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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)

**References:**

- APA Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. American Psychiatric Association. Arlington, VA, APA 2013.
- Cooper J, Mancuso SG, Borland R, Slade T, Galletly C, Castle D. Tobacco smoking among people living with a psychotic illness: the second Australian Survey of Psychosis. *Aust N Z J Psychiatry* 2012 Sep;46(9):851–63.
- Evidence review of e-cigarettes and heated tobacco products 2018. Public Health England. March 2018.
- Fiore MC, Jaén CR, Baker TB, Bailey WC, et al. for the Guideline Panel. Treating tobacco use and dependence: 2008 update. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service, May 2008.
- Fraser T, Glover M, Truman P. Government and public health responses to e-cigarettes in New Zealand: vapers' perspectives. *Harm Reduct J.* 2018; 15: 13.
- Gideon St. Helen, GS; Eaton, DL. Public Health Consequences of e-Cigarette Use. *JAMA Intern Med.* 2018;178(7):984-986. doi:10.1001/jamainternmed.2018.1600.
- Hajek P, Phillips-Waller A, Przulj D, et al. A randomised trial of E-cigarettes versus nicotine-replacement therapy. *NEJM* 2019 Feb 14;380(7):629-637. DOI:10.1056/NEJMoa1808779
- Mendlesohn CP, Kirby DP, Castle DJ. Smoking and Mental Illness. An Update for Psychiatrists. *Australasian Psychiatry* 2015, 23(1) 37-43.
- Ministry of Health; The New Zealand Guidelines for Helping People to Stop Smoking. Ministry of Health, New Zealand. June 2014.
- NHMRC CEO Statement: Electronic Cigarettes (E-Cigarettes) 2017. <https://nhmrc.gov.au/health-advice/all-topics/electronic-cigarettes>

- Quitnow.gov.au.
- Rustin TA. Assessing Nicotine Dependence. Am Fam Physician. 2000 Aug 1;62(3):579-58.
- Shearer J, Shanahan M. Cost effectiveness analysis of smoking cessation interventions. Aust NZ J Public Health 2006;30:428–34.
- Supporting smoking cessation: a guide for health professionals (Smoking cessation guidelines for Australian general practice) The Royal Australian College of General Practitioners Victoria. July 2014. <racgp.org.au>.
- World Health Organization. The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines (Vol. 1). World Health Organization. 1992.
- Zwar N, Richmond R, Borland R et al. Supporting Smoking Cessation: A Guide for Health Professionals. Royal Australian College of General Practitioners, 2014.

#### 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 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:

***'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
<b>A problematic pattern of tobacco use leading to clinically significant impairment or distress. Endorsement of at least two criteria in the past 12-months:</b>	<b>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:</b>
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  $\alpha 4\beta 2$  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  $\alpha 4\beta 2$  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](http://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 medication 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
<ul style="list-style-type: none"><li>Your knowledge about how to quit.</li></ul>	As you have had previous attempts you think your understanding is okay.
<ul style="list-style-type: none"><li>Enjoyment of nicotine or smoking behaviour.</li></ul>	You are really going to miss smoking – especially for the social reasons described above and how it makes you feel.
<ul style="list-style-type: none"><li>Fear of weight gain.</li></ul>	You are worried about more weight gain as the schizophrenia medication (see below) has made you put on weight.
<ul style="list-style-type: none"><li>Fear that quit attempt will be unsuccessful.</li></ul>	You hope this time will be better – but still doubt yourself about quitting long term.
<ul style="list-style-type: none"><li>Living with other smokers.</li></ul>	Neither of your parents smoke – they would be so happy if you managed to quit for good. Work will be harder.
<ul style="list-style-type: none"><li>Circumstances that result in you giving quitting a low priority, such as poverty and social isolation.</li></ul>	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:**

- 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 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>	

#### 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 exercise.

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

- 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 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>	

**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 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>	

### GLOBAL PROFICIENCY RATING

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

<b>Circle One Grade to Score</b>	<b>Definite Pass</b>	<b>Marginal Performance</b>	<b>Definite Fail</b>
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