Committee for Examinations
Objective Structured Clinical Examination

Station 5
Gold Coast April 2019

The Royal Australian & New Zealand College of Psychiatrists

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1.0 Descriptive summary of station:

In this station, the candidate is to assess Glen, a 65-year-old man, referred to the outpatient clinic by his GP due to concerns that Glen is depressed, but unwilling to trial antidepressant medication. The candidate is expected to establish that Glen's depression is mild to moderate, that non-pharmacological management is the more appropriate option, and to discuss the appropriate treatment options with Glen. Better candidates will utilise shared decision making to work with Glen in creating a management plan.

1.1 The main assessment aims are to:

- Evaluate the candidate's knowledge of non-pharmacological management options for treating mild to moderate depression.
- Assess the candidate's collaborative approach to working with a patient in development of a management plan.

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

- Explore current and past risk of suicide.
- Discuss at least one psychological treatment, one social treatment and one lifestyle treatment.
- Recommend non-pharmacological management only.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category**: Mood Disorders
- **Area of Practice**: Old Age Psychiatry
- **CanMEDS Domains**: Medical Expert
- **RANZCP 2012 Fellowship Program Learning Outcomes**: Medical Expert (Assessment – Data Gathering Content; Management – Therapy; Management – Treatment Contract)

References:

- American Psychiatric Association (APA) (2013) *Diagnostic and Statistical Manual of Mental Disorders* 5th Edition, Washington DC: American Psychiatric Publishing.
- Australian Commission on Safety and Quality in Health Care - https://www.safetyandquality.gov.au/our-work/shared-decision-making/.
- Bridle C, Spanjers K, Patel S, et al. (2012) Effect of exercise on depression severity in older people: Systematic review and meta-analysis of randomised controlled trials. *The British Journal of Psychiatry* 201: 180–185.
- Calati R, Salvina Signorelli M, Balestri M, et al. (2013) Antidepressants in elderly: Metaregression of double-blind, randomized clinical trials. *Journal of Affective Disorders* 147: 1–8.
- Gin S Malhi 1, 2, Darryl Bassett 3, 4, Philip Boyce 5, Richard Bryant 6, Paul B Fitzgerald 7, Kristina Fritz 8, Malcolm Hopwood 9, Bill Lyndon 10, 11, 12, Roger Mulder 13, Greg Murray 14, Richard Porter 13 and Ajeet B Singh 15 *Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders* (First published in Australian and New Zealand Journal of Psychiatry 2015, Vol. 49(12) 1-185).
- World Health Organisation (1992), International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10). Geneva: WHO.

1.4 Station requirements:

- Standard consulting room; no physical examination facilities.

a. Four chairs (examiner x 1, role player x 1, candidate x 1, observer x 1).
b. Laminated copy of 'Instructions to Candidate'.
c. Role player – early 60's male, casually dressed.
d. Pen for candidate.
e. 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 outpatient setting. You are about to see Glen Hobbins, a 65-year-old retired engineer, who has been referred by his GP, Dr White, for your opinion.

Glen had a myocardial infarction six months ago. He underwent coronary artery bypass grafting, and has made a good recovery. His cardiovascular risk factors are now well controlled.

Dr White has referred Glen for an opinion on management as in the last six weeks Dr White has been concerned that has been unwilling to trial an antidepressant for depression. Dr White reports that Glen had a CT Head and MRI Head, and no abnormalities were detected. Glen's MMSE was 30/30, and Glen's MOCA score was 30. Dr White is worried that Glen's reluctance to take an antidepressant may be due to his low mood.

Your tasks are to:

- Obtain a relevant focussed history from Glen.
- Discuss treatment options with Glen.

You are not required to examine Glen physically or to test his cognition.

You will not receive any time prompts.

Station 5 - Operation Summary

Prior to examination:

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

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 / time prompts for you to give.
- DO NOT redirect or prompt the candidate unless scripted – the role player 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.

There are no prompts.

The role player opens with the following statement:

'I'm not going to take anymore new medication.'

3.2 Background information for examiners

In this station, the candidate is required to assess a 65-year-old man referred to the outpatient clinic by his GP due to concerns over low mood, and reluctance to trial antidepressant medication. The candidate is expected to establish a diagnosis of depression of mild to moderate depression, and that therefore the patient's request for non-pharmacological management, is an appropriate option.

The candidate should display a knowledge of non-pharmacological management options for treating depression, and the ability to work collaboratively with a patient in development of a management plan.

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

- Explore current and past risk of suicide.
- Discuss at least one psychological treatment, one social treatment and one lifestyle treatment.
- Recommend non-pharmacological management only.

A surpassing candidate may recognise the opportunity for shared decision making, and potential barriers to this in older patients.

Depression is the most common mental illness among older people, and is associated with increased morbidity, premature mortality and greater healthcare utilisation. However, for the majority of older people, treatment of depression is inadequate / suboptimal due to complications of poor recognition, increased prevalence of medication side-effects, polypharmacy and poor adherence to treatment (Bridle C, Spanjers K, Patel S, et al.).

Diagnosing primary depressive episodes on the background of poor physical health also requires more consideration.

DMS-5 Criteria for Depression

A. Five (or more) of the following symptoms have been present during the same 2-week period, and represent a change from previous functioning; at least one of the symptoms is either:

(1) depressed mood or

(2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (*Note:* In children and adolescents, can be irritable mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (*Note:* In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Note: Criteria A – C represent a major depressive episode.

Note: Responses to a significant loss (e.g. bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history, and the cultural norms for the expression of distress in the context of loss.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum, and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.

Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance induced or are attributable to the physiological effects of another medical condition.

Specify:
With anxious distress
With mixed features
With melancholic features
With atypical features
With mood-congruent psychotic features
With mood-incongruent psychotic features
With catatonia
With peripartum onset
With seasonal pattern (recurrent episode only).

ICD-10 Criteria for a Depressive Episode

ICD-10 Diagnostic criteria for depression uses an agreed list of ten depressive symptoms.

Key symptoms:

At least one of the following, most days, most of the time for at least two weeks:

- persistent sadness or low mood; and / or
- loss of interests or pleasure; and / or
- fatigue or low energy.

If any of the above present, ask about associated symptoms:

- disturbed sleep
- poor concentration or indecisiveness
- low self-confidence
- poor or increased appetite
- suicidal thoughts or acts
- agitation or slowing of movements
- guilt or self-blame.

The 10 symptoms then define the degree of depression, and management is based on the particular degree:

- **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).

Symptoms should be present for a month or more, and every symptom should be present for most of every day.

The international literature supports non-pharmacological (biological) over pharmacological interventions for more mild to moderate depressive episodes.

There is evidence to suggest that response to antidepressant medication may be less in older people than younger cohorts. Calati R, Salvina Signorelli M, Balestri M, et al. found that there is a lower rate of response to antidepressants of all classes in patients of male gender, of older age, and with a longer mean duration of the current episode.

The Royal Australian and New Zealand College of Psychiatrists' Clinical Practice Guidelines on mood disorders divides the non-biological management of mood disorders into the subcategories of psychological treatments, social treatments, and lifestyle treatments -

Psychological Treatments

- *Brief Cognitive Behavioural Therapy* – 4–8 sessions, focussed on a targeted and limited number of cognitions and behaviours felt to be the most likely to maintaining depression.
- *Formal Cognitive Behavioural Therapy* – usually 12–10 sessions, aims to modify dysfunctional cognitions and associated behaviours that are presumed to maintain depression.
- *Interpersonal Therapy* – based on the fact that the onset of depression is usually associated with something going on in the person's current personal life, focusses on the problems in personal relationships and the skills needed to deal with these.
- *Mindfulness* – emphasis on cultivating awareness and acceptance of the present moment, and decreasing rumination and mind wondering, which are both implicated in maintaining depression.
- *Acceptance and Commitment Therapy* – approximately 12 sessions, focusses on three areas – accept reactions and be present, choose a valued direction, take action.
- *Schema Therapy* – used for chronic depression, aims to help change from early maladaptive schemas to more adaptive schemas and coping strategies.
- Low intensity interventions (e.g. internet education) are also recognised as beneficial.

Social Treatments

- *Family Psychoeducation* – has been shown to decrease duration of episode and to reduce relapse rates of depression.
- *Family / Friends* – decreased isolation is associated with recovery from depressive episodes.
- *Formal Support Groups* – teach skills, encourage healthy activities and provide social support.
- *Community Groups* – increase social connectivity, social support and activity.
- *Caregivers* – primary supports being aware of depression is associated with earlier intervention and increased likelihood of accessing of treatment.
- *Employment* – depression rates are elevated in the unemployed population (especially long-term unemployed), maintaining employment or work attendance during an episode of depression is associated with improved recovery rates, difficult or unsupportive work environments can contribute to the development of depression.
- *Housing* – housing problems are associated with a greater risk of depression, depression risks are over ten times greater in the homeless population.

Lifestyle Treatments

- *Exercise* – inactivity is a risk factor for the development of depression, exercise is highly effective treatment intervention for depression.
- *Diet* – adherence to a 'healthy' diet pattern is associated with reduced likelihood of depression.
- *Smoking cessation* – associated with reduced depression, anxiety and stress, and improved mood and quality of life.

- *Alcohol cessation* – alcohol is a depressant, there is an increased incidence of self-harm and completed suicide in people with alcohol problems.
- *Ceasing drugs* – identifying and, if possible, ceasing medications associated with depression (e.g. beta-blockers, corticosteroids, benzodiazepines, anti-Parkinson medication, statins).
- *Managing substance misuse* – depression and substance use are common co-morbidities, ongoing substance misuse increases duration of illness and chance of relapse.
- *Sleep* – although there is no strong evidence that targeting sleep aids in the treatment of depression, there is evidence of a causal link between poor sleep and negative mood, and therefore sleep should be assessed, and behavioural intervention for improving sleep implemented if required.

The guideline advises that in mild to moderate episodes of depression, psychological management alone may be adequate, especially early in the course of illness, and reports that psychological therapies (particularly CBT and related approaches, and IPT) are as effective in reducing mild to moderate depression as pharmacological treatments.

Shared Decision Making

The Australian Character of Healthcare Rights states that consumers should be informed about services, treatments options and costs, and included in decisions and choices regarding care.

The New Zealand Code of Health and Disability Services Consumers' Rights states consumers have the right to effective communication, to be fully informed, and to make an informed choice and give informed consent.

The Australian Commission for Safety and Quality in Health Care advised that shared decision making requires more than providing information regarding evidence-based treatments. It involves integration of a patient's values, goals and concerns along with providing evidence about benefits, risks and uncertainties of treatment, in order to achieve collaborative health care decisions. In partnership with their clinician, patients are encouraged to express their treatment preferences, and to consider the available management options to help select the course of action that best fits their preferences. It differs from other types of decision making – paternalistic and informative – and that decision is made in partnership, and involves an exchange of knowledge and opinions.

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 Glen, a 65-year-old, retired engineer. You have been happily married to Faith for 45 years. You have two grown children, Michael (43) and Emily (41), and five grandchildren. Your children live locally and you see them regularly – there is a family lunch every Sunday.

Your GP has referred you to see a psychiatrist as he wants you to start a course of antidepressants, as he thinks you are depressed, but you do not want to.

The candidate should ask you about the features of depression

You should not volunteer this information without being asked, but these are the responses you should make about the following features:

Symptom	Response
Mood	*You have been feeling down for a month or so, you feel like this every day.*
Do you feel better or worse at any time of day?	*You have not noticed any difference.*
Changes to sleep	*In the last few weeks, you have been waking earlier than you used to (at 4 am when you previously woke after 6 am).*
Changes to appetite	*In the last one to two months, you have not been very interested in food and your clothes are getting big on you. Faith has been trying to get you to eat.*
Motivation / Drive	*This is lower than usual in the last few weeks, but you can be encouraged to do things.*
Energy	*This is decreased and you tire easily. The last three Sundays, you've needed to have a sleep after the family left and this is unusual for you.*
Concentration	*You haven't noticed a problem, you are still able to read and watch TV.*
Enjoyment	*Although you are less interested in doing things, but you are still able to enjoy them, you particularly enjoy time with your grandchildren.*
Libido/sex-drive	*Not brilliant to start with, but this is decreased.*
Negative thoughts	*You do not feel guilty, helpless or worthless.*
Hopelessness	*You do worry that your health issues may prevent you from doing things you want to do.*
Agitation / restlessness	*You have not noticed or felt this.*
Suicide or thoughts of harming yourself	*You have not experienced any of these thoughts, you are still planning on travelling with Faith.*

You had enjoyed working as an engineer, and had planned to work until you were 70. You had been looking forward to retirement, and in particular, to travelling with Faith. But retirement occurred earlier than anticipated when you had a heart attack six months ago. You were at work when suddenly you had a terrible pain in your chest and arm, and you were taken to the hospital in an ambulance, and told that you would need open-heart surgery.

Despite being a huge shock, you feel that you managed all of this well, and remained positive during and after the surgery. You decided to retire as the heart attack made you feel like you needed to make the most of the rest of your life. However retirement has not been quite as you'd hoped, and you now feel frustrated and like the decision of when to retire has been taken out of your hands.

When you were still in hospital, you planned to make some life changes, and to prioritise your health. You had always worked long hours, and didn't exercise often. When you were at work, you had tended to eat a lot of takeaway, and had a particular weakness for fried foods. You had smoked 20 a day since you were 16.

After your heart attack you made plans to exercise more, eat better, and to stop smoking. You did stop smoking and had been proud of this, but now you sometimes wonder if it was worth it. Your wife, Faith, has been providing you with more healthy food, but you're less interested in food than you used to be. You did initially start exercising, and joined a walking group with Faith, but you haven't really done any in the last few weeks.

You felt hopeful when you left hospital, but you have found the treatment required to try and prevent another heart attack difficult. Prior to the heart attack, you had never had any health problems, and had never been on any medication. You had significant problems with some of the medications that you were started on after the heart attack (please see section below of medication). Things are better on the medications that you are on now, but you do not want to change any of your medications or add in any new medication in case you have problems.

<u>If you are asked about any of these unusual experiences</u>

- You have not heard voices.
- You are not worried that you are dying or that your organs are rotting.
- You do not feel that you have done something terrible.
- You do not feel that anyone wants to harm you or hurt you.
- You do not feel that you are destitute or that you or your family have no money.

<u>If you are asked about alcohol or drug use</u>

- You smoked 20 a day from age 16 but stopped after the heart attack.
- You drink 2–3 beers a night – this has been unchanged for many years.
- You have never used any other drugs.

<u>If you are asked about your family</u>

- Your father had a stroke in his 80s. Your mother, Dorrie, is still alive and in nursing home. You visit her once a week.
- There are no other significant health issues in your family.
- As far as you know, no one in your family has ever had problem with depression or their nerves, and you have never had problems with your mood or nerves in the past. You've never tried to harm yourself or attempted suicide.

4.2 How to play the role:

To be dressed in casual attire. You are to be firm about the fact that you do not want to take medication, but otherwise polite and willing to work with the candidate. You are open to treatment that does not involve taking tablets. If the candidate insists on you taking medication, you are to become irritated / annoyed.

4.3 Opening statement:

'I'm not going to take anymore new medication.'

4.4 What to expect from the candidate:

The candidate should discuss your recent medical problems, and also ask questions about mood (this would include asking about things, such as your sleep and appetite as per the table under **4.1**). The candidate should respect your preference not to take medication, and discuss other treatment options with you.

4.5 Responses you MUST make:

'***I don't want to feel the way I'm feeling now.'***

'***I'm not against help, is there anything else?'***

4.6 Responses you MIGHT make:

If asked why you don't want to take medication -
Scripted response: ***'I'm on so much already. I don't want any more.'***

If asked about the heart attack or your general health –
Scripted response: ***'The heart attack was the least of my problems, the medications were much worse.'***

If the candidate recommends no medication – **(NOTE: this is the correct recommendation)**
Scripted response: ***'What am I going to say to Dr White – he won't be happy!'***

4.7 Medication and dosage that you need to remember

You were started on several medications after your heart attack – most of them caused you problems. You can write them on a piece of paper if you wish.

Medication	**Side Effects / Problems**
Clopidogrel 75 milligrams daily	You can't really remember what it is for – but it replaced the aspirin.
Candesartan 8 milligrams daily (current blood pressure medication)	You've had several medications for blood pressure - you were on two to start with. These both had to be stopped as one of them gave you a cough and the other made you dizzy. The doctors then gave you different medication and you had terrible nightmares on it.
Regular *Aspirin*	Made you feel ill – you had pains in your stomach, itchy skin and headaches and so this was stopped.
Cholesterol medication	You can't remember its name, but made your legs weak. You couldn't walk up the stairs. You are no longer on medication for cholesterol.

STATION 5 – MARKING DOMAINS

The main assessment aims are to:

f. Evaluate the candidate's knowledge of non-pharmacological management options for treating mild to moderate depression.

g. Assess the candidate's collaborative approach to working with a patient in development of a management plan.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.2 Did the candidate take appropriately detailed and focussed history for depressive symptoms? (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; explores features of agitation and melancholia.

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; hypothesis-driven history taking; integrating key sociocultural issues relevant to the assessment; demonstrating ability to prioritise; eliciting the key issues; completing a risk assessment relevant to the individual case; demonstrating phenomenology; clarifying important positive and negative features to address level of severity (e.g. psychosis); assessing for typical and atypical features.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Explore current and past risk of suicide.

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 (e.g. not exploring risk in any way).

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 ☐

1.14 Did the candidate demonstrate an adequate knowledge and application of relevant psychological / social therapies and lifestyle interventions? (Proportionate value - 35%)

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

Achieves the Standard by:
demonstrating the understanding of these (station specific) treatments; identifying specific treatment outcomes and prognosis; appropriate selection (benefits / risks, application, adherence, monitoring of specific interventions); application of psychoeducation, choice and rationale for specific psychotherapies, social / occupational / family therapies; considering sensitively barriers to implementation.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Discuss at least one psychological treatment, one social treatment and one lifestyle treatment.

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.

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

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

1.15 Did the candidate adequately engage, inform and discuss the treatment plan with the patient including suitably incorporating the patient's treatment preferences? (Proportionate value - 40%)

Surpasses the Standard (scores 5) if:
clearly achieves the overall standard with presentation of a plan that is comprehensive and sophisticated; incorporates shared decision making and clearly highlighting or referencing the patient's goals for treatment, or discusses potential barriers to shared decision making in older patents.

Achieves the Standard by:
demonstrating the ability to clearly communicate indications for treatment, range of options, and recommendations; working within patient treatment goals, and negotiating targeted outcomes; informing in relation to treatment risks / benefits and complications, including potential adverse outcomes, not recommending other biological treatments (ECT, TMS) as first line treatment.

To achieve the standard ***(scores 3)*** the candidate **MUST:**
a. Recommend non-pharmacological management only.

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.

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**