Committee for Examinations
Objective Structured Clinical Examination

Station 1 Bye
Melbourne April 2016

The Royal Australian & New Zealand College of Psychiatrists

BYE STATION NOTES

This Station 1 Bye material can be taken into Station 1. You may make notes on this document or on your notepad.

This station has **TWO (2)** tasks:

- You have **twenty (20) minutes** to complete preparing the **FIRST** task while in this active Bye Station.
- After you leave the bye station you have **five (5) minutes outside the examination room** to read and prepare for the **SECOND** task.

You are the Junior Psychiatrist covering for Dr Cameron Duke who is on 6 months' leave; he has provided you with his handover notes regarding Mr James West. He has requested you to take over the care of this patient.

The **FIRST** task is to:

- Develop a focussed and prioritised short term and a longer term management plan for Mr James West to present to the examiners in Station 1.

James West. DOB: 18/02/1983

Mr West is a 33-year-old man living with his partner of 11 years. He is unemployed and has been on a disability pension for the past 2 years. His main supports, apart from his partner Mary, are his mother and sister who reside locally. He was referred by his General Practitioner, Dr Neal Jones, in September 2015 for opinion and management. I initially assessed him in October 2015 and have seen him regularly since December 2015.

He complains of low mood that is worse in the morning, low energy levels leading to easy fatigability and anhedonia. He also experiences initial and terminal insomnia and poor quality of the sleep with multiple interruptions. He has a poor appetite with weight loss of 4 kg over for the past 6 months. His concentration and motivation are significantly impaired. He reported strong negative cognitions of worthlessness, hopelessness and helplessness; which were further impacted by suicidal thoughts and a plan but with no clear intent. He does have an active social life where he meets with his friends on a daily basis, however the activities are mostly related to use of alcohol and drugs.

He also described poor attention span, distractibility, difficulty in organising tasks, impulsivity, inability to sit still, mood swings and emotional outbursts due to low frustration tolerance.
Mr West is currently before the Court on the charge of driving a motor vehicle without a driver's licence while disqualified by Court Order. He does acknowledge that he was driving his car without a licence but he felt he needed to see his friend who was in need and felt that no one would notice, and at the same time did not care if he was caught.

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Mental State Examination on 31.03.2016

James presented as a young man of Caucasian descent dressed casually with reduced self-care and wearing a baseball cap. His demeanour is casual but with a sullen response to the interview. He appeared sober. There was no psychomotor agitation or retardation. However there was evidence of low tolerance to frustration. His conversation appeared factual and goal oriented, but he needed reassurance to engage in the interview process.

James' speech is slowed and of reduced volume with difficulty in articulation (which has been consistent throughout all his appointments). The interview had to be conducted in simple language due to his level of understanding. He maintained a depressed and frustrated manner throughout the interview.

James described his mood as 'alright'. He appeared generally dysphoric; with a reactive and congruent affect. There was evidence of neuro-vegetative symptoms of depression.

The content of his thoughts revolved around his anxiety about the impending court case. There were systematised and well circumscribed thought processing with a degree of anxiety and negativity, with strong negative cognitions of helplessness and hopelessness, but no evidence of delusional beliefs. He reported ongoing thoughts of suicide but denied any intent or plans. He had no current wish to harm anyone else.

He denied any perceptual disturbance and none was evident in the interview.

Cognitively, he appeared below average in his intelligence and was orientated in time, place and person. No other cognitive tests were performed on this occasion.

He recognised he has significant psychological issues and acknowledged the need for ongoing treatment.

Past Psychiatric History

James was diagnosed with Attention Deficit Hyperactive Disorder at the age of 15 but it is of note that this disorder has been persistent from a very early age. He has been treated with Ritalin (Methylphenidate) 20mg twice daily for his Attention Deficit Hyperactive Disorder since then with good response, despite being sporadically compliant until recently.

He also has previously confirmed diagnoses of conduct disorder, substance abuse and borderline intellectual functioning through assessments at the Sydney Developmental Clinic.

Based on the report from the Sydney Developmental Clinic, James' IQ was assessed and the confirmation was that he rated in the borderline range for his full scale IQ while his verbal rating was in the low average range.

Neuropsychological assessment showed significant delayed latencies on the auditory evoked potential which would indicate poor auditory processing and poor concentration.

He was started on Lexapro (Escitalopram), 5 years ago for a Major Depressive Disorder, which he has continued with erratic compliance. He denied any side effects to this medication and reports a partial response to treatment, however ongoing functional deficits appear to have continued.

His only inpatient treatment was 15 years ago when he was admitted following an argument with his mother, he was hospitalised for 10 days. However there have been presentations to the Emergency Department in emotional crisis, the last being 3 months ago.

Current Medication

1. Lexapro (Escitalopram) 10mg daily.
2. Ritalin (Methylphenidate) 20mg twice daily.

Personal History

James is the younger of two siblings. His parents separated when he was 9 years and he lived with his mother whom he continues to find supportive. There is an extensive addiction history in the father's family but no other mental illness. He described his father as an alcoholic and physically violent towards him. His father died of a heart attack in 1993.

James grew up in Sydney in an impoverished environment. He did not do well in school and struggled to have meaningful social interaction with peers. He struggled academically and was bullied throughout his school years to which he retaliated with aggression, impulsivity and demonstrated low threshold for frustration. He left school early in year 10 to work as an unskilled labourer. However it has been challenging for him to maintain any employment.

His current relationship has been his longest - for 11 years - but it is marked with disruptions and periods of separation due to relationship conflict. He and his partner have a 10-year-old boy, Damien, who is cared for by Mr West's mother.

Drug and Alcohol History

James has been using drugs since the age of 13, primarily marijuana and alcohol. He reports increasing usage as a way to cope with frequent relationship stress as well as the challenges of being a father. Alcohol and marijuana have also impacted on his social abilities with important activities being given up for alcohol consumption. He has made multiple efforts to give up alcohol and marijuana with frequent relapses. He has reduced his alcohol intake with periods of abstinence, but there are periods of excess use triggered by emotional stimuli. However he continues to rely on marijuana to help him calm down. He says he is now keen to address this.

He has always denied using his Ritalin in excess or taking other illicit forms of stimulants.

Forensic History

He has had charges related to drink driving, driving without licence and driving unregistered vehicle. His level of remorse has not yet been assessed in depth. He denied any other charges or convictions.

Please leave this document inside Station 1 when you exit.

Committee for Examinations
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Station 1
Melbourne April 2016

The Royal Australian & New Zealand College of Psychiatrists

1.0 Descriptive summary of station:

Mr James West is a 33-year-old man with a more recent diagnosis of major depressive disorder on the background of attention deficit hyperactivity disorder, polysubstance abuse and intellectual disability. He is also facing charges for driving a motor vehicle without a licence. His usual treating psychiatrist has gone on leave for six months and has provided a clinical summary from which the candidate must develop a focussed short and a longer term management plan.

1.1 The main assessment aims are to:

- Review and assimilate the written clinical handover in order to develop a biopsychosocial management plan from the information obtained in the Bye Station.
- Ensure that the plan covers short and longer term interventions which involves the multi-disciplinary team and other agencies in the provision of comprehensive treatment.
- Demonstrate an understanding of the key areas to be covered in a court report in order to address a pending charge.

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

- Confirm compliance to treatment in the context of ADHD and intellectual disability.
- Recommend increasing the dose of escitalopram.
- Recommend specific psychological interventions tailored to the patient's intellectual capacity to address relationship issues and maladaptive coping skills.
- Review readiness to change for alcohol and marijuana.
- Refer to AA and / or other support groups.
- Adequately address the person's unsoundness of mind, understanding the nature of the charge and their fitness to stand trial.

1.3 Station covers the:

- **RANZCP OSCE Blueprint Primary Descriptor Category of:**
  Mood Disorders, Core Assessment Skills
- **Area of Practice:**
  Adult Psychiatry
- **CanMEDS Domains of:**
  Medical Expert, Collaborator, Professional
- **RANZCP 2012 Fellowship Program Learning Outcomes of:**
  Medical Expert (Management), Collaborator (Teamwork, External Relationships), Professional (Compliance & Integrity)

References:

- Malhi GS, Bassett D, Boyce P, Bryant R, Fitzgerald PB, Fritz K, Hopwood M, Lyndon RW, Mulder R, Murray G, Porter R, Singh AB. Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for Mood Disorders. Australian & New Zealand Journal of Psychiatry 2015, Vol. 49(12) 1087–1206
- Depression: The NICE Guideline on the Treatment and Management of Depression in Adults: NICE Guidelines [CG90] Published date: October 2009
- Attention deficit hyperactivity disorder: diagnosis & management NICE guidelines [CG72] Published date: September 2008
- Taylor, D., Paton, C., Kapur. S. (April 2015). Maudsley *Prescribing Guidelines in Psychiatry*, 12th Edition. Wiley Press.
- National Health and Medical Research Council. *Attention deficit hyperactivity disorder*. Canberra: Commonwealth of Australia, 1997
- Professional Practice Guideline 11: Developing reports and conducting independent medical examinations in medico-legal settings. RANZCP February 2015.
- Janet Treasure. Motivational interviewing. *Advances in Psychiatric Treatment* Aug 2004, 10 (5) 331-337; DOI: 10.1192/apt.10.5.331
- Carver, C. S. (2011). Coping. in R. J. Contrada & A. Baum (Eds.), *The Handbook of Stress Science: Biology, Psychology, and Health* (pp. 221–229). New York, NY: Springer Publishing Company.

1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiners x 2, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- No role player required.
- Pen for candidate.
- Timer and batteries for examiners.

2.0 Instructions to Candidate

You have **fifteen (15) minutes** to complete this station and **five (5) minutes** of reading time outside the examination room.

This is a VIVA station.

In this station your FIRST task is to:

- Present a short term and a longer term management plan for Mr James West to the examiners.

Mr West is due to appear in court to face his charge of driving a motor vehicle without a driver's licence while disqualified by Court Order. His lawyer has requested you to prepare a report for this hearing on the issues of criminal responsibility (often referred to as mental impairment or unsoundness of mind) and fitness for trial.

Your SECOND task is to:

- Describe the key areas to address in relation to these matters in a court report to the examiners (assume patient consent).

You will receive a prompt at **twelve (12) minutes** to commence the second task.

Station 1 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
  - 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 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 and say:
  "Please commence the first task"
- TAKE NOTE of the time prompt at **twelve (12) minutes** that you are to give.
- DO NOT redirect or prompt the candidate unless scripted.
- If the candidate asks you for information or clarification say:
  "Your information is in front of you – you are to do the best you can."
- At **twelve (12) minutes** prompt the candidate to commence the second task by saying:
  "Please proceed to the second task."
- At **fifteen (15) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your co-examiner's and your mark sheet in **<u>one</u>** 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 first task (i.e. before 12 minutes):

- You are to state the following:
  "Are you satisfied you have completed the first task?
  If so, do you want to proceed to the second task?"
- If yes, say the following:
  "You may proceed to the second task and you can return to the first task at a later time."

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 <u>must</u> remain in the room and <u>NOT</u> proceed to the next station until the bell rings."
- If the candidate asks if you think they should finish or have done enough etc. refer them back to their instructions and ask them to decide whether they believe they have completed the task(s).

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

This is a VIVA station, please direct the candidate to address the first task:

"Please commence the first task"

Please provide the following prompt if the candidate has not commenced the second task by **twelve (12) minutes**:

"Please proceed to the second task"

Your role is to observe the presentation of short term and long term management plan by the candidate. The candidate is also expected to list the key areas to address in the pending court case.

3.2 Background Information for Examiners

In this station the candidate is expected to review a written clinical summary for patient Mr James West who is a 33-year-old man with recent diagnosis of major depressive disorder on the background of attention deficit hyperactivity disorder, polysubstance abuse and intellectual disability. His usual treating psychiatrist has gone on leave for six months and has provided a clinical summary from which the candidate must develop a short and a longer term management plan.

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

- Confirm compliance to treatment in the context of ADHD and intellectual disability.
- Recommend increasing the dose of escitalopram.
- Recommend specific psychological interventions tailored to the patient's intellectual capacity to address relationship issues and maladaptive coping skills.
- Review readiness to change for alcohol and marijuana.
- Refer to AA and / or other support groups.
- Adequately address the person's unsoundness of mind, understanding the nature of the charge and their fitness to stand trial.

<u>First Task</u>

In the first task the candidate is expected to develop a biopsychosocial management plan that involves a multi-disciplinary team approach and includes other agencies in the provision of comprehensive treatment. The plan should outline short and longer term approaches.

Consensus psychiatrist feedback on key components of the management plan include:

NB: Throughout the presentation clarify which activities or interventions members of the MDT will be responsible for:

Safety

- acute changes in mental state and suicidal ideation.
- review risks in light of mood symptoms and recent stressors (e.g. court case, current relationship with partner, ongoing substance use).
- comment on role of compulsory treatment and consideration of any benefit of admission.
- monitor behavioural responses to stress in light of impulsivity and prior aggression.
- may consider safety of partner and son.

Short term biological management of low mood and weight loss.

- ascertain quality of response to medication.
- seek collateral.
- mechanisms to enhance compliance: explore ambivalence / attitudes / meaning, psychoeducation, webster packing, checking impact of substance use on capacity to be compliant, close monitoring by case manager / key worker / mental health clinician.

- increase escitalopram to maximum dose, then consider switch if required.
- consider role of Ritalin in presentation.

Clarify substance use
- details of current usage, salience and motivation to change.
- details of previous attempts to stop and what strategies have worked / been helpful in past.
- window of opportunity to increase motivation for reduction based on pending court appearance.
- consider benefit of a group program that meets on a consistent basis to provide repetition to assist in processing and new learning.
- consider AA or other support services / groups.

Management of ADHD and borderline IQ
- clarify diagnoses by beginning to source available information / reports / collateral.
- if not already done, check cardiac history and order ECG in case as decision is made to increase Ritalin (to maximum 30mg bd or longer-acting alternative).
- no specific change to management in short term.

Social interventions
- permission to engage partner and family.
- ensure access to legal aid to assist him with his court case.

Maintain engagement
- goal setting with patient.
- provide consistency and provision of supportive / behavioural therapeutic interventions.

Monitor mental state and develop a risk management plan
- monitor suicidal ideation and impulsivity.

Ensure depression remits
- work through biological and psychological interventions as required (SNRI, augmentation, quetiapine, CBT) taking into account capacity to manage multiple / complex treatment regimes.

Review diagnoses
- despite prior diagnostic clarification.
- specific assessment of learning, reasoning, planning, abstract thinking, concentration.
- neurocognitive and neuropsychological assessment, psychometric testing to assist in rehab plan.

Ongoing participation in AOD programs
- longer term motivational interviewing, action planning and rehabilitation.
- consider need for residential rehab if not able to manage alone; considering he is surrounded by substance using peers.
- ensure not abusing Ritalin and manage storage of drugs (substance abusing friends, son visiting).

Interventions for intellectual disability
- assess areas of difficulty and identify available strategies to manage IQ between 70-80.
- referral to ID services/ Disability Support Services.
- does he meet criteria for NDIS in Australia.

Psychosocial engagement
- follow-up outcome of court case including bail restrictions or recommendations made by the court as these could include psychiatric care, drug and alcohol counselling or community work.
- ongoing involvement of partner / family.
- alternative social engagement outside of a drug focus.
- relationship counselling, social skills interventions, distress tolerance skills development, problem-focussed coping strategies, anger management, parenting skills.
- may consider benefit of addressing childhood abuse and early paternal loss if able to engage psychologically on that level.

Vocational rehabilitation
- work training and placement in keeping with interests and capability.
- leisure management assistance.

Candidates should conduct the interview and follow up in a respectful manner, recognising the change in role with Dr Duke being away and recognising the impact of borderline IQ on capacity to understand and engage. The candidate needs to incorporate the impact of ADHD and intellectual disability on formulating and implementing a management plan. Because of his wide range of difficulties with life skills, learning, vocation, addiction and mental illness he is likely to need case management and would benefit from a mentor / support worker who can help him attend and participate in treatment as well as gain social and emotional skills.

Frequent checking that Mr West understands the conversations and recommendations is vital, as is the importance of increasing non-drug using adult supports.

It is important to confirm compliance to treatment in this context including whether James manages his medication in an erratic manner due to the intellectual disability and the ADHD. ADHD and intellectual disability will also influence how his substance abuse and relationship issues are addressed.

Drug interactions and side effects need ongoing review. Particularly as methylphenidate may increase the blood levels and effects of escitalopram which is likely to lead the patient to experience side effects, including serotonin syndrome: symptoms such as confusion, hallucinations, seizures, extreme changes in blood pressure, increased heart rate, fever, excessive sweating, shivering or shaking, blurred vision, muscle spasm or stiffness, tremor, incoordination, stomach cramp, nausea, vomiting, and diarrhoea.

This man will benefit from specific psychological interventions tailored to his intellectual capacity to address relationship issues and maladaptive behaviours. These maladaptive behaviours are inhibiting his ability to adjust to situations and while this type of behaviour is often used to reduce anxiety in the short term, the result is dysfunctional and non-productive and tends to result in an increase in dysfunction by maintaining and strengthening the disorder. So the candidate should consider seeking input from a psychologist to provide a tailored approach addressing these issues including gaining more adaptive coping skills: for instance through problem-focussed coping strategies.

When choosing an effective coping strategy, it is useful to consider the changeability of the stressor and the patient's reaction to the stressor, as well as the adaptability of physiological responses. Problem-focused coping focuses on changing or modifying the primary cause of the stress, such as work-related problems and family-related problems. This can be an effective method of coping when it is practical, and the stressor is modifiable. The overarching goal for this type of coping is to reduce or remove the cause of the stressor and focusses on a person taking control of the relationship between them and the stressor. In addition, problem-focussed coping may include information seeking, or developing strategies to avoid the source of the stress. Problem-focussed coping is ineffective when an individual cannot exert control over a circumstance or stressor, or cannot make an adjustment to the stressor.

Emotion-focussed coping strategies involve efforts to regulate the emotional consequences of stressful or potentially stressful events. Stressors perceived as less controllable, like certain kinds of health problems, are better addressed using more emotion-focussed coping. People tend to use both types of strategies to combat most stressful events.

Anger management is readily available in most communities and on the internet and aims to assist people to better understand their anger and why it happens. These techniques encourage the person to prevent anger from occurring in the first place by recognising their triggers and early warning signs, or managing a situation before it gets out of control by learning and practising better ways of expressing anger and techniques to calm down.

It is important that candidates identify and outline their own role and those of other members of the multi-disciplinary team in treatment and reducing risk of relapse. Interface and referral with other stakeholders and service providers should also be clarified. This will include involvement family and friends and agencies like department of child services or similar services to improve child safety. Social worker input will be helpful in this regard. The candidate may consider recommending NGOs / support services to James' partner and services to provide psychological support to the child.

A surpassing candidate may:

- Meet the majority of the treatment plan as identified by the consensus group
- Clearly outline a hierarchy of options for the treatment of depression, particularly about the timing and choice of augmentation or switching.
- Consider the possibility of an antisocial personality and how this is difficult to diagnose on a background of ADHD and ID.
- Tailor the type of psychological interventions to the specific needs of James.

<u>Second Task</u>

Mr West is also facing charges for driving a motor vehicle without a licence for which a court report is due and for the second task the candidate should identify the key areas that need to be addressed in a court report for the pending charge; including the nature of the court report request and details of the charges as provided by the police and the potential impact of disposition. The candidate should be able to discern between a letter of

fact and a letter of opinion. The letter of fact, being written by the treating doctor about issues related to the diagnosis and treatment, the patient's possible level of wellness at the time and attendance for ongoing care. The letter of opinion focusses more on whether the person is deemed to not be criminally responsible because of a serious mental illness; whether they were deprived of capacity at the time of the alleged offence and whether they are fit for trial.

The candidate needs to demonstrate that they are familiar with the assessment process to complete a court report. This would include clarifying the whether the mental illness was active at the time, whether it has an impact on decision making capacity, specifically to know the nature and quality of the act, capacity and fitness to plead/stand trial, whether there are other relevant issues (dispute of facts, intoxication).

Some jurisdictions also consider culpability (insanity defence), responsibility and mitigation. A better candidate will also comment on the impact of any court decision on mental health and recommendations to court regarding treatment and make cautious comment on discussing the risk of re-offending.

A candidate may also comment on the detail of the report itself, which involves outlining your qualifications, explaining your relationship and role with Mr James including the time period you have known him, responding to the specific areas that the lawyer has requested for comment if a legal request, details as to the limits of confidentiality discussed, assessment of capacity, mental state assessment, overall summary and confirmation of mental health follow up, possible disposition options.

The McNaughton (M'Naghten) Rule:

In 1843, a man named Daniel McNaughton attempted an assassination on the British Prime Minister Robert Peel, and mistakenly shot the secretary of the Prime Minister's secretary Edward Drummond. McNaughton believed the government was out to get him.

McNaughton was acquitted of his actions because he was deemed "insane," and was not held accountable for his actions. The House of Lords established the main idea that posed as the question, "did the defendant know what he was doing, or, if so, that it was wrong?" ("United Kingdom House of Lords Decisions," 1843).

Essentially in the McNaughton Rule:

- There is a presumption, that the defendant is sane, and that they are responsible for their criminal acts.
- At the time of the crime, the defendant must have been suffering from a "disease of the mind."
- If the defendant knows the nature of the crime, do they know what they did was wrong.

Whether a particular condition amounts to a disease of the mind within the Rules is not a medical but a legal question and it is decided in accordance with the ordinary rules of interpretation. Any disease which produces a malfunctioning of the mind is a disease of the mind and need not be a disease of the brain itself.

In 1851, the McNaughton Rule was adopted in the US court system. There were several criticisms to the McNaughton Rule including:

- There was medical irrelevance, making it not as valid.
- There was ineffectiveness to distinguish between those who represent a public danger, and who do not.
- There were problems with sentencing.
- It did not permit complete and adequate testimony, making it less trusted.

When considering an understanding of the charges, there is no clear definition of 'dispute of facts' apart from that the common interpretation. The person charged with an offence may choose to dispute the facts recorded in the charge sheet / court brief. The dispute of facts is less to do with mental health and more a legislative implication.

Therefore if the person disputes the documented facts they can argue their case in court. In a court report the psychiatrist would usually make a note stating whether the person agrees to or disputes what is written on the charge sheet/court brief. No further action is required for a report.

Presser Criteria:

The 'Presser criteria', the test for unfitness to stand trial derives from the judgment of Justice TW Smith in the case of R v Presser (Presser). In the case of R v Pressor Justice TW Smith expanded the Prithcard criteria described in the 1836 R v Pritchard case (which had set out the following questions for the jury to answer in determining a defendant's sanity:

'There are three points to be enquired into:- first, whether the prisoner is mute of malice or not; secondly, whether he can plead to the indictment or not; thirdly, whether he is of sufficient intellect to comprehend the course of the proceedings in the trial so as to make a proper defence - to know that he might challenge any of you [the jury] to whom he may object - and to comprehend the details of the evidence, which in a case of this nature must constitute a minute investigation.'

The seven Pritchard criteria determine unfitness to stand trial:

- ability to understand the charge.
- ability to plead to the charge and to exercise the right to challenge jurors ability to understand generally the nature of the proceedings (that it is an inquiry as to whether the accused did what they are charged with).
- ability to follow the course of the proceedings.
- ability to understand the substantial effect of any evidence that may be given against them.
- ability to make their defence or answer to the charge.
- ability to give any necessary instructions to their legal counsel.

An accused person is unfit to stand trial for an offence if, because their mental processes are disordered or impaired, they are or, at some time during the trial will be:

- unable to understand the nature of the charge.
- unable to enter a plea to the charge and to exercise the right to challenge jurors or the jury.
- unable to understand the nature of the trial.
- unable to follow the course of the trial.
- unable to understand the substantial effect of any evidence given against them.
- unable to give instructions to their legal practitioner.

Each of these criteria stands alone. An accused person need only satisfy one of the above criteria to be found unfit to stand trial.

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 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.

STATION 1 – MARKING DOMAINS

The main assessment aims are to:

- Review and assimilate the written clinical handover in order to develop a biopsychosocial management plan from the information obtained in the Bye Station.
- Ensure that the plan covers short and longer term interventions which involves the multi-disciplinary team and other agencies in the provision of comprehensive treatment.
- Demonstrate an understanding of the key areas to be covered in a court report in order to address a pending charge.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.14 Did the candidate demonstrate an adequate knowledge and application of relevant biological and psychosocial treatments as per examiners instructions? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:
Achieves a score of at least 4 *and* includes a clear understanding of levels of evidence to support treatment options; demonstrates knowledge of capacity to manage the interaction between methylphenidate and escitalopram.

Achieves the Standard if:
addresses the clinical value of methylphenidate, considers implications with escitalopram; checks for side effects; consider augmentation or switch of the antidepressant; demonstrates consideration of other barriers to implementation including substance abuse; recognises their role in treatment plan implementation; proposes motivational interviewing to address substance abuse; considers issues regarding his relationship with his partner especially looking at anger management.

To score 3 or above the candidate **MUST**:
a. Confirm compliance to treatment in the context of ADHD and intellectual disability.
b. Recommend increasing the dose of escitalopram.

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:
errors or omissions in plan would impact adversely on patient care; lack of tailoring of plan to this patient's specific needs or circumstances would have adverse consequences; candidate demonstrates level of skill and knowledge which is grossly inadequate.

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

1.16 Did the candidate formulate an appropriate longer term management plan, including preventative treatment and referral to other specialists / resources? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* overall plan is sophisticated, tailored yet comprehensive; tailors each psychological intervention to his unique levels of functioning; identifies long term therapy needs to address relationship issues and impact of mental illness on the child; elaboration of discharge / termination arrangements.

Achieves the Standard if:
prioritises and implements evidence based care; gives priority to continuity of care; long term monitoring of use of antidepressants and stimulants and complications; ongoing monitoring of substance abuse to reduce risk of relapse; identifying therapy options to address relationship issues and the impact of mental illness on the child; appropriate reference to long-term outcomes; acknowledging appropriately realistic possibility of treatment failure – of treatment alliance, resources, drug or psychological therapies.

To score 3 or above the candidate **MUST**:
a. Recommend specific psychological interventions tailored to his intellectual capacity to address relationship issues and maladaptive coping skills.

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:
errors or omissions will adversely affect outcomes; candidate has difficulty with most of the skills above.

1.16. Category: MANAGEMENT - long-term, preventative	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

3.0 COLLABORATOR

3.1 Did the candidate demonstrate an appropriately skilled involvement of multidisciplinary team members? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* takes a leadership role; effectively negotiates complex issues; works to reduce conflict.

Achieves the Standard if:
involves other disciplines in the multi-disciplinary team especially psychologist, drug and alcohol services and social worker; demonstrates respect, by acknowledging and understanding other roles and contributions; listening to differing views; maintaining open communication while providing leadership; actively encouraging contributions; demonstrating awareness of interpersonal issues that affect functioning.

To score 3 or above the candidate **MUST**:
a. Review readiness to change for alcohol and marijuana.

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 if:
does not readily identify relevant people / agencies involved in care; any errors or omissions adversely on constructive teamwork.

3.1. Category: TEAMWORK	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

3.3 Did the candidate demonstrate an appropriately skilled approach to consumer / carer representatives / other health professionals / community agencies? (Proportionate value - 15%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* recognises complexity of liaison; manages potential conflicts of interest; readily contributes to interagency activities. Involve psychological support for his partner and child.

Achieves the Standard if:
liaising with relevant stakeholders / agencies; interface with Department of Child Safety or equivalent service; utilising services available; demonstrating respect, acknowledging and understanding roles, listening to differing views; building therapeutic relationships to improve patient outcomes; maintaining an effective working alliance; effectively liaising with other psychiatrists in complex clinical situations.

To score 3 or above the candidate **MUST**:
a. Refer to AA and / or other support groups.

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:
any errors or omissions adversely impact on collaborative relationships.

3.3. Category: EXTERNAL RELATIONSHIPS	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

7.0 PROFESSIONAL

7.2 Did the candidate demonstrate an adequate knowledge of legislation / regulatory requirements? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 below *and* analyses and incorporates professional guidelines and codes of conduct into practice; considers aspects of individual rights / rights to natural justice for the patient; competently articulates McNaughton's rule and Presser criteria.

Achieves the Standard if:
demonstrates capacity to apply relevant medicolegal assessment requirements; seeks advice and support as required; refers to McNaughton's rule / Presser criteria; discusses dispute of facts; clarifies letter of fact versus letter of opinion.

To score 3 and above the candidate MUST*:*

- adequately address the person's unsoundness of mind, understanding the nature of the charge and their fitness to stand trial.

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:
poor knowledge of medicolegal frameworks for assessing offences; does not seek advice or support if unfamiliar with key aspects; does not see the court report as part of their role.

7.2. Category: COMPLIANCE & INTEGRITY	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
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 defined tasks?

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

Committee for Examinations
Objective Structured Clinical Examination

Station 2
Melbourne April 2016

The Royal Australian & New Zealand College of Psychiatrists

1.0 Descriptive summary of station:

The candidate is to interview a 35-year-old mother with borderline personality disorder to discuss her concerns about her parenting and the effect of her disorder on her children. She is willingly presenting to the community mental health clinic 48 hours post overdose.

1.1 The main assessment aims are:

- To evaluate the candidate's ability to support a parent with borderline personality disorder to enhance protective factors as well as identify and reduce risk factors for their children. This requires:
  - Assessment of the candidate's ability to establish rapport and a therapeutic alliance with the mother;
  - Assessment of the candidate's knowledge of the day to day parenting difficulties faced by patients with borderline personality disorder and how addressing parenting can achieve positive health outcomes for the parent and the child;
  - Assessment of the candidate's ability to negotiate and develop a plan for the parent to address the issues.

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

- Modulate the patient's distress when discussing topics that are potentially shameful, ensuring that the patient is ready to have the conversation about her parenting skills.
- Demonstrate non-judgemental intervention with appropriate consideration of risk issues.
- Elicit history of common problematic behaviours towards their children in a parent with personality disorder and the common problems experienced by children with parents with borderline personality disorder.
- Briefly exclude family violence and current parental substance abuse.
- Be specific about the strategies like setting rules and limits, ensuring the safety of the children, or increasing positive interactions.
- Consider child protection issues.
- Effectively engage the patient in discussion of relevant strategies to address her concerns.
- Elicit the patient's goals and incorporate these in the plan.
- Appropriately acknowledge and respond to the patient's negative feelings towards her daughter.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category of:**
  Child and Adolescent Disorders (Children of Parents with Mental Illness)
- **Area of Practice:**
  Adult Psychiatry
- **CanMEDS Domains of:**
  Medical Expert; Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes of:**
  Medical Expert (Assessment, Management), Communicator (Conflict Management)

References:

- Barnow, S., Spitzer, C., Grave, H.J., Kessler, C. & Freyberger, H.J. (2006) Individual characteristics, familial experiences, and psychopathology in children of mothers with borderline personality disorder. *Journal of the American Academy of Child and Adolescent Psychiatry,* 45(8), 965-972
- Dutton, D.G., Denny-Keys, M.K. & Sells, J.R. (2011) Parental personality disorder and its effects on children: a review of the current literature, *Journal of Child Custody*, 8(4), 268-283
- Project Air Strategy for Personality Disorder (2015) *Treatment guidelines for personality disorders,* 2nd edition, NSW Health and IHMRI
- Stepp, S.D., Whalen, D.J., Pilkonis, P.A., Hipwell, A.E. & Levine, M.D. (2012) Children of mothers with borderline personality disorder: Identifying parenting behaviours as potential targets for intervention, *Personality Disorders: Theory, Research and Treatment,* 3(1), 55-65
- Family Crisis Plans: http://ihmri.uow.edu.au/content/groups/public/@web/@ihmri/documents/doc/uow194246.pdf

1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Five chairs (examiner x 2, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player – young woman, preferably in her thirties: must be plausible mother of children aged 8-14 years.
- Pen for candidate.
- Timer and batteries for examiners.

2.0 Instructions to Candidate

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

You are working as a junior consultant psychiatrist in an adult mental health community team.

Margaret is a 35-year-old mother of two children who has been referred to you for review 48 hours after presenting with an overdose to the Emergency Department (ED). The referral notes from the Registrar who assessed her in the ED record that this was an impulsive overdose occurring in the context of current stressors at work.

The Registrar documented that Margaret is well engaged in individual psychotherapy and a Dialectical Behaviour Therapy (DBT) group. Whilst the overdose is part of a longitudinal pattern in dealing with stress, there are clear indicators that, over time, she is managing distressing affects and stress in more functional ways.

However the Registrar has noted that Margaret is the single mother of two children, that there has not been an assessment of Margaret's parenting as part of her care plan and Margaret is expressing concerns about this.

Your tasks are to:

- Discuss with Margaret her concerns as a parent.
- Briefly assess any risk or safety concerns for the children with Margaret.
- Discuss with Margaret strategies to address her concerns about her parenting.

You will not receive any time prompts.

Station 2 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
  - 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 and co-examiner.

During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- TAKE NOTE there are no cues for any scripted prompts in this station.
- 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 **fifteen (15) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

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

If a candidate elects to finish early:

- 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 time prompts for the examiner.

The role player opens with the following statement:

"Doctor, I would like to discuss some issues with my kids. It's really getting me down".

3.2 Background information for examiners

In this station the candidate is asked to interview a 35-year-old divorced mother with borderline personality disorder to discuss her concerns about her parenting and the effect of her disorder on her children. Margaret is willingly presenting to the community mental health clinic 48 hours after an impulsive overdose following conflict at work.

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

- Modulate the patient's distress when discussing topics that are potentially shameful, ensuring that the patient is ready to have the conversation about her parenting skills.
- Demonstrate non-judgemental intervention with appropriate consideration of risk issues.
- Elicit history of common problematic behaviours towards their children in a parent with personality disorder and the common problems experienced by children with parents with borderline personality disorder.
- Briefly exclude family violence and current parental substance abuse.
- Be specific about the strategies like setting rules and limits, ensuring the safety of the children, or increasing positive interactions.
- Consider child protection issues.
- Effectively engage the patient in discussion of relevant strategies to address her concerns.
- Elicit the patient's goals and incorporate these in the plan.
- Appropriately acknowledge and respond to the patient's negative feelings towards her daughter.

The candidate is expected to discuss with Margaret her concerns about her parenting in a non-judgemental and empathic manner in order to establish a working alliance with her. The candidate must undertake an assessment of any risk or safety concerns and should briefly elicit information about her parenting and her family life as it relates to the better understanding of the situation.

The candidate needs to demonstrate their knowledge of the common problematic behaviours of parents with borderline personality disorder: e.g. lack of basic parenting skills, low sensitivity and responsivity; inconsistent discipline; role-reversal. They should also demonstrate their knowledge of the common problems experienced by children of parents with borderline personality disorder: e.g. risk of emotional, behavioural, social and cognitive difficulties; high transmissibility of self-harm behaviours; inter-generational transmission of the disorder; as well as knowledge of how these intersect with the developmental needs of the child.

The candidate needs to demonstrate their skills at modulating the patient's distress as Margaret discusses topics that are potentially shameful (as patients have a tendency to view themselves as 'bad' or not be satisfied with their parenting role) and will raise fear of the involvement of child protection authorities. In order to do this the candidate needs to observe and work with negative feelings by the parent towards the child (e.g. anger or jealousy) and manage their own countertransference. This is in conjunction with the candidate being able to assess whether Margaret is ready for this conversation: for example, does not find discussion of her parenting and family life traumatic; is not currently in crisis or actively suicidal.

Appropriate consideration of child protection issues and brief exclusion of family violence and parental alcohol and substance abuse is expected to be covered.

The candidate is expected to discuss strategies with Margaret on how to address her concerns about her parenting. Non-judgmental intervention with the parent is aimed at building self-efficacy, confidence and

promoting positive parent-child interactions. The candidate should explain how discussing parenting can help them and their children. Issues like addressing fears, reluctance, negative feelings towards a child; that no-one is a perfect parent; and exploring current challenges and strengths can be covered.

Practical strategies include:

- Separating parenting from personality disorder: talking to children about personality disorder; shielding children from the symptoms; ensuring children do not take on adult responsibilities; maintaining simple routines at home; setting limits in a positive way; considering the children's needs and feelings; spending enjoyable time together;
- Developing a Family Crisis Care Plan (see example appended);
- Reinforce role of the parent having treatment;
- Consider need for referral for further specialist intervention.

A variety of approaches can be taken to developing a Family Crisis Care Plan. They tend to be prepared in case children's legal guardian (mother) is unable to care for them temporarily due to mental illness or hospitalisation. The plan aims to represent the intentions of the legal guardian at the time of creation, and includes who they are to stay with; who can visit / access them and other information like the children's daily routine (daycare, school, activities, food, bedtime, etc.): things that help settle the children when upset (likes, dislikes, favourite toys or books, etc.); and any health or medical needs; and how the parent would like to keep in touch with their children. Ideally, all legal guardians will be aware of, and in agreement with, this plan.

A better candidate may:

- Provide a more sophisticated approach to encourage positive interactions between parent and child:
  - Discuss the attachment bond and how this can be strengthened;
  - Reflect on the relationship patterns between the parent and child;
  - Use of mindfulness in interaction with the child;
- Be better at separating out the individual developmental needs of each child.

3.3 The Standard Required

In order to:

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

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

i. they have competence as a ***medical expert*** who can apply psychiatric knowledge including medico-legal expertise, clinical skills and professional attitudes in the care of patients, (such attitudes may include an ability to tolerate uncertainty, balance, open-mindedness, curiosity, "common sense" and a scientific approach).
ii. they can act as a ***communicator*** who effectively facilitates the doctor patient relationship.
iii. they can ***collaborate*** effectively within a healthcare team to optimise patient care.
iv. they can act as ***managers*** in healthcare organisations who contribute to the effectiveness of the healthcare system, organise sustainable practices and make decisions about allocating resources.
v. they can act as ***health advocates*** to advance the health and well-being of individual patients, communities and populations.
vi. they can act as ***scholars*** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.
vii. they can act as ***professionals*** who are committed to ethical practice and high personal standards of behaviour.

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

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 Margaret, a 35-year-old woman, who works as a part-time secretary to a senior academic at the local University. You live with your two children, Matilda aged 8 years and Harry aged 14 years, in rented accommodation. You earn a reasonable living but finances are always tight. Your relationship with your boss is positive and he has been very understanding when you have missed time from work as a result of a crisis (for example, see below) or the children being unwell.

Life has been difficult for you for a long time. You are the eldest child in a family of 5 children and grew up in a middle-class family in secure circumstances up until you were about 8 years of age. At that time you were sexually abused by a trusted neighbour over a period of 12 months. The abuse was discovered when he was arrested for molesting another child. After a criminal trial in which you were a witness, the man was sent to jail. You were eventually awarded victim's compensation but this led to serious conflict between your parents as your mother wanted to invest the money for your future and your father wanted to use the money at the time for a new home for the family. Eventually a child advocate arranged for the money to be held in trust. But you always felt as a result that your relationship with your parents was damaged and that you were responsible for any family unhappiness.

You did well at school and started an Arts degree but really couldn't settle and quickly dropped out. Later on you trained as a secretary and you have always been employed. You have been settled for the last 5 years in your current job. You are reasonably happy there and enjoy particularly the intellectual stimulation of assisting the Professor in preparing his teaching materials and papers.

You feel that no-one really knows you well. You think that most people would be very surprised to learn how much you struggle with depression and self-loathing. You started a pattern of self-harm in response to thoughts of self-hatred as an adolescent. The methods have varied over time: delicate self-cutting as an adolescent, later binge drinking, as a young adult emotionally destructive sexual relationships, not taking care of your health or ignoring medical advice about physical ailments, binge eating, allowing yourself to get physically sicker and sicker with ailments like the flu, and periodic (every couple of months or so) overdoses of any available medication.

The latest overdose happened after a misunderstanding with your boss; you over-reacted which left you feeling helpless and full of self-hatred. You left work early, went home and drank a tumbler of wine which didn't make you feel any better; you hit yourself around the face a few times and then impulsively took some old Valium (you can't even remember why or when you were prescribed it in the first place). Then you calmed down and realised the children would be home from school soon and called a neighbour to drive you to hospital (fortunately another neighbour was available to meet the children when they arrived home).

Relationships have always been so difficult for you – in fact you sometimes think that is really the biggest problem that you have. You don't feel you can trust people or be really close to them; you don't think people really care about you; and you constantly feel misunderstood. A few years ago you felt really desperate to sort yourself out, so you asked your GP for a referral to a psychiatrist. You really connected with the person that you see (Dr Mary Smith) and you have been seeing her twice a week for about 3 years. You feel so much calmer generally and just not as tossed around by your moods. She suggested about a year ago that you join a DBT group and that has been incredible in helping you feel that you can manage even better.

DBT or Dialectical Behaviour Therapy is a type of cognitive behavioural therapy (CBT) which aims to teach people skills to cope with stress, to regulate their emotions and improve relationships with others. DBT is very helpful for people who have urges to harm themselves, such as those who self-injure or who have suicidal thoughts and feelings. It was originally developed for people with borderline personality disorder, but has since been adapted for other conditions where a person has self-destructive behaviour, such as eating disorders and substance abuse. The major skills and techniques taught are:

1) Mindfulness techniques – techniques designed to increase the ability of clients to stay 'present focussed' and to overcome the mental wrestle over unwanted intrusive thoughts, images and emotions.
2) 'Interpersonal Effectiveness Skills' – skills at negotiating interpersonal challenges, especially confrontation and conflict.
3) Emotion Regulation Skills – skills designed to replace unhelpful and / or destructive emotion coping approaches.
4) 'Distress Tolerance' Skills – skills to tackle the extreme emotional pain, often associated with crises.

It combines traditional CBT with techniques such as mindfulness and acceptance.

Apart from the Valium you found from long ago, you have never been prescribed regular mental health / psychiatric medication. You have no physical health problems, you rarely drink alcohol and have no history of abusing any kind of drugs.

You became pregnant at 21 years old to George. You didn't really think there was any future as he was so reliable and dull but you went along with his wish to get married. It was unhappy from the start and George left soon after your second child, Matilda, was born. There is no history of domestic violence. He has been a responsible 'absent' father and has provided financially for the kids and sees them regularly. He did remarry a few years back and your eldest child, Harry, doesn't really like his step-mother. There is a bit of tension there but it seems not too bad at the moment. You do think George could do more in terms of taking the kids to give you a break but haven't felt able to ask him this because somewhere in the back of your mind you fear that one day he might seek custody.

Harry is now aged 14 years. You had some spontaneous miscarriages before falling pregnant with Matilda, now aged 8 years. You have already discussed with your therapist that you think some really painful feelings are being stirred up as she is now the age at which you were abused and it makes you feel scared for her as well as really angry and distressed at how your life changed as a result.

Both pregnancies to term were normal. Both children are developmentally normal and succeeding at school. Harry is a quiet and serious boy, and you are worried that he feels very responsible for looking after you. You remember many times from his childhood that you felt tired and overwhelmed, often impulsively responding to him when a strong response wasn't warranted (sometimes surprising yourself at how angry you can be when he does something minor, like turning the TV up too loud). Sometimes you feel hopeless and overwhelmed by all the times you have been a '*bad parent'* (e.g. Harry saw you self-harm some times when he was young, you sometimes get angrier than you should with the kids, you can be inconsistent with rules and discipline, you haven't always been the strong one like a parent should be) and find it hard to hold onto the good things you have done.

You know that Harry was also exposed to some of your self-harming behaviour, including binge drinking and he did find you after an overdose when he was about 9 years of age and had to call an ambulance. He rings you during the day, sometimes several times if he thinks you are in a bad space. He rushes home every afternoon to help you around the house. Sometimes he will even come to the bathroom door if he thinks you have been in there too long, just to check on how you are. You wish Harry would be less worried about you and would spend more time outside the family home mixing with his friends; sometimes he makes you angry when he hovers around you. You feel your anger rising, you feel tense, you clench your fists, you become spiteful. You also notice that he is very protective towards his younger sister, sometimes fussing over her which you don't think is appropriate for a boy of his age. His teacher made a comment at a recent parent-teacher night that you can't get out of your head about sometimes children being too close to their families.

Matilda is a bright young girl, well liked at school and talented. You feel that you have a very intense relationship with her and she can be quite demanding, even a bit coercive with you, like she is the parent and rules the home. In contrast to Harry, you don't think she has been exposed to your self-harm behaviours but probably was a bit more exposed to all the disruption and high emotion following the divorce. Sometimes, especially lately you've felt a bit frightened of her and that you don't really like her – but you can't really pin down why this would be.

You readily acknowledge that you can be inconsistent with the rules and discipline, although you do try to keep the home routine predictable. You enjoy weekend outings to the park with the children, helping them with their homework and the quiet time in the evening watching TV with them in the lounge which is a great chance to talk to them about the day.

You do not currently feel depressed or suicidal. You are willing to engage in intervention focussed on your parenting skills. You will raise with the candidate in the interview, your fear that child protection authorities may become involved (see scripted question).

4.2 How to play the role:

You are co-operative and willing, eager to discuss your problems and concerns regarding parenting. However you are very sensitive to any hint of criticism. You are ashamed of the negative feelings that you have towards your children.

There will be a small component of non-verbal behaviour to indicate shame that will be discussed during the training.

You accept that you have a borderline personality disorder and understand that this means difficulty in managing relationships including intense fear of abandonment, as well as mood swings, rapid changes in self-identity and strong negative emotions which all leave you vulnerable to self-hatred, suicidal ideas and impulsivity.

4.3 Opening statement:

"Doctor, I would like to discuss some issues with my kids. It's really getting me down".

4.4 What to expect from the candidate:

The candidate should ask you detailed questions about your concerns and proceed to explore your understanding of how discussing parenting can assist with your recovery journey and be helpful to your children's development. The candidate should address your fears or reluctance to address issues, help you reflect on the ways you do provide good care for your children (including preparing meals, shared activities etc), explore your goals with you and collaboratively develop a shared understanding of what kind of interventions might be helpful.

They should speak with you about ways of keeping the children safe, separating parenting from personality disorder, developing a family crisis plan and reflecting on your relationships with your children to allow them to be children, considering their needs and feelings, and spending enjoyable time together.

Any risk assessment of your risks of self-harming by the candidate should be brief. The risk assessment for the children should indicate that you are generally parenting well enough that there are no serious, immediate or acute concerns.

4.5 Responses you MUST make:

The anticipated question would be inviting you to expand on your opening statement:

Scripted response:

"Sometimes I feel so ashamed of the terrible person that I am, the things I've done in the past". Here you are referring to the issues mentioned in the vignette.

The anticipated question would be inviting you to raise any additional concerns:

Scripted response:

"Will child protection need to get involved?"

The anticipated question would be more detailed exploration of the interventions / treatments you have received:

Scripted response:

"Therapy and DBT is very helpful and I am really committed to it. But I don't really want to use this time to talk about me – I want to focus on the children".

4.6 Responses you MIGHT make:

The anticipated question would be a narrow inquiry about what you think is the impact of your disorder on the children. The anticipated response is designed to broaden inquiry to focus on each of the children as individuals.

Scripted response:

"But how is the impact of my personality disorder different for Harry and Matilda?"

STATION 2 – MARKING DOMAINS

The main assessment aims are:

- To evaluate the candidate's ability to support a parent with borderline personality disorder to enhance protective factors as well as identify and reduce risk factors for their children. This requires:
  - Assessment of the candidate's ability to establish rapport and a therapeutic alliance with the mother;
  - Assessment of the candidate's knowledge of the day to day parenting difficulties faced by patients with borderline personality disorder and how addressing parenting can achieve positive health outcomes for the parent and the child;
  - Assessment of the candidate's ability to negotiate and develop a plan for the parent to address the issues.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.1 Did the candidate adequately conduct an assessment of the patient? (Proportionate value - 10%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* clearly achieves the standard overall with a superior performance in a number of areas; superior technical competence in eliciting information.

Achieves the Standard by:
managing the interview environment; integrating generalist and sub-specialist assessment skills; demonstrating flexibility to adapt the interview style to the patient; being attuned to patient disclosures including non-verbal communication of shame; recognising emotional significance of the patient's story and responding empathically; sensitively evaluating quality and accuracy of information; clarifying inconsistent information efficiently.

To score 3 or above the candidate **MUST**:
a. modulate the patient's distress when discussing topics that are potentially shameful, ensuring that the patient is ready to have the conversation about her parenting skills.
b. demonstrate non-judgemental intervention with appropriate consideration of risk issues.

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:
significant deficiencies such as being insensitive or judgemental to the patient; using aggressive or interrogative style; having a disorganised approach; fails to acknowledge the patient's strengths and positive behaviours towards her children. Neither (a) nor (b) demonstrated.

1.1. Category: ASSESSMENT – data gathering process	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

1.2 Did the candidate take appropriately detailed and focussed history? (Proportionate value - 20%)

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

Achieves the Standard by:
obtaining a history relevant to the patient's problems and circumstances with appropriate depth and breadth; taking a history that is hypothesis-driven; demonstrating ability to prioritise and eliciting the key issues; completing a risk assessment relevant to the individual case; exploring role of the children's father.

To score 3 or above the candidate **MUST**:
a. elicit the common problematic behaviours towards their children in parents with personality disorder and the common problems experienced by children with parents with borderline personality disorder. Note each of the children exhibits different elements of these problematic behaviours.
b. briefly exclude family violence and current parental substance abuse.

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

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 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

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

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

Achieves the Standard by:
demonstration of ability to prioritise and implement evidence based care skills; risk management including a family crisis plan; recommend specific treatments; safe skilful engagement of appropriate treatment resources / support; communication to necessary others, particularly the children's father about his role; recognition of their role in effective treatment; identification of potential barriers; safe, realistic time frames / risk assessment / review plan; recognition of the need for consultation / referral / supervision.

To score 3 or above the candidate **MUST**:
a. be specific about the strategies like setting rules and limits, ensuring the safety of the children, or increasing positive interactions.
b. consider child protection issues.

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:
errors or omissions will impact adversely on patient care; plan lacks structure or is inaccurate; plan not tailored to patient's immediate needs or circumstances; fails to address safety issues.

1.13. Category: MANAGEMENT - Initial Plan	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

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

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* 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:
demonstrating ability to: clearly communicate range of options and recommendations; work within patient goals and negotiate targeted outcomes; obtain consent with due consideration to sharing information with the children's father as non-custodial parent; reasonably establish that the patient understands and is in agreement with treatment; adequately inform regarding treatment risks / benefits and complications, including potential adverse outcomes; recommend psychoeducational material; arrange or commit to ongoing management, including crisis options; employ a psychologically informed approach, especially to risky behaviours.

To score 3 or above the candidate **MUST**:
a. effectively engage the patient in discussion of relevant strategies to address her concerns.
b. elicit the patient's goals and incorporate these in the plan.

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:
description of the management plan lacks structure; inaccuracies or errors about specific therapies impact adversely on patient care; difficulty tailoring treatment to the patient's specific circumstances.

1.15. Category: MANAGEMENT - Treatment Contract	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

2.0 COMMUNICATOR

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

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* demonstrates sophisticated reflective listening skills.

Achieves the Standard by:
acknowledging and responding empathically to the patient's feeling that she is a 'bad parent'.

To score 3 or above the candidate **MUST**:
a. appropriately acknowledge and respond to the patient's negative feelings towards her daughter.

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 score 1.

Does Not Achieve the Standard (scores 0) if:
any errors or omissions impair attainment of positive outcomes; judgemental / rejecting attitude.

2.3. Category: CONFLICT MANAGEMENT	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
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 defined tasks?

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

Committee for Examinations
Objective Structured Clinical Examination

Station 3
Melbourne April 2016

The Royal Australian & New Zealand College of Psychiatrists

1.0 Descriptive summary of station:

This is a long station where the candidate must conduct part of their session with a long-term psychotherapy patient who presents a gift. The candidate must determine the key issues arising in the session, specifically addressing the gift giving, and decide on a course of action including their reasons for these actions.

1.1 The main assessment aims are:

- To assess the capacity of the candidate to empathically conduct part of a psychotherapy session addressing the issue of being given a gift by a patient.
- To demonstrate ethical conduct and practice in relation to a long term psychotherapy patient during feedback to the examiners.
- To demonstrate effectively the capacity to communicate to the patient and the examiners the reasoning behind their decisions about the gift.

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

- Demonstrate a thoughtful and empathic attitude during the discussion of the acceptance / refusal of the gift.
- Reflect on the nature and timing of a gift.
- Describe the principles surrounding management of gift giving from a more general perspective.
- Specify when it is / is not appropriate to accept a gift.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category of:**
  Personality Disorders and Ethics
- **Area of Practice:**
  Psychotherapy
- **CanMEDS domains of:**
  Medical Expert, Collaborator, Professional
- **RANZCP 2012 Fellowship Program Learning Outcomes of:**
  Medical Expert (Assessment), Collaborator (Patient Relationships), Professional (Ethics)

References:

- Receiving gifts from patients - a pragmatic shade of grey. Marois,J. BC Medical Journal, 2010 ; 52:129
- "Hysterical and Histrionic Personality Disorders" (Ch 17), in Psychodynamic Psychiatry in Clinical Practice; Glen O Gabbard.
- "Long-term Psychotherapy: A Basic Text. Core Competencies in Psychotherapy" Glen O Gabbard.
- "Boundaries in the Doctor-Patient Relationship", Nadelson & Notman. Theoretical Medicine and Bioethics 2002; 23: 191 – 201.
- The Concept of Boundaries in Clinical Practice: theoretical and risk management dimensions. American J Psychiatry 1993; 150-188-196.

1.4. Station requirements:

- Standard consulting room; no physical examination facilities required.
- Five chairs (examiners x 2, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Simulated patient – female, age early 30s.
- Gift CD with a ribbon (blank CD).
- Pen for candidate.
- Timer and batteries for examiners.

2.0 Instructions to Candidate

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

The psychotherapy supervisor will be played by the examiner.

You are working as a junior consultant psychiatrist in a community mental health service. You are in an appointment with your patient, Elizabeth, whom you have been seeing for weekly psychotherapy for the past six months. As she walked into the clinic, you noticed that she was carrying a gift.

Elizabeth is a 31-year-old music teacher who has a past history of a mild Major Depressive Episode (now resolved) and personality issues of low self-esteem, apparent passivity in relationships, and compulsive care-giving. The depression was precipitated by the break-up of a relationship around September 2014.

She has previously given you gifts at various times throughout the therapy such as a Christmas card, a small bunch of flowers at New Year, and recently, a souvenir (a pen) from a trip to Dreamworld, which you have accepted.

Your tasks are to:

- Spend the first part of this station managing this psychotherapy session.
- At **ten (10) minutes** you will be advised to proceed to the second task (if you have not already done so) where you **must** summarise the situation and provide the reasons for your approach and decisions to your psychotherapy supervisor.

Station 3- Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario, e.g. wrapped gift for the patient.
- 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 and co-examiner.

During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number on entry.
- TAKE NOTE of the time for the scripted prompt you are to give at **ten (10) minutes**.
- 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 **ten (10) minutes**, as indicated by the timer, if the candidate has not commenced the second task, one examiner offers a verbal prompt:

  "Please proceed to the second task."
- At **fifteen (15) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking and place your co-examiner's and your mark sheet in **<u>one</u>** 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 <u>must</u> remain in the room and <u>NOT</u> proceed to the next station until the bell rings."

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

The psychotherapy supervisor will be played by the examiner.

There is no opening statement from the examiner.

The role player opens with:

"Doctor, before we go any further today I wanted to thank you with this CD I made especially for you. Happy 6 month anniversary."

One examiner should keep time and offer a verbal prompt at ten (10) minutes:

"Please proceed to the second task."

3.2 Background information for examiners

This station aims to assess how a candidate responds to a patient in long-term psychotherapy presenting them with a small, though not trivial, gift. The tasks are to manage the consultation with the patient and present matters arising with their psychotherapy supervisor, who will be played by one of the examiners.

The candidate is expected to briefly explore and take a focussed history from the patient addressing her rationale for bringing the gift. Using an empathic manner the candidate should investigate the possible significance of Elizabeth presenting a gift to her therapist and respond skilfully in managing the situation. This situation should be dealt with, with compassion, honesty and integrity.

In the second task the candidate should demonstrate how they identified the ethical issues involved. They should justify their response to Elizabeth, and demonstrate awareness of how their own behaviour and response may affect the patient.

A critical aspect of this station is that there is 'no single right answer' but a number of different responses and approaches that can be taken by the candidate. The station assessment is looking at how the candidate responds to the patient and how they justify their response while attempting to maintain the integrity of the therapeutic relationship.

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

- Demonstrate a thoughtful and empathic attitude during the discussion of the acceptance / refusal of the gift.
- Reflect on nature and timing of a gift.
- Describe the principles surrounding management of gift giving from a more general perspective.
- Specify when it is / is not appropriate to accept a gift.

Whilst the station presents a relatively common scenario in clinical practice, it raises obvious clinical and ethical issues, which may not be easily identified and managed by less experienced and sophisticated candidates. Guidelines and writings regarding the acceptance of gifts from patients are uniform in stating that expensive, suggestive, or inappropriate gifts should be politely refused with an appropriate explanation. On the other hand, inexpensive or seemingly benign gifts must be understood within the context of the therapy and could be accepted with good grace. Sometimes an apparently benign offering at a culturally appropriate time, such as a Christmas card, need not be explored. However most gifts given have greater significance for the patient, and therefore for the therapist.

Issues that should be considered include the nature and cost of the gift, the therapeutic relationship between the doctor and patient, and the transference issues that lead to giving the gift. Giving the gift might be an attempt on the patient's part to make the doctor like her or keep "in the good books"; represent an attempt to equalise the power structure of the relationship; or to gain greater control. In some cases more damaging dynamics may be at play, such as the gift-giving being a hostile or seductive act, or perhaps a conscious or unconscious bribe. In some instances accepting a gift could perpetuate an erotic or other transference and could be quite harmful to the therapeutic relationship — and ultimately to the patient.

In the interview with the patient, candidates should demonstrate a thoughtful and empathic attitude toward her, and ideally see the situation as "grist for the therapeutic mill". The patient should not be rejected outright, although the gift itself may be rejected with adequate and appropriate discussion as to why. They should explore the meaning of the gift with the patient, inform the patient of their decision about the gift and the implications of accepting / rejecting it, and explore the patient's feelings about their decision. Better candidates will comfortably discuss with the patient that the doctor-patient relationship and psychotherapy alliance creates special conditions wherein gifts may interfere with / undo / limit the quality of the work and clearly raise issues about reasonable boundaries. For example, candidates may point out that gift-giving by a patient with gift-acceptance by the therapist may promote a situation whereby the therapist becomes coerced into a non-therapeutic stance where he / she is uncomfortable addressing problems in the therapy. In so doing, the patient who is seeking to appear "good" may be rendered a "non-patient" through an impotent therapy. For some dyads this will play out as a stalemated long-term relationship where the patient neutralises the therapist so that he / she is unable to do anything hurtful, yet neither participant can become safely closer or leave.

In the presentation to the psychotherapy supervisor candidates should offer a number of possibilities about the meaning of gifts from patients and be able to discuss how this likely applies to this patient. In addition, they should demonstrate that they have considered whether accepting or refusing the gift adversely affects the well-being of this patient, and therefore be able to justify their response accordingly.

Better candidates will be able to coherently discuss relevant countertransference issues such as the therapist's wish to be liked or seen as helpful / powerful, and may offer comment upon how the interaction may affect therapy in the future. They may draw upon concepts such as the "slippery slope" of ethical behaviour breaches.

3.3 The Standard Required

In order to:

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 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 Elizabeth, a 31-year-old single music teacher with a past history of mild Major Depression which is now better. You have low self-esteem, and being quite passive in your relationships – trying not to upset people or being too demanding. Over the years, you have found that you enjoy looking after others, it makes you feel better about yourself and gives you some sense of meaning. This 'care giving' extends to behaviours like giving gifts to others. You like to be liked and particularly enjoy helping others, but this has sometimes led to problems at work and in your personal life with others finding you intrusive and clingy.

You have previously given the doctor small cards and gifts throughout the therapy such as a Christmas card, a small bunch of flowers at New Year, and more recently, a souvenir (pen) from a trip to Dreamworld, which he / she accepted.

You have brought along a gift today to show your appreciation of the help you are getting from this doctor. It is personal and more so than your previous gifts for the doctor so far. But it is inexpensive and 'small' compared to the gifts you would usually give to others for 'special' occasions. You are not aware of there being any special significance to the meaning of your gift, or of your feelings toward the doctor.

You developed your first Major Depressive Episode about eighteen months ago. This is also called a MDE and you presented with feelings of anxiety, sadness and tearfulness, not being able to sleep well, feeling tired all the time and experiencing headaches. At the time you had difficulty thinking clearly and concentrating at work and had occasional thoughts of death. The symptoms occurred most of the day, nearly every day for months.

Treatment for the MDE by your GP with Prozac did not fully "*clear it up*". So you were referred to the local Community Mental Health Service in May 2015 where you saw a psychiatrist who increased your Prozac dose and talked to you generally about your life. By October 2015 you felt a lot better and the psychiatrist referred you to see 'the candidate', for psychotherapy so that you could sort out the relationship problems you have had.

The MDE began about one month after a relationship break-up in September 2014. John, your boyfriend at the time, was a police officer whom you had been seeing for a few months. He broke it off with you when he became angry that you could never offer a view or make up your mind about what you wanted. You had also commented that he did not seem to like the birthday present (a $1500.00 TAG Heuer watch) you gave him a few weeks earlier. He reacted by saying that you were "*too nice*" for him but also called you "*hard work*", and you are still not sure what he meant by this.

You have had a number of other boyfriends who have invariably treated you badly (ignored you, favoured going out with friends drinking, possibly unfaithful), and who have seemed to you to need rescuing from their own misdemeanours or unhappiness. Unfortunately they never seem to reciprocate your good intentions toward them and most relationships have ended with you in tears feeling somewhat exploited. Your girlfriends say you choose the wrong men.

You enjoy your job as a music teacher in a primary school but don't seek great career advancement. You have close girlfriends from school and college, and sing in a covers pop group with friends from Teachers College. You have worked in a few pubs and clubs on weekends and recently made a CD with them.

You report your mood is fine now, as are sleep patterns, energy, and concentration. Your outlook for the future is bright though conservative…"*good*". Your family is nearby – you're the third of 4 girls, where your two older sisters are 6 and 8 years older respectively. Your family is close – there are no major problems within the family that you can identify. Before retiring your father was a school principal and your mother a registered nurse. Your parents have always been community minded and generous.

4.2 How to play the role:

At the beginning, you are warm and pleasant. You are feeling pleased with your choice of gift, and expect that the doctor will accept it gracefully and with interest. You are eager to please and friendly, perhaps slightly flirtatious, but not too seductive.

You should be pleased when / if the gift is accepted and chatter on for a short while about the pleasure you had in creating this music and compiling the CD, and the release of positive feelings within you that the music enables. Then respond to the direction that the candidate takes for the remainder of the session within the limits of the information you have been given about yourself.

You should be puzzled when / if the gift is rejected and seek reasons. Whatever the reasons given, state these were not your intention: as it is '*just a little acknowledgement'*, and offer your gift again.

If the candidate precedes their rejection of the gift with an exploration about your feelings and thoughts in preparing and giving the gift, and / or provides you with sensitive disclosure about their own feelings and thoughts or other meaningful discussion, accept their decision but say that you do not really understand.

If the candidate rejects the gift outright without any preamble, then persist with getting an explanation, behave somewhat hurt by the rejection.

If the candidate vacillates as to whether to accept or not, follow their lead.

4.3 Opening statement:

As soon as possible after candidate enters the room say:

"Doctor, before we go any further today I wanted to thank you with this CD I made especially for you *[*Put hands over the gift***]. Happy 6 month anniversary."***

4.4 What to expect from the candidate:

The candidate should attempt to discuss what giving the gift means in an empathic and engaging manner, and perhaps gently suggest possibilities. Some candidates may not accept the gift, and if this happens they would be expected to explain why it is they have accepted your other gifts but have rejected this gift.

4.5 Responses you MUST make:

Anticipated situation: If candidate starts to refuse gift.

Scripted responses:

- ***"I hope I'm not out of line."***
- Whatever the reasons given, state these were not your intention: as it is ***'just a little acknowledgment'***, and offer your gift again.
- ***"I guess you could always give it to your partner if you don't really like it."***

Anticipated situation: If the candidate accepts the gift.

Scripted response:

- ***"Can I just ask Doctor, are you going to listen to it and tell me what you think of it?"***

4.6 Responses you MIGHT make:

Anticipated situation: If the candidate directs the interview towards anything for which you are unprepared or uncertain, be a little taken off-guard and direct them back to the issue of the gift by saying:

Scripted responses:

- ***"I feel a bit silly now, maybe I overstepped the line" <u>OR</u>***
- ***"Doctor, I'm not really sure that you like my gift." <u>OR</u>***
- ***"Well, I'm a bit lost for words now…"***

Anticipated situation: If the candidate appears to abruptly or admonishingly deal with the patient.

Scripted response:

- ***"Perhaps we should just finish early today."***

4.7 Medication and dosage that you need to remember:

Antidepressant Prozac (Fluoxetine) 20 milligrams in the morning, increased to 40 milligrams after a few weeks after commencement.

STATION 3 – MARKING DOMAINS

The main assessment aims are:

- To assess the capacity of the candidate to empathically conduct part of a psychotherapy session addressing the issue of being given a gift by a patient.
- To demonstrate ethical conduct and practice in relation to a long term psychotherapy patient during feedback to the examiners.
- To demonstrate effectively the capacity to communicate to the patient and the examiners the reasoning behind their decisions about the gift.

Level of Observed Competence:

1.0 MEDICAL EXPERT

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

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* clearly achieves the standard overall with a superior performance in a number of areas; competent overall management of the interview; superior technical competence in eliciting information.

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

To score 3 or above the candidate **MUST**:
a. demonstrate a thoughtful and empathic attitude during the discussion of the acceptance / refusal of the gift.

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 score 1.

Does Not Achieve the Standard (scores 0) if:
significant deficiencies such as being insensitive to the patient; using aggressive or interrogative style; having a disorganised approach.

1.1. Category: ASSESSMENT – data gathering process	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

1.2. Did the candidate take appropriately detailed and focussed history? (Proportionate value - 30%)

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

Achieves the Standard by (scores 3 or 4):
conducting a detailed but targeted assessment; obtaining a history relevant to the circumstances with appropriate depth and breadth; history taking is hypothesis-driven; integrating key psychosocial issues relevant to the assessment; eliciting the key issues; clarifying important positive and negative features.

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:
superficial exploration of the issues pertaining to the gift giving and relevant background history; patchy history taking; limited recognition of the importance of exploring personality style and gift giving.

Does Not Achieve the Standard (scores 0) if:
obvious omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in history.

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** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

3.0 COLLABORATOR

3.4 Did the candidate develop an appropriate therapeutic relationship with the patient? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* gives priority to continuity of care and meeting changing needs of the patient.

Achieves the Standard by:
demonstrating ability to maintain the therapeutic relationship; gathering information and responding to concerns raised; maintaining open communication; appropriately informing; providing opinion.

To score 3 or above the candidate **MUST**:
a. reflect on nature and timing of a gift.

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 score 1.

Does Not Achieve the Standard (scores 0) if:
lack of consideration of individual goals; any errors or omissions adversely impact on alliance.

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

7.0 PROFESSIONAL

7.1 Did the candidate appropriately adhere to principles of ethical conduct and practice? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* able to discuss in a sophisticated manner some of the guidelines underlying management of gift giving, including discussion of patient's attitudes to gift giving, and having a gift rejected and how to help patient deal with feelings of rejection; stipulates the importance of seeking supervision / peer review in difficult countertransference situations.

Achieves the Standard by:
demonstrating capacity to: identify and adhere to professional standards of practice in accordance with College Code of Ethics; integrate ethical practice into the clinical setting; utilise ethical decision-making strategies to manage the impact on patient care; maintain appropriate interpersonal boundaries; applying ethical principles to resolve conflicting priorities.

To score 3 or above the candidate **MUST**:
a. describe the principles surrounding management of gift giving from a more general perspective.
b. specify when it is / is not appropriate to accept a gift.

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:
does not appear aware of or adhere to accepted medical ethical principles.

7.1. Category: ETHICS	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
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 defined tasks?

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

Committee for Examinations
Objective Structured Clinical Examination

Station 4
Melbourne April 2016

The Royal Australian & New Zealand College of Psychiatrists

1.0 Descriptive summary of station:

In this station candidate is expected to make a diagnosis of agoraphobia and panic disorder, and discuss an initial non-pharmacological management plan with Patricia, a 36-year-old mother who is mainly concerned about the significant chronic agoraphobia symptoms. This initial assessment is undertaken in a community setting at the request of her GP.

1.1 The main assessment aims are:

- To evaluate candidate's ability to:
  - Accurately confirm the diagnoses of agoraphobia and panic disorder including the severity and impact of the presentation.
  - Demonstrate their knowledge of the major non-pharmacological management of agoraphobia when talking with a patient.

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

- Elicit core symptoms of agoraphobia to make a diagnosis; specifically including situational avoidance due to fear of panic.
- Confirm recurrent unexpected panic attacks.
- Mention the diagnoses of both panic disorder and agoraphobia.
- Outline the level of disability associated with agoraphobia.
- Accurately explain the components of in-vivo exposure programme.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category of:**
  Anxiety Disorders
- **Area of Practice:**
  Adult Psychiatry
- **CanMEDS Domains of:**
  Medical Expert and Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes of:**
  Medical Expert (Assessment, Formulation, Management), Communicator (Patient Communication)

References:

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- Martin A Katzman, Pierre Bleau, Pierre Blier, Pratap Chokka, Kevin Kjernisted, Michael Van Ameringen,: Canadian clinical practice guidelines for management of anxiety, posttraumatic stress and obsessive compulsive disorder: *BMC Psychiatry* 2014 : 14(Suppl 1): S1
- Price, M., Mehta, N., Tone, E. B., & Anderson, P. L. Does engagement with exposure yield better outcomes? Components of presence as a predictor of treatment response for virtual reality exposure therapy for social phobia. *Journal of anxiety disorders, 2011; 25(6), 763-770.*
- Van Apeldoorn, F. J., Van Hout, W. J., Timmerman, M. E., Mersch, P. P. A., & den Boer, J. A. Rate of improvement during and across three treatments for panic disorder with or without agoraphobia: Cognitive behavioural therapy, selective serotonin reuptake inhibitor or both combined. *Journal of affective disorders, 2013;150(2), 313-319.*
- Wittchen, H-U., Gloster, A.T., Beesdo-Baum, K, Fava, G.A.,Craske, M.G. Agoraphobia: A review of the diagnostic classificatory position and criteria. *Depression and Anxiety; 2010: 27:113–133.*
- Sanchez-Meca J, Rose-Alcazar Al, Marin-MartinezF, Gomez-Conesa A: Psychological treatment of panic
- Disorder with or without agoraphobia: a meta-analysis. Clin Psychol Rev 2010 30:37-50.

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 around the age of 35, casually but neatly dressed.
- Pen for candidate.
- Timer and batteries for examiner.

2.0 Instructions to Candidate

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

You are working as a junior consultant psychiatrist in a community mental health clinic that specialises in mood and anxiety disorders. You are about to see Patricia, 36-year-old mother of two children for an initial review. She has been referred to your clinic by her GP for your opinion. One of her daughters has driven Patricia to the clinic for this review and will come back and fetch her later**.**

Your tasks are to:

- Take a focussed history of her presenting complaints to be able to diagnose Patricia's concerns.
- Explain your findings and rationale for your diagnostic assessment to Patricia.
- Discuss an initial non-pharmacological management plan with Patricia.

You will not receive any time prompts.

Station 4 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
  - 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 are no cues or time prompts for you to give.
- 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 <u>must</u> remain in the room and <u>NOT</u> proceed to the next station until the bell rings."

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

You have no opening statement or prompts.

The role player opens with the following statement:

"It took a lot for me to be here, as I don't usually go out of my house".

3.2 Background information for examiners

The first part of this station is where the candidate is expected to make a diagnosis of agoraphobia. The presentation is in the context of panic disorder which the candidate should also identify. Secondly, the candidate should explain, using appropriate language, the diagnoses and is expected to justify their assessment of severity of the presentation to Patricia. In the final part of the station the candidate must discuss an initial non-pharmacological management plan with Patricia, focussing mainly on the symptoms of chronic agoraphobia. The candidate should not discuss pharmacological interventions in this station.

The assessment is undertaken in a community setting at the request of her GP and it is not expected that the candidate will recommend compulsory treatment or inpatient admission.

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

- Elicit core symptoms of agoraphobia to make a diagnosis; specifically including situational avoidance due to fear of panic.
- Confirm recurrent unexpected panic attacks.
- Mention the diagnoses of both panic disorder and agoraphobia.
- Outline the level of disability associated with agoraphobia.

For agoraphobia, the symptoms elicited should include most of the following: significant avoidance of situations / environments, cognitions of not being able to escape to safety, anticipatory anxiety and significant anxiety if she had to be in such situations. When taking the history the candidate is expected to focus on the associated disability in some detail. When explaining the diagnosis to Patricia the candidate should include the duration as part of their standard nosological criteria.

For panic disorder the candidates should elicit symptoms which include the majority of the following: establishing panic attacks as per any standard criteria. The candidate should establish bodily / physical symptoms and the cognitive sense of impending doom. The candidate should also elicit the de-novo nature of the same along with strong anticipatory anxiety.

A better candidate may:

- Demonstrate their knowledge of almost all the symptoms for both disorders within the allotted timeframe of the station.
- Effectively screen for other comorbidity especially anxiety disorders, depression, and substance misuse.

The candidate must give feedback to Patricia about diagnoses of panic disorder and agoraphobia, explaining that these are anxiety disorders. Candidates are expected to recognise and acknowledge that the agoraphobia is very disabling and justify the same by giving reasons. These reasons may include severe social drift, significant impact on her ability to carry out activities of daily living and higher level occupational functioning, being house bound, impact of her behaviour on her children, etc.

The treatment focus that candidates present must include in-vivo exposure as a preferred modality of treatment. Candidates should be able to explain the principle in-vivo exposure, most importantly, habituation / extinction. Their explanation should reflect a brief outline of the programme which should include the construction of hierarchy based on the subjective distress in these situations; how long a typical exposure session should last; when to progress down the hierarchy of activities; how each session of exposure continues until the anxiety peaks and comes down significantly from the maximum distress; movement to the

next task on the hierarchy when the previous exposure situation is no longer distressing or significant reduction in baseline anxiety. Candidates are also expected to explain about safety behaviours and their significance in maintaining the anxiety symptoms.

A better candidate may:

- Talk about advantages and disadvantages of different frequency and intensity of exposure approaches. These candidates may also elaborate on issues related to self / therapist directed exposure.
- Provide an accurate account of other non-pharmacological interventions for agoraphobia.
- Identify the need to treat panic disorder if complete recovery is to be aimed for.
- Discuss psychological interventions for panic disorder (e.g. Panic Control Treatment (PCT)) and how they can enhance the treatment programme.

Diagnostic considerations

According to Wittchen et al (2010), the community prevalence of agoraphobia without a history of panic disorder and even the prevalence of agoraphobia without the presence of panic attacks or panic-like symptoms has been found to be at least as high as the combined rates of panic disorder with and without agoraphobia across all epidemiological studies. In clinical settings however, a diagnosis of agoraphobia without the history of panic disorder is rarely assigned in clinical practice. However it is worth noting that DSM-5 has separated agoraphobia into a separate diagnostic category.

Similar age of onset curves for panic disorder and panic attacks (with or without agoraphobia) indicate that the mean age of onset is 21–23 years. As a function of different sample composition, some studies report slightly higher ages but the studies consistently show that two thirds of all panic disorder patients develop symptoms before age 35. Findings for agoraphobia are less clear, and among those specifically addressing agoraphobia without panic attacks, a slightly later mean onset was shown, ranging from 25–29 years. Overall, however the age of onset does not necessarily assist in diagnostic clarification.

In the majority of cases, agoraphobia seems to be associated with preceding panic attack or panic-like symptoms and / or are subsequently mediated by the expectation of panicking in particular situations. However a significant group of agoraphobia patients develop symptoms for reasons other than or in addition to panic. So, the most plausible interpretation is the existence of multiple pathogenic pathways involved in the development of agoraphobia.

With regard to levels of impairment, studies consistently find the greatest impairment for those with both panic disorder and agoraphobia, with the lowest impairment for those with panic attacks without meeting criteria for either disorder.

While few studies have allowed for direct comparisons of comorbidity patterns in community samples, there is agreement that panic disorder and agoraphobia both are rarely seen in pure forms and both are significantly associated with many other diagnoses, including other anxiety, mood, substance, and somatoform disorder.

There is no evidence that agoraphobia and panic disorder or any other anxiety disorder demonstrate differences in the structure and frequency of life events over the life span; however, all conditions were increased when past significant life events were reported. Other risk factors apart from stressful life events can include poor health, and lower education and income.

The clinical course of agoraphobia and panic disorder in clinical and epidemiological samples have been reported as being chronically persistent and chronically recurrent respectively. The presence of severe agoraphobic avoidance has been the most consistent of the predictors of poorer long-term outcome of panic disorder.

Classificatory models

ICD-10 defines agoraphobia as a separate diagnosis to panic disorder and does not necessarily assume that it arises from panic attacks: in fact agoraphobia takes precedence over panic attacks. There is however, historical evidence that that panic attacks and panic-like features may play a core role in the development of some but not all agoraphobia patients.

In the DSM-5 the biggest change (from DSM-IV-TR) with these two disorders is that panic disorder and agoraphobia are no longer linked together, but recognised as two separate disorders. The APA justifies this unlinking because they found that a significant number of people with agoraphobia do not experience panic symptoms.

The agoraphobia symptom criteria remain unchanged from DSM-IV, apart from the fact that endorsement of fears from two or more agoraphobia situations is now required, because this is a robust means for distinguishing agoraphobia from specific phobias. Additionally, the criteria for agoraphobia are extended to be consistent with criteria sets for other anxiety disorders (e.g., clinician judgment of the fears as being out of proportion to the actual danger in the situation, with a typical duration that must be of 6 months or more).

DSM-5 criteria for agoraphobia include:

- Marked fear or anxiety about • 2 of the following 5 groups of situations:
  (1) Public transportation (e.g. traveling in automobiles, buses, trains, ships, or planes).
  (2) Open spaces (e.g. parking lots, market places, or bridges).
  (3) Being in shops, theatres, or cinemas.
  (4) Standing in line or being in a crowd.
  (5) Being outside of the home alone in other situations.
- The individual fears or avoids these situations due to thoughts that escape might be difficult or help might not be available in the event of panic-like symptoms.
- The agoraphobic situations almost always provoke fear or anxiety.
- The situations are actively avoided, require presence of a companion, or endured with marked fear or anxiety.
- The fear or anxiety is out of proportion to actual danger posed by agoraphobic situation.
- The fear, anxiety, or avoidance is persistent, typically lasting • 6 months.
- The fear, anxiety, and avoidance cause clinically significant distress or functional impairment.

DSM-5 Panic Disorder (includes previous DSM-IV diagnoses of panic disorder with agoraphobia and panic disorder without agoraphobia)

A. Recurrent unexpected panic attacks.
B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:
   - Persistent concern or worry about additional panic attacks or their consequences (e.g. losing control, having a heart attack, going crazy).
   - Significant maladaptive change in behaviour related to the attacks (e.g. behaviours designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).
   - The panic attacks are not restricted to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hyperthyroidism, cardiopulmonary disorders).
   - The panic attacks are not restricted to the symptoms of another mental disorder.

<u>Non-pharmacological interventions</u>

Evidence suggests that Cognitive Behavioural Therapy (CBT) is a very effective form of treatment for both panic disorder and agoraphobia. CBT is not a single approach to treatment, but a process that manages the factors that cause and maintain the symptoms of anxiety in patients. Some of the core components of CBT include exposure, arousal management (e.g. relaxation training, diaphragmatic breathing), cognitive restructuring and management of safety behaviours. There is strong evidence to suggest, it is an effective form of treatment when the above components are used in varied combination. Further evidence also supports the exposure as being the most useful of the components in the treatment of the above disorders.

There is an impressive body of evidence on the efficacy of exposure in treating agoraphobia. The details are described above. There are options for intense exposure versus starting the programme with the least distressing situation, as well as more frequent sessions versus regular spaced out sessions. There are also options of therapist assisted vs self-driven approaches.

In-vivo exposure draws from the concepts of classic and operant conditioning. The two most important principles that are in play are habituation and extinction. In habituation, when a response is elicited repeatedly, the strength of the response reduces. In the context of exposure, the intensity of anxiety is reduced with prolonged and repeated exposure.

In extinction (as per classic conditioning), when a conditioned stimulus is presented repeatedly without the unconditioned stimulus, the conditioned response will decrease. In the context of exposure treatment, when

a person is exposed to the avoided situation (conditioned stimulus) and does not experience feared arousal in the form of severe anxiety (unconditioned stimulus) then the avoidance behaviour reduces significantly.

Many other forms of therapy can be applied with CBT, including possible positive effects of conventional psychotherapy.

Today, technology such as virtual reality and the internet are providing opportunities for people with agoraphobia to begin therapy in the 'safe' environment of their home. Virtual Reality Exposure Therapy (VRET) is a popular form of exposure therapy and has produced positive effects on reducing the symptoms of agoraphobia in an Australian study (Malbos, Rapee, Kavakli, 2012). Similar to the findings on VRET in other anxiety disorders, the argument in agoraphobia studies is that merely creating a fear rating through realness and presence does not correlate with a positive treatment outcome. The level of involvement of the participant plays an important role in predicting the treatment outcome (Price, Mehta, Tone, & Anderson, 2011).

Panic Control Treatment (PCT) is a widely used, empirically validated cognitive behavioural treatment for panic disorder. Initially it was developed for the treatment of panic disorder with limited agoraphobic avoidance, but more recently has been applied in more broad applications. The general goal of PCT is to enable patients to develop the ability to identify and correct maladaptive thoughts and behaviours that initiate, sustain, or exacerbate anxiety and panic attacks. It combines education, cognitive interventions, relaxation and controlled breathing procedures and interoceptive exposure (form of in vivo exposure) to the bodily cues that initiate and maintain panic symptoms. It is usually delivered in 11 or 12 weekly sessions, either individually to patients or in a small group format.

The two disorders continue to be treated together, as well as separately. Increasingly, medication (usually SSRIs) and cognitive behavioural therapy are used together. This combined treatment has proven to be more effective in the treatment of anxiety disorders. With moderate-to-severe agoraphobia, the combined treatment was more effective in reducing panic attacks. Long-term follow-up studies of CBT therapy in the treatment of panic disorder with agoraphobia revealed that the positive behaviour and reduced symptoms were maintained.

3.3 The Standard Required

In order to:

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

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

i. they have competence as a ***medical expert*** who can apply psychiatric knowledge including medico-legal expertise, clinical skills and professional attitudes in the care of patients, (such attitudes may include an ability to tolerate uncertainty, balance, open-mindedness, curiosity, "common sense" and a scientific approach)
ii. they can act as a ***communicator*** who effectively facilitates the doctor patient relationship.
iii. they can ***collaborate*** effectively within a healthcare team to optimise patient care.
iv. they can act as ***managers*** in healthcare organisations who contribute to the effectiveness of the healthcare system, organise sustainable practices and make decisions about allocating resources.
v. they can act as ***health advocates*** to advance the health and well-being of individual patients, communities and populations.
vi. they can act as ***scholars*** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.
vii. they can act as ***professionals*** who are committed to ethical practice and high personal standards of behaviour.

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

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 Patricia, 36-year-old single mother of two teenage daughters who live with you. Your daughters are Chloe aged 16 and Amy who is almost 18. You separated from your husband 6 years ago.

You have been referred by your GP to see a psychiatrist in a specialist community service. Your GP, Dr Andrews, suggested that it would be a good idea to get opinion from a psychiatrist about your anxiety problems, which you have had for years. You have been driven to the appointment by your older daughter, as you have not driven in 6 years and are too scared to drive. Your daughter has gone to do some shopping and will come back and pick you up.

You have been suffering from anxiety for the last 6 years. This started becoming an issue following separation from your husband Mark. Over time your anxiety has become worse and in the last 3 years it has become disabling. This means you are house bound and you have hardly left your house in the last 3 years. You are overwhelmed by thoughts of "*not being able to get to safety*" when you are out. This includes activities like driving, being in shopping centres, visiting relatives / friends, or going to your hairdresser.

The above problems followed on from when you had a sudden-onset attack of anxiety 6 years ago while at a shopping centre with your daughters. During this time you felt that your knees were going to buckle. For no reason you suddenly got overwhelmed with your heart racing, you felt sweaty, nervous, dizzy, shaky, and thought you were going crazy. The incident lasted for a few minutes during which time it felt as though you were having a heart attack and needed urgent help, but you could not ask for the same. This experience was very difficult to cope with.

You have subsequently learned that this was a 'panic attack'. Since then you have felt very anxious to be in these kinds of situations and have even started having panic attacks at the thought of being in such places. You always have thoughts of "*not being able to get to safety*" and so over time you have actively avoided going out of your house and you feel very comfortable within your home. Over the last 3 years, even the thought of having to go out alone makes you very anxious. You have been increasingly distressed by this anxiety but have managed to cope with life by doing most of your shopping online or sending your daughters, and organising things like having the hairdresser come to your house.

In the last two years your bedroom has become your safe space and with difficulty you come out of your room. You spend most of your day there. On the odd occasion of you having to go out of your room, you do it swiftly so that you are back to your safe space. During this time you have not been cooking and find it difficult to look after your house. You get a lot of support from your teenage daughters to manage day-to-day things who are almost acting as the adults of the house, which you are quite distressed about.

If you are to imagine going out of your room and even spending time in other parts of your house, you at times have a panic attack thinking about it. Further you think that that the anxiety will be as high as 90/100 (100 being the worst anxiety you have ever experienced) if you were to have to do those activities for a significant period of time. The same is true in your mind for activities like going to the garden, sitting in the backyard, walking to the next block, catching public transport.

Along with the above complaints you also suffer from panic attacks that come out of the blue once in every few weeks. Though you feel overwhelmed by the thought of going out of your safe zone, these panic attacks are distinct and they come for no reason and they make you feel that you are going crazy. You experience a strange sense of anxiety, feel that things around you are changing shapes; your heart pounds and you experience severe sweating and you get a terrible feeling of impending doom that you cannot really explain. At times you worry that you might have an attack and when your heart starts pounding it makes you think that you might have a panic attack.

Though you have these spontaneous panic attacks, you are relieved they are not as frequent these days. You are more distressed by the fact that you are house bound. Although you are worried about both problems you are keen to address your fears of leaving the house first. This is mainly because, even though you feel like your house is your safe zone, it is overwhelming for you to think of doing anything outside this zone.

Up until now you have been hesitant to see your GP, but you saw him recently at the insistence of your teenage daughters. Even though you are afraid, you are open to understanding about your problems and explore treatment options, as you have been informed by your GP that there are potential treatments available. You feel it is very important to get help to improve your home and social circumstances. Your knowledge about your problem is limited, the only thing you know is that you are feel so terribly anxious.

With regard to your past personal life, if you are asked - when you were growing up you lived with your younger sister, father and mother. You were close to your sister and mother. However your father was a violent alcoholic. You were quite scared of him. He was very angry when drunk and at times was physically aggressive toward you and your sister. Your mother found it difficult to manage life with him. After a long period of struggle, your mother separated from your father when you were 15. You and your sister went on to finish high school while mother was working full time to support the family financially.

You remember that you were nervous as a child and were not very bold. Your schooling was largely uneventful except for some minor troubles with bullying on occasions. Despite these issues you went on to finish high school and worked in retail for a year. Consequently you met your husband Mark when you were 18 and got married to him the next year.

Initially you had a good relationship with your husband. However, in the years leading up to separation, Mark felt that the relationship had become distant and "*called it quits*". After the separation you felt very distressed, unsupported and emotionally out of control. You remember that the current problems date back to this time.

In the initial years of the onset of your anxiety, you used to meet up with your mother and sister intermittently. In the last 3 years you have almost become estranged, as you cannot go out and they rarely come over to see you. Both your children are teenagers and almost independent. The older daughter is in the process of enrolling into University to do optometry.

You do not have any physical health problems (except when you think you are having a heart attack during a panic attack) and you are not on any medication. You have no allergies.

With regard to other mental health symptoms, if you are asked - you have not felt depressed over the last few years. You feel you have a lot to live for as your daughters are doing well in studies and you think they have a bright future. You sleep okay and your appetite is good. Though on occasion you do question the need for such an existence you have not ever wished you were dead or felt suicidal.

You have not had obsessive thoughts that come into your mind over and over again or symptoms to suggest fear of specific things such as animals, lifts or heights. You are not worried about being judged by people while in groups nor are you worried about performance anxiety - what other people might think of you. You also don't have problems related to your weight or body image.

You do not hear any voices or have any other unusual experiences such as thinking that you are being followed or troubled by other people.

You do not consume drugs (including coffee or cigarettes) or alcohol and have never really done so.

4.2 How to play the role:

People with agoraphobia most commonly have a fear of public places. Agoraphobia is an anxiety disorder involving a persistent fear of certain environments, often either due to their crowdedness or openness. This fear is disproportional to the threat or danger posed by the environment. The person who has agoraphobia will go to great lengths to avoid the environment, and the presence or anticipated presence of the environment will create a high level of distress. These irrational fears and reactions result in interferences with social and work life.

You should play the role as an anxious lady with some level of agitation in the interview. You present this anxiety by repeatedly linking the troubles that you are having with not being able to go out. However you are also very polite and cooperative and should give information freely when the candidate questions you.

You are keen to know about your condition and the initial suggestions for treatment. If the candidate explains about exposure treatment in a manner that you understand please show a keen interest and accept the advice.

Please come dressed in casual but neat attire.

4.3 Opening statement:

"It took a lot for me to be here, as I don't usually go out of my house."

4.4 What to expect from the candidate:

Expect the candidate to ask you about your complaint of "Not being able to go out of your house". Candidates may ask about your 'safe space' within the house. Further they may also ask about anxiety and distress levels if you are asked to spend time out of your room. Then answer as per the script.

Candidates should also ask for the details of your panic attacks, and other problems such as fear of being in groups, animals, etc.

Candidates should aim to be reassuring and polite with you despite your repeated talk about distress.

4.5 Responses you MUST make:

"I am literally house bound because of these problems and keen to address this first."

"What is wrong with me doctor?"

"How bad are my symptoms doctor?"

If the candidate talks about 'exposure treatment' you must ask for details of the treatment.

If the candidate does not mention 'exposure treatment' you must say:
"My daughter read about something called exposure."

If the candidate uses terms like 'habituation or hierarchy' please ask for an explanation of the term.

4.6 Responses you MIGHT make:

These responses are dependent on whether the candidate raises the issue:

"I am keen to reconnect with my family."

"If you advised medication treatment I am happy to accept it."

Any questions that are asked respond as per the script. If it is not scripted respond by saying,
"*I am unsure*" or "*I don't think so.*"

4.7 Medications:

Nil

STATION 4 – MARKING DOMAINS

The main assessment aims are:

- To evaluate candidate's ability to:
  - o Accurately confirm the diagnoses of agoraphobia and panic disorder including the severity and impact of the presentation.
  - o Demonstrate their knowledge of the major non-pharmacological management of agoraphobia when talking with a patient.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed history? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication; also explores in detail other anxiety spectrum disorders such as Simple Phobia, GAD, OCD, PTSD, Body Dysmorphic disorder with accurate phenomenology.

Achieves the Standard by:
conducting a targeted assessment to elicit almost all of the key symptoms of both agoraphobia and panic disorder; screening for depression, substance use, psychotic features, suicidality; integrating symptoms with exploration of social drift because of her anxiety issues along with difficulties in relationships; exploring in detail about the problems in day- to-day living in the context of the above.

To score 3 or above the candidate **MUST**:
a. elicit core symptoms of agoraphobia to make a diagnosis; specifically including situational avoidance due to fear of panic.
b. confirm recurrent unexpected panic attacks.

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

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** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

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

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* demonstrates prioritisation; communicates findings in a sophisticated manner.

Achieves the Standard by:
correctly communicating both as being anxiety disorders; justifying their assessment of the level of disability by giving reasons; explaining about anxiety disorders and their impact on function; reassuring about the absence of other comorbid disorders.

To score 3 or above the candidate **MUST**:
a. mention the diagnosis of both panic disorder and agoraphobia.
b. outline the level of disability associated with agoraphobia.

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:
incorrectly interprets symptoms of anxiety disorders; significant deficiencies including inability to synthesise information obtained; inadequate diagnostic statement.

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

1.15 Did the candidate adequately engage, inform and discuss the treatment plan with the patient including suitably incorporating patient goals / preferences? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* clearly achieves the overall standard with presentation of a specific and sophisticated plan; weighs up advantages and disadvantages of options related to intensity, frequency; accurately identifies alternative options; includes the need to treat panic disorder and offers options like Panic Control Treatment (PCT).

Achieves the Standard by:
accurately defining habituation / extinction; talking further about the principles of operant conditioning / classic conditioning; providing practical examples of a session taking a real life scenario; highlighting that additional cognitive techniques can improve outcomes; taking into account patient's goals; reasonably establishing that the patient understands and is in agreement with the plan.

To score 3 or above the candidate **MUST**:
a. recommend in vivo exposure as a preferred modality of treatment.
b. accurately explain the process of an in vivo exposure programme.

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:
description of the management plan lacks structure; inaccuracies or errors about specific therapies impact adversely on patient care; difficulty tailoring treatment to the patient's specific circumstances.

1.15. Category: MANAGEMENT - Treatment Contract	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

2.0 COMMUNICATOR

2.1 Did the candidate demonstrate an appropriate professional approach to gathering information from patient / family / carer? (Proportionate value - 10%)

Surpasses the Standard (scores 5) if:
able to generate a complete and sophisticated understanding of complexity; effectively tailors interactions to maintain rapport within the therapeutic environment.

Achieves the Standard if (scores 4 or 3) if:
adopts a polite and reassuring style of interview while the patient presents as being very anxious; makes an effort to avoid jargon and asks questions to facilitate better understanding; attempts to normalise the disorders; explains the team's role and what can be offered.

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:
the candidate does not effectively put the patient at ease; uses technical language that impairs the therapeutic alliance / acceptability of plans.

Does Not Achieve the Standard (scores 0) if:
errors or omissions adversely impact on alliance; inadequately reflects on relevance of information obtained; unable to maintain rapport.

2.1. Category: PATIENT COMMUNICATION - to patient	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
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 defined tasks?

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

Committee for Examinations
Objective Structured Clinical Examination

Station 5
Melbourne April 2016

The Royal Australian & New Zealand College of Psychiatrists

1.0 Descriptive summary of station:

In this station, the candidate is expected to perform cardiopulmonary resuscitation on Ken, an elderly man (manikin) who has collapsed in his unit within a retirement village.

1.1 The main assessment aims are to:

- Demonstrate the ability to perform cardiopulmonary resuscitation (CPR) while providing a commentary to the examiner.
- Demonstrate skills on how to use an automated external defibrillator (AED) and contraindications for the use of AED.
- Demonstrate knowledge of when to stop CPR and the difference between adult CPR and that in children and infants.

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

- Check for safety and responsiveness.
- Demonstrate correct adult CPR technique - position and depth of hands, 30 compressions to 2 breaths.
- Be aware of at least 2 of the reasons to stop CPR.
- Know that CPR takes precedence over defibrillation, except when the AED machine specifically commands this.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category of:**
  Medical Disorders in Psychiatry
- **Area of Practice:**
  Adult Psychiatry
- **CanMEDS Domains of:**
  Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes of:**
  Medical Expert (Assessment - Physical Technique, Selection, Examination Commentary)

References:

- ANZCOR – Australian New Zealand Council of Resuscitation guideline, January 2016.
- Cardiopulmonary Resuscitation – Australian Resuscitation Council, December 2010.
- International Liaison Committee on Resuscitation (ILCOR) at www.ilcor.org

1.4 Station requirements:

- Large consulting room with clear floor area.
- Three chairs (examiner x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate' (3 copies).
- Simulated patient – manikin.
- Automated external defibrillator (AED)
- Alcohol wipes, disposable gloves, sufficient protective face shields for hygiene during mouth-to-mouth component of CPR.
- Pen for candidate.
- Timer and batteries for examiner.

2.0 Instructions to Candidate

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

You are working as a junior consultant psychiatrist in the older persons' mental health community team. During a residential care home visit, you are guided to Ken, an elderly gentleman who has collapsed on the floor.

Your tasks are to:

- Respond to the situation and perform cardiopulmonary resuscitation (CPR) while providing a running commentary of your actions to the examiner.
- Demonstrate how to use an automated external defibrillator (AED) and explain the key safety concerns and contraindications to consider when using an AED.
- Explain to the examiner when you would stop performing CPR on any casualty and the technique for performing CPR on a child and an infant.

If you have not already commenced, you will receive a time prompt at **four (4) minutes** to proceed to the second and third tasks.

NOTE: Appropriate steps will be taken to disinfect and clean the manikin between each candidate.

If you have any physical condition that would limit your ability to complete these tasks, please alert the examiner.

Please note that post-exam, you will be requested to provide a medical report detailing your physical condition.

Station 5 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario, e.g. space to set up manikin and have protective face shields and alcohol wipes nearby, space to undertake CPR on a manikin, fan is switched on, etc.
- On the desk, in clear view of the candidate, place:
  - Duplicate copy of 'Instructions to Candidate'.
  - Pens.
  - Water & tissues are available for candidate use.
- On the floor, in clear view of the candidate, place:
  - Manikin with shirt.
  - Protective face shields for candidate use.
  - Alcohol antibacterial / disinfectant wipes.
  - Duplicate copy of 'Instructions to Candidate'.
  - Automated External Defibrillator (AED).

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 and say:

  "Doctor, the door was open so I came in and found him on the floor. I checked for a pulse. I hope that was the right thing to do?"
- TAKE NOTE of the time for the scripted prompt you are to give at **four (4) minutes.**
- DO NOT redirect or prompt the candidate unless scripted. If the candidate asks you for information or clarification say:

  "Your information is in front of you – you are to do the best you can."
- At **four (4) minutes,** as indicated by the timer, you are to say:

  "Please proceed to the second task."
- 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**).
- **IMPORTANT**: During the 2 minutes reading time, after you have completed marking the candidate, please ensure room is set up again for next candidate:
  - Pour multiple water cups and place them on the table for easy access to the candidates.
  - Switch on the fan and ensure it is blowing in the general direction over the manikin.
  - Clean the manikin's mouth with disinfectant wipes and dry with paper towels at the beginning of the day and after each candidate.
  - Turn off AED and place the electrodes within the AED box.
  - Zip up the manikin's shirt in preparation for the next candidate.
  - Place the protective face shields nearby.
  - Duplicate copy of 'Instructions to Candidate' is placed in its original position on the floor.
  - Use the room deodoriser spray as required.

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 and say:

"Doctor, the door was open so I came in and found him on the floor. I checked for a pulse. I hope that was the right thing to do?"

At **four (4) minutes** if the candidate has not moved to the second task the examiner says:

"*Please proceed to the second task.*"

IMPORTANT: **Please turn off the AED immediately after the candidate has demonstrated how to use the AED to avoid loud beeps.**

When the candidate leaves the room,

- Pour multiple water cups and place them on the table for easy access to the candidates.
- Ensure the fan is blowing in the general direction over the manikin.
- Clean the manikin's mouth with disinfectant wipes and dry with paper towels at the beginning of the day and after each candidate.
- Ensure the AED is turned off and place the electrodes within the AED box.
- Zip up the manikin's shirt in preparation for the next candidate.
- Place the protective face shields nearby.
- Use the room deodoriser spray as required.

3.2 Background information for examiners

In this station the candidate is expected to explain how to perform CPR on an adult and also demonstrate use of a defibrillator (AED). The candidate will explain the differences between CPR for adults and infants / children. The candidate must demonstrate that they understand when to stop CPR and the contraindications for use of AED.

In order to do this the candidate should:

- Take control of the situation as soon as they enter the station.
- Seek help if available.
- Perform cardiopulmonary resuscitation and provide running commentary.
- Be aware of key safety concerns to consider when using a defibrillator.
- Explain how to perform CPR on a child.

It would be acceptable for the candidate to ask the examiner if you (as the clinician) have had CPR training and are able to assist. They might instruct you to look out for the ambulance to direct the paramedics in as quickly as possible.

To **Achieve** in this station the candidate **MUST**:

- Check for safety and responsiveness.
- Demonstrate correct adult CPR technique – position and depth of hands, 30 compressions to 2 breaths.
- Be aware of at least 2 of the reasons to stop CPR.
- Know that CPR takes precedence over defibrillation, except when the AED machine specifically commands this.

When responding to a situation where someone has collapsed, the chain of survival includes early access to care including early activation of the ambulance service and timely, effective provision of CPR. The purpose of CPR is to maintain blood flow and therefore oxygen to vital organs until ambulance paramedics can provide more advanced care. Defibrillation is another important early intervention. Defibrillation stops certain dangerous cardiac rhythms and assists in regaining normal rhythm. It should not be administered to the patient in asystole.

A primary survey of the situation should be undertaken using: DRS ABCD (more recently – CAB: Danger, Responsiveness, Seek for help, Chest compressions, Airway and Breathing).

Danger – check for hazards / risks / safety. Identify hazards at the scene and prioritise risk to yourself; then any bystanders and finally the casualty. Bystanders should be kept at a safe distance or asked to seek support, call an ambulance etc.

If it is safe to do so, any hazards should be removed or controlled in order to prevent further injuries – in this situation the candidate should consider environmental hazards like gas leaks or electrical discharge in the house, etc.

Responsiveness – determine the casualty's level of consciousness, initially done through 'talk and touch' but not by rigorous shaking; often following COWS:

- Can you hear me?
- Open your eyes
- What is your name?
- Squeeze my hands

Send for Help – request an ambulance.

ABCD - If unconscious, as in this case, follow Airway, Breathing, CPR, Defibrillation

Airway	• Tilt head back. • Look in mouth for foreign bodies, finger sweep technique (index & middle finger). • Remove dentures if loose. • If water / vomit / blood etc. place the person in the recovery position.
Breathing	• Look. • Listen. • Feel.
CPR	• Administered to a person who is **unresponsive** and not breathing **normally.**
Defibrillation	• Use of an Automated External Defibrillator (AED).

The candidate is expected to accurately perform the CPR technique:

1. Partially remove any clothing that may inhibit performance of compressions.
2. Place heel of one hand on the centre of the lower half of the chest, on the sternum.
3. Place other hand on top.
4. Demonstrated high quality chest compressions – adequate rate of 100-120/minute, adequate depth of 2 inches or 5 cm, allowing full chest recoil between compressions, minimising interruptions in chest compressions and avoiding excessive ventilation.
5. Tilt head back and give two rescue breaths.
6. Continue cycle of compressions and rescue breaths, ratio of 30 compressions: 2 breaths.
7. Continue until (1) paramedics or another person takes over, (2) the casualty is responsive and breathing normally, (3) it becomes impossible for you to continue (due to safety or exhaustion).

Compressions and breathing should be to **the standard, and with the acceptable variations (as indicated at training)**.

CPR in non-adults:

Child: use one hand only for compressions and rescue breaths are not required.

Infant: use two fingers only and do not tilt head back. Rescue breaths are not required.

Recent evidence has shown that compression only CPR may work as well as CPR with rescue breaths, but this has not yet been adopted into the national standards. The exceptions to this are children and victims of drowning.

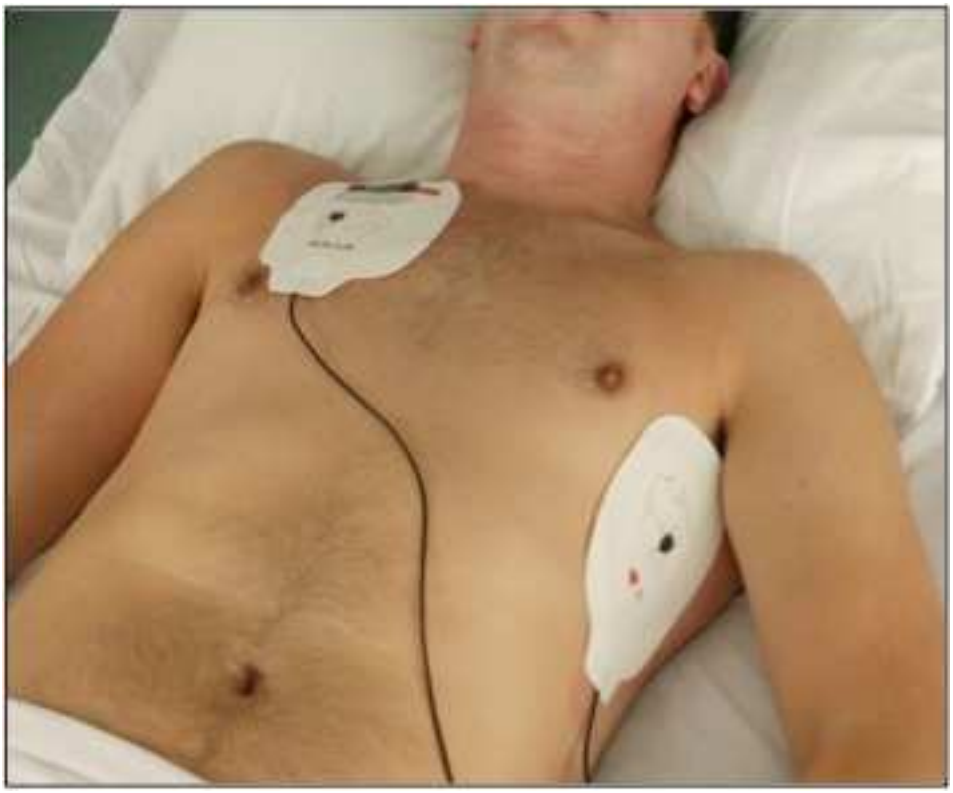
Defibrillation

NOTE: CPR takes precedence over defibrillation and the candidate should be aware that the preparation to use an AED must be done with minimal interference to the person providing CPR,

Before using an AED, check for puddles or water near the person who is unconscious. Move him or her to a dry area, and stay away from wetness when delivering shocks as water conducts electricity.

Turn on the AED's power. The device will give you step-by-step instructions. You will hear voice prompts and see prompts on a screen.
Expose the person's chest. If the person's chest is wet, dry it. AEDs have sticky pads with sensors called electrodes. Apply the pads to the person's chest as pictured on the AED's instructions.

Place one pad on the right centre of the person's chest above the nipple. Place the other pad slightly below the other nipple and to the left of the ribcage.



Picture from: ANZCOR Guideline 7 – Automated External Defibrillation in Basic Life Support

Make sure the sticky pads have good connection with the skin. If the connection is not good, the machine may repeat the phrase "check electrodes."

If the person has a lot of chest hair, you may have to trim it (AEDs usually come with a kit that includes scissors and / or a razor). If the person is wearing a medication patch that is in the way, remove it and clean the medicine from the skin before applying the sticky pads.

Remove metal necklaces and underwire bras. The metal may conduct electricity and cause burns. You can cut the centre of the bra and pull it away from the skin.

Check the person for implanted medical devices, such as a pacemaker or implantable cardioverter defibrillator (the outline of these devices is visible under the skin on the chest or abdomen, and the person may be wearing a medical alert bracelet). Also check for body piercings.

Move the defibrillator pads at least 1 inch away from implanted devices or piercings so the electric current can flow freely between the pads.

Check that the wires from the electrodes are connected to the AED. Make sure no one is touching the person, and then press the AED's "analyse" button. Stay clear while the machine checks the person's heart rhythm.

If a shock is needed, the AED will let you know when to deliver it. Stand clear of the person and make sure others are clear before you push the AED's "shock" button.

Start or resume CPR until emergency medical help arrives or until the person begins to move. Stay with the person until medical help arrives, and report all of the information you know about what has happened.

Primary Safety Concerns:

1. Non-Contact: no person or conductive material to be either in direct or indirect contact with the causality at the time of defibrillation.
2. Non-Conduction: no conductive items in the areas of the causality (water / rain, fluids like vomit, blood or perspiration on chest).
3. Non-Explosive: do not defibrillate if there is chance of explosion due to oxygen, petroleum liquid or other flammable substances.

There are times when CPR should be ceased:

a) the victim responds or begins breathing normally.
b) it is impossible to continue (e.g. exhaustion) or danger.
c) a health care professional or another person takes over CPR.
d) a health care professional directs that CPR be ceased.

Better candidates may surpass if:

- they know that the current CPR guidelines are being reviewed again (e.g. consideration of dropping the rescue breaths completely and increasing the pressure to half the chest depth).
- they are able to provide statistics about the survival rates associated with delayed CPR and defibrillation (e.g. every minute defibrillation is delayed there is approximately 10% reduction in survival from a cardiac arrest due to ventricular fibrillation).
- They know that AEDs are not used in asystole.

CHECKLIST FOR ASSESSMENT OF ADEQUACY OF CPR

	Attempted Adequate	**Attempted Inadequate**	**Not Attempted**
Assesses DANGER in environment [e.g. “no gas, fire, electricity”]			
Assesses consciousness / RESPONSIVENESS [“unconscious, unresponsive to touch”]			
AIRWAY: Checks airway for obstruction [“no obstruction”]			
Positions head and neck correctly to clear airway			
BREATHING: Assesses breathing [“not breathing”]			
Initiates effective expired air respiration gives 2 effective rescue breaths			
COMPRESSIONS: Initiates high quality chest compressions, lower half sternum, heel of hand and other over			
Correct ratio of compressions: Respirations 30:2			
Correct rate of compression At the rate of 100-120 / min Depth of 2 inches / 5 cm			

3.3 The Standard Required

In order to:

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

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

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

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

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

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

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

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

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

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

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.

STATION 5 – MARKING DOMAINS

The main assessment aims are to:

- Demonstrate the ability to perform cardiopulmonary resuscitation (CPR) while providing a commentary to the examiner.
- Demonstrate skills on how to use an automated external defibrillator (AED) and contraindications for the use of AED.
- Demonstrate knowledge of when to stop CPR and the difference between adult CPR and that in children and infants.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.5 Did the candidate demonstrate adequate technique in performing CPR? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* performs a detailed, rapid and comprehensive assessment; overall technique is accurate and well organised; is aware that there is evidence that compressions only without rescue breaths would also be effective, but this has not been accepted into the national standards; recognises the exceptions for this are children and people who have drowned.

Achieves the Standard by:
demonstrating an accurate examination, covering all essential aspects; determines DRS CAB; opens airway, removes foreign materials, checks breathing (look, listen and feel), giving at an adequate rate of 100-120/minute; allowing full chest recoil between compressions.

To score 3 or above the candidate **MUST**:
a. check for safety and responsiveness.
b. demonstrate correct adult CPR technique - position and depth of hands, 30 compressions to 2 breaths.

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:
incorrect technique is utilised; inadequate technique in more than one assessment area above.

1.5 Category: ASSESSMENT – Physical - Technique	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

1.5 Did the candidate demonstrate adequate technique in using the AED? (Proportionate value – 30%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* performs a detailed, rapid display of how to use the AED; overall technique is accurate and well organised; confident about the range of safety concerns and contraindications of defibrillators.

Achieves the Standard by:
clearly knowing where to place the leads and quickly follows the prompts provided by the AED; being aware of most of the dangers, care should be taken not to touch the person during shock delivery and is aware that asystole is a contraindication to using an AED; clarifying that CPR takes precedence and that the person using the AED must not ask for the CPR to be stopped, except when the machine specifically commands this.

To score 3 or above the candidate **MUST**:
a. know that CPR takes precedence over defibrillation, except when the AED machine specifically commands this.

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 score 1.

Does Not Achieve the Standard (scores 0) if:
there is inadequate technique in more than one part of the process; does not demonstrate any familiarity with an AED; recommends technique that places self and others at risk.

1.5 Category: ASSESSMENT – Physical - Technique	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

1.8 Did the candidate make an appropriate selection of processes involved in CPR? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* is able to explain the differences between infant, child and adult CPR and the rationale; able to specify all of the four conditions under which CPR should be stopped.

Achieves the Standard by:
being able to enumerate 3 of the conditions under which CPR can be stopped; being aware of the method for CPR in a child or infant, but not both.

To score 3 or above the candidate **MUST**:
a. be aware of at least 2 of the reasons to stop CPR.

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 score 1.

Does Not Achieve the Standard (scores 0) if:
is unaware of when to stop CPR; describes incorrect technique for infants and children; is unaware of differences between adult, child and infant CPR.

1.8 Category: ASSESSMENT - Selection	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

1.7 Did the candidate undertake tasks with appropriate commentary as per examiner instructions? (Proportionate value - 10%)

Surpasses the Standard (scores 5) if:
the candidate provides sophisticated running commentary and is focussed on describing all necessary findings.

Achieves the Standard (scores 4 or 3) by:
providing a generally accurate description of the technique while performing CPR; the candidate instructs the examiner to seek for further help; provides adequate explanation of rationale for each process / task; any errors are minor.

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:
the candidate partly provides commentary or is vague when requesting for further help.

Does Not Achieve the Standard (scores 0) if:
the candidate incorrectly describes technique; commentary is incomplete or disorganised, does not mention seeking for any further help.

1.7 Category: ASSESSMENT – Examination Commentary	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
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 defined tasks?

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail

Committee for Examinations
Objective Structured Clinical Examination

Station 6
Melbourne April 2016

The Royal Australian & New Zealand College of Psychiatrists

1.0 Descriptive summary of station:

This station tests the ability of the candidate to conduct a psychiatric assessment of a young man with a preoccupation with hair loss and his appearance, which is having a significant impact on his personal and professional life. This station assesses capacity to take an empathic psychological history in order reach a diagnosis of Body Dysmorphic Disorder (BDD).

1.1 The main assessment aims are to:

- Take an appropriately focussed history, consider the diagnostic possibilities and establish a diagnosis of Body Dysmorphic Disorder.
- Communicate the diagnosis and reasoning to the patient including potential differential diagnosis in a non-judgemental, non-stigmatising empathic manner.

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

- Specifically ascertain that the patient's concern is far in excess of the physical evidence.
- Establish how Body Dysmorphic Disorder symptoms are affecting function across a range of areas.
- Sensitively explain the working diagnosis of Body Dysmorphic Disorder.
- Not diagnose Delusional Disorder or Psychosis as a primary diagnosis.
- Effectively manage resistance from the patient in a non-judgemental, empathic manner.
- Not collude with patient e.g. by agreeing to send them to see another specialist or test the hair.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category of:**
  Other Disorders: Obsessive Compulsive and Related Disorders
- **Area of Practice:**
  Adult Psychiatry
- **CanMEDS Domains of:**
  Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes of:**
  Medical Expert (Assessment), Communicator (Synthesis), Collaborator (Patient Relationships)

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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).
- Table fan, room spray / air freshener.
- Laminated copy of 'Instructions to Candidate'.
- Role player – young man wearing a cap or hat. Must have a full head of hair.
- 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 GP Liaison setting and one of the local GPs has requested assessment of a patient to assist with his diagnostic clarification.

John is a 29-year-old single man, who has been sent to you for assessment because the GP is quite concerned about his recent abnormal behaviour that includes bringing in samples of hair for testing to enable him to get treated for baldness.

John is worried that he is rapidly going bald. He has also been seeking repeated referrals to various specialists for this complaint. He has now started reporting suicidal thoughts related to the distress and worries.

Your tasks are to:

- Take a focussed history from John.
- Discuss your diagnosis and differential diagnoses with John.

You will not receive any time prompts.

Station 6 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- Ensure table fan is turned on.
- Ensure 3-4 cups of water are placed on the desk for easy access to the candidates. Replace when used.
- 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.
  - Tissues 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 scripted prompt for you to give.
- 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 any time prompt from the examiner.

The role player opens with the following statement:

"Hello doctor. I don't know how you can help me from losing my hair!"

3.2 Background information for examiners

In this station the candidate is expected to conduct a psychiatric assessment with a focus on the psychological history, specifically to elicit core symptoms to arrive at a preferred diagnosis of Body Dysmorphic Disorder (BDD), and identify the significant impact it is having on the patient's personal and professional life.

BDD is a severe disorder characterised by distressing or impairing preoccupations with nonexistent or slight defects in one's physical appearance. BDD is also characterized by repetitive behaviours in response to the appearance concerns (e.g., mirror checking, excessive grooming; American Psychiatric Association, 2013). BDD is common, with a prevalence of 1.7–2.4% in nationwide population-based surveys (Rief et al., 2006; Koran et al., 2008; Buhlmann et al., 2010).

This station revolves around John, a 29-year-old single man who has been sent by his GP for review in the context of his repeatedly seeking referrals to specialists for problems like hair loss or paleness of skin. More recently, his GP is finding it quite difficult to deal with John's complaints and reports that John has started showing increasingly abnormal behaviour like bringing samples of hair for testing to enable him to get treated for baldness.

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

- Specifically ascertain that the patient's concern is far in excess of the physical evidence.
- Establish how BDD symptoms are affecting function across a range of areas.
- Sensitively explain the working diagnosis of BDD.
- Not diagnose Delusional Disorder or Psychosis as a primary diagnosis.
- Effectively manage resistance from the patient in a non-judgemental, empathic manner.
- Not collude with patient e.g. by agreeing to send him to see another specialist or test his hair.

The candidate should ask questions about the breadth of perceived, imagined or slight flaws. There seems to be gender differences in body parts of concern with men more likely to obsess about their genitals, body build and hair thinning / balding, whereas women are more likely to obsess about their skin, stomach, weight, breasts, buttocks, thighs, legs, hips, toes, and excessive body hair. The candidate's line of questioning should elicit that the patient has a preoccupation with imagined defects in appearance with disproportionate concern regarding the anomaly.

The candidate's questions should reflect this, although more general screening is also expected: including evidence that they are aware that the focus is most commonly on the face or head such as hair thinning, acne, wrinkles, scars, vascular markings, paleness or redness of the complexion, swelling, facial asymmetry or disproportion (e.g. > 80% focus on some part of face). Other common preoccupations include the shape, size, or some other aspect of a body part (the nose, eyes, eyelids, eyebrows, ears, mouth, lips, teeth, jaw, chin, cheeks, or head).

A better candidate would focus on specific questioning to show that the candidate is aware that any part of the body can be a focus or the focus could even be the overall body size. The better candidate may enquire about whether John's preoccupation focusses on a number of body parts simultaneously. They may clarify whether his complaint is specific (which is more common) or more vague. A better candidate will also ask if his symptoms run a continuous course (body part focus can remain the same or change over time, with a mean number of 5-7 parts, with skin, nose or hair being the most common in both genders).

The history of BDD should include that it is a chronic disorder which started in adolescence, and that the diagnosis may not have been made earlier because of the patient's secrecy / reluctance to openly discuss bodily preoccupations (BDD usually starts in early adolescence, but can begin as early as five; onset may be gradual or abrupt, prevalence is similar in men and women).

The candidate must elicit that even though there is minimal or no physical anomaly present, John's concern is markedly excessive, and is causing high levels of distress and impairment in his social, occupational and / or other important areas of functioning. Through their questioning the candidate should show evidence that they are aware that the core belief in BDD is that the person is somehow defective or unattractive and this is accompanied by low self-esteem, embarrassment, shame and fear of rejection.

The candidate needs to try to elicit how John's social impairment correlates with symptom severity and any co-morbidity, especially co-morbid depression, particularly as John does not have strong primary interpersonal relationships because of his BDD.

Approximately 80% of individuals with BDD have experienced suicidal ideation, about a quarter have attempted suicide (Veale et al., 1996; Phillips and Diaz, 1997; Phillips, 2007). BDD is usually associated with substantial impairment across work and social domains (Didie et al., 2008; Phillips, 2009). BDD is characterized by poor psychosocial functioning and high rates of suicidality (Buhlmann et al. 2010; Phillips et al. 2005b, 2008; Veale et al. 1996a), yet BDD usually goes undiagnosed in clinical settings (Conroy et al. 2008; Grant et al. 2001).

The candidate should ask about suicidal ideation (in psychiatric treatment settings up to 70% report a history of suicidal ideation and 24% have attempted suicide: even those in the population not seeking treatment have high rates - 25% ideation and 7% attempts. People with BDD have many of the risk factors associated with suicide; namely, being single or divorced, high co-morbidity, poor social supports, poor self-esteem, high anxiety levels, depression and hostility, high rates of psychiatric admissions).

The predominant view today is that BDD is an obsessive-compulsive spectrum disorder due to strong evidence of the overlap between BDD and obsessive-compulsive disorder (OCD) in terms of phenomenology, comorbidity, and treatment response. Given the recent research attention on the strong relationship between BDD and OCD, DSM-5 now includes BDD under a new section for OCD and related disorders.

As all BDD patients engage in a range of associated time-consuming features, the candidate needs to establish what common behaviours John undertakes; including any mirror checking, excessive grooming, camouflaging (including wearing a hat / cap), seeking reassurance or questioning others regarding their looks, touching and comparing the 'defect' to other people directly or through pictures, seeking dermatological or cosmetic surgical treatments.

Findings from family studies indicate that the prevalence of BDD is significantly higher among first-degree relatives of probands with OCD compared with other obsessive-compulsive spectrum disorders, such as hypochondriasis, eating disorders, and impulse control disorders, which supports the conceptualization of BDD as an obsessive-compulsive spectrum disorder. The candidate should ask about a family history of any mental illness and specifically of BDD and OCD.

BDD is relatively common in various outpatient mental health settings, including among patients with OCD, social anxiety disorder, and atypical major depressive disorder (Kelly and Phillips, 2011). Among psychiatric inpatients, 13–16% have BDD (Grant et al., 2001; Conroy et al., 2008), which is more common than many other disorders, including schizophrenia and bipolar disorder (Grant et al., 2001).

Comorbidity rates with other disorders are very high, with men and women having similar rates of depression, OCD, social phobia, agoraphobia, and anorexia nervosa. The longitudinal association is strongest with major depression (found in at least 36-50% people with BDD). Substance use is common with over one third of men with BDD having a substance use disorder, and 25% of women. Even though John does not currently have active symptoms of comorbidity, he has experienced a prior depressive episode and suicidal ideation.

The candidate should try to assess for more common differential diagnoses which include:

- **Normal appearance concerns and clearly noticeable physical defects**

  BDD differs from normal appearance concerns in being characterised by excessive appearance-related preoccupations and repetitive behaviours that are time-consuming, are usually difficult to resist or control, and cause clinically significant distress or impairment in functioning. Physical defects that are clearly noticeable (i.e. not slight) are not diagnosed as BDD. However, skin picking as a symptom of body dysmorphic disorder can cause noticeable skin lesions and scarring (Didie et al. 2010); in such cases, BDD should be diagnosed.

- **Eating disorders**

  In an individual with an eating disorder, concerns about being fat are considered a symptom of the eating disorder rather than BDD. However, weight concerns may occur in BDD. Eating disorders and BDD can be comorbid, in which case both should be diagnosed.

- **Other obsessive-compulsive and related disorders**

  The preoccupations and repetitive behaviours of BDD differ from obsessions and compulsions in OCD in that the former focus only on appearance. These disorders have other differences, such as poorer insight in BDD (Phillips et al. 2010a). When skin picking is intended to improve the appearance of perceived skin defects, BDD, rather than excoriation (skin-picking) disorder, is diagnosed. When hair removal (plucking, pulling, or other types of removal) is intended to improve perceived defects in the appearance of facial or body hair, body dysmorphic disorder is diagnosed rather than trichotillomania (hair-pulling disorder).

- **Illness anxiety disorder**

  Individuals with BDD are not preoccupied with having or acquiring a serious illness and do not have particularly elevated levels of somatization (Phillips et al. 2010b).

- **Major depressive disorder**

  The prominent preoccupation with appearance and excessive repetitive behaviours in BDD differentiate it from major depressive disorder. However, major depressive disorder and depressive symptoms are common in individuals with BDD (Phillips et al. 2010b), often appearing to be secondary to the distress and impairment that BDD causes. BDD should be diagnosed in depressed individuals if diagnostic criteria of BDD are met.

- **Anxiety disorders**

  Social anxiety and avoidance are common in BDD (Phillips et al. 2010a). However, unlike social anxiety disorder (social phobia), agoraphobia, and avoidant personality disorder, BDD includes prominent appearance-related preoccupation, which may be delusional, and repetitive behaviours, and the social anxiety and avoidance are due to concerns about perceived appearance defects and the belief or fear that other people will consider these individuals ugly, ridicule them, or reject them because of their physical features. Unlike generalised anxiety disorder, anxiety and worry in BDD focus on perceived appearance flaws.

- **Psychotic disorders**

  Many individuals with BDD have delusional appearance beliefs (i.e., complete conviction that their view of their perceived defects is accurate) (Phillips et al. 2010b), which are diagnosed as BDD, with absent insight / delusional beliefs, not as delusional disorder. Appearance-related ideas or delusions of reference are common in BDD (Phillips et al. 2008); however, unlike schizophrenia or schizoaffective disorder, BDD involves prominent appearance preoccupations and related repetitive behaviours, and disorganised behaviour and other psychotic symptoms are absent (except for appearance beliefs, which may be delusional).

- **Other disorders and symptoms**

  BDD should not be diagnosed if the preoccupation is limited to discomfort with or a desire to be rid of one's primary and / or secondary sex characteristics in an individual with gender dysphoria or if the preoccupation focusses on the belief that one emits a foul or offensive body odour as in olfactory reference syndrome (which is not a DSM-5 disorder). Body identity integrity disorder (apotemnophilia, which is not a DSM-5 disorder) involves a desire to have a limb amputated to correct an experience of mismatch between a person's sense of body identity and his or her actual anatomy. However, the concern does not focus on the limb's appearance, as it would in BDD (Phillips et al. 2010b). Koro, a culturally related disorder that usually occurs in epidemics in South-eastern Asia, consists of a fear that

the penis (labia, nipples, or breasts in females) is shrinking or retracting and will disappear into the abdomen, often accompanied by a belief that death will result. Koro differs from body dysmorphic disorder in several ways, including a focus on death rather than preoccupation with perceived ugliness (Phillips et al. 2010b). Dysmorphic concern (which is not a DSM-5 disorder) is a much broader construct than, and is not equivalent to, BDD. It involves symptoms reflecting an over concern with slight or imagined flaws in appearance.

Insight is usually partial and patients may display non-bizarre, monothematic beliefs that may become delusional. The delusional variant of BDD in people who are completely convinced that their perceived defects or flaws are truly abnormal appearing is no longer coded as both delusional disorder, somatic type and BDD. It is now designated as only BDD with the absent insight / delusional beliefs specifier.

A better candidate will sensitively seek to clarify whether John has sought medical cosmetic and surgical interventions (±75% seek non-psychiatric cosmetic medical care, with approximately ±23% receiving surgical procedures. Over 75% of non-psychiatric treatments for BDD defects lead to no change or worsening of the overall disorder, with patients being dissatisfied or very dissatisfied with the outcome. Only 7% lead to a decrease in concern and overall improvement. The poor outcomes may include vexatious litigation or risk of violence to others which is possibly more common in men).

A surpassing candidate will try to elicit:

- Whether John has ever attempted to change his appearance himself (a small number of people with BDD are so dissatisfied with approved interventions that they perform 'do-it-yourself' cosmetic procedures, especially after consulting internet websites. People can also harm themselves in order to get the surgery if it has been turned down. DIY has been found to often be associated with a person spending many hours of mirror gazing and experiencing intense disgust about their perceived defect).

- Whether the presence of poor insight indicates the likelihood of John meeting the absent insight / delusional beliefs specifier according to DSM-5.

Feedback to the patient:

The candidate should provide feedback about the diagnosis and reasoning to John in an empathic and sensitive manner. They should explain the features of BDD that are consistent with their findings. They should be able to generate a few key differential diagnoses and try to distinguish as to how they have ruled them out from being the primary diagnosis.

The candidate should not provide too much technical or less relevant information that will negatively impact on initial engagement.

The candidate should not try to convince John that his entrenched ideas and beliefs are irrational or that he looks normal, as this is unlikely to persuade them to accept psychiatric treatment or referral.

A surpassing candidate would be able to specifically demonstrate some of the following:

- Not collude with the patient.
- Not reassure them that they look fine or that surgical / dermatological treatment is necessary.
- Not display anger or irritation if the patient does not seem to be convinced about the diagnosis.
- Not suggest referral to cosmetic surgeon / dermatologist.
- Not offer investigations of patient's hair.

<u>Rating Scales:</u>

Current severity can be measured using the rater administered Yale-Brown Obsessive Compulsive Scale Modified for Body Dysmorphic Disorder (BDD-YBOCS) (Phillips et al., 1997). The Brown Assessment of Beliefs Scale (BABS) assesses the degree to which body-image beliefs are delusional (Eisen et al., 1998).

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 Role Player

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

You are John a 29-year-old single man who works as a financial analyst in a merchant bank in the city. It is a competitive environment. You have been with the company for 6 years since graduating from university, but your career has stalled. It is 3 years since your last promotion and your explanation for this is that you are losing your scalp hair and this is costing you a promotion.

Since your adolescence (about 16 years) you have been quite concerned about your appearance and grooming. It began with a strong belief that in some way your face was asymmetrical which you believed was obvious to other people. This led to you checking your facial features in a mirror several times a day; and this confirmed your 'repulsiveness'. Then you began to notice facial flaws and different shades of pigmentation and worried that these made you look ugly. You started using creams and lotions to camouflage the area of paleness of skin leading to excessive spending on skin beauty products and spending a lot of time on browsing through websites to find a solution.

If asked by the candidate, it is your core belief that somehow you are defective or unattractive and this is accompanied by low self-esteem, embarrassment, shame and fear of rejection. You admit to experiencing significant distress and can describe this as 'intensely painful', 'tormenting', or 'devastating'.

Regularly checking your facial appearance during the day has now become part of your daily life. Each mirror-checking episode lasts several minutes with you having to reassure yourself that there are no new blemishes and that the existing blemishes are not getting worse. It is difficult to do this as regularly as you would like to at work, you can probably get to the bathroom once every two hours for a few minutes. At home it is easier where you can inspect your entire head and face several times per day. If asked, you have to agree that the total amount of time you spend checking your appearance in front of the mirror, touching, examining, picking at almost every skin pore and hair follicle, could be about four hours per day on the weekends.

You still live at home with your parents, who are both school teachers approaching retirement. Your mother worries a lot about having a clean and tidy home and does spend a lot of time cleaning in the kitchen. If asked by the candidate, this behaviour has never been so out of control that your mother needed to see anyone. Your parents have become accustomed to you asking "*How do I look*?" or, "*Is there something wrong with my face / skin / mouth / eyes / ears? Are there any spots of pale skin on my face*?". Their unfailing reassurance that there is nothing wrong with your appearance does not reduce any of your concerns as you are sure they are only saying that because they love and care about you.

In the past decade you have spent a fortune on male beauty products, facial treatments, massages, hair styling and allergy free soaps, shaving creams and cosmetics in an attempt to treat or camouflage your skin defects. You have also consulted a dermatologist on at least two occasions because you were concerned that blemishes and pimples were not healing, but were dissatisfied with the outcome of the consultation.

Because of your concerns for your skin you do not like to socialise where people are smoking and would never consider smoking yourself. For similar reasons you do not drink and avoid direct sun exposure as much as you can. Your self-consciousness can lead to avoidance of wider family and social activities. You also avoid crowds and public transport in order to avoid the embarrassment of strangers looking too closely at your facial and head features -– all leading to significant social impairment as you don't have any close friends.

Over the last few months you have been monitoring the number of scalp hairs you have found on the floor in your shower cubicle after a shower. Although it may only be 2-3 hairs you have come to believe two things. The first is that the cumulative hair loss means that you are going bald and secondly that the resultant change in your hair density and thickness is obvious to others. You are quite convinced that you are going bald and worry about not getting married and losing out on life and its opportunities with occasional suicidal ideations. You have never attempted self-harm or suicide though suicidal thoughts have crossed your mind.

You have brought in some hair because you have found on the internet that certain laboratories can do tests on hair that can diagnose problems. You hope that the doctor will be able to send your hair sample to a lab that does these tests.

You often find your preoccupations difficult to control, and sometimes you make little or no attempt to resist them. So, you can spend hours / day thinking about your defects, so much that this seems to dominate your life. Sometimes you do feel as if there might be a link between how bad the defects are and whether you avoid people more at these times.

Although you believe you are conscientious and reliable at work, your progress has stalled. Lately you have been taking a few more days of sick leave and are preoccupied about the hair loss and appearance. Fellow candidates from your intake cohort seem to have left you behind. You are certain that this obvious hair loss has influenced your employers not to promote you because thinning hair / baldness and poor / unhealthy looks are not in keeping with the image that the company wants to portray to its customers. More recently you have been tempted to attend one of those private hair clinics they advertise for men on the TV, and have been saving up so you can pay for a course of treatment.

You have just had a performance appraisal interview and have once again been passed over for promotion. In response to this you have decided to seek medical advice about the diagnosis and treatment of your hair loss. You do not trust your family GP because he previously dismissed your concerns and said there was nothing wrong with you, so you are seeking an unbiased opinion from the doctor. You brought a sample of your hair with you so that it could be analysed to find a cause of the excessive loss. You have passed the sample to the nurse on your way into the room.

You have never heard voices or seen things that others do not and never have suspected that people are after you or that your life may be at risk. You have never had any manic or hypomanic symptoms such as an unduly elevated mood, excess energy, increased spending and increased sexual drive. You feel distressed and occasionally depressed about the state of affairs that you are in. However, you still enjoy things as much, do not have reduced energy levels and do not experience hopelessness, helplessness or decreased concentration.

You do not repeatedly check locks, lights and have doubts about cleanliness or symmetry or other repetitive thoughts or actions other than specified above.

If the candidate asks you to show the hair that you have brought, say that you have left the hair with the nurse.

4.2 How to play the role:

You are a young male, must be slightly scruffily dressed and wearing a hat or cap (which you must not take off unless asked to by the candidate). Once removed insist on showing the doctor your 'receding hair line' (if there is a mirror in the consulting room you can show the candidate in the mirror) as well as areas of paleness of skin on your face.

You will look anxious and be somewhat irritable. You will try to be co-operative during the interview and with any examination of your head and face the candidate attempts. Questions regarding your physical and psychological health should be answered as scripted. If there is no scripted response then you should inform the candidate that you have not experienced that symptom.

After your opening statement (see 4.3) your subsequent behaviour and emotional reactions will be in response to the way the interview unfolds. If the doctor rushes to a judgement and dismisses your concerns without tact, empathy or appropriate discussion, then your irritability and exasperation can increase.

If the doctor suggests that the problem is psychological, but also realises the sensitive nature of your underlying psychiatric problem, including the extent of your difficulties and concerns, and they can effectively engage you then be defensive and sceptical, but be prepared to listen and interact appropriately.

Do not willingly volunteer history of your rituals or checking behaviour unless asked. These have been behaviours you have kept secret for years, but may be relieved when at last someone is able to encourage you to talk about them.

4.3 Opening Statement:

"Hello doctor. I don't know how you can help me from losing my hair!"

4.4 What to expect from the candidate:

The candidate is to do an initial assessment of your symptoms and the reasons for wanting your hair assessed. To do this they will ask questions about your recent history including your concerns related to various parts of your body, other medical and psychiatric history and your personal history – answer as per the information provided.

They are likely to assess your mood, as well as current and usual coping styles in order to assess the breadth of your symptoms. Do not volunteer specific information unless asked, be cooperative but anxious, with a sense of irritation if the candidate states that you have a mental disorder.

Expect the candidate to work hard to form an alliance with you and treat your symptoms and distress sensitively.

4.5 Responses you MUST make:

"*I want the hair I brought to be analysed by a specialist!"*

"You've got to tell me what is going on!"

"Can you please refer me to a skin specialist or cosmetic surgeon who will do a hair transplant for me?"

4.6 Responses you MIGHT make:

"***Let me show you where I'm going bald",*** then proceed to show the doctor various parts of your hairline.

If asked about any other physical health problems, you have not noticed anything.

If asked about any mood symptoms, you have recently felt frustrated and down because of your current situation. Sometimes you do have difficulty getting to sleep but this has not happened recently. You have also had a period of time when your mood was very low and you wished you were dead. This was about 5 years ago and the symptoms passed without any intervention within a few months.

If asked about suicidal ideation or attempts, you had thought of gassing yourself when you were about 22 years old when you had a particularly bad period of acne around exam time, but you have not felt this bad since, although you do feel desperate sometimes and think that it may be better to die than to carry on this way. You have never attempted suicide and strongly reassure the doctor that it would only be the last resort if matters were not sorted. You love your parents too much to hurt them this way.

If asked about appetite and weight, you have no problems with your appetite but obviously take care of what you eat because you don't want to add to your worries by being overweight as well.

If asked about vague or generalised symptoms of anxiety, you deny this.

If asked about other specific anxiety symptoms, like fear of leaving the house, or performing in some way in front of others, these do not really concern you except when it relates to what you look like.

If asked about other obsessions (intrusive thoughts) or compulsions (repetitive behaviours or mental actions), you do not have any that do not link directly with your looks and your hair loss.

If asked about the course of your symptoms, it has been continuous since your teens with few symptom-free intervals, although the symptom intensity waxes and wanes, but does seem to be worsening over time.

If asked about family history of psychiatric or medical illnesses, there is none.

STATION 6 – MARKING DOMAINS

The main assessment aims are to:

- Take an appropriately focussed history, consider the diagnostic possibilities and establish a diagnosis of Body Dysmorphic Disorder (BDD).
- Communicate the diagnosis and reasoning to the patient including potential differential diagnosis in a non-judgemental, non-stigmatising empathic manner.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed history? (Proportionate value - 35%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* completes sophisticated assessment of the pattern of symptom presentation; identifies the relevant family history and past personal history of depressive symptoms; links exacerbations to stressors and comorbidities.

Achieves the Standard by:
demonstrating 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; history taking is hypothesis-driven; demonstrating ability to prioritise; completing a risk assessment relevant to the individual case; demonstrating phenomenology; clarifying important positive and negative features including possible delusional disorder and ruling out depressive and anxiety disorder symptoms.

To score 3 or above the candidate **MUST**:
a. specifically ascertain that the patient's concern is far in excess of the physical evidence.
b. establish how Body Dysmorphic Disorder symptoms are affecting function across a range of areas.

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:
significant omissions in history and not prioritising symptoms of Body Dysmorphic Disorder.

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** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

1.9 Did the candidate formulate and describe the relevant working diagnoses / differential diagnoses to the patient? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* integrates information in a manner that can effectively be utilised by the patient; provides succinct and professional information.

Achieves the Standard by:
providing accurate and structured feedback about the diagnosis; prioritising and synthesising information; adapting communication style to the setting; the use of language so as to enhance patient understanding; demonstrating discernment in selection of content; discussing need to speak with other specialists and GP, recognising the importance of explanations to the patient.

To score 3 or above the candidate **MUST**:
a. sensitively explain the working diagnosis of Body Dysmorphic Disorder.
b. not diagnose Delusional disorder or Psychosis as a primary 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:
any errors or omissions impact on the accuracy of information provided.

1.9. Category: DIAGNOSIS	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

2.0 COMMUNICATOR

2.1 Did the candidate demonstrate effective communication skills and an appropriate professional approach to gathering information from the patient? (Proportionate value - 35%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* professionally and sensitively accommodates the patient's distress and respond to it empathically and address the concerns raised effectively.

Achieves the Standard by:
demonstrating ability to develop a therapeutic relationship; addressing to concerns raised; helping the patient feel at ease; sensitively but appropriately responding to the request for hair to be examined; forming a partnership with the patient demonstrating empathy and ability to establish rapport.

To score 3 or above the candidate **MUST**:
a. effectively manage resistance from the patient in a non-judgemental, empathic manner.
b. not collude with patient e.g. by agreeing to send them to see another specialist or test the hair.

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:
lacking consideration of individual capabilities or preference; using aggressive, patronising or interrogative style; gives in to the patient's demands for further investigations; any errors or omissions adversely impact on alliance.

2.1. Category: PATIENT COMMUNICATION – To Patient	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
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 defined tasks?

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

Committee for Examinations
Objective Structured Clinical Examination

Station 7
Melbourne April 2016

The Royal Australian & New Zealand College of Psychiatrists

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 <u>must</u> remain in the room and <u>NOT</u> proceed to the next station until the bell rings."

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

There is no 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
Symptoms present for 2 weeks and are a change from usual functioning, must include either low mood OR loss of interest or pleasure. Must include 5 or more of the following: • Depressed mood for most of the day, either reported subjectively or observed by others. • Loss of pleasure or interest in all or most activities for most of the day. • Significant weight loss or weight gain not related to dieting or increased or decreased appetite. • Insomnia or hypersomnia most days. • Psychomotor retardation or agitation. • Fatigue and / or loss of energy. • Feelings of worthlessness and / or guilt. • Difficulty concentrating and / or difficulty making decisions. • Suicidal ideation or attempts.	• Depressive episode should last at least 2 weeks. • Never experienced hypomania or mania. • Not attributable to substance use or organic mental disorder. Somatic Syndrome include 4 of the following: • Loss of interests or pleasure. • Lack of emotional reactions. • Early morning wakening ± 2hours. • Worse depression in the morning. • Psychomotor retardation. • Poor or increased appetite. • Marked weight loss. • Marked loss of libido. Should last at least 2 weeks, most days, most of the time: • Depressed mood. • Loss of pleasure.

• Symptoms cause significant impairment in functioning. • Symptoms are not caused by a substance or a medical condition. • Symptoms are not better explained by another diagnosis.	• Fatigue or low energy. • Poor concentration or indecisiveness. • Low self-esteem or confidence. • Suicidal thoughts or acts. • Guilt or self-blame or reproach. • Changes in sleep and appetite. • Psychomotor changes. The symptoms then define the degree of depression: • **Not depressed** (fewer than four symptoms). • **Mild depression** (four symptoms). • **Moderate depression** (five to six symptoms). • **Severe depression** (seven or more symptoms, with or without psychotic symptoms). • With or without Somatic Syndrome.
PTSD DSM-5	**PTSD ICD-10**
Post-traumatic stress disorder is: 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 occured to a family member or a close friend, experiencing repeated or extreme exposure to aversive details of the traumatic event. B. Presence of one or more of the following: 1. Recurrent, involuntary and intrusive distressing memories of the traumatic event. 2. Recurrent distressing dreams in which the content and / or affect of the dream are related to the traumatic event. 3. Dissociative reactions e.g. flashbacks. 4. Intense or prolonged psychological distress at exposure to internal or external cues of the trauma. 5. Marked physiological reactions to internal or external cues of the trauma. C. Persistent avoidance of stimuli associated with the traumatic event: 1. Avoidance of or efforts to avoid distressing memories, thoughts, feelings about or that closely associated with the traumatic event. 2. Avoidance of or attempts to avoid external reminders that arouse distressing memories, thoughts or feelings about or closely associated with the traumatic event. D. Negative alterations in cognitions and mood associated with the traumatic event. 2 or more of the following: 1. Inability to remember an important aspect of the traumatic event. 2. Persistent and exaggerated negative beliefs or expectations about oneself, others or the world. 3. Persistent, distorted cognitions about the cause or consequence of the traumatic event that leads to the individual blaming themselves or others. 4. Persistent negative emotional states. 5. Marked diminished interest or participation in significant activities. 6. Feelings of detachment or estrangement from others. 7. Persistent inability to experience positive emotions.	Stressor criterion: A. Exposure to a stressful event or situation of exceptionally threatening or catastrophic nature, and likely to cause pervasive distress in almost anyone. B. Persistent remembering or 'reliving' the stressor (Repetitive intrusive recollection or re-enactment of the event in memories, daytime imagery, or dreams). C. Actual or preferred avoidance of circumstances resembling or associated with the stressor. Symptom criterion: D. Either: • Inability to recall, either partially or completely, some of the period of exposure to the stressor. • Persistent symptoms of increased psychological sensitivity and arousal to the stressor shown by any 2 of the following: o Difficulty falling or staying asleep. o Irritability or outbursts of anger. o Difficulty concentrating. o Hyper-vigilance. o Exaggerated startle response. Other typical symptoms: Sense of 'numbness' and emotional blunting, detachment from others, unresponsiveness to surroundings, anhedonia.

E. Marked alterations in arousal and reactivity associated with the traumatic event. 2 or more of the following: 1. Irritable behaviour and angry outbursts. 2. Reckless or self-destructive behaviour. 3. Hypervigilance. 4. Exaggerated startle response. 5. Problems with concentration. 6. Sleep disturbance. F. Duration of disturbance is more than a month: 1. Symptoms cause significant impairment in functioning. 2. Symptoms are not caused by a substance or a medical condition. 3. Symptoms are not better explained by another diagnosis. 4. Specifiers for PTSD: o With dissociative symptoms. o With delayed expression.	

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~~s~~ 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 to 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**:
a. 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** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

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**:
a. Elicit enough symptoms to justify a diagnosis of major depressive disorder *and* make the diagnosis.
b. 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** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

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** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

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**

Committee for Examinations
Objective Structured Clinical Examination

Station 8
Melbourne April 2016

The Royal Australian & New Zealand College of Psychiatrists

1.0 Descriptive summary of station:

In this station the candidate is to assess and manage nicotine addiction in Alex, a 35-year-old man who suffers from schizophrenia and requires an extended hospitalisation for an orthopaedic procedure and subsequent rehabilitation. Alex also has comorbid epilepsy. The candidate is required to negotiate a preferred management plan and simultaneously educate the patient about the risks of his using bupropion, which is his preferred choice of treatment (bupropion is contraindicated in epilepsy).

1.1 The main assessment aims are:

- To take a relevant history.
- To explain treatment options and assist the patient in making a decision about his treatment.

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

- The ability to assess the patient's readiness to quit.
- Knowledge that psychological interventions are an essential component of therapy.
- Knowledge of at least 2 pharmacological options from nicotine replacement therapy, veranicline, and nortriptyline.
- The ability to impart adequate information to the patient highlighting the risk of bupropion.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category of:**
  Substance Use Disorders
- **Area of Practice:**
  Addiction
- **CanMEDS Domains of:**
  Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes of:**
  Medical Expert (Assessment, Management)
  Communicator (Conflict Management)

References:

- Mendlesohn CP, Kirby DP, Castle DJ. *Smoking and Mental Illness. An Update for Psychiatrists*. Australasian Psychiatry 2015, 23(1) 37-43.
- Zwar N, Richmond R, Borland R et al. *Supporting Smoking Cessation: A Guide for Health Professionals*. Royal Australian College of General Practitioners, 2014.
- Rustin TA. *Assessing Nicotine Dependence*. Am Fam Physician. 2000 Aug 1;62(3):579-58
- *The New Zealand Guidelines for Helping People to Stop Smoking*. Ministry of Health, June 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 – Male. Mid 30s. Preferably slightly overweight. Walks with a limp.
- Pen for candidate.
- Timer and batteries for examiner.

2.0 Instructions to Candidate

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

You are working as a junior consultant psychiatrist in the community team. You have been asked to see Alex, a 35-year-old man, who is a patient of the service and suffers from schizophrenia which is well maintained on his current treatment. He has comorbid stable epilepsy. He is due to have an operation in the near future and will require an extended admission. To avoid acute nicotine withdrawal, the hospital team has advised Alex that he should stop smoking cigarettes before his admission, as smoking is not possible during his hospital stay. His current medication is olanzapine 15mg at night and valproate 500mg twice daily.

Your tasks are to:

- Take focussed history that relates to substance use.
- Explain the management options available to Alex.
- Negotiate a management plan with Alex.

You will not receive any time prompts.

Station 8 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
  - Duplicate copy of 'Instructions to Candidate'.
  - Any other candidate material specific to the station e.g. investigation results.
  - Pens.
  - Water & 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 scripted prompt for you to give.
- 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 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 <u>must</u> remain in the room and <u>NOT</u> proceed to the next station until the bell rings*.**"

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

Observe the history taking, the explanation of management options, the interaction between the candidate and role player in defining a treatment plan and defined tasks as outlined in 1.1 and 1.2.

When the candidate enters the room briefly check ID number.

You have no opening statements or prompts.

The role player opens with:

"*I have a long spell in hospital coming up! They want me to stop smoking before the op*."

3.2 Background information for examiners

There are higher rates of smoking and nicotine dependence in people with mental illness. About 30% of Australians with mental illness smoke compared to 16% of those without mental illness. 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.

Nicotine is a drug of abuse. It 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 as 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.

The optimal treatment for smoking is combination of counselling, pharmacotherapy and ongoing support. The treatment pathway of the 5As 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.

A modified CAGE questionnaire, 2 '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 30min is a very strong indicator of addiction, and "how many cigarettes do you smoke?" - greater than 20 indicates a higher-level addiction.

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.

Nicotine Replacement Therapy (NRT), varenicline, bupropion and nortriptyline are recommended pharmacological interventions for nicotine addiction. Both combination NRT (patches plus short-acting preparation) and varenicline are the most efficacious pharmacotherapies. Patients with mental illness often require greater doses of NRT and for longer duration due to higher levels of nicotine dependence.

NRT increases quit rates by 60%. 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 2 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 except in pregnancy. Side effects can include insomnia, disturbed dreams, skin irritation (with patch), nausea, heartburn and mouth irritation (with oral preparation). Initially patches of Nicotine 21mg should be used. Oral preparations are available as strips, gum, lozenges, or inhaled cartridges.

Varenicline is the most effective mono therapy for smoking cessation. It should be commenced 1 week before the quit date and continued for 12 weeks. The initially dose is Varenicline 0.5mg daily increasing gradually to 1mg twice daily after 1 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. It should be commenced 1 week before the quit date and should be continued for at least 9 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 1 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.

Tobacco smoke reduces serum levels of a number of psychotropic drugs by inducing cytochrome P450 enzyme. Nicotine does not affect serum levels. Therefore serum levels of certain drugs - olanzapine, clozapine and fluvoxamine can rise significantly after smoking cessation. It is recommended that the olanzapine dose is reduced by 30% within a few days of cessation, and certainly by 1 week. The dose will need to be increased if smoking recommences.

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

- identify, within the history, features of nicotine dependence:
  - the candidate may utilise the modified CAGE questionnaire, 4 Cs test, or similar inquiry.
- assess the motivation to quit:
  - identify how the patient feels about their smoking.
- have a reasonable understanding of management options available for nicotine dependence:
  - understand that psychological interventions are an essential component of therapy;
  - be aware of at least 2 pharmacological options for treatment;
  - be aware of some of the side effects of treatment.
- be able to tailor the management taking into account the patient's wishes and needs.
- be aware that Bupropion is contraindicated in seizure disorders and / or Nortriptyline should be used with caution in seizure disorders.

A better candidate may:

- explore reinforcers for smoking behaviour and / or identify triggers or high risk smoking situations.
- have a detailed understanding of management options for nicotine dependence:
  - understand all pharmacological options and side effects;
  - be aware of varying efficacy of treatments.
- understand the pharmacological impact of smoking cessation, and the pharmacological interactions of agents used in smoking cessation.

3.3 The Standard Required

In order to:

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

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

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

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

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

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

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

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

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

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

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 Alex, a 35-year-old man, living alone in rented accommodation.

You have a long history of schizophrenia and currently have regular contact with the community mental health team. You had 2 admissions in your mid 20s when you first developed psychotic symptoms: you believed that the government was spying on you, that the radio was giving you messages, and you could somehow intercept secret radio messages about you with your mind. 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 had been working as a landscape gardener but were injured in a motor vehicle accident (you were a pillion passenger on a motorbike) earlier this year. Your knee was operated on but there was a subsequent infection affecting the joint requiring another surgery and an admission for a few days. There was a brief relapse of your psychotic symptoms during your first admission following the operation. The psychiatrist in the hospital increased your olanzapine from 10mg to 15mg and referred you to the community mental health team for support.

You are now due to go to hospital for a third operation in about four weeks to try to rectify the problem. The plan involves staying in hospital for an extended period and then having a spell in the rehabilitation unit. As you will be confined to your bed, and then have a long stay in hospital, it has been recommended that you address your smoking habit.

You currently take olanzapine 15mg at night. You also take sodium valproate 500mg twice daily to treat epilepsy. You have not had a seizure for 2 years. Prior to that you had grand mal epilepsy where your entire body would have jerky movements. You are not troubled by side effects besides being a few kilos heavier than you were before starting the olanzapine.

You have smoked from an early age – about 17 years. You smoke about 20 cigarettes per day. This can increase to about 30 cigarettes daily at times of stress but this does not happen often. You feel that smoking helps you feel calm and manage the day better than if you were ‘smoke free’. You even feel that you would ‘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 frequently need breaks at work for a ‘smoko’ and your boss has complained that you take too many during the day, but he has never taken any action. You have tried to quit before but have never had any success - you have 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 from lung cancer. He too had schizophrenia and smoked heavily for most of his life. You drink alcohol a couple of times per week - a couple of beers watching the football. You have used marijuana, but only rarely as you found it made you very anxious and ‘edgy’ and have not used any for over a year. You have not used any other illicit drugs and you do not gamble.

After hearing about ‘not smoking’ for the entire admission you initially thought that this would not be possible. During your previous stays you were at least able to go outside the hospital in a wheelchair. You have thought about it more and 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 again. You have had a look on the internet and a medication ‘BUPROPION' has appealed to you. You have read positive comments about its success and tolerability from people who have used it. You would prefer to use this if possible.

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 proffered and may raise questions about them. You will prefer to use ‘bupropion’ 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:

"I have a long spell in hospital coming up! They want me to stop smoking before the op."

4.4 What to expect from the candidate:

The candidate will introduce themselves, explain their role and summarise the information that they have been given. They will limit further inquiry to explore your diagnosis, treatment, recent hospitalisation and use of substances (tobacco, alcohol and drugs). The candidate should then explain the various treatment options available highlighting risks and benefits. The candidate should opt to avoid bupropion due to the risk of seizure. They should discuss a plan to start the treatment before a designated quit date. A better candidate will discuss altering the dose of olanzapine because of your stopping smoking.

4.5 Responses you MUST make:

"I have read good reports about bupropion."

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.

STATION 8 – MARKING DOMAINS

The main assessment aims are:

- To take a relevant history.
- To explain treatment options and assist the patient in making a decision about his treatment.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed history? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication. The candidate would have a sophisticated and in depth understanding of the available screening questions for addiction; will explore reinforcers for smoking behaviour and identify triggers or high risk smoking situations.

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; obtain information regarding compulsion to smoke, difficulty in quitting, the need to smoke first thing in the morning, history taking is hypothesis-driven; integrating key sociocultural issues relevant to the assessment; demonstrating ability to prioritise.

To score 3 or above the candidate **MUST**:
a. assess the patient's readiness to quit 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 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 score 1.

Does Not Achieve the Standard (scores 0) if:
omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in history.

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** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

1.13 Did the candidate formulate and describe a relevant management plan? (Proportionate value - 40%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* provides a sophisticated link between the plan and key issues identified; clearly addresses difficulties in the application of the plan. The candidate has a detailed understanding of pharmacological management of nicotine addiction which may include dosing schedules, combination strategies, varying efficacies of treatments, the pharmacological interaction of agents used in smoking cessation, and the impact of nicotine cessation upon other medication dosing.

Achieves the Standard by:
demonstrating the ability to prioritise and implement evidence based acute care skills; recommend medication and other specific treatments; have some understanding of side effect profile / dosing of treatment suggested, safe skilful engagement of appropriate treatment resources / support; safe, realistic time frames / risk assessment / review plan; recognition of their role in effective treatment; identification of potential barriers.

To score 3 or above the candidate **MUST**:
a. be aware that psychological interventions are an essential component of therapy, such interventions include motivational interviewing, counselling, assessing and understanding reinforcers to smoking behaviour and triggers to reduce the risk of relapse.
b. be aware of at least 2 pharmacological options from nicotine replacement therapy, veranicline, and nortriptyline.

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:
errors or omissions will impact adversely on patient care; plan lacks structure or is inaccurate; plan not tailored to patient's immediate needs or circumstances.

1.13. Category: MANAGEMENT - Initial Plan	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

2.0 COMMUNICATOR

2.3 Did the candidate demonstrate capacity to recognise and manage challenging communications (i.e. the ability to explain to the patient why bupropion is inappropriate medication)? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* effectively manages challenging communications, demonstrates sophisticated reflective listening skills.

Achieves the Standard by:
listening to differing views demonstrating empathy and ability to establish rapport; forming a partnership using language and explanations tailored to the functional capacity of the client taking regard of culture, gender, ethnicity etc.; providing education; communicating plans and discussing acceptability; recognising confidentiality and bias.

To score 3 or above the candidate **MUST**:
a. provide information to the patient highlighting the risk of bupropion.

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 score 1.

Does Not Achieve the Standard (scores 0) if:
agrees to start the patient on bupropion; *inadequate* ability to reduce conflict, errors or omissions adversely impact on alliance; inadequately reflects on relevance of information obtained; unable to maintain rapport.

2.3. Category: CONFLICT MANAGEMENT	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
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 defined tasks?

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail

Committee for Examinations
Objective Structured Clinical Examination

Station 9
Melbourne April 2016

The Royal Australian & New Zealand College of Psychiatrists

1.0 Descriptive summary of station:
In this station the candidate is working in a forensic service and utilises this case as an example to teach the junior doctor an outline of risk assessment, then develop a management plan that takes into account the risk factors and the ethical issues involved in the situation.

1.1 The main assessment aims are to:
- Teach a junior doctor about assessing risk of future violent behaviour incorporating static and dynamic factors.
- Formulate a management plan taking into account the risk factors of future violence.
- Consider the ethical issues pertaining to breach of confidentiality in the context of future risk.

1.2 The candidate MUST demonstrate the following to achieve the required standard:
- Use the scenario to describe dynamic and static risks.
- Consider use of the mental health act and the appropriate treatment setting.
- Prioritise substance use management and compliance strategies in the management plan.
- Explain the duty to protect potential victims.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category of:**
  Psychotic Disorders
- **Area of Practice:**
  Forensic Psychiatry
- **CanMEDS Domains of:**
  Medical Expert, Professional
- **RANZCP 2012 Fellowship Program Learning Outcomes of:**
  Medical Expert (Assessment, Management), Professional (Ethics)

References:

- Dolan, M, Doyle, M. (2000) Violence risk prediction: *Clinical and actuarial measures and the role of the Psychopathy Checklist.* British Journal of Psychiatry 177:303-311
- McSherry, B. (2004) *Risk Assessment by Mental Health Professionals and the Prevention of Future Violent Behaviour. Trends and Issues in Crime and Criminal Justice.* Australian Institute of Criminology No. 281;1-6.
- Felthous, AR. (2006) *Warning a Potential Victim of a Person's Dangerousness: Clinician's Duty or Victim's Right?* Journal of the American Academy of Psychiatry Law September;34:3 338-348
- Sadoff, RL. (2011) *Ethical Issues in Forensic Psychiatry: Minimizing Harm.* John Wiley and Sons Ltd.
- Mendelson, D., Mendelson, G. (1991) *Tarasoff down under: the psychiatrist's duty to warn in Australia.* The Journal of Psychiatry and Law/Spring-Summer; 33-61.
- RANZCP Code of Ethics (2010).
- Volavka, J. (2013) *Violence in Schizophrenia and Bipolar Disorder.* Psychiatria Danubina Vol. 25, No.1,pp 24-33.

1.4 Station requirements:
- Standard consulting room; no physical examination facilities required.
- Three chairs (examiner x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player – examiner will role-play the junior doctor.
- 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.

This is a VIVA station.

The examiner will play the role of the junior doctor.

You are working as a junior consultant in Forensic Psychiatry. You have just assessed Eric, who has schizophrenia with a history of violence and significant alcohol and stimulant use. Eric lives in the community and has been non-compliant with his depot antipsychotic medication. His delusions involve being a secret agent to combat terrorism. He just described hearing the Prime Minister say, "*The country is on alert*." In the past week, he was seen to be monitoring movement around Parliament House and 'interrogating' people. He has made specific threats about killing a prominent member of the community, whom he believes is aiding the terrorists.

The **FIRST TASK** is:

"Using the above case vignette, conduct a teaching session with your junior doctor about assessment of risk of future violence."

The examiner will present you with the second task at five (5) minutes.

Station 9 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
  - Duplicate copy of 'Instructions to Candidate'.
  - Paper, pen.
  - Water and tissues are available for candidate use.
- Ensure you have your Second Question to read out and then you will give it to the candidate.
- Ensure you have additional copies of the Second Question in case the candidate inadvertently takes the paper with them from the room, or they have written on it or it needs to be changed for some reason.

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 of the cue for the scripted prompt you are to give at **five (5) minutes**
- DO NOT redirect or prompt the candidate unless scripted.
- If the candidate asks you for information or clarification say:
  "Your information is in front of you – you are to do the best you can".
- At **five (5) minutes**, as indicated by the timer, hand the second task to the candidate and say:
  "Please proceed to the second task."
  The ***SECOND TASK*** is:
  Please outline your management plan to reduce the risk of future violence, and outline the ethical considerations within your plan.
- 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 first task (i.e. before 5 minutes):

- You are to state the following:
  "Are you satisfied you have completed the first task?
  If so, do you want to proceed to the second task?"
- If yes, handover the second task to the candidate and say the following:
  "Please proceed to the second task and you can return to the first task at a later time."

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

- You are to state the following:
  "Are you satisfied you have completed the task(s)?
  If so, you must remain in the room and NOT proceed to the next station until the bell rings."
- If the candidate asks if you think they should finish or have done enough etc. refer them back to their instructions and ask them to decide whether they believe they have completed the task(s).

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

This is a VIVA station**.**

In this station, you are playing the role of the junior doctor. You can use your own given name if asked by the candidate. There is no further prompt or script for you after delivering the second task.

The candidate has the First Task from the 'Instructions to Candidate'.

FIRST TASK:

"Using the above case vignette, conduct a teaching session with your junior doctor about assessment of risk of future violence."

At five (5) minutes, hand the ***SECOND TASK*** to the candidate and say:

"Please proceed to the second task."

The ***SECOND TASK*** is:

"Please outline your management plan to reduce the risk of future violence, and outline the ethical considerations within your plan."

If the candidate has completed the first task before five minutes - you are to state the following:

"Are you satisfied you have completed the first task?
If so, do you want to proceed to the second task?"

If yes, handover the second task to the candidate and say the following:

"Please proceed to the second task and you can return to the first task at a later time."

There are no other prompts for this station.

3.2 Background information for examiners

This is a short viva station that examines the core skills of risk assessment in Forensic Psychiatry, with better candidates likely to consider in detail the ethical aspects of confidentiality in the forensic setting. This station is concerned with the competencies of Medical Expert and Professional, rather than emphasising the communicator role to the junior doctor. Medical Expert in this scenario relates to the ability to explain risk assessment and the development of a management plan that contains the risk. The Professional competency is interested in the candidate appropriately adhering to principles of ethical conduct and practice.

The candidate is expected to describe some of the principles of risk assessment. The risk assessment as pertains to this forensic scenario must consider the risk of future violent behaviour, specifically dynamic and static risk factors. There are specific structured risk assessment tools used in the forensic setting that assist in determining future risk of violence that better candidate may present. To justify level of risk candidates should recommend or mention use of a specific risk assessment tool.

The candidate must then include management, aspects of which include:

- Disease management – specifically substance use management and compliance strategies for reducing risk of future violence.
- Actions to contain risk – mental health act status, setting of treatment (inpatient / community).
- Need for consultation / escalation to their superiors due to the nature and possible imminence of the risk.

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

- Use the scenario to describe dynamic and static risks.
- Describe the limitations of risk assessment.
- Consider use of the mental health act and the appropriate treatment setting.
- Prioritise substance use management and compliance strategies in the management plan.
- Explain the duty to protect the potential victim.

A "**surpassing"** candidate may also discuss:

- The complexity of violence risk assessment, evidence of its limitations (meta analyses of various instruments show an effect size of ~0.5 (Cohen's d), showing moderate to good efficacy, but far from the certainty levels expected by sections of the society).
- The content matter and properties of one of the instruments in detail.
- How PCL-R appears to have better predictive validity for 'violent recidivism'.
- Issues related to confidentiality in a more sophisticated way, including legal precedents in the US (Tarasoff v Regents of The University of California).
- The relevance of the RANZCP Code of Ethics in situations exemplified by the case vignette.
- Having to weigh up the potential consequences of a breach of confidentiality to ensure safety of third party; such as breach of contract, breach of confidence, legal claim for negligence as well as professional disciplinary action. If they do not breach confidentiality, there may be increased risk to the patient or others.

Assessment of possible future risk of violence

- Some of the principles of risk assessment for future violence are:
  - Violence risk prediction is an inexact science, which has led to the development of systematic structured protocols to assist in the assessment of the risk of violent behaviours.
  - Violence prediction will never be entirely accurate; given violence is a complex concept.
  - Risk assessment is necessary when considering involuntary commitment of those diagnosed with mental illness.
  - In forensic psychiatry risk assessment is important when considering an accused person of offending or re-offending.
  - Obtaining all the available information, including information from various collateral sources, enhances the validity of assessment and improves management.
  - Both ethics and law hold that confidentiality is relative not absolute.

- Assessment of risk of violence is done using the conventional classification of 'static' and 'dynamic' factors, including:
  - **Static factors** (pre-existing vulnerabilities) are enduring unchangeable characteristics linked to the offending behaviour.
    - Male gender.
    - Single, never married.
    - Young age / under 25 years of age at first violent incident.
    - Conduct disorder / antisocial personality disorder / traits.
    - Major mental illness.
    - History of previous violence / sexual offence – best predictor of future violence is past violence.
    - Criminal history; history of imprisonment.
    - History of substance abuse.
    - Childhood abuse, neglect, or harsh inconsistent parenting.
    - Lifestyle instability.
    - Employment problems.
    - Relationship instability.
  - **Dynamic factors** (tend to change and moderate static risk factors) are acute rapidly changing changeable characteristics; may indicate that a re-offense will occur within a short period of time
    - Negative attitudes such as anger and hostility.
    - Suspiciousness, irritability, impulsivity.
    - Lack of insight.
    - Intoxication / withdrawal – exposure to substances.
    - Cognitions supporting violence.
    - Carries weapon / access to firearm.
    - Recent threats or other aggressive actions / thoughts.
    - Victim availability.
    - Intimacy deficits.
    - Collapse of social supports.
    - At risk of sexually abusing others.
    - Unresponsive to treatment.
    - Noncompliance with remediation attempts.
    - Stress.
    - Symptoms of mental illness related to risk include active symptoms, poor compliance with medication and treatment, poor engagement with treatment services.
    - Elevated mood state.
    - Psychotic symptoms - command hallucinations, threat-control-override and misidentification symptoms, morbid jealousy.

Structured risk assessment instruments:

A combination of clinical and actuarial (historical risk factors) approaches increasingly used in settings where there is the possibility of serious violence or offending behaviours. There is good evidence that these instruments have reasonable predictive validity when assessing the risk of violent behaviours.

Some of the commonly used instruments to assess risk of violent behaviours are:

1. Hare Psychopathy Checklist Revised (PCL-R) is a 20-item rating scale with semi-structured interview and collateral information. It has shown to be a relatively good predictor of violence across diverse populations.

2. Historical Clinical Risk (HCR-20) is a 20-item rating scale with 10 historical variables (static-past documented), 5 clinical variables (dynamic-present observed), and 5 risk management factors (speculative-future projected).

3. Violent Risk Appraisal Guide (VRAG) is a 12-item actuarial scale used to predict risk of violence within a specific time frame following release in violent, mentally disordered offenders.

The HCR-20 has 20 items: (History, Clinical and Risk parameters)

- 10 items concerning the patient's history.
- 5 items related to clinical factors.
- 5 items that deal with risk management.
- Total score range from 0 – 40.

The HCR-20 scores each item as 0, 1, or 2, depending on how closely the patient matches the described characteristic. The higher the score, the higher the likelihood of violence in the coming months. The scores on the subscales will assist the clinician in formulating an appropriate intervention plan to contain the risks.

Items from the Historical, Clinical, and Risk Management (HCR-20)

Historical items ***History of problems with…***	**Clinical items** ***Recent problems with…***	**Risk Management items** ***Future problems with…***
H1 Violence *Previous violence*	C1 Insight ▪ Mental Disorder *Lack of insight* ▪ Violence risk ▪ Need for treatment	R1 Professional services and plans *Plans lack feasibility*
H2 Other antisocial behaviour *Young age at first incident*	C2 Violent ideation or intent *Negative attitudes*	R2 Living situation *Exposure to destabilisers*
H3 Relationships *Relationship instability*	C3 Symptoms of major mental disorder	R3 Personal support *Lack of personal support*
H4 Employment *Employment problems*	C4 Instability *Impulsivity*	R4 Treatment or supervision response ▪ Compliance *Noncompliance with remediation attempts* ▪ Responsiveness
H5 Substance use *Substance use problems*	C5 Treatment or supervision response *Unresponsive to treatment*	R5 Stress or coping
H6 Major mental disorder		
H7 Personality disorder *Psychopathy*		
H8 Traumatic experiences *Early maladjustment*		
H9 Violent Attitudes		
H10 Treatment or supervision response *Prior supervision failure*		
Score each item 0, 1, or 2, depending on how closely the patient matches the described characteristic. For example, when scoring item C3 (active symptoms of major mental illness), a patient gets 0 for "no active symptoms," 1 for "possible / less serious active symptoms," or 2 for "definite / serious active symptoms." An individual can receive a total HCR-20 score of 0 to 40. The higher the score, the higher likelihood of violence in the coming months.		
Source: Reprinted with permission from Webster CD, Douglas KS, Eaves D, Hart SD. HCR-20: *assessing risk for violence, version 2.* Burnaby, British Columbia, Canada: Simon Fraser University, Mental Health, Law, and Policy Institute; 1997 & adjusted from HCR-20, Version 3 (2013)		

Formulate a management plan that reduces the risk of future violence:

The candidate must use the case vignette and then elaborate further in their discussion about risk assessment and risk management. They should take into account the spectrum of risk considerations dependent on the profile of the patient (e.g. a patient who has means opposed to one who does not).

- Attempt to modify "dynamic risk factors' by:
  - Thorough clinical assessment – presents high risk of harm to others.
  - Assertive management of mental illness – treating and monitoring active symptoms of mental illness.
  - Use of Mental Health Act or other appropriate legislation.

- Decide on the best setting for treatment – inpatient, secure facility / high dependence unit.
- Request input from local Forensic services, including Forensic Risk Assessment.
- Professional service plans – consider types of "leave" processes to monitor adjustment, and compliance. Reduction in intensity of monitoring to commence only after adequate clinical response.
- Ensure adequate supervision in the community.
- Consider legislated restrictions in the community, if appropriate – liaising with other agencies effectively.
- Aim to improve insight – motivational interviewing, therapeutic alliance, stages of change model; compliance with treatment.
- Identify stressors, aim to reduce occurrence of likely stressors and improve coping.
- Management of substance abuse, including motivational counselling, prophylactic medications.
- Enhance compliance through compliance therapy / adherence therapy.
- Treatment of symptom resistance and responsiveness - consider clozapine in treatment resistant psychosis, mood stabilisers, ECT, etc.
- Change negative / antisocial attitudes through cognitive behavioural approaches.
- Manage emotions / behavioural instability such as use of dialectical behaviour therapy.
- Collaborate with family, friends and other associates. Encourage personal support and limit / discourage antisocial support and influences.
- Increase opportunities for prosocial support – vocational, recreational.
- Social skills training.
- Living situation – consider optimising environment to reduce violence and improve opportunities for monitoring; limit exposure to destabilisers and monitor for exposure such as substances, explore and restrict access to weapons, victims.
- Notify the intended victim about the statement made by the patient, as soon as possible.
- Notify the police about the patient's statements.
- Consult the Medical Director and Hospital Lawyers prior to these actions.

Ethical aspects:

It is now generally accepted that psychiatrists have a duty to warn an identifiable victim of a patient's serious threat of harm. The legal precedent was the Tarasoff v. Regents of the University of California decision of the Supreme Court of California in 1976.

The ethical dimension of psychiatry provides a system of moral principles, rules and standards governing the practice of psychiatry and professional conduct. The Code of Ethics includes the principle of confidentiality – psychiatrists shall strive to maintain confidentiality of patients and their families. Confidentiality is at the core of the doctor-patient relationship, involving a 'holding in trust' process and shall not be undermined.

Principle 4.3 of the RANZCP Code of Ethics states that a breach of confidentiality may be justified on rare occasions in order to promote the best interests and safety of the patient or of other people. Psychiatrists may have a duty to inform the intended victim(s) and / or relevant authorities. Principle 4.4 states the clinical information may need to be shared with colleagues in order to provide best possible care (annotation 3.9 being mindful of the constraints of confidentiality, psychiatrists shall provide relevant clinical information when the care of a patient is transferred to a colleague or institution).

The patient should be informed of the general limits of confidentiality. Where the patient is unable to understand the concept of confidentiality and its limits, substitute consent may be required. The Code of Ethics serves to guide ethical conduct and is a benchmark of satisfactory ethical behaviour in the practice of psychiatry as this is interpreted in Australia and New Zealand. Since the Code is a public document, it may be referred to in a court of law or in other statutory contexts.

Do psychiatrists have a duty to protect potential victims of their patients' violence?

The general policy is to promote public safety over privacy concerns in certain circumstances. It involves issues of predicting violence, breaching confidentiality, defensive practices and insurance implications that can be overcome by this duty of care. There is a risk that the actions of a third party can be imposed on a psychiatrist if there is a failure to prevent harm caused by someone else. In psychiatric patients they at times are not deemed morally responsible for their actions due to insanity. Psychiatrists must be seen to have appropriately used medication, therapy and compulsory detention to reduce the risk of violence.

The psychiatrist or mental health professional must, pursuant to the standards of their profession determine, if the patient presents a serious danger of violence to another, thereby incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of the duty to protect and the duty to warn may require the therapist to take one or more various steps, depending on the nature of the case. It holds that the obligation is to use reasonable care to protect the intended victim against danger. It may call the psychiatrist to warn the intended victim or others likely to apprise the victims of that danger, to notify the police or take whatever steps are reasonably necessary under the circumstances, including determining if there is a past history of violence, any thoughts about seriously harming another person / group, symptom management, deteriorating mental illness, and patients' ability to control their violent impulses. Further steps can be warning the potential victim(s), informing mental health services of the threat, notifying police, use of Mental Health Act, professional supervision and so on. Code of Ethics for psychiatrists entails the duty to warn and protect.

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.

STATION 9 – MARKING DOMAINS

The main assessment aims are to:

- Teach a junior doctor about assessing risk of future violent behaviour incorporating static and dynamic factors.
- Formulate a management plan taking into account the risk factors of future violence.
- Consider the ethical issues pertaining to breach of confidentiality in the context of future risk.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate adequately present a detailed description of the process of risk assessment? (Proportionate value - 40%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* clearly achieves the overall standard with a superior performance in a range of areas; demonstrates depth in their knowledge regarding the complexity of assessment of violence risk and the difficulties with accuracy and the implications for the treatment of psychiatric patients; accurately describes details of more than one risk assessment tool; defines assessment of violence using actuarial techniques.

Achieves the Standard by:
considering the information from the vignette relevant to a risk assessment linked to the patient's problems and circumstances with appropriate depth and breadth; exploring the key issues; clarifying from the vignette the important positive and negative features; outlining any typical and atypical features; providing details about application of risk assessment tools; synthesising static and dynamic factors with information provided about the patient.

To score 3 or above the candidate **MUST**:
a. demonstrate awareness of static and dynamic risk factors.

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 score 1.

Does Not Achieve the Standard (scores 0) if:
demonstrates significant deficiencies including omissions adversely impact on the obtained content; substantial omissions in history considered.

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** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

1.13 Did the candidate formulate and describe a relevant management plan to the junior doctor? (Proportionate value - 40%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* provides a sophisticated link between the plan and key issues identified; effectively explains decision-making in terms of the risk components in the scenario; clearly addresses difficulties in the application of the plan; clearly advocates organisational risk mitigation.

Achieves the Standard by:
being able to prioritise and implement a plan that takes into account and mitigates the risk, considering the relevant static and dynamic factors; recommending medication optimisation and other specific treatments; safe, realistic time frames / risk assessment / review plan; multidisciplinary framework for implementing the plan; skilful engagement of appropriate resources / support; communication with necessary others; identification of potential barriers; consideration of the ethical issues in the development of the management plan; recognition of the need for consultation / supervision / escalation.

To score 3 or above the candidate **MUST**:
a. consider use of the Mental Health Act and the appropriate treatment setting.
b. prioritise substance use management and compliance strategies in the treatment plan.

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:
Errors or omissions will impact adversely on patient care; plan lacks structure or is inaccurate; plan not tailored to patient's immediate needs or circumstances.

1.13. Category: MANAGEMENT – initial plan	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

7.0 PROFESSIONAL

7.1 Did the candidate appropriately adhere to principles of ethical conduct and practice? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* seamlessly incorporates the principles of ethical conduct and practice; good knowledge of professional Code of Ethics; balances the aspects of static and dynamic risk factors for violence with the ethical considerations.

Achieves the Standard by:
demonstrating capacity to: identify and adhere to professional standards of practice in accordance with College Code of Ethics and institutional guidelines; applying ethical principles to resolve conflicting priorities; utilising ethical decision-making strategies to manage the impact on patient care; recognising the importance and limitations of obtaining consent and keeping confidentiality; justifying breach of confidentiality in order to promote safety of the patient or other people; addressing duty to inform intended victim(s) and / or relevant authorities; sharing of clinical information with colleagues in order to provide best possible care.

To score 3 or above the candidate **MUST**:
a. explain the duty to protect the potential victim.

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 score 1.

Does Not Achieve the Standard (scores 0) if:
errors or omissions will impact adversely on patient care; does not take into account principles of ethical conduct and practice; lacks structure or is inaccurate.

7.1. Category: ETHICS	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
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 defined tasks?

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

Committee for Examinations
Objective Structured Clinical Examination

Station 10
Melbourne April 2016

The Royal Australian & New Zealand College of Psychiatrists

1.0 Descriptive summary of station:

The candidate is to undertake an assessment with the spouse of a 70-year-old man suffering from Alzheimer's disease. He has displayed a recent episode of verbal aggression. The candidate will then present their understanding of the situation and outline the general principles of early management to the spouse.

1.1 The main assessment aims are to:

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

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

- Exploration of the aggressive episode OR the risk.
- Check for a medication induced disorder OR symptoms of depression, hallucinations, delusions.
- Explain the concept of Behavioural and Psychological Symptoms of Dementia.
- Recommend further assessment involving members of a Multi-Disciplinary Team.
- Counsel about referral to community support services and / or Alzheimer's Association / Alzheimer's NZ.

1.3 Station covers the:

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

References:

- Dementia Collaborative Research Centres (2012) (Authors: Burns K, Jayasingha R, Tsang R, Brodaty H) "Management of behavioural and psychological symptoms of dementia":
  1. "Behaviour management: a guide to good practice"
  2. "A clinician's field guide to good practice"
  3. "A guide for family carers"
  <http://www.dementiaresearch.org.au/images/dcrc/pdf/A_Clinicians_Field_Guide_to_Good_Practice_Managing_Behavioural_and_Psychological_Symptoms_of_Dementia_2014.pdf>
- RANZCP & NSW Ministry of Health (2013) "Assessment and management of people with behavioural and psychological symptoms of dementia (BPSD): a handbook for NSW health clinicians", <https://www.ranzcp.org/Files/Publications/A-Handbook-for-NSW-Health-Clinicians-PSD_June13_W.aspx>
- Best Practice Advocacy Centre New Zealand (2014) "Antipsychotics in dementia" <http://www.bpac.org.nz/a4d/resources/guide/guide.asp>
- Alexopoulos GS, Jeste DV et al (2005) "The expert consensus guideline series: Management of dementia and its behavioural disturbances", Post grad Med: Jan 2001 Spec No: 1-111.

1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player – woman in her 60s, in semi-smart dress.
- Pen for candidate.
- Timer and batteries for examiner.

2.0 Instructions to Candidate

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

You are working as a junior consultant psychiatrist in a community mental health clinic. You are about to interview Maria, a 66-year-old who lives with her 70-year-old husband Antonio. Antonio was diagnosed with moderate Alzheimer's disease by a neurologist one year ago.

Maria has been referred by her local general practitioner after an episode last week when Antonio did not recognise Maria, shouted at her for the first time and loudly threatened to have her "taken away". The GP noted that when reviewed that day, Antonio's mental state was stable and unchanged from his previous assessment.

Your tasks are to:

- Undertake a focussed assessment of the aggressive incident.
- Feedback to Maria your understanding / formulation of the situation.
- Present the general principles of early management to Maria.

You will not receive any time prompts.

Station 10 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
  - 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 are no cues or time prompts for you to give.
- 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 <u>must</u> remain in the room and <u>NOT</u> proceed to the next station until the bell rings."

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

You have no opening statement or prompts.

The role player opens with the following statement:

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

3.2 Background information for examiners

In this station the candidate is to complete a biopsychosocial assessment with Maria, the spouse of Antonio who is a 70-year-old man suffering from Alzheimer's disease. This is in the specific context of an incident when he displayed a recent episode of verbal aggression. The candidate then needs to present their understanding of the situation and explain the general principles of early management to the spouse.

The candidate needs to demonstrate their skill in undertaking a behavioural assessment of agitation and verbal aggression. When specifically assessing the aggressive behaviour, the candidate could work through a problem-solving process to define the seriousness of Antonio's behaviour. A review of how much of a problem the aggression is, including assessment of whether other behaviours are also a problem, and whether any of them are related to the environment or interactions with others. The next step is to consider the situation and look at the circumstances contributing to the aggression: when and where the behaviour occurred or did not occur, and if he has possibly behaved in the same way in the same place. Finally, assessment needs to be made of Antonio in the situation and whether he seemed to be in pain or discomfort, or unwell; if he was tired, overstimulated, bored, lacking in social contact or anxious, embarrassed, ignored or misunderstood. He could also have been responding to an unpleasant incident, a change or a provocation or even been hallucinating, delusional or depressed.

Through their history taking the candidate should demonstrate their ability to assess risk in this setting and to apply their knowledge of the potential contributions of concurrent psychiatric illness, medical factors and medication side effects.

The candidate is expected to accurately communicate their findings and demonstrate skill in formulating and negotiating an initial management plan which should involve multidisciplinary community team assessment in the home and an awareness that psychotropic medications are NOT recommended as a first line management strategy.

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

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

- Demonstrate exploration of the aggressive episode OR the risk;
- Check for a medication induced disorder OR symptoms of depression, hallucinations, delusions;
- Explain the concept of Behavioural and Psychological Symptoms of Dementia (BPSD);
- Recommend further assessment involving members of a multi-disciplinary team;
- Counsel about referral to community support services and / or Alzheimer's Association.

A better candidate may:

- Show an awareness of literature and College guidelines on management of BPSD;
- Make mention of scales and rating instruments for BPSD: agitation, aggression, wandering;
- Involve a bi-cultural clinician or consider involving a language and cultural interpreter.

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

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

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

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

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

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

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

Tests / Instruments:

There are more than 75 different instruments that have been used in BPSD.

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

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

The diagnosis of BPSD is based on obtaining a clinical history, direct observation, psychiatric and physical examinations, and reports by care providers; exclusion of physical problems (e.g. an infection, pain, constipation or poor eyesight or hearing) or mental illnesses such as depression. Laboratory tests can assess for the presence of medical conditions that can trigger or exacerbate the clinical presentation of BPSD. It is important to exclude unmet medical needs.

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

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

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

1) Aggression (RAGE=Rating Scale for Aggressive Behaviour in the Elderly)

2) Agitation (CMAI=Cohen-Mansfield Agitation Inventory; PAS=Pittsburgh Agitation Scale)

3) Depression (CSDD=Cornell Scale for Depression in Dementia; GDS=Geriatric Depression Scale)

4) Pain (PAINAD=Pain Assessment in Advanced Dementia; the Abbey Pain Scale; PACSLAC=Pain Assessment Checklist for seniors with Limited Ability to Communicate) agitation).

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

Principles of Management. The key principle in caring for a person with dementia is the involvement of a multidisciplinary team using a "person-centred care" approach which aims to develop an understanding of the person as an individual (RANZCP & NSW Health, 2013). This focuses on identifying and meeting the specific needs of the individual. Forming a working partnership between the person, the carer and the clinical team assists in developing shared goals based on the person's values and experience. Clinicians need to focus on establishing rapport with both the carer and person to properly assess and prioritise physical, psychological and social goals. Factors guiding assessment and treatment include: 1) the person's response to their past and current environments; 2) their personal history, culture and religious background; 3) personal likes and dislikes; 4) interpretation of precipitants to behaviours; and 5) unmet needs (RANZCP & NSW Health, 2013).

Management priorities should include 1) managing physical care needs (investigating physical problems such as pain, infection, constipation, poor eyesight or hearing and possible mental disorders such as delirium or depression); 2) behavioural and environmental strategies; 3) psychological engagement; 4) maximising residual strengths in the person; and 5) caring for the carer. Cautious consideration of psychotropic medication is only indicated if there are risk issues or psychosocial strategies have not relieved the situation (e.g. not as a first line choice in the present case).

Communication is a key in working with a person with dementia, including attention to body language and tone of voice. Strategies to improve verbal communication include: 1) minimising background noise; 2) speaking in a gentle voice; 3) using simple, calm hand gestures and facial expressions; 4) explaining tasks slowly in simple terms; 5) allowing time to be understood; 6) clarifying by repeating or rewording; and 7) using personal reference where available (person's or relative's name).

"Top 5 Strategies" One useful intervention in the RANZCP & NSW Health booklet on BPSD management is to identify with the carer the "Top 5 Strategies" they have found useful in reassuring the person with cognitive impairment. These top 5 strategies include developing a list of: 1) things that cause distress; 2) things that settle distress; 3) established reassuring routines; 4) repeated anxieties or questions; and 5) triggers indicating an unmet need. Composing such a list acknowledges the expertise of the carer and may assist them to take a step back from troublesome behavioural interactions.

Psychosocial management includes: 1) maintaining safety; 2) modifying the environment; 3) sleep hygiene; 4) modifying or revising the timing of activities. Specific non-pharmacological treatments include: 1) behavioural assessment and management = ABC (identification of Antecedent events, Behaviour and Consequences); 2) music therapy; 3) aromatherapy and hand massage (particularly for agitation); and 4) psychological interventions including reminiscence, validation and orientation therapies.

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

Carer Support. Candidates should mention the need to assess Maria's stress levels, mental well-being and current coping, as well as to screen for the development of a treatable mental disorder. Providing her with practical support may improve her ability to continue caring for Antonio at home. Specific attention should be paid to 1) mobilising and engaging established social network; 2) arranging domestic assistance, home maintenance, in-home respite and home care; 3) referral to community services; 4) financial, legal, and guardianship matters; and 5) encouraging contact with Alzheimer's organisations for information and social support.

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

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

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

- behaviour: onset, triggers, frequency, occurrence of the behaviour and when does it not occur. It is usually best to record the behaviour, what happened before and afterwards.
- person: characteristics, life history, dementia diagnosis and severity, mood, support needs.
- Caregiver(s): characteristics, carer's own health, communication approach, relationship factors, stress threshold.
- environment: physical, social, cultural, emotional, spiritual.

Non-pharmacologic interventions are now considered the foundation of BPSD treatment. Problem behaviours can be seen as meaningful responses to unmet needs in the therapeutic milieu. Because the progression and impact of BPSD varies between patients, interventions must be designed, implemented, and reviewed on an individual basis. They include: family support and education, psychotherapy reality orientation, validation therapy, reminiscence and life review, behavioural interventions, therapeutic activities and creative arts therapies, environmental considerations (including restraint-free facilities), behavioural intensive care units, and workplace design and practices that aid the ongoing management of caregiver stress.

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

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

Resources:

Books, DVDs, Help sheets

Online – www.alzheimers.org.au
www.dementiacareaustralia.com
www.dasinternational.org (Dementia Advocacy and Support Network for people with dementia)
www.careraustralia.com.au
www.dbmas.org.au (Dementia Behaviour Management Advisory Services)
www.alzheimers.org.nz
ilearn.careerforce.org.nz/mod/book/view

3.3 The Standard Required

In order to:

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

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

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

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

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

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

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

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

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

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

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:

Background information

You are Maria, a 66-year-old lady, married to Antonio, age 70. You have been married for 46 years and have 3 grown children (Paola age 45 living nearby, Marco age 43 living in Rome, and Andrea age 41 living interstate). You live in the home Antonio built for the family 40 years ago. Antonio was a builder until he sold the business and retired 5 years ago. You stayed home to raise the children, then worked as a childcare assistant at the local day care centre. You retired 3 years ago, when you noticed Antonio having trouble coping with retirement.

Diagnosis of dementia

A few years ago, you noticed Antonio's memory was slipping. Then he had trouble paying the bills. When he turned into a one way street two years ago, you decided to do all the driving and Antonio agreed. Last year your GP, Dr Jones, did tests and scans. He said Antonio was suffering from dementia and referred you to a private nerve specialist. After two appointments, the neurologist said Antonio had Alzheimer's disease. He prescribed a memory tablet called Aricept but Antonio just seemed to get worse. After four months you stopped the tablets and have not seen the neurologist since.

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

Living with dementia

You sometimes argue with Antonio when he does not remember things. You get particularly frustrated when Antonio just sits in his lounge chair for hours, staring at the television. If you shout at him "*Why don't you say something?*" he just says "*I'm okay. Leave me alone*."

At other times Antonio follows you wherever you go and does not let you out of his sight. He even stands by the door when you go to the toilet. He still goes shopping with you, but stays close by your side. You take him to the beach a couple of time a week, but these days he doesn't want to get out of the car. At home, he repeatedly asks "*When are we going to eat?"* but when a meal is served you have to encourage him to eat the food.

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

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

Concerning symptoms

Risk: Antonio is a gentle man and has never abused you or the children. You do not think Antonio could ever hurt himself or anyone else. You are not afraid of him and he has never threatened to harm you or himself. You do worry how he would cope if anything ever happened to you. Your main worry is about his safety and what might happen if he got out of the house or the fenced backyard. You are frightened that if he wandered about the neighbourhood, he could not find his way home again.

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

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

Aggression: Antonio raised his voice to you last week for the first time in your marriage, when he did not recognise you. He asked "*Where is Maria? What have you done with her*?". You burst into tears and ran from the room when he said "*Who are you? What are you doing in my house?*', and told you that he would "*have the police take you out of my house*". When you returned in half an hour, Antonio asked "*Where have you been, Maria? I've been so worried."* When you told Dr Jones about this incident, he immediately referred you to the Community Mental Health Clinic.

Relevant negatives

Delirium (acute change in mental state): Other than the one occasion of not recognising you last week, Antonio has not seemed much different over the past month. He is able to focus his attention on a task, concentrate on it for a short time and is not easily distracted. His awareness does not change rapidly throughout the day. He does not see things or hear voices.

Depression: Antonio does not appear to be down, sad or depressed. He does not dwell on negative thoughts or express guilt. His sleep is undisturbed, retiring at 9 pm, arising to toilet once but returning to sleep readily, and awakens at 7 am. He is often muddled and uncertain where he is on awakening, but this settles with reassurance. His appetite is good and weight steady. He has few interests and spends much of the day sitting in the lounge room staring blankly at the television. He does potter about the back garden in good weather, moving pot plants from place to place on the patio in an aimless manner. He has never spoken of wishing to die. You do not think he would contemplate suicide as he always considered it a sin.

Psychosis: Antonio has never accused you of being unfaithful or expressed any ideas of being persecuted, followed, spied upon or interfered with in any way. He does not seem to be responding to unseen things or talk to others when no one is present. He does not speak of hearing voices and does not appear to see things or have visions of unshared occurrences.

Attitude to future management

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

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

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

4.2 How to play the role:

You are feeling the strain of caring single-hand for your husband over the past year. You feel isolated, yet unable to ask for assistance believing that it is your fate to care for Antonio. You have mixed feelings about getting help. You find it hard to see the man you love, your life partner, disappear before your eyes. You are stressed by the worry and constant care needs, but reluctant to let others do any caring. You are lonely, but are too embarrassed to talk to friends and worry that Antonio might "*say something silly*".

4.3 Opening statement:

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

4.4 What to expect from the candidate:

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

Candidates might then move on to explore Antonio's symptoms of restless pacing, trying to leave the house and the episode of not recognising you. The candidate may ask about risk of harm or concerns you might have about your safety. They should explore whether Antonio experiences depression, hallucinations, unusual fixed but false beliefs or sudden changes in alertness, awareness and attention.

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

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

4.5 Responses you MUST make:

Nil

4.6 Responses you MIGHT make:

If the candidate recommends medication, say:
"***I don't want Antonio drugged or sedated.***"

If the candidate suggests that others might help care for Antonio, say:
"No one loves Antonio like I do … Nobody could care for him as I do."

4.7 Medications:

Currently not on regular medication. Tried Aricept for 4 months (started on one tablet at night and increased to one tablet in the morning and one at night after a month). This was ceased as Antonio seemed to be getting worse. You are not keen for him to have any tablets like this again.

STATION 10 – MARKING DOMAINS

The main assessment aims are to:

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

Level of Observed Competence:

1.0 MEDICAL EXPERT

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

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

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

To score 3 or above the candidate **MUST**:
a. demonstrate exploration of the aggressive episode OR the risk.
b. check for a medication induced disorder OR symptoms of depression, hallucinations, delusions.

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

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** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

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

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

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

To score 3 or above the candidate **MUST**:
a. explain the concept of Behavioural and Psychological Symptoms of Dementia.

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

Below the Standard (scores 2 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 score 1.

***Does Not Achieve the Standard (scores 0) if**:*
significant deficiencies including inability to synthesise information obtained; providing an inadequate formulation or diagnostic statement.

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

3.0 COLLABORATOR

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

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

Achieves the Standard if:
discusses the need to assess psychological issues relevant to patient; offers strategies to deal with problematic behaviours; acknowledges carer's expert knowledge of patient; usefulness of social worker to explore social referral or interventions; psychologist to assess capacities and retain of functions; occupational therapist to assess home safety and functional capacity; community nurse to provide practical support; GP to oversee management plan.

To score 3 or above the candidate **MUST**:
a. recommend further assessment involving members of a Multi-Disciplinary Team.

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:
recommends medication as a first line treatment; recommends hospital admission; plan not tailored to carer and patient needs or circumstances; errors or omissions impact adversely on the finalised plan.

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

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

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

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

To score 3 or above the candidate **MUST**:
a. counsel about referral to community support services and / or Alzheimer's Association.

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:
lack of consideration of individual perception of roles, capabilities or preference; any errors or omissions adversely impact on alliance.

3.3. Category: EXTERNAL RELATIONSHIPS	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
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 defined tasks?

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

Committee for Examinations
Objective Structured Clinical Examination

Station 11
Melbourne April 2016

The Royal Australian & New Zealand College of Psychiatrists

1.0 Descriptive summary of station:

In this station the candidate is expected to take a history from a 27-year-old man who is at risk of losing his residential rehabilitation placement due to his lack of motivation and poor self-care. The candidate must differentiate negative symptoms of schizophrenia from other differential diagnoses including neuroleptic induced deficit syndrome, extrapyramidal symptoms, substance use (cannabis) and depressive symptoms.

1.1 The main assessment aims are to:

- Demonstrate capacity to engage a patient with poor motivation and engagement.
- Demonstrate the ability to identify negative symptoms of schizophrenia by excluding depression and extrapyramidal side effects.
- Consider collateral that the candidate considers important for differentiation.

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

- Check for negative symptoms of schizophrenia.
- Enquire about psychological symptoms of depression.
- Enquire about extrapyramidal side effects of parkinsonism.
- Raise questions for the manager about sleep, activities of daily living or whether the manager has observed any evidence of movement disorders.
- Aim to find out what the manager thinks is causing the change in behaviour.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category of:**
  Psychotic Disorders
- **Area of Practice**:
  Adult Psychiatry
- **CanMEDS Domains of:**
  Medical Expert and Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes of:**
  Medical Expert (Assessment), Collaborator (Patient Relationships)

References:

- Andreasen NC: Scale for the Assessment of Negative Symptoms (SANS), Iowa City, University of Iowa, 1984.
- Buchanan, R. (2007) Persistent Negative Symptoms in Schizophrenia: An Overview *Schizophrenia Bulletin. 33: 1013–1022.*
- Johns, A. Psychiatric effects of cannabis. *BJP 2001;178:116-122*
- Tanden R, Gaebel W, et al. Definition and description of schizophrenia in the DSM-5. *Schiz Res 2013 http://dx.doi.org/ 10.1016/j.schres.2013.05.028*

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 – Late 20s Caucasian male, ideally long hair and beard, with poor self-care.
- Pen for candidate.
- Timer and batteries for examiner.

2.0 Instructions to Candidate

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

You are working as a junior consultant psychiatrist in a Community Mental Health Centre. You have been asked to see Jimmy in your outpatient clinic.

Jimmy is a 27-year-old male with a diagnosis of chronic schizophrenia who resides in one of the Community Residential Rehabilitation facilities. The accommodation manager there has concerns that Jimmy is in danger of losing this rehabilitation placement because he is not engaging with the day program and she has asked that you assess him to work out why.

Sue (the accommodation manager who has known Jimmy since he moved in and is well respected by your service) has been caught in traffic and suggested you to start the assessment without her.

Your tasks are to:

- Take a history from Jimmy, focussing on the concerns raised and any relevant psychiatric history to discriminate possible causes.
- State to the examiner the questions you will prepare to ask the accommodation manager to help confirm your diagnosis.

You will be given a time prompt to commence the second task at **six (6) minutes**.

NOTE: The examiner is **not** playing the part of the accommodation manager.

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:
  - 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 of the time for the scripted prompt you are to give at **six (6) minutes**.
- 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 **six (6) minutes**, as indicated by the time, if the candidate has not started the second task, say:
  "Please proceed to the second task."
- 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 <u>must</u> remain in the room and <u>NOT</u> proceed to the next station until the bell rings."

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

Assess the candidate's performance according to the details provided in the station assessment aims (1.1 and 1.2) and mark the candidate's performance on the marking sheet as per guidelines.

You have no scripted instruction.

The role player will open with:

"Sue is worried about me, she says I may lose my flat."

There is one station specific prompt at **six (6) minutes,** if the candidate has not started the second task by then, you are to say:

"Please proceed to the second task.'

3.2 Background information for examiners

In this station the candidate first interviews a patient and then at six (6) minutes provides the examiner with any questions they would want to ask the accommodation manager of the residential rehabilitation service where the patient currently lives.

The station aims to assess the candidate's ability to differentiate the primary negative symptoms of schizophrenia from other differential diagnoses of neuroleptic induced deficit syndrome, extrapyramidal symptoms and depressive symptoms.

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

- Check for negative symptoms of schizophrenia.
- Enquire about psychological symptoms of depression.
- Enquire about extra-pyramidal side effects of parkinsonism.
- Raise questions for the manager about sleep, activities of daily living or whether the manager has observed any evidence of movement disorders.
- Aim to find out what the manager thinks is causing the change in behaviour.

In the first task the candidate is expected to take a history that focusses on:

- Symptoms of schizophrenia and consider whether there are symptoms of a separate depressive disorder.
- Questions that relate to side effects of medication that could lead to this presentation including physical manifestations of extra pyramidal side effects, particularly parkinsonism.
- Excluding other causes of deterioration in behaviour.

In the second task the candidate should prioritise the following kinds of statements:

- Questions to determine level of functioning (ability to complete activities of daily living).
- Questions to determine what Sue thinks is going on (bearing in mind Sue is an experienced manager).

The preferred diagnostic formulation is one that is consistent with negative symptoms of schizophrenia, i.e. young gentleman with a diagnosis of schizophrenia who is isolated due to passive avoidance, with limited enduring motivation to plan and structure his day. The cannabis use may be further impacting on his presentation. He has been treated with second generation antipsychotics and had a number of previous admissions in the past. The differential can include depression, severe extrapyramidal side effects causing profound bradykinesia, or ongoing positive symptoms as well as negative symptoms of schizophrenia. A good candidate will be able to ask questions / physically examine to differentiate between these as well as demonstrate the ability to use a collateral history to confirm or deny their suspicions.

A better candidate may:

- Be able to manage, at a sophisticated level, the lack of engagement from Jimmy and his monosyllabic replies.
- Explain in a succinct way the questions the candidate would ask of the manager to differentiate negative symptoms v. depression v. extra pyramidal side effects.
- Exclude impact of increased cannabis use as a primary cause of the deterioration.
- Use their time efficiently in order to exclude positive symptoms of schizophrenia as the driver of secondary negative symptoms (e.g. guardedness and active social withdrawal).
- Undertake screening questions to exclude specific physical disorders that could exacerbate amotivation.

History

The negative symptoms of schizophrenia, defined as the absence or diminution of normal behaviours and functions, have been recognised since Kraepelin and Bleuler. Kraepelin's description of the “avolitional syndrome” manifested as a “weakening of those emotional activities which permanently form the mainsprings of volition,” and resulting in “emotional dullness, failure of mental activities, loss of mastery over volition, of endeavour, and of ability for independent action,” represents one of the most elegant descriptions of negative symptoms.

Negative Symptoms

Negative symptoms are identified as one of the core criteria of schizophrenia in both the DMS-5 and ICD-10. They include blunted affect or decline in emotional response, alogia, amotivation, avolition, asociality and anhedonia. They tend to persist longer than positive symptoms and are more difficult to treat, and account for much of the long-term morbidity and poor functional outcome of patients with schizophrenia. Improvements in negative symptoms are associated with a variety of improved functional outcomes, including independent living skills, social functioning, and role functioning. Targeting these symptoms in the treatment of schizophrenia may have significant functional benefits.

In both DSM IV and DSM-5, negative symptoms are classified under criterion A (Characteristic Symptoms).

According to DSM-5, avolition and diminished emotional expression have been found to describe two distinguishable aspects of negative symptoms in schizophrenia, and diminished emotional expression better describes the nature of affective abnormality in schizophrenia than affective flattening.

Persistent negative symptoms include the negative symptoms of schizophrenia that:

1. are primary to the illness.
2. interfere with the ability of the patient to perform normal role functions.
3. persist during periods of clinical stability.
4. represent an unmet therapeutic need.

Prevalence

In clinical samples, patients with the deficit form of schizophrenia or primary negative symptoms represent about 20%–30% of patients, whereas in population-based samples approximating incidence samples, patients with the negative symptoms of schizophrenia comprise 14%–17% of patients with schizophrenia.

Assessment

There is increasing interest in subjective aspects of therapy and rehabilitation. The clinical assessment of persistent negative symptoms is based on cross-sectional and longitudinal evaluation of negative symptoms, in conjunction with the use of other symptom criteria designed to minimize the inclusion of secondary negative symptoms (such as medication side effects). Restricted affect, diminished emotional range, and poverty of speech are mainly evaluated by observation, while curbing of interest, diminished sense of purpose, and diminished social drive by interview.

The Scale for the Assessment of Negative Symptoms (SANS) or Positive and Negative Symptom Scale (PANSS) are currently the standard scales used to assess negative symptoms, but they have a number of limitations including insufficient number of items to assess the full range of negative symptoms, inclusion of nonspecific items that can be found in other psychiatric disorders, inadequately defined anchors, lack of standardised scoring methods or lack of sensitivity to change over brief periods of time.

Differential Diagnosis:

The negative symptoms of schizophrenia can closely resemble the symptoms of a depressive episode (these include apathy, extreme emotional withdrawal, lack of affect, low energy and social isolation).

Negative symptoms may be medication related effects (secondary negative symptoms due to sedation and extrapyramidal symptoms). These are known as the Neuroleptic Induced Deficit Syndrome (NIDS); a term used to focus attention on the adverse mental effects of neuroleptics on affective, cognitive and social function. Patients with NIDS appear to be uninterested in responding to environmental stimuli, and apathetic. They often complain of feeling drugged and drowsy or feeling like a 'zombie', and suffer from lack of motivation.

The bradykinesia, limb stiffness, and mask-like facies seen in parkinsonism are a social and functional handicap. The development of symptoms is dose dependent and emerges in about 20% to 40% of patients. With continuation of medication, the parkinsonian symptoms may gradually subside and tolerance may develop. Asking specifically about the symptoms of muscle rigidity, tremor, bradykinesia, postural abnormalities and 'increased' salivation are critical to making or excluding this as a possible cause of Jimmy's behaviour.

While cognitive symptoms of schizophrenia have been accepted for many years they are not specifically included in the diagnostic criteria for schizophrenia in DSM-5 because of the lack of specificity to the disorder.

Other possible causes that a candidate may consider are whether Jimmy is increasing his use of drugs like cannabis, so undertaking a brief focussed substance use history is appropriate. An amotivational syndrome (personality deterioration with loss of energy and drive to work) from heavy cannabis abuse is not clearly supported in the literature although case studies have been published, and it may represent ongoing intoxication – feelings of detachment and relaxation. Of course cannabis may increase the risk of relapse of psychotic symptoms which could lead to active social withdrawal and preoccupation.

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 Jimmy, a 27-year-old single man, who has been living at a local supported flat for 2 years after a prolonged admission to the local psychiatric hospital. At the accommodation there are 8 independent living flats supported by a manager (Sue) who lives in one of the flats. You have come to the clinic where you about to see a doctor you have not met before.

When you first moved into this residential rehabilitation place you had dreams of getting a job as a helper at the local zoo and developing a better group of friends, and maybe getting into a relationship or even married. Initially you tried hard to participate and gain new skills on the program but have always found it difficult to concentrate and learn new things. Over the years it has led you to lack confidence in yourself and you tend to be a bit of a quiet, shy person.

These days you tend to spend your day watching TV or playing computer games; the local takeaway knows you by your first name and your favourite order is Chicken Chop Suey. You are quite socially isolated, you have no family and the only friend you have is Charlie (who is another mental health patient who lives in one of the other apartments). There is not much structure or substance to your day and your friend Charlie has started bringing cannabis round which you both smoke whilst playing Minecraft.

For the last few months you have increased your cannabis smoking to every day, around $10 in joints you share with Charlie. You do not drink and you do not use any other drugs (and never tried any other drugs). You know that the cannabis smoking has decreased your motivation to get out and participate in other activities even further as you find that you feel more and more '*chilled out*' when you smoke. However, the manager, Sue, is now worried that they are probably not going to be able to support you in your longer term rehabilitation.

Sue was supposed to be meeting you here to attend this appointment, as she has been concerned about how you are managing your daily self-care, which she thinks is deteriorating. She has also talked with you that she is concerned that you seem to be lacking energy and don't seem to have any structure to your day. Unfortunately she has been caught in traffic and is running late. You had been doing well with support from Sue around cooking and tidying your flat but have always needed a lot of prompting with this as well as with your self-care. In your opinion, you reluctantly consider that these changes may be worsening in line with your cannabis smoking.

If asked about your past personal history; you did not do well at school and so your baseline educational level is low having not finished school. You have never had a job apart from temporary odd labouring jobs when you were younger. Your first contact with the mental health services was when you were 21 after a period of heavy cannabis use that seemed to have such a bad effect on you that you needed to be admitted to the local psychiatric hospital.

Your past psychiatric history includes a total of 5 admissions of increasing length of time (first admission 2 months, most recent admission in 2014 was one year), and decreasing time spent out of hospital. Each time you went into hospital it was noticed that your ability to cope with stress decreased and you became a little 'slower' in your thoughts. Your initiative to do your activities of daily living correspondingly decreased. You had these long admissions because you felt unable to cope living on your own and the stress would lead to your psychotic symptoms returning. In the past you have tried '*all sorts'* of medications – so many you can't remember all their names – respond '*I can't remember'* if the candidate offers you a list of name.

Things improved after the last admission and you were discharged to this supported living arrangement. You have been living there successfully for the last 2 years. A support worker comes around regularly to check up on how you are doing and give you a hand with your day-to-day activities. They also try to engage you in some vocational activities and encourage you to go to the local community centre for BBQs and other social activities.

You are also supported by the local community mental health service and you see the nurse once a month for your injection, called paliperidone which was started at the time of your last admission. If asked, you have never been on antidepressant medications or medications called mood stabilisers. You cannot remember the dose of the injection and the last time you saw your psychiatrist / doctor – it was probably about 3 months ago.

Candidates may ask if you feel stiff in your muscles, experience a tremor (shakiness, especially of your hands), notice a slowness of your movements / feeling slowed up) and increased salivation / dribbling. You do not experience any of these. These symptoms are called extrapyramidal symptoms (EPSE) and are a side effect of some medications. Some candidates may ask you to move your limbs to exclude stiffness, they should explain what to do if they are going to do this.

4.2 How to play the role:

Your self-care is poor (as poor as you can, hair ruffled, clothes scruffy, you look as though you have not changed your clothes for a few days). You should come across as quite flat (but not depressed) with little facial animation.

Generally your responses are slow, drawn out and of one or two words. While you will generally be cooperative, you come across as vaguely disinterested in most questions. There are times that you speak more but most of the time it is difficult to get much out of you. There is little spontaneous speech and the candidate will be doing most of the talking.

The only time you really get more interested is if the candidate suggests you are going to lose your accommodation.

4.3 Opening statement:

"Sue is worried about me, she says I may lose my flat."

4.4 What to expect from the candidate:

Candidates should ask you about symptoms of psychosis (see below), symptoms of depression and drug use. They will also ask you about your past psychiatric history.

Better candidates will make you feel comfortable by altering their questioning and speech to match your style of talking and thinking. The better candidates will do a brief examination where they assess your ability to move your limbs (how stiff you are), they will explain what they are doing and what they want you to do.

Poor candidates will come across as having a checklist of questions and be inflexible in their approach.

4.5 Responses you MUST make:

"I like where I live."

"I am worried about losing my friendship with Sue."

"I don't feel depressed."

If you are asked about the following symptoms of depression: sleep, mood, appetite, energy, enjoyment and general concentration; just say "***it is fine" or "it is good"*** (short affirmative answers).

4.6 Responses you MIGHT make:

If asked about your sleep patterns or appetite, respond that they are '***OK'*** as is your mood. You are not feeling sad or overly depressed.

If asked about suicidal ideation or thoughts to harm others: deny any thoughts.

If asked about whether you experience / hear voices or think people may be out to get you / harm you in some way (symptoms of psychosis):

"That was a while ago, last time I was in hospital I think."

4.7 Medications:

Paliperidone antipsychotic injection given to you once a month. You do not know the dose.

STATION 11 – MARKING DOMAINS

The main assessment aims are:

- Demonstrate capacity to engage a patient with poor motivation and engagement.
- Demonstrate the ability to identify negative symptoms of schizophrenia by excluding depression and extrapyramidal side effects.
- Consider collateral that the candidate considers important for differentiation.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.1 Did the candidate adequately conduct an assessment of the patient? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* clearly achieves the standard overall with a superior performance in a number of areas; superior technical competence in eliciting information.

Achieves the Standard (scores 4 or 3) by:
managing the interview environment; engaging the patient as well as can be expected; demonstrating flexibility to adapt the interview style to the patient; prioritising information to be gathered; appropriate balance of open and closed questions; being attuned to patient disclosures, including non-verbal communication; sensitively evaluating quality and accuracy of information.

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:
has some difficulty engaging the patient; demonstrates reduced flexibility in interview style; interview technique impedes the quality of data elicited. Significant omissions affecting quality scores 1.

Does Not Achieve the Standard (scores 0) if:
significant deficiencies such as being insensitive to the patient; using aggressive or interrogative style; having a disorganised approach.

1.1. Category: ASSESSMENT – data gathering process	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

1.2 Did the candidate take appropriately detailed and focussed history for negative symptoms, cognitive deficits and depression? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication; excludes positive symptoms that could be driving behaviour.

Achieves the Standard by:
conducting a detailed but targeted assessment; obtaining a history relevant to the patient's circumstances with appropriate depth and breadth; eliciting the key features; completing a risk assessment relevant to the individual case; demonstrating phenomenology; checking for cognitive symptoms; clarifying important positive and negative features.

To score 3 or above the candidate **MUST**:
a. check for negative symptoms of schizophrenia.
b. enquire about psychological symptoms of depression.

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

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 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

1.2 Did the candidate take appropriately detailed and focussed history related to differential diagnoses? (Proportionate value - 35%)

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

Achieves the Standard by:
demonstrating use of a tailored biopsychosocial approach; obtaining a history relevant to the patient's circumstances; history taking is hypothesis-driven; demonstrating ability to prioritise information to be gathered; excluding sedation; testing for side-effects; excluding impact of increased cannabis use as a primary cause of the deterioration.

To score 3 or above the candidate **MUST**:
a. enquire about extra-pyramidal side effects of parkinsonism.

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 score 1.

Does Not Achieve the Standard (scores 0) if:
omissions adversely impact on the obtained content; significant deficiencies such as substantial omissions in history.

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** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

3.0 COLLABORATOR

3.4 Did the candidate consider an appropriate therapeutic relationship with the manager as a relevant other? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:
achieves a score of at least 4 *and* able to generate a complete and sophisticated understanding of the complexity of the situation; gives priority to continuity of care and meeting changing needs.

Achieves the Standard by:
demonstrating ability to consider therapeutic relationships; gathering a range of relevant information; considering concerns raised, respecting confidentiality.

To score 3 or above the candidate **MUST**:
a. raise questions for the manager about sleep, activities of daily living or whether the manager has observed any evidence of movement disorders.
b. aim to find out what the manager thinks is causing the change in behaviour.

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

Below the Standard (scores 2 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:
lack of consideration of individual goals, capabilities or preference; any errors or omissions adversely impact on alliance.

3.4. Category: PATIENT RELATIONSHIPS	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Standard Not Achieved**
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 defined tasks?

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