY CARDS are used to track emotions and behaviours.

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 Maryanne, a 44-year-old woman who has come to the outpatient clinic to talk to your daughter's psychiatrist at your daughter Tahlia's request. Your daughter is 22 years old.

Tahlia experiences a range of psychological disturbances, and harms herself when she is distressed. She has asked you to talk to her psychiatrist because she wants you to better understand what she is going through, and to discuss treatment approach that she has been offered. You are aware this treatment is called 'DBT', but don't really know what that is. Your opinion is that Tahlia just needs to think more about her physical appearance and get some exercise.

Tahlia is not currently working or studying, and is supported by you. She completed Year 12 at school, and did not go to university. She has previously had a few jobs in retail, but none since she has been with you.

She has come to live with you and your second husband, Paul, about six months ago. Previously she had been living with your ex-husband Graeme, her father, in Perth. The reason Tahlia had come to live with you was to try to get away from the friends she had when she was living with Graeme. Graeme told you they were 'a bad lot', but you do not know what he meant by that.

It has been really difficult having Tahlia come to stay. You love the thought of having your daughter around, but cannot cope with the things she does. She has had several short admissions to hospital with self-inflicted lacerations – she cuts her arms and legs. The last one was really bad. Tahlia had cut her arm so badly that she had needed to have two tendons repaired. She was at home and you had thought everything was okay. You had dinner together as a family. Your younger daughter, Mia, aged 14, had been very excited about winning a dance competition, and you had a little celebration at home. Tahlia had been a bit quiet, but seemed to be happy for Mia. Tahlia went to her room after dinner, as she usually does, but then woke you up at around 11.30pm. There was blood everywhere. This was the third time she had needed surgery to repair a laceration. You hate the terrible scars that have been left as a result of her cutting.

Shortly after she moved in with you, Tahlia met a young man called Cody with whom she had a relationship. You did not like him much but did not know him well. However, you know that they had been using drugs together – cigarettes and dope (marijuana), but maybe even some of the stronger stuff. She did self-harm after arguments with Cody, and when they split up. You are pleased that this relationship has ended.

<u>If the candidate asks you about the following issues please provide the information below:</u>

You are concerned that Tahlia is still smoking some dope, and you worry that she might use other drugs, but she denies it and you have no evidence. At least she doesn't drink alcohol at all.

Tahlia had tried a bit to reconnect with her friends from when she lived here previously in her teens, but found that she hasn't got much in common with them. You think she tends to be unforgiving if her friends do something to upset her.

Tahlia has also had problems with eating. She goes through periods of eating very little, then she will eat secretly and all the treats in the pantry will be gone. You think she sometimes intentionally vomits. Her weight goes up and down a bit, but it is not extreme. She isn't actually overweight, but you think she would be more confident if she was slimmer. You are a personal trainer, and think that it's important to look after your body. You like to go to the gym, and recognise that you use the gym as a way of managing stress. You think that if she exercised regularly she would feel better about herself, as this works for you. You firmly believe that if she went to the gym more, and if she lost weight, she would feel a lot better about herself, and would manage stress better. You also try to encourage her to wear makeup and present herself better, because she could be really pretty if she tried harder.

Talia is a very moody girl and her moods are unpredictable. You have no idea what gets her upset. One minute she looks fine, and then you find her crying or even cutting. You do not think she is depressed as she does not remain that way for long periods of time. She has never reported hearing voices or feeling that she is being watched or followed.

<u>About your and Tahlia's family background:</u>

You had separated from Graeme when Tahlia was four years old. It was a difficult and bitter break up. For the first few years, Tahlia had lived one week with you and the other with Graeme. Both you and Graeme met new partners, and had new families. When Tahlia was 14, Graeme had taken a job in Perth. She visited him in the holidays. As a teenager Tahlia had been quite temperamental. You and Paul had tried to set some limits, but there was a lot of conflict. When she was 16, she decided to go and live with Graeme. He was always very busy with his work, and you thought she took advantage of this, and was pretty wild. She would still come to visit you on holidays, but you were not close.

If you are asked about childhood sexual abuse, Tahlia was sexually abused by a non-family member when she was nine. You do not know much about it as she was staying with Graeme at that time. You had two small children with Paul, and had asked Graeme to have her for a while as you were struggling a bit. You know that she had moved schools because of the assault, and it had all settled down. You and Graeme had both agreed that it was best to not make a big deal of it. You have never spoken to her about it.

If you are asked, no one in the family has any history of mental illness. Tahlia was the only child from your first marriage, and you have two more girls, Mia 14 and Krystal 16, with Paul. You would rather not talk about what went wrong with you and Graeme. It is not important but your current marriage is stable, and no one has any problems, but you do worry about the effect Tahlia's behaviour will have on the younger girls.

4.2 How to play the role:

You are well presented and smartly dressed, preferably in tight gym clothes, otherwise a chic outfit. You clearly take a pride in your appearance. You can wear quite heavy makeup.

You are really worried about Tahlia, and at your wits end about how to help her. You are very frightened at the possibility that she may kill herself either by cutting or some other accidental way. You are also worried about her weight and eating habits, and think she should exercise more.

If the candidate does not appear to listen to your ideas and respect your opinion, then you can respond in a more irritable manner.

4.3 Opening statement

'I want to help Tahlia, but I really can't understand why she does these terrible things to herself.'

4.4 What to expect from the candidate:

The candidate should be interested in listening to your concerns and ideas. They need to try to understand what is going on for Tahlia, and are likely to start by asking about the issues at home, what she does to herself and how it comes about. They are then expected to explain Tahlia's behaviour in the context of a mental health diagnosis of a personality disorder, and how the DBT treatment can help her. They should also try to explain that just doing exercise, and wearing makeup is unlikely to be enough for her to manage her emotions and behaviours.

4.5 Responses you MUST make:

'I just want to know what is wrong with her? What is borderline personality disorder?' (You can be quite irritable initially)

'Why does she cut herself?'

'I really think that if she just ate better, went to the gym, lost weight, then she would feel better about herself.' (Once again you can be pretty hostile about this)

'Tahlia said she is going to do DBT. What is that?'

4.6 Responses you MIGHT make:

If asked about suicide attempts:
Scripted response: ***'No, she has never done anything really dangerous, but the scars are awful. I can't stand seeing her arms.'***

4.7 Medication and dosage that you need to remember:

None

STATION 8 – MARKING DOMAINS

The main assessment aims are:

- Outline the main features of borderline personality disorder to the mother.
- Explain to the mother that her daughter self-harms as a way to manage her feelings, and that feelings of being rejected are frequently a trigger.
- Describe the main features and components of DBT.
- Address the mothers concerns empathically.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.9 Did the candidate describe the features of borderline personality disorder? (Proportionate value - 20%)

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; demonstrating detailed understanding of diagnostic systems to provide justification for 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, and according to good judgment while communicating to the mother.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Demonstrate knowledge of DSM or ICD criteria for Borderline Personality Disorder.

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 ☐

1.11 Did the candidate generate an adequate explanation to make sense of the presentation? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:
provides a superior performance in a number of areas; demonstrates prioritisation and sophistication; applies a sophisticated sociocultural formulation.

Achieves the Standard by:
identifying and succinctly summarising important aspects of the history; synthesising information using a biopsychosocial framework; integrating medical, developmental, psychological and sociological information; developing hypotheses to make sense of the patient's predicament; commenting on missing or unexpected data; analysing vulnerability and resilience factors.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Explain that self-harm is usually a way of managing strong feelings and that perceived rejection is often the trigger.

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) if:
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) if:
scores 1 if there are significant omissions affecting quality.

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

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

1.14 Did the candidate demonstrate an adequate knowledge and application of relevant psychological therapies? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:
includes a clear understanding of levels of evidence to support treatment options. May refer to other evidence-based therapies, such as Schema therapy and Mentalisation Based Psychotherapy.

Achieves the Standard by:
demonstrating the understanding of DBT; identifying specific treatment outcomes and prognosis; appropriate selection (benefits / risks, application, adherence, choice and rationale for specific psychotherapies); monitoring of specific interventions; considering sensitively barriers to implementation; identifying the role of other health professionals.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Include the four (4) skills modules in the description of DBT.

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 (for example does not describe the four skills modules).

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

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

2.0 COMMUNICATOR

2.3 Did the candidate demonstrate capacity to recognise and manage challenging communications? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:
constructively de-escalates the situation; demonstrates sophisticated reflective listening skills.

Achieves the Standard by:
recognising challenging communications; listening to differing views; demonstrating capacity to apply management strategies; allowing the mother to express her frustration and providing her with explanations for the daughter's behaviour; dealing with the guilt and frustration calmly.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. De-escalate the mother's hostility around her perception that her daughter should lose weight and go to the gym.

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).

2.3. Category: CONFLICT MANAGEMENT	**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**

Committee for Examinations
Objective Structured Clinical Examination

Station 9
Gold Coast April 2019

The Royal Australian & New Zealand College of Psychiatrists

The Royal Australian & New Zealand College of Psychiatrists

1.0 Descriptive summary of station:

The candidate is meeting with Sarah, who has an 8-year-old son named Jason. Jason has just been assessed having attention deficit hyperactivity disorder (ADHD). Sarah has some specific questions about medications and other treatments. She is also concerned that his problems are her fault.

1.1 The main assessment aims are:

- Explain ADHD to Sarah, and discuss medications used to treat ADHD.
- Outline non-pharmacological strategies that can help with Jason.
- Appropriately listen and respond to the concerns raised by Sarah.

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

- Discuss the likely genetic linkages.
- Establish that Jason has symptoms across more than two domains (school, home and friendships).
- Discuss at least one stimulant and one non-stimulant medication.
- Indicate that psychological and / or behavioural therapy is needed for both the child and the parents.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category**: Child & Adolescent Disorders
- **Area of Practice**: Child & Adolescent
- **CanMEDS Domains**: Medical Expert, Scholar
- **RANZCP 2012 Fellowship Program Learning Outcomes**: Medical Expert (Assessment – Data Gathering Content; Diagnosis; Management – Therapy); Scholar (Application of Knowledge).

References:

- The National Health and Medical Research Council (NHMRC) developed clinical practice points on the Diagnosis, Assessment and Management of ADHD in Children and Adolescents (http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/mh26_adhd_cpp_2012_120903 .pdf).
- Attention Deficit Hyperactivity Disorder: Diagnosis and Treatment in Children and Adolescents, Rockville (MD): Agency for Healthcare Research and Quality (US); 2018 Jan.
- Editors Kemper AR[1], Maslow GR[1], Hill S[1], Namdari B[1], Allen LaPointe NM[1], Goode AP[1], Coeytaux RR[1], Befus D[1], Kosinski AS[1], Bowen SE[1], McBroom AJ[1], Lallinger KR[1], Sanders GD[1]. Source: Rockville (MD): Agency for Healthcare Research and Quality (US); 2018 Jan.
- Kelly A. Brown, Sharmeen Samuel, and Dilip R. Patel, Transl Pediatr. 2018 Jan; 7(1): 36–47. doi: 10.21037/tp.2017.08.02 : PMC5803014 PMID: 29441281 Pharmacologic management of attention deficit hyperactivity disorder in children and adolescents: a review for practitioners.
- ADHD, stimulant treatment, and growth: a longitudinal study. *Harstad EB, Weaver AL, Katusic SK, Colligan RC, Kumar S, Chan E, Voigt RG, Barbaresi WJ Pediatrics. 2014 Oct; 134(4):e935-44.*Pediatrics.
- ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents Subcommittee on attention-deficit / hyperactivity disorder, Steering Committee on Quality Improvement and Managememt. Author manuscript; available in PMC 2015 Jul 13. Published in final edited form as: Pediatrics. 2011 Nov; 128(5): 1007–1022. Published online 2011 Oct 16. doi: 10.1542/peds.2011-2654 PMCID: PMC4500647 NIHMSID: NIHMS701937 PMID: 22003063.
- Position Statement 55 – RANZCP Attention Deficit Hyperactivity Disorder in Childhood and Adolescence.

1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: woman in her early thirties casually dressed.
- 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 are working as a junior consultant psychiatrist in a community outpatient clinic.

Your patient, Sarah, comes to you wanting to discuss her son, Jason, whom the paediatrician has just diagnosed with ADHD. She has some questions for you about ADHD.

Sarah has been successfully treated for an episode of major depression that required an admission three years ago. She is in remission, and you have no concerns about her mental state.

Your tasks are to:

- Elicit a history that will enable an explanation of ADHD to Sarah.
- Discuss evidence-based interventions used in the management of ADHD with Sarah.

You will not receive any time prompts.

Station 9- 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 unless scripted – 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.

The role player opens with the following statement:

'Doctor**, **I'm fine, but I'm really worried that Jason has just been diagnosed with ADHD.'

3.2 Background information for examiners

In this station the candidate is expected to be able to discuss the presentation of attention deficit hyperactivity disorder (ADHD) in a school age child. They are expected to be able to describe the diagnostic criteria for ADHD, and determine from the mother which symptoms may have lead to the paediatrician making the diagnosis.

It is imperative that a thorough diagnosis is made so that comprehensive treatment is provided to limit the burden of disease.

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

- Discuss the likely genetic linkages.
- Establish that Jason has symptoms across more than two domains (school, home and friendships).
- Discuss at least one stimulant and non-stimulant medications.
- Indicate that psychological and / or behavioural therapy is needed for both the child and the parents.

A surpassing candidate may:

- Discuss the management in a more sophisticated manner, and comprehensively relate all aspects to the specific scenario of Jason, including collaboration with his school, both parents and his social network.
- Explain the pros and cons of medication including stimulant and non-stimulant medication.
- Also include the importance of regular reviews of his response to all interventions, and the priority to maintain his engagement in his education and with his peer group.

About ADHD

ADHD is the most common neurodevelopmental disorder of childhood, and is a complex syndrome of impairment of brain functions associated with both self-management and executive function. It is a disorder which is recognised globally, and has a high morbidity related to loss of academic, interpersonal and occupational successes or indirectly from high risk-taking behaviours or co-morbid psychiatric diagnoses including mood & substance use disorders.

The core features of ADHD are attention, concentration, hyperactivity, impulsivity and emotional dysregulation, and it is more commonly diagnosed in boys and if left untreated, can affect self-confidence and self-esteem. Factors of inattention and executive dysfunction are important discussion points as these commonly persistent throughout life, and can have debilitating effects into adulthood.

It is critical to obtain information about the child's behaviour across multiple environments in order to make the diagnosis: assessment from the family and school are important parts of a thorough assessment.

DIAGNOSIS

The diagnosis is based on the child displaying symptoms of hyperactivity, impulsivity and inattention. Either the Diagnostic Statistical Manual (DSM-5) or International Classification of Disease (ICD-10) may be used. In the latter it is named a Hyperkinetic disorder rather than Attention Deficit Hyperactivity Disorder.

The following table summarises the diagnostic criteria.

TABLE. **Comparison of DSM-5 and ICD-10 diagnostic criteria for ADHD**

	DSM-5	ICD-10
Name	ADHD	Hyperkinetic disorder
Onset	Some symptoms before age 12	Some symptoms before age 6
Symptom criteria for children	ADHD combined: 6 of 9 symptoms of inattention and 6 of 9 symptoms of hyperactivity/impulsivity; ADHD predominantly inattentive: 6 of 9 symptoms of inattention; ADHD predominantly hyperactive/ impulsive: 6 of 9 symptoms of hyperactivity/ impulsivity	Must have a combination of impaired attention AND hyperactivity; the only subtype is hyperkinetic conduct disorder for those who meet criteria for both disorders
Symptom criteria for persons aged ≥ 17	ADHD combined: 5 of 9 symptoms of inattention and 5 of 9 symptoms of hyperactivity/impulsivity; ADHD predominantly inattentive: 5 of 9 symptoms of inattention; ADHD predominantly hyperactive/ impulsive: 5 of 9 symptoms of hyperactivity/ impulsivity	Must have a combination of impaired attention and hyperactivity
Settings	Several symptoms present in ≥ 2 settings	Full syndrome in ≥ 2 settings and observed by clinician
Duration	≥ 6 months	≥ 6 months
Impairment	Interference with social, academic, or occupational functioning; includes severity specifiers: mild, moderate, severe	Clinically significant distress or impairment in social, academic, or occupational functioning

From http://www.psychiatrictimes.com/special-reports/are-we-overdiagnosing-and-overtreating-adhd

Common Presenting Features are summarised below (adapted Chan et al)

Inattention	Does not listen Difficulty following multi-step commands Disorganised room, locker, desk. Forgetful Easily distracted (except video games)
Hyperactivity & Impulsivity	Fidgets or squirms Runs or climbs excessively – unable to walk slowly. Blurts out answers or thoughts even if really inappropriate Cannot wait to take a turn Interrupts Intrudes on others
School problems	Cannot sit still Easily overwhelmed Speaks out of turn Easily bored

PREVELANCE

There are difficulties with research into the prevalence of ADHD as there is great variation between studies including diagnostic criteria, methods of collecting data and different settings: pooled data estimating prevalence in children is between 3.4 – 8.8%.

TREATMENT
Treatment is both pharmacological and non-pharmacological.

Medication	Action	Common side effects
Methylphenidate	Stimulant	Headache Insomnia loss of appetite Decreased weight Nausea & vomiting Nervousness Dizziness Increased heart rate Increased blood pressure Growth Retardation Aggression
Dexamphetamine	Stimulant	Headache Insomnia Loss of appetite Decreased weight Nausea & vomiting Nervousness Dizziness Increased heart rate Increased blood pressure Aggression
Atomexetine	SSRI Slow onset of action, takes about 4 weeks to start working.	Sedation Anorexia Nausea & vomiting Insomnia Increased alertness Dizziness Constipation Fatigue Skin rashes Jaundice/hepatic damage Aggression
Clonidine	Alpha-blocker	Fatigue Postural Hypotension Dry Mouth Insomnia Constipation Depression

Behavioural treatments include a range of options. The table below (from ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents) outlines Evidence-Based Behavioural Treatments for ADHD.

Intervention Type	Description	Typical Outcome(s)	Median Effect Size[a]
Behavioural parent training (BPT)	Behaviour-modification principles provided to parents for implementation in home settings	Improved compliance with parental commands; improved parental understanding of behavioural principles; high levels of parental satisfaction with treatment	0.55
Behavioural classroom management	Behaviour-modification principles provided to teachers for implementation in classroom settings	Improved attention to instruction; improved compliance with classroom rules; decreased disruptive behaviour; improved work productivity	0.61
Behavioural peer interventions (BPI)[b]	Interventions focussed on peer interactions / relationships; these are often group-based interventions provided weekly and include clinic-based social-skills training used either alone or concurrently with behavioural parent training and / or medication	Office-based interventions have produced minimal effects; interventions have been of questionable social validity; some studies of BPI combined with clinic-based BPT found positive effects on parent ratings of ADHD symptoms; no differences on social functioning or parent ratings of social behaviour have been revealed	

[a] Effect size **=** (treatment median − control median) / control SD.
[b] The effect size for behavioural peer interventions is not reported, because the effect sizes for these studies represent outcomes associated with combined interventions. A lower effect size means that they have less of an effect. The effect sizes found are considered moderate.

Adapted from Pelham W, Fabiano GA. *J Clin Child Adolesc Psychol.* 2008;37(1):184–214.

3.3 The Standard Required

Surpasses the Standard – a better 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 medico-legal 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 well-being 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 Sarah, a 33-year-old woman married to Paul, and a mother of two children, Katherine and Jason.

You have come to your routine mental health appointment today, and want to discuss Jason's recent diagnosis of attention deficit hyperactivity disorder (ADHD) that was made by a child health specialist (paediatrician).

About Jason's mental health:

Jason is 8 years old, and in Grade 1. Your son had been struggling at school, and his ability in reading is particularly poor. He has not been able to make many friends, and is always 'busy'.

The school suggested you take Jason to a paediatrician who then gave you and your husband the diagnosis of ADHD two days ago, and you have a follow-up appointment next week to discuss treatment options. You really want to talk with your psychiatrist before this, so you can be more prepared for the next appointment with the paediatrician.

Jason had been assessed by a team of specialists prior to the diagnosis being made:
Jason saw a psychologist, and a neuropsychologist assessed his learning abilities. Jason's teacher also spoke to the clinical team. You and your husband were asked to answer a series of questions about Jason's development, and his behaviour at home.

The candidate should ask you a series of questions for which you can provide the following information:

Jason struggled at kindergarten, and always wanted to go outside. Now he is at school, he is struggling with reading, writing, mathematics, and making friends. The teacher says he gets up during class when the children are working on a task, and goes to other tables, looks at the notices and posters on the wall, and sometimes just asking questions completely unrelated to the topic. He fidgets all the time, cannot seem to sit still in any situation.

The teacher has also told you that Jason struggles to wait his turn in class, and will blurt out his answers. He is often not able to go outside at break because he cannot find his hat, which then leads him to be even more disruptive when the other children return.

You had thought that it was endearing when Jason was being 'busy' all the time as a toddler. His constant fidgeting, jiggling his legs when sitting, and pulling at his clothing often causes you to be irritable with him, and you feel guilty that sometimes you nag him about it. He is impulsive, often damaging things in a rush to do something which leads to problems with his dad, Paul, who loves to make model cars as a hobby.

The following behaviour at home with Katherine should only be told reluctantly, as you are embarrassed that Jason breaks things in anger as you think it represents bad parenting: he is very active at home, and fights with his sister Katherine (10 years old) all the time. Jason will often break her things when she won't share or if he cannot use them properly. The worst argument was when he broke her iPad that had been her 10th birthday present – she was playing a word game that Jason could not understand.

Only provide this information if you are asked about your own mental health:

You have been coming to the mental health services for the treatment of an episode of major depression 3 years ago that led to you being admitted to a mental health unit for two weeks. You are still on medication, and have been attending the clinic every two months for review. Your mental health is very stable, and have been discussing discharge back to your GP with the psychiatrist. When you were depressed, the family had rallied around and helped with the children, and they do not appear to have any adverse problems from your depression.

Only provide this information if you are asked about anything similar for yourself and your family:

You have one brother, Mark, and he struggled at school, and was regularly being sent to the headmistress for interrupting in class. He left school at 15 years old to be a jackaroo in outback Australia (if a candidate asks what a jackaroo is – a young man working on a sheep or cattle station to gain experience). Mark has always found it difficult to settle down to one task for long, and has had minor problems with legal system as he always seems to get into debt.

You found concentrating at primary school difficult as you were always 'day dreaming', but you had no problems academically. You work as a receptionist in a tour company, and have held that job for many years.

Your husband has no problems like this, in fact he can be very focussed, and loves spending hours with his car models. Katherine does not present with any behaviour problems at school or at home.

4.2 How to play the role:

You are casually dressed in clean tidy clothes. You are well presented, and easily engaged by the candidate. You are interested in the answers the candidate gives, and generally have positive interactions with your psychiatrist.

Initially you are a little anxious, and worried about what this diagnosis means. The candidate should aim to reassure you by the explanations given. You are also worried that your 'day dreaming' at primary school, and your brother possibly having ADHD may have given Jason ADHD. You can also be interested in whether they think that your illness had any impact on it developing.

You are very worried about medication and possible side effects for Jason now, and into the future. You are worried about his growth and development, and want to know what possible side effects of medication he may get.

You want to take notes so you can discuss it with your husband.

4.3 Opening statement:

'Doctor, I'm fine, but I'm really worried that Jason has just been diagnosed with ADHD.'

4.4 What to expect from the candidate:

The candidate is expected to take a history about how Jason has been behaving, and may ask you about you and your family. They should explore with you how the diagnosis was made, and when you found out.

The candidate should then discuss the possible treatments that may be suggested by the paediatrician next week. These can include medications (which you are not keen on), and other strategies that can be either psychological or in response to his behaviour.

The candidate should provide clear information that is understandable to a non-medical person.

4.5 Responses you MUST make:

'So, do you think he got his ADHD from us?'

'What can medications do?'

'I've heard that these medications stop children growing, is that right?'

'Is there anything else that we can do to help at home?'

4.6 Responses you MIGHT make:

If asked about drug and alcohol use at home: you and your husband drink alcohol socially but generally only a few times a month. Neither of you have ever used illicit substances.

If asked how things are at home:
Scripted response: ***'Home life is generally fine.'***

4.7 Medication and dosage that you need to remember:

None

STATION 9 – MARKING DOMAINS

The main assessment aims are:

- Explain ADHD to Sarah, and discuss medications used to treat ADHD.
- Outline non-pharmacological strategies that can help with Jason.
- Appropriately listen and respond to the concerns raised by Sarah.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed collateral history from the mother? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:
clearly achieves the overall standard with a superior performance in a range of areas; gathers information in systematic and logical approach to enable ADHD diagnosis: demonstrates prioritisation and sophistication.

Achieves the Standard by:
demonstrating use of a tailored biopsychosocial approach; conducting a detailed but targeted assessment; incorporating a sub-specialist approach related to assessment of a child; obtaining a history relevant to the patient's problems and circumstances with appropriate depth and breadth; prioritising information to be gathered to justify proposed diagnosis of ADHD; integrating key sociocultural issues relevant to the data collection; demonstrating phenomenology; clarifying important positive and negative features; assessing for typical and atypical features.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Discuss the likely genetic linkages.

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 formulate and describe the features of a diagnosis of ADHD? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:
demonstrates a superior performance; integrates information in a manner that can effectively be utilised by the mother; provides clear and professional information in a manner that is non-threatening; 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 the diagnosis; demonstrating detailed understanding of diagnostic criteria to provide justification for diagnosis; prioritising adequately relevant history, utilising a biopsychosocial approach, and / or identifying relevant predisposing, precipitating perpetuating and protective factors; including communication in appropriate language and detail for the mother.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Establish that Jason has symptoms across more than two domains (school, home and friendships).

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 ☐

6.0 SCHOLAR

6.4 Did the candidate prioritise and apply appropriate and accurate knowledge of ADHD interventions based on available literature / guidance? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:
outlines the complexities of choices in medication options; incorporates continuity of care and not just initial management; recognises the impact of environment, people and new knowledge on current understanding; acknowledges their own gaps in knowledge.

Achieves the Standard by:
identifying key treatment aspects supported by evidence; commenting on the voracity of the available evidence; discussing major strengths and limitations of available evidence; describing the relevant applicability of theory to the specific scenario; acknowledging that there are multiple options available; incorporates both pharmacological and non-pharmacological treatment recommendations.

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

a. Discuss at least one stimulant and one non-stimulant medication.

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).

6.4. Category: APPLICATION OF KNOWLEDGE	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

1.0 MEDICAL EXPERT

1.14 Did the candidate demonstrate an adequate knowledge and application of relevant psychological / behavioural interventions for ADHD? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:
includes a clear understanding of levels of evidence to support psychological and behavioural options.

Achieves the Standard by:
demonstrating the understanding of these treatment modalities; identifying specific treatment outcomes and prognosis; appropriate selection (benefits / risks, application); application of psychoeducation on rationale for specific therapies; considering sensitively barriers to implementation; identifying the role of other health professionals.

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

a. Indicate that psychological and / or behavioural therapy is needed for both the child and the parents.

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).

1.14. Category: MANAGEMENT - Therapy	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

Committee for Examinations
Objective Structured Clinical Examination

Station 10
Gold Coast April 2019

The Royal Australian & New Zealand College of Psychiatrists

The Royal Australian & New Zealand College of Psychiatrists

1.0 Descriptive summary of station:

The candidate is to take a focussed history from Jennifer Manning, a 29-year-old woman with a history of bipolar disorder who is currently stable on sodium valproate. She wants advice about family planning, and the candidate must explain management recommendations including referring to the latest suggested changes to practice guidance regarding sodium valproate, its associated risks, and more robust consent processes.

1.1 The main assessment aims are to:

- Take a focussed history from a patient with bipolar affective disorder, identifying the key issues to enable recommendations around pregnancy to be made to the patient.
- Explain the risks and benefits of management strategies to a patient wanting to get pregnant for a second time.
- Specifically refer to medications usually prescribed for bipolar disorder, and their role in pregnancy in a careful and considered manner.

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

- Elicit that Jennifer's bipolar disorder stability has been dependent on maintenance valproate.
- Outline at least one significant effect on the offspring caused by valproate.
- Provide a risk benefit analysis for at least one pharmacological option to replace valproate.
- Explain the need for effective contraception, without interruption, throughout treatment with valproate.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category**: Mood Disorders
- **Area of Practice**: Adult Psychiatry
- **CanMEDS Domains**: Medical Expert, Communicator, Scholar
- **RANZCP 2012 Fellowship Program Learning Outcomes**: Medical Expert (Management - Therapy); Communicator (Patient Communication - To Patient; Synthesis); Scholar (Application of Knowledge)

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1.4 Station requirements:

- Standard consulting room.
- 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 late 20s, not overweight.
- 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 are working as a junior consultant psychiatrist in a private consulting room.

You are about to see Jennifer Manning, a 29-year-old married woman, who has been referred by her GP for advice about her psychotropic medication. She has a history of bipolar disorder (type 1), and is currently being treated for this condition with valproate. She has a daughter who is nearly 5 years old, and now Jennifer and her husband would like a second child.

Your tasks are to:

- Assess the risks and benefits of Jennifer's current treatment in the context of her history.
- Make recommendations about treatment options to Jennifer.

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
  - 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 / scripted prompts for you to give.
- DO NOT redirect or prompt the candidate unless scripted – 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.

The role player opens with the following statement:

'Mark and I are planning for a second child, and were told to consult you before I become pregnant.'

3.2 Background information for examiners

In this station, the candidate is to take a history to establish the information required to conduct a risk benefit analysis and discussion with the patient. This involves confirming the current presentation and previous management strategies tried. A screen for co-morbidities, strengths and risk factors are also important, as well as a review of supports.

Given this is a difficult choice facing the patient, the candidate is expected to sensitively engage Jennifer, demonstrating empathy and utilising reflective listening skills. There is a significant risk of relapse in this case even with effective management strategies, and this would need to be discussed with the patient. While the candidate may not give a precise figure of the risk of relapse, it must be acknowledged as high and the importance of a good management plan emphasised.

The discussion should involve risks and benefits of continuing treatment which must be weighed up with risks and benefits of changing treatments. The risk of exposure to a teratogen must be acknowledged, and options including termination if she falls pregnant while on this medication can be raised. The key is to present the risks of treatment with the current agent, an alternative agent or no pharmacological treatment at all. The candidate should also consider the preferred option of ceasing the valproate, and outline how this should be replaced; including which choice of alternative, the timing of the medication change, the speed of tapering off the valproate, and the value of adding folic acid.

The key is to present the risks of treatment with current agent, an alternative agent or no pharmacological treatment. Consultation is essential, and the idea is to support the patient to make an informed decision.

The candidate is not expected to focus non-pharmacological interventions in the treatment recommendations.

In keeping with the latest UK guidance[21] candidates should demonstrate some awareness of the recommended changes to consent that have been endorsed by the National Health Service (NHS) and Europe.

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

- Elicit that Jennifer's bipolar disorder stability has been dependent on maintenance valproate.
- Outline at least one significant effect on the offspring caused by valproate.
- Provide a risk benefit analysis for at least one pharmacological option to replace valproate.
- Explain the need for effective contraception, without interruption, throughout treatment with valproate.

A surpassing candidate will skilfully guide the patient through their choices, encourage the involvement of family; emphasise integrated perinatal care planning, working in liaison with the obstetrician and GP; and consider the option of a second opinion. The candidate may also incorporate non-pharmacological interventions alongside the pharmacological ones, including how the aspects of a comprehensive birthing plan will mitigate risk of relapse.

It is both effective and cost-effective to integrate perinatal mental health care into obstetric and primary care settings. Providing adequate perinatal care and parenting support, as well as monitoring for both perinatal depression and anxiety alongside any emergence of manic symptoms will reduce risks.

Whether to prescribe medication or not is based on a growing body of literature that suggests that untreated maternal mental illness can have serious adverse outcomes on foetal wellbeing that may be equal to, or worse, any potential adverse effects of psychotropic medications. For instance, untreated ante-natal depression and / or anxiety has been associated with reduced maternal nutrition, poor antenatal attendance, increased smoking and substance use. Increased risks of obstetric complications (e.g. spontaneous abortion, pre-eclampsia, increased uterine artery resistance, intra-uterine growth retardation, pre-term delivery, and low birth-weight babies) have also been noted. Neonates born to depressed and / or anxious mothers tend to have smaller head circumferences, lower Apgar scores, higher cortisol levels at birth (which could lead to psychopathology later in life), and an increased need for special care nursery due to some medical complication.

Since valproate was introduced in 1974, product information has included a warning about the possible risk of birth defects. As the risks to unborn children have been increasingly understood, the warnings have been strengthened. Recent review and recommendations were carried out by the Pharmacovigilance Risk Assessment Committee (PRAC), the Committee responsible for the evaluation of safety issues for human medicines. The PRAC recommendations were adopted by the Co-ordination Group for Mutual Recognition and Decentralised Procedures– Human (CMDh) that endorsed a strengthened regulatory position on valproate medicines in March 2018. [*The CMDh represents European Union Member States as well as Iceland, Liechtenstein and Norway and is responsible for ensuring safety standards for medicines authorised via national procedures across the EU. Its recommendations are sent to the European Commission, which make EU-wide legally binding decisions*.]

The recommendation is that valproate must no longer be used in any woman or girl able to have children unless she has a 'pregnancy prevention programme' in place. This recommendation is intended to ensure that patients are fully aware of the risks, and the need to avoid becoming pregnant.

The European Medicines Agency statement (EMA/145600/2018) recommends that a pregnancy prevention programme should include:

- an assessment of each patient's potential for becoming pregnant,
- pregnancy tests before starting and during treatment as needed,
- counselling about the risks of valproate treatment and the need for effective contraception throughout treatment,
- a review of ongoing treatment by a specialist at least annually,
- introduction of a new *risk acknowledgement form* that patients and prescribers will go through at each such annual review to confirm that appropriate advice has been given and understood.

Valproate is approximately 90% protein bound and cleared through hepatic metabolism. Pregnancy may affect the disposition of valproate, especially in late pregnancy[11].

Maternal use of valproate, both as monotherapy and as part of a polytherapy regimen, has been associated with an increased risk of congenital malformations[2-6]. Birth defects associated with valproate use during pregnancy include:

- spina bifida
- facial and skull malformations (including cleft lip and palate)
- malformations of the limbs, heart, kidney, urinary tract and sexual organs.

'Foetal valproate syndrome' refers to a consistent craniofacial phenotype, often with major malformations, growth deficiency or neurodevelopmental dysfunction[6]. Several studies have suggested that the risk for major congenital malformations is dose dependent, with greater risks associated with doses equal to or greater than 1000mg daily[2, 3, 6].

Infants exposed to valproate in utero may develop neurological manifestations, including irritability, jitteriness, hypotonia, hypertonia (or variable tone) and feeding problems. These signs and symptoms usually occur within 12 to 48 hours after birth[12]. Other possible neonatal complications include hepatic toxicity and hypoglycaemia[1, 12, 13].

In women who take valproate while pregnant, approximately 3–4:10 children may have developmental problems, and several studies suggest that children exposed to valproate in utero show poorer cognitive outcomes compared to infants exposed to other antiepileptic medicines[14, 15]. The long-term effects are not well known but the effects on development can include:

- developmental delay: infants of women taking antiepileptic medicines may have an increased risk of growth restriction, small for gestational age, transiently reduced Apgar score and low birth weight[9, 10]
- lower intelligence
- poor speech and language skills
- memory problems.

Maternal use of valproate has also been associated with an increased risk of autism spectrum disorder and childhood autistic spectrum disorders[16, 17]. There is also some evidence children may be more likely to be at risk of developing symptoms of attention deficit hyperactivity disorder (ADHD).

The decision to treat should be made on an individual case basis by considering the risks and benefits to both mother and foetus. Most research to date on valproate use during pregnancy has been in women with epilepsy. Seizure activity and genetic predisposition in epileptic women may have independent effects on congenital malformation rates[1].

Women taking valproate should consider changing to an alternative mood stabiliser in the pre-conception period to minimise teratogenic risk. Discontinuation of a maintenance treatment for bipolar disorder, however, is associated with high rates of relapse, especially if discontinuation occurs abruptly. A trial of a slow dose reduction should be considered. Untreated or inadequately treated bipolar disorder during pregnancy increases the risk of pregnancy complications.

Women on valproate should be counselled and encouraged to plan their pregnancies. If a woman decides to take the risk of remaining on valproate, folic acid should be commenced as soon as effective contraception has ceased, as valproate is known to interfere with folate metabolism[1]. Alternatively, folic acid supplementation (5mg daily) is recommended to commence at least one month prior to conception and during pregnancy to reduce teratogenic risk[1].

When valproate is the treatment of choice during pregnancy, valproate levels should be monitored and titrated to the lowest effective dose[1]. When valproate treatment during pregnancy cannot be avoided, use the lowest effective dose (preferably as monotherapy) to minimise teratogenic risk[8]. Appropriate ultrasonographic and other examinations (such as measuring maternal serum levels of alpha-fetoprotein and foetal cardiography) should be offered to women using valproate during pregnancy[1, 3].

It is recommended that if pregnancy does occur on valproate that high resolution USS is critical, with closer and more frequent monitoring. Other factors that need to be considered: planning of the delivery, close monitoring post-partum; proactive consultation with experts (obstetrician, perinatal psychiatrist and paediatrician); possible admission to a specialist mother and baby unit.

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 Jennifer Manning, a 29-year-old female who has been married to Mark for six years. You have a daughter, Emma, who will turn 5 years old in May, and started preschool (or kindergarten) this year. You have returned to work, and are currently employed as a primary school teacher.

Why you need to talk to a psychiatrist:

You and Mark are happily married, and have been discussing having a second child. Currently you 'always use condoms' for contraception. Mark is 28 years old, fit and well, and employed in information technology.

You have a history of bipolar disorder, which is a chronic mental illness that presents with episodes of depression or elevated mood (which is called mania). Your illness has been very stable for three years, and you are currently well - your mood is stable. You have been taking a medication called valproate for nearly five years. You remember being told that the medication you are on may be a problem in pregnancy.

You would like to know what your options are, especially as you are very worried about stopping valproate – based on the history below you would be very reluctant to stop it, as you can't afford to get unwell again – it was too traumatic and disruptive the last time. That is why you asked your GP to refer you to a psychiatrist for a specialist opinion.

If asked, you are sleeping well, you have a good appetite and can concentrate well. You have no thoughts of harming yourself or others. You are not troubled by excessive anxiety. You do not have any unusual experiences / symptoms. You understand that you have bipolar disorder, what the symptoms are, and agree that your illness needs treatment.

Mark does not have any relevant past medical or psychiatric history.

History of your bipolar disorder:

You have had three severe episodes of illness related to your bipolar disorder plus a couple of more minor relapses.

You first became unwell at age 21 (in 2011) when you experienced an episode of elevated mood, like feeling over the moon; increased energy, really busy tidying the apartment and organising all sorts of things - that irritated your flatmates; decreased need for sleep, being up for many nights in a row; racing thoughts and increased activity; making lots of plans for study and work, but actually difficulty concentrating while studying teaching at college. You can also recall spending excessive amounts of money like buying about 10 pairs of shoes in one go.

After about a week of these symptoms you became convinced that one of your flatmates was trying to poison you. You told your mother about your concerns, and she took you to hospital – she was worried you were on drugs. You were admitted to the acute psychiatric unit for three weeks as an involuntary patient. You were diagnosed with bipolar disorder, and started on two medications called quetiapine and lithium. Unfortunately, you didn't manage to get used to the 'terrible' side effects of headache, tremor of your hands, and nausea and diarrhoea – which you were told was due to the lithium – so the lithium was stopped. Your symptoms settled enough for you to go home, and you remained well for about 18 months on the quetiapine and continued your studies.

However, you started getting unwell again near mid-year exams. Your private psychiatrist, Dr Hatcher, added a medication called valproate five days after you were admitted to hospital for the second time as your acute symptoms only partially responded to increased doses of quetiapine (you can't remember what the higher dose was). You responded well to the combination of medications, and made a full recovery by the time of discharge four weeks later. You were followed up by your private psychiatrist who decided to stop the quetiapine after six months (in early 2013), and the valproate after seven months (end of 2013), and discharged you back to your GP.

Around that time, you also found out you were pregnant, and Emma was delivered in May 2014. It is likely that you had been taking valproate in the first few weeks after Emma was conceived, but you are unsure as it was a long time ago.

You managed with some minor mood instability during the pregnancy but unfortunately, you had to be admitted with a manic relapse three weeks after delivery. You experienced similar symptoms to those described above, as well as getting into arguments with Mark in particular, because of your concerns about the general wellbeing of your baby. The valproate and quetiapine were restarted in the ward. You admit that you actually knew that you had started to get progressively unwell near the end of the pregnancy but didn't seek help – looking back you realise that was a really frightening decision to make.

Dr Hatcher agreed to stop the quetiapine after about a year due to weight gain (7 kilograms), and you have remained on valproate since that time. On occasion, if you feel a bit unwell, your illness is managed by the crisis and assessment team of the public mental health service, who insist on recommencing the quetiapine for short periods.

You currently take a dose of 1000 milligrams twice a day of valproate. You had stopped seeing your private psychiatrist two years ago due to the expense, and have been managed by your GP, Dr Berry, since that time. You have had no further episodes and have been very good with taking your treatment, and have attended your appointments regularly. Your GP has been regularly checking blood tests for your liver function and full blood count, but you cannot remember having a valproate blood level.

Other symptoms you may be asked about:

You have never had an episode of depression where you have felt sad, cried a lot, feel socially withdrawn, or had poor sleep.

You have never felt suicidal, and never harmed yourself or others in any way.

Your baby has never been at any risk from you – you have not ever had thoughts to harm her – even when unwell.

You have never been in trouble with the police – even when unwell.

You do not have any other medical history, specifically including thyroid gland problems.

You are on no other regular medications.

You have one to two glasses of wine a week (you prefer white wine), and have never tried illegal drugs.

About your personal life if asked:

You were born and raised in the rural town of Roma where your parent still live; they are a six-hour drive from Gold Coast. Your father is 60 and he is a retired truck driver. Your mother is 55 and works part time at a nursing home. Your parents have a happy marriage and they have been together for 35 years. You are an only child.

You have been told that your mother had an episode of 'psychosis' after your birth. Your parents were always reluctant to talk about this, and so you do not know what that really means or have any details except that she was in hospital and took a while to recover. You suspect it may be something similar to what you have been through. She never had any further episodes.

Your childhood was happy and there was no history of trauma or abuse. You were an average student at school, you were able to make and keep friends, and you had no history of behavioural problems. After finishing secondary school, you went to College to study teaching, and have remained in teaching ever since – except when you took time off with Emma. There are no issues at your work.

You had a couple of relationships, before meeting your husband, that were not serious. You met Mark through a friend while at College. You have a group of close friends who all have children. You enjoy reading, going to the movies and gardening. You are usually a quiet and introverted person. Emma appears to be doing well and there are no concerns about her health.

4.2 How to play the role:

You will be neatly dressed, but casual. You will be cooperative and openly answer the questions asked of you, but you will not volunteer information unless asked. You will be very worried about what may happen to your illness if the candidate suggests you stop the valproate, and will not readily agree to any advice to do so or to change medication to lithium or quetiapine. You have been well for so long on valproate, and are afraid to risk that by medication changes, or stopping medication.

4.3 Opening statement:

'Mark and I are planning for a second child, and were told to consult you before I get pregnant.'

4.4 What to expect from the candidate:

Most candidates will start by taking your history, and then move on to asking more specific questions about how you have been recently. The candidate should be sensitive to your situation; recommendations should be checked carefully with you, about you and your husband's feelings.

4.5 Responses you MUST make:

'Can I just stay on the valproate?'

'Nothing happened to Emma; what could go wrong this time?'

'Is there any new information for women of my age on valproate?'

4.6 Responses you MIGHT make:

If asked about your thoughts on termination of pregnancy should there be a problem with the baby.

Scripted response: ***'I don't think Mark and I would ever consider termination.'***

4.7 Medication and dosage that you need to remember

Valproate at a dose of 1000 milligrams twice a day.

Previously:

Lithium – you cannot remember the dose as it was so long ago.

Quetiapine (KWET-I-APEEN) when more unwell, up to 800 milligrams a day divided in two doses.

STATION 10 – MARKING DOMAINS

The main assessment aims are:

- Take a focussed history from a patient with bipolar affective disorder, identifying the key issues to enable recommendations around pregnancy to be made to the patient.
- Explain the risks and benefits of management strategies to a patient wanting to get pregnant for a second time.
- Specifically refer to medications usually prescribed for bipolar disorder, and their role in pregnancy in a careful and considered manner.

Level of Observed Competence:

2.0 COMMUNICATOR

2.1 Did the candidate demonstrate an appropriate professional approach to gathering information from the patient? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:
elicits and integrates information in a manner that can effectively be utilised to come to a conclusion; able to generate a complete and sophisticated understanding of complexity and the conflictual situation; effectively tailors interactions to maintain rapport within the therapeutic environment.

Achieves the Standard by:
demonstrating empathy and ability to establish rapport; forming a therapeutic partnership using language tailored to the functional capacity of the patient; communicating in a non-judgemental manner; utilising clinical expertise to elicit key factors in the history of the presenting complaint; sensitively identifying issues, risks and concerns related to the presentation; accommodating communication style and history taking techniques in response to the patient interaction.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Elicit that Jennifer's bipolar disorder stability has been dependent on maintenance valproate.

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; errors or omissions significantly adversely impact on alliance and information obtained; unable to maintain rapport.

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

2.1. Category: PATIENT COMMUNICATION - To Patient	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Domain Not Addressed**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

2.5 Did the candidate demonstrate effective communication skills appropriate to sensitively delivering information in this situation? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:
integrates information in a manner that can effectively be utilised by the audience; provides succinct and professional information; takes care to deliver the message while carefully responding to and managing levels of distress.

Achieves the Standard by:
providing accurate and structured verbal feedback on the risks to the foetus / child; prioritising and synthesising evidence to aid in decision making; weighing up the general risks and benefits of treatment and pregnancy; adapting communication style to the setting; using language so as to enhance patient understanding; demonstrating discernment in selection of content to mitigate levels of distress.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Outline at least one significant effect on the offspring caused by valproate.

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; errors or omissions significantly impact on the accuracy of information provided.

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

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

1.0 MEDICAL EXPERT

1.14 Did the candidate demonstrate an adequate knowledge and application of relevant biological therapies? (Proportionate value - 40%)

Surpasses the Standard (scores 5) if:
includes a clear understanding of levels of evidence to support treatment options; refers to available guidance; considers value of second opinions.

Achieves the Standard by:
demonstrating the understanding of preferred medications during pregnancy; identifying specific treatment outcomes; outlining appropriate selection, benefits / risks relevant to the patient; recommending involvement of her partner and family in decision making; clearly specifying medication(s) choice, dosing and monitoring; selecting information sources to explain benefits / risks in pregnancy versus risk of relapse, application of psychoeducation regarding medications; sensitively considering barriers to implementation; identifying the roles of other health professionals and recommending close liaison with MDT.

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

a. Provide a risk benefit analysis for at least one pharmacological option to replace valproate.

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; errors or omissions significantly impact adversely on patient care.

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

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

6.0 SCHOLAR

6.4 Did the candidate prioritise and apply appropriate and accurate knowledge based on available literature and guidance? (Proportionate value - 10%)

Surpasses the Standard (scores 5) if:
candidate acknowledges that scientific information is continuously being updated; that evidence is in a state of known versus unknown and is subject to debate; recognises the delay between evidence and application into clinical practice; acknowledges their own gaps in knowledge; explains the latest European guidance recommending a pregnancy prevention programme.

Achieves the Standard by:
identifying key aspects of the available literature and guidance; commenting on the voracity of the available evidence; specifying the key proponents of current knowledge base; discussing major strengths and limitations of available evidence; describing the relevant applicability of theory to the scenario; recognising how research has led to a greater understanding of how to develop core clinical skills.

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

a. Explain the need for effective contraception, without interruption, throughout treatment with valproate.

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; unable to demonstrate adequate knowledge of the literature / evidence relevant to the scenario.

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

6.4. Category: APPLICATION OF KNOWLEDGE	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?

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail

Committee for Examinations
Objective Structured Clinical Examination

Station 11
Gold Coast April 2019

The Royal Australian & New Zealand College of Psychiatrists

The Royal Australian & New Zealand College of Psychiatrists

1.0 Descriptive summary of station:

This station tests the candidate's knowledge of current expectations in Australia and New Zealand regarding seclusion, and ongoing government direction towards reduction of this practice which is regarded as a form of restraint. In this station the nurse-in-charge of an inpatient ward has raised concerns about seclusion practices on the ward. The candidate should be able to demonstrate knowledge of recovery oriented practices, and an understanding of trauma-informed care. The candidate is also expected to negotiate the team dynamics sensitively as would be expected at the level of a junior consultant.

1.1 The main assessment aims are to:

- Evaluate knowledge of policy and underlying theory behind current thinking on use of seclusion in Australia and New Zealand.
- Evaluate ability of candidate to recognise and negotiate a change within a complex team dynamic.

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

- Outline three accepted strategies likely to contribute to reduction in use of seclusion.
- Describe the key principles of trauma-informed care.
- Identify three leadership / change management factors relevant to this situation.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category**: Governance Skills
- **Area of Practice**: Adult Psychiatry
- **CanMEDS Domains**: Manager, Scholar
- **RANZCP 2012 Fellowship Program Learning Outcomes**: Manager (Policy usage; Governance), Scholar (Application of knowledge).

References:

- A Case for Change Position Statement on seclusion, restraint and restrictive practices in mental health services. Australian Government May 2015.
- Department of Health and Social Care England. Positive and Proactive Care: Reducing the Need for Restrictive Interventions. Policy Paper April 2014, UK, <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf>.
- Health Quality and Safety Commission New Zealand: Zero Seclusion 2020 Project, 27 February 2018 blog, <https://www.hqsc.govt.nz/blog/why-eliminating-seclusion-by-2020-is-an-aspirational-goal/>.
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- National Mental Health (Aust) Consumer and Carer Forum. Ending seclusion and restraint in Australian Mental Health Services Position statement 2009.
- National Mental Health Commission (Aust) Seclusion and Restraint Declaration 2013, <http://www.mentalhealthcommission.gov.au/media/97455/NMHC_Seclusion_and_Restraint_Dec.pdf>.
- RANZCP Position Statement 61: Minimising the use of Seclusion and Restraint in people with Mental Illness.
- Reducing and Eliminating Seclusion in Mental Health Inpatient Services. An Evidence Review for the Health Quality and Safety Commission New Zealand. Te Pou o Te Whakaaro Nui June 2018.
- Safewards: <http://www.safewards.net>.
- Six core Strategies to Reduce Seclusion and Restraint Use NASMHPD Publications. (National Association of State Mental Health Directors), 2008, <https://www.nasmhpd.org/content/six-core-strategies-reduce-seclusion-and-restraint-use>.
- Six Core Strategies New Zealand Adaption Te Pou O Te Whakaaaro Nui. 2013.
- Tobin, M. and J. Wells, Psychiatrists managing change: lost control or at a loss. Australasian Psychiatry, 1999. 7(4): p. 194-198.

The Royal Australian & New Zealand College of Psychiatrists

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: male in his 30's, confident, neatly dressed.
- 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 are a newly appointed junior consultant in an acute inpatient service. You are approached by Tony, the nurse-in-charge, who had observed a recent seclusion event, and has raised concerns about the unit's use of seclusion practices which he feels are not in line with current government policies. You have agreed to give some time to Tony now to discuss your stand point on the use of seclusion, and how you see the unit moving forward in the approach to, and use of seclusion.

Your tasks are to:

- Outline relevant policies and methods guiding efforts towards reducing the use of seclusion in inpatient mental health settings.
- Explain the current theories which justify reduction in the use of seclusion.
- Identify important issues that could impact on efforts to change the use of seclusion in this ward environment.

You will not receive any time prompts.

Station 11 - 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 unless scripted – 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.

The role player opens with the following statement:

'Thanks for giving me this time to discuss seclusion as I'm hoping we can make some changes around here.'

3.2 Background information for examiners

In this station, the candidate is expected to demonstrate knowledge of current goverment policy regarding seclusion, and ongoing direction towards reduction and eventual elimination of this practice which is regarded as a form of restraint. The theoretical background including trauma-informed care is expected to be covered by the candidate. The candidate is also expected to sensitively negotiate the team dynamics with a new nurse-in-charge. This question is focussed primarily on demonstrating understanding of policy and theory which is similar across all Australian states and NZ, rather than the applciation of Mental Health Acts or other legislation affecting the legalities of seclusion which differs across jurisdictions.

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

- Outline three accepted strategies likely to contribute to reduction in use of seclusion.
- Describe key principles of trauma-informed care.
- Identify three leadership / change management factors relevant to this situation.

A surpassing candidate will be able to demonstrate that they have clearly considered these issues, and have more than a basic theoretical understanding of both seclusion related issues, and of change management which they can apply to the scenario.

Since the early 2000s there has been increasing concern about potential overuse of seclusion and restraint in inpatient mental health units. The following are examples of how seclusion and restraint impact on people's human rights:

- Being confined in a space of which someone cannot freely exit.
- Reduction of personal space and taking away freedom.
- Humiliating and disempowering.
- Punishment and abandonment.
- Dehumanised by having your freedom taken away.

Trauma-informed Care

There is considerable discussion and concern that use of seclusion can be traumatic for patients and for staff. This is linked to the theories of trauma-informed care and recovery-focussed practice. The former is based on the theory that past traumatic experiences are very common in mental health patients, and frightening emotions can be very easily retriggered by experiences in a mental health ward if patients are placed in a situation where they feel vunerable and powerless. Trauma-informed care aims to reduce or eliminate these situations, improve recognition by staff of the signs and symptoms of trauma, and build a patient's sense of safety, control and empowerment. The consumer advocacy movement and increasing 'patient voice' has been closely involved in the development of policies stemming from these theories and issues.

Generally, the following five primary trauma-informed care principles can form a strong foundation for change in practice (Roger D. Fallot and Maxine Harris, 2006):

- Safety – which includes creating spaces where people feel culturally, emotionally, and physically safe as well as an awareness of an individual's discomfort or unease.
- Transparency and trustworthiness.
- Choice.
- Collaboration and mutuality.
- Empowerment.

An awareness of cultural, historical and gender issues are also identified as important factors.

Along with a set of principles, four key elements for a trauma-informed approach are outlined below (Cieslak et al., 2014; Isobel & Edwards, 2017).

1. Realisation of the widespread impact of trauma on people, families, groups, organisations, and communities; an understanding of pathways to wellbeing.
2. Recognition of the signs and symptoms of trauma through understanding the profound neurological, biological, psychological, and social effects of trauma and violence on people; coupled with an ability to recognise the signs and symptoms of trauma in people accessing services, staff, and others.
3. Responding by integrating trauma knowledge into policies, procedures, programmes, and practice.
4. Avoiding the re-traumatisation of people accessing services, and the workforce.

Trauma-informed care acknowledges the need for services to address the safety and wellbeing of staff who may experience indirect trauma or organisational or hierarchical disempowerment**.** In countries impacted by colonisation research indicates trauma-informed care needs to include an additional element. In order to fully engage with the impacts of colonisation on the wellbeing of people, the impact of historical trauma events and their contribution to negative health disparities, needs to be included.

Recovery-focussed / based / oriented Practice includes principles as follows: uniqueness of the individual, real choices, attitudes and rights, dignity and respect, partnership and communication, and evaluating recovery. The unwell individual is regarded as the expert on their own personal distress.

> '*From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self. It is important to remember that recovery is not synonymous with cure. Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery – hope, healing, empowerment and connection – and external conditions that facilitate recovery – implementation of human rights, a positive culture of healing, and recovery-oriented services.'* (Jacobson and Greenley, 2001 p.482).

Policy

With regard to changing practice and influencing better outcomes, there has been publication of position statements by government and state bodies in USA, Australia, UK and NZ on the practices of seclusion and restraint, and the need to reduce their use. This has lead to data collection, trial 'beacon' projects, and publication of guidelines and strategies to encourage healthboards and hospitals to try to reduce their rates of seclusion and restraint. Common to these documents are ideas expressed as the 'Six Core / Key Strategies to Reduce Seclusion and Restraint.'

In Australia, the National Mental Health Consumer and Carer Forum's (NMHCCF) lists the following strategies:

- Better Accountability.
- Implementation of Evidence Based Approaches to Ending Seclusion and Restraint.
- Adherence to Standards and Public Reporting.
- Support for Mental Health Professionals Towards Cultural and Clinical Practice Change.
- Better Care Planning.
- Review Relevant Mental Health Legislation.

In New Zealand Te Pou (national centre of evidence based workforce development for the mental health, addiction and disability sectors) have produced another version (Te Pou NZ):

- 'Leadership towards organisational change' – outlining a philosophy of care that targets seclusion and restraint reductions.
- 'Consumer roles in inpatient settings' – having an inclusive approach which involves consumers, carers and other advocates in seclusion and restraint reduction initiatives.
- 'Using data to inform practice' – using data in an empirical, non-punitive way to review, analyse and monitor patterns of seclusion and restraint.
- 'Workforce' – developing procedures, practices and education that promote mental health recovery.
- 'Use of seclusion and restraint reduction tools' – using assessments and other resources to develop individual aggression prevention approaches.
- 'Debriefing techniques' – analysing why seclusion and restraint events occurred and evaluating the impacts on individuals with lived experience, families and carers and service providers.

The RANZCP recognises these common themes in documents aiming to reduce seclusion and restraint national direction and appropriate funding:

- leadership towards organisational, clinical and cultural change use of data to inform practice
- improved governance and review
- workforce development, including de-escalation and debriefing strategies
- use of practical and evidence-based seclusion and restraint prevention tools – minimising the use of seclusion and restraint in people with mental illness
- service user development and participation
- better care planning
- consumer roles in inpatient settings
- debriefing techniques
- review of relevant mental health legislation.

Specific non-pharmacological strategies that encompass the functioning of staff as a whole are available and more popular options currently include *Safewards*, beacon sites*. *Safewards* originated in the UK from a broad body of evidence and many services are implementing it locally. The *Safewards* model and associated interventions have been highly effective in reducing conflict and containment, and increasing a sense of safety and mutual support for staff and patients. The original model focusses on orginating factors (e.g. team strucutres and rules), flashpoints (e.g denial of a leave request) and staff modifiers (e.g. staff frustration, teamwork, or technical mastery).

*** Beacon Sites** (https://meteor.aihw.gov.au/content/index.phtml/itemId/596362)

Use of restrictive practices during admitted patient care

Health Ministers endorsed the National safety priorities in mental health: a national plan for reducing harm (the Plan), Australia's first national statement about safety improvement in mental health, in 2005. The Plan identified 4 national priority areas for national action including 'reducing use of, and where possible eliminating, restraint and seclusion'.

*In line with the Plan, the National Mental Health Seclusion and Restraint Project (2007–2009), known as the **Beacon Project,** was developed as a collaborative initiative to establish **demonstration sites** as centres of excellence aimed towards reducing seclusion and restraint in public mental health facilities. Key to this work has been translating international lessons and initiatives to the Australian environment and the development and implementation of policies, guidelines and staff training based on good practice. Project outcomes were positive, with several **Beacon sites** reporting significant reductions in the use, and / or duration of seclusion, thus providing the foundation for further change.*

The RANZCP position statement also discusses barriers to implementing changes to seclusion practice as below; the main barriers to reducing seclusion and restraint are:

- lack of identified good practice / agreed clinical standards for the use of seclusion and restraint
- lack of quality improvement activity and clinical review – i.e. poor governance
- inappropriate use of interventions and variation in practice – e.g. using threat of restraint or seclusion to coerce particular behaviour
- lack of staff knowledge or skills to prevent, identify and use alternative interventions or to safely use restraint and seclusion interventions in emergency situations
- lack of staff knowledge or skills regarding appropriate triaging of mental health presentations
- lack of staff training and knowledge about early warning signs of agitation and aggression and effective interventions to prevent the use of seclusion and restraint
- lack of staff education and training, particularly in non-mental health care settings
- lack of resources and poor facilities.

This station also evaluates the candidate's knowledge and abilities in leadership and change management. Expectations are laid out in pre-fellowship guidelines as below:

'Leadership • Knowledge of contemporary leadership theory • Understanding the importance of organisational culture • Understanding the importance of context • Followship and near leadership • Understanding of systems theory • Analyse complex problems to discern risks and benefits of actions and plan appropriately - SWOT analysis • Adapts approach to the context • Change management theory and practice.'

Change Management

There are many different change management models in existence of which some are deemed more suitable for healthcare than others. Issues considered include: whether change is planned or naturally evolving, whether it is episodic or continuous, whether is it imposed from above or coming from grassroots employees / end-users, power relations within an organisation, environmental and technological factors, organisational capacity and complexity, human and financial resources, dynamic power of leaders and buy-in of staff, whether it is a closed or open system (systems theory).

SWOT analysis is a frequently used technique in health settings to evaluate the need for and process of change. It utilises the model of identifying strengths, weaknesses, opportunities and threats as a framework for the change process.

In practice, change leaders must ensure that they have resources (financial, human, and otherwise), in addition to a general appreciation of the need for change, buy-in from senior staff in the organisation, and a clear outline of how the change will transpire in order to improve their likelihood of successfully achieving change. As the end goal is to improve patient experience of care, the patient's role is critical and actions must be taken enable their input and buy in to whatever approach is taken to improve their experience. Without patient input, health providers may be misguided and waste resources in their attempts to improve patient experience.

Within psychiatry, one article, by Tobin and Wells, discusses the issue of implementing change in leadership and management to ultimately improve patient care in Australia and New Zealand. The change management model used in this article to structure the change effort aligns with Hinings and Greenwood's model of change dynamics. In their analysis of how the change initiative should be undertaken, Tobin and Wells outline situational constraints, such as a newly enacted mental health policy intended to achieve improved quality and effectiveness of service delivery. Tobin and Wells go on to describe interpretive schemes and interests through a discussion of psychiatrist-management relations and areas of tension. Dependencies of power, which include how psychiatrists can influence management and power dynamics between clinicians and non-clinical managers, are outlined. This is followed by a discussion of how management can exercise effective leadership and the importance of effective training for management. While Tobin and Wells do not explicitly state their use of Hinings and Greenwood's model of change dynamics, their analysis of change management in psychiatry employs all of Hinings and Greenwood's change management principles, (situational constraints, interpretive schemes, interests, dependence of power, and organisational capacity) thereby validating its applicability in this area of clinical practice.

In this scenario a range of leadership and change management opportunities arise, such as (but not exclusively): difficulty in immediately initiating change as a new and junior consultant in an established team; the need to form relationships; need to find out what unit policies are and if any plans in place to make changes; the importance of exploring the views of key people such as the other clinicians, consultants and managers; the importance of engaging senior staff including managers; need to collect data; methods to evaluate possible barriers to change including environmental, funding, training; recognition of the need to get a range of staff on board with idea; stressing importance of patient, family and peer advocate roles in this process, possibility of the fact they are new could be opportunity for change if others are ready but needing a catalyst; use of both top down and bottom up approaches to effect change; recognising the importance of a multi-disciplinary approach with clarification of roles and responsibilities and measures of success.

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 Tony Matthews, aged 31, a senior mental health nurse. You are the nurse-in-charge on this acute mental health ward. You have asked to speak with the newly appointed psychiatrist working in the ward, as you have some concerns about whether the use of seclusion is up-to-date, and in keeping with latest evidence in the literature and with government policy.

Seclusion has been used for many years with mental health patients to manage periods of extreme violence to one's self or others when they are very unwell. Seclusion is defined as the confinement of the patient at any time of the day or night, alone in a room or area from which free exit is prevented. So seclusion means that a person is placed in this secure environment by themselves with the intent that when exposed to less stimulation they may find it easier to calm down, and gain more control over their behaviour.

Both seclusion and restraint (where an acutely unwell person is held by staff – either to enable a treatment intervention or to reduce risk of imminent harm to self or others) have long been used as an emergency measure to manage violent behaviour or agitation in mental health settings. Over the years, there has been an increasing desire from governments, policy makers and clinicians to reduce the need for, and use of these practices as it has been shown that, while imminent risk may be managed, the use of seclusion and restraint can be very traumatising for both patients and staff involved.

You have recently met the candidate who is a newly graduated psychiatrist working on the ward. You are concerned about a recent seclusion of an agitated young woman admitted who had been shouting and lashing out at staff. You feel seclusion wasn't necessary, and that it just made her more upset and traumatised.

You feel that the other psychiatrists on the ward are old fashioned in their thinking, and use the practice of seclusion too freely – and that this is not in line with how things are in some other wards, and other hospitals where you have worked.

You have tried to raise the issue with them but feel that they are not willing to listen to you. You are keen to find out if the new consultant is more in line with your beliefs that seclusion is overused on the ward, and if they are going to be willing to help you to reduce, and hopefully eventually stop, the practice.

4.2 How to play the role:

You are an experienced mental health nurse who has also run wards in other hospitals. You are neatly dressing in casual work clothing.

You are not wanting to get into any discussion about the specific case scenario – it is provided as a brief basis from which the conversation can arise. Your key interest is in what they can tell you about the current thinking around the use of seclusion, and then how they may be able to play an important role with you to change culture in the ward. They should tell you about current government policies to reduce and stop seclusion.

They should describe some specific strategies which can be used to reduce seclusion, but hopefully mention that it is tricky as they are new here, and do not know what has been discussed by other consultants, managers, nursing staff about this issue.

4.3 Opening statement:

'Thanks for giving me this time to discuss seclusion as I'm hoping we can make some changes around here.'

4.4 What to expect from the candidate:

The candidate should ask you what it is that you are worried about, and what it is you want to change, and you tell them about the young woman who was secluded, and that you want to stop this from happening.

The candidate should be able to enter into a discussion with you about the pros and cons of seclusion, and the impact of secluding people. They should then go on to identify some difficulties with making changes, and some ideas on what they can do to assist in changes occurring.

4.5 Responses you MUST make:

'So what do think of seclusion and how it should be used in acute wards nowadays?'

'It makes people feel terrible. Do doctors know about that?'

'So how can you and I make some changes and stop this happening?'

'People are so traumatised by seclusion – it's just not okay!'

4.6 Responses you MIGHT make:

If asked about what you know about the seclusion literature and policy, defer to them with suggested comments like:

Scripted response: ***'I'd like to know what you think about seclusion'*** or ***'I'm asking for your opinion.'***

If asked about the diagnosis of the young woman:

Scripted response: ***'I don't know the details – just that she was very upset and seclusion didn't help.'***

If asked what you think you should do or how do you think it should be done:

Scripted response: '***Just stop seclusion – I'm hoping you can tell me how in this ward!'***

STATION 11 – MARKING DOMAINS

The main assessment aims are:

- Evaluate knowledge of policy and underlying theory behind current thinking on use of seclusion in Australia and New Zealand.
- Evaluate ability of candidate to recognise and negotiate a change within a complex team dynamic.

Level of Observed Competence:

4.0 MANAGER

4.5 Did the candidate demonstrate effective understanding of policy and current practice? (Proportionate value 40%)

Surpasses the Standard (scores 5) if:
demonstrates a sophisticated knowledge of policy expectations; takes in a system / organisational consideration to decision making; quotes specific documents or government strategies being utilised in their region for seclusion reduction; outlines rationales for the focus on reduction of seclusion; demonstrates familiarity with interventions like Safewards, Beacon sites.

Achieves the Standard by:
incorporating likely service policies into decision making; identifying and applying policy expectations into practice; describing a range of accepted strategies (as outlined in the Six Core / Key strategies for seclusion reduction) e.g. use of quality improvement methodology, sensory modulation, consumer leadership, environmental changes to wards, post seclusion debriefing for staff and patients, peer support, workforce development and training.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Outline three accepted strategies likely to contribute to reduction in use of seclusion.

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).

4.5. Category: POLICY USAGE	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

6.0 SCHOLAR

6.4 Did the candidate prioritise and apply appropriate and accurate knowledge based on available literature / research / clinical experience? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:
recognises the impact of environment, people and new knowledge on current understanding; provides a comprehensive outline of trauma-informed care; acknowledges their own gaps in knowledge; outlines principles of and specific applicable factors of Recovery-focussed / based / oriented Practice; recognises how research has led to a greater understanding of how this can contribute to better patient care.

Achieves the Standard by:
identifying key aspects of the literature and describing the relevant applicability of theory to the scenario; describing options identified in the literature and policy; including a number of principles and factors applicable to reducing seclusion; postulating applicability of trauma-informed care to this scenario.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Describe the key principles of trauma-informed care.

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).

6.4. Category: APPLICATION OF KNOWLEDGE	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

4.0 MANAGER

4.1 Did the candidate demonstrate a capacity to apply principles of clinical governance? (Proportionate value - enter value 30%)

Surpasses the Standard (scores 5) if:
able to tolerate and manage uncertainly; effectively describes complex governance issues and change management barriers; mentions change theory models or utilises change theory terminology.

Achieves the Standard by:
identifying principles of clinical governance and standards, applying governance within organisational structures; demonstrating capacity to distinguish between leadership and management; contributing to principles of change management and change processes; mentioning any of a broad range of leadership and change issues applicable to this scenario.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Identify three leadership / change management factors relevant to this situation.

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 (e.g. does not acknowledge the importance of their new status on the team regarding making changes).

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

4.1. Category: GOVERNANCE	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