

1.0 Descriptive summary of station:

This is a short VIVA station, where the candidate is asked to prepare to assess a woman, Jenny Jones, with schizophrenia who has mild symptoms of relapse in the context of relationship stress. Her new partner is using methamphetamine and most likely diverting family income to pay for it. He is becoming increasingly angry, threatening, and probably physically abusive. He is not the biological father of Jenny's two children, aged 4 and 2. The candidate is to present to the examiner what their concerns may be, and interventions that may be appropriate.

1.1 The main assessment aims are:

- To consider the potential causes of the presentation, and identify the important features of domestic violence (DV) that need to be addressed further with Jenny.
- To describe an appropriate range of interventions to support Jenny.

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

- Clarify with Jenny the causes of her injuries in the context of the available history.
- Identify domestic violence (intimate partner violence) as the most likely trigger for relapse of symptoms.
- Specifically address safety and welfare of Jenny and children as a priority.
- Consider whether reporting to child safety services is required.
- Assist Jenny to organise ongoing support in relation to domestic violence.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Other Skills (e.g. ethics, consent, capacity, collaboration, advocacy)
- **Area of Practice:** Child & Adolescent Psychiatry
- **CanMEDS Domains:** Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Content, Formulation, Management – Initial Plan, Management – Long-term, Preventative)

References:

- Bacchus L, Mezey G, Bewley S (2003) Experiences of seeking help from health professionals in a sample of women who experienced domestic violence. *Health Soc Care Comm* 11(1): 10–18.
- Johnston J, Roseby V, & Kuehnle K. (2009). *In the name of the child: A developmental approach to understanding and helping children of conflicted and violent divorce*. New York: Springer Publishing Company.
- Keeling J & Birch L (2004) Asking pregnant women about domestic abuse. *Brit J Midwifery* 12(12): 746–49.
- Kropp, R. (2008). Intimate partner violence risk assessment and management. *Violence and Victims*, 23(2), 202-220.
- McIntosh, J. (2003). Children living with domestic violence: Research foundations for early intervention. *Journal of Family Studies*, 9(2), 187-199.
- Position Statement 56 -Children of parents with mental illness, *Mental Health for the Community-Principles to underpin effective mental health service delivery to the community*, February 2012.
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- Robinson E, Moloney L (2010) Family Violence. Towards a Holistic Approach to Screening and Risk Assessment in Family Support Services. Australian Family Relationships Clearinghouse. Canberra: Australian Institute of Family Studies.
- http://www.wpanet.org/uploads/Latest_News/News_from_WPA_Sections/WPA_IPV_SV_Curriculum.pdf
- Webster J & Holt V (2004) Screening for partner violence: direct questioning or self-report? *Obstet Gynecol* 103(2): 299–303.
- World Psychiatric Association (WPA) International Competency-Based Curriculum for Mental Health Care Providers on Intimate Partner Violence and Sexual Violence against Women, Donna E. Stewart CM, MD, FRCPC University Professor, University of Toronto Senior Scientist, Toronto General Hospital Research Institute Research Head, University Health Network Centre for Mental Health Toronto, Canada.

Committee for Examinations
Objective Structured Clinical Examination
Station 4
Adelaide September 2017



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'.
- 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, there is no role player.

You are working as a junior consultant psychiatrist in a community psychiatry setting. The case manager has asked you to urgently review Ms Jenny Jones, and has provided the following information:

Jenny has chronic schizophrenia, and is usually somewhat disorganised. She now reports difficulties with concentration, loss of motivation, and feeling sad. She also has derogatory auditory hallucinations telling her she is worthless and a bad mother, and feels that people are aware of and talking about her badness.

Jenny is a loving but disorganised mother of two children - Joey aged 4, and Gemma aged 2. For example, she has difficulty getting them to childcare and kindergarten on time. Her sister, Melissa, lives close by and is very involved.

Yesterday Melissa informed the case manager that Jenny said that she had tripped to explain bruising on her arm and face. Melissa thought it would be best to have the children stay the night with her.

The case manager is concerned that twelve months ago Jenny started a relationship with a co-patient, Phil. He has a drug induced psychosis, forensic history and regularly uses methamphetamine. He moved into Jenny's house two months ago.

Jenny always receives her monthly depot paliperidone 100mg on time, and has been stable on this dose for 6 months.

Your tasks are to:

- Describe to the Examiner the issues of concern that you need to address at Jenny's next appointment.
- Describe to the Examiner the interventions you would consider.

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:
 - A copy of 'Instructions to Candidate'.
 - Pens.
 - Water and tissues are available for candidate use.

During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your place.
- At the **second bell**, start your timer, check candidate ID number on entry.
- TAKE NOTE that there are no cues / scripted prompts for you 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 **eight (8) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

At conclusion of examination:

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

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

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

3.0 Instructions to Examiner

3.1 In this station, your role is to:

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

When the candidate enters the room briefly check ID number.

This is a VIVA station.

3.2 Background information for examiners

In this VIVA station the candidate is asked to consider the potential causes of the change in presentation of a woman, Jenny, mother of two children aged 4 and 2. She has schizophrenia, and has mild symptoms of relapse in the context of relationship stress. Her partner of a few months is using methamphetamine, and the history provided indicates that he is becoming increasingly angry, threatening and physically abusive. He may also be diverting family income to pay for drugs. The candidate is to identify the important features of domestic violence that need to be addressed further with Jenny, and then describe an appropriate range of interventions to support Jenny.

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

- Clarify with Jenny the causes of her injuries in the context of the available history.
- Identify domestic violence (intimate partner violence) as the most likely trigger for relapse of symptoms.
- Specifically address safety and welfare of Jenny and children as a priority.
- Consider whether reporting to child safety services is required.
- Assist Jenny to organise ongoing support in relation to domestic violence.

The candidate is expected to see the changes in presentation within the 'bigger picture' using a biopsychosocial model. The candidate must specifically address the role of domestic violence (Intimate Partner Violence - IPV), and be able to comment about the impact on mental health of the individual and her family. The candidate should clarify:

- The possible reasons for this relapse, with a high index of suspicion that domestic violence is a significant contributing factor.
- Alternative causes for the change in presentation (e.g. Jenny using substances).
- The welfare of the patient: what is the extent of the domestic violence; her relationship with Phil; how she is coping, and to what extent is her family involved as support?
- The welfare of the children and what interventions should be considered.
- Discussions with the case manager, the appropriate use of a community team approach and the capacity to act as leader in this situation.
- Whether a notification to child protection services should be considered.

Candidates should be able to allude to the issues related to under recognition and under reporting of domestic violence, and that clinicians often do not enquire about it or fail to appropriately put strategies in place. Consideration of shame and the consequences of DV on individuals and children are also relevant.

Better candidates may outline the relevant factors which include that Phil is not the biological father and the implications of this; the nature of Jenny's symptoms - some reality basis and perhaps the need to follow Jenny's cues, which may help her to clarify the issues that are troubling her.

Any intervention recommended must address issues of safety (including the children's safety and welfare), and consideration of options such as referral to a women's refuge; assisting Jenny with evicting Phil, and the taking out of a legal order with the police. They should also consider the role of the extended family for further information / collateral, and as a resource for initial support and their ability to look after the children in the short and medium term.

The role of the consultant is to ensure that the team is involved and delegation of tasks occurs, e.g. case manager, social worker, registrar for mental state review.

A better candidate will be able to describe in depth the issues of IPV and the treatment - short, medium, and long-term consequences of IPV and any interventions.

Domestic Violence

According to the Australian Federal Department of Health, '*domestic violence (also referred to as intimate partner violence or family violence) occurs when one person attempts to control and dominate another in an intimate or familial relationship. Numerous studies have demonstrated that domestic violence is primarily perpetrated against women and children. Domestic violence manifests in a variety of forms, including physical, psychological, economic, social and sexual abuse. Domestic violence is relatively common during pregnancy. The frequency and severity of violence initiated by male partners against women may be higher during pregnancy (Burch & Gallup 2004; Martin et al 2004) but the evidence is not consistent (Campbell et al 2004; Walsh 2008)*'.

Intimate partner violence (IPV) is a global public health and human rights problem that causes physical, sexual and psychological harms to men and women. IPV includes physical aggression, sexual coercion, psychological abuse and / or controlling behaviours perpetrated by a current or previous intimate partner in a heterosexual or same-sex relationship. IPV affects both men and women, but women are disproportionately affected with nearly one third reporting IPV during their lifetime. Physical and sexual harms from IPV include injury, increased risk for sexually transmitted diseases, pregnancy complications and sometimes death. Psychological consequences include depression, anxiety, posttraumatic stress disorder, substance abuse, impulsivity and suicidality, and non-specific physical complaints thought to be related to the traumatic nature and chronic stress of IPV. Children who witness IPV are also negatively impacted in the short and long term.

Robinson & Moloney conclude that there are several core propositions which are supported in the literature: family violence is a significant problem, which is associated with a broad range of poor outcomes for children and for other family members; consensus supports that definitions of family violence must encompass the ways in which violence is expressed, and the range of ways in which one individual seeks to control the life of another. Violence is not just physical, and significant fear can be engendered by attitudes and behaviours that are not necessarily obvious to the untrained observer. While it is acknowledged that not all violence is gender specific, there are a variety of reasons why gender plays an important role in the institutionalisation and maintenance of violence, and this cannot be ignored.

Violence against women (VAW) or gender-based violence (GBV) are endemic and may present in many forms in war and peace. Intimate partner violence (IPV) and sexual violence (SV) in women are common abuses with serious physical and mental health consequences. Women are more likely than men to experience more severe forms of violence and abuse, and sustain more serious physical and mental health sequelae.

Health professionals are increasingly being expected to be alert and assess for signs and symptoms of violence, and most of the research in this area has focussed on the perinatal period. Research indicates that very few women who experienced abuse / violence ever told a doctor, and very few doctors reported ever asking about victimisation. This is also true in mental health settings.

The NICE guidelines note that health professionals should give women the opportunity to disclose in an environment in which they feel secure. Research has shown that most women find it acceptable for health professionals to ask them about experiences of domestic violence (Keeling & Birch 2004). Some women may not disclose to health professionals (Bacchus et al 2003) unless asked directly. Screening or assessment tools may increase the identification of domestic violence (Webster & Holt 2004) as they provide a series of structured questions asked of all women.

The major barriers offered by psychiatrists towards discussing two common forms of abuse, intimate partner or sexual violence, include: lack of adequate training about how to ask or respond; lack of knowledge regarding prevalence; scepticism about treatment effectiveness; uncertainty about appropriate referrals; patient resistance; physician discomfort with the issues; time constraints; fear of losing patients; and fear of safety of the person or oneself.

It is important to be alert and consider when to ask, who can / should ask and what to do next. If a clinician has any suspicions of domestic violence, then that is the time to ask. More recent recommendations suggest asking about the risk of any form of domestic violence as part of a routine assessment.

- Clinicians can explain that enquiring about domestic violence is a routine part of assessment and that it aims to identify individuals who would like / may need assistance. It is important to reinforce confidentiality and provide opportunities for people to discuss domestic violence in privacy (e.g. without their partner present).
- A clinician may need to seek support, depending on their skills and experience, when discussing domestic violence and assisting individuals. Most jurisdictions are developing training programs and support resources for clinicians. There are also the options of clinical supervision, mentoring and / or helplines.
- Taking a holistic approach if a person affirms that they are experiencing domestic violence; considerations include counselling and ongoing support. The safety of the person and any children should be assessed, and referral to other services (e.g. police, emergency housing, community services) made as required.
- As available support services vary by location it is important for mental health clinicians to know their local area.
- Documenting the discussion in the medical record, especially any evidence of injuries, treatment provided because of injuries, referrals made and any information the person provides.
- Be aware of relevant legislation as each State and Territory (Australia), and New Zealand has requirements about reporting violence as set out in its legislation.

Once identified, when providing first-line support to a person who has been subjected to violence, four kinds of needs deserve attention:

- Immediate emotional / psychological health needs
- Immediate physical health needs
- Ongoing safety needs
- Ongoing support and mental health needs.

It is critically important to recognise the effects of family violence on children, not only in terms of violence directed at children, but also the effects of 'inter-parental' violence and abuse on a range of physical and psychological factors that impact on a parent's capacity to remain attuned to the needs of their children. Clinicians may be able to make a difference by clearly communicating information to parents that summarises what is known about the impact of family violence on children; including those likely to exist and continue even if there are no signs of physical harm. A range of child-focussed resources exist to support clinicians, including the mechanisms by which family violence leads to a range of poor outcomes for children (e.g. In the Name of the Child by Johnston, Roseby, & Kuehnle, 2009 which explores 'the prism and the prison' of the child caught up in these circumstances).

3.3 The Standard Required

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

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

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

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

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 4 – MARKING DOMAINS

The main assessment aims are:

- To consider the potential causes of the presentation, and identify the important features of domestic violence that need to be addressed further with Jenny.
- To describe an appropriate range of interventions to support Jenny.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate consider an appropriately detailed history and collateral history? (Proportionate value – 25%)

Surpasses the Standard (scores 5) if:

clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication; carefully considers alternatives to domestic violence that need to be ruled out.

Achieves the Standard by:

identifying a detailed but targeted assessment; content of history taking is hypothesis-driven; integrating key psychosocial issues relevant to the assessment; demonstrating ability to prioritise; focussing on the key issues; considering important positive and negative features; considering their role in assisting Jenny to acknowledge relationship triggers; checking on symptoms and stability of her mental illness.

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

- Clarify with Jenny the causes of her injuries in the context of the available history.

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:

omissions will adversely impact on the obtained content; does not consider following up on collateral 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 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

1.11 Did the candidate generate an adequate formulation of the information to make sense of the presentation? (Proportionate value – 25%)

Surpasses the Standard (scores 5) if:

identifies potential barriers to disclosure of domestic violence by Jenny; provides a superior performance in a number of areas; demonstrates prioritisation and sophistication; applies a sophisticated biopsychosocial formulation.

Achieves the Standard by:

identifying and succinctly summarising important aspects of the history; synthesising information using a biopsychosocial framework; integrating psychological and sociological information; developing hypotheses to make sense of the patient's predicament; accurately describing recognised theories and evidence; commenting on missing data to be collected; accurately linking formulated elements to any diagnostic statement; analyses vulnerability and resilience factors.

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

- Identify domestic violence (intimate partner violence) as the most likely trigger for relapse of symptoms.

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 including inability to synthesise information obtained; failure to consider domestic violence; provide inadequate formulation.

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

1.13 Did the candidate formulate and describe a relevant initial management plan? (Proportionate value – 25%)

Surpasses the Standard (scores 5) if:

provides a sophisticated link between the plan and key issues identified; clearly addresses difficulties in the application of the plan.

Achieves the Standard by:

demonstrating the ability to prioritise and implement acute interventions, plan for risk management; selecting treatment environment; engaging safely and skilfully the appropriate treatment resources / support; providing safe, realistic time frames / risk assessment / review plan; keeping record and communicating to necessary others; recognising of their role in effective treatment; identifying potential barriers; recognising the need for consultation / referral / supervision.

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

- a. Specifically address safety and welfare of Jenny and children as a priority.
- b. Consider whether reporting to child safety services is required.

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; plan does not consider children's welfare.

1.13. Category: MANAGEMENT – Initial Plan	Surpasses Standard	Achieves Standard		Below the Standard		Standard Not Achieved
ENTER GRADE (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

1.16 Did the candidate formulate an appropriate longer term management plan, including preventative interventions and referral to specialists / resources? (Proportionate value – 25%)

Surpasses the Standard (scores 5) if:

acknowledges the broader issues related to children's performance at school / preschool; overall plan is sophisticated, tailored yet comprehensive; incorporates a sophisticated psychosocial approach into plan; plan separates out the specific needs of both patients involved.

Achieves the Standard by:

giving priority to continuity of care; demonstrating awareness of episode reducing / ameliorating effects of specific interventions; seeking out community support for domestic violence victims available longer term; putting in place monitoring systems to reduce recurrence; acknowledging appropriately realistic possibility of treatment failure of treatment alliance, resources, or psychological therapies; recognising the needs of the partner who is also a patient.

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

- a. Assist Jenny to organise ongoing support in relation to domestic violence.

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

GLOBAL PROFICIENCY RATING

Did the candidate demonstrate adequate overall knowledge and performance at the defined tasks?

Circle One Grade to Score	Definite Pass	Marginal Performance	Definite Fail
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