

## 1.0 Descriptive summary of station:

This station is about a 20-year-old Sri Lankan female who has been accepted as a refugee and who has been referred by her GP for confirmation of a diagnosis of depression. The candidate must identify that she also has undiagnosed post-traumatic stress disorder (PTSD) as a comorbid diagnosis.

## 1.1 The main assessment aims are:

- To perform a brief diagnostic assessment (history and MSE) focussed on confirming a diagnosis of major depression, assessing its severity, and identifying an additional diagnosis of PTSD.
- To explain the findings to the patient in a culturally sensitive and individually tailored manner.

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

- Elicit enough symptoms to justify a diagnosis major depressive disorder *and* make the diagnosis.
- Identify witnessing the attempted hanging as the primary stressor for the PTSD.
- Identify enough symptoms to justify a diagnosis of PTSD *and* make the diagnosis.
- Describe the diagnosis of depression and PTSD having elicited and taken into account the patient's cultural explanatory models

## 1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category of:**  
Mood disorders
- **Area of Practice:**  
Adult Psychiatry
- **CanMEDS Domains of:**  
Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes of:**  
Medical Expert (Assessment, Diagnosis), Communicator (Cultural Diversity)

### **References:**

- Principles on the provision of mental health services to asylum seekers and refugees (RANZCP position statement 46, February 2012, under review) [PDF; 107 KB]
- Refugee and Asylum Seeker Health (position statement, May 2015, Royal Australasian College of Physicians)
- American Psychiatric Association (APA) (2004) *Psychiatric evaluation of adults*, second edition.
- Filges, T., Montgomery, E., Kastrup, M., Jorgensen, AK. *The impact of detention on the health of asylum seekers: A systematic review*. 2015:13

## 1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiners x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player – woman of Indian sub-continent origin aged in early 20s. Casually attired.
- Pen for candidate.
- Timer and batteries for examiner.

## 2.0 Instructions to Candidate

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

You are working as a junior consultant in a community mental health centre and about to see a referral from a General Practitioner (GP).

*Dear Colleague,*

*Thank you for seeing Shalini Vijaykumar.*

*Shalini is single 20-year-old woman who lives alone. She is on unemployment benefits and is looking for work. She came to see me a few days ago with sleep problems. I think she is suffering from depression.*

*She is a Sri Lankan Tamil. She was in a refugee camp in Malaysia after fleeing her home at age 18 after her parents were killed in a bombing. She was accepted as part of the refugee intake for re-settlement 6 months ago.*

- *There is no relevant past psychiatric or medical history.*
- *She is not on regular medications and has no allergies.*
- *She denied a drug or alcohol history.*
- *There is no relevant family psychiatric history.*

*She was an only child to loving parents; did well at school, could make and keep friends and didn't admit to any history of behavioural issues.*

*Thank you for your diagnostic opinion.*

*Dr Jeff Blogs*

Your tasks are to:

- Collect a focussed history from the patient.
- Explain your findings to the patient.

**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:
  - Duplicate copy of 'Instructions to Candidate'.
  - Any other candidate material specific to the station e.g. investigation results.
  - Pens.
  - Water and tissues are available for candidate use.
- Do a final rehearsal with your simulated patient.

### During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- TAKE NOTE - there is no cue / time for any scripted prompt.
- DO NOT redirect or prompt the candidate – the simulated patient has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:  
*“Your information is in front of you – you are to do the best you can”.*
- At **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

### At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your mark sheet in an envelope by / under the door for collection (**do not seal envelope**).
- Ensure room is set up again for next candidate. (See 'Prior to examination' above.)

### If a candidate elects to finish early:

- 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.

There is no scripted introduction or specific prompts for the examiner.

The role player opens with the following statement:

***“I am sorry for bothering you, doctor.”***

#### 3.2 Background information for examiners

In this station the candidate is expected to collect a history and incorporate their observations of the patient’s presentation at the time of the interview that allows identification of symptoms that meet criteria to make diagnosis of major depressive disorder and post-traumatic stress disorder (PTSD). Both diagnoses should be given to the patient and the approach is crucial and needs to take into account the cultural sensitivities of the patient.

The diagnosis of major depressive disorder and post-traumatic stress disorder should be made according to recognised diagnostic criteria but explained in a manner that is understandable to a patient for whom English is a second language. The candidate needs to demonstrate some degree of awareness of the Australian and / or New Zealand approach to asylum and refugees.

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

- Elicit enough symptoms to diagnose major depressive disorder *and* make the diagnosis.
- Identify witnessing the attempted hanging as the primary stressor for the PTSD.
- Identify enough symptoms to justify a diagnosis of post-traumatic stress *and* make the diagnosis.
- Describe the diagnoses of depression and PTSD having elicited and taken into account the patient’s cultural explanatory models.

A surpassing candidate may take a history that enables them to identify ALL symptoms of PTSD and major depressive disorder. Better candidates are likely to assess severity and absence of psychotic symptoms in the context of depression. Better candidates may assess for the following DSM-5 specifiers for PTSD “- with dissociative symptoms” or “- with delayed expression”. The explanation of the diagnosis is detailed and explains how depression and PTSD impact upon each other (both need to be effectively treated).

Diagnostic aspects of the station - the candidates can utilise either of the major diagnostic classificatory systems to come to the diagnoses.

Major Depressive Disorder DSM-5	Major Depressive Disorder ICD-10
<p>Symptoms present for 2 weeks and are a change from usual functioning, must include either low mood OR loss of interest or pleasure.</p> <p>Must include 5 or more of the following:</p> <ul style="list-style-type: none"> <li>• Depressed mood for most of the day, either reported subjectively or observed by others.</li> <li>• Loss of pleasure or interest in all or most activities for most of the day.</li> <li>• Significant weight loss or weight gain not related to dieting or increased or decreased appetite.</li> <li>• Insomnia or hypersomnia most days.</li> <li>• Psychomotor retardation or agitation.</li> <li>• Fatigue and / or loss of energy.</li> <li>• Feelings of worthlessness and / or guilt.</li> <li>• Difficulty concentrating and / or difficulty making decisions.</li> <li>• Suicidal ideation or attempts.</li> </ul>	<ul style="list-style-type: none"> <li>• Depressive episode should last at least 2 weeks.</li> <li>• Never experienced hypomania or mania.</li> <li>• Not attributable to substance use or organic mental disorder.</li> </ul> <p>Somatic Syndrome include 4 of the following:</p> <ul style="list-style-type: none"> <li>• Loss of interests or pleasure.</li> <li>• Lack of emotional reactions.</li> <li>• Early morning waking <math>\pm</math> 2hours.</li> <li>• Worse depression in the morning.</li> <li>• Psychomotor retardation.</li> <li>• Poor or increased appetite.</li> <li>• Marked weight loss.</li> <li>• Marked loss of libido.</li> </ul> <p>Should last at least 2 weeks, most days, most of the time:</p> <ul style="list-style-type: none"> <li>• Depressed mood.</li> <li>• Loss of pleasure.</li> </ul>

<ul style="list-style-type: none"> <li>• Symptoms cause significant impairment in functioning.</li> <li>• Symptoms are not caused by a substance or a medical condition.</li> <li>• Symptoms are not better explained by another diagnosis.</li> </ul>	<ul style="list-style-type: none"> <li>• Fatigue or low energy.</li> <li>• Poor concentration or indecisiveness.</li> <li>• Low self-esteem or confidence.</li> <li>• Suicidal thoughts or acts.</li> <li>• Guilt or self-blame or reproach.</li> <li>• Changes in sleep and appetite.</li> <li>• Psychomotor changes.</li> </ul> <p>The symptoms then define the degree of depression:</p> <ul style="list-style-type: none"> <li>• <b>Not depressed</b> (fewer than four symptoms).</li> <li>• <b>Mild depression</b> (four symptoms).</li> <li>• <b>Moderate depression</b> (five to six symptoms).</li> <li>• <b>Severe depression</b> (seven or more symptoms, with or without psychotic symptoms).</li> <li>• With or without Somatic Syndrome.</li> </ul>
<b>PTSD DSM-5</b>	<b>PTSD ICD-10</b>
<p>Post-traumatic stress disorder is:</p> <p>A. Exposure to actual or threatened death, serious injury or sexual violence in one or more of the following ways. Directly experiencing the event, witnessing the event that had occurred to someone else, learning the event had occurred to a family member or a close friend, experiencing repeated or extreme exposure to aversive details of the traumatic event.</p> <p>B. Presence of one or more of the following:</p> <ol style="list-style-type: none"> <li>1. Recurrent, involuntary and intrusive distressing memories of the traumatic event.</li> <li>2. Recurrent distressing dreams in which the content and / or affect of the dream are related to the traumatic event.</li> <li>3. Dissociative reactions e.g. flashbacks.</li> <li>4. Intense or prolonged psychological distress at exposure to internal or external cues of the trauma.</li> <li>5. Marked physiological reactions to internal or external cues of the trauma.</li> </ol> <p>C. Persistent avoidance of stimuli associated with the traumatic event:</p> <ol style="list-style-type: none"> <li>1. Avoidance of or efforts to avoid distressing memories, thoughts, feelings about or that closely associated with the traumatic event.</li> <li>2. Avoidance of or attempts to avoid external reminders that arouse distressing memories, thoughts or feelings about or closely associated with the traumatic event.</li> </ol> <p>D. Negative alterations in cognitions and mood associated with the traumatic event. 2 or more of the following:</p> <ol style="list-style-type: none"> <li>1. Inability to remember an important aspect of the traumatic event.</li> <li>2. Persistent and exaggerated negative beliefs or expectations about oneself, others or the world.</li> <li>3. Persistent, distorted cognitions about the cause or consequence of the traumatic event that leads to the individual blaming themselves or others.</li> <li>4. Persistent negative emotional states.</li> <li>5. Marked diminished interest or participation in significant activities.</li> <li>6. Feelings of detachment or estrangement from others.</li> <li>7. Persistent inability to experience positive emotions.</li> </ol>	<p>Stressor criterion:</p> <p>A. Exposure to a stressful event or situation of exceptionally threatening or catastrophic nature, and likely to cause pervasive distress in almost anyone.</p> <p>B. Persistent remembering or 'reliving' the stressor (Repetitive intrusive recollection or re-enactment of the event in memories, daytime imagery, or dreams).</p> <p>C. Actual or preferred avoidance of circumstances resembling or associated with the stressor.</p> <p>Symptom criterion:</p> <p>D. Either:</p> <ul style="list-style-type: none"> <li>• Inability to recall, either partially or completely, some of the period of exposure to the stressor.</li> <li>• Persistent symptoms of increased psychological sensitivity and arousal to the stressor shown by any 2 of the following: <ul style="list-style-type: none"> <li>○ Difficulty falling or staying asleep.</li> <li>○ Irritability or outbursts of anger.</li> <li>○ Difficulty concentrating.</li> <li>○ Hyper-vigilance.</li> <li>○ Exaggerated startle response.</li> </ul> </li> </ul> <p>Other typical symptoms:</p> <p>Sense of 'numbness' and emotional blunting, detachment from others, unresponsiveness to surroundings, anhedonia.</p>

<p>E. Marked alterations in arousal and reactivity associated with the traumatic event. 2 or more of the following:</p> <ol style="list-style-type: none"> <li>1. Irritable behaviour and angry outbursts.</li> <li>2. Reckless or self-destructive behaviour.</li> <li>3. Hypervigilance.</li> <li>4. Exaggerated startle response.</li> <li>5. Problems with concentration.</li> <li>6. Sleep disturbance.</li> </ol> <p>F. Duration of disturbance is more than a month:</p> <ol style="list-style-type: none"> <li>1. Symptoms cause significant impairment in functioning.</li> <li>2. Symptoms are not caused by a substance or a medical condition.</li> <li>3. Symptoms are not better explained by another diagnosis.</li> <li>4. Specifiers for PTSD: <ul style="list-style-type: none"> <li>o With dissociative symptoms.</li> <li>o With delayed expression.</li> </ul> </li> </ol>	
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### Cultural aspects of the station

The candidate should ask the patient for a description of their symptoms and aim to elicit whether there is a cultural 'meaning / perception' of this illness as well as their own explanation of the cause of the mental health problem.

Cultural assessment should take into account any distress associated with any differences in cultural morals or values. The candidate should consider whether the patient is using any traditional health practices or trying to find traditional health providers. Cultural explanation of the illness; the meaning and severity of her symptoms and consideration of cross-cultural concerns should be demonstrated during the second task.

The candidate is unlikely to have time to undertake all aspects of a comprehensive cultural assessment which would include details like when the patient left Sri Lanka, actual reasons for leaving, how much time she spent in Malaysia as a refugee, whether she left other family members behind and whether there are any plans of reunification. However, they should seek to gain some cultural context to the presentation.

Security of her residency status may impact on her wellbeing. Working out what she is seeking in Australia and how involved she has managed to become with the Australian culture may assist in assessment, including how changes in activities, diet, socialisation with other cultures, and use of English are affecting her mood.

A surpassing candidate will also take into account the impact of culture and of trauma in a manner that reflects the College stance (see below) and recognises the United Nations' Universal Declaration of Human Rights 1948. The Universal Declaration of Human Rights (UDHR) is a milestone document that was drafted by representatives with different legal and cultural backgrounds from all regions of the world. It was proclaimed by the United Nations General Assembly in Paris on 10 December 1948 (General Assembly resolution 217 A) as a common standard of achievements for all people and nations and the foundation of freedom, justice and world peace.

The Charter reaffirmed humanity's faith in fundamental human rights, in the inherent dignity and worth of the human person and in the equal rights of men and women and was determined to promote social progress, the equal and inalienable rights of all people to better standards of life. Of the 30 *Articles* that make up the Declaration there are many that can be applied to this scenario, e.g.:

*Article 2:* Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

*Article 3:* Everyone has the right to life, liberty and security of person.

*Article 5:* No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

*Article 6:* Everyone has the right to recognition everywhere as a person before the law.

*Article 9:* No one shall be subjected to arbitrary arrest, detention or exile.

*Article 13:* (1) Everyone has the right to freedom of movement and residence within the borders of each state.

(2) Everyone has the right to leave any country, including his own, and to return to his country.

*Article 14:* (1) Everyone has the right to seek and to enjoy in other countries asylum from persecution.

(2) This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations.

There is some evidence to suggest an independent adverse effect of detention on the mental health of asylum seekers. According to a recent systematic review, the studies used in the data synthesis reported adverse effects on the detained asylum seekers' mental health, measured as PTSD, depression and anxiety.

Current evidence suggests an independent deterioration of mental health due to detention of a group of people who are already highly traumatised. Prior experiences of torture or other forms of persecution in the country of origin, and the stresses created by the length and conditions of detention increase the risk of mental distress. The stress caused by an uncertain future and being unable to make future plans and can lead to people feeling stressed and powerless. Adverse effects on the mental health were found even after people were released from detention, which implies that the adverse mental health effect of detention may be prolonged, extending well beyond the point of release into the community.

The Australian government defines an asylum seeker as someone who is seeking international protection but whose claim for refugee status has not yet been determined. The Australian Human Rights Commission defines an asylum seeker as a person who has fled their own country and applies to the government of another country for protection as a refugee.

The 1951 Refugee Convention and its 1967 Protocol are the only global legal instruments explicitly covering the most important aspects of a refugee's life. A refugee is someone who has been recognised under the Convention to be a refugee. The Convention defines a 'refugee' as any person who:

*...owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it ..".* [UNHCR, Convention relating to the status of refugees, UNHCR, Geneva, 2007, p. 16, accessed 2 December 2014].

A person may no longer be a refugee when the basis for his or her refugee status ceases to exist, e.g. when refugees voluntarily repatriate to their home countries once the situation their permits such return, or when refugees integrate or become naturalised in their host countries and stay permanently.

As with many other countries Malaysia is not a signatory to the Convention and there is little positive information related to conditions for refugees in Malaysia. There are no legal or administrative frameworks to address the refugee situation which makes their status unpredictable and difficult. There are no refugee camps in Malaysia; alternatively refugees live in cities and towns in low cost housing / flats side by side with local Malaysians. It is not uncommon to have four or five families or large numbers of individuals all living together in one low cost apartment. By law they are not distinguished from undocumented migrants so face arrest, detention and deportation for immigration offences. Refugees in Malaysia also have no access to legal employment for formal education. Refugees can access health care, like other Malaysians, however, access to clinics, medical care costs and language are all barriers.

According to the United Nations Refugee Agency, Malaysia 30% of refugees and asylum seekers in Malaysia are women and while both men and women face similar kinds of harm, women tend to get subjected to specific forms of abuse and violence like rape, harassment and offers of assistance in exchange for sex. Refugees also face difficulties with language.

When refugees and asylum seekers come to Australia they may be eligible for a range of supports. Specific supports and resources are provided to refugees and asylum seekers in the community. In Australia refugees receive short-term assistance from the Department of Social Services under the Humanitarian Settlement Services program, which aims to help them settle effectively once they have received permanent residency. Funding is provided to assist asylum seekers living in the community through the Asylum Seekers Assistance Scheme and Community Assistance Support Program. This assistance is provided through NGOs such as the Australian Red Cross.

In Australia, according to the RANZCP Position Statement 46: The provision of mental health services to asylum seekers and refugees; "Australia is the only country to detain asylum seekers in jail-like conditions

for months, some times more than a year at a time, while necessary background and security checks are completed. In contrast, New Zealand places all asylum seekers at a refugee resettlement centre in Mangere, South Auckland, where they undertake a six week orientation program to assist their assimilation into society. If granted refugee status they are released into the community and have access to financial assistance from the Government”.

The RANZCP also acknowledges that migrants from cultural backgrounds where isolation is heightened by the absence of fellow countrymen / women are at greater risk of mental and emotional problems and that for asylum seekers and refugees, facing uncertain futures, as well as social and professional isolation, this risk is particularly amplified. Appropriate treatment requires an understanding of an individual's cultural background and experiences, for example, the meaning one gives to violence and trauma can vary depending on culture.

Whilst the situation in New Zealand is more humane, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) has ongoing concerns about the mental health of asylum seekers and refugees in both countries.

Other useful resources include:

- Australian Centre for Posttraumatic Mental Health (ACPMH) (2013) *Australian guidelines for the treatment of adults with acute stress disorder and posttraumatic stress disorder.*
- Department of Veterans Affairs and Department of Defence (2010) *VA/DoD clinical practice guideline for management of post-traumatic stress.*
- International Society for Traumatic Stress Studies (ISTSS) (2010) *Effective treatments for PTSD*, 2nd edition.
- National Institute for Clinical Excellence (NICE) (2005) *The management of PTSD in adults and children in primary and secondary care.*
- International Society for Traumatic Stress Studies (ISTSS) (2012) *The ISTSS expert consensus treatment guidelines for complex PTSD in adults.*
- Swinson RP, Anthony MM, Bleau P, et al. for the Canadian Psychiatric Association (2006) Chapter 8: Posttraumatic stress disorder. In: *Clinical practice guidelines: Management of anxiety disorders.* *Canadian Journal of Psychiatry* 51 (Suppl 2); 57S–63S.
- Adults Surviving Child Abuse (ASCA) (2012) *'The Last Frontier': Practice guidelines for treatment of complex trauma and trauma informed care and service delivery.*
- *Children in immigration detention* (position statement 52, February 2015) [PDF; 180 KB].



### 3.3 The Standard Required

#### In order to:

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

**Achieve the Standard** – the candidate demonstrates competence expected of a junior consultant psychiatrist. That is the candidate is able to demonstrate, *taking their performance in the examination overall*, that

- i. they have competence as a **medical expert** who can apply psychiatric knowledge including 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 well-being of individual patients, communities and populations.
- vi. they can act as **scholars** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.
- vii. they can act as **professionals** who are committed to ethical practice and high personal standards of behaviour.

**Below the Standard** – the candidate demonstrates significant defects in several of the domains listed above.

**Does Not Achieve the Standard** – the candidate demonstrates significant defects in most of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

## 4.0 Instructions to the Role Player

### 4.1 This is the information you need to memorise for your role:

You are Shalini Vijaykumar, a 20-year-old refugee. You are currently on unemployment benefits but you are looking for any kind of job you can get. You have been living alone in a rental flat for the past 6 months. You are originally from Sri Lanka and are of Tamil heritage; you fled Sri Lanka after a bomb hit your home village one day and killed your parents in early 2014.

With some help from a friend of your father you managed to get to Langkawi, Malaysia by boat – your aim was just to escape all the risks that Tamils face but you had no real idea where you would end up. People you happened to meet said that Australia was a good place to go because there was no war in that country; you had heard of other Sri Lankans going there. You managed not to get caught up in the Thai authority's crackdown on smuggling rings in 2015 which resulted in what came to be known as the "boatpeople crisis in the Andaman Sea."

When you arrived in Malaysia you had to stay in a small apartment with a family of six, two other women plus two men just outside of Kuala Lumpur. Although there isn't much of a formal system to support refugees you managed to get registered as an asylum seeker at the office of the UNHCR (this stands for United Nations High Commissioner for Refugees), were accepted for resettlement and have been living in Australia for the past 6 months. You were so relieved.

You have been told that your residency status in Australia is secure. You are relieved to have some stability but are really lonely and sad as it has been difficult to settle as you have no friends. You have a couple of support workers through the Community Assistance Support Program who helped you with accommodation and benefits but you do not see them regularly anymore. It has been difficult to get more involved in the Australian culture and get used to the changes in activities, food, socialisation with other cultures, but your use of English is slowly improving. You spend your time looking for work or watching TV.

Last week you went to see a GP as you are worried about your troubles sleeping. He explained to you that he thought you actually had depression and suggested that you see a doctor at the local community mental health centre to have the diagnosis confirmed. He also found that you have no physical health problems that could be causing your symptoms.

You have a one year history of low mood / feeling sad and empty that started when you were a refugee in Malaysia. Over the last 2-3 months, even though you try to go to sleep at about 10pm, you have trouble going to sleep (it takes up to 2 hours), wake frequently during the night (3 to 5 times and are up for 1 hour each time), you are only getting about 3 hours a night and feel exhausted during the day. You often have bad dreams.

You lost your appetite while a refugee in Malaysia and continued to do so even after you arrived here. You think you have lost 5kg in weight over the last few months. You are having difficulty concentrating and your memory is poor. You haven't found things to enjoy; in the beginning you enjoyed going to the library and reading as many books as you could in English. You struggle to feel hopeful, but you often feel guilty that you survived and your family have not. You feel like you are a bad person. While you have no active plans to harm yourself or attempt suicide, you sometimes wish you had not survived but had died in the bomb with your parents.

You can accept you may be depressed, even though you are a bit ashamed, but would like an explanation about what depression is.

With regard to aspects of your past personal life:

- You did well at school, could make and keep friends and there was no history of behavioural issues.
- You did not witness the death of your parents as it happened when you were out at school.
- There is no other history of trauma in your early life.

While in Malaysia you did not receive much financial support although had access to some services, including access religious facilities and television in the apartment on the outskirts of Kuala Lumpur. You were unable to access library services and other educational facilities. You tried to earn money by working informally for a local restaurant as a cleaner in order to buy clothes, footwear, toiletries, hygiene products and other personal items.

**YOU WILL ONLY GIVE THE FOLLOWING INFORMATION IF SPECIFICALLY ASKED WHETHER YOU HAVE HAD ANY OTHER BAD EXPERIENCES IN YOUR LIFE OR WHETHER YOU HAVE ANY DREAMS OR NIGHTMARES:**

Your symptoms started after you witnessed another refugee attempted to hang himself in the apartment after a visit to the UNHCR office after their claim for asylum was rejected. This was six weeks before you came to Australia. You were there at the time with another Burmese woman who lived in the apartment and both of you were horrified to see him trying to do this, and had to help get him down. You all kept the incident quiet for fear of repercussion, but the man moved out of the apartment soon afterwards and you often wonder what happened to him. Since that time you have noticed the following:

- You have had recurrent, involuntary and intrusive distressing memories of seeing the man attempting to kill himself by hanging. This is so strong and vivid that you feel like it has just happened all over again.
- You have recurrent distressing dreams in which the content of the dream is related to the hanging.
- You have intense psychological distress and physical reactions to both external reminders (news on the radio and TV about asylum seekers) and internal triggers (thinking about your time in Malaysia).
- You have periods when you avoid distressing memories and anxious feelings of the hanging incident by keeping yourself busy or going for walks to the Westfield shopping centre and you try to avoid external reminders of the event (e.g. you stop watching TV even though it is your main way of spending free time).
- You have periods when you feel very guilty for surviving and feel that it should have been you who died.
- You struggle to feel positive emotions and often feel guilty. You feel detached from others and have lost interest in trying to find places to engage in things you previously enjoyed (e.g. reading, dancing).
- You frequently feel on edge, you are “jumpy” i.e. easily startled, and these have added to your problems with concentration and sleep. Sometimes you have periods when you struggle with sudden outbursts of anger.
- These experiences / symptoms have had a big, negative impact on your life and you have been less confident to go out to meet others and feel unsure of yourself.
- You do not have periods when you feel detached from yourself or your surroundings (dissociation).

With regard to aspects of your past personal life:

- You did well at school, could make and keep friends and there was no history of behavioural issues.
- You did not witness the death of your parents as it happened when you were out at school.
- There is no other history of trauma in your early life.

If asked about your understanding of your condition and help seeking behaviour, you acknowledge that you have these symptoms because you are sad. From the perspective of your culture your symptoms mean you are being “weak”. So you think the cause of your illness is sadness making you weak. You had thought of seeking out a traditional Sri Lankan healer but even back home your family were more focussed on western medical practices.

#### 4.2 How to play the role:

You will be anxious but cooperative in your role and answer all questions asked of you freely, even though you are hesitant in your responses due to poor confidence in speaking English. You will not volunteer information but answer the questions put to you.

You will become a bit distressed when talking about the traumatic experiences you have been through. You will listen to the explanation of diagnosis without interruption and will ask no questions.

#### 4.3 Opening statement:

*“I am sorry for bothering you, doctor.”*

#### 4.4 What to expect from the candidate:

The candidate is likely to review some historical material but should focus on current symptoms. If the candidate asks a question that has not been covered in the script you will respond that you are not sure. Toward the end of the session each candidate will provide an explanation of diagnosis, which you will listen to and if asked if you have any questions you will respond “**No**”.

#### 4.5 Responses you MUST make:

*Anticipated Question: When asked about your sleep.*

*Scripted response: "I am not sleeping well. Only few hours every night".*

*Anticipated Question: When asked about what these symptoms mean to you / why you are experiencing these symptoms.*

*Scripted Response: "I feel sad but I think I may just be being weak."*

#### 4.6 Responses you MIGHT make:

*Anticipated Question: When asked if you have had unusual experiences such as hallucinations (hearing voices or seeing things that others do not), feeling there was hidden meanings in things around you, feeling you were being watched or followed.*

*Scripted Response: "No" or "Never."*

*Anticipated Question: If asked about past psychiatric or medical history, regular medications, allergies, drug or alcohol use, or any mental illness in your family.*

*Scripted Response: "I have already told that GP all of this."*

*Anticipated Question: If asked about your childhood and growing up in your family.*

*Scripted Response: "I had a very happy childhood but I have already told that GP all of this."*

*Anticipated Question: Was there anything that happened around the time the depression started?*

*Scripted Response: "No, but I suppose I got tired on not being able to make friends."*

*Anticipated Question: Does anything wake you up at night?*

*Scripted Response: "I get nightmares about that day most nights"*

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

Nil.

## STATION 7 – MARKING DOMAINS

The main assessment aims are:

- To perform a brief diagnostic assessment (history and MSE) focussed on confirming a diagnosis of major depression, assessing its severity, and identifying an additional diagnosis of PTSD.
- To explain the findings to the patient in a culturally sensitive and individually tailored manner.

**Level of Observed Competence:**

### 1.0 MEDICAL EXPERT

#### 1.2 Did the candidate demonstrate adequate proficiency in collecting the history and taking into account the presentation? (Proportionate value - 45%)

**Surpasses the Standard (scores 5) if:**

achieves a score of at least 4 *and* the information is relevant to the patient's problems and circumstances; it is conducted at a sophisticated level and in a systematic fashion; all symptoms are identified to meet diagnostic criteria and both diagnoses are made.

**Achieves the Standard by:**

conducting an organised and accurate history using of a tailored biopsychosocial approach; undertaking a detailed but targeted assessment; obtaining a history relevant to the patient's problems and circumstances with appropriate depth and breadth; integrating key sociocultural issues relevant to the assessment; demonstrating phenomenology.

To score 3 or above the candidate **MUST**:

- Identify witnessing the attempted hanging as the primary stressor for the PTSD.

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

**Below the Standard (scores 2 or 1) if:**

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response. Significant omissions affecting quality scores 1.

**Does Not Achieve the Standard (scores 0) if:**

significant deficiencies in technique, organisation and accuracy.

1.2 Category: ASSESSMENT data gathering content	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

#### 1.9 Did candidate describe relevant diagnoses to the patient? (Proportionate value - 30%)

**Surpasses the Standard (scores 5) if:**

achieves a score of at least 4 *and* demonstrates a superior performance; proficiently explains major depressive disorder of moderate severity, single episode, without psychotic features and post-traumatic stress disorder without dissociative features and using language that can be understood by the patient.

**Achieves the Standard by:**

integrating available information in order to give the diagnoses; demonstrating detailed understanding of diagnostic systems to provide justification for diagnosis; adequate prioritising of conditions relevant to the obtained history and findings, utilising a biopsychosocial approach, communication in appropriate language and detail and according to good judgment when communicating to patient.

To score 3 or above the candidate **MUST**:

- Elicit enough symptoms to justify a diagnosis of major depressive disorder *and* make the diagnosis.
- Identify enough symptoms to justify a diagnosis of post-traumatic stress disorder *and* make the diagnosis.

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

**Below the Standard (scores 2 or 1) if:**

scores 2 if the candidate does not meet (a) or (b) above, or has omissions that would detract from the overall quality response. Significant omissions affecting quality scores 1.

**Does Not Achieve the Standard (scores 0) if:**

inaccurate or inadequate diagnostic formulation; errors or omissions are significant and do materially adversely affect conclusions. Failure to identify both (a) and (b).

1.9. Category: DIAGNOSIS	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
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"/>

**2.0 COMMUNICATOR**

**2.4 Did the candidate demonstrate a culturally sensitive approach to patient? (Proportionate value - 25%)**

**Surpasses the Standard (scores 5) if:**

achieves a score of at least 4 and demonstrates a sophisticated and knowledgeable approach to cultural and linguistic aspects of patient; competently incorporates cultural meaning into their assessment; attempts to elicit cultural information in more detail.

**Achieves the Standard by:**

demonstrating the use of language so as to address cultural and linguistic aspects of patient presentation; recognising and incorporating cultural needs / expectations; demonstrating flexibility to adapt the interview style to the patient's special needs; recognising emotional significance of the patient's material and responding empathically; adapting assessment to the specific cultural needs; considering when to use interpreters.

To score 3 or above the candidate **MUST**:

- a. Describe the diagnosis of depression and PTSD having elicited and taken into account the patient's cultural explanatory models.

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

**Below the Standard (scores 2 or 1) if:**

scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response. Significant omissions affecting quality scores 1.

**Does Not Achieve the Standard (scores 0) if:**

ignores sociocultural meaning and aspects of the scenario; insensitive approach to cultural needs of the patient.

2.4. Category: CULTURAL DIVERSITY	Surpasses Standard	Achieves Standard			Below the Standard		Standard Not Achieved
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 defined tasks?

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail
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