Committee for Examinations
Objective Structured Clinical Examination
Station 11
Auckland September 2018

The Royal Australian & New Zealand College of Psychiatrists

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1.0 Descriptive summary of station:

The candidate is required to assess opioid withdrawal and dependence in a 29-year-old woman who has been taking an increasing amount of oxycodone for her back pain. She is a patient in an acute psychiatry inpatient unit where she was admitted for management of suicidal ideation after her boyfriend left her. She has not taken oxycodone for 3 days, and now presents with a range of opioid withdrawal symptoms. The candidate is expected to communicate appropriately the findings of opioid dependence, and withdrawal to the patient. In addition, the candidate is expected to explain to the patient the management of opioid dependence / withdrawal.

1.1 The main assessment aims are to:

- Obtain a focussed history on opioid dependence and withdrawal.
- Communicate the findings appropriately to the patient.
- Explain the management plan for opioid dependence / withdrawal.

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

- Establish the time and amount of last opioid medication use.
- Explain the link between opioid dependence and recent development of withdrawal.
- Discuss both symptomatic treatments and opioid substitution therapy for the management of opioid withdrawal.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Substance Use Disorders
- **Area of Practice:** Addictions
- **CanMEDS Domains:** Medical Expert, Communicator
- **RANZCP 2012 Fellowship Program Learning Outcomes**: Medical Expert (Assessment – Data Gathering Content; Management – Treatment Contract), Communicator (Synthesis).

References:

- American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Brandish, E. K., Owen, C. T., & Sinclair, J. M. (2017). Acute management of alcohol and other drug problems. *Medicine*, *45*(2), 68-73.
- Foote, E., & Dukes, C. H. (2017). Acute management of substance-related and addictive disorders: a review. *Psychiatric Annals*, *47*(4), 192-199.
- National Guidelines for Medication-Assisted Treatment of Opioid Dependence: Online ISBN: 978-1-74241-945-9. Commonwealth of Australia 2014.
- New Zealand Practice Guidelines for Opioid Substitution Treatment. Ministry of Health. 2014. Wellington.

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 in late 20s
- Pen for candidate.
- Timer and batteries for examiner.

2.0 Instructions to Candidate

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

You are working as a junior consultant psychiatrist in an acute inpatient unit.

Kylie is a 29-year-old woman who was admitted last night with acute suicidal ideation. She had an argument with her boyfriend Jason, and he left her a week ago. Kylie is afraid he may not come back, and she had felt that she would rather die. She has no history of previous suicide or self-harm attempts. Her suicidal ideation has settled since the admission.

The nurse looking after Kylie for today has asked for a consultant review. Kylie is upset, and is asking for pain medication for back pain. Basic observations taken this morning are within the normal range.

Your tasks are to:

- Take a relevant history to ascertain the diagnosis.
- Explain your findings and short term management options to Kylie.

You will not receive any time prompts.

No physical examination is required in this station.

Station 11 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
  - A copy of 'Instructions to Candidate' and any other candidate material specific to the station.
  - Pens.
  - Water and tissues 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 that there is no cue / time for any scripted prompt you are 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 after the <u>final task</u>:

- 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 role player opens with the following statement:

'Doctor, I don't feel suicidal anymore, I just feel terrible.'

3.2 Background information for examiners

In this station the candidate is expected to obtain a focussed history of opioid dependence, and withdrawal from a 29-year-old woman who has been taking an increasing amount of oxycodone for her back pain. She has not taken oxycodone for 3 days, and now presents with a range of opioid withdrawal symptoms. The candidate is expected to synthesis the findings of opioid dependence and withdrawal, and communicate it appropriately to the patient. In addition, the candidate is expected to explain to the patient the management of opioid dependence / withdrawal.

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

- Establish the time and amount of last opioid medication use.
- Explain the link between opioid dependence and recent development of withdrawal.
- Discuss both symptomatic treatment and opioid substitution therapy for the management of opioid withdrawal.

A surpassing candidate achieves the overall standard with a superior performance in a range of areas; demonstrates a superior knowledge of the treatment of opioid withdrawal; clearly differentiates treatment of opioid withdrawal from ongoing treatment for opioid dependence; integrates information in a manner that can effectively be utilised by the patient; suggests the use of an opioid withdrawal scale to guide treatment.

Diagnosis of opioid dependence

Dependence on opioid drugs can develop rapidly. Furthermore, the proportion of people who start injecting opioids and become dependent (25-50%) is much higher than the proportion of people who use alcohol, sedative-hypnotics or psychostimulants and progress to dependence.

The features of opioid dependence include rapid development of tolerance, progressive orientation of the person's life around using, very strong cravings for use, risky behaviours (like committing crimes to support their dependence, using shared injecting equipment), and unpleasant withdrawal symptoms.

Evidence of opioid dependence

- A diagnosis of opioid dependence from history and examination of patient.
- A positive urine or oral fluid drug screens for opioids.
- Objective signs of opioid withdrawal.
- Recent sites of injection (depending on route of administration of opioids).

Detecting the person at risk of withdrawal

A person who is dependent on opioids is at risk of withdrawal when they cease their drug use, although the withdrawal symptoms are rarely life threatening or associated with significant aberrations of mental state. Opioid withdrawal is uncomfortable but not usually life-threatening, whereas opioid toxicity can lead to death. As opioid withdrawal is unpleasant it commonly leads to resumption of drug use. So, on presentation it is important to fully assess the person for their level of opioid dependence, and the likelihood of opioid withdrawal.

The pattern of symptoms is similar for withdrawal from different types of opioids (e.g. heroin, morphine, codeine, methadone), although the severity and duration of symptoms vary according to the type of opioids and the mode of reduction. Longer acting opioids (e.g. codeine, methadone) are associated with more protracted withdrawal symptoms than short-acting opiates (e.g. heroin). A sudden cessation of heroin use produces withdrawal symptoms of greater severity, but shorter duration than withdrawal symptoms associated with a cessation of methadone.

Untreated oxycodone withdrawal tends to start within 8-16 hours after the last dose. In general, oxycodone withdrawal peaks 72 hours after cessation of use and resolves in 7-10 days. However, oxycodone withdrawal symptoms may last from couple of hours to several days.

Drug seeking behaviour becomes prominent through requests for medication or attempts to self-medicate. The physical syndrome of opioid withdrawal resembles a severe bout of influenza.

The following table outlines the major signs and symptoms associated with opioid use.

Signs of Opioid Intoxication	**Signs of Opioid Overdose**	**Signs and Symptoms of Opioid Withdrawal**
Constriction of pupils	Pinpoint pupils	Dilation of pupils (mydriasis)
Itching and scratching	Loss of consciousness	Lacrimation
Sedation and somnolence	Respiratory depression	Rhinorrhoea
Lowered blood pressure	Hypotension	Anxiety and restlessness
Slowed pulse	Bradycardia	Dysphoria
Hypoventilation	Pulmonary oedema	Muscle, joint and bone ache
		Muscle cramps
		Abdominal cramps
		Nausea, vomiting, anorexia
		Diarrhoea
		Sweating and piloerection
		Hot and cold flushes
		Palpitations and tachycardia
		Fatigue and insomnia
		Yawning
		Raised blood pressure

Assessment of opioid withdrawal

The following questions should be asked specifically about opioid use:

- route of use
- time and amount of last use (to anticipate onset / resolution of intoxication and withdrawal syndromes)
- quantity, frequency and pattern of use (over last week or month)
- context of use to identify associated risks, for example, needle sharing, clubbing and high-risk sexual behaviour
- features of dependence
- history of withdrawal and complications, such as seizures, delirium and psychosis
- co-morbidity including psychiatric symptoms.

A collateral history should be obtained from family, friends, bystanders, paramedics and old notes. Consult other health professionals involved in the patient's care, for example the general practitioner and community mental health team where possible.

Severity of withdrawal symptoms can be determined by applying standardised tools / questionnaires, for instance, the Clinical Opioid Withdrawal Scale (COWS):

Clinical Opioid Withdrawal Scale (COWS) **INTERVAL**	**0**	**30 mins**	**2 hours**	**4 hours**
DATE: DD / MM / YYYY **TIME**				
	Score	Score	Score	Score
Resting Heart Rate (measure after lying or sitting for 1 minute): **0** HR 80 or below **1** HR 81-100 **2** HR 101-120 **4** HR greater than 120				
Sweating (preceding 30 minutes and not related to room temp / activity): **0** no report of chills or flushing **1** subjective report of chills or flushing **2** flushed or observable moistness on face **3** beads of sweat on brow or face **4** sweat streaming off face				
Restlessness (observe during assessment): **0** able to sit still **1** reports difficulty sitting still, but is able to do so **3** frequent shifting or extraneous movements of legs / arms **5** unable to sit still for more than a few seconds				
Pupil size: **0** pupils pinned or normal size for room light **1** pupils possibly larger than normal for room light **2** pupils moderately dilated **5** pupils so dilated that only the rim of the iris is visible				
Bone or joint aches (not including existing joint pains): **0** not present **1** mild diffuse discomfort **2** patient reports severe diffuse aching of joints / muscles **4** patient is rubbing joints / muscles plus unable to sit still due to discomfort				
Runny nose or tearing (not related to URTI or allergies): **0** not present **1** nasal stuffiness or unusually moist eyes **2** nose running or tearing **4** nose constantly running or tears streaming down cheeks				
GI upset (over last 30 minutes): **0** no GI symptoms **1** stomach cramps **2** nausea or loose stool **3** vomiting or diarrhoea **5** multiple episodes of vomiting or diarrhoea				
Tremor (observe outstretched hands): **0** no tremor **1** tremor can be felt, but not observed **2** slight tremor observable **4** gross tremor or muscle twitching				
Yawning (observe during assessment): **0** no yawning **1** yawning once or twice during assessment **2** yawning three or more times during assessment **4** yawning several times / minute				
Anxiety or irritability **0** none **1** patient reports increasing irritability or anxiousness **2** patient obviously irritable or anxious **4** patient so irritable or anxious that participation in the assessment is difficult				
Gooseflesh skin **0** skin is smooth **3** piloerection (goosebumps) of skin can be felt or hairs standing up on arms **5** prominent piloerection				
SCORE INTERPRETATION: 5-12 = MILD 13-24 = MODERATE 25-36 = MODERATELY SEVERE > 36 = SEVERE WITHDRAWAL	**TOTAL**	**TOTAL**	**TOTAL**	**TOTAL**
	INITIALS	**INITIALS**	**INITIALS**	**INITIALS**

The ICD-10 and DSM-5 opioid dependence / withdrawal diagnostic criteria are:

ICD-10 F11.23 **Opioid dependence with withdrawal**	**DSM-5 Opioid withdrawal**
Criteria for dependence (mild, moderate, severe) ▪ Compulsion to use ▪ Impaired control over drug use ▪ Withdrawal symptoms ▪ Increased tolerance ▪ Priority of drug use ▪ Continued use despite harmful effect **Withdrawal State** A group of symptoms of variable clustering and severity occurring on absolute or relative withdrawal of a substance after repeated, and usually prolonged and / or high dose, use of that substance. Onset and course of the withdrawal state are time-limited and are related to the type of substance and the dose being used immediately before abstinence.	A. Either of the following: - cessation of (or reduction in) opioid use that has been heavy and prolonged (several weeks or longer) - administration of an opioid antagonist after a period of opioid use B. Three (or more) of the following, developing within minutes to several days after Criterion A: - dysphoric moods - nausea or vomiting - muscle aches - lacrimation or rhinorrhoea - pupillary dilation, piloerection, or sweating - diarrhoea - yawning - fever - insomnia C. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. D. The signs or symptoms are not due to another medical condition and are not better accounted for by another mental disorder, including intoxication or withdrawal from another substance.

Opioid use and pain

Patients with opioid tolerance and dependence require higher doses of opioid analgesic drugs to achieve reasonable pain relief. Repeated requests for analgesia or specifically for opioid drugs beyond what would be expected from the clinical circumstances can indicate a substance use disorder. Complex issues, like high risk behaviours, significant misuse of other drugs, doctor shopping, serious comorbid physical or mental health conditions should be explored. It is safe to provide higher doses to treat pain if the patient is reviewed regularly and monitored for evidence of toxicity.

Opioid substitution is not suitable for all patients and should also only be used as part of the patient's rehabilitation if clinically indicated. Alternative therapies include acute management of withdrawal, abstinence-focussed programs, behavioural interventions like contingency management approaches, and self-directed interventions such as Narcotics Anonymous.

However, certain psychiatric and medical conditions (e.g. chronic pain) can be destabilised during detoxification and attempts to sustain an opioid-free lifestyle. These patients are often better advised to consider opioid substitution treatment / therapy (OST). If substitution treatment is prescribed, this should be viewed as managing the opioid dependence; pain should be treated separately, as it is for other patients, while acknowledging their altered tolerance.

There are two indications for OST: brief treatment of opioid withdrawal and prolonged maintenance therapy. Evidence indicates that the former is used in acute settings, but only the latter has good correlation with long-term outcomes like remission and recovery.

For patients that are opioid-dependent and not already on OST who need to remain in hospital for an extended period, substitution therapy may be required to manage detoxification or prevent withdrawal while other medical conditions are treated. Specialist input from a clinician with experience in methadone or buprenorphine prescribing should be sought.

Management of opioid withdrawal

The primary aim of a managed opioid withdrawal is to reduce acute physical and psychological discomfort. The severity of withdrawal is influenced by a number of factors, including the duration of a client's opioid use, the use of other substances (such as benzodiazepines), and general physical health and psychological factors, such as the client's reasons for undertaking withdrawal and their fear of withdrawal. Severity of opioid withdrawal is determined by the dose (the greater the dose, the more severe the withdrawal symptoms), rate of reduction (the more rapid the rate of reduction, the more severe the withdrawal symptoms) and type of opioid used (withdrawal from short-acting opioids can be more severe than withdrawal from long-acting opioids).

As the severity of withdrawal depends on psychological as well as pharmacological factors, the psychological management during withdrawal is as important as the medication regime.

Good communication is vital, e.g. taking the time to explain the likely course of the symptoms and acknowledge distress and frustration, being up-front and honest about the fact that although treatments reduce discomfort, they may not eradicate all symptoms, as this may not be safe. For example, higher doses of benzodiazepines can cause respiratory depression. A collaborative, empathic and non-judgemental approach can reduce symptoms that can be worsened by stress, and supportive care includes reassurance, attendance to hydration and nutrition. Reassurance should be provided to the patient that their withdrawal will be managed symptomatically. Complementary medications, massage, acupuncture and other physical / body therapies may be useful. Any specific treatment provided needs to be explained, including how often, and what the patient can expect to achieve. Clear boundaries and expectations should be explained and agreed upon with the patient.

Pharmacological support includes the prescription of medications for symptomatic relief, including non-opioid analgesics, anti-emetics, clonidine, benzodiazepines and antispasmodics. Pharmacologic management options include full or partial opioid agonists (e.g., methadone, buprenorphine), alpha-2 adrenergic agonists (e.g., clonidine), and an opioid antagonist (e.g., naltrexone) in combination with clonidine, with sedation, or with general anaesthesia. Opioid agonists and clonidine have all been shown to reduce COWS scores, with the opioid agonists having greater efficacy than clonidine alone.

Symptoms	**Suggested treatments**
Muscle aches / pains	Paracetamol 1000 mg, every 4 hours p.r.n. (max 4000 mg in 24 hours)
Nausea	Metoclopramide 10 mg, three times a day p.r.n. or Prochlorperazine 5 mg, three times a day p.r.n.
Abdominal cramps	Hyoscine 20 mg, every 6 hours p.r.n.
Diarrhoea	Loperamide 2 mg p.r.n. (maximum 16mg / 24 hrs)
Sleeplessness	Temazepam 10-20 mg at night
Agitation or anxiety	Diazepam 5 mg four times a day p.r.n.
Restless legs	Diazepam (as above)
Sweating or agitation	Clonidine 75 mcg every 6 hours (ensure blood pressure >90 mmHg systolic or >50 mmHg diastolic and heart rate >50 bpm)

In the management of opioid withdrawal, **clonidine** is typically administered orally as two to four doses per day, with the total dose adjusted daily according to withdrawal symptoms and side effects (particularly blood pressure). A test dose of 150mcg is often administered to check for hypotensive effects. If tolerated, treatment is continued at 12-15mcg/kg/day in four divided doses. Maximal doses are generally required for only a few days around the time of maximum withdrawal, usually two to four days after cessation of opioids. Doses are then tapered and ceased seven to ten days after cessation of opioids. Most protocols suggest 0.1 mg every 4 to 6 hours as needed for withdrawal on the first day, increasing by 0.1 or 0.2 mg per day to a maximum of 1.2 mg total daily dose, with careful monitoring of blood pressure and withdrawal symptoms.

Benzodiazepines can also be used for anxiety, agitation and insomnia but as they have a high potential for dependence they should be used with cautious and only under close supervision.

Relapse risk is thought to be related, in part, to post-acute opioid withdrawal, which includes symptoms similar to acute opioid withdrawal but reduced in intensity. Some patients experience reduced blood pressure, decreased heart rate and body temperature, and miosis. Opioid agonist maintenance treatment with either methadone or buprenorphine alleviates this relapse risk, reduces the risk of developing infectious diseases by reducing injection drug use, stops post-acute withdrawal symptoms, and improves health and immune function.

While a range of health benefits often result from managed withdrawal, there is no evidence detoxification alone contributes to lasting abstinence from opioids in the longer term. Relapse after opioid withdrawal is very common; therefore, a negotiated and detailed relapse prevention plan with the individual patient should be developed. The plan should always include the role of the client's support people and may include a residential treatment option.

Opioid substitution therapy (OST) should not be initiated until the prescribed dose and last dosing details have been confirmed. If someone is already on OST it should not be ceased because someone is in hospital. Adjustments may be required because of missed doses or the current clinical situation.

The COWS can be used to assist in determining an initial dose of methadone (in a methadone maintenance clinic) or of buprenorphine to be used to reduce withdrawal symptoms. The dose is then increased until all withdrawal symptoms have subsided. Fewer than 10% of people not connected to addictions treatment immediately after detoxification are able to maintain their sobriety, so all patients should be offered maintenance therapy.

The standard regime for opioid detoxification is based on the use of **buprenorphine**. The recommended dose is 4-24mg once daily. It is recommended that an interval of at least 2-3 days be available from the time of the last buprenorphine dose to the time of planned discharge. Duration of dosing will be determined by the length of admission available, e.g. in a 7-day admission, treatment will be limited to the first 4-5 days.

The sublingual preparation is well suited to individuals who cannot tolerate oral medications. Caution should be used in prescribing buprenorphine or other opioids in individuals with certain medical conditions. The clonidine-diazepam regime may be preferred for such patients; it is used to manage arousal from opioid cravings.

There is little literature on the use of buprenorphine with prescribed opioids. The following information is related primarily to heroin and methadone but is likely to be relevant to the other opioids.

The aim of using buprenorphine in withdrawal is the reduction of withdrawal symptoms and cravings; it is *not* the complete removal of all symptoms or the intoxication of the patient. The clinician should discuss patient's expectations of the medication with them and address any misconceptions. In general, buprenorphine is well suited to use in inpatient withdrawal settings, given its ability to alleviate the discomfort of withdrawal symptoms without significantly prolonging their duration.

The following principles regarding doses should be understood by the patient:

- Buprenorphine doses that are too high can result in increased rebound withdrawal, prolonged duration of symptoms, increased side-effects, and increased cost of the medication.
- Alternatively, use of doses that are too low can result in unnecessary withdrawal discomfort, continued use and treatment drop-out.
- Continued use or cravings may not be due to inadequate doses of medication. For example, patients who continue to associate with other heroin users, and are present when others are acquiring or using heroin, can expect to have cravings regardless of their dose of buprenorphine.

Buprenorphine is a partial opioid agonist. It can precipitate opioid withdrawal in someone who has recently used any opioid, e.g. heroin (within the past 6 hours) or methadone.

All doses of **methadone** should be supervised, where possible, and a clinician (doctor, nurse, pharmacist) should review the patient daily during the first week of treatment, corresponding to the greatest risk period for methadone-related overdose. The review provides an opportunity to assess intoxication (e.g. sedation, constricted pupils) or withdrawal symptoms, side effects, other substance use and the patient's general well-being.

- Commence with 20 to 30mg daily. Lower doses (e.g. 20mg or less) are suited to those with low or uncertain levels of opioid dependence, with high risk polydrug use (alcohol, benzodiazepines) or with severe other medical complications. Higher doses (30-40mg) should be considered with caution if clinically indicated, at the discretion of the prescriber. Consultation with a specialist is recommended before commencing.
- Patients at doses greater than 40mg the risk overdose.
- Dose increases should be made following review of the patient and should reflect side effects, features of withdrawal (suggesting not enough methadone) or intoxication (suggesting too much methadone or other drug use), ongoing cravings and substance use.

- Dose increments of 5 to 10mg every three to five days will result in most patients being on doses of between 30 and 50mg by the end of the first week, and 40 to 60mg by the end of the second week.
- Supplementary doses can be considered for patients returning in severe withdrawal 4 to 6 hours after dosing, but only after review by the prescriber. This requires coordination between the prescriber and dispenser.
- The dose should be gradually increased in order to achieve cessation (or marked reduction) in unsanctioned opioid use, and alleviation of cravings and opioid withdrawal features between doses, whilst minimising methadone side effects. Daily methadone doses above 80mg will also markedly reduce the effects of any ongoing heroin or other opioid use.

Naltrexone hydrochloride is a pure opioid antagonist which markedly attenuates or completely blocks, reversibly, the subjective effects of intravenously administered opioids. It has been used in this situation to hasten withdrawal symptoms, without increasing patient discomfort. The evidence on the effectiveness of naltrexone maintenance treatment is limited by low rates of retention in studies, and the small number of comparable studies. Current evidence indicates no significant difference in treatment retention or abstinence for people treated with naltrexone, with or without adjunctive psychosocial therapy, compared to placebo or psychosocial therapy alone.

The best approach to initiation of naltrexone maintenance treatment is to manage withdrawal from opioids with small doses of buprenorphine before commencing naltrexone. Introduce naltrexone with caution if there is any uncertainty about time of last opioid use. An interval of five days between last buprenorphine and first naltrexone is recommended for generalist settings. If heroin was the last opioid used, an interval of 7 days is recommended, and 10-14 days if methadone was the last opioid used. If a faster transition is desired, seek specialist advice or referral. Urine drug screening is of little use during naltrexone induction. The best approach is to advise the patient that the first dose of naltrexone may precipitate withdrawal if opioids have been used recently. If there is a risk of precipitated withdrawal due to uncertain recent opioid use, seek specialist advice.

Commence naltrexone at 25mg per day for three days, then increase to 50mg per day if tolerated. Note that the onset of withdrawal triggered by naltrexone can be delayed following buprenorphine treatment.

3.3 The Standard Required

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

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

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

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

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

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

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

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

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

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

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

4.0 Instructions to the Role Player

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

You are Kylie, a 29-year-old single woman who has been in a relationship with Jason for the past 3 years. You had an argument with Jason, and he left you a week ago. You have been feeling sad and suicidal since. You have been staying at home feeling miserable, and forgot to pick up the medication you take for your back pain. You haven't had any pain medication for **3 days**. This is the first time you have gone without the medication. Last night you felt sick and impulsively decided you could not face living without Jason, and felt acutely suicidal. This led to your friend Jane bringing you to hospital because you were so upset. You have never attempted to take your life before; and currently you are relieved to be alive and don't have a plan to take your life.

How you are feeling today

However, physically you are in a lot of pain, especially backache and aches in your muscles. You have also been struggling with agitation, restlessness and anxiety. You also have stomach cramps, diarrhoea, nausea and vomiting. You have been bothered by a runny nose and sweating, and feel you are coming down with flu as you are shivering even though it is not that cold outside.

History of opioid drug use

You started using pain medication (codeine) after a back injury following a car accident 2 years ago, which put you off work for a few months. If asked, you can point to the general area of your lower back as the part that hurts. You have been to several doctors and have tried various pain medications - so many you can't recall all the names but know that paracetamol and Brufen® don't work. For the past **6 months** you have been taking **oxycodone** 20milligram tablets. Your GP prescribes these tablets and you are supposed to take them every 12 hours (i.e. twice a day). However, in the last **2 months** you have been taking them every 3 to 4 hours because it doesn't seem to reduce your ongoing back pain. You never saw a problem in this as the pain is real and the medication helps; and you have never tried to stop it.

You were using up your supply of oxycodone tablets very quickly. A month ago, you had to lie to your GP that you had lost all your oxycodone tablets, and she prescribed you with another 3 months of the medication. When your boyfriend found out about your increasing use, and your recent lying to the doctor he became angry, and both of you ended up in an argument that led to him calling you a *junkie* and walking out. You have had no contact with him for the past week. He is not responding to your calls or messages.

If asked, you have never injected any drugs or medicine yourself.

How you felt in the last week

Prior to Jason leaving you a week ago, you had been coping well. Your sleep has always been poor but for the past 2 days you haven't been able to sleep at all. There has been no change in your appetite. You feel tired occasionally but can get on with things. You felt you wouldn't be able to cope without Jason. You want things to improve, and now think that if you come off the pain medication you will get your boyfriend back.

Before last week, you have had bad days like everyone else, but they never lasted for more than a day or two. You have never had a period of persistently low mood, loss of motivation or loss of interest in everything. You never felt high / elevated or euphoric. You have never seen or heard things that other people do not, never had strange beliefs of being watched or monitored. You have never seen a psychiatrist or psychologist.

Your past medical history

Apart from your back injury, you have had no other medical problems and you are not allergic to any medication. If asked specifically, you can say that you have been constipated on and off for the past couple of months, but thought it was because of a lack of exercise and a poor diet, and you have not done anything about it.

Your personal history

Both your parents (in their late 50s) are alive and well. You have one younger brother Paul (age 22). Your mother suffered from anxiety and your brother has been addicted to many drugs, you are not sure which and you don't have much to do with him. There is no other mental illness in the family. You get along well with your parents, but they are unaware of the current situation and you do not want to worry them.

You had a happy childhood; you always worked hard to be the best. You didn't have many friends, but you got along at school. You went to college and finished accounting. You were never in any serious relationship until Jason. You worked as an account person in a local supermarket until the car accident 2 years ago, after which it is hard for you to work as you cannot sit for long periods of time. You have had a few brief jobs since then and are now living off your savings, and get some financial help from your parents at times.

You drink socially (1 to 2 glasses of wine every week), and have avoided illicit drugs. Until recently, you didn't feel you have a drug problem but since the conflict with your boyfriend you realise that your use of the painkillers may be excessive, and you want to sort out the problem. You do not gamble.

You have not ever been in trouble with the police, and there are no outstanding legal issues.

Discuss these symptoms only if specifically asked:

With regards to symptoms of opioid **dependence**:

- Compulsion to take oxycodone – you cannot cope without the medications.
- Impaired control over use – you have lied to your GP for more medication.
- Increased tolerance – you need more and more medicine to get the same effect to control the pain.
- Priority of drug use – you have been neglecting usual chores and relate this to back pain and need for medication.

If asked the specifics of your use of oxycodone:

- You have been taking one 20milligram tablet every 3-4 hours every day for the last 2 months: so about 5 times a day.
- You don't wake up at night to take another tablet but need one first thing in the morning as you don't feel too well in the morning.

With regards to symptoms of opioid **withdrawal** you are experiencing the following for the past 2 days:

- Tears, running eyes
- Running nose
- Sweating
- Gooseflesh
- Hot and cold flushes
- Tiredness
- Yawning
- Restlessness
- Poor sleep
- Muscle aches, leg cramps
- Joint pain, particularly backache
- Stomach cramps, diarrhoea,
- Nausea, vomiting, loss of appetite
- Unpleasant mood

You thought it was 'the flu' and so have taken paracetamol but the pain is really bad now.

4.2 How to play the role:

You are feeling sad and upset because your boyfriend has left you. You did think of taking your life yesterday if Jason is not coming back, but this thought has subsided since you were admitted to the hospital last night. You find the hospital environment supportive and you are not feeling lonely.

You have been taking medications for back pain, and you think your boyfriend misunderstands you as he thinks of you having a drug problem. You want this to be clarified, and are willing to do anything to get things back in control and get your boyfriend back. You do not believe you have an addiction. You do wonder whether you might be coming down with a flu, as opposed to withdrawing from opioids. On occasion you will yawn, and use a tissue to wipe your 'runny nose' at times.

4.3 Opening statement:

'Doctor, I don't feel suicidal anymore, I just feel terrible.'

4.4 What to expect from the candidate:

The candidate should explore your report of feeling terrible. The candidate will ask you about your regular medication.

Do not tell the candidate you are taking oxycodone unless they ask you about any regular medication you might take. The candidate will then clarify the details of opioid use and withdrawal symptoms, and other aspects of history that may influence their management plan. They should explain to you what opioid withdrawal is, how this is treated, and what to expect during withdrawal.

4.5 Responses you MUST make:

'I am in a lot of pain! Can you do something about it?'

4.6 Responses you MIGHT make:

'Can you help me to come off oxycodone?'

'How can something my doctor prescribes be so bad?'

IF the candidate did not explore symptoms of opioid withdrawal, you will say:

'Can you do something about my nausea and diarrhoea?'

4.7 Medication and dosage that you need to remember:

Oxycodone (oxi-co-done) 20mg tablets for pain.

Your GP has prescribed it for every 12 hours, but you have been taking it every 3 to 4 hours.

STATION 11 – MARKING DOMAINS

The main assessment aims are:

- Obtain a focussed history on opioid dependence and withdrawal.
- Synthesis the findings and communicate it appropriately to the patient.
- Explain the management plan for opioid dependence / withdrawal.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately a detailed and focussed history on opioid dependence and withdrawal? (Proportionate value - 35%)

Surpasses the Standard (scores 5) if:
clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication when eliciting a detailed history to confirm the diagnosis of opioid dependence and withdrawal.

Achieves the Standard by:
demonstrating use of a tailored biopsychosocial approach; conducting a detailed but targeted assessment; eliciting the key issues; attuning to patient disclosures, including non-verbal communication; obtaining relevant history on opioid dependence and eliciting symptoms of opioid withdrawal; enquiring about other substances of abuse including alcohol, prescription medication and illicit drugs; taking into account psychosocial stressors and support network; any omissions to be minor and not materially adversely impact on the obtained content.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Establish the time and amount of last opioid medication use.

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

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

Below the Standard (scores 1):
scores 1 if there are significant omissions affecting quality; focusses only on the self-harm and suicidality which results in significant deficiencies and substantial omissions in history; does not elicit history of opioid dependence and withdrawal.

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

1.2 Category: ASSESSMENT – Data Gathering Content	**Surpasses Standard**	**Achieves Standard**		**Below the Standard**		**Domain Not Addressed**
ENTER GRADE (X) IN ONE BOX ONLY	**5** ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

2.0 COMMUNICATOR

2.5 Did the candidate demonstrate effective communication skills when explaining the diagnosis of opioid dependence and withdrawal to the patient? (Proportionate value - 30%)

Surpasses the Standard (scores 5) if:
integrates information in a manner that can effectively be utilised by the patient; provides succinct and professional information; considers protective and vulnerability factors.

Achieves the Standard by:
prioritising and synthesising information; correctly communicating findings of an opioid dependence and withdrawal in suitable language, with appropriate detail and sensitivity; being responsive to the patient's embarrassment; demonstrating discernment in selection of content; utilizing a biopsychosocial approach; identifying relevant predisposing, precipitating perpetuating and protective factors with communicating diagnosis in appropriate language.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Explain the link between opioid dependence and recent development of withdrawal.

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

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

Below the Standard (scores 1):
scores 1 if there are significant omissions affecting quality; provides grossly inaccurate or incorrect information; unable to communicate the diagnosis of opioid dependence or withdrawal.

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

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

1.0 MEDICAL EXPERT

1.15 Did the candidate adequately engage, inform and discuss the treatment plan with the patient including suitably incorporating patient goals / preferences? (Proportionate value - 35%)

Surpasses the Standard (scores 5) if:
clearly achieves the overall standard with presentation of a plan that is comprehensive and sophisticated; demonstrates a superior knowledge of the treatment of opioid withdrawal; differentiates treatment of opioid withdrawal from ongoing treatment for opioid dependence; uses an opioid withdrawal scale (e.g. COWS) to guide treatment; identifying the need to address pain management separately to opioid addiction; discuss two or more pharmacological options used for the management of opioid withdrawal (methadone, buprenorphine, naltrexone, or clonidine).

Achieves the Standard by:
Including aspects of management of both withdrawal and dependence; demonstrating the ability to communicate immediate treatment plan; sufficiently addressing symptoms of opioid withdrawal e.g. nausea, diarrhoea; clearly communicating indications for ongoing treatment, range of options, risks and recommendations; working within patient treatment goals and negotiating targeted outcomes; offering psychoeducational material; outlining specific treatment components such as systematic monitoring and routine supportive care; addressing ongoing pain management.

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

a. Discuss both symptomatic treatments and opioid substitution therapy for the management of opioid withdrawal.

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

Below the Standard (scores 2):
scores 2 if the candidate does not meet (a) above, or has omissions that would detract from the overall quality response; difficulty tailoring treatment to the patient's specific circumstances.

Below the Standard (scores 1):
scores 1 if there are significant omissions affecting quality; inaccurate or incorrect treatment of opioid withdrawal and dependence which impacts adversely on patient care.

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

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

GLOBAL PROFICIENCY RATING

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

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