Committee for Examinations
Objective Structured Clinical Examination
Station 11
Perth September 2019

The Royal Australian & New Zealand College of Psychiatrists

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1.0 Descriptive summary of station:

The candidate is expected to demonstrate their competence in utilising motivational skills and strategies (e.g. readiness ruler, importance / confidence, good-less good, etc.) to assist a 37-year-old man who has been a heavy user of cannabis for ten years, and is currently in a stage of contemplation to move into action after being charged with driving while intoxicated.

1.1 The main assessment aims are to:

- Demonstrate knowledge and understanding of Motivational Interviewing (MI) skills and strategies.
- Effectively engage a patient utilising Motivational Interviewing techniques in a manner that encourages their willing participation.

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

- Avoid confronting the patient about the need to stop cannabis.
- Utilise at least three of the 'OARS' skills relevant to this scenario (open-ended questions, affirmation, reflective reasoning, summarising).
- Accurately apply at least two MI strategies.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category**: Substance Use Disorders
- **Area of Practice**: Psychotherapies
- **CanMEDS Marking Domains Covered**: Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes**: Medical Expert (Management – Therapy, Assessments – Strategies, Selection), Communicator (Conflict Management).

References:

- DiClemente, Carlo C, Hughes, S.O. Stages of change profiles in outpatient alcoholism treatment. Journal of Substance Abuse, Vol 2, Issue 2, 1990, Pages 217–235
- McConnaughy, Eileen A.; DiClemente, Carlo C.; Prochaska, James O.; Velicer, Wayne F. Stages of change in psychotherapy: A follow-up report. Psychotherapy: Theory, Research, Practice, Training, Vol 26(4), 1989, 494-503.
- Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing: Helping people change*. Guilford press.
- Morton, K., Beauchamp, M., Prothero, A., Joyce, L., Saunders, L., Spencer-Bowdage, S., Dancy, B. and Pedlar, C., 2015. The effectiveness of motivational interviewing for health behaviour change in primary care settings: a systematic review. Health Psychology Review, 9(2), pp.205-223.

1.4 Station requirements:

- Standard consulting room.
- Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: male in mid-30s, casually dressed.
- Pen for candidate.
- Timer and batteries for examiners.

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 a community alcohol and drug treatment service.

Your next patient is Gary Fletcher who is a 37-year-old man presenting with ambivalence about his cannabis use. He was recently charged with driving under the influence after a camping weekend, and he now risks losing his licence which will affect his occupation. In a session last week, he admitted to being a heavy regular user of cannabis for at least ten years.

Your task is to:

- Demonstrate a brief intervention for cannabis use focussing on motivational interviewing techniques to assist Gary to shift to the action stage of change.

Station 11 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
  - A copy of 'Instructions to Candidate' and any other candidate material specific to the station.
  - Pens.
  - Water and tissues (available for candidate use).
- Do a final rehearsal with your simulated patient and co-examiner.

During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- DO NOT redirect or prompt the candidate unless scripted – 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 co-examiner's and your mark sheet in **one** envelope by / under the door for collection (**do not seal envelope**).
- Ensure room is set up again for next candidate. (See 'Prior to examination' above.)

If a candidate elects to finish early after the final task:

- You are to state the following:

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

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

There is no opening statement or prompts for you to give.

The role player opens with the following statement:

'So doc, you going to give me a lecture?'

3.2 Background information for examiners

In this station, the candidate is expected to engage a 37-year-old man (Gary) who presents with a chronic cannabis dependence, and assist him to move towards making changes to his pattern of use. They are to demonstrate their competence in utilising motivational skills and strategies (e.g. readiness ruler, importance / confidence, good-less good, etc.) with the patient, who is currently in a stage of contemplation to move into action after being charged with driving while intoxicated.

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

- Avoid confronting the patient about the need to stop cannabis.
- Utilise at least three of the 'OARS' skills relevant to this scenario (open-ended questions, affirmation, reflective reasoning, summarising).
- Accurately apply at least two MI strategies.

The candidate is expected to be able to effectively communicate with the patient to facilitate a good rapport by demonstrating a balanced use of open-ended questions and reflective reasoning. The candidate is expected to be able to create an atmosphere in which the patient's ambivalence can be gently explored. The candidate needs to demonstrate their ability to become an ally in Gary's recovery, and work with him to come up with a plan the patient is happy to implement.

A surpassing candidate would skilfully engage Gary in a non-judgemental manner, and specifically not get into an argumentative approach with him, and demonstrate clear expertise in MI by accurately applying a range of strategies tailored to the specific aspects of the scenario.

The candidate is expected to demonstrate their knowledge of generally accepted Motivational Interviewing skills and strategies used to support a patient to shift from the contemplation to the action stage of the wheel of change.

The 'stages of change' (James Prochaska & Carlo Diclemente) is a useful model of working out how to look at changing something significant in a person's life.

Change is associated with different thoughts and feelings – excitement, hope, fear, uncertainty, anticipation, vulnerability, worry, relief, enthusiasm, anger, a desire to be in control, fear of losing relationships.

Considering responses to certain kinds of questions can confirm the contemplation stage: Do you think you have a problem with alcohol or other drugs? Are you clear about why you want to quit / stop smoking cannabis?

MI is collaborative in that the candidate needs to ask questions or make statements that will affect the willingness of the patient to disclose information about their use. Being confrontational (argumentative, aggressive, antagonistic) is unhelpful, and generally leads the patient to become defensive and to withhold important information.

A more person-centred approach of engaging that fits with recovery, and has regard to the person's behaviour as their own personal choice, letting them decide on the size of the problem, i.e., how important it is for them to quit, and avoids argumentation and confrontation, encourages discrepancy / inconsistency from where the patient can initiate change, and helps patients re-evaluate their substance use.

Validating the patient's lack of readiness:

- Clarifying that the decision to make changes is the patient's.
- Encouraging the evaluation of pros and cons of behaviour.
- Identifying and promoting new positive outcome expectations.

MI **skills** can be used for raising sensitive issues like alcohol use, and encourage the use of open-ended questions, affirming the patient, listening reflectively and summarising throughout (often called *OARS*).

- *Open-ended* questioning encourages ongoing exploration.
- *Affirmation* of personal successes and helpful coping strategies aims to build a sense of personal capacity to achieve their goals, and recognition of the patient's strengths and resilience. Assessing capacity of the candidate to affirm (e.g. through compliments and statements of appreciation or understanding) indicates their ability to express empathy and support the patient. Affirmations can be statements or gestures that identifies the patient's strengths, and amplifies behaviours that push the patient towards positive change.
- *Reflective* listening, checks whether what the candidate has 'heard' what the patient meant, and allows the patient to correct any wrong understanding, and add more information. It also provides feedback on the patient's concerns. It is potentially one of the most powerful interviewing skills. Reflection makes an estimation as to what the person means, it is not a question, but is a statement which reflects or amplifies the meaning of what the patient has said.
- *Summarising* helps to ensure there is a clear communication between the doctor and the patient. It can be a launching pad for change. Summaries are an extended application of reflective reasoning. Summaries are used at several points during a clinical review but are very important at transition points, such as after the patient has concluded their conversation about a subject or discussed a personal experience or when the clinical review is about concluding. Summaries should be concise, emphasise change statements, should include relevant clinical information and should end with clarifying question such as "did I miss anything?"

The candidate needs to demonstrate capacity to reflect: using exact repeating, rephrasing with no new meaning, paraphrasing including inference of meaning and reflection of feeling (often regarded as the deepest form as it aims to capture the way the patient is feeling). When using a reflection of feeling, it is generally better to understate rather than overstate the strength of the feeling.

To '*Achieve'*, the candidate must be able to listen, understand and summarise the information provided by the patient. The candidate must demonstrate capacity to provide a brief overview of what has been discussed, tie up what has been covered and allow for a shift to another topic, or to start a new approach. This skill involves the ability to highlight the main discoveries, encourage exploration of more detail, give patients the opportunity to hear their own concerns or reasons for change and highlight ambivalence (to change). A better candidate will use summarising as a way to show 'discrepancy', where the candidate mirrors back to the patient a summary of their position in a way that highlights the discrepancies in how the patient sees themselves.

The candidate must demonstrate through their approach that they are familiar with the main elements of motivational interviewing (Miller and Rollnick, 2002). They should express empathy with more listening, and less 'telling'. They should show some capacity to develop discrepancy, and take opportunities to focus the patient's attention on any discrepancy developed.

Any level of argument is likely to reduce the candidate's capacity to '*Achieve'* as the aim of MI is for the patient, and not the candidate, to argue for change. Resistance is strongly determined by the style of the clinician - when dealing with people who are unsure if they want to change or are feeling overwhelmed, there is a tendency for the clinician to deny, or become frustrated or angry. The candidate should avoid increasing their efforts to try to persuade the patient that they have a serious problem which needs committed effort to change: this then leads to further resistance and defensiveness in the patient. The aim is to 'roll with the resistance.'

The candidate should try not to provide solutions, rather respond and acknowledge the patient's perceptions (roll with the resistance). A better candidate will be able to provide an opportunity for the patient to identify their own solutions in the time available. MI may be 'confrontational' in its purpose (to increase awareness of problems and the need to do something about them), but this is a different kind of confrontation to arguing or convincing. If the patient resists, the better candidate will recognise this as indication that they are taking the wrong approach and shift.

The candidate's intervention should also support of self-efficacy, eliciting the patient's confidence in their ability to implement, and sustain changed behaviour (as self-efficacy influences whether or not they attempt and persist with efforts of change).

The candidate should use a neutral low-key interviewing style – as if they are curious to find out exactly what happens, and how their use of substances fits in their broader life context. The MI strategies express the 'spirit' of MI in that they are collaborative, evocative (suggestive), and encourage autonomy.

Through their interview the candidate should be able to demonstrate some capacity to undertake one or more of generally accepted MI **strategies** which could include:

1. Good Things / Less Good Things (Decisional Balance)
2. Looking Back, Looking Forwards
3. A Typical Day
4. Exploring Concerns
5. Readiness Ruler
6. Ask, Tell, Ask.

1. Good Things / Less Good Things (Decisional Balance)

   Aim: to explore people's feelings about their substance use, without putting the clinician's own assumptions and beliefs about whether use is problematic. The patient needs to identify potential problem areas.

   Function: often used at first session to build a relationship and test a person's level of concern. It is useful in assessing readiness for change. Resistance is minimised when the discussion commences first with the 'good things' about ongoing substance use then moves to talk about the 'less good things' or concerns. Using terminology like 'bad' things should be avoided. The responses and associated identified consequences are often tabled in a decision-making matrix so as to provide a visual representation for the person; alternatively in the 4-column diagram (Birmingham 1986) of likes and dislikes of ongoing use or abstinence.

2. Looking Back / Looking Forward

   Aim: to assist the patient to consider how substance use has changed things in their lives, and to consider what things they could do to change to have a better future.

   Function: it incorporates personal experiences that can stand alongside good and less good things. The person tells their own story without a judgemental approach from the clinician.
   Looking Back: sometimes it is useful to have a person remember times before the problem started, and to compare this with the present situation: 'Do you remember when…?', 'What were things like before...?', 'How has alcohol stopped you from...?'.
   Looking Forward: Helping people to picture a changed future, asking the person to describe how things might be after a change.

3. Typical Day / Session

   Aim: to explore the person's substance use by going through one particular recent day or session in detail, exploring the details of what happened, and how the person felt about the events.

   Function: often used near the beginning of the first session, this strategy serves to strengthen the relationship and keeps the discussion within a positive non-judgemental atmosphere. It gives the beginning indications of the function of substance use in their life, and provides a way of gaining the amount and type of use. It assists in exploring all the concerns they identify (in contrast with 'good things').

4. Exploring Concerns

   Aim: to help people express and elaborate on what concerns they have about their substance use.

   Function: this is often the foundation for building motivation. It highlights ambivalence, and can lead to the development of discrepancy – a sense of discomfort – which often precedes the decision to make a change, e.g. the alcohol use is not in keeping with their own self-image. Looking at past experiences of quitting can assist in building confidence.

5. Readiness Ruler

   Aim: to help people talk about whether they are willing and able to change.

   Function: assists in identifying how *important* making a change would be to that person, and then assessing the patient's level of *confidence*, which then helps them to make positive changes. The focus is therefore placed on highlighting positive changes already made, regardless of how small they are, and encouraging the person to identify their own self-positives, or positive self-talk. It should help to highlight exceptions or times when they have managed well, and successes of setting small achievable goals. A critical technique is asking the person to explain why a lower number was not picked, encouraging the patient to justify their level of importance / confidence against your lower suggestion.

6. Ask, Tell, Ask (or similar approach) – often considered more part of a Brief Intervention than MI.

   Aim: to provide factual information, without telling the person something they know already, and to offer further opportunities for discussion.

   Function: this is often the opening conversation in raising awareness without causing offence. Also known as Elicit, Provide, Elicit and is used to emphasise personal choice and control, work out existing knowledge / experience, ask permission to provide information / feedback / recommendations, and obtain the patient's reactions / interpretations. Sometimes MI strategies can be linked together to get a better outcome, especially if that is where the conversation with the patient is taking the clinician. MI requires the identification of a specific target behaviour for change, and 'change talk' is unique to MI: this is what the patient says in the sessions with the clinician, eliciting self-change talk in the context of being ready, willing and able (want, able, need). Change talk can be positive which supports change or negative which tends to maintain the status quo.

NZ laws for drug testing

According to the Ministry of Transport in New Zealand, it is an offence to drive while impaired, and with evidence in the bloodstream of a qualifying drug. The presence of a qualifying drug alone is not sufficient for an offence; there must first be impairment as demonstrated by unsatisfactory performance of the compulsory impairment test. It is also an offence to drive or attempt to drive while under the influence of drink or drugs to the extent of being incapable of proper control of a motor vehicle.

Police can test for the presence of qualifying drugs (*Misuse of Drugs Act 1975*) if a driver fails a compulsory impairment test. Parliament agreed that the law should also cover benzodiazepines, and these medications can be found in the Medicines Regulations 1984 <http://www.legislation.govt.nz/regulation/public/1984/0143/latest/DLM95668.html>.

In analysing the results of the blood test, police target most likely drugs including opiates, amphetamines, cannabis, sedatives, antidepressants and methadone.

Where a police officer has 'good cause to suspect' that a driver has consumed a drug or drugs, the officer may require the driver to take a compulsory impairment test. Grounds for having good cause to suspect include erratic driving or, if the driver has been stopped for another reason, appearing to be under the influence of drugs, e.g., a person stopped at an alcohol checkpoint is behaving in an intoxicated manner but passes a breath alcohol test. The compulsory test includes:

- an eye assessment – pupil size, reaction to light, lack of convergence, nystagmus (i.e. abnormal eye movement - irregular eye movement can be a marker for drug impairment)
- a walk and turn assessment
- a one leg stand assessment.

If the driver does not satisfactorily complete the compulsory impairment test, the police officer may forbid the driver to drive, and require the driver to provide a blood sample. Forbidding the person to drive deals with the immediate road safety risk represented by the impaired driver, for up to 12 hours (the period of prohibition applied to a driver who is over the legal adult breath alcohol limit), but this may vary depending on the discretion on the police officer.

The procedure for taking a blood sample is the same as for drink drivers who opt for a blood test. When the blood test results are known, police make a decision whether or not to charge the driver. The penalties for drug impaired driving are aligned with the penalties for drink driving offences.

Australia laws for drug testing

In Australia, roadside drug testing can be performed randomly similar to testing for alcohol. It is performed using a saliva sample.

3.3 The Standard Required

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

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

i. they have competence as a ***medical expert*** who can apply psychiatric knowledge including medicolegal expertise, clinical skills and professional attitudes in the care of patients (such attitudes may include an ability to tolerate uncertainty, balance, open-mindedness, curiosity, 'common sense' and a scientific approach).

ii. they can act as a ***communicator*** who effectively facilitates the doctor patient relationship.

iii. they can ***collaborate*** effectively within a healthcare team to optimise patient care.

iv. they can act as ***managers*** in healthcare organisations who contribute to the effectiveness of the healthcare system, organise sustainable practices and make decisions about allocating resources.

v. they can act as ***health advocates*** to advance the health and wellbeing of individual patients, communities and populations.

vi. they can act as ***scholars*** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.

vii. they can act as ***professionals*** who are committed to ethical practice and high personal standards of behaviour.

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

Domain Not Addressed – the candidate demonstrates significant defects in all of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

4.0 Instructions to the Role Player

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

You are a Gary Fletcher, a 37-year-old man, who was pulled over by the 'booze bus' (police) while driving intoxicated with cannabis three weeks ago. You have decided to attend an alcohol and drug service to see what they have to say.

You work as a civil engineer in a construction firm in the city. You had been camping for the weekend with some of your mates from work, and were driving home that evening when you went through a random drug test. Your lawyer suggested you go to an addiction treatment service as part of preparation for your possible pending court case. You are uncomfortable about being here, but recognise that you do need to do something about your cannabis use even though you really enjoy it, including the social aspects associated with smoking with your friends.

You started smoking cannabis when you were in your mid-teens (about 21 years old) and have slowly increased your use over the years. You had not had any major concerns about smoking as most of your friends tend to use in the same pattern as you. For instance, university was one big party with drinking and drugs, and you managed to pass with ease. Looking back, those were great days – and you like to reminisce about how great things were.

You met your partner, Amy, after you left university and have been together since then. Earlier this year, she started complaining that your ('stoned') weekend trips with the guys; it was not where she saw herself going in her life. She has been getting 'clucky', and wanting to settle down and have kids – you think that you would like to have kids one day as well, but are really enjoying your current laid-back lifestyle. Amy got annoyed with your refusal to take life more seriously, and surprised you by threatening to leave you just before your birthday in April.

She moved out three months ago, and you often can't believe she has gone. You have not been happy getting home after work to an empty house, which is why you went away this weekend. You have a friend, Jack, who lives down the road, and have started spending more time over there since she left. You and Jack sit together and share bongs, and occasionally you have fallen asleep at Jack's house, and also been getting to work late because you can't get up on time in the mornings.

There are also a few things that concern you about your cannabis use – this is the second time you have been caught driving under the influence in two years; you think you have lost Amy, and you really thought she was 'the one'; over the last few months since she left, you have been spending even more time at Jack's or camping out in the bush as you hate being at home alone; you are spending more money on cannabis; you are getting into trouble with your boss for absenteeism.

Physically, you have recently been feeling 'crook', and have become worried about a cough that just won't seem to go away. You have never previously been concerned about any health-related problems. You used to play in a social touch rugby team with mates from work, and enjoyed the comradeship associated with this, but you have let that go by the wayside. You can grudgingly admit that you are putting on weight, and blame this on spending so much time sitting around smoking bongs, and eating junk food.

You do not want the candidate to think that everything is bad about smoking cannabis. There are many things you really like; it relaxes you, you feel more comfortable and relaxed, and have been told you are really funny when you are high. You have a close group of friends dating back to university, and your social lives revolve around smoking with them. You have never really considered giving up or cutting down before.

The following information should only be provided if the candidate asks you.

Your pattern of use:

At present, you are smoking almost every day, and prefer hydroponics than naturally grown. You think you smoke about 5 to 10 cones per night, usually sharing with Jack (and sometimes one or two other friends). You usually drive home after spending the evening smoking with these friends. Apart from Amy, one of your closer friends has made snide remarks about you losing control, and sometimes you know they are mocking you for being a 'stoner'.

This second driving while intoxicated is a bit of a wake up as you are really worried about the charge. The first time was at the end of last year, and you did not think that it was that much of a worry, and just became more careful. You have never previously thought you should look at your habit before this, but at the back of

your mind, you have to admit that you have stated wondering what it would take to get your relationship with Amy back.

If you are asked what goals you have, they would be to spend less time stoned, and not go to work feeling wasted most days (you admit that it could end up costing you your job if you can't keep on top of your tasks). You can see yourself settling down, and having a family, but are also anxious about such a big commitment. You would like to lose some weight, and definitely want to be sure that you do not end up an addict like your grandfather.

You can admit now it is *important* for you to address your use, (if you are asked you would rate the importance, put it at about 7/10 (10 being very important). You would not rate it lower because you realise you really want to get Amy back, and to stop spending most evenings on Jack's couch or putting your job at risk.

As most of your close friends smoke cannabis, it is a strong socialising activity for you - you are not sure that you feel that *confident* about stopping / reducing (4/10): you worry about your will power, what would you do with yourself instead of smoking / socialising! If asked what would help shift your confidence from a '4' to a '5', respond that having more support from your friends would help. You have never stopped for a prolonged period of time. Most recently, you stayed off cannabis for one day only, and that was the day after you had been caught by the police.

If you are asked, you do have a family history of alcohol problems, with your paternal grandfather being described as a violent alcoholic. You are aware that he died of alcoholic cirrhosis. Your brother, Steve, used to smoke cannabis, and drink heavily when he was younger. He ended up being charged for drug dealing, and barely managed to escape a custodian conviction on a legal technicality.

4.2 How to play the role:

You are to be casually dressed, and can be slightly scruffy in your grooming. You think of yourself as a 'regular kind of guy' who is hoping to 'beat' this charge.

You must initially be defensive and avoidant (because you are embarrassed and worried), and you don't want health professionals telling you what to do. You feel that you are in control – most of the time – and can initially be a bit sarcastic if the opportunity arises.

If the candidate takes time to listen and does not tell you what to do, you will become more pleasant, as you are a pretty straightforward kind of person, and deep down, you know that you probably need to get more control over your cannabis use. You will be happy to engage with the candidate if they don't lecture you on the dangerousness of your lifestyle, but try to work with you to look at what is important to you about considering decisions about cannabis use.

4.3 Opening statement:

'So doc, you going to give me a lecture?'

4.4 What to expect from the candidate:

The candidate is expected to encourage you to shift your current use of smoking cannabis, to consider at least cutting down and making some changes to your current lifestyle. They should do this by trying a range of strategies which could include talking about what you like about your smoking, what are the good things about smoking or not smoking – and what are less good. They may ask you how confident you are about quitting (which you do not want to do) or cutting down (which you may consider), or what things used to be like in the past, and where you see yourself going when you look forward to your future. Candidates should quickly move to encouraging you to talk about why you might want to quit / control your smoking.

They may advise you that you have cannabis use disorder, but no other mental illness. At present, you are prepared to consider ways that you could manage your cannabis use, and are happy to answer reasonable questions. They should spend little time taking a history but focus more on working with you to identify your own reasons for changing your cannabis use habits, then may move to provide you with some suggestions and a plan for follow-up. It is not expected that candidates will focus on any medication options or spend too much time on your drug use history.

4.5 Responses you MUST make:

'I don't think I'd ever stop completely.'

'I have got a bit of a cough.'

4.6 Responses you MIGHT make:

If the candidate asks about your past psychiatric / mental health history:
Scripted Response: ***'I don't have any mental problems.'***

If the candidate asks about your physical health:
Scripted Response: ***'I feel fit and healthy most of the time except for my cough.'***

If the candidate asks if you use other drugs.
Scripted Response: ***'I don't doc.'***

4.7 Medication and dosage that you need to remember:

There are no medications for you to remember.

STATION 11 – MARKING DOMAINS

The main assessment aims are:

- Demonstrate knowledge and understanding of Motivational Interviewing (MI) skills and strategies.
- Effectively engage a patient utilising Motivational Interviewing techniques in a manner that encourages their willing participation.

Level of Observed Competence:

2.0 COMMUNICATOR

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

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

Achieves the Standard by:
recognising challenging communication; listening to differing views; utilising communication techniques to effectively promote positive outcomes.

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

a. Avoid confronting the patient about the need to stop cannabis***.***

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; any errors impair attainment of positive outcomes; inadequate ability to reduce resistance.

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

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

1.0 MEDICAL EXPERT

1.14 Did the candidate demonstrate an adequate knowledge of relevant psychological approaches? (Proportionate value - 35%)

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

Achieves the Standard by:
application of supportive therapy and general psychoeducation; demonstrating understanding of motivational interviewing; considering sensitively barriers to application; avoiding using only generic forms of motivational conversation.

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

a. Utilise at least three of the 'OARS' skills relevant to this scenario (open-ended questions, affirmation, reflective reasoning, summarising).

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

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

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

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

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

1.8 Did the candidate make an appropriate choice of MI strategies? (Proportionate value - 45%)

Surpasses the Standard (scores 5) if:
expertly applies the most appropriate strategies and incorporates them in a skilful manner to achieve the desired outcome.

Achieves the Standard by:
prioritising and selecting the optimal range of MI strategies; adapting range of available options in response to the interaction with the patient; choosing strategies that suit the conversation; not attempting to incorporate too many strategies.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Accurately apply at least two MI strategies.

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; incorrectly chooses even routine / standard range of therapeutic strategies; unable to prioritise relevant MI strategies.

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

1.8. Category: ASSESSMENT – Strategies, Selection	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Domain Not Addressed**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

GLOBAL PROFICIENCY RATING

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

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