Committee for Examinations
Objective Structured Clinical Examination
Station 3
April 2021 AV OSCE

The Royal Australian & New Zealand College of Psychiatrists

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1.0 Descriptive summary of station:

This station involves history taking, establishing diagnosis and outlining pharmacological management. The candidate is required to take a history from Tayla Roberts, a 50-year-old woman who has developed an alcohol use disorder following the end of her 20-year marriage. Following the establishment of a diagnosis, the candidate is to outline pharmacological management for a person with alcohol use disorder, and present a formulation to the examiner.

1.1 The main assessment aims are to:

- Evaluate the candidate's ability to take a focussed alcohol and drug history, and establish a diagnosis of alcohol use disorder based on the findings.
- Evaluate the candidate's ability to outline the management of alcohol use disorder with particular focus on alcohol pharmacotherapy.

1.2 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category**: Core skills
- **Area of Practice**: Addictions
- **CanMEDS Marking Domains Covered**: Medical Expert, Communicator, Collaborator
- **RANZCP 2012 Fellowship Program Learning Outcomes**: Medical Expert (Assessment – Data Gathering Content, Formulation, Diagnosis, Management – Initial Plan, Management – Long-term Preventative *with focus on pharmacotherapy*), Communicator (Communication – Findings), Collaborator (External relationships)

References:

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- American Psychiatry Association (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*: American Psychiatric Pub
- World Health Organization. (1993). The ICD-10 classification of mental and behavioural disorders: diagnostic criteria for research (Vol. 2): World Health Organization
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- Health Promotion Agency, https://www.alcohol.org.nz/help-advice/advice-on-alcohol/low-risk-alcohol-drinking-advice
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- Anton, R. F., O'Malley, S. S., Ciraulo, D. A., Cisler, R. A., Couper, D., Donovan, D. M., . . . Zweben, A. (2006). Combined pharmacotherapies and behavioral interventions for alcohol dependence: the COMBINE study: a randomized controlled trial. *Jama, 295*(17), 2003-2017. doi:10.1001/jama.295.17.2003

- Kirchmayer, U., Davoli, M., Verster, A. D., Amato, L., Ferri, A., & Perucci, C. A. (2002). A systematic review on the efficacy of naltrexone maintenance treatment in opioid dependence. *Addiction, 97*(10), 1241-1249. doi:10.1046/j.1360-0443.2002.00217.x
- National Health and Medical Research Council, Australian guidelines for te Treatment of Alcohol Problems 2009 https://www.health.gov.au/sites/default/files/guidelines-for-the-treatment-of-alcohol-problems_0.pdf
- The American Psychiatric Association Practice Guideline for the pharmacological treatment of patients with Alcohol Use Disorder. https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9781615371969
- Minozzi, Silvia et al. "Baclofen for alcohol use disorder." *The Cochrane database of systematic reviews* vol. 11,11 CD012557. 26 Nov. 2018, doi:10.1002/14651858.CD012557.pub2

1.3 Station requirements:

- Standard room with suitable IT equipment and internet connection for all participants.
- Accessibility to Zoom for all participants (examiners x 2, role player x 1, candidate x 1, observer x 1).
- A set of 'Instructions to Candidate'.
- Role player: well dressed female in her early 50s.
- Pen for candidate.

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 a community outpatient clinic.

You are going to see Tayla Roberts, a 50-year-old woman for the first time at an appointment requested by her General Practitioner, Dr Sara Smith. Her referral letter reads as follows.

Dear Doctor,

Thank you for seeing Ms Tayla Roberts, who is a relatively new patient at the practice where I work. During a recent routine check-up, I referred her for blood tests. The results showed that she has a slightly deranged liver function and a subsequent ultrasound revealed fatty liver. All other blood tests were normal. I have attached the reports for your review.

I am worried about her alcohol intake, and she agrees that she needs to cut down on her alcohol use as well. Could you please help her with this request?

Thanking you
Dr Sara Smith

Your tasks are to:

- Take a history **from Tayla**.
- Explain the diagnosis and possible differential diagnoses **to Tayla**.
- Explain pharmacological management options **to Tayla**.
- Present a formulation **to the Examiners**.

Roberts, Tayla

Haematology	Current Result	Units	Reference
Date	26/02/21		
Time	07:57		
Lab ID	848677945		
Haemoglobin	137	g/L	(119-160)
RCC	4.7	x10^12/L	(3.8-5.8)
Haematocrit	0.40		(0.35-0.48)
MCV	85	fL	(80-100)
MCH	29.3	pg	(27.0-32.0)
MCHC	343	g/L	(310-360)
RDW	13.5		(10.0-15.0)
WCC	4.0	x10^9/L	(4.0-11.0)
Neutrophils	2.15	x10^9/L	(2.0-7.5)
Lymphocytes	1.35	x10^9/L	(1.0-4.0)
Monocytes	0.37	x10^9/L	(0.0-1.0)
Eosinophils	0.11	x10^9/L	(0.0-0.5)
Basophils	0.02	x10^9/L	(0.0-0.3)
NRBC	<1.0	/100 WBC	(<1)
Platelets	248	x10^9/L	(150-450)
ESR	22	mm/h	(1-35)

Comment on Lab ID 848677945
Full blood count is within reference limits

Biochemistry	Current Result	Units	Reference
Date	26/02/21		
Time	07:57		
Lab ID	848677945		
Status	Fasting		
Sodium	140	mmol/L	(135-145)
Potassium	4.4	mmol/L	(3.5-5.5)
Chloride	106	mmol/L	(95-110)
Bicarbonate	26	mmol/L	(20-32)
Urea	6.0	mmol/L	(3.0-8.0)
Creatinine	80	umol/L	(45-85)
eGFR	69	mL/min/1.73m2	(>59)
Calcium	2.34	mmol/L	(2.15-2.55)
Corr Calcium	2.30	mmol/L	(2.15-2.55)
Bili.Total	10	umol/L	(3-15)
ALP	102	U/L	(30-115)
GGT	106	U/L	(5-35)
LD	207	U/L	(120-250)
AST	38	U/L	(10-35)
ALT	50	U/L	(5-30)
Total Protein	74	g/L	(64-83)
Albumin	45	g/L	(36-47)
Globulin	29	g/L	(23-39)
Cholesterol	4.8	mmol/L	(3.9-5.5)
Triglycerides	0.7	mmol/L	(0.5-1.7)
CK	74	U/L	(30-150)

Surgery Use

☐ Normal

☐ No Action

☐ Contact Patient

☐ See Patient

☐ See File

☐ Continue Treatment

Signed .....

Date .....

ROBERTS, TAYLA

Referred by: DR S SMITH

Name of Test: ULTRASOUND Liver

Requested: 12/03/2021 **Performed:** 16/03/2021 **Reported:** 16/03/2021 12:36

HISTORY:
Persistent elevation of LFTs

FINDINGS:
Liver:
Size: Normal.
Echogenicity: Hyperechoic, heterogeneous in keeping with mild fatty infiltration
Portal Vein: Hepatopetal flow. 8mm
Cyst: None.
Solid lesion: None.
Intrahepatic bile ducts: Normal.
Common Bile Duct: 4mm. The common bile duct is not dilated.
Gallbladder:
Gallstones: None.
Gallbladder polyps: Single polyp measuring 4mm
Gallbladder sludge: Not present.

COMMENT:
Mild fatty liver.
Small gallbladder polyp.

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.

When the candidate enters the station briefly check photo ID.

The role player opens with the following statement:
'Thanks for seeing me, my doctor believes you have some medicines that may help me.'

3.2 Background information for examiners

The aims of this station are to test the candidate's ability to take a focussed drug and alcohol history, and establish a diagnosis of alcohol use disorder. The history should be comprehensive and include enquiring about the use of substances other than Alcohol. The candidate must explain the diagnosis to the patient, and outline initial and longer-term management options with a focus on alcohol pharmacotherapy. They will then present a formulation.

In this scenario, the candidate is expected to discuss the risks and benefits of different options in the management of alcohol use disorder – this must include a discussion about abstinence, controlled drinking and alcohol pharmacotherapy.

In order to 'Achieve' the standard in this station, the candidate should be able to:

- Elicit sufficient information to clearly establish a diagnosis of alcohol use disorder using the DSM V or ICD 11 diagnostic criteria.
- Explain the diagnosis of alcohol use disorder in a non-judgmental manner.
- Highlight the importance of alcohol pharmacotherapy in the management of alcohol use disorder; discuss in detail at least two pharmacotherapy options with level one evidence-based for alcohol use disorder (Acamprosate and Naltrexone).
- Rule out non-substance use psychiatry diagnosis.
- Present an adequate formulation.

A better candidate should be able to:

- not only take a comprehensive drug and alcohol history, but assess for behavioural addictions, such as gambling use disorder.
- establish a diagnosis of severe alcohol use disorder.
- describe full remission as a period of abstinence for at least three months, and further state the chances of achieving long term abstinence, and the goal of controlled drinking is better achieved after attaining full remission.
- discuss the prognosis of controlled drinking in established severe alcohol use disorder.
- hypothesise about the parallels between her losses and those of her mother.

Substance/Alcohol Misuse Screening

1. Conduct an initial screening by asking about tobacco, gambling and drug use during the patient interview. Use a non-judgmental approach when asking these questions.
2. Use open-ended questions. May use statements like 'Tell me about your alcohol use?' instead of 'Do you drink alcohol?' assuming that all patients consume some alcohol may yield more forthright answers. Confirm responses by asking about frequency (how many days per week on average) and quantity (how many drinks on a typical day).
3. Alternatively, candidates can incorporate a short substance use screening instrument, such as the 4-item CAGE or The AUDIT-C.

The CAGE questionnaire, the name of which is an acronym of its four questions, is a widely used screening test for problem drinking and potential alcohol problems. The questionnaire takes less than one minute to administer, and is often used in primary care or other general settings as a quick screening tool.

The CAGE questionnaire asks the following questions:

1. Have you ever felt you needed to Cut down on your drinking?
2. Have people Annoyed you by criticising your drinking?
3. Have you ever felt Guilty about drinking?
4. Have you ever felt you needed a drink first thing in the morning (Eye-opener) to steady your nerves or to get rid of a hangover?

Two 'yes' responses indicate that the possibility of alcohol use disorder should be investigated further.

The AUDIT-C (Alcohol Use Disorders Identification Test – Consumption) is a 3-question screen that can help identify patients with alcohol misuse. The AUDIT-C is scored on a scale of 0-12 points (scores of 0 reflect no alcohol use in the past year). It reliably identifies patients who are hazardous drinkers or have active alcohol use disorders. When alcohol abuse is indicated, follow-up with additional interview questions to learn more. The AUDIT-C questions are:

1. How often do you have a drink containing alcohol?
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
3. How often do you have six or more drinks on one occasion?

DSM-5 Diagnostic Criteria for Alcohol Use Disorder

A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Alcohol is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
4. Craving, or a strong desire or urge to use alcohol.
5. Recurrent alcohol use resulting in a failure to fulfil major role obligations at work, school, or home.
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
8. Recurrent alcohol use in situations in which it is physically hazardous.
9. Alcohol 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 alcohol.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of alcohol.
11. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome for alcohol (refer to Criteria A and B of the criteria set for alcohol withdrawal, pp. 499–500).
    b. Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

Specify if:

- **In early remission:** After full criteria for alcohol use disorder were previously met, none of the criteria for alcohol use disorder have been met for at least three months but for less than 12 months (with the exception that Criterion A4, 'Craving, or a strong desire or urge to use alcohol,' may be met).

- **In sustained remission:** After full criteria for alcohol use disorder were previously met, none of the criteria for alcohol use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A4, 'Craving, or a strong desire or urge to use alcohol,' may be met).

Specify if:

- **In a controlled environment:** This additional specifier is used if the individual is in an environment where access to alcohol is restricted.

Code based on current severity/remission
Specify current severity/remission:
- 305.00 (F10.10) Mild: Presence of 2–3 symptoms.
- (F10.11) Mild: In early remission.
- (F10.11) Mild: In sustained remission.
- 303.90 (F10.20) Moderate: Presence of 4–5 symptoms.
- (F10.21) Moderate: In early remission.
- (F10.21) Moderate: In sustained remission.
- 303.90 (F10.20) Severe: Presence of 6 or more symptoms.
- (F10.21) Severe: In early remission.
- (F10.21) Severe: In sustained remission.

Alcohol Dependence is defined in ICD-11 as (Saunders, 2019):

A disorder of regulation of alcohol use arising from repeated or continuous use of Alcohol. The characteristic feature is a strong internal drive to use Alcohol, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use Alcohol. Physiological features of dependence may also be present, including tolerance to the effects of Alcohol, withdrawal symptoms following cessation or reduction in use of Alcohol, or repeated use of Alcohol or pharmacologically similar substances to prevent or alleviate withdrawal symptoms. The features of dependence are usually evident over a period of at least 12 months, but the diagnosis may be made if alcohol use is continuous (daily or almost daily) for at least one month.

There are three diagnostic guidelines for Alcohol Dependence, any two of which need to be present for the specified time:

1. **Impaired control over alcohol use** – in terms of the onset, level, circumstances, or termination of use, often but not necessarily accompanied by a subjective sensation of urge or craving to use Alcohol.

2. **Alcohol use becomes an increasing priority in life** – such that its use takes precedence over other interests or enjoyments, daily activities, responsibilities, or health or personal care. Alcohol use takes an increasingly central role in the person's life and relegates other areas of life to the periphery, and it often continues despite the occurrence of problems.

3. **Physiological features** – (indicative of neuroadaptation to Alcohol) as manifested by: (i) tolerance, (ii) withdrawal symptoms following cessation or reduction in use of Alcohol, or (iii) repeated use of alcohol (or a pharmaco-logically similar substance) to prevent or alleviate withdrawal symptoms. Withdrawal symptoms must be characteristic for the withdrawal syndrome for Alcohol, and must not simply reflect a hangover effect.

Hazardous Alcohol Use
In ICD-11 it is defined as: A pattern of alcohol use that appreciably increases the risk of harmful physical or mental health consequences to the user or to others to the extent that warrants attention and advice from health professionals. The increased risk may be from the frequency of alcohol use, from the amount used on a given occasion, or from risky behaviours associated with alcohol use or the context of use, or from a combination of these. The risk may be related to short-term effects of Alcohol or to longer-term cumulative effects on physical or mental health or functioning. Hazardous alcohol use has not yet reached the level of having caused harm to the physical or psychological health of the user or others around the user. The pattern of alcohol use often persists in spite of awareness of increased risk of harm to the user or to others.

Alcohol Intoxication
This is defined in ICD-11 as: A clinically significant transient condition that develops during or shortly after the consumption of Alcohol that is characterized by disturbances in consciousness, cognition, perception, affect, behaviour, or coordination. These disturbances are caused by the known pharmacological effects of Alcohol and

their intensity is closely related to the amount of Alcohol consumed. They are time-limited and abate as Alcohol is cleared from the body. Presenting features may include impaired attention, inappropriate or aggressive behaviour, lability of mood, impaired judgment, poor coordination, unsteady gait, and slurred speech. At more severe levels of intoxication, stupor or coma may occur.

Alcohol Withdrawal
It is defined in ICD-11 as: A clinically significant cluster of symptoms, behaviors and/or physiological features, varying in degree of severity and duration, that occurs upon cessation or reduction of use of Alcohol in individuals who have developed Alcohol dependence or have used Alcohol for a prolonged period or in large amounts. Presenting features of Alcohol Withdrawal may include autonomic hyperactivity, increased hand tremor, nausea, retching or vomiting, insomnia, anxiety, psychomotor agitation, transient visual, tactile or auditory hallucinations, and distractibility. Less commonly, the withdrawal state is complicated by seizures. The withdrawal state may progress to a very severe form of delirium characterized by confusion and disorientation, delusions, and prolonged visual, tactile or auditory hallucinations. In such cases, a separate diagnosis of Alcohol-induced Delirium should also be assigned.

The current NHMRC draft guideline recommendations to reduce health risks from drinking alcohol are:

1. ***Healthy men and women****:*
   To reduce the risk of harm from alcohol-related disease or injury for healthy men and women, drink no more than 10 standard drinks per week and no more than 4 standard drinks on any one day.
   The less you choose to drink, the lower your risk of alcohol-related harm. For some people not drinking at all is the safest option.

2. ***Children and young people****:*
   To reduce the risk of injury and other harms to health, children and young people under 18 years of age should not drink Alcohol.

3. ***Pregnancy and breastfeeding****:*
   To reduce the risk of harm to their unborn child, women who are pregnant or planning a pregnancy should not drink Alcohol.
   For women who are breastfeeding, not drinking Alcohol is safest for their baby.

The **New Zealand Health Promotion Agency** Low-risk alcohol drinking advice is:

<u>Advice for adults</u>
To reduce your long-term health risks by drinking no more than:
- Two standard drinks a day for women and no more than 10 standard drinks a week.
- Three standard drinks a day for men and no more than 15 standard drinks a week AND at least two alcohol-free days every week.
- Reduce your risk of injury on a single occasion of drinking by drinking no more than:
  - four standard drinks for women on any single occasion.
  - five standard drinks for men on any single occasion.

<u>Advice for women who could be pregnant, are pregnant or trying to get pregnant</u>
Stop drinking alcohol.
There is no known safe level of alcohol use at any stage of pregnancy.

<u>Advice for parents of children and young people under 18 years</u>
Not drinking alcohol is the safest option for children and young people under 18 years.

Those under 15 years of age are at the greatest risk of harm from drinking alcohol, and not drinking in this age group is especially important.

For young people aged 15 to 17 years, the safest option is to delay drinking for as long as possible.
If 15 to 17-year-olds do drink alcohol, they should be supervised, drink infrequently and at levels usually below and never exceeding the lower adult daily limits.

Tips for low-risk drinking
These include:

- Know what a standard drink is
- Keep track of how much you drink – daily and weekly
- Set limits for yourself and stick to them
- Start with non-alcoholic beverages and alternate with alcoholic drinks
- Drink slowly
- Try drinks with a lower alcohol content
- Eat before or while you are drinking
- Never drink and drive
- Be a responsible host
- Talk to your kids about alcohol.

Management of Alcohol Use Disorder
In the initial psychiatric evaluation of a patient with suspected alcohol use disorder, include assessment of current and past use of tobacco, alcohol and other substances, including prescribed or over-the-counter medications or supplements.
The initial psychiatric evaluation of a patient with suspected alcohol use disorder includes a quantitative behavioural measure to detect the presence of alcohol misuse and assess its severity.
Physiological biomarkers may be used to identify persistently elevated levels of alcohol consumption as part of the initial evaluation of patients with alcohol use disorder or in the treatment of individuals who have an indication for ongoing monitoring of their alcohol use.
Patients can be assessed for co-occurring conditions (including substance use disorders, other psychiatric disorders, and other medical disorders) that may influence the selection of pharmacotherapy for alcohol use disorder.

The initial goals of treatment of alcohol use disorder (e.g., abstinence from alcohol use, reduction or moderation of alcohol use, other elements of harm reduction) be agreed on between the patient and clinician, and that this agreement be documented in the medical record. This should include discussion of risks to self (e.g., physical health, occupational functioning, legal involvement), and others (e.g., impaired driving) from continued use of Alcohol. Patients with alcohol use disorder should have a documented comprehensive and person-centred treatment plan that includes evidence-based nonpharmacological and pharmacological treatments.

Selection of a pharmacotherapy with level one evidence (naltrexone or acamprosate) should be offered to patients with moderate to severe alcohol use disorder who have a goal of reducing alcohol consumption or achieving abstinence.
Antidepressant medications cannot be used for treatment of alcohol use disorder unless there is evidence of a co-occurring disorder for which an antidepressant is an indicated treatment.
For individuals with alcohol use disorder, benzodiazepines are not be used unless treating acute alcohol withdrawal or unless a co-occurring disorder exists for which a benzodiazepine is an indicated treatment, such as a benzodiazepine use disorder.
For pregnant or breastfeeding women with alcohol use disorder, pharmacological treatments are not used unless treating acute alcohol withdrawal with benzodiazepines or unless a co-occurring disorder exists that warrants pharmacological treatment.

Alcohol Pharmacotherapy

Management of Alcohol Withdrawal

Onset of alcohol withdrawal is usually between six and 24 hours after the last drink. In some severely dependent drinkers, withdrawal can occur when the blood alcohol level is decreasing, even if the patient is still intoxicated or has consumed alcohol recently; a significant proportion of dependent drinkers experience the onset of withdrawal symptoms before the blood alcohol level reaches zero. Patient care should not be decided on based upon blood alcohol level alone. Alcohol withdrawal rating scales can be used to assess the patient's level of alcohol withdrawal symptoms.

While for most people the alcohol withdrawal syndrome is short-lived and inconsequential, in others it increases in severity through the first 48 to 72 hours of abstinence. The patient becomes highly vulnerable to psychological and physiological stress during this time. Psychological symptoms of alcohol withdrawal, including dysphoria, sleep disturbance and anxiety, often persist for several weeks after drinking cessation.

Other substance use, medical and psychiatric conditions can affect the onset, severity and duration of alcohol withdrawal. Use of benzodiazepines or other sedatives often delays the onset of withdrawal and diminishes its severity. It also provides guidance on prevention and treatment of Wernicke's encephalopathy in these patients.

Predicting the severity of alcohol withdrawal for an individual patient requires assessment of current drinking patterns, past withdrawal experience, concomitant substance use, and concomitant medical or psychiatric conditions. Given the variability of alcohol withdrawal severity, it is important to monitor all patients carefully during alcohol withdrawal, particularly those suspected of heavy alcohol use.

Benzodiazepines are anti-anxiety and sedative-hypnotic medications that enhance gamma-amino butyric acid (GABA) activity in the central nervous system. A wide variety of benzodiazepines have been used for alcohol withdrawal. In general, long-acting benzodiazepines with a rapid onset of action (particularly important in seizure prophylaxis) are most commonly recommended.

Diazepam is the benzodiazepine of choice. Diazepam is well absorbed orally, has a rapid onset of action (within one hour), and has prolonged duration of effects (up to several days), important in preventing symptom recurrence between doses. The Clinical Institute Withdrawal Assessment for Alcohol–Revised (CIWA-Ar) relating to Alcohol Withdrawal is usually used as a guide for dosing in a supervised setting, a score of 8-12 will require 5-10 mg of diazepam every 2-4 hours, and a score of 13 to 20 will require 10-20 mg every 2-4 hours. Chlordiazepoxide, a long-acting and rapid-onset benzodiazepine, is widely used internationally but is not registered in Australia.

In certain clinical circumstances, long-acting benzodiazepines such as diazepam may be problematic. Shorter acting benzodiazepines (such as midazolam, lorazepam, oxazepam) should be used where there is concern about prolonged sedation, such as in the elderly, recent head injury, liver failure, respiratory failure, other serious medical illness or in severely obese patients (due to accumulation of lipophilic diazepam and active metabolites). Short-acting benzodiazepines have a simpler hepatic metabolism (conjugation that is less affected by liver disease or aging) without active metabolites, and can be more easily discontinued in the event of clinical deterioration, such as head injury.

Benzodiazepines given at fixed dosing intervals are a common therapy for alcohol withdrawal management, and are well suited to ambulatory withdrawal, community residential and inpatient withdrawal settings. Fixed schedules are also appropriate for complex hospitalised patients, ideally with daily review by specialist drug and alcohol clinicians. Fixed schedule regimens typically involve reducing doses over a period of 3-6 days, and require regular clinical review (minimum of daily) to ensure the patient is not over or under-medicated. Fixed schedule regimens may be supplemented with additional diazepam as needed for people with low tolerance of withdrawal discomfort (for example, 5 mg six hourly as needed, based on clinical observation or alcohol withdrawal scale scores).

Thiamine and other supplements
Thiamine supplements are recommended for all people undergoing alcohol withdrawal. In patients showing no clinical features of Wernicke's encephalopathy or memory impairment, thiamine is recommended as a prophylactic measure. The dose, route and duration of thiamine administration depend on the patient's nutritional status. For example, healthy patients with good dietary intake may be administered oral thiamine 300 mg per day (100 mg three times daily for 3-5 days, and maintained on 100 mg oral thiamine for a further 4-9 days (for a total of 1-2 weeks of oral thiamine).

Intestinal absorption of oral thiamine supplements is slow and may be incomplete in patients with poor nutritional status, hence chronic drinkers with poor dietary intake and general poor nutritional state should be administered parenteral thiamine doses. The recommended dose of thiamine is 300 mg intramuscularly or intravenously per day for 3-5 days, and subsequent oral thiamine doses of 300 mg per day for several weeks. Thiamine (oral or intramuscular) should be given **before** any carbohydrate load (for example, intravenous glucose).

Deficiencies of other B-complex vitamins, vitamin C, zinc and magnesium are not uncommon, and an oral multivitamin preparation can be given to nutritionally depleted patients for several days. Thiamine supplementation should be continued indefinitely in an alcohol-dependent patient who continues to drink alcohol.

Longer Term Pharmacotherapy

Naltrexone is an opioid receptor antagonist that is thought to reduce the reward, the excitement associated with drinking alcohol and the related cues in the environment (anticipatory excitement). It is the first line treatment for alcohol use disorder, the efficacy was demonstrated in the combined study by Anton et al 2006. Naltrexone is listed on the PBS as an authority item for alcohol dependence. Naltrexone is contraindicated in individuals with liver toxicity. Patients are often started on a half tablet (25 mg) daily for the first 3–5 days to minimise adverse effects. There are no specific ill effects from alcohol consumption during treatment, and patients do not need to be advised to stop therapy if they relapse. It has a slightly larger effect size than Acamprosate, but has more adverse effects including headache, nausea, lethargy and dysphoria. These effects are usually transient and rarely lead to cessation of therapy. It is

usually not prescribed in clients with chronic pain disorder and advanced liver disease. Guidelines in the UK, France, USA and Australia recommend that naltrexone should be considered as a first-line treatment for alcohol dependence. but treatment can be started while patients are still drinking and during medically assisted withdrawal from Alcohol. Opioids should be stopped 7–10 days before hand, and naltrexone should not be used as a treatment for alcohol use disorder by individuals who use opioids or who have an anticipated need for opioids.

Acamprosate is a structural analogue of gamma aminobutyric acid (GABA). It is thought to work by affecting calcium channels, and modifying transmission along GABA and glutamine pathways in the brain. This may result in decreased positive reinforcement of alcohol intake and withdrawal cravings. There is some evidence that acamprosate confers neuroprotection. Five previous meta-analyses concluded that abstinence was significantly higher with Acamprosate in comparision to placebo. It is considered first line in Australia. The recommended dose is two 333 mg tablets, three times a day for individuals over 60 kg.
It is a very well tolerated medication. The most common adverse side effect is transient diarrhea and flatulence. It is not addictive, and has limited interaction with Alcohol or drugs commonly prescribed in people living with alcohol use disorder, such as antidepressants, anxiolytics, disulfiram, naltrexone and neuroleptics. It can be given to patients with liver dysfunction. Acamprosate should not be used by patients who have severe renal impairment. In patients with mild to moderate renal impairment, acamprosate should not be used as a first-line treatment and, if used, the dose of acamprosate be reduced compared with recommended doses in individuals with normal renal function.
Recent studies have shown that acamprosate had a significantly larger effect size than naltrexone on the maintenance of abstinence. Naltrexone had a larger effect size than acamprosate on the reduction of heavy drinking and cravings. In the treatment for alcohol use disorder, acamprosate is slightly more efficacious in promoting abstinence. Naltrexone is slightly more efficacious in reducing heavy drinking and cravings.

Disulfiram (Antabuse) interferes with the degradation of Alcohol resulting in the accumulation of acetaldehyde. Alcohol is broken down in the liver by the enzyme alcohol dehydrogenase to acetaldehyde. The enzyme acetaldehyde dehydrogenase converts acetaldehyde to the harmless acetic acid. Disulfiram blocks the enzyme acetaldehyde dehydrogenase. After alcohol intake under the influence of disulfiram, the concentration of acetaldehyde in the blood may be 5-10 times higher than that found during metabolism of the same quantity of Alcohol alone. Acetaldehyde is one of the major causes of the symptoms of 'hangover'. This produces a severe negative reaction to alcohol intake. Symptoms include flushing of the skin, accelerated heart rate, shortness of breath (Disulfiram reaction). The utility and effectiveness of disulfiram are considered limited because compliance is generally poor. It is not for emotionally unstable clients. The prescription must be done under expert guidance. Disulfiram may cause peripheral neuropathy in high doses.
Disulfiram may be offered to patients with moderate to severe alcohol use disorder who have a goal of achieving abstinence, prefer disulfiram or are intolerant to or have not responded to naltrexone and acamprosate, and are capable of understanding the risks of alcohol consumption while taking disulfiram, and have no contraindications to the use of this medication.

Topiramate is a sulfamate-substituted monosaccharide related to fructose. It is an antiepileptic with neuroprotective properties. It reduces the rewarding effects of acute alcohol use by suppressing dopamine release and normalises dopamine activity in chronic alcohol use. This reduces cravings for alcohol and withdrawal symptoms. Topiramate is a mood stabiliser. It is useful in clients with co-morbidity e.g., bipolar disorder, borderline personality disorder and post-traumatic stress disorder (most individuals living with AUD have co-morbidity). Topiramate may be viewed as a way to address multiple disorders with one drug. Topiramate can be commenced before cessation of Alcohol. Dosing requires slow titration from 25 mg daily to a maximum of 150 mg twice daily. Adverse effects are dizziness paraesthesia, psychomotor slowing, memory or concentration impairment and weight loss. A syndrome consisting of acute myopia associated with secondary angle closure glaucoma has occasionally been reported. If there are sudden vision changes, eye pain or redness, then topiramate should be ceased, and an urgent medical review arranged. Topiramate can be offered to patients with moderate to severe alcohol use disorder who have a goal of reducing alcohol consumption or achieving abstinence. Topiramate can be offered if intolerant to or have not responded to naltrexone and acamprosate, and have no contraindications to the use of these medications.

Baclofen While numerous case reports, case series, and open-label trials have been published, indicating the effectiveness of baclofen in people with AUD, a Cochrane review concluded that compared with placebo, baclofen makes little or no difference to participants who dropped out from treatment, dropped out due to adverse events or the number of participants with at least one adverse event. Baclofen probably makes little difference to the number of participants who start drinking again, nor to how much or how often they drink. Baclofen may make little or no difference in the percentage of days people remain alcohol-free. It also found that baclofen may increase the amount of use measured by number of drinks per drinking days, and that it increased adverse events like depression, vertigo, somnolence, numbness and muscle rigidity but they did not find significant differences between baclofen and placebo for other adverse events.

Methadone is a treatment for opioid dependence and must not be used for alcohol use disorder.

Formulation

Formulation is a formal requirement in the College 2012 Fellowship Program in the presentation of the Observed Clinical Activity (OCA). OCA Formulation Guidelines can be found on the RANZCP website, and registrars will have completed multiple OCAs during their training. As such, candidates are expected to be practised and well prepared to present a sophisticated formulation of the current case.

According to the RANZCP OCA guidelines, "formulation is a set of explanatory hypotheses (or speculations), which address the question:
'Why does **this patient** suffer from **this problem** at **this point** in time?'
The formulation is an integrated synthesis of the data. It should demonstrate an understanding of this unique individual, with his/her vulnerabilities and resources and how he/she comes to be in the current predicament.

The essential task in formulation is to highlight possible linkages or connections between different aspects of the case. The focus upon these inter-relationships adds something new to what has already been presented. In this sense, the formulation is more than a summary." It is synthesis.

In the biopsychosocial formulation, the candidates provides their understanding of how the predisposing, precipitating, perpetuating and protective factors interact to explain the predicament of the patient.

There is no universally accepted format or framework for presenting formulations. The candidate may consider a number of perspectives based on a hypothetic-deductive model. Reasonable hypotheses that could potentially explain the current psychiatric presentation should be offered, and such hypotheses might be tested in further enquiries in a deductive manner. The College guidelines suggest that a variety of models or frameworks may be used in preparing a formulation.

In the current scenario, candidates might choose to highlight some of the following aspects:

Biological aspects might include:

- Tayla has reported a family history of alcohol use disorder which may represent a genetic predisposition to suffering this condition.
- She has recently experienced a low mood and weight loss after her marriage break up.
- She has also developed tolerance and has had withdrawal symptoms.

Psychological, Developmental and Social aspects might include:

- Tayla's dedication to work success, and desire to prevent anyone from knowing about her alcohol use disorder put her at risk of experiencing shame, and increases her risk for depression.
- Her loss of her husband through divorce and her absence of her son have led to worsening social isolation and loss of her support network.
- The absence of her father when she was young, and the relatively early sudden death of her mother (at an age similar to her current age) are additional unresolved issues.
- The distress associated with abandonment by Lachlan for a younger woman were further worsened by legal issues, shame and financial stress.

There are some protective factors, however. Tayla has no past psychiatric illness and no other substance use history. There is no evidence of personality disorder. Her work history and professional success are other potential positive factors that might promote resilience.

The RANZCP Guidelines suggests a formulation comprising three sections.

Section I – Presentation and Context

This will usually be a brief introductory statement that places the patient's predicament in context. In this case, an example might be: '*Tayla is a 50-year-old divorced woman who works in a law firm and lives alone, who was referred by her GP for concerns regarding her alcohol use.'*

Section II – Focussed history with potential explanatory power

This section highlights the candidates' sense of emphasis and priority in presenting the most important aspects of the history. The biological, psychological and socio-cultural aspects listed above might well be presented here. One might expect to hear a detailed account of the series of interpersonal losses Tayla has suffered over the past two years, as well as the ongoing stress related to her inability to control her alcohol intake. Some attempt to identify aspects of Tayla's premorbid personality, and her past coping strategies would be usefully presented here.

Section III – Linkages using theoretical framework

Here, the College Guidelines note that 'the task in this section is to make linkages between the material of Section I and II using hypotheses derived from an acceptable model or framework. Thus, the patient's vulnerabilities are juxtaposed with current stressors (and/or environment) to provide a plausible explanatory statement'. Given the trainee's limited knowledge of the patient, the formulation will invariably be hypothetical. In other words, it would usually involve a set of 'educated guesses'. It is the plausibility of these speculations which makes the difference between a good and a poor formulation.

In the present case, one would expect the candidate at a junior consultant level to provide some theoretical framework within which to speculate on the meaning, impact and/or personal salience of the losses Tayla has suffered. Such a framework might include concepts, such as: loss sensitivity; attachment style; pathological grief; personality traits and coping mechanisms; relative lack of social support; feelings of estrangement; limited coping strategies or maladaptive defences; concepts of temperament and character; concepts from psychodynamic theories of depression or any other of a wide range of possibly relevant theories.

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:

Introduction

You are Tayla Roberts, a 50-year-old single mother, who has a 19-year-old son Maxwell, who is away in the UK studying at university. You currently work as an administrative manager of a law firm, and you have worked in this company for 15 years. In the last year, you ended a 27-year marriage to Lachlan, after you found out he was having extra-marital relationships. This was followed by an acrimonious divorce that resulted in an escalation in your alcohol use. You have been referred to a psychiatrist by your General Practitioner (GP or family doctor) to get some advice on how to cut down on your drinking.

Alcohol use history

You started drinking socially (once/twice a month) at the age of 17 years. You have been drinking regularly for a few years. Lachlan and you were in the habit of having a glass of wine with dinner every night (you prefer red to white and a nice Shiraz is your favourite), and occasionally, when you had company you would have two or three glasses of red wine.

Over the past year, you have been drinking a whole lot more wine every day. You initially started out with a few glasses of wine to help manage anxiety and to 'lift your spirits' following the divorce, but in the last month you have had more than one bottle of wine daily. You drink in the evening after work and never go to work drunk. You often have a few glasses during the day on days when you are not working. You had your last drink yesterday evening.

Your longest alcohol-free period in the past year has been five days when you had the flu around six months ago. Your trial at doing 'dry July' failed after a few days, and previous attempts at cutting down have failed. You have also experienced blackouts, where you do not remember events from the previous day after you have had too much to drink. You experience cravings which are worse in the evenings. You have had problems with work as you have called in sick (which was actually a bad hangover) a few times without a medical certificate, and you have used up all your sick leave. Your boss (whose name is Robert Brown), the senior partner at the law firm, is patient because you have been a reliable member of staff for 15 years, and he is aware of your personal circumstance, that is your separation and divorce from Lachlan.

You have never had seizures (or fits) but have experienced symptoms of alcohol withdrawal, such as shaky hands, nausea, retching or vomiting, and anxiety. In recent times, you manage these withdrawal symptoms by having a drink at lunch time. You do not need alcohol first thing in the morning (called an eye opener). You do feel guilty about the amount of alcohol you drink. No one is aware of how much you drink, and so you have never been criticised for drinking too much.

You have not had a fall or hurt your head, and have not had periods of confusion or experienced odd things like seeing or hearing things that other do not.

You would like to be able to have an occasional drink and so your intention is not to stop alcohol use, but to start a medication that will reduce your desire to drink.

If the candidate asks you about gambling, you say you only play the lotto when there is a big prize. You do not go to casinos or play the pokies. If the candidate should ask about tobacco and other drugs, you deny the use of these substances ever. You only use the internet when you have to, and do not play games online. You can express shock and disgust if you are asked about viewing pornography on the internet.

Other psychiatric history

You don't think you are depressed but your mood has been average and anxious, your energy and motivation are reduced. Your sleep has been broken and you do not wake up refreshed. You love to read books and enjoyed watching TV, but you are struggling to complete any book at present or watch the telly as you spend most of your free time with a bottle of wine. You have had no suicidal ideation and have never tried to harm yourself. Your appetite has been affected by the increased alcohol intake, and you eat less and have lately been nauseous. You are unsure if you have lost or gained any weight. Your memory and concentration have not been the best. You have no unusual or psychotic experiences, such as hearing voices or seeing strange things that other people do not. You have no strange thoughts or beliefs.

You have no current legal problems, but you have driven whilst intoxicated once. You consider this a new low and are quite ashamed to talk about this.

Medical history

What prompted your visit to your general practitioner is repeated vomiting and reflux for a few weeks. You often feel nauseous, but have never vomited blood or passed blood in your stool. Your blood results showed that you had raised liver function test, and ultrasound of your liver revealed fatty liver. She has sent you for upper gastrointestinal endoscopy and a diagnosis of gastric reflux was made, and you have recently started omeprazole 20 mg daily.

You are also scheduled to have a dental appointment for dental infection, and you are on Panadeine Extra (500 mg of paracetamol and 15 mg of codeine per tablet) – two tablets three times a day in the last week. Otherwise, you are in good health.

You have no allergies to any medication.

Personal history

If asked about your early life, you come from a loving family. Your parents separated just before you were born. Your biological father had a drinking problem, and your mother had repeatedly told him to stop. She finally said that she would leave if he did not quit and acted on this. You have never had any contact with him, and Mum told you that he left the city where they were living, and moved to Singapore where he had family. He died when you were seven years old from alcohol related liver disease. Mum described him as 'a good man with one big flaw'. She never spoke of him being abusive, and was sad that he did not attempt to make contact with you and your sister after he left. Mum worked hard to bring you and your sister up, and did not have any other relationships that you were aware of. She died in a car accident while you were in university (she was 50 then, the same age you are now), and you feel sad that you did not get a chance to care for her as she grew older. If asked, you did not miss having a father – you were a happy, busy girl.

You have an older sister, Sarah, who lives in New York, but you have a good relationship with her. There is no history of trauma or abuse in your earlier life. You did well at school and did an arts degree at university. You have a few uncles and aunts on Mum's side whom you saw regularly when you were young, but everyone is getting older now.

There is no other history of alcohol or drug problems in your family and as far as you know, no one had major problems with their mental health. You have always been able to make and keep friends, but have not stayed in contact much over the past months.

Lachlan was your childhood sweetheart, and you thought you were happily married. You had been together for 31 years and married for 25 of these years. You do not want to discuss the details of his infidelity or your breakup, except that it was very painful to you. Lachlan is an Engineer and has been very hostile, he has refused relationship counselling, mediation and has forced you to hire a lawyer and forensic accountant (he had transferred your assets to himself), because he has chosen not to have an amicable separation. You do not know 'the little minx' whom he has moved in with.

Your son, Maxwell, is 19 years old – loving, good looking and the perfect son. He got a scholarship to study Literature at Oxford when he was 17, and so was not around when all the troubles with Lachlan erupted. You have not seen him for over a year and miss him dreadfully, but are glad that he is not being exposed to the problems in your marriage and your drinking problem. He does not know details of your current issues – you would rather him not be involved.

There is no history of you having behavioural problems or getting into trouble with police or driving offences as noted previously. You have never been charged with driving under the influence of alcohol. You have supportive friends and family members.

If asked about your job, it is a highly stressful job, but you enjoy it and you feel it is what has given you some structure in the last year.

4.2 How to play the role:

Corporately dressed, sophisticated and well spoken. You are initially a little reluctant to talk about your alcohol use and ashamed to admit that you have driven under the influence of alcohol, but you don't have any charges.

During the discussion you accept that you have an alcohol use disorder, and that is the only issue you have. You are keen to hear about the pharmacological management of Alcohol Use Disorder.

Let the candidate know you are not depressed. You are keen to hear about a medication you heard on a TV morning show that could be a miracle cure for alcohol use disorder (you do not remember its name).

4.3 Opening statement:

'Thanks for seeing me, my doctor believes you have some medicines that may help me.'

4.4 What to expect from the candidate:

The candidate is likely to start by introducing themselves, and asking about why you have come to see them. You will discuss about your doctor's concern about your alcohol use. You will answer the questions asked of you freely, but will not elaborate too much. You will accept the candidate's diagnosis without question and emphasise your desire to continue drinking, but at a reduced level and your keenness to hear about medications that reduce your desire to drink alcohol. You are very clear that you do not want to have any psychological treatment, and do not want to go to Alcoholics Anonymous or any other groups. You will listen to the treatment options outlined without interrupting except to clarify anything you do not understand. You will ask the candidate if you can start any of these medications straight way. At the conclusion, you will thank the candidate, and will ask to be given some time to think about it.

4.5 Responses you MUST make:
'I have a bad toothache and I am taking Panadeine Extra.'

'I would prefer to not stop drinking alcohol, just reduce how much I drink. Is there a safe amount for me?'

When the candidate advises you of the diagnosis of Alcohol Use Disorder:

'Are you saying I am an alcoholic?'

'What medications help with treating this condition?'

'I do not want to go to a psychologist or do any therapy.'

4.6 Responses you MIGHT make:
If asked: Your mood is average but anxious in the morning, your appetite, concentration, memory, energy levels and motivation have reduced since you increased your alcohol intake. You have never had periods of having an elevated mood or feeling high. You never lost touch with reality.

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

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

Your preferred goal is controlled drinking, and you would like to know what the acceptable levels of daily alcohol intake are.

4.7 Medication and dosage that you need to remember:

Omeprazole 20 mg daily for Gastroesophageal reflux disease (recent diagnosis and your GP believes its linked to your alcohol use).

Panadeine Extra (500 mg of paracetamol and 15 mg of codeine per tablet). Recommended dosage is two tablets every eight hours. **You have never exceeded six tablets in 24 hours, and you don't take it every day**.

Your dental appointment is next week.

STATION 3 – MARKING DOMAINS

The main assessment aims are to:

- Evaluate the candidate's ability to take a focussed drug and alcohol history, and establish Alcohol Use Disorder based on the findings.
- Evaluate the candidate's ability to outline management options for alcohol use disorder with particular focus on alcohol pharmacotherapy.
- Present a formulation that links her earlier life with her current presentation.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.1 Did the candidate take an appropriately detailed and focussed history from the patient? (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; excludes other use disorders, such as gambling; elicits the severity of the condition from the history taken (six or more criteria listed in DSM 5).

Achieves the Standard (scores 3 or 4) by:
Demonstrating use of a tailored biopsychosocial approach; conducting a detailed but targeted assessment; obtaining a history relevant to the patient's substance use with appropriate depth and breadth; taking hypothesis-driven history; clarifying important positive and negative features; enquiring about other substances of abuse including alcohol, prescription medication and illicit drugs; eliciting enough criteria to clearly establish a diagnosis of Alcohol use disorder/dependence and explore the personal life of the patient.

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:
the candidate has omissions that would detract from the overall quality response.

Below the Standard (scores 1) if:
omissions adversely impact on the obtained content; significant deficiencies, such as substantial omissions in history including a failure to enquire about other substance misuse.

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

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

2.0 COMMUNICATOR

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

Surpasses the Standard (scores 5) if:

communicates findings in a sophisticated manner; explains the criteria used to assess the severity of the alcohol use disorder.

Achieves the Standard (scores 3 or 4) by:

correctly communicating findings of alcohol use disorder in suitable language, with appropriate detail and sensitivity; reflecting on the patient's recent medical complications associated with her use; communicating in a non-judgemental manner.

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

Below the Standard (scores 2) if:

the candidate has omissions that would detract from the overall quality response.

Below the Standard (scores 1) if:

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

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

2.4. Category: COMMUNICATION – Findings	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Domain Not Addressed**
Cross (X) in ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

1.9 Did candidate describe the relevant differential diagnosis? (Proportionate value - 10%)

Surpasses the Standard (scores 5) if:

provides a superior performance in a number of areas; demonstrates prioritisation and sophistication.

Achieves the Standard (scores 3 or 4) by:

demonstrating capacity to integrate available information in order to formulate a differential diagnosis; demonstrating detailed understanding of diagnostic systems to provide justification for differential diagnosis; adequate prioritising of conditions relevant to the obtained history and findings; communicating in appropriate language and detail; considering an alcohol related mood disorder; emphasising the role of non-substance use psychiatry diagnosis as an independent process, e.g., a mood disorder or an adjustment disorder with depressed mood or unresolved grief.

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:

the candidate has omissions that would detract from the overall quality response.

Below the Standard (scores 1) if:

there are significant omissions affecting quality; inaccurate or inadequate diagnoses; errors or omissions are significant and do materially adversely affect conclusions.

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

1.9. Category: DIAGNOSIS	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Domain Not Addressed**
Cross (X) in ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

3.0 COLLABORATOR

3.5 Did the candidate demonstrate an appropriate knowledge about the importance of collaboration when working with a patient with substance use disorder? (Proportionate value - 10%)

Surpasses the Standard (scores 5) if:
recognises complexity of working with a client whose goal is to continue drinking despite obvious medical problems; develops and uses a therapeutic alliance to engage the client in treatment; uses supportive and empathic counselling; succinctly covers generally accepted relapse prevention strategies with the goal of controlled drinking, such as drink diary, setting daily/weekly limits, craving management plan and regular follow up; manages countertransference whilst maintaining a recovery perspective.

Achieves the Standard (scores 3 or 4) by:
recognising the importance of developing a positive therapeutic alliance; suggesting abstinence is the best option; accepting the patient's reluctance to stop alcohol completely; demonstrateing an understanding and acceptance of the client; communicating to the client that they will be helping her to help herself; expressing empathy and a willingness to listen to the client's formulation of the problem and what she believes is the solution; listening to differing views during the session without judgement; identifying appropriate techniques to enhance engagement; fosters hope for positive change; discussing the NHMRC guidelines for drinking in Australia or the New Zealand Health Promotion Agency low-risk alcohol drinking advice.

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:
the candidate has omissions that would detract from the overall quality response.

Below the Standard (scores 1) if:
there are significant omissions affecting quality; errors or omissions adversely impact on collaborative relationships; insists on the client accepting a non-pharmacological method of treatment as first line.

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

3.5. Category: EXTERNAL RELATIONSHIPS	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Domain Not Addressed**
Cross (X) in ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

1.11 Did the candidate develop and describe a relevant initial management plan? (Proportionate value - 10%)

Surpasses the Standard (scores 5) if:
utilises a model of communication that fits in with her stage of change; clearly addresses difficulties in the application of the plan.

Achieves the Standard (scores 3 or 4) by:
explaining alternate methods to cut down on alcohol and offering channels of ongoing support for this, including support from friends and the GP; discussing detoxification with and without medication aids or gradual reduction by keeping a drink diary; discussing basic relapse prevention strategies, such as keeping a drink diary and craving management strategies (e.g., distraction techniques); demonstrating the ability to prioritise and implement evidence-based acute care) skills; planning for risk management; selecting treatment environment; recommending medication and other specific treatments in accordance with evidence and guidelines; record keeping and communicating to necessary others; recognising their role in effective treatment; identifying potential barriers.

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:
the candidate has omissions that would detract from the overall quality response.

Below the Standard (scores 1) if:
there are significant omissions affecting quality; omissions will impact adversely on patient care; plan lacks structure or is inaccurate; plan not tailored to patient's immediate needs or circumstances.

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

1.11. Category: MANAGEMENT – Initial Plan	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Domain Not Addressed**
Cross (X) in ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

1.12 Did the candidate discuss options for longer term Alcohol Pharmacotherapy in detail? (Proportionate value - 15 %)

Surpasses the Standard (scores 5) if:
overall plan is sophisticated, tailored yet comprehensive; incorporates a sophisticated approach to describing the role of medication in treatment; succinctly covers generally accepted pharmacotherapy options, side effects and how to commence these medications safely; recognises the danger posed by starting Naltrexone whilst she is on an opioid agonist, and the risk of precipitated withdrawal on Panadeine Extra; provides the pros and cons of the different treatment options to the patient.

Achieves the Standard (scores 3or 4) by:
demonstrating the ability to prioritise and implement evidence-based care; discussing both level one evidence-based pharmacotherapy treatment (Naltrexone and Acamprosate); giving priority to continuity of care; demonstrating awareness of possible complications of treatment and available interventions/monitoring; acknowledging appropriately realistic possibility of treatment failure and the need for follow up; demonstrating awareness that medications can be used only if she remains abstinent.

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:
the candidate has omissions that would detract from the overall quality response.

Below the Standard (scores 1) if:
errors or omissions adversely affect outcomes; candidate has difficulty with most of the skills above.

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

1.12. Category: MANAGEMENT – Long-term, Preventative	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Domain Not Addressed**
Cross (X) in ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

1.8 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 (scores 3or 4) by:
identifying and succinctly summarising important aspects of the history, observation and examination; synthesising information using a biopsychosocial framework; integrating medical, developmental, psychological and sociological 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; including a sociocultural formulation; analysing vulnerability and resilience factors; being able to link the early life difficulties and her minimisation of the likely significance of the absence of a father figure, the similarities between her life events and those of her mother.

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:
the candidate has omissions that would detract from the overall quality response.

Below the Standard (scores 1) if:
there are significant omissions affecting quality; significant deficiencies including inability to synthesise information obtained; fails to question veracity where this is important; provides an inadequate formulation or diagnostic statement.

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

1.8. Category: FORMULATION	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Domain Not Addressed**
Cross (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?

Cross (X) in ONE BOX ONLY	Clearly Proficient ☐	Marginal Performance ☐	Not Proficient ☐