The Royal Australian & New Zealand College of Psychiatrists

2012 Fellowship Program

EPA Handbook Stage 1 and 2

309 La Trobe Street, Melbourne VIC 3000 Australia
T +61 3 9640 0646 F +61 3 9642 5652
ranzcp@ranzcp.org www.ranzcp.org
ABN 68 000 439 047

Acknowledgements

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Document version history

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v0.21	Approved EPA added: ST2-FP-EPA3. Table 1 updated.	08/11/18
v0.20	Approved EPAs added: ST2-RES-EPA1, ST2-RES-EPA2, ST2-RES-EPA3 and ST2-RES-EPA4. Table 1 updated. References updated: ST1-GEN-EPA5, ST1-GEN-EPA6, ST2-EXP-EPA2 and ST2-EXP-EPA3.	05/10/18
v0.19	References updated: ST1-GEN-EPA5, ST2-EXP-EPA3, ST2-PSY-EPA4, ST2-AP-EPA2, ST2-AP-EPA3, ST2-AP-EPA4, ST2-AP-EPA5 and ST2-AP-EPA6	01/11/17
v0.18	Updated short title for ST2-INDAU-EPA1 and ST2-INDAU-EPA2	05/07/17
v0.17	References updated: ST2-EXP-EPA1, ST2-EXP-EPA2, ST2-EXP-EPA3.	02/05/17
v0.16	Amendments made to introduce new WBA (DOPS) tool.	02/12/16
v0.15	Amendments made to ST2-EXP-EPA2	26/09/16
v0.14b	Reference updated: ST1-GEN-EPA5.	30/08/16
v0.14a	Minor amendment to update duplicated EPA names.	11/02/16
v0.14	Obsolete EPAs archived to appendix: ST1-GEN-EPA2, ST1-GEN-EPA4, ST2-EXP-EPA4 and ST2-PSY-EPA1. Implementation plan added to appendix and table 1 updated.	22/12/15
v0.13	Approved EPAs added: ST2-AP-EPA9; ST2-AP-EPA10; ST2-AP-EPA11; ST2-AP-EPA12. Amendments made to EPA: ST2-PSY-EPA4. Preamble and table 1 updated.	09/11/15
v0.12	Approved EPAs added: ST2-AP-EPA3; ST2-AP-EPA4, ST2-EPA5; ST2-AP-EPA6; ST2-AP-EPA7; ST2-AP-EPA8.Table 1 updated.	31/07/15
v0.11	Obsolete EPAs archived to appendix: ST1-GEN-EPA1; ST1-GEN-EPA3. Table 1 updated.	18/05/15
v0.10	Amendments made to EPAs: ST2-INDAU-EPA1; ST2-INDAU-EPA2.	20/11/14
v0.9	Approved EPAs added: ST1-GEN-EPA5; ST1-GEN-EPA6. Preamble and table 1 revised to reflect EPA changes.	30/05/14
v0.8	Amendments made to EPAs: ST2-INDNZ-EPA1; ST2-INDNZ-EPA2.	08/01/14
v0.7	Approved EPAs added: ST2-INDNZ-EPA1; ST2-INDNZ-EPA2.	19/12/13
v0.6	Preamble revised to include text on rural settings.	13/12/13
v0.5	Keyword title changed: ST2-EXP-EPA5.	12/11/13
v0.4	Approved EPA added: ST2-PSY-EPA4.	21/01/13
v0.3	Approved EPAs added: ST2-EXP-EPA5; ST2-CAP-EPA1; ST2-CAP-EPA2; ST2-PSY-EPA1; ST2-PSY-EPA2; ST2-PSY-EPA3; ST2-AP-EPA1; ST2-INDAU-EPA2. Amendments made to EPAs: ST2-ADD-EPA1; ST2-ADD-EPA2; ST2-POA-EPA1; ST2-INDAU-EPA1.	21/11/12
v0.2	Approved EPAs added: ST1-GEN-EPA1, ST2-EXP-EPA2, ST2-ADD-EPA1, ST2-POA-EPA1, ST2-AP-EPA2, ST2-INDAU-EPA1. Amendments made to EPAs: ST1-GEN-EPA2, ST1-GEN-EPA3, ST1-GEN-EPA4.	02/08/12
v0.1	First version of EPA Handbook published on website.	21/05/12

Table of contents

Preamble

In 2012, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) introduced competency-based training. Entrustable Professional Activities (EPAs) form a key component of the Fellowship program. EPAs were first described by Professor Olle ten Cate of the Netherlands as a way to help supervisors determine the competence of their trainees. In daily practice, 'supervisors consider whether or not to delegate professional activities to trainees'.[1] This informed decision, as to whether a trainee may be trusted to perform a specialised task with sufficient independence, can be considered a measure of the trainee's acquired competence.

EPAs in RANZCP training are specialised tasks that a trainee must demonstrate their ability to perform with only distant (reactive) supervision. EPAs are entrusted when a supervisor is confident the trainee can demonstrate the knowledge, skills and attitude required of the task, knows when to ask for additional help and can be trusted to seek assistance in a timely manner.

EPAs are summative assessments and it is necessary for trainees to be entrusted with particular EPAs as they progress through training. EPAs are not set to assess every professional activity that trainees engage in; rather they assess a representative sample of the professional activities in which trainees must attain competence. The EPAs prescribed for RANZCP training are:

- tasks of high importance for daily practice (core business)
- high-risk or error-prone tasks
- tasks that are exemplary of a number of CanMEDS roles.

Significant work has gone into the development of the EPAs including extensive peer review.

This handbook describes each Stage 1 and Stage 2 EPA and the requisite knowledge, skills and attitude that underpin competence in the task. The description of the knowledge, skills and attitude required is not intended to be exhaustive or prescriptive. It is to assist, not supplant, the expert judgement of supervisors.

Standard

EPAs are set and assessed at the standard expected by the end of the designated stage of training, ie. a Stage 1 EPA requires demonstration of the knowledge, skills and attitude expected of a trainee who has successfully completed 12 months of full-time training. The Developmental Descriptors document (available on the RANZCP website) can assist

supervisors to determine what standard can be expected at each stage of training for many aspects of practice.

Which EPAs and how many?

The following is a summary only. For the detailed EPA requirements for each stage of training, please refer to the EPA Policy and Procedure available on the Regulations, policies and procedures page of the RANZCP website.

Trainees must attain two EPAs in each 6-month full-time equivalent (FTE) rotation they undertake in the Fellowship Program.

Stage 1

In order to complete Stage 1, trainees must be entrusted with the following EPAs:

- Use of an antipsychotic medication in a patient with schizophrenia/psychosis.
- Providing psychoeducation to a patient and their family and/or carers about a major mental illness.

Trainees are also eligible to attain the Stage 2 general psychiatry and psychotherapy EPAs.

Stage 2

In order to complete Stage 2, trainees must be entrusted with the following general psychiatry EPAs.

- Demonstrating proficiency in all the expected tasks associated with prescription, administration and monitoring of ECT.
- The application and use of the Mental health Act.
- Assessment and management of risk of harm to self and others.
- Assess and manage adults with cultural and linguistic diversity.

These EPAs may be attained in any area of practice rotation during Stage 1 or Stage 2 according to opportunity. The general psychiatry EPAs will be assessed at a proficient standard, ie. that of a trainee who has successfully completed 36 months of full-time training, regardless of whether they are achieved during Stage 1 or Stage 2.

In addition, trainees must be entrusted with two EPAs for each 6-month FTE rotation they undertake (rotation-based EPAs). The EPAs are area of practice specific, thus trainees must attain:

- two child and adolescent psychiatry EPAs in their mandatory child and adolescent psychiatry rotation
- two consultation–liaison psychiatry EPAs in their mandatory consultation–liaison psychiatry rotation

- two EPAs associated with each of their elective 6-month FTE rotations, ie. if a trainee undertakes an adult psychiatry rotation, they must attain adult psychiatry EPAs during the course of that rotation.

By the end of Stage 2, trainees must also be entrusted with:

- two addiction psychiatry EPAs
- two psychiatry of old age EPAs.

Trainees who undertake elective rotations in addiction psychiatry and/or psychiatry of old age must attain the associated EPAs during the rotation(s); however, if a trainee completes elective rotations in other areas of practice, they must attain the two EPAs associated with those elective rotations and complete the addiction psychiatry and/or psychiatry of old age EPAs when opportunity arises (ie. in any area of practice rotation).

Psychotherapy EPAs

By the end of Stage 2, trainees must be entrusted with two (of three possible) psychotherapy EPAs:

- Psychodynamically informed patient encounters and managing the therapeutic alliance.
- Supportive psychotherapy.
- Cognitive–behavioural therapy (CBT) for management of anxiety.

Trainees must attain the remaining (third) psychotherapy EPA by the end of Stage 3. This EPA will be assessed at a proficient standard.

Trainees are eligible to attain the psychotherapy EPAs in Stage 1. These EPAs may be attained in any area of practice rotation according to opportunity.

See table 1 for a list of the EPAs in Stage 1 and Stage 2 of training.

Entrustment process

To entrust an EPA, the supervisor draws on all the available data regarding the trainee's competence in that task, including their performance in relevant Workplace-Based Assessments (WBAs) and information from other staff or sources.

The Fellowship Program uses five WBA tools:

- Case-based discussion (CbD)
- Direct Observation of Procedural Skills (DOPS)
- Mini-Clinical Evaluation Exercise
- Observed Clinical Activity (OCA)
- Professional presentation.

WBAs and EPAs

WBAs form part of the evidence base that informs a supervisor's judgement as to whether a trainee can be entrusted with a particular EPA. To ensure a broad evidence base, a minimum of three WBAs must be used to assess each EPA. That does not mean a trainee must complete three WBAs on the same activity as that of the EPA. Training environments are clinically diverse so the WBAs can be on any aspect of the task that is relevant to the trainee.

For example, an EPA that must be entrusted in a trainee's Stage 2 consultation–liaison psychiatry rotation is 'Care for a patient with delirium'. A trainee does not have to complete three WBAs solely using patients with delirium. While they may demonstrate the required skill 'Negotiates clinical role throughout the course of the delirium episode' (figure 1) in a CbD about a patient with delirium, they may demonstrate other skills, eg. 'Considers the patient's capacity to consent and any implications', with a WBA using another patient with a different clinical presentation.

If the trainee adequately considers capacity to consent and the supervisor judges the trainee's knowledge of delirium and its associated implications to be good, the supervisor can extrapolate that the trainee will be capable of considering issues of consent in a patient with delirium.

Figure 1 – Selected skills from ST2-CL-EPA1: Care for a patient with delirium

- Explains the nature of delirium to families and staff.
- Integrates information from the assessment into a comprehensive formulation, accurate diagnosis and differential diagnosis.
- Develops an appropriate management plan for the specific patient and setting.
- Considers the patient's capacity to consent and any implications.
- Uses effective and empathic verbal and non-verbal communication skills:
  - verbally communicated information is understandable, concise and accurate
  - information is documented in an understandable, concise and accurate manner.
- Negotiates an appropriate management plan with the treating team.
- Clarifies the referring agent's expectation of the consult.
- Negotiates clinical role throughout the course of the delirium episode.
- Appropriately prioritises allocation of their own time to the case.

Who can entrust an EPA?

In Stages 1 and 2, the entrusting supervisor does not need to have a Certificate of Advanced Training (where available) in the EPA's area of practice in order to assess the trainee's competence; however, the supervisor must be College-accredited and should be recognised as appropriately skilled and experienced in the area.

Rural settings

Rural settings provide valuable training opportunities, offering insight into the distinctive world of rural psychiatry. Rural psychiatrists often work with patients across all age ranges, treating a wider array of issues than psychiatrists in cities. The rural environment can affect the aetiology or manifestation of an illness and there are unique challenges in arranging access to appropriate mental healthcare and treatment.

The RANZCP supports and promotes rural training as part of a range of strategies that are aimed at enabling rural communities to access a full range of mental health services as near to their place of residence as possible.

Trainees can be encouraged to think about rural practice (regardless of their training location) in WBAs, eg. 'Would you do anything differently if this patient presented in a rural setting?'

Confirmation of Entrustment form

The *EPA Handbook* is intended as a detailed resource for supervisors and trainees to clarify what is required to entrust/be entrusted with an EPA and to promote a more uniform standard of entrustment. The handbook contains the full version of every EPA available in Stages 1 and 2 of the Fellowship Program. In addition, every EPA also has a Confirmation of Entrustment (COE) form which briefly describes the EPA and which must be signed by the supervisor assessing the EPA (and principal supervisor, if different), trainee and Director of Training to confirm EPA attainment. (An example of the COE form can be found on page 13.)

Each EPA attained will also be recorded on the trainee's In-Training Assessment (ITA) report and reflected on the trainees record.

Reference

[1] TEN CATE, O. Entrustability of professional activities and competency-based training. *Med Educ* 2005; 39: 1176–7.

Table 1 – EPAs in Stage 1 and Stage 2 of RANZCP Fellowship training

Area of practice	*EPA number*	*Title*
Stage 1 mandatory EPAs		
Adult psychiatry 12 months adult psychiatry training, 6 months in an acute setting.	ST1-GEN-EPA5	Use of an antipsychotic medication in a patient with schizophrenia/psychosis.
	ST1-GEN-EPA6	Providing psychoeducation to a patient and their family and/or carers about a major mental illness.
Stage 2 general psychiatry EPAs – may be entrusted during Stage 1, must be entrusted by the end of Stage 2		
General psychiatry Mandatory EPAs to be attained by the end of Stage 2. These general psychiatry EPAs may be attained in any area of practice rotation during Stage 1 or Stage 2 and will be assessed at a proficient (Stage 2) standard.	ST2-EXP-EPA1	Demonstrating proficiency in all the expected tasks associated with prescription, administration and monitoring of ECT.
	ST2-EXP-EPA2	The application and use of the Mental health act.
	ST2-EXP-EPA3	Assessment and management of risk of harm to self and others.
	ST2-EXP-EPA5	Assess and manage adults with cultural and linguistic diversity.
Psychotherapy EPAs – may be entrusted during Stage 1		
Trainees must attain two (of three) EPAs by the end of Stage 2: The remaining EPA must be attained by the end of Stage 3. These EPAs may be attained in any area of practice rotation and will be assessed at a proficient (Stage 2) standard.	ST2-PSY-EPA2	Psychodynamically informed patient encounters and managing the therapeutic alliance.
	ST2-PSY-EPA3	Supportive psychotherapy.
	ST2-PSY-EPA4	Cognitive–behavioural therapy (CBT) for management of anxiety.
Stage 2 mandatory EPAs		
Child and adolescent psychiatry Mandatory rotation, must complete associated EPAs.	ST2-CAP-EPA1	Develop a management plan for an adolescent where school attendance is at risk.
	ST2-CAP-EPA2	Clinical assessment of a prepubertal child.
Consultation–liaison psychiatry Mandatory rotation, must complete associated EPAs.	ST2-CL-EPA1	Care for a patient with delirium.
	ST2-CL-EPA2	Manage clinically significant psychological distress in the context of the patient's medical illness in the general hospital.

Area of practice	*EPA number*	*Title*
Stage 2 mandatory EPAs		
Addiction psychiatry (Elective rotation) Mandatory EPAs, may be attained in any rotation.	ST2-ADD-EPA1	Management of substance intoxication and substance withdrawal.
	ST2-ADD-EPA2	Comorbid mental health and substance use problems.
Psychiatry of old age (Elective rotation) Mandatory EPAs, may be attained in any rotation.	ST2-POA-EPA1	Behavioural and psychological symptoms in dementia (BPSD).
	ST2-POA-EPA2	The appropriate use of antidepressants and antipsychotics in patients aged 75 years and over (or under 75 with excessive frailty).
Adult psychiatry (elective rotation) if first Stage 2 adult psychiatry rotation, trainee must undertake two of the following adult psychiatry EPAs. If second Stage 2 adult psychiatry rotation, trainee may undertake any Stage 2 EPAs.		
General Adult psychiatry	ST2-AP-EPA1	Assess treatment-refractory psychiatric disorders.
	ST2-AP-EPA2	Physical comorbidity 2.
Adult Eating disorders psychiatry	ST2-AP-EPA3	Assess and manage a patient with anorexia nervosa presenting in a severely underweight state.
	ST2-AP-EPA4	Assess and manage an adult with bulimia nervosa.
Adult Perinatal psychiatry	ST2-AP-EPA5	Assess and manage a woman experiencing a major postpartum illness within 12 months of childbirth.
	ST2-AP-EPA6	Assess and manage a pregnant woman presenting with a psychiatric disorder.
Adult Neuropsychiatry	ST2-AP-EPA7	Assess and manage a mental illness occurring in an adult with an established diagnosis of epilepsy.
	ST2-AP-EPA8	Assess and manage psychological and behavioural symptoms in an adult under the age of 50 with an acquired brain injury.
Pacific peoples' mental health	ST2-AP-EPA9	Assessment of people of Pacific Island descent.
	ST2-AP-EPA10	Collaborative management of people of Pacific Island descent.
Early Psychosis Intervention	ST2-AP-EPA11	Differential diagnosis in people presenting for the first time with psychosis.
	ST2-AP-EPA12	Engagement with people with first episode psychosis and with their families.

Area of practice	*EPA number*	*Title*
Other elective rotations – if undertaken, must entrust associated EPAs relevant to the Area of Practice		
Forensic psychiatry (Elective rotation)	ST2-FP-EPA1	Violence risk assessment and management 2.
	ST2-FP-EPA2	Expert evidence 2.
	ST2-FP-EPA3	Understanding and managing psychological issues in forensic patients and carers.
Indigenous mental health – Australia (Elective rotation)	ST2-INDAU-EPA1	Interviewing an Aboriginal or Torres Strait Islander patient.
	ST2-INDAU-EPA2	Develop a mental healthcare management plan for an Aboriginal or Torres Strait Islander patient.
Indigenous mental health – New Zealand (Elective rotation)	ST2-INDNZ-EPA1	Interviewing a Māori patient.
	ST2-INDNZ-EPA2	Develop a mental healthcare management and recovery plan for a Māori patient.
Research (Elective rotation)	ST2-RES-EPA1	Planning and initiating a research project 2.
	ST2-RES-EPA2	Planning, conducting and reporting a review of scientific literature 2.
	ST2-RES-EPA3	Skills in research methodology and data collection 2.
	ST2-RES-EPA4	Skills in data analysis and synthesis 2.

For the detailed **Stage 1 Mandatory requirements**, please see the Education Training Regulation Stage 1 Mandatory requirements Policy page of the RANZCP website.

For the detailed **Stage 2 Mandatory requirements**, please see the Education Training Regulation Stage 2 Mandatory requirements Policy of the RANZCP website.

For the detailed **Stage 2 Elective Rotations**, please see the Education Training Regulation Stage 2 Elective Rotations page of the RANZCP website.

The Royal Australian & New Zealand College of Psychiatrists

CONFIRMATION OF ENTRUSTMENT FORM

RANZCP ID:	
Surname:	
First name:	
Zone:	
Hospital/service:	

This document satisfies RANZCP training requirements only as outlined in the RANZCP Fellowship Regulations 2012 and is not intended for any other purpose. Any queries regarding its purpose and/or use should be directed to the Education department at the College: training@ranzcp.org

Example COE form			
Area of practice	C–L psychiatry	***EPA identification***	ST2-CL-EPA1
Stage of training	Stage 2 – Proficient	***Version***	v0.4 (BOE-approved 04/05/12)
Title	***Care for a patient with delirium.***		
Description	The trainee can assess, make an accurate diagnosis, conduct appropriate physical and cognitive assessment and describe the evidence for the use of a specific management strategy. They are able to communicate the concept of delirium to patients and families within the general hospital setting. The trainee demonstrates awareness of challenges posed by a consultative model of care provision where a patient is not under the direct care of the psychiatrist.		

Please refer to the EPA handbook's preamble for a more detailed description of the EPA assessment process. The corresponding EPA contains the knowledge, skills and attitude that must be demonstrated by the trainee in order to be entrusted with this activity.

ENTRUSTING SUPERVISOR DECLARATION
In my opinion, this trainee can be trusted to perform the activity described with only distant (reactive) supervision. I am confident the trainee knows when to ask for additional help and will seek assistance in a timely manner. The trainee has completed three related WBAs in preparation for this activity.

Supervisor Name (print) ……

Supervisor RANZCP ID: …….. Signature ……..... Date …….....

PRINCIPAL SUPERVISOR DECLARATION *(if different from above)*
I have checked the details provided by the entrusting supervisor and verify they are correct.

Supervisor Name (print) ……

Supervisor RANZCP ID: …….. Signature ……..... Date …….....

TRAINEE DECLARATION
I have completed three related WBAs in preparation for this activity. I acknowledge that this is a RANZCP training document only and cannot be used for any other purpose.

Trainee name (print) ……..... Signature …….... Date .....

DIRECTOR OF TRAINING DECLARATION
I verify that this document has been signed by a RANZCP-accredited supervisor.

Director of Training Name (print) ……

Director of Training RANZCP ID: …….. Signature …… Date …….....

Stage 1 EPAs – mandatory

Adult psychiatry

ST1-GEN-EPA5 – Antipsychotic use

Area of practice	Adult psychiatry	***EPA identification***	ST1-GEN-EPA5
Stage of training	Stage 1 – Basic	***Version***	v0.3 (EC-approved 14/03/14)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Use of an antipsychotic medication in a patient with schizophrenia/psychosis.***			
Description Maximum 150 words	The trainee understands the role and use of antipsychotics, including clozapine, their risks, benefits and alternatives. They are aware of the common and potentially serious side effects, their detection and appropriate management. The trainee adheres to the protocols, documentary and administrative obligations and other aspects of safe initiation, monitoring and treatment. The trainee can engage where possible with the patient, obtaining consent as far as possible, can listen and respond to the patient's concerns and provide explanations in a clear manner. They are aware of the factors that may contribute to non-adherence and those that may improve treatment adherence. They have a respectful and professional attitude towards the patient and other members of the multidisciplinary team.			
Fellowship competencies	**ME**	1, 2, 3, 4, 5	**HA**	
	COM	1, 2	**SCH**	
	COL	1, 2, 3	**PROF**	1, 2
	MAN			
Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Positive and negative symptoms and cognitive deficits in schizophrenia, the current dominant hypotheses for schizophrenia and their mechanisms. • The antipsychotic effect and other effects of these drugs on thinking and behaviour.			

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Education Committee approved 14/03/14; WBA tool (OCA) added 01/12/16; references updated 05/10/18

	• The common time period for the onset of the full antipsychotic effect and issues surrounding polypharmacy. • Pharmacology of antipsychotics and drug interactions. • Knowledge of protocols, safe monitoring and side effects (eg. EPSE and metabolic syndrome), including life-threatening side effects (eg. myocarditis, agranulocytosis). Knows how to respond to problems and will appropriately seek assistance. • Factors other than non-adherence that can initiate or maintain a relapse, eg. high expressed emotion, illicit drugs, drug interactions (eg. smoking with clozapine and olanzapine). • Understands options for mode of delivery of antipsychotic treatment, eg. oral/injectable (depot). • The concept of a biopsychosocial approach to treatment. • Issues of informed consent in the chronically mentally ill, ethical issues. **Skills** • Physical and mental state assessment. • Adapts approach to fit the patient's personal and cultural background, mental state and diagnosis. • Establishes rapport, involves patient and where appropriate support network in decision making, risk–benefit analysis and incorporates patient aims in the treatment plan. • Applies the biopsychosocial model in formulation and management including patients with treatment resistance. • Assesses and manages side effects. • Able to give explanations in a way that is understandable and meaningful. • Clear and respectful communication with other staff, both written and verbal. Clear, legible documentation. • Manages discontinuation and recommencement. • Able to manage acute and longer-term treatment. • Applies the principles of rehabilitation psychiatry. **Attitude** • Professional approach to patient and others including respect for the views of the patient and others. • Willingness to learn from others involved in the patient's care.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	One WBA could focus on clozapine. • Case-based discussion. • Mini-Clinical Evaluation Exercise.

	• Observed Clinical Activity (OCA).

References

GALLETLY C, CASTLE D, DARK F et al. *Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders*. *Aust NZ J Psychiatry* 2016; 50: 410–72.

THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS VICTORIAN BRANCH. *Position paper: Enabling supported decision-making*. Melbourne: RANZCP, May 2018. Viewed 5 October 2018, <www.ranzcp.org/Files/Branches/Victoria/Enabling-supported-decision-making-Vic-Branch-Posi.aspx>.

COL, Collaborator; COM, Communicator; HA, Health Advocate; MAN, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

ST1-GEN-EPA6 – Providing psychoeducation

<table>
<tr><td>Area of practice</td><td colspan="2">Adult psychiatry</td><td>EPA identification</td><td>ST1-GEN-EPA6</td></tr>
<tr><td>Stage of training</td><td colspan="2">Stage 1 – Basic</td><td>Version</td><td>v0.2 (EC-approved 14/03/14)</td></tr>
<tr><td colspan="5">The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.</td></tr>
<tr><td>Title</td><td colspan="4">Providing psychoeducation to a patient and their family and/or carers about a major mental illness.</td></tr>
<tr><td>Description
Maximum 150 words</td><td colspan="4">The trainee can provide evidence-based, understandable and relevant information on the nature of a condition, its treatment(s), rehabilitation and recovery that addresses the needs of the patient and their family and/or carers. They are able to establish rapport, listen to and deal empathically with concerns and misconceptions. The trainee can be tactful, sensitive to the possible impact of what they say, and understand the impact of stress or illness on the ability to take in information. They are aware of the phases of grief and coping strategies. The trainee is able to handle the ethical and legal issues around consent, patient autonomy and confidentiality and they have a respectful and professional approach to the patient and their family/carers.</td></tr>
<tr><td rowspan="4">Fellowship competencies</td><td>ME</td><td>1, 3, 5</td><td>HA</td><td>1</td></tr>
<tr><td>COM</td><td>1, 2</td><td>SCH</td><td>2</td></tr>
<tr><td>COL</td><td>1, 2</td><td>PROF</td><td>1, 2</td></tr>
<tr><td>MAN</td><td></td><td colspan="2"></td></tr>
<tr><td>Knowledge, skills and attitude required
The following lists are neither exhaustive nor prescriptive.</td><td colspan="4">Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.
Ability to apply an adequate knowledge base
• The principles and aims of psychoeducation.
• Diagnosis, treatment and course of major mental illness, including individual variability and uncertainty.
• Coping strategies, phases of grief and adjustment.
• The benefit of information in improving compliance and engagement, coping, empowering patients, supporting patients and carers, normalising where appropriate and reducing stigma.
• Principles of recovery-oriented practice.
• Local resources for the patient and family/carers.</td></tr>
</table>

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Education Committee approved 14/03/14; WBA tool (DOPS) added 01/12/16; references updated 05/10/18

	Skills • Tailors information to the needs and capacity of the patient and family/carers. • Ability to deal with individuals under stress. • Bolsters coping strategies that reduce the risk of relapse and recurrence. • Documents important information clearly with tact and respect. • Appropriately negotiates relevant ethical and legal issues including patient autonomy, consent, privacy and confidentiality. • Ability to balance the needs of family and carers. • Willingness to advise caregivers of where they may seek further support or help if required, tactful awareness of boundary issues involved. • Wherever possible, instils hope and a sense of being supported. **Attitude** • Respectful and non-judgemental; empowering patients, their families or caregivers. • Supports shared decision-making, respecting the patient's own lived experience and choice. • Committed to reducing stigma.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion. • Direct Observation of Procedural Skills (DOPS).

References

BÄUML J, FROBÖSE T, KRAEMER S et al. Psychoeducation: a basic psychotherapeutic intervention for patients with schizophrenia and their families. *Schizophr Bull* 2006; 32 (Suppl. 1): S1–9.

COLOM F. Keeping therapies simple: psychoeducation in the prevention of relapse in affective disorders. *Br J Psychiatry* 2011; 198: 338–40.

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COL, Collaborator; COM, Communicator; HA, Health Advocate; MAN, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

Stage 2 EPAs – mandatory

General psychiatry

ST2-EXP-EPA1 – Electroconvulsive therapy (ECT)

Area of practice	General psychiatry	***EPA identification***	ST2-EXP-EPA1
Stage of training	Stage 2 – Proficient	***Version***	v0.10 (BOE-approved 04/05/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Demonstrating proficiency in all the expected tasks associated with prescription, administration and monitoring of ECT.***			
Description Maximum 150 words	The trainee is proficient in the modern use of ECT including appropriate: selection and work-up of patients, explanation to the patient and family (or carer where appropriate) and liaison with ward, ECT, theatre and anaesthetic staff. The trainee complies with administrative, legal and documentary requirements. They demonstrate correct administration including electrode placement, seizure monitoring and titration and can manage the course, side effects and complications.			
Fellowship competencies	**ME**	1, 2, 3, 4, 6	**HA**	1
	COM	1, 2	**SCH**	1, 2
	COL	1, 2, 3, 4	**PROF**	1, 2
	MAN	2, 4, 5		
Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Relevant RANZCP guidelines. • Local protocols, procedures, relevant documentation. • Relevant legal aspects including relevant sections of the local Mental Health Act. • Pre-ECT physical, cognitive and psychiatric evaluation. • Indications, situations of higher risk and contraindications. • How to approach special precautions/higher risk (eg. pacemakers, warfarin, intracranial lesions).			

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	• Issues of concurrent medications. • Adverse events, physiological changes during ECT, memory changes. • Role of anaesthetist, all aspects of anaesthesia pertinent to the psychiatrist. • Physical monitoring (examples may include muscle relaxation, pre-Deep Tendon Knee Reflex [DTKR], fasciculation). • Equipment. • Knowledge of dosing protocols, titration procedures and procedures for different electrode placements. • Markers of seizure adequacy. • How stigma and history can impact on the acceptance of ECT for the patient and others. **Skills** *General* • Interactions with patients, carers, staff/liaison with anaesthetic staff. • Ability to obtain informed consent/sufficient information from patient/carer if involuntary treatment and where feasible. • Communication with other staff involved with the patient, clear documentation. *Technical* • ECT technique. • Familiar with the use of equipment, airways, mouth guards, ECT machine. • Determining dose/charge. • Thorough knowledge of EEG monitoring. • Cuff monitoring or similar if or as required. • Set dose/charge. • Skin preparation, testing impedance. • Lead placement (examples may include EEG and ECG, treatment leads). **Attitude** • Ethical and professional approach to patient, carers and other staff.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details *(these include, but are not limited to, WBAs)*	• Case-based discussion. • Mini-Clinical Evaluation Exercise. • Direct Observation of Procedural Skills (DOPS).

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	• Feedback from appropriate sources. • Supervision during ECT sessions. Confidence the trainee has received sufficient training in ECT.

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TILLER J & LYNDON R, eds. *Electroconvulsive therapy: an Australasian guide*. Melbourne: Australian Postgraduate Medicine, 2003.

COL, Collaborator; COM, Communicator; HA, Health Advocate; MAN, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

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ST2-EXP-EPA2 – Mental health Act

Area of practice	General psychiatry	***EPA identification***	ST2-EXP-EPA2
Stage of training	Stage 2 – Proficient	***Version***	v0.12 (EC-approved 02/09/16)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***The application and use of the mental health Act.***
Description Maximum 150 words	The trainee can apply the provisions of the relevant mental health Act to provide care on an involuntary basis. The trainee provides explanations to patients and their carers, engages them where possible and deals with their concerns. They comply with documentary and administrative obligations. The trainee is aware of the factors which justify involuntary care under the local mental health Act, including the principle that involuntary care must contribute to treatment of mental illness and consequent improvements in autonomy. The trainee seeks to optimise the autonomy of patients receiving involuntary care and promotes pathways to less restrictive care.

Fellowship competencies	**ME**	1, 2, 3, 4, 5, 8	**HA**	1, 2
	COM	1, 2	**SCH**	2
	COL	1, 2, 3, 4	**PROF**	1, 2, 3
	MAN	2, 5		

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.

Ability to apply an adequate knowledge base

- History of mental health legislation in the relevant jurisdiction.
- Psychiatry as an agent of society.
- The involuntary treatment provisions of the relevant mental health Act, its objects, principles and required procedures.
- Ethical principles of autonomy, freedom from coercion and duty of care to the patient and the community.
- Common psychiatric conditions and their treatment.
- Awareness of legal and societal consequences of enforced treatment including consideration of stigma.

Skills

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Board of Education approved 12/07/12 (v0.9); amended and Education Committee approved 02/09/16 (references updated 05/10/18)

	• Determination of whether or not the patient suffers a mental illness or mental disorder as variously defined in the relevant legislation. • Assessment of a variety of harms (differing from jurisdiction to jurisdiction) that involuntary treatment may protect a patient or others from. These include harms such as the experience of the symptoms of mental illness, physical harm, dangers to health or safety, diminished ability to care for self and harms associated with the patient's possible deterioration. • Risk assessment (with risk of harm to self considering self-harm, neglect, exploitation, damage to relationships and reputation; risk of harm to others considering the patient's context and the presence of children) including risk–benefit analysis of enforcing treatment. • Assessment of harms that might be associated with enforcing involuntary treatment, including stigma, loss of rapport and nosocomial suicide. • Assessment of decision-making capacity, as defined in the common law or relevant mental health Act, with respect to the decision to refuse the treatment proposed. • Ability to provide support to a patient who would otherwise lack decision-making capacity. • Ability to identify the mode of safe and effective care that will provide the least restriction on the patient's freedom and human rights. • Ability to identify the mode of treatment that best reflects the person's will and preferences via note of the person's expressed preferences, either currently or in an advance directive, and information gathered from family and friends. • Conflict resolution and ability to negotiate and compromise. • Communication and collaboration with the patient, family and others as necessary, eg. police, emergency services. • Ability to prepare reports and appear before relevant bodies as required by the legislation. **Attitude** • Commitment to providing treatment in the least restrictive setting. • An appropriate regard for the hazards associated with involuntary care and the harms associated with coercive care. • Professional approach to patient and others.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion. • Mini–Clinical Evaluation Exercise. • Professional presentation. • Observed Clinical Activity (OCA).
References	

Relevant to all Australasian jurisdictions

CALLAGHAN S & RYAN CJ. An evolving revolution: evaluating Australia's compliance with the Convention on the Rights of Persons with Disabilities in mental health law. *UNSW Law Journal* 2016; 39: 596–624.

RYAN CJ, CALLAGHAN S & LARGE M. The importance of least restrictive care: the clinical implications of a recent High Court decision on negligence. *Austras Psychiatry* 2015; 23: 415–7.

RYAN C, CALLAGHAN S & PEISAH C. The capacity to refuse psychiatric treatment: a guide to the law for clinicians and tribunal members. *Aust NZ J Psychiatry* 2015; 49: 324–33.

THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS. *Code of Ethics*. Melbourne: RANZCP, 2009.

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Relevant to the Australian Capital Territory

Mental Health Act 2015 (ACT) [especially ss 5–10, 15–17, 19–32, 52, 54, 56, 62, 99].

AUSTRALIAN CAPITAL TERRITORY HEALTH. *The plain language guide for the Mental Health Act 2015 (Australian Capital Territory), February 2016*. Canberra: ACT Health, February 2016. Viewed 16 August 2016, <health.act.gov.au/sites/default/files//Plain%20Language%20Guide_MH%20ACT.pdf>.

Relevant to New South Wales

Mental Health Act 2007 (NSW) [especially ss 3, 12, 14, 15, 68, 70–72].

RYAN CJ & CALLAGHAN S. The impact on clinical practice of the 2015 reforms to the NSW Mental Health Act. *Austras Psychiatry 2017;* 25: 43–7.

NSW MENTAL HEALTH REVIEW TRIBUNAL AND NSW MENTAL HEALTH COMMISSION. *What to expect at a hearing of the Mental Health Review Tribunal: a guide for clinicians.* Gladesville: NSW Mental Health Review Tribunal and NSW Mental Health Commission, 2016. [Video available at: www.mhrt.nsw.gov.au/the-tribunal/dvds.html]

Relevant to New Zealand

Mental Health (Compulsory Assessment and Treatment) Act 1992 (NZ) [especially ss 2 (definition of mental disorder), 5, 7A, 27].

DAWSON J & GLEDHILL K (eds). *New Zealand's Mental Health Act in Practice*. Wellington: Victoria University Press, 2013.

Relevant to the Northern Territory

Mental Health and Related Services Act 1998 (NT) [especially ss 3, 6, 6A, 7, 7A, 9-13, 14-16].

DEPARTMENT OF HEALTH AND FAMILIES. *General hospital clinicians mental health and related services guide*. Darwin: Department of Health and Families, 2009.

Relevant to Queensland

Mental Health Act 2016 (Qld) [especially ss 3, 5, 10–14, 18, 25, 48, 53, 205, 222].

QUEENSLAND HEALTH. *A guide to the Mental Health Act 2016*. Brisbane: Queensland Government, 2016. Viewed 16 August 2016, <www.health.qld.gov.au/publications/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act/implementation/guide-to-mha.pdf>.

Relevant to South Australia

Mental Health Act 2009 (SA) [especially ss 6, 7, 21].

Relevant to Tasmania

Mental Health Act 2013 (Tas) [especially ss 3 (definition of 'representative'), 4, 7, 8, 12, 15, 40, 135, sch 1].

TASMANIAN DEPARTMENT OF HEALTH AND HUMAN SERVICES. *Tasmania's Mental Health Act 2013: A guide for clinicians*. Hobart: Tasmanian Government, 2014. Viewed 16 August 2016, <www.dhhs.tas.gov.au/__data/assets/pdf_file/0017/152315/CliniciansGuide_CombinedAllChapters.pdf>.

Relevant to Victoria

Mental Health Act 2014 (Vic) [especially ss 4, 5, 10, 11, 19, 23–24, 48, 55, 64, 69-71, 75, 76].

VICTORIAN GOVERNMENT. *Mental Health Act 2014 handbook*. Melbourne: Victorian Government, 2015. Viewed 16 August 2016, <www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook>.

Relevant to Western Australia

Mental Health Act 2014 (WA) [especially ss 6–11, 13, 17, 18, 20, 25, 179, 263–279, sch 1].

GOVERNMENT OF WESTERN AUSTRALIA. Clinicians' Practice Guide to the Mental Health Act 2014. Perth: Mental Health Commission of Western Australia, 2015. Viewed 28 April 2017, <www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2015/11/CPG_Edition-3_25112015.pdf>.

COL, Collaborator; COM, Communicator; HA, Health Advocate; MAN, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

ST2-EXP-EPA3 – Risk assessment

Area of practice	General psychiatry	***EPA identification***	ST2-EXP-EPA3
Stage of training	Stage 2 – Proficient	***Version***	v0.6 (BOE-approved 04/05/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Assessment and management of risk of harm to self and others.***			
Description Maximum 150 words	The trainee can undertake a systematic assessment of the risk of harm to self and others posed by a patient. They can formulate and communicate an appropriate management plan that addresses such risks.			
Fellowship competencies	**ME**	1, 2, 3, 4, 5, 7, 8	**HA**	2
	COM	1, 2	**SCH**	
	COL	4	**PROF**	1, 2, 3
	MAN	4		
Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Knowledge of evidence-based static and dynamic risk and protective factors for both 'harm to self' (including suicide) and 'harm to others'. • Knowledge of appropriate biopsychosocial interventions to enhance protective, and minimise risk, factors. • Awareness of the strengths and limitations of different approaches to assessing risk including: unstructured clinical, actuarial and structured professional judgment approaches. • Relevant statistical concepts including: sensitivity, specificity, positive predictive value, negative predictive value, 'numbers needed to treat' applied to risk reduction, base rates and ROC Analysis. • Key legal constructs including standard of care, duty of care. • High-risk periods for suicide and for harm to others (eg. soon after discharge, early in course of ECT). • Basic principles of ethical and legal obligations. **Skills**			

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	• Formulate an assessment of risk of harm to self and others, including a consideration of evidence-based risk and protective factors (both static and dynamic) and an estimate of likelihood, severity and imminence of harm. • Formulate a risk-management plan arising from risk assessment with the multidisciplinary team, with due consideration of clinical, legal and contextual interventions. • Engage patients and carers, be aware of central role of therapeutic relationships, in risk management. • Communicate and collaboratively implement a risk-management plan with the multidisciplinary team. • Work in collaborative and respectful fashion with the multidisciplinary team. • Ability to weigh up pros and cons of particular interventions and show high quality decision-making processes, including use of risk–benefit analyses. **Attitude** • A diligent attitude to obtaining sufficient information from available sources, including carers. • A diligent attitude to communicating information where appropriate to carers and health workers involved. • Appropriate attitude to balancing competing priorities, eg. civil liberties, confidentiality, therapeutic rapport, when managing risk. • Commitment to adopting an evidence-based approach. • Awareness of own limitations and willingness to seek other's opinion when required. • Awareness that risk in general can only be reduced, not eliminated, and that there is a necessary role for 'therapeutic risk taking' in psychiatric practice. • Appropriate level of diligence in documentation of assessment, decisions and reasoning. • Adherence to framework that conceives risk assessment as managing identified risk by meeting relevant clinical needs, not simply providing a predictive categorical label.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion. • Mini-Clinical Evaluation Exercise. • Direct Observation of Procedural Skills (DOPS). • Observed Clinical Activity (OCA).

References

THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS. *Risk Basics*. Melbourne: RANZCP, October 2016. Viewed 2 May 2017 <learnit.ranzcp.org/User/Course/Search?query=riskbasics> [member login required].

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Carter, G., Page, A., Large, M., Hetrick, S., Milner, A., Bendit, N., Walton, C., Draper, B., Hazell, P., Fortune, S., Burns, J., Patton, G., Lawrence, M., Dadd, L., Robinson, J. & Christensen, H. (2016). Clinical practice guideline for the management of deliberate self-harm. *Australian and New Zealand Journal of Psychiatry*, 50 (10): 939-1000

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COL, Collaborator; COM, Communicator; HA, Health Advocate; MAN, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

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ST2-EXP-EPA5 – Cultural awareness

Area of practice	General psychiatry	***EPA identification***	ST2-EXP-EPA5
Stage of training	Stage 2 – Proficient	***Version***	v0.7 (BOE-approved 15/10/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Assess and manage adults with cultural and linguistic diversity.***
Description Maximum 150 words	The trainee can appropriately assess and manage patients from culturally and linguistically diverse (CALD) backgrounds, including demonstrating respect for cultural issues in the conduct of the interview. The trainee can engage families, carers and others as appropriate in assessment and management. They are able to work properly and effectively with interpreters and/or cultural advisors/member of the person's cultural group including family. The trainee can develop a cultural formulation and integrate understanding of culture into the psychiatric formulation and diagnosis. They implement a culturally sensitive management plan that demonstrates understanding of the specific cultural needs of the patient. The trainee can reflect upon their own cultural and linguistic background and reach an understanding of its contribution to their engagement with, and understanding of, CALD patients and their families.

Fellowship competencies				
	ME	1, 2, 3, 4, 5, 6	**HA**	
	COM	1	**SCH**	
	COL	1, 2, 3	**PROF**	1, 2
	MAN			

Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Understands the principles of cultural responsiveness. • Understands the impact of culture on verbal and non-verbal communication. • Aware of the barriers and facilitators to the use of interpreters. • Understands the domains of a cultural formulation including an understanding of: - the impact of cultural beliefs on identity - explanatory models of illness

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	- cultural factors related to psychosocial environment and the impact of cultural factors and expectations on functioning - the relationship between the clinician and the patient. • Understands the distinction between culturally sanctioned beliefs and psychopathology. • Understands the impact of cultural values on recovery-oriented mental healthcare including biological interventions and psychosocial rehabilitation. **Skills** • Able to effectively utilise interpreters in psychiatric interviews. • Adapts approach to psychiatric interview and intervention in a culturally sensitive manner. • Interacts with patients and their families and carers in a manner that is respectful of their cultural values. • Acknowledges the impact of bilateral cultural factors in the interaction between the patient and clinician. • Able to incorporate identified cultural beliefs, values and formulation into management. **Attitude** • Motivated to remain culturally sensitive in approach and interaction with patients, families and carers. • Willingness to be respectful of cultural diversity. • Willingness to learn from cultural advisors and patients from CALD backgrounds about their worldview and health beliefs.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details *(these include, but are not limited to, WBAs)*	• Case-based discussion. • Observed clinical activity (OCA) – where a cultural advisor or language interpreter is present. • Review of a brief written cultural formulation. • Direct Observation of Procedural Skills (DOPS).

References

MEZZICH J, CARACCI G, FABREGA H & KIRMAYER L. Cultural formulation guidelines. *Transcult psychiatry* 2009; 46: 383–405.

KLEINMAN A, EISENBERG L & GOOD B. Clinical lessons from anthropologic and cross-cultural research. *Ann Intern Med* 1978; 88: 251–8.

COL, Collaborator; COM, Communicator; HA, Health Advocate; MAN, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

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Psychotherapy

ST2-PSY-EPA2 – Therapeutic alliance

Area of practice	Psychotherapy	***EPA identification***	ST2-PSY-EPA2
Stage of training	Stage 2 – Proficient	***Version***	v0.4 (BOE-approved 08/11/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Psychodynamically informed patient encounters and managing the therapeutic alliance.***
Description Maximum 150 words	The trainee can create and manage a therapeutic alliance with patients including those who are challenging or resistant. The trainee will be able to recognise points of conflict and disjunction and take steps to repair these. These steps will be informed by a familiarity with the evidence base in managing the therapeutic alliance.

Fellowship competencies				
	ME	5	**HA**	
	COM	1	**SCH**	1,
	COL	1, 2	**PROF**	1, 2, 3
	MAN			

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.

Ability to apply an adequate knowledge base

- Positive correlates of therapeutic alliance quality, for example:
  - client characteristics such as psychological mindedness, expectation for change and attachment quality
  - therapist characteristics and behaviours such as warmth, flexibility, honest, respectful, trustworthy, confident, interested and higher maternal care (good attachment).
- Negative correlates of therapeutic alliance quality, for example:
  - client characteristics such as avoidance, interpersonal difficulties, depressive thoughts
  - therapist characteristics such as rigidity, highly critical attitudes, being distant, disconnected and indifferent.
- Basic understanding of defence mechanisms including those used by distressed patients.
- The impact of transference and countertransference on the clinical encounter.

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	Skills • Exploration. • Reflection. • Noting past success. • Accurate interpretation. • Facilitating the expression of affect. • Attending to the patient's experience. • The ability to engage patients under challenging circumstances. • The ability to work towards shared treatment goals using empathy and rapport. **Attitude** • Situational sensitivity – a permanent alertness/responsiveness for the feedback regarding the therapeutic alliance and progress and/or obstacles. • Therapeutic flexibility – openness to adapt the therapeutic approach following the feedback of the patient. • Alertness for therapeutic obstacles and risk for drop-out. • Open and questioning attitude towards their own (the trainee's) blind spots.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion of three patients: - a patient seen in an emergency situation - a patient who is described as 'difficult' in an inpatient setting - a patient managed in the community by the trainee for at least 4 weeks. • Direct Observation of Procedural Skills (DOPS).

References

ACKERMAN SJ & HILSENROTH MJ. A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clin Psychol Rev* 2003; 23: 1–33.

DUNCAN B & MILLER S. *The outcome and session rating scales: the revised administration and scoring manual, including the child outcome rating scale*. Chicago: Institute for the study of therapeutic change, 2008.

HERSOUG AG, HØGLEND P, HAVIK O et al. Therapist characteristics influencing the quality of alliance in long-term psychotherapy. *Clin Psychol Psychother* 2009; 16: 100–10.

OKIISHI J, LAMBERT MJ, NIELSEN SL & OGLES BM. Waiting for supershrink: an empirical analysis of therapist effects. *Clin Psychol Psychother* 2003; 10: 361–73.

COL, Collaborator; COM, Communicator; HA, Health Advocate; MAN, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

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ST2-PSY-EPA3 – Supportive psychotherapy

<table>
<tr><td>Area of practice</td><td colspan="2">Psychotherapy</td><td>EPA identification</td><td>ST2-PSY-EPA3</td></tr>
<tr><td>Stage of training</td><td colspan="2">Stage 2 – Proficient</td><td>Version</td><td>v0.3 (BOE-approved 08/11/12)</td></tr>
<tr><td colspan="5">The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.</td></tr>
<tr><td>Title</td><td colspan="4">Supportive psychotherapy.</td></tr>
<tr><td>Description
Maximum 150 words</td><td colspan="4">The trainee is able to see a patient in a dyadic treatment and use direct measures to ameliorate symptoms and maintain, restore or improve self-esteem, ego functions and adaptive skills. They can develop and implement a psychotherapeutic treatment plan within a comprehensive treatment plan, when required. This includes determining which form of therapy would be suitable for the patient’s needs and awareness of the resources available. The trainee is able to adapt their treatment to the needs of the patient and, where appropriate, incorporate other techniques (eg. techniques borrowed or modified from cognitive–behavioural therapy [CBT], analytic approaches or others) within the underlying supportive approach. The trainee understands the term therapeutic alliance and how to bolster this.</td></tr>
<tr><td rowspan="4">Fellowship competencies</td><td>ME</td><td>1, 3, 4, 5</td><td>HA</td><td></td></tr>
<tr><td>COM</td><td>1</td><td>SCH</td><td></td></tr>
<tr><td>COL</td><td>1, 2</td><td>PROF</td><td>1, 2</td></tr>
<tr><td>MAN</td><td></td><td colspan="2"></td></tr>
<tr><td>Knowledge, skills and attitude required
The following lists are neither exhaustive nor prescriptive.</td><td colspan="4">Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.
Ability to apply an adequate knowledge base
• The principle objectives of supportive psychotherapy – to maintain or improve the patient’s self esteem, ameliorate or prevent recurrence of symptoms, improve psychological or ego functioning and enhance adaptive capacities.
• Understands that the practice of supportive psychotherapy is used in many therapeutic encounters.
• The paramount importance of the patient–therapist relationship.
• Indications and contraindications for supportive psychotherapy including grief, bereavement.
Skills</td></tr>
</table>

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	• Establishes and maintains a positive therapeutic alliance and interacts with the patient in an empathic, respectful, direct, responsive and non-threatening manner. • Establishes realistic and appropriate treatment goals. • Uses supportive therapy interventions (clarification, confrontation, interpretation, advice, reassurance, encouragement, praise, rationalisation, reframing) in an appropriate and timely manner. • Respects and strengthens adaptive defences, distinguishes between adaptive and maladaptive defences and works to minimise anxiety in an appropriate and timely way. • Provides education about the patient's psychiatric condition and medication and if necessary about community systems of care and ancillary treatments. • Focuses on the patient's present day life while not ignoring the past; consistently works at improving self-esteem, promoting adaptation and ego functions and ameliorating symptoms. **Attitude** • Respectful, open, non-judgemental and collaborative; able to tolerate ambiguity plus display confidence in the efficacy of supportive psychotherapy. • Understands that appropriate boundaries (confidentiality, professional attitude) must be established and maintained. • Sensitive to sociocultural, socioeconomic and educational issues that arise in the therapeutic relationship.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion. • Direct Observation of Procedural Skills (DOPS).

References

WINSTON A, ROSENTHAL RN & PINSKER H. *Learning supportive psychotherapy: an illustrated guide*. Arlington: American Psychiatric Publishing, 2012.

BROWN N & MALIK A. Case-based discussion. In: Bhugra D, Malik A & Brown N, eds. *Workplace-based assessments in psychiatry*. London: RCPsych Publications, 2007.

COL, Collaborator; COM, Communicator; HA, Health Advocate; MAN, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

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ST2-PSY-EPA4 – CBT: Anxiety management

Area of practice	Psychotherapy	***EPA identification***	ST2-PSY-EPA4
Stage of training	Stage 2 – Proficient	***Version***	v0.5 (EC-approved 04/09/15)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Cognitive–behavioural therapy (CBT) for management of anxiety.***
Description Maximum 150 words	The trainee can manage anxiety in psychiatric patients. The trainee demonstrates an ability to assess anxiety and employ basic management skills such as psychoeducation, structured problem solving and de-arousal strategies to a proficient level.

Fellowship competencies				
	ME	1, 3, 4, 5, 6, 7	**HA**	
	COM	1, 2	**SCH**	2
	COL	1, 2	**PROF**	1, 3
	MAN			

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.

Ability to apply an adequate knowledge base

- Knowledge of the role of adaptive anxiety responses.
- Knowledge of how disordered anxiety responses can lead to increased difficulties in coping with challenging situations.
- Knowledge of the importance of outcome measurement.
- Knowledge of evidence-based treatment strategies in the treatment of anxiety.

Skills

- Use of appropriate symptom measures at baseline and to assess the effectiveness of treatment.
- Provision of psychoeducation around normal and disordered anxiety responses in the individual patient.
- Use of Socratic questioning to develop a collaborative understanding with the patient of how their responses (cognitive and/or behavioural) to anxiety symptoms might be leading to worsening symptoms.
- Ability to describe a formulation or outline a model that summarises maintaining cycles.

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Board of Education approved 10/01/13 (v0.3); amended and approved 04/09/15 (v0.5; WBA tool [DOPS] added 01/12/16)

	• Use of that collaborative understanding of maintaining cycles to identify targeted interventions to break the cycle. These may include: cognitive challenging, mindfulness, graded exposure, exposure and response prevention, etc. • Implement basic management strategies such as relaxation training, basic cognitive challenging and structured problem solving. • Identify the need, and make appropriate referrals, for expert provision of more advanced CBT strategies. **Attitude** • Working as a co-therapist with the patient as their own therapeutic agent. • Scientist practitioner.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details *(these include, but are not limited to, WBAs)*	Trainees should undertake CBT with a range of patients. As a minimum standard, experience with three patients is recommended. • Mini-Clinical Evaluation Exercise. • Case-based discussion. • Direct Observation of Procedural Skills (DOPS). • Observe use of Socratic questioning (including by means of audio or video recordings). • Review written cognitive–behavioural formulations, provision of specific treatment interventions and assess impact on patient's treatment goals, ensure that need for referral for more targeted treatment or provision of advanced strategies is considered. • Supervisor may consider use of assessment tools such as the Cognitive Therapy Formulation Scale (CFRS), Revised Cognitive Therapy Scale (CTS-R) or Cognitive Therapy Awareness Scale (CTAS) when reviewing casework, written formulations/treatment planning or observing clinical activities.

References

SIMMONS J & GRIFFITHS R. *CBT for beginners*. London: SAGE Publications, 2009.

WESTBROOK D, KENNERLEY H & KIRK J. *An introduction to cognitive behaviour therapy: skills and applications*. London: SAGE Publications, 2008.

WRIGHT JH, RAMIREZ BASCO M & THASE ME. *Learning cognitive–behaviour therapy: an illustrated guide*. Arlington: American Psychiatric Publishing, 2006.

For supervisors (including assistance in assessing competence):

DRYDEN W & BRANCH R eds. *The CBT handbook*. London: SAGE Publications, 2012.

COL, Collaborator; COM, Communicator; HA, Health Advocate; MAN, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

Child and adolescent psychiatry

ST2-CAP-EPA1 – Manage an adolescent

Area of practice	Child and adolescent psychiatry	***EPA identification***	ST2-CAP-EPA1
Stage of training	Stage 2 – Proficient	***Version***	v0.5 (BOE-approved 08/11/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Develop a management plan for an adolescent where school attendance is at risk.***
Description Maximum 150 words	The trainee can: • identify relevant information from multiple sources, ie. young person, family, school, other agencies • identify key developmental issues • conduct a comprehensive mental state examination • describe the family, school and sociocultural factors impacting on the adolescent • consider and justify a range of differential diagnoses • develop a management plan that is cognisant of the above that incorporates appropriate communication with systems involved in case.

Fellowship competencies	**ME**	1, 2, 3, 4, 5	**HA**	1, 2
	COM	1	**SCH**	2
	COL	1, 2, 3	**PROF**	1, 2
	MAN			

Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Understands adolescent developmental theory. • Understands family and interpersonal dynamics. • Aware of the importance of rapport with, and engagement of, families/carers.

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	• Understands issues of informed consent and the principles and limits of confidentiality. • Understands appropriate personal and interpersonal boundaries with young people and families/carers. **Skills** • Conducts an appropriate assessment to inform a biopsychosocial formulation. • Develops an evidence-based management plan driven by the formulation. • Communicates management plan effectively to patient and family/carers. • Uses culturally and developmentally appropriate verbal and non-verbal communication. • Reviews the management plan in accordance with patient response and/or family and systemic change. • Encourages discussion, questions and interaction within the clinical encounter. • Develops and maintains effective relationships with the multidisciplinary team, GPs and other agencies. • Develops a therapeutic alliance with patients, families and carers. • Demonstrates an understanding of the child and family's perspective. • Recognises and manages the conflicts between the interest of the young person and family/carers. **Attitude** • Demonstrates appropriate respect for patients and their families. • Ensures care is child- and family-focussed with a systemic perspective.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion. • Mini-Clinical Evaluation Exercise. • Observed Clinical Activity (OCA).
References	

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ST2-CAP-EPA2 – Prepubertal child

Area of practice	Child and adolescent psychiatry	***EPA identification***	ST2-CAP-EPA2
Stage of training	Stage 2 – Proficient	***Version***	v0.5 (BOE-approved 08/11/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Clinical assessment of a prepubertal child.***
Description Maximum 150 words	The trainee conducts a developmentally appropriate clinical interview with a child under 10 years old and their family. The trainee can: • introduce themselves, explain their role and the purpose and process of the interview • engage the child in a developmentally appropriate manner including arranging the environment, selection of toys and/or activities, language level and non-verbal communication • sensitively direct the course of the interview in a child-centred way • conclude interview with a sensitive summary statement appropriate to the issues discussed and knowledge of the case • present a diagnostic formulation.

Fellowship competencies	**ME**	1, 2, 3, 7	**HA**	
	COM	1, 2	**SCH**	2
	COL	1,	**PROF**	1, 2
	MAN			

Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Understands normal child development. • Understands family and interpersonal dynamics. • Aware of the importance of rapport with, and engagement of, families/carers. • Aware of the importance of professional boundaries. **Skills**

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	• Conducts a developmentally appropriate assessment including mental state examination and physical assessment. • Takes history sensitive to individual, family, social, cultural and developmental context. • Gathers additional information from relevant sources including family, school, other agencies. • Integrates information obtained (from patient and other sources) into a biopsychosocial formulation. • Develops and maintains therapeutic relationships with patients and their families/carers. • Uses culturally and developmentally appropriate verbal and non-verbal communication. • Encourages discussion, questions and interaction within the clinical encounter. • Develops and maintains effective relationships with the multidisciplinary team, GPs and other agencies. • Written communication is clear, succinct and unambiguous. **Attitude** • Demonstrates appropriate respect for patients and their families. • Ensures care is child- and family-focussed with a systemic perspective.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Observed Clinical Activity (OCA). • Case-based discussion. • Mini-Clinical Evaluation Exercise. • Direct Observation of Procedural Skills (DOPS).
References	

COL, Collaborator; COM, Communicator; HA, Health Advocate; MAN, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

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Consultation–liaison psychiatry

ST2-CL-EPA1 – Delirium

Area of practice	Consultation–liaison psychiatry	***EPA identification***	ST2-CL-EPA1
Stage of training	Stage 2 – Proficient	***Version***	v0.4 (BOE-approved 04/05/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Care for a patient with delirium.***			
Description Maximum 150 words	The trainee can assess, make an accurate diagnosis, conduct appropriate physical and cognitive assessment and describe the evidence for the use of a specific management strategy. They are able to communicate the concept of delirium to patients and families within the general hospital setting. The trainee demonstrates awareness of challenges posed by a consultative model of care provision where a patient is not under the direct care of the psychiatrist.			
Fellowship competencies	**ME**	1, 2, 3, 4, 5, 6, 7, 8	**HA**	1
	COM	1, 2	**SCH**	1, 2
	COL	1, 2, 3, 4	**PROF**	1, 2, 3, 4
	MAN	4, 5		
Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Considers appropriate use of mental health and other relevant legal frameworks. • Understands additional resources, eg. special nurses, out-of-hours psychiatry review. • Understands most suitable setting for patient care. • Accesses, appraises and applies best level of evidence. **Skills** • Comprehensive assessment, including: - appropriate cognitive tests - laboratory/relevant investigations			

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	- collateral history - medication review. • Explains the nature of delirium to families and staff. • Integrates information from the assessment into a comprehensive formulation, accurate diagnosis and differential diagnosis. • Develops an appropriate management plan for the specific patient and setting. • Considers the patient's capacity to consent and any implications. • Uses effective and empathic verbal and non-verbal communication skills: - verbally communicated information is understandable, concise and accurate - information is documented in an understandable, concise and accurate manner. • Negotiates an appropriate management plan with the treating team. • Clarifies the referring agent's expectation of the consult. • Negotiates clinical role throughout the course of the delirium episode. • Appropriately prioritises allocation of their own time to the case. • Identifies possible stigma surrounding delirium. • Demonstrates effective conflict resolution skills, as needed. **Attitude** • Models and encourages a non-judgemental approach to the patient. • Takes on teaching opportunities as they arise in the case. • Treats the patient and referring team with respect. • Seeks appropriate supervision.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details *(these included, but are not limited to, WBAs)*	• Case-based discussion. • Mini-Clinical Evaluation Exercise. • Direct Observation of Procedural Skills (DOPS). • Observed Clinical Activity (OCA). • Feedback from appropriate sources.
References	

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ST2-CL-EPA2 – Psychological distress

Area of practice	Consultation–liaison psychiatry	***EPA identification***	ST2-CL-EPA2
Stage of training	Stage 2 – Proficient	***Version***	v0.4 (BOE-approved 04/05/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Manage clinically significant psychological distress in the context of the patient's medical illness in the general hospital.***			
Description Maximum 150 words	The trainee can assess and manage clinically significant psychological distress in the general medical setting. The trainee demonstrates awareness of challenges posed by a consultative model of care provision where a patient is not under the direct care of the psychiatrist.			
Fellowship competencies	**ME**	1, 2, 3, 4, 5, 6	**HA**	1
	COM	1, 2	**SCH**	2
	COL	1, 2, 3, 4	**PROF**	1
	MAN	4		

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.

Ability to apply an adequate knowledge base

- Applies and communicates current best level of evidence for the assessment and management of the case.
- Considers the relevant legal frameworks.
- Appreciates relevant psychodynamic factors, eg. transference/countertransference.
- Appreciates different manifestations of psychological distress.
- Understands additional resources, eg. social worker, appropriate follow up.
- Understands most suitable setting for patient care.
- Reviews information on psychological responses to physical illness, eg. somatoform disorders, normal grief.

Skills

- Explains the nature of psychological distress and its origins to patients, families and staff and engages the relevant persons in a negotiated management plan.
- Exercises good judgement in the allocation of resources for the optimal care of the patient, family and ward milieu.

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	• Comprehensive assessment, including consideration of:
	  - premorbid psychological functioning
	  - social and cultural setting
	  - prognosis
	  - loss
	  - normal/abnormal illness behaviour
	  - physiological disturbance.
	• Integrates information from the assessment into a comprehensive formulation, accurate diagnosis and differential diagnosis.
	• Develops an appropriate management plan for the specific patient and setting.
	• Uses effective and empathic verbal and non-verbal communication skills:
	  - verbally communicated information is understandable, concise and accurate
	  - information is documented in a sensitive, understandable, concise and accurate manner.
	• Negotiates an appropriate management plan with the treating team.
	• Clarifies the referring agent's expectation of the consult.
	• Negotiates clinical role throughout the course of the treatment episode.
	• Appropriately prioritises allocation of their own time to the case.
	• Identifies possible stigma surrounding psychological distress.
	• Advocates for the adequate provision of health information to the patient and family.
	• Recognises any abnormal treatment behaviour.
	• Proposes strategies for resolving disputes/disagreement.
	Attitude
	• Models and encourages a non-judgemental approach to patients, including patients with previous mental illness and/or personality disorder.

Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion. • Mini-Clinical Evaluation Exercise. • Direct Observation of Procedural Skills (DOPS). • Observed Clinical Activity (OCA).

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	• Feedback from appropriate sources.
References	

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Addiction psychiatry

ST2-ADD-EPA1 – Intoxication and withdrawal

Area of practice	Addiction psychiatry	***EPA identification***	ST2-ADD-EPA1
Stage of training	Stage 2 – Proficient	***Version***	v0.10 (BOE-approved 15/10/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Management of substance intoxication and substance withdrawal.***
Description Maximum 150 words	The trainee can assess substance intoxication and substance withdrawal and effectively and safely manage these conditions. The trainee demonstrates an ability to identify critical concepts in the medical emergency management of intoxication and is able to plan a withdrawal regimen from the relevant substance(s). This involves assessment (psychiatric and medical), initiation of psychotropic medications within safe limits to facilitate supported withdrawal to completion of detoxification and arrangement of appropriate follow-up.

Fellowship competencies	**ME**	1, 2, 3, 4, 5, 6, 7	**HA**	
	COM	1, 2	**SCH**	
	COL	1, 2, 3	**PROF**	1, 2
	MAN			

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.

Ability to apply an adequate knowledge base

- Knowledge of medical complications associated with intoxication from common substances including alcohol, cannabis, benzodiazepines, caffeine, psychostimulants and opioids.
- Knowledge of appropriate medical management to reduce risk of harm.
- Knowledge of commonly utilised protocols for managing detoxification from alcohol, benzodiazepines, cannabis, nicotine, psychostimulants and opioids.
- Ability to integrate detoxification with ongoing treatment.
- Knowledge of basic pharmacology as it relates to medications utilised in withdrawal, including the potential for interaction with other medications/substances.

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	• Ability to interpret breathalyser and serum levels of substances to facilitate management of intoxication and withdrawal. • Capacity to provide advice to and liaise with other health practitioners regarding withdrawal. • Capacity to provide training regarding detoxification procedures and management to the wider community including junior medical staff and allied health professionals. **Skills** • Demonstrates an ability to conduct a medical and psychiatric assessment of a patient who is acutely intoxicated, including initiation of appropriate measures to acutely minimise risk of harm. • Demonstrates an ability to conduct a medical and psychiatric assessment of a patient who requires pharmacologically facilitated withdrawal. This includes both acute and planned withdrawal. • Demonstrates an ability to incorporate the management of psychiatric and physical comorbidity during detoxification. • Demonstrates an ability to tailor the treatment plan according to the individual patient needs, taking into account the medical, psychiatric, social and substance use history when deciding the appropriate environment for detoxification to take place (ie. inpatient vs outpatient settings). • Demonstrates an ability to decline detoxification in patients who are not ready for this treatment. • Demonstrates an ability to manage detoxification through to completion including arranging a post-withdrawal management plan. • Demonstrates an ability to explain the purpose and process of withdrawal to the patient and supports so that informed consent can be assured. • Works in conjunction with other health professionals and key stakeholders during the process of withdrawal to facilitate coordinated patient care. **Attitude** • Adopts a non-judgemental, empathic and hopeful approach to the engagement of the patient. • Respects and appreciates the role of other health professionals and key stakeholders during the process of withdrawal to facilitate coordinated patient care. • Utilises a recovery-based approach tailored to the patient's stage of change.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details *(these include, but are not limited to, WBAs)*	• Case-based discussion. • Mini-Clinical Evaluation Exercise. • Feedback from appropriate sources. • Observed Clinical Activity (OCA).

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Board of Education approved 12/07/12 (v0.8); amended and approved 15/10/12 (v0.10; WBA tool [OCA] added 01/12/16)

References

Currently used local, state and national withdrawal protocols and guidelines.

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Board of Education approved 12/07/12 (v0.8); amended and approved 15/10/12 (v0.10; WBA tool [OCA] added 01/12/16)

ST2-ADD-EPA2 – Comorbid substance use

Area of practice	Addiction psychiatry	***EPA identification***	ST2-ADD-EPA2
Stage of training	Stage 2 – Proficient	***Version***	v0.6 (BOE-approved 04/05/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Comorbid mental health and substance use problems.***
Description Maximum 150 words	Integrated assessment and management of a person's substance use and mental health problems. The trainee demonstrates the ability to assess, conduct appropriate physical and cognitive assessment, formulate, consider differential diagnoses and develop integrated management strategies. They are able to explain the relationship between the person's substance use and mental health to patients, family and staff. The trainee demonstrates awareness of challenges posed by comorbidity.

Fellowship competencies				
	ME	1, 2, 3, 4, 5, 6, 7	**HA**	
	COM	1, 2	**SCH**	1, 2
	COL	1, 2, 3, 4	**PROF**	1, 2, 5
	MAN	4		

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.

Ability to apply an adequate knowledge base

- Management plan shows appropriate use of services available to persons with comorbidity.
- Theories explaining comorbid substance use and other mental health disorders.
- Understand the effects of ongoing substance use on diagnostic accuracy.

Skills

- Appropriate assessment of each problem and their interrelatedness (including temporal relationship) for this person.
- Appropriate ongoing assessment and diagnostic revision.
- Ability to formulate for the patient, their family and colleagues.
- Appropriate engagement of family and others in assessment and management.

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	• Implementation of a management plan that shows a detailed understanding of the interrelatedness of the comorbid conditions. • Demonstration of advocacy for patients with comorbid substance use problems. **Attitude** • Adopts a non-judgemental, empathic and hopeful approach to the engagement of persons with mental illness and substance use disorder. • Willingness to engage with such persons who are often poorly serviced. • Maintains therapeutic optimism.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion. • Observed Clinical Activity (OCA). • Professional presentation – of a specific comorbidity, eg. cannabis and psychosis, anxiety/depression and alcohol.
References	

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Psychiatry of old age

ST2-POA-EPA1 – Behavioural and psychological symptoms in dementia

Area of practice	Psychiatry of old age	***EPA identification***	ST2-POA-EPA1
Stage of training	Stage 2 – Proficient	***Version***	v0.7 (BOE-approved 12/07/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Behavioural and psychological symptoms in dementia (BPSD).***			
Description Maximum 150 words	The trainee can perform a comprehensive assessment of an older person with dementia presenting with behavioural and psychological symptoms and develop a comprehensive care plan.			
Fellowship competencies	**ME**	1, 2, 3, 4, 5, 6, 7, 8	**HA**	1
	COM	1, 2	**SCH**	2
	COL	1, 2, 3, 4	**PROF**	1, 2, 3
	MAN	1, 2		

Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Size of the problem (epidemiology), impact on carers and services. • Access and availability of services. • Clinical manifestations of BPSD. • Contributing and aetiological factors (eg. biological, psychological, social, environmental and cultural). • Biopsychosocial treatment of BPSD (eg. identification and management of delirium, infection, pain, constipation, sensory impairment, fatigue, care needs, psychiatric symptoms, carer stress and restraint). • Interventions for patients, family and carers, including staff of residential aged care facilities. • Environmental approaches to management (dementia friendly unit design), role of activity, music, etc.

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	• Role and risk–benefit of antidepressants, antipsychotics (including in dementia with Lewy bodies and Parkinson's dementia), mood stabilisers, sedatives, cholinesterase inhibitors. Note the poor response of some behaviours (wandering, calling out) to medication. • Knowledge of time course of BPSD; stopping rules for medication. • Issues of consent in cognitively-impaired persons. • Awareness of objective measures to assess severity and response to treatment. **Skills** • Clarify the questions/concerns from the referring agency. • Collecting collateral information from multiple sources including carers, family and GP. • Comprehensive biopsychosocial assessment and management, including: - mental state assessment - behavioural analysis including, where relevant, charting behaviours - appropriate cognitive tests - physical assessment and appropriate lab tests - auditing current and past medication - assessing physical environment - assessing carer's ability to cope - differential diagnosis (including delirium) - risk assessment (risk of harm to self and others including falls, fire, driving, exploitation, misadventure, malnutrition) - psychoeducation of family and carers (including paid staff) - modifying the physical environment (to address BPSD) - arrange appropriate consultations and referrals, eg. dental, eyes, hearing, podiatry, dietician, etc. - institute behavioural management strategy, including modifying carer behaviour, in collaboration with the multidisciplinary team - liaise with the GP and other healthcare providers - engage appropriately with primary carers and substitute decision makers - consider any necessary legal implications, eg. decision making, guardianship, financial administration - describe appropriate follow-up plan. **Attitude** • Empathic, respectful and professional approach to patient, carers and others involved in patient care.

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	• Appreciates circumstances of carers and values their opinions. • Willingness to educate others either formally or informally. • Ethical principles. • Recognising when a palliative care approach is appropriate in dementia. • Person-centred care. • Recognising limitations of medications and their place within a broader treatment approach.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion. • Mini-Clinical Evaluation Exercise. • Observed Clinical Activity (OCA). • Direct Observation of Procedural Skills (DOPS). • Professional presentation.

References

INTERNATIONAL PSYCHOGERIATRIC ASSOCIATION. *The IPA complete guides to behavioral and psychological symptoms of dementia (BPSD): Specialists guide*. Northfield: IPA, 2012.

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ST2-POA-EPA2 – Medication in patients 75 and over

Area of practice	Psychiatry of old age	***EPA identification***	ST2-POA-EPA2
Stage of training	Stage 2 – Proficient	***Version***	v0.4 (BOE-approved 04/05/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***The appropriate use of antidepressants and antipsychotics in patients aged 75 years and over (or under 75 with excessive frailty).***
Description Maximum 150 words	The trainee can use antidepressants and antipsychotics to provide quality care for those elderly patients at high risk of drug interactions and adverse effects. They have a comprehensive understanding of the problem and can apply it to this group; they can engage the patient and relevant others, providing an explanation of the rationale, risk–benefits and relevant side effects. Medication is used, where appropriate, as part of a comprehensive biopsychosocial management plan. They display an ethical and professional approach to the patient and others involved in the patient's care.

Fellowship competencies				
	ME	1, 2, 3, 4, 5, 6, 7, 8	**HA**	2
	COM	1, 2	**SCH**	1, 2
	COL	2, 3, 4	**PROF**	1, 5
	MAN	1, 2, 4, 5		

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.

Ability to apply an adequate knowledge base

- Implications of a patient's advancing age and physical disease on prescribing practice.
- Poor adherence not uncommon (under-/overuse, hoarding old medications, sharing).
- Risk of polypharmacy with age, problems with cognition, vision and dexterity.
- Knowledge of common side effects, eg. sedation, falls, confusion, hyponatraemia, parkinsonism, CVA and mortality risk, hypotension.

Skills

- Assess
  - psychiatric and medical diagnoses

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	- capacity to consent to treatment - other current medications - past history of drug response - risk benefit. • Plan; tailor drug to the patient - consider interactions with other drugs and general medical diagnosis - consider evidence base - consider potential adverse affects - consider duration and possible sequential treatments or augmentation strategies - situate prescribing within the context of the broader treatment plan. • Implement - educate patients, carers and families - consider route administration and adherence/supervision - consider health service requirements and resource implications - monitor the patient for toxicity, efficacy and side effects - modify drug dose appropriately. • Evaluate - evaluation of outcome from an appropriate range of perspectives, eg. patient report, objective measures, carer report, mental state exam - plan for long term follow up - treatment resistance. **Attitude** • Professional and ethical attitude towards patient, their supports and others involved in the care of the patient. • Willingness to educate others formally and informally as required. • Avoiding ageist stereotypes and therapeutic nihilism.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion. • Mini-Clinical Evaluation Exercise. • Professional presentation.

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References

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Stage 2 EPAs – if enrolled in associated area of practice

Adult psychiatry

ST2-AP-EPA1 –Treatment-refractory psychiatric disorders

Area of practice	Adult psychiatry	***EPA identification***	ST2-AP-EPA1
Stage of training	Stage 2 – Proficient	***Version***	v0.7 (BOE-approved 15/10/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Assess treatment-refractory psychiatric disorders.***			
Description Maximum 150 words	The trainee can assess patients with a range of treatment-refractory psychiatric disorders (with refractory defined as the failure of at least three different pharmacological agents with each being trialled for an adequate length of time at an adequate dose). These disorders may include bipolar disorder, schizophrenia, major depression, obsessive–compulsive disorder, etc. The trainee can develop a biopsychosocial management plan for them considering detailed case review, treatment timeline, organic aetiologies, psychosocial factors, Axis II factors and second opinions.			
Fellowship competencies	**ME**	1, 2, 3, 4, 5, 6, 7	**HA**	1
	COM	1, 2	**SCH**	
	COL	1, 2, 3, 4	**PROF**	1
	MAN	2, 4		

Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Demonstrates knowledge of biological, psychological and social factors that may render a person's mental illness refractory to treatment. • Demonstrates knowledge of the definitions and controversies of treatment-refractory disorders. • Demonstrates knowledge of evidence-based interventions in treatment-refractory psychiatric disorders. • Demonstrates knowledge of what constitutes adequate trials of treatment for treatment-refractory psychiatric disorders.

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	• Demonstrates an understanding of the role of families and carers. • Demonstrates knowledge of other assessment tools including outcome measures, neuropsychiatric assessment and occupational therapy assessment. • Demonstrates knowledge of how to assess the success or otherwise of therapeutic interventions. **Skills** • Provides a comprehensive biopsychosocial assessment including diagnostic issues, treatment adherence, family and cultural issues, a patient's understanding of illness and illness behaviours. • Demonstrates appropriate skills in working with families/carers. • Works collaboratively with other professions and agencies to provide assessment of patients with treatment-refractory psychiatric disorders. • Develops an integrated management plan in a biopsychosocial framework. • Demonstrates effective verbal and written communication skills. **Attitude** • Provides appropriate clinical leadership. • Maintains therapeutic optimism, instilling hope into both patients and carers. • Advocates on behalf of patients and carers and takes into account their wishes for treatment. • Demonstrates an ethical approach.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion (CbD) – at least one. • Observed Clinical Activity (OCA) – at least one (with a different patient [in a different diagnostic category] to CbD).
References	

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ST2-AP-EPA2 – Physical comorbidity 2

Area of practice	Adult psychiatry	***EPA identification***	ST2-AP-EPA2
Stage of training	Stage 2 – Proficient	***Version***	v0.5 (BOE-approved 12/07/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Physical comorbidity 2.***			
Description Maximum 150 words	The trainee demonstrates comprehensive assessment and management of patients with significant physical comorbidity or physical sequelae of psychiatric treatment. The trainee must have a broad understanding of the significance of physical disorders for the patient and develop a management plan which results in appropriate intervention, and/or appropriate liaison with other medical practitioners. The trainee must demonstrate this in at least three patients.			
Fellowship competencies	**ME**	1, 2, 3, 4, 5, 6, 7, 8	**HA**	1, 2
	COM	1, 2	**SCH**	1
	COL	1, 2, 3, 4	**PROF**	1, 2
	MAN			
Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Understand the relationship between the psychiatric disorder and physical comorbidity or physical sequelae of psychiatric illness or treatment in terms of their impact on each other. **Skills** • Conduct an appropriate assessment of physical comorbidity in psychiatric patients including conducting a physical examination to the extent that these are relevant for comprehensive understanding and management of the patient. • Conduct a comprehensive assessment of physical sequelae of psychiatric illness or treatment including relevant physical examination. • Order relevant investigations based on the assessment.			

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	• Develop and implement, in collaboration with the patient, a treatment plan to manage and/or minimise potential important sequelae of psychiatric treatment such as the metabolic syndrome, sexual dysfunction, extrapyramidal side effects (EPSE) and drug toxicity. **Attitude** • Acknowledge limitations of own knowledge and skill to enable appropriate referral to other medical and non-medical professionals in order to coordinate and optimise overall treatment. • Proactive in approach to detection and management of physical comorbidities and sequelae of psychiatric treatment.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion. • Mini-Clinical Evaluation Exercise. • Direct Observation of Procedural Skills (DOPS). • Observed Clinical Activity (OCA).
References Lambert, T., Reavley, N., Jorm, A. & Oakley Brown, M. (2017). Royal Australian and New Zealand College of Psychiatrists expert consensus statement for the treatment, management and monitoring of the physical health of people with an enduring psychotic illness. *Australian and New Zealand Journal of Psychiatry*, 51(4): 322-337.	

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ST2-AP-EPA3 – Anorexia nervosa 2

Area of practice	Adult psychiatry (Eating disorders)	***EPA identification***	ST2-AP-EPA3
Stage of training	Stage 2 – Proficient	***Version***	v0.4 (EC-approved 24/07/15)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Assess and manage a patient with anorexia nervosa presenting in a severely underweight state.***
Description Maximum 150 words	The trainee will be proficient in assessing and in developing a management plan for a patient with anorexia nervosa who presents in a state of severe malnutrition and low weight in which their physical welfare is at risk. The trainee will be able to assess their physical state and ensure appropriate medical interventions are put in place to improve their physical health. The trainee will develop an appropriate risk management plan and engage the patient in interventions aimed at restoring their weight to a safe level.

Fellowship competencies				
	ME	1, 2, 3, 4, 5, 6, 7, 8	**HA**	
	COM	1, 2	**SCH**	
	COL	1, 2, 3	**PROF**	1, 2
	MAN			

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.

Ability to apply an adequate knowledge base

- Knowledge of the diagnostic features of anorexia nervosa.
- Physical effects and sequelae of extreme malnutrition and how to assess and identify these, including history, physical examination and laboratory tests.
- Theories of the underlying psychopathology of anorexia nervosa.
- The role of interpersonal and psychological factors in predisposing and perpetuating anorexia nervosa.
- The principles of medical resuscitation of a person with severe malnutrition.
- Evidence-based biological and psychological interventions in anorexia nervosa.
- Evidence base that informs decisions about admission vs community management of anorexia nervosa.

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Education Committee approved 24/07/15; WBA tool (DOPS) added 02/12/16

	Skills • Comprehensive diagnostic and biopsychosocial assessment. • Proficient risk assessment of a patient who is severely underweight, including consideration of factors regarding the use of the mental health Act, parenteral feeding and management by a medical vs psychiatric team. • Proficient aetiological formulation of biopsychosociocultural factors involved. • When appropriate, proficient assessment of the quality and nature of family relationships and how they influence the illness in the patient. • Development of a management plan that aims to restore the patient to a medically safe weight. • Development of a longer-term management plan to assist the patient to maintain a medically safe weight. • Ability to liaise with other agencies and staff involved in supporting the patient (eg. medical team, dietitians, general practitioners, etc.) and integrate elements of multidisciplinary care. **Attitude** • Ethical and professional approach to the patient and to family/carers when appropriate. • Balancing the respect for autonomy vs the need to protect from harm in clinical decisions regarding coercive care. • Collaborating with the patient and their family/carers in all aspects of care, as appropriate. • Nonjudgmental approach to communication with the patient and with others involved in their care.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Observed Clinical Activity (OCA) – in which the trainee undertakes a comprehensive assessment of a patient presenting with severe anorexia nervosa which required medical stabilisation or resuscitation (after patient is stabilised). • Mini-Clinical Evaluation Exercise. • Case-based discussion. • Direct Observation of Procedural Skills (DOPS) – Direct observation of the trainee undertaking a physical examination of a severely underweight patient with anorexia nervosa.

References

HAY P, CHINN D, FORBES D et al. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders. *Aust NZ J Psychiatry* 2014; 48: 977–1008.

TREASURE J. *A guide to the medical risk assessment for eating disorders*. London: King's College London, 2009. Viewed 28 November 2014, <www.kcl.ac.uk/ioppn/depts/pm/research/eatingdisorders/resources/GUIDETOMEDICALRISKASSESSMENT.pdf>.

THE ROYAL COLLEGES OF PSYCHIATRISTS, PHYSICIANS AND PATHOLOGISTS. *MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa*. London: RCPysch, October 2014. Viewed 28 November 2014, <www.rcpsych.ac.uk/files/pdfversion/CR189.pdf>.

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ST2-AP-EPA4 – Bulimia nervosa 2

<table>
<tr><td>Area of practice</td><td colspan="2">Adult psychiatry (Eating disorders)</td><td>EPA identification</td><td>ST2-AP-EPA4</td></tr>
<tr><td>Stage of training</td><td colspan="2">Stage 2 – Proficient</td><td>Version</td><td>v0.4 (EC-approved 24/07/15)</td></tr>
<tr><td colspan="5">The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.</td></tr>
<tr><td>Title</td><td colspan="4">Assess and manage an adult with bulimia nervosa.</td></tr>
<tr><td>Description
Maximum 150 words</td><td colspan="4">The trainee will have proficient skills in assessing and developing an outpatient management plan and risk management plan for an adult with bulimia nervosa, addressing any psychiatric and medical comorbid disorders. The management plan will aim to help the patient gain control over bingeing, purging and other weight-control behaviour and apply an appropriate variety of psychological treatments to be utilised in an outpatient setting.</td></tr>
<tr><td rowspan="4">Fellowship competencies</td><td>ME</td><td>1, 2, 3, 4, 5, 6, 7</td><td>HA</td><td></td></tr>
<tr><td>COM</td><td>1, 2</td><td>SCH</td><td></td></tr>
<tr><td>COL</td><td>1, 2, 3</td><td>PROF</td><td>1, 2</td></tr>
<tr><td>MAN</td><td></td><td colspan="2"></td></tr>
<tr><td>Knowledge, skills and attitude required
The following lists are neither exhaustive nor prescriptive.</td><td colspan="4">Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.
Ability to apply an adequate knowledge base
• Identification and assessment of diagnostic features and medical sequelae of bingeing, purging and other weight-control behaviour, including history, physical examination and laboratory tests.
• Knowledge of the common psychiatric comorbidities of bulimia nervosa and how these can be managed.
• Knowledge of the evidence base for commonly used psychological interventions in bulimia nervosa.
• Awareness of medical complications that might require intervention, including hospitalisation.
• Knowledge of the evidence base for pharmacological interventions in bulimia nervosa.
Skills
• Proficient assessment of an adult with bulimia nervosa, including:
- biopsychosocial assessment</td></tr>
</table>

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	- physical assessment - risk assessment. • Proficient aetiological formulation of the biopsychosocial factors involved. • Development of a management plan informed by the formulation. • Ability to liaise with other professionals involved in the management of the patient (eg. GP, psychologist, drug and alcohol service, dietitian) and integrate elements of multidisciplinary care. • Appropriate monitoring and care of the patient as an outpatient. **Attitude** • Ethical and professional approach to the patient. • Collaboration with the patient, partner or other family members, as appropriate. • Non-judgmental approach to communication with the patient and others involved in their care.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Mini-Clinical Evaluation Exercise. • Case-based discussion. • Observed Clinical Activity (OCA) – an assessment of a newly referred patient with bulimia nervosa for outpatient treatment. • Direct Observation of Procedural Skills (DOPS). • Professional presentation – eg. on the assessment and management of bulimia nervosa, including common psychiatric and medical comorbidities.

References

HAY P, CHINN D, FORBES D et al. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders. *Aust NZ J Psychiatry* 2014; 48: 977–1008.

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ST2-AP-EPA5 – Postpartum mental illness 2

Area of practice	Adult psychiatry (Perinatal)	***EPA identification***	ST2-AP-EPA5
Stage of training	Stage 2 – Proficient	***Version***	v0.5 (EC-approved 24/07/15)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Assess and manage a woman experiencing a major postpartum illness within 12 months of childbirth.***
Description Maximum 150 words	The trainee will be proficient in assessing and developing a management plan for a woman presenting with an acute major mental illness, such as psychosis or mood disorder, within 12 months of childbirth. This includes diagnostic assessment and formulation of predisposing and precipitating factors for the development of this illness, especially those related to the perinatal period. The trainee will be able to assess the nature of family relationships and the quality of mother–infant attachment. The management plan will be informed by this assessment and incorporate appropriate biological, psychological, social and systemic interventions.

Fellowship competencies				
	ME	1, 2, 3, 4, 5, 6, 7, 8	**HA**	2
	COM	1, 2	**SCH**	2
	COL	1, 2, 3, 4	**PROF**	1, 2, 5
	MAN			

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.

Ability to apply an adequate knowledge base

- Risk factors for development of postpartum mental illness.
- Understanding of attachment theory and its application to mother–infant assessment.
- The range of phenomenology in the presentation of postpartum mental illness.
- The role of family and social factors in the development of postpartum mental illness.
- Risk assessment of mother and baby, including a clear understanding of mandatory reporting obligations.
- Appropriate use of psychotropic medication in the postpartum period, including safety of medications in breastfeeding.
- Principles of systemic and family interventions in women recovering from a postpartum mental illness.

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Education Committee approved 24/07/15; WBA tool (DOPS) added 02/12/16

	Skills • Comprehensive biopsychosocial assessment. • Assessment of the quality of a mother's attachment to, and bonding with, her infant. • Proficient assessment of the quality and nature of supportive family relationships around the mother and infant. • Provision of counselling to a mother about the decision to breastfeed, including education about the risks and benefits of psychotropic medication during breastfeeding. • Counselling for mother and partner about future risks of mental illness, including postpartum illness after a future pregnancy, and developing a management plan about how these risks may be minimised. • Ability to liaise with other agencies involved in supporting the mother and family, such as child welfare agencies, GPs, mother–baby nurses, etc. **Attitude** • Ethical and professional approach to patient, her partner and family. • Placing the safety and welfare of the infant as the highest priority, but also ensuring the safety and welfare of the mother is paramount in management decisions. • Collaborating with the mother and her family in all aspects of care. • Being accepting, noncritical and nonjudgmental in communicating with the patient and her family. • Encouraging the patient and her family to develop a positive attitude to her recovery and to her role as a mother.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	At least one WBA should be with a patient with postpartum depression and one WBA with a patient with postpartum psychosis. • Mini-Clinical Evaluation Exercise – observing a mother and infant together and assessing the nature and quality of attachment between mother and infant. • Case-based discussion. • Observed Clinical Activity (OCA). • Direct Observation of Procedural Skills (DOPS) – providing assessment of, and/or counselling/education to, a mother together with her partner/family.

References

Malhi G, Bassett D, Boyce P, Bryant R, Fitzgerald P, Fritz K, Hopwood M, Lyndon B, Mulder R, Murray G, Porter R & Singh, A (2015) Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders. *Australian and New Zealand Journal of Psychiatry* 49(12): 1-185.

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ST2-AP-EPA6 – Psychiatric disorders in pregnancy 2

Area of practice	Adult psychiatry (Perinatal)	***EPA identification***	ST2-AP-EPA6
Stage of training	Stage 2 – Proficient	***Version***	v0.5 (EC-approved 24/07/15)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Assess and manage a pregnant woman presenting with a psychiatric disorder.***
Description Maximum 150 words	The trainee will be proficient in assessing and developing a management plan for a pregnant woman presenting with psychiatric symptoms, taking account of the effects of any treatment on the developing foetus. The assessment will include consideration of the welfare of the woman's partner and any existing children. The trainee will maintain liaison with the woman's obstetrician and/or midwife and provide any necessary support required for the optimal care of the woman and baby.

Fellowship competencies				
	ME	1, 2, 3, 4, 5, 6, 7, 8	**HA**	
	COM	1, 2	**SCH**	2
	COL	1, 2, 3	**PROF**	1, 2, 5
	MAN			

Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Awareness of the impact of psychiatric illness on a mother's ability to care for her pregnancy. • The range of psychiatric disorders presenting in pregnant women and the assessment and management of these. • The use of psychotropic medication in pregnancy, particularly the evidence regarding effects of medication on the developing foetus. • Knowledge about the safe use of ECT in pregnancy. • The potential effects of maternal psychiatric illness on existing children, the partner and family as a whole. • Knowledge of mandatory reporting requirements. • The risk of developing a psychiatric disorder in future pregnancies.

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	Skills • Proficient biopsychosocial assessment and risk assessment, leading to an appropriate decision about the setting for the care of the patient. • Proficient aetiological formulation of the biopsychosocial factors involved in the development of the psychiatric disorder in pregnancy. • Development of an appropriate management plan which is safe for all parties. • Proficient assessment of how a mental illness in a pregnant woman impacts on her partner and existing children. • Proficient and sensitive approach to any mandatory reporting obligations. • Proficient at dealing with presentations that have a high prevalence in the community. • Proficient counselling of the woman and her partner with regard to the illness and its treatment, such as the possible impact on development and delivery of the baby, postnatal course and risks of recurrence in future pregnancies. • Liaison and collaboration with the woman's obstetrician, GP and any other professionals involved in her care. • Organisation of appropriate postnatal care of the woman and baby. **Attitude** • Ethical and professional approach to patient and family. • Collaboration with the patient, partner and family in all aspects of the patient's care. • Collaboration with obstetric team in management of the patient's pregnancy.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Observed Clinical Activity (OCA). • Case-based discussion. • Mini-Clinical Evaluation Exercise. • Professional presentation – eg. on the management of psychiatric disorders in pregnancy, including the safe use of medication and ECT and involvement of the partner and family.

References

Malhi G, Bassett D, Boyce P, Bryant R, Fitzgerald P, Fritz K, Hopwood M, Lyndon B, Mulder R, Murray G, Porter R & Singh, A (2015) Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders. *Australian and New Zealand Journal of Psychiatry* 49(12): 1-185.

Galletly C, Castle D, Dark F, Humberstone V, Jablensky A, Killackey E, Kulkarni J, McGorry P, Nielssen O & Tran N (2016) Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders. *Australian and New Zealand Journal of Psychiatry* 50(5): 1-117.

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Education Committee approved 24/07/15; WBA tool (DOPS) added 02/12/16

ST2-AP-EPA7 – Epilepsy and mental illness 2

Area of practice	Adult psychiatry (Neuropsychiatry)	***EPA identification***	ST2-AP-EPA7
Stage of training	Stage 2 – Proficient	***Version***	v0.4 (EC-approved 24/07/15)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Assess and manage a mental illness occurring in an adult with an established diagnosis of epilepsy.***
Description Maximum 150 words	The trainee will be proficient in the assessment of an adult who has a proven diagnosis of epilepsy made by a neurologist, who presents with symptoms of a mental illness. The trainee will undertake an integrated assessment of organic and psychosocial factors contributing to the psychiatric symptoms and develop a management plan to address the mental illness, taking into account the patient's neurological disorder. The trainee will work with the multidisciplinary team and the patient's family/carers in developing this management plan.

Fellowship competencies				
	ME	1, 2, 3, 4, 5, 6, 7	**HA**	1
	COM	1, 2	**SCH**	
	COL	1, 2, 3	**PROF**	1, 2
	MAN			

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.

Ability to apply an adequate knowledge base

- Proficient knowledge of the neurophysiology of the brain, especially in relation to ictal phenomena.
- Understanding of the mechanisms by which epilepsy may produce behavioural and psychological symptoms.
- The role of the EEG in assessment of epilepsy and how to correlate EEG findings with the clinical presentation.
- Knowledge of the common neuropsychiatric sequelae of epilepsy and how these can present.
- Awareness of the differences between neuropsychiatric symptoms that occur during pre-ictal (aura), ictal and interictal periods.
- Proficient knowledge of the use of psychotropic medication in patients with epilepsy, including their evidence base, side effects, risks and toxicity, especially in relation to effect on seizure threshold.

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	• Proficient knowledge of the use of anticonvulsant medications for psychiatric disorders, including their evidence base, proposed mechanism of action and their side effects, risks and toxicity. **Skills** • Proficient biopsychosocial assessment including a careful cognitive evaluation. • Able to apply EEG reports and results of electrophysiological investigations to the assessment and management of the patient. • Proficiently conducts a neurological examination relevant to the neuropsychiatric history. • Formulates an appropriate aetiological explanation for the patient's symptoms, integrating biological, psychological and social contributions. • Develops a management plan to address the psychological and behavioural symptoms of the patient. This should be done in conjunction with the multidisciplinary team, including neurology, neuropsychology and nursing and allied heath staff. • Appropriate prescription of anticonvulsant medication for psychiatric indications, in collaboration with a neurologist. **Attitude** • Ethical and professional approach to patient and family. • Advocacy on behalf of patients and their family/carers. • Appropriate involvement of the patient/family/carers in the patient's care. • Collaborative and integrated care of the patient in conjunction with the neurologist and the neurology team.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	At least one WBA focusing on the interpretation of an EEG report and clinical correlation of the results with the patient's presentation. • Mini-Clinical Evaluation Exercise. • Case-based discussion. • Observed Clinical Activity (OCA). • Direct Observation of Procedural Skills (DOPS) – conducting an appropriate neurological examination of a patient with epilepsy.
References	

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ST2-AP-EPA8 – Acquired brain injury 2

<table>
<tr><td>Area of practice</td><td colspan="2">Adult psychiatry (Neuropsychiatry)</td><td>EPA identification</td><td>ST2-AP-EPA8</td></tr>
<tr><td>Stage of training</td><td colspan="2">Stage 2 – Proficient</td><td>Version</td><td>v0.4 (EC-approved 24/07/15)</td></tr>
<tr><td colspan="5">The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.</td></tr>
<tr><td>Title</td><td colspan="4">Assess and manage psychological and behavioural symptoms in an adult under the age of 50 with an acquired brain injury.</td></tr>
<tr><td>Description
Maximum 150 words</td><td colspan="4">The trainee will be proficient in the assessment of an adult (under 50 years of age) who has an acquired brain injury. The trainee will develop a management plan for challenging behaviours, mood symptoms, cognitive impairments and other neuropsychiatric sequelae of head injury. The trainee will work with the multidisciplinary team and family/carers to develop the management plan.</td></tr>
<tr><td>Detailed description
If needed</td><td colspan="4">Note: the age restriction is so that the focus is on deficits caused by brain injury rather than problems related to ageing or a neurodegenerative disorder.</td></tr>
<tr><td rowspan="4">Fellowship competencies</td><td>ME</td><td>1, 2, 3, 4, 5, 7</td><td>HA</td><td>1</td></tr>
<tr><td>COM</td><td>1, 2</td><td>SCH</td><td></td></tr>
<tr><td>COL</td><td>1, 2, 3</td><td>PROF</td><td>1, 2</td></tr>
<tr><td>MAN</td><td></td><td colspan="2"></td></tr>
<tr><td>Knowledge, skills and attitude required
The following lists are neither exhaustive nor prescriptive.</td><td colspan="4">Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.
Ability to apply an adequate knowledge base
• Proficient knowledge of the functional neuroanatomy of the brain, correlating this knowledge with the clinical signs and symptoms of the person with a brain injury.
• Understanding the mechanisms by which a brain injury may influence behaviour and psychological function.
• The role of neuroimaging in assessment of brain injury and how to correlate neuroimaging findings with the clinical presentation.
• Understanding neurocognitive testing, including executive function and other higher cortical functions.
• Knowledge of the common neuropsychiatric sequelae of head injury and how these can present.</td></tr>
</table>

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	• Awareness of how the behavioural sequelae of brain injury, such as impulsivity and disinhibition, can influence the risk assessment. • Knowledge of the use of psychotropic medications in persons with brain injury, including their evidence base, side effects, risks and toxicity. **Skills** • Proficient biopsychosocial assessment. • Proficiently conducts a relevant neurocognitive assessment. • Interprets findings in common neuroimaging investigations and incorporates these into assessments. • Proficiently conducts a neurological examination relevant to the neuropsychiatric history. • Formulates an appropriate aetiological explanation for the patient's symptoms, integrating biological, psychological and social contributions. • Proficiency in risk assessment informed by the formulation. • In collaboration with the relevant multidisciplinary team, which may include neurology, neurosurgery, neuropsychology, rehabilitation medicine and nursing and allied heath staff, develops a management plan to address the psychological and behavioural symptoms. **Attitude** • Advocacy on behalf of patients and their family/carers. • Appropriate involvement of the patient/family/carers, in the patient's care. • Maintenance of a professional, optimistic and hopeful attitude to the patient's prognosis and recovery. • Demonstration of a good understanding of ethical issues in the assessment and treatment of individuals with brain injury. In particular, nonmaleficence (the avoidance of iatrogenic harm) and the maintenance of as much autonomy as possible, while managing risks appropriately and safely.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Mini-Clinical Evaluation Exercise. • Case-based discussion. • Observed Clinical Activity (OCA). • Direct Observation of Procedural Skills (DOPS) – conducting a neurocognitive assessment in a person with brain injury or an appropriate neurological examination in a person with a brain injury.
References	

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ST2-AP-EPA9 – Assessment of Pacific people

Area of practice	Adult psychiatry (Pacific peoples' mental health)	***EPA identification***	ST2-AP-EPA9
Stage of training	Stage 2 – Proficient	***Version***	v0.2 (EC-approved 06/11/15)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Assessment of people of Pacific Island descent.***			
Description Maximum 150 words	The trainee can engage Pacific people (in the context of their family, as appropriate) so as to conduct a holistic psychiatric assessment and build a therapeutic alliance. They are able to create a culturally safe context for the interview including an appropriate environment, approach, assessment framework and the presence of appropriate supports, eg. family. The trainee can adapt their communication style to meet the needs of the person and family and promote engagement.			
Fellowship competencies	**ME**	1, 2, 3	**HA**	
	COM	1, 2	**SCH**	
	COL	1, 2, 3, 4	**PROF**	1, 2
	MAN			

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.

Ability to apply an adequate knowledge base

- Understanding how immigration and urbanisation have impacted on Pacific peoples' cultural identity including the fragmentation of traditional customs, language and disconnection with origins; and the effects this may have on presentation.
- Recognition that Pacific people are a heterogeneous group from different nations and island groups with different languages and customs.
- Understanding that the specific Pacific culture of a patient and their family is an important tool in engagement and forming a therapeutic alliance and the importance of working alongside cultural workers and community leaders.
- Understanding the historical context linking New Zealand or Australia with Pacific nations and island groups.
- Understanding the different Pacific cultural nuances of interaction in the doctor–patient relationship, eg. issues about eye contact as a sign of respect.

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	• Knowledge about the differing presentation of symptoms by Pacific people, eg. that these may represent culturally defined phenomena rather than psychopathology (although both can co-exist) and the somatic presentation of psychological symptoms such as in depression. • Knowledge about the epidemiology of Pacific peoples' mental health and health outcomes in the modern New Zealand or Australian context, especially metabolic risk factors in relation to physical health issues. • Understanding of the relevant cultural beliefs and explanatory models of illness. • Knowledge of the importance of spirituality and of the extended family to Pacific people and of the need for a holistic biopsychosociocultural approach. • Understanding that difficulties in engagement and therapeutic alliance may reflect issues around stigma, or a lack of trust of the dominant culture and health models which do not embrace traditional cultural ideologies and practices. **Skills** • Engagement and collaboration with cultural workers when assessing Pacific people and their family. • If the cultural worker cannot act as an interpreter, skills in carrying out assessments of Pacific people using an appropriate interpreter, where necessary. • Utilisation of culturally appropriate assessment tools to identify important cultural dimensions, where relevant. • Ability to integrate appropriate cultural models of health with modern psychiatric practice during assessments. • Ability to communicate cultural dimensions both verbally and in writing. **Attitude** • An ethical, professional and collaborative approach to Pacific people and their families. • Openness to learning from cultural advisors, community leaders, patients and families. • Awareness and self-reflection on own cultural biases and how these may impact on understanding Pacific people.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Observed Clinical Activity (OCA). • Mini-Clinical Evaluation Exercise. • Case-based discussion. • Direct Observation of Procedural Skills (DOPS).

References

Le Va. Manukau City: Le Va, 2015. Viewed 13 August 2015, <www.leva.co.nz>. [Attending a *Engaging Pasifika cultural competency workshop*, run by Le Va is recommended.]

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LUI D. *Family – a Samoan perspective*. Keynote presentation to the SF National Conference. Christchurch, September 2003. Wellington: Mental Health Commission, 2003. <http://www.hdc.org.nz/media/199714/family.%20a%20samoan%20perspective.doc>

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SAMU KS & SUAALII-SAUNI T. Exploring the 'cultural' in cultural competencies in Pacific mental health. *Pac Health Dialog* 2009; 15: 120–30.

COL, Collaborator; COM, Communicator; HA, Health Advocate; MAN, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

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ST2-AP-EPA10 – Management of Pacific people

Area of practice	Adult psychiatry (Pacific peoples' mental health)	***EPA identification***	ST2-AP-EPA10
Stage of training	Stage 2 – Proficient	***Version***	v0.2 (EC-approved 06/11/15)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Collaborative management of people of Pacific Island descent.***			
Description Maximum 150 words	The trainee can develop appropriate management and recovery plans for Pacific people. They understand Pacific peoples' models of health and traditional healing practices and integrate these into management planning as necessary. The trainee understands the role of family in supporting care and recovery and forms collaborative relationships with the family and other caregivers, as appropriate.			
Fellowship competencies	**ME**	4, 5, 6, 7, 8	**HA**	1
	COM	1, 2	**SCH**	
	COL	1, 2, 3, 4	**PROF**	1, 2
	MAN			
Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Understanding of the crucial role of family, the roles and responsibilities within Pacific families and the nature of family relationships with people with mental illness, in supporting the care and recovery of Pacific people with mental illness. • Understanding of the role of cultural advisors and the skills involved in working alongside Pacific people and their families. • Understanding that the specific Pacific culture of a patient and their family is an important tool in engagement and forming a therapeutic alliance and the importance of working with cultural workers and community leaders. • Knowledge of the importance of spirituality and of the extended family to Pacific people, that Pacific people may regard spiritual interventions as key contributors to their recovery and of the need for a holistic biopsychosociocultural approach in management.			

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	• Understanding that difficulties in engagement and therapeutic alliance in implementing management and recovery plans may reflect issues around stigma, or a lack of trust of the dominant culture and health models which do not embrace traditional cultural ideologies and practices. • Knowledge of the particular physical health issues and the increased risk factors from psychotropic medications in Pacific peoples, especially the need for metabolic screening and intervention. • Knowledge of Pacific peoples' models of health, especially regarding treatments and healing practices. • Knowledge of the available services and supports for Pacific people. **Skills** • Engagement and collaboration with cultural workers when developing and implementing care and recovery plans with Pacific people and their family. • If the cultural worker cannot act as an interpreter, skills in the continuing follow-up and management of Pacific people using an appropriate interpreter, where necessary. • Integration, where appropriate, of traditional healing practices and cultural beliefs into the management and recovery plan. • The ability to work with cultural advisors and to respect the patient's wish for self-determination and autonomy as well as their need for family and community connectedness in developing a collaborative management and recovery plan. • Ability to use appropriate outcome measures (eg. Health of the Nation Outcome Scales [HoNOS]) and adjust management planning accordingly. **Attitude** • An ethical, professional and collaborative approach to care and recovery work with Pacific people and their families. • Openness to learning about culturally appropriate treatment and healing interventions from cultural advisors, patients and families. • Awareness and self-reflection on own cultural biases and how these may impact on working with Pacific people.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details *(these include, but are not limited to, WBAs)*	• Mini-Clinical Evaluation Exercise. • Case-based discussion. • Direct Observation of Procedural Skills (DOPS). • Supervision discussion following an *Engaging Pasifika cultural competency workshop*, such as run by Le Va, is recommended.
References Le Va. Manukau City: Le Va, 2015. Viewed 13 August 2015, <www.leva.co.nz>.	

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LUI D. *Family – a Samoan perspective*. Keynote presentation to the SF National Conference. Christchurch, September 2003. Wellington: Mental Health Commission, 2003. <http://www.hdc.org.nz/media/199714/family.%20a%20samoan%20perspective.doc>

MEDICAL COUNCIL OF NEW ZEALAND. *Best health outcomes for Pacific peoples: practice implications*. Wellington: MCNZ, May 2010. Viewed 13 August 2015, <www.mcnz.org.nz/assets/News-and-Publications/Statements/Best-health-outcomes-for-Pacific-Peoples.pdf>.

PULOTU-ENDEMANN FK. *Fanofale model of health*. Auckland: Health Promotion Forum of New Zealand, 2010. Viewed 13 August 2015, <www.hauora.co.nz/resources/Fonofalemodelexplanation.pdf>.

SAMU KS & SUAALII-SAUNI T. Exploring the 'cultural' in cultural competencies in Pacific mental health. *Pac Health Dialog* 2009; 15: 120–30.

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ST2-AP-EPA11 – Differential diagnosis of first time psychosis

<table>
<tr><td>Area of practice</td><td colspan="2">Adult psychiatry (Early Psychosis Intervention)</td><td>EPA identification</td><td>ST2-AP-EPA11</td></tr>
<tr><td>Stage of training</td><td colspan="2">Stage 2 – Proficient</td><td>Version</td><td>v0.2 (EC-approved 06/11/15)</td></tr>
<tr><td colspan="5">The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.</td></tr>
<tr><td>Title</td><td colspan="4">Differential diagnosis in people presenting for the first time with psychosis.</td></tr>
<tr><td>Description
Maximum 150 words</td><td colspan="4">The trainee can develop and discuss an appropriate formulation and differential diagnoses in young people and adults presenting for the first time with psychosis. This includes the ability to undertake a full assessment, organise appropriate investigations, gather collateral information and from all these, determine likely differential diagnoses according to a recognised diagnostic system. The trainee can develop a management plan based on these differential diagnoses and discuss and explain differential diagnoses with patients and families/carers after assessment and during follow-up.</td></tr>
<tr><td rowspan="4">Fellowship competencies</td><td>ME</td><td>1, 2, 3, 4, 5, 6, 7</td><td>HA</td><td>2</td></tr>
<tr><td>COM</td><td>1, 2</td><td>SCH</td><td>2</td></tr>
<tr><td>COL</td><td>1, 2, 3, 4</td><td>PROF</td><td>1, 2</td></tr>
<tr><td>MAN</td><td></td><td colspan="2"></td></tr>
<tr><td>Knowledge, skills and attitude required
The following lists are neither exhaustive nor prescriptive.</td><td colspan="4">Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.
Ability to apply an adequate knowledge base
• Knowledge of relevant diagnostic systems and categories and their benefits and limitations including an appreciation of the diagnostic instability of first episode psychosis.
• Knowledge of how to develop an appropriate biopsychosociocultural diagnostic formulation.
• Understanding how to weigh the strengths and weaknesses of various differential diagnoses so as to determine the most likely option or options.
• Understanding the ways in which psychosis may present with unusual features in young people presenting with first episodes.
• Understanding the pros and cons of making a definite diagnosis vs avoiding foreclosing on one diagnosis too early in the course of a psychosis.</td></tr>
</table>

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	• Understanding and articulating the arguments for and against the use of the diagnostic category psychosis not otherwise specified (NOS) vs utilising a diagnosis of schizophrenia as soon as diagnostic criteria are met. • Understanding how differing developmental levels may affect diagnosis in first onset psychosis. • Understanding how to discuss the formulation and differential diagnoses with patients and families/carers. • Understanding how to apply the formulation and differential diagnoses in developing treatment and recovery plans. • Understanding the features and significance of 'at risk mental states' (ARMS) in people at risk of developing early psychoses. • Understanding the application of clinical staging models to diagnosis in early psychosis. • Understanding and applying the stress-vulnerability model (or other explanatory model) in formulating the development of a psychotic episode. • Understanding that psychotic and psychotic-like experiences sit on a spectrum and how social, cultural and religious factors may influence presentation. **Skills** • Ability to initially assess people presenting with early psychosis or 'at risk mental states' so as to develop a differential diagnosis. This includes history, mental state evaluation, gathering collateral information and other investigations. • Ability to apply relevant diagnostic systems to determine appropriate differential diagnoses in the assessment of people with early psychosis. • Ability to integrate information to develop diagnostic formulations and to present and explain these. • Ability to discuss and explain differential diagnoses to patients and families/carers after assessment and during follow-up, especially as regards avoidance of foreclosing and promotion of hope, realism and pragmatic options. • Ability to explain and apply the stress-vulnerability model (or other explanatory model) with patients, families and others. • Ability to apply the diagnostic formulation and differential diagnoses in developing treatment and recovery plans. • Ability to review and revise likely differential diagnoses in the light of developing evidence across the course of a person's follow-up and in the light of clinical staging models. • Ability to diagnose comorbid problems complicating the presentation of early psychosis or 'at risk mental states'. **Attitude** • An ethical and professional approach to patients, their families and other people important to them during assessment and diagnosis. • Respect for the knowledge brought by patients, their families and others and a willingness to learn and to develop the diagnosis accordingly.

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	• Commitment to personal development, eg. reading early intervention-specific literature to develop knowledge and skills specific to diagnosis and the attendant issues in the early intervention field.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Observed Clinical Activity (OCA). • Mini-Clinical Evaluation Exercise. • Case-based discussion.

References

EARLY PSYCHOSIS GUIDELINES WRITING GROUP. *Australian Clinical Guidelines for Early Psychosis*. 2nd edn. Melbourne: Orygen Youth Health, 2010.

MCGORRY PD, KILLACKEY E & YUNG A. Early intervention in psychosis: concepts, evidence and future directions. *World Psychiatry* 2008; 7: 148–56.

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ST2-AP-EPA12 – Engagement with people with first episode psychosis

Area of practice	Adult psychiatry (Early Psychosis Intervention)	***EPA identification***	ST2-AP-EPA12
Stage of training	Stage 2 – Proficient	***Version***	v0.2 (EC-approved 06/11/15)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Engagement with people with first episode psychosis and with their families.***			
Description Maximum 150 words	The trainee can engage with people with first episode psychosis and with their families and other important people in their lives, both at initial assessment and across subsequent follow-up. The trainee demonstrates skill in managing the relationship with patients, families and others so as to promote engagement and collaboration and is able to negotiate potential barriers to engagement such as stigma or cultural differences.			
Fellowship competencies	**ME**	1, 2, 3, 4, 5, 6	**HA**	1, 2
	COM	1, 2	**SCH**	2
	COL	1, 2, 3, 4	**PROF**	1, 2
	MAN	3, 4		

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.

Ability to apply an adequate knowledge base

- Understanding the concept of engagement and the evidence in the literature about how to improve engagement, such as a youth-friendly attitude, a spirit of optimism, focussing on strengths, problem solving, motivational interviewing approaches, a collaborative approach, respect for the person and their family's beliefs and patience.
- Understanding the factors causing barriers to engagement, such as poor insight, concerns about stigma, negative perception of mental health services, comorbid substance use, symptoms of the illness itself, cultural differences and issues linked to a young person's developmental stage (eg. mistrust of 'authority', lack of interest in own healthcare, peer pressure).
- Understanding how the development of good engagement contributes to prevention and promotion.
- Understanding the importance of service interface and structure to reducing barriers to accessing mental healthcare and improving engagement, (eg. flexibility in place and time of contacts, youth-friendly and culturally appropriate services).

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	• Understanding the importance of engagement to reduce duration of untreated psychosis (DUP) and why this is important for best outcomes in early psychosis. **Skills** • Ability to improve engagement, including (but not limited to) the ability to develop rapport, convey hope, to focus on strengths, to aid problem solving and to collaborate with the person and their family/carers in a positive manner. • Ability to apply motivational interviewing approaches regarding health behaviours, with an additional outcome being improved engagement. • Ability to address barriers to engagement as detailed above, wherever this is possible, in the trainee's work with patients and their families/carers. • Ability to show some leadership in the multidisciplinary team and/or local services so as to improve engagement and address barriers to engagement. • Ability to work collaboratively with cultural workers so as to improve engagement and quality of care for people with early psychosis and their families and others. **Attitude** • An ethical, professional and collaborative approach to engaging people with early psychosis and their families. • Positive attitudes assisting engagement such as maintaining a spirit of optimism and respect for others. • Openness to learning more about ways to improve engagement and reduce barriers to engagement.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Mini-Clinical Evaluation Exercise. • Observed Clinical Activity (OCA). • Case-based discussion. • Direct Observation of Procedural Skills (DOPS). • Professional presentation – about engagement in early psychosis intervention.

References

BURNS J & BIRRELL E. Enhancing early engagement with mental health services by young people. *Psychol Res Behav Manag* 2014; 7: 303–12.

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ORYGEN YOUTH HEALTH. *The acute phase of early psychosis: a handbook on management.* Parkville: Orygen Youth Health, 2004.

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Forensic psychiatry

ST2-FP-EPA1 – Violence risk assessment 2

Area of practice	Forensic psychiatry	***EPA identification***	ST2-FP-EPA1
Stage of training	Stage 2 – Proficient	***Version***	v0.6 (BOE-approved 04/05/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Violence risk assessment and management 2.***			
Description Maximum 150 words	Develop a formulation, risk assessment and management plan for a patient with a remote and/or recent history of violence.			
Fellowship competencies	**ME**	1, 3, 4, 5, 7, 8	**HA**	2
	COM	2	**SCH**	
	COL	4	**PROF**	1, 2, 3
	MAN	4		

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.

Ability to apply an adequate knowledge base

- Knowledge of evidence-based static and dynamic risk factors for violence.
- Evidence of the strengths and limitations of different approaches to assessing risk including: unstructured clinical, actuarial and structured professional judgment (SPJ) approaches.
- Basic working knowledge of at least one actuarial and at least one SPJ violence risk assessment tool.
- Basic knowledge of the construct of 'psychopathy' and its relevance to violence.
- Basic knowledge of evidence base linking mental disorder to violence.

Skills

- Elicit from patient or obtain from other sources an appropriately detailed account of past violence.
- Based on obtained history and mental state, construct a formulation that demonstrates understanding of aetiology of violence in the specific case, including an understanding of relevant evidence-based dynamic and static risk factors.

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	• Assessment of likelihood and gravity of future violence, including possible scenarios of elevated risk. • Development of appropriate management plan to minimise future risk of harm including a consideration of: - biological treatments - psychosocial interventions - victim-safety planning - legal issues. **Attitude** • Non-judgmental approach to the problem of violent behaviour, constructing violence as a problematic behaviour to be treated, rather than a moral failing to be condemned. • A diligent attitude to communicating information and plans where appropriate to carers and health workers involved. • Appropriate attitudes to balancing competing priorities, eg. civil liberties, confidentiality, therapeutic rapport, when managing risk. • Awareness of own limitations and willingness to seek other's opinion when required. • Awareness that risk in general can only be reduced, not eliminated, and that there is a necessary role for 'therapeutic risk taking' in psychiatric practice. • Appropriate level of diligence in documentation of assessment, decisions and reasoning. • Adherence to ethical framework that conceives risk assessment as systematically articulating and then striving to meet relevant clinical needs, not simply providing a predictive categorical label.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details *(These include, but are not limited to, WBAs)*	• Observed Clinical Activity (OCA) – of a previously unknown case. • Case-based discussion – includes review of collateral information and production of a written report (as for a consultation request). • Direct Observation of Procedural Skills (DOPS) – Observe interviews and oral evidence given by the trainee providing feedback.
References	

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ST2-FP-EPA2 – Expert evidence 2

Area of practice	Forensic psychiatry	***EPA identification***	ST2-FP-EPA2
Stage of training	Stage 2 – Proficient	***Version***	v0.6 (BOE-approved 04/05/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Expert evidence 2.***			
Description Maximum 150 words	Assess patients for legal purposes, provide psychiatric evidence, by way of written and oral testimony to a legal body (tribunal/panel/court) relating to one of the following. • Detention/supervision/release reviews (including civil Mental Health Act boards/tribunals or equivalents). • Disposition/sentencing.			
Fellowship competencies	**ME**	1, 2, 3, 4	**HA**	1
	COM	1, 2	**SCH**	
	COL	4	**PROF**	1, 2
	MAN			
Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Understands the requirements of the legal body seeking opinion/testimony. • Basic understanding of the role of the expert witness and how this differs from usual 'treating doctor' role. What an expert is and where the limits of expertise lie. • The psychiatric knowledge as it applies to the task at hand, including awareness of the limits and weakness of that knowledge. **Skills** • Conduct an organised and comprehensive interview consistent in scope with the requirements of the required opinion or testimony. This includes effective communication of their role, limits of confidentiality and consent. • Write a structured, relevant and focused report specifically addressing the issues required. They should demonstrate flexibility in their approach to balancing the competing needs for rigour and concise writing. The opinion should be clear			

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	and understandable in the context of the body of their report. Unnecessary jargon should be avoided. Collateral information should be appropriately sought and integrated into the report in a coherent fashion. • When writing opinion or giving oral evidence the trainee should be able to translate the psychiatric issues into understandable language for the legal forum involved. • Oral evidence should be clear, concise and relevant. The trainee should demonstrate the capacity to maintain composure when challenged and be prepared to justify, expand upon or modify their opinion appropriately. **Attitude** • The trainee must demonstrate an awareness of the potential ethical problems arising (including confidentiality, conflicts of agency, etc.) and an ability to resolve such problems professionally. • In both written and oral work the trainee should demonstrate the capacity to maintain objectivity and not be influenced by potential outcomes or fiscal reward. • The trainee must understand the need for professional disinterest in the legal outcome and that it is not their role, as an expert witness, to attempt to 'win' the case or argument. • The trainee should display an awareness of the limits of their opinion/testimony and communicate this effectively.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details *(these include, but are not limited to, WBAs)*	• Case-based discussion. • Direct Observation of Procedural Skills (DOPS). • At least one submitted report completed under supervision. • Observe interviews and oral evidence given by the trainee providing feedback.
References	

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ST2-FP-EPA3 – Psychological issues in forensic mental health

Area of practice	Forensic Psychiatry	***EPA identification***	ST2-FP-EPA3
Stage of training	Stage 2 – Proficient	***Version***	v0.1 (EC-approved 26/10/18)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Understanding and managing psychological issues in forensic patients and carers***			
Description	The trainee has a good grasp of the key psychological issues seen in patients and their carers, within forensic services. In addition to having an adequate theoretical understanding of these, the trainee can recognise these issues, elicit them sensitively in assessments, and is able to integrate psychological issues into formulations and discuss psychological interventions to assist patients and carers.			
Fellowship competencies	**ME**	1, 2, 3, 4, 5	**HA**	1
	COM	1, 2	**SCH**	2
	COL	1, 2, 3	**PROF**	1, 2, 3, 4
	MAN			

Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitudes described below. **Ability to apply an adequate knowledge base** • Knowledge of the psychological mechanisms and theories underpinning violence and antisocial behaviour. • Knowledge of psychological theories relevant to the aftermath of violence or antisocial offending, such as denial, remorse, depression, and posttraumatic reactions. • Knowledge of psychological issues affecting the families of forensic patients, such as grief, denial, shame, anger – especially where a family member was the victim of an offence. • Knowledge of psychological issues facing forensic service staff, such as burnout, vicarious trauma, etc. • Knowledge about psychological interventions which may be used in the forensic setting and with patients' families – indications, modalities, the evidence-base for efficacy. **Skills** • Ability to elicit a comprehensive history including a psychological developmental history; trauma and abuse history;

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	affective, anxiety and posttraumatic symptoms; anger management; coping mechanisms; psychological insight. • Ability to conduct an interview process and establish adequate rapport, so as to elicit psychological issues relevant to the patient's offending, mental state, treatment, and patterns of relating to others – including their likely relationships with staff in forensic services. • Ability to integrate psychological predisposing, precipitating, perpetuating and protective factors into formulations of forensic patients. • Ability to provide information and psychoeducation on psychological issues, where appropriate, to family members and to other health professionals in the forensic setting. • Identify the need for psychotherapy where appropriate. Includes awareness of potential risks and barriers. • Ability to conduct some aspects of psychotherapy with patients and/or families, or to assist as a co-therapist. However, if therapy is not undertaken directly, the trainee should at least be able to incorporate psychological issues into formulations and management plans and to write adequate referrals for psychotherapy. **Attitude** • Ability to maintain ethical standards and clear boundaries when working with forensic patients, their families, and with staff involved in their care. • Non-judgemental attitudes and a willingness to attempt to understand psychological issues in forensic patients. • Ability to empathise with the victims and family members of forensic patients, and with staff involved in their care. • A wish to avoid adding to stigma affecting forensic patients and their families, and to counteract this wherever possible. • Ability to be self-reflective and to recognise one's own emotional reactions when working in a forensic setting, and to discuss these in supervision.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion • Mini-Clinical Evaluation Exercise • OCA

References

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COL, Collaborator; COM, Communicator; HA, Health Advocate; MAN, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

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Indigenous mental health – Australia

ST2-INDAU-EPA1 – Interviewing an Aboriginal or Torres Strait Islander patient

Area of practice	Indigenous – Australia	***EPA identification***	ST2-INDAU-EPA1
Stage of training	Stage 2 – Proficient	***Version***	v0.6 (BOE-approved 12/07/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Interviewing an Aboriginal or Torres Strait Islander patient.***
Description Maximum 150 words	The trainee can use an interview with an Aboriginal or Torres Strait Islander patient to conduct a psychiatric assessment, develop rapport and build a therapeutic alliance. They can adapt their communication style to take into account barriers to communication between a psychiatrist and an Aboriginal or Torres Strait Islander patient. The trainee is able to create a culturally safe context for the interview including use of appropriate environments and presence of appropriate supports (which may include an Aboriginal and Torres Strait Islander mental health worker). The trainee can use the interview to diminish stigma around both mental illness and government health services.

Fellowship competencies				
	ME	1, 2, 3	**HA**	1
	COM	1	**SCH**	2
	COL	1, 2, 3	**PROF**	1, 2
	MAN			

Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Understands the concept of cultural safety. • Understands the role of an Aboriginal and Torres Strait Islander mental health worker (cultural interpreter). • Understands cultural aspects of verbal and non-verbal communication. • Understands historical knowledge and context of the patient's community and how this may impact on the patient's presentation or the manner in which they relate to the interviewer.

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Board of Education approved 12/07/12; WBA tool (DOPS) added 02/12/16, EPA short title updated 05/07/17

	• Knowledge of cultural belief systems including an awareness that cultural beliefs may be misunderstood as psychiatric symptoms. • Awareness of culture-bound syndromes. • Aware of possible patient perceptions of psychiatric services and how these may be a barrier to therapeutic alliance. **Skills** • Adjusts communication style as appropriate to promote patient engagement. • Communicates with empathy and uses jargon-free language. • Interviews the patient with an Aboriginal and Torres Strait Islander mental health worker to overcome language and cultural understanding barriers. • Differentiates manifestations of mental illness from culture-bound syndromes and cultural belief systems. **Attitude** • High level of self-awareness, in particular how the psychiatrist's own prejudices can impact on the process of developing a therapeutic relationship. • Willingness to defer to the Aboriginal and Torres Strait Islander mental health worker as the expert in relation to traditional languages and cultural understandings. • Motivated to continuously work towards reducing stigma towards mental illness.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Observed Clinical Activity (OCA). • Mini-Clinical Evaluation Exercise. • Case-based discussion. • Direct Observation of Procedural Skills (DOPS).

References

THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS. *Module 1: Interviewing an Aboriginal or Torres Strait Islander patient*. Melbourne: RANZCP, October 2014. Viewed 20 November 2014, <Learn*it*: Module 1: Interviewing an Aboriginal or Torres Strait Islander patient>

COL, Collaborator; COM, Communicator; HA, Health Advocate; MAN, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

ST2-INDAU-EPA2 – Management plan for an Aboriginal or Torres Strait Islander patient

Area of practice	Indigenous – Australia	***EPA identification***	ST2-INDAU-EPA2
Stage of training	Stage 2 – Proficient	***Version***	v0.9 (BOE-approved 15/10/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Develop a mental healthcare management plan for an Aboriginal or Torres Strait Islander patient.***
Description Maximum 150 words	The trainee can develop an innovative and creative mental healthcare management plan for an Aboriginal or Torres Strait Islander patient in collaboration with stakeholders as appropriate. They understand the impact of socioeconomic disadvantage, historical trauma, transgenerational trauma and re-traumatisation on vulnerability to mental illness and the manner in which these factors contribute to barriers to accessing mental healthcare. They consider the availability of standard services in the community and utilise the alternate resources available, including extended family, non-government organisations and informal resources. The trainee has knowledge of the patient's community of origin and cultural beliefs and facilitates incorporation of cultural supports such as traditional healers, Elders and Aboriginal and Torres Strait Islander mental health workers into the care plan.

Fellowship competencies	**ME**	4, 5, 6, 7	**HA**	1,
	COM	1, 2	**SCH**	2
	COL	1, 2, 3	**PROF**	1, 2
	MAN	4		

Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Knowledge of limitations of service delivery and government resources in some Aboriginal and Torres Strait Islander communities. • Knowledge of alternative community resources that may be included in a management plan. • Understands the strengths and difficulties present in different Aboriginal and Torres Strait Islander communities and the complexity this adds to the development of a mental healthcare plan.

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Board of Education approved 15/10/12; WBA tool (DOPS) added 02/12/16, updated EPA title 05/07/17

	• Understands the crucial role of family and the wider community in supporting the treatment and recovery of an Aboriginal or Torres Strait Islander person with mental illness. • Understands Aboriginal and Torres Strait Islander kinship structure. • Knowledge of culture-bound syndromes and the role of the traditional healer. • Understands the historical context of Aboriginal and Torres Strait Islander peoples and the implications for mental health. • Understands the link between social determinants and mental illness in the Aboriginal and Torres Strait Islander population. **Skills** • Ability to develop a collaborative relationship with the extended family/community in order to develop a management plan. • Ability to consult and liaise with a wide range of stakeholders. • Ability to work with an Aboriginal and Torres Strait Islander mental health worker and/or other members of the Aboriginal and Torres Strait Islander workforce to develop an understanding of available resources and barriers to mental health treatment in any given Aboriginal or Torres Strait Islander community. • Ability to communicate with Aboriginal and Torres Strait Islander patients and family in jargon-free language to promote understanding of the patient's condition and ongoing treatment needs. • Ability to, where appropriate, incorporate the role of a traditional healer into a patient's treatment plan. • Ability to advocate, and lobby for, improved socioeconomic conditions in Aboriginal and/or Torres Strait Islander communities. **Attitude** • Sensitivity to specific community factors that may contribute to risk. • Patience in attaining information and coordinating a care plan with multiple stakeholders. • Willingness to consider oneself as the 'coordinator' and others as the experts. • Creative thinking in utilising limited resources to come up with solutions to complex problems. • Adopt a pro-active leadership role in advocating for the patient and their community.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Observed Clinical Activity (OCA). • Mini-Clinical Evaluation Exercise. • Case-based discussion.

	• Direct Observation of Procedural Skills (DOPS).

References

THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS. *Module 2: Developing a mental health management plan for an Aboriginal or Torres Strait Islander patient*. Melbourne: RANZCP, October 2014. Viewed 20 November 2014, <Learn*it*: Developing a mental health management plan for an Aboriginal or Torres Strait Islander patient>

COL, Collaborator; COM, Communicator; HA, Health Advocate; MAN, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

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Indigenous mental health – New Zealand

ST2-INDNZ-EPA1 – Interviewing a Māori patient

Area of practice	Indigenous – New Zealand	***EPA identification***	ST2-INDNZ-EPA1
Stage of training	Stage 2 – Proficient	***Version***	v0.6 (EC-approved 08/01/14)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Interviewing a Māori patient.***			
Description Maximum 150 words	The trainee can engage a tangata whaiora Māori (Māori consumer) to conduct a psychiatric assessment and build a therapeutic alliance. They are able to create a culturally safe context for the interview including an appropriate environment, approach, assessment framework and the presence of appropriate supports, eg. whānau (family). The trainee can adapt their communication style to meet the needs of the tangata whaiora and whānau and promote engagement.			
Fellowship competencies	**ME**	1, 2, 3	**HA**	
	COM	1, 2	**SCH**	
	COL	1, 2, 3	**PROF**	1, 2
	MAN			

Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Understand how colonisation processes have impacted on Māori cultural identity and the fragmentation of traditional customs, language and disconnection with lands and the implications this may have on presentation. • Recognise that Māori are a heterogeneous group from different areas with different dialects and customs. • Understand the role of the Treaty of Waitangi and the implications for Māori health and wellbeing, particularly with regard to Articles 2 and 3. • Understand that knowing where the tangata whaiora (consumer) is from (ie. tribal area) is an important tool in engagement and forming a therapeutic alliance. • Understand the different Māori cultural nuances of interaction in the doctor–patient relationship, eg. tāngata whaiora not making eye contact as a sign of respect or feelings of whakamā (shame)/feeling stink.

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Education Committee approved 19/12/13 (v0.5); amended and approved 08/01/14 (v0.6; WBA tool [DOPS] added 02/12/16)

	• Understand the role of cultural advisors and the skills involved in working alongside Māori and whānau. • Understand that some symptoms may represent culturally defined phenomena and may not represent psychopathology although both can co-exist. • Up-to-date understanding of the epidemiology of Māori mental health and disproportionately poor health outcomes with knowledge of the causative factors. • Awareness of the cultural concepts of tapu (sacred) and noa (ordinary) and their application to the doctor–patient relationship. • Recognise that poor engagement and therapeutic alliance may reflect a lack of trust towards the dominant culture and models of health which do not embrace traditional cultural ideology and practice. **Skills** • Engage and collaborate with cultural support staff when interviewing a tangata whaiora and their whānau (family) for the first time. This may involve traditional rituals of encounter such as mihi (greeting), whakatau (welcome), karakia (ritual chants/prayers), etc. • Recognise that whānau speak for themselves offering their experiences and perspectives of the illness. • Encourage te reo Māori (Māori language) during the interview and consultation process. (Note, the trainee needs to be guided by the preference of the tangata whaiora for te reo Māori, English or both and adapt accordingly.) • Utilise culturally appropriate assessment tools to identify important cultural dimensions where relevant. • Apply Māori models of hauora (health), eg. Te Whare Tapa Whā, to the clinical situation. • Communicate cultural dimensions both verbally and in writing. **Attitude** • Aware and self-reflective of own cultural biases and how these may impact on understanding tāngata whaiora.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Observed Clinical Activity (OCA). • Mini-Clinical Evaluation Exercise. • Case-based discussion. • Direct Observation of Procedural Skills (DOPS).
References OAKLEY BROWNE MA, WELLS JE & SCOTT KM, eds. *Te Rau Hinengaro: the New Zealand mental health survey*. Wellington: Ministry of Health, 2006. ***Glossary***	

hauora – health and wellbeing.

karakia – often defined as ritual chants and prayers, karakia provide a mechanism to clear and mediate spiritual pathways.

mihi – speech of greeting, acknowledgement, tribute.

noa – to be made neutral, ordinary or unrestricted and made free from the extensions of tapu.

tangata whaiora (*s*)**/tāngata whaiora** *(pl)* – a term used to describe a person who uses services; it is literally translated to mean a person who is pursing health, wellness and recovery.

tapu – a term used to describe something sacred, prohibited, restricted, forbidden.

te reo Māori – the Māori language.

whakamā – to be ashamed, shy, embarrassed. Whakamā can be experienced by an individual or a group (eg. whānau). It can also affect how a collective might relate to an individual.

whakatau – a welcome or welcome speeches.

whānau – extended family, family group. In the contemporary context, the term is also used to include friends who may not have any kinship ties to other members.

Glossary of Māori terms from:
TE POU O TE WHAKAARO NUI. *He rongoā kei te kōrero. Talking therapies for Māori: wise practice guide for mental health and addiction services.* Auckland: Te Pou o Te Whakaaro Nui, 2010.

COL, Collaborator; COM, Communicator; HA, Health Advocate; MAN, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

ST2-INDNZ-EPA2 – Management plan for a Māori patient

Area of practice	Indigenous – New Zealand	***EPA identification***	ST2-INDNZ-EPA2
Stage of training	Stage 2 – Proficient	***Version***	v0.5 (EC-approved 08/01/14)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Develop a mental healthcare management and recovery plan for a Māori patient.***
Description Maximum 150 words	The trainee can develop an innovative management and recovery plan for a tangata whaiora Māori (Māori consumer). They understand Māori models of health and traditional healing practices and address these in the management plan where appropriate. The trainee understands the role of whānau (family) in supporting recovery and is able to form collaborative relationships with the whānau as appropriate.

Fellowship competencies				
	ME	4, 5, 6, 7	**HA**	1
	COM	1, 2	**SCH**	
	COL	1, 2, 3	**PROF**	1, 2
	MAN			

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.

Ability to apply an adequate knowledge base

- Understand the crucial role of whānau (family) in supporting the treatment and recovery of Māori with mental illness.
- Understand the different roles and responsibilities within whānau and the nature of whānau relationships with tāngata whaiora (consumers).
- Understand the role of cultural advisors and the skills involved in working alongside Māori and whānau.
- Knowledge of Māori models of health, eg. Te Whare Tapa Whā, Te Wheke, Te Pae Mahutonga, etc.
- Awareness of the traditional healing practices that Māori may consider using to support health and wellbeing.
- Recognise that tāngata whaiora may consider waiata (songs), karakia (ritual chants/prayers) and te reo Māori (Māori language) as contributors to their recovery.
- Awareness of available kaupapa Māori (Māori ideology) services and supports.

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Education Committee approved 19/12/13 (v0.4); amended and approved 08/01/14 (v0.5; WBA tool [DOPS] added 02/12/16)

	Skills • Collaborate with a whānau adviser to support tāngata whaiora to connect or reconnect with their whakapapa (genealogy), marae (meeting grounds), whānau, hapū (subtribe) and iwi (tribe). • Support tāngata whaiora to engage in activities that optimise cultural linkages and whānau connectedness. • Encourage te reo Māori during the consultation process. (Note, the trainee needs to be guided by the preference of the tangata whaiora for te reo Māori, English or both and adapt accordingly.) • Incorporate Māori models of hauora (health) in the management plan, where appropriate. • Incorporate, where appropriate, traditional healing practices into the management plan. • Utilise appropriate outcome measures (eg. Hua Oranga, Health of the Nation Outcome Scales [HoNOS]) and adjust management plan accordingly. **Attitude** • Advocate for self-determination and autonomy. • Recognise and support the resourcefulness of tāngata whaiora and whānau.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion. • Mini-Clinical Evaluation Exercise. • Direct Observation of Procedural Skills (DOPS).

References

Glossary

hapū – a kinship group, commonly a subtribe or a section of a larger kinship group.

hauora – health and wellbeing.

iwi – an extended kinship group, tribe, nation, people, nationality, race; often refers to a large group of people descended from a common ancestor.

karakia – often defined as ritual chants and prayers, karakia provide a mechanism to clear and mediate spiritual pathways.

kaupapa Māori – Māori ideology; a philosophical doctrine incorporating the knowledge, skills, attitudes and values of Māori society.

marae – a traditional meeting place for whānau, hapū and iwi members.

tangata whaiora (*s*)**/tāngata whaiora** *(pl)* – a term used to describe a person who uses services; it is literally translated to mean a person who is pursing health, wellness and recovery.

tapu – a term used to describe something sacred, prohibited, restricted, forbidden.

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Education Committee approved 19/12/13 (v0.4); amended and approved 08/01/14 (v0.5; WBA tool [DOPS] added 02/12/16)

te reo Māori – the Māori language.

waiata – song. The most performed songs are waiata which take many forms and are used for a variety of purposes. Waiata are often performed at the end of speeches to support what has been said, they can also be sung to remove tapu or to engage, entertain, calm or comfort the listener.

whakapapa – genealogy, lineage, descent.

whānau – extended family, family group. In the contemporary context, the term is also used to include friends who may not have any kinship ties to other members.

Glossary of Māori terms from:
TE POU O TE WHAKAARO NUI. *He rongoā kei te kōrero. Talking therapies for Māori: wise practice guide for mental health and addiction services.* Auckland: Te Pou o Te Whakaaro Nui, 2010.

COL, Collaborator; COM, Communicator; HA, Health Advocate; MAN, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

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Education Committee approved 19/12/13 (v0.4); amended and approved 08/01/14 (v0.5; WBA tool [DOPS] added 02/12/16)

Research

ST2-RES-EPA1 – Research Skills – Planning and initiating a research project 2

Area of practice	Research	***EPA identification***	ST2-RES-EPA1
Stage of training	Stage 2 - Proficient	***Version***	v0.7 (EC-approved 25/05/18)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Planning and initiating a research project 2.***			
Description Maximum 150 words	The trainee will demonstrate skills in formulating a research question and planning how to investigate this question in an appropriately designed study. The trainee will demonstrate competence in determining resources required to conduct the study and in applying for appropriate approval of the study, including from an Ethics Committee.			
Fellowship competencies	**ME**	7	**HA**	1
	COM	1	**SCH**	1,2,3
	COL	3,4	**PROF**	1,2,3
	MAN	1,3,		

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.

Ability to apply an adequate knowledge base

- Knowledge of different study designs suitable for psychiatric research (quantitative and qualitative)
- Knowledge of resources required to undertake psychiatric research.
- Knowledge of key concepts that influence the power of a study
- Knowledge of processes involved in gaining approval for a research study, including an application for Ethics Approval

Skills

- Formulating a research question that can be investigated
- Developing testable hypotheses based on this question and defining appropriate Aims for the Study

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	• Determining the type of study design that will best test the hypotheses and achieve the Aims of the study • Determining the resources (financial, human, time etc) that will be needed to complete the Study • Undertaking a Power calculation as required, e.g. estimating the numbers of subjects required to have sufficient power to test hypotheses. • Appropriate and skilled use of blinding and randomisation techniques • Determining if a Pilot Study is required, and if it is, planning this Pilot Study • Modifying the study design based on assessment of the above issues and an appropriate literature review • Gaining appropriate approval for the Study e.g. submitting an application for ethics approval (if applicable), submitting a proposal for a research degree to an academic institution (if applicable) **Attitude** • Efficient utilisation of resources and time when planning and initiating a research study • Collaborative involvement of supervisor and colleagues in the research/academic team • Maintaining an attitude of academic rigour and critical analysis when planning a research study • Demonstrate an appropriate ethical attitude to the research process
Assessment method	• Progressively assessed during individual and academic supervision, including three appropriate WBAs. • at least one professional presentation to an academic meeting that reports the final proposed study design
Suggested assessment method details	• DOPS and other professional presentations that assess progress at different stages of the planning process • The supervisor should review written Ethics Application and any other written Research Proposals • Supervision may include "Research-Based Discussions" that involve the trainee presenting to their supervisor several aspects of their proposal, e.g. the supervisor asking the trainee to present their hypotheses/research question, proposed study design, power calculation, Pilot Study, literature review etc, which may be conducted as a DOPS

References

FREEMAN C AND TYRER P (eds) (2006) *Research Methods in Psychiatry: A Beginner's Guide*. Third Edition. Royal College of Psychiatrists London: Gaskell.

GILLON, R (1994) Medical ethics: four principles plus attention to scope. *British Medical Journal* 309 (184). doi:10.1136/bmj.309.6948.184.

NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL (NHMRC) (2007) *Australian Code for the Responsible Conduct of Research (the Code)*. Canberra, Australia: Australian Government

National Health and Medical Research Council Act 1992 (Cth)

NHMRC (2007) *National Statement on Ethical Conduct in Human Research* - updated May 2015. Canberra, Australia: Australian Government.

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MACFARLANE M, KISELY A, LOI S ET AL. (2014) Getting started in research: research questions, supervisors and literature reviews. *Australasian Psychiatry* 23: 8–11.

MACFARLANE M, KISELY A, LOI S ET AL. (2014) Getting started in research: designing and preparing to conduct a research study. *Australasian Psychiatry* 23: 12–15.

COL, Collaborator; COM, Communicator; HA, Health Advocate; MAN, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

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ST2-RES-EPA2 – Research skills – Literature review 2

<table>
<tr><td>Area of practice</td><td colspan="2">Research</td><td>EPA identification</td><td>ST2-RES-AOP-EPA2</td></tr>
<tr><td>Stage of training</td><td colspan="2">Stage 2 – Proficient</td><td>Version</td><td>v0.7 (EC-approved 25/05/18)</td></tr>
<tr><td colspan="5">The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.</td></tr>
<tr><td>Title</td><td colspan="4">Planning, conducting and reporting a review of scientific literature 2.</td></tr>
<tr><td>Description
Maximum 150 words</td><td colspan="4">The trainee will demonstrate skills in planning, conducting and reporting a review of scientific literature relevant to a research project the trainee is undertaking. The trainee will demonstrate competence in developing a search strategy, critical analysis of papers reviewed and synthesis of information into justifiable conclusions.</td></tr>
<tr><td rowspan="5">Fellowship competencies</td><td>ME</td><td>7</td><td>HA</td><td>1</td></tr>
<tr><td>COM</td><td>1</td><td>SCH</td><td>1,2,3</td></tr>
<tr><td>COL</td><td>3,4</td><td>PROF</td><td>1,2,3</td></tr>
<tr><td>MAN</td><td>1,3</td><td colspan="2"></td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>Knowledge, skills and attitude required
The following lists are neither exhaustive nor prescriptive.</td><td colspan="4">Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.

Ability to apply an adequate knowledge base
• Knowledge of the principle of evidence based medicine in psychiatry
• Understanding the different types of literature review, such as narrative reviews, systematic reviews and meta-analyses, when they should be used and what their advantages and disadvantages are.
• Detailed knowledge of different search strategies, and how these can be used to search academic literature databases
• Broad knowledge of factors that determine the quality of research methodology used in published articles, such as sources of bias, and how these can be objectively assessed
• Knowledge of statistical techniques that can be used to analyse aggregated data obtained from a systematic review

Skills</td></tr>
</table>

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	• Choosing and conducting an appropriate search strategy relevant to the type of literature review being conducted, which is sufficiently comprehensive for the outcome desired. • Developing criteria for selecting articles from these searches for analysis and review • Critically reviewing these articles, including an assessment of their quality as well as the merit of their conclusions • Synthesising this review into a coherent narrative • Appropriate acknowledgement of the source of information • Drawing justifiable conclusions, identifying limitations and proposing future research • Using the outcomes of a review to inform and adapt the trainee's own research plans • Choosing the structure tool relevant to the review being undertaken (e.g. Prisma). **Attitude** • Efficient utilisation of resources and time when conducting the literature review • Collaborative involvement of supervisor and colleagues in the research/academic team • Maintaining an attitude of academic rigour, balance and objectivity when reviewing articles and synthesising information • Ensuring all conclusions are justified and all limitations to those conclusions identified • Demonstrate an appropriate ethical attitude to the research process
Assessment method	• Progressively assessed during individual and academic supervision, including three appropriate WBAs. • at least one professional presentation to an academic meeting that reports the final outcome of the literature review
Suggested assessment method details	• DOPSs and other professional presentations that assess progress at different stages of the literature review process • The supervisor should review search strategies and written drafts of reviews as part of regular supervision. • Supervision may include "Article Based Discussions" that may involve the trainee presenting to their supervisor several papers retrieved by their search, with the supervisor asking the trainee to present their critique from a selected few, in a format similar to and adapted from the Case-Based Discussion protocol, and may be conducted as a DOPS

References

BEN TOVIM, D (1994) Handy hints on completing a psychiatric research project: 3. On reading the literature. *Australasian Psychiatry* 2(3):109-110

FREEMAN C AND TYRER P (eds) (2006) *Research Methods in Psychiatry: A Beginner's Guide*. Third Edition. Royal College of Psychiatrists London: Gaskell.

GREENHALGH, T (2014) *How to Read a Paper*, 5th edn, BMJ Publishing, London, UK.

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KISELY S, CHANG A, CROWE J, et al. (2014) Getting started in research: systematic reviews and meta-analyses**.** *Australasian Psychiatry* 23: 16–21.

MACFARLANE M, KISELY A, LOI S et al. (2014) Getting started in research: research questions, supervisors and literature reviews**.** *Australasian Psychiatry* 23: 8–11.

MOHER D, SHAMSEER L, CLARKE M, GHERSI D, LIBERATI A, PETTICREW M, SHEKELLE P, STEWART LA (2015) Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA-P) 2015 statement. *Systematic Reviews*. 4:1. doi: 10.1186/2046-4053-4-1

COL, Collaborator; COM, Communicator; HA, Health Advocate; MAN, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

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ST2-RES-EPA3 – Research Skills – Data collection 2

Area of practice	Research	***EPA identification***	ST2-RES-EPA3
Stage of training	Stage 2 – Proficient	***Version***	v0.6 (EC-approved 25/05/18)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Skills in research methodology and data collection 2.***			
Description Maximum 150 words	The trainee will demonstrate skills in research methodology through data collection in a research project undertaken during the research rotation. The trainee will demonstrate competence in planning methodology that best suits the aims of the project, e.g. outcome measurement, use of blinding and randomisation techniques and qualitative data collection (if relevant to the study).			
Fellowship competencies	**ME**	7	**HA**	1
	COM	1	**SCH**	1,2,3
	COL	3,4	**PROF**	1,2,3
	MAN	1,3		
Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Knowledge of research methods used in psychiatric research (quantitative and qualitative) • Knowledge of outcome measures, ratings scales and other instruments commonly used in studies in the area for which the trainee is conducting a study. • Knowledge of key concepts involved in accurate data collection, including randomisation and blinding • Knowledge of processes utilised to record data in preparation for analysis **Skills** • Planning all aspects of methodology best suited to the aims of the study and the research question being investigated, e.g.: o Subject inclusion and exclusion criteria			

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	o Demographic data to be collected o Determining what outcome measures will be appropriate, inc. if any new measures might need to be developed • Receiving appropriate training to achieve competence in the administration of any instruments to be utilised in the study • If applicable, skills in collection of qualitative data e.g., speech extracts, subject interviews, surveys • Construction and design of any forms or surveys to be used in the study • Skills in accurate collection of data by the use of rating scales, assessments of subjects etc. • Stores all data in a secure and appropriate way **Attitude** • Efficient utilisation of resources and time when collecting data for a research study • Collaborative involvement of supervisor and colleagues in the research/academic team • Maintaining an attitude of academic rigour and objectivity when collecting data • Demonstrate an appropriate ethical attitude to the research process
Assessment method	• Progressively assessed during individual and academic supervision, including three appropriate WBAs. • at least one professional presentation to an academic meeting reporting the methodology used and some preliminary results from early collection of data • The supervisor should directly observe the trainee collecting data in at least one DOPS, e.g. administering a rating scale, interviewing a subject etc. If data is collected purely by survey, the DOPs should involve a discussion of how data from the survey forms has been collated and recorded.
Suggested assessment method details	• DOPS' and other professional presentations that assess progress at different stages of the data collection process. • Supervision may include "Research-Based Discussions" that may involve the trainee presenting to their supervisor several aspects of their methodology, e.g. subject inclusion and suitability, use of rating scales etc, which may be conducted as a DOPS

References

BEN TOVIM, D (1994) Handy hints on completing a psychiatric research project: 4. On Protocols and Ethics. *Australasian Psychiatry* 2(4);171-172

BEN TOVIM, D (1994) Handy hints on completing a psychiatric research project: 5. On Forms, Notebooks and Copies. *Australasian Psychiatry* 2(5);228-229

FREEMAN C AND TYRER P (eds) (2006), *Research Methods in Psychiatry: A Beginner's Guide*. Third Edition. Royal College of Psychiatrists London: Gaskell.

COL, Collaborator; COM, Communicator; HA, Health Advocate; MAN, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

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ST2-RES-EPA4 – Research Skills – Data analysis and synthesis 2

Area of practice	Research	***EPA identification***	ST2-RES-EPA4
Stage of training	Stage 2 – Proficient	***Version***	v0.6 (EC-approved 25/05/18)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Skills in data analysis and synthesis 2.***
Description Maximum 150 words	The trainee will demonstrate skills in analysis of data for a research project being undertaken during the research rotation. The trainee will demonstrate competence in analysing the results of the project, e.g. use of appropriate statistical techniques, reporting significance and effect size, drawing conclusions and identifying limitations (as relevant to the study).

Fellowship competencies				
	ME	7	**HA**	1
	COM	1	**SCH**	1,2,3
	COL	3,4	**PROF**	1,2,3
	MAN	1,3		

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.

Ability to apply an adequate knowledge base

- knowledge of statistical methods used in psychiatric research (quantitative studies)
- If a qualitative study, advanced knowledge of key concepts in analysis of qualitative data, e.g. data saturation.
- Knowledge of key concepts involved in analysis, such as bias, corrections, significance, effect size etc.
- Knowledge of techniques used to best present results in various forms and various settings

Skills

- Application of statistical methods to analyse data collected in a study, reporting statistical significance and effect size (for quantitative research)
- Presentation of results in graphical, tabular and text form in clear and standard formats
- If the study is qualitative, skilled use of techniques such as thematic analysis etc.
- Drawing justifiable conclusions from the analysis of results

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	• Placing conclusions in the context of current knowledge, and identifying the implications of the findings in furthering that knowledge/evidence base • Identifying limitations of the conclusions from the study • Identifying areas for further research • Developing a plan for dissemination/publication of results **Attitude** • Efficient utilisation of resources and time when analysing data from a research study • Collaborative involvement of supervisor and colleagues in the research/academic team • Maintaining an attitude of academic rigour and objectivity when analysing data and reporting results • Demonstrate an appropriate ethical attitude to the research process Trainees may develop and demonstrate additional skills using relevant statistical analysis tools in Excel, SPSS or other available programs
Assessment method	• Progressively assessed during individual and academic supervision, including three appropriate WBAs. • at least one professional presentation to an academic meeting reporting the results of the study and the conclusions from, and implications and limitations of, these results
Suggested assessment method details	• DOPS' and other professional presentations that assess progress at different stages of the data analysis process • Supervision may include "Research-Based Discussions" that may involve the trainee presenting to their supervisor several aspects of their analysis, e.g. primary outcomes and secondary outcomes, conclusions etc. The supervisor may read and critique draft presentations of results and conclusions in text, graph and table forms. These can be adapted to be conducted as DOPS

References

FREEMAN C AND TYRER P, (eds) (2006), *Research Methods in Psychiatry: A Beginner's Guide*. Third Edition. Royal College of Psychiatrists London:

BEN TOVIM, D (1994) Handy hints on completing a psychiatric research project: 6. On Holidays, Data Sheets, Computers and Consultants. *Australasian Psychiatry* 2(6):277-278

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NEYELOFF, J. L., FUCHS, S. C., & MOREIRA, L. B. (2012). Meta-analyses and Forest plots using a Microsoft excel spreadsheet: Step-by-step guide focusing on descriptive data analysis. *BMC Research Notes*, 5(1), 52. doi:10.1186/1756-0500-5-52

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Appendix

Implementation plan

IMPLEMENTATION PLAN TO SUPPORT THE EPA CHANGES TO ADDRESS STAGE 1 AND 2 BURDEN OF ASSESSMENT CONCERNS

Implementation principles:

The development and assessment of skills is operationalised through EPAs – rather than covering the syllabus in its entirety they are core, high-risk activities that are emblematic of training.

EPAs provide opportunities for supervisors to assess trainees' skills and for trainees to receive structured feedback.

EPAs are attained (entrusted) when a trainee demonstrates their competence to their supervisor(s) using the (formative) WBA tools.

As trainee progression and success could not have been hindered by feedback received as part of EPA attainment, there is no resulting 'disadvantage' by the rationalisation and improvement of certain EPAs.

[Definition of disadvantage: an unfavourable circumstance or condition that reduces the chances of success or effectiveness.]

A trainee who believes they have been disadvantaged should be referred to the Education Review process and the RANZCP Reconsideration and Appeal Policy.

		CURRENT			RECOMMENDATION	FUTURE		
Stage	**Standard**	**EPA Code**	**Short Name**	**Full Title**		**EPA Code**	**Short Name**	**Full Title**
Stage 1	Basic	ST1-GEN-EPA1	Discharge and transfer of care	Producing discharge summaries and organising appropriate transfer of care.	**REMOVED. Repetitive of medical graduate competencies**			
Stage 1	Basic	ST1-GEN-EPA2	Initiating an antipsychotic	Initiating an antipsychotic medication in a patient with schizophrenia.	**COMBINE** with **STAGE 2** Clozapine EPA to create a broader and more complex **STAGE 1** EPA			
Stage 1	Basic	ST1-GEN-EPA3	Team meeting	Active contribution to the multidisciplinary team meeting.	**REMOVED. Repetitive of medical graduate competencies**			
Stage 1	Basic	ST1-GEN-EPA4	Communicating with a family	Communicating with a family about a young adult's major mental illness.	**COMBINE** with **STAGE 2** Psychoeducation EPA to create a broader and more complex **STAGE 1** EPA			
Stage 1	Basic				(new)	ST1-GEN-EPA5	Antipsychotic use	Use of an antipsychotic medication in a patient with schizophrenia/psychosis.
Stage 1	Basic				(new)	ST1-GEN-EPA6	Providing psychoeducation	Providing psychoeducation to a patient and their family and/or carers about a major mental illness.
Stage 2	Proficient	ST2-EXP-EPA1	Electroconvulsive therapy (ECT)	Demonstrating proficiency in all the expected tasks associated with prescription, administration and monitoring of ECT.	(unchanged)	ST2-EXP-EPA1	Electroconvulsive therapy (ECT)	Demonstrating proficiency in all the expected tasks associated with prescription, administration and monitoring of ECT.
Stage 2	Proficient	ST2-EXP-EPA2	Mental Health Act	The application and use of the Mental Health Act.	(unchanged)	ST2-EXP-EPA2	Mental Health Act	The application and use of the Mental Health Act.
Stage 2	Proficient	ST2-EXP-EPA3	Risk assessment	Assessment and management of risk of harm to self and others.	(unchanged)	ST2-EXP-EPA3	Risk assessment	Assessment and management of risk of harm to self and others.
Stage 2	Proficient	ST2-EXP-EPA4	Clozapine	The safe and effective use of clozapine in psychiatry.	**COMBINE** with **STAGE 1** Initiating an antipsychotic EPA to create a broader and more complex **STAGE 1**			
Stage 2	Proficient	ST2-EXP-EPA5	Cultural awareness	Assess and manage adults with cultural and linguistic diversity.	(unchanged)	ST2-EXP-EPA5	Cultural awareness	Assess and manage adults with cultural and linguistic diversity.
Stage 2	Proficient	ST2-PSY-EPA1	Psychoeducation	The provision of psychoeducation in a formal interactive session.	**COMBINE** with **STAGE 1** Communicating with a family EPA to create a broader and more complex **STAGE 1** EPA			
Stage 2	Proficient	ST2-PSY-EPA2	Therapeutic alliance	Psychodynamically informed patient encounters and managing the therapeutic alliance.	(unchanged)	ST2-PSY-EPA2	Therapeutic alliance	Psychodynamically informed patient encounters and managing the therapeutic alliance.
Stage 2	Proficient	ST2-PSY-EPA3	Supportive psychotherapy	Supportive psychotherapy.	(unchanged)	ST2-PSY-EPA3	Supportive psychotherapy	Supportive psychotherapy.
Stage 2	Proficient	ST2-PSY-EPA4	CBT: Anxiety management	Cognitive–behavioural therapy (CBT) for management of anxiety.	(unchanged)	ST2-PSY-EPA4	CBT: Anxiety management	Cognitive–behavioural therapy (CBT) for management of anxiety.
		13 EPAs = 39 WBAs to entrust				**9 EPAs = 27 WBAs to entrust**		

SUMMARY

Trainees commencing training after implementation date (rotation two, 2014)

Trainees who commence Stage 1 training after the above date do *not* have the option of doing **ST1-GEN-EPA1, EPA2, EPA3 and EPA4.**
Rather, these trainees must attain the (new) **ST1-GEN-EPA5 and EPA6.**
They are also not required to attain the Stage 2 **ST2-EXP-EPA4** Clozapine EPA, or **ST2-PSY-EPA1** Psychoeducation.

2013 and 2014 intake:

The (old) ST1-GEN-EPA1 Discharge and transfer of care and (old) ST1-GEN-EPA3 Team Meeting

Trainees are *no longer required* to achieve **ST1-GEN-EPA1** and **ST1-GEN-EPA3** in order to complete Stage 1.
Trainees who have already attained either/both of the EPAs will continue to have them reflected on their training record.
Reason: Feedback has been received on the implementation of the 2012 Fellowship Program that the above EPAs are too basic and repetitive of competencies expected of a medical graduate.
Data gathered for the first rotation of 2013 reveals more than 50% of trainees attained both of these EPAs.

The (old) ST1-GEN-EPA2 Initiating an antipsychotic, (old) ST2-EXP-EPA4 Clozapine and the (new) ST1-GEN-EPA5 Antipsychotic use

Trainees who have attained *both* **ST1-GEN-EPA2** *and* **ST2-EXP-EPA4**, are *not required* to attain **ST1-GEN-EPA5**.
Trainees who have *not yet attained* either **ST1-GEN-EPA2** or **ST2-EXP-EPA4**, *must* attain **ST1-GEN-EPA5**.
Trainees who have attained *either* **ST1-GEN-EPA2** or **ST2-EXP-EPA4**, *must attain either* **ST1-GEN-EPA5** *or* the EPA not yet attained. REASON: Trainees may have completed a number of WBAs toward the 'old' EPA.
In order to accommodate the above combinations, the 'old' and 'new' EPAs will co-exist from date of implementation to the end of 2015.

The (old) ST1-GEN-EPA4 Communicating with a family, (old) ST2-PSY-EPA1 Psychoeducation and the (new) ST1-GEN-EPA6 Providing psychoeducation

Trainees who have attained *both* **ST1-GEN-EPA4** *and* **ST2-PSY-EPA1**, are *not required* to attain **ST1-GEN-EPA6**.
Trainees who have *not yet attained* either **ST1-GEN-EPA4** or **ST2-PSY-EPA1**, *must* attain **ST1-GEN-EPA6**.
Trainees who have attained *either* **ST1-GEN-EPA4** or **ST2-PSY-EPA1**, *must attain either* **ST1-GEN-EPA6** *or* the EPA not yet attained. REASON: Trainees may have completed a number of WBAs toward the 'old' EPA.
In order to accommodate the above combinations, the 'old' and 'new' EPAs will co-exist from date of implementation to the end of 2015.

Archived EPAs (no longer required)

ST1-GEN-EPA1 – Discharge and transfer of care

Area of practice	Adult psychiatry	***EPA identification***	ST1-GEN-EPA1
Stage of training	Stage 1 – Basic	***Version***	v0.3 (BOE-approved 12/07/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Producing discharge summaries and organising appropriate transfer of care.***			
Description Maximum 150 words	The trainee can produce succinct and informative discharge summaries and organise appropriate transfer of care. They understand the importance of clinical records in transfer of care and discharge and can make appropriate arrangements for medication and/or ongoing psychotherapy and liaise with appropriate clinicians, teams, community organisations and primary care providers. The trainee formulates relapse prevention and recovery plans in collaboration with the patient and provides appropriate and timely handover of written information. The discharge summaries are succinct yet informative and can function as a clinical handover and historical record of the patient's hospitalisation, treatment and progress including key points of decision making.			
Fellowship competencies	**ME**	1, 3, 4, 6,	**HA**	
	COM	1, 2	**SCH**	
	COL	1, 2, 3, 4	**PROF**	1, 2
	MAN			
Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Understands the importance of handover of information especially during transition of clinical care. • Understands the principles of relapse prevention and recovery. • Demonstrates knowledge of risks associated with transfer of care, eg. loss of information, lack of follow-up. • Demonstrates knowledge of range of follow-up and community services. • Understands the importance of clinical records in communication.			

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	Skills • Uses effective and timely verbal and written communication (including electronic communication where appropriate). • Grasps and formulates the essentials of the case and the treatment plan including relapse-prevention and risk-management plans. • Communicates key points of decision making. • Communicates and collaborates effectively with patients and families/carers in organising transfer of care. • Uses tact where required, avoids pejorative language. • Appropriately considers privacy issues and consent. **Attitude** • Willingness to supplement with verbal communication (eg. by phone) when required. • Exhibits a patient-centred approach to care. • Demonstrates willingness to include all appropriate stakeholders in the transfer of care process. • Appropriate respect for the patient, other members of the multidisciplinary team, patient supports and their views.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion.
References THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS. *Communication between psychiatrists, medical practitioners and other healthcare providers*. Melbourne: RANZCP, 2009. Viewed 24 February 2012, <www.ranzcp.org>.	

COL, Collaborator; COM, Communicator; HA, Health Advocate; MA, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

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ST1-GEN-EPA1 – Discharge and transfer of care (COE form)			
Area of practice	Adult psychiatry	***EPA identification***	ST1-GEN-EPA1
Stage of training	Stage 1 – Basic	***Version***	v0.3 (BOE-approved 12/07/12)
Title	***Producing discharge summaries and organising appropriate transfer of care.***		
Description	The trainee can produce succinct and informative discharge summaries and organise appropriate transfer of care. They understand the importance of clinical records in transfer of care and discharge and can make appropriate arrangements for medication and/or ongoing psychotherapy and liaise with appropriate clinicians, teams, community organisations and primary care providers. The trainee formulates relapse prevention and recovery plans in collaboration with the patient and provides appropriate and timely handover of written information. The discharge summaries are succinct yet informative and can function as a clinical handover and historical record of the patient's hospitalisation, treatment and progress including key points of decision making.		

Please refer to the EPA handbook's preamble for a more detailed description of the EPA assessment process. The corresponding EPA contains the knowledge, skills and attitude that must be demonstrated by the trainee in order to be entrusted with this activity.

ENTRUSTING SUPERVISOR DECLARATION

In my opinion, this trainee can be trusted to perform the activity described with only distant (reactive) supervision. I am confident the trainee knows when to ask for additional help and will seek assistance in a timely manner. The trainee has completed three related WBAs in preparation for this activity.

Supervisor Name (print) ……

Supervisor RANZCP ID: …….. Signature ……..... Date …….....

PRINCIPAL SUPERVISOR DECLARATION *(if different from above)*

I have checked the details provided by the entrusting supervisor and verify they are correct.

Supervisor Name (print) ……

Supervisor RANZCP ID: …….. Signature ……..... Date …….....

TRAINEE DECLARATION

I have completed three related WBAs in preparation for this activity. I acknowledge that this is a RANZCP training document only and cannot be used for any other purpose.

Trainee name (print) ……..... Signature ……..... Date .....

DIRECTOR OF TRAINING DECLARATION

I verify that this document has been signed by a RANZCP-accredited supervisor.

Director of Training Name (print) ……

Director of Training RANZCP ID: …….. Signature …… Date …….....

ST1-GEN-EPA2 – Initiating an antipsychotic

Area of practice	Adult psychiatry	***EPA identification***	ST1-GEN-EPA2
Stage of training	Stage 1 – Basic	***Version***	v0.8 (BOE-approved 16/03/12; amended 12/07/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Initiating an antipsychotic medication in a patient with schizophrenia.***			
Description Maximum 150 words	The trainee can engage where possible with the patient, obtaining informed consent as far as possible, listen and respond to the patient's concerns and provide explanations in a clear manner. They are aware of the factors that may contribute to noncompliance and efforts to improve compliance. The trainee understands the role and use of antipsychotics, their risks, benefits and alternatives as well as common and potentially serious side effects, their detection and appropriate management. They have a respectful and professional attitude towards the patient and other members of the multidisciplinary team.			
Fellowship competencies	**ME**	2, 5	**HA**	
	COM	1	**SCH**	
	COL	1, 2	**PROF**	1, 2
	MAN			
Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Positive and negative symptoms and cognitive deficits in schizophrenia, the current dominant hypotheses for schizophrenia and their mechanisms. • The antipsychotic effect and other effects of these drugs on thinking and behaviour. • The common time period for the onset of the full antipsychotic effect. • The concept of a ceiling for the more specific antipsychotic effects, the possibility of inadvertent 'behavioural toxicity' and issues surrounding polypharmacy.			

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	• Factors other than noncompliance that can initiate or maintain a relapse, eg. high expressed emotion, illicit drugs, drug interactions (eg. smoking with clozapine and olanzapine). • Pharmacology of antipsychotics and drug interactions. • The concept of a biopsychosocial approach to treatment. • Issues of informed consent in the chronically mental ill, ethical issues. • Biopsychosocial understanding of noncompliance. • Awareness of culture. **Skills** • Engage patient, establish rapport and work with the patient's aims. • Adapt approach to fit the patient's personal background, cultural background and mental state. • Able to deal with a hostile patient in a safe manner for self, other staff and the patient. This includes the principles of de-escalation, an understanding of the factors that can contribute to hostility and biopsychosocial treatments. • Able to give explanations in a way that is understandable and meaningful. • Clear and respectful communication with other staff, both written and verbal. Clear, legible documentation. • Physical and mental state assessment. **Attitude** • Professional approach to patient and others including respect for the views of the patient and others. • Attitude of scholarship.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion. • Mini-Clinical Evaluation Exercise. • Direct observation.

References

THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS. *Code of Ethics*. Melbourne: RANZCP, 2009.

ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS CLINICAL PRACTICE GUIDELINES TEAM FOR THE TREATMENT OF SCHIZOPHRENIA AND RELATED DISORDERS. *Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the treatment of schizophrenia and related disorders*. Aust NZ J Psychiatry 2005; 39:1–30.

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Board of Education approved 16/03/12 (v0.7); amended and approved 12/07/12 (v0.8)

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ST1-GEN-EPA2 – Initiating an antipsychotic (COE form)			
Area of practice	Adult psychiatry	***EPA identification***	ST1-GEN-EPA2
Stage of training	Stage 1 – Basic)	***Version***	v0.8 (BOE-approved 12/07/12)
Title	***Initiating an antipsychotic medication in a patient with schizophrenia.***		
Description	The trainee can engage where possible with the patient, obtaining informed consent as far as possible, listen and respond to the patient's concerns and provide explanations in a clear manner. They are aware of the factors that may contribute to noncompliance and efforts to improve compliance. The trainee understands the role and use of antipsychotics, their risks, benefits and alternatives as well as common and potentially serious side effects, their detection and appropriate management. They have a respectful and professional attitude towards the patient and other members of the multidisciplinary team.		

Please refer to the EPA handbook's preamble for a more detailed description of the EPA assessment process. The corresponding EPA contains the knowledge, skills and attitude that must be demonstrated by the trainee in order to be entrusted with this activity.

ENTRUSTING SUPERVISOR DECLARATION

In my opinion, this trainee can be trusted to perform the activity described with only distant (reactive) supervision. I am confident the trainee knows when to ask for additional help and will seek assistance in a timely manner. The trainee has completed three related WBAs in preparation for this activity.

Supervisor Name (print) ……..…….....

Supervisor RANZCP ID: …….. Signature ……..... Date …….....

PRINCIPAL SUPERVISOR DECLARATION *(if different from above)*

I have checked the details provided by the entrusting supervisor and verify they are correct.

Supervisor Name (print) ……..…….....

Supervisor RANZCP ID: …….. Signature ……..... Date …….....

TRAINEE DECLARATION

I have completed three related WBAs in preparation for this activity. I acknowledge that this is a RANZCP training document only and cannot be used for any other purpose.

Trainee name (print) ……..... Signature ……..... Date .....

DIRECTOR OF TRAINING DECLARATION

I verify that this document has been signed by a RANZCP-accredited supervisor.

Director of Training Name (print) ……..…….....

Director of Training RANZCP ID: …….. Signature …… Date …….....

ST1-GEN-EPA3 – Team meeting

Area of practice	Adult psychiatry	***EPA identification***	ST1-GEN-EPA3
Stage of training	Stage 1 – Basic	***Version***	v0.8 (BOE-approved 16/03/12; amended 12/07/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Active contribution to the multidisciplinary team meeting.***			
Description Maximum 150 words	The trainee can contribute to multidisciplinary team meetings as they are well informed about their patients and able to provide an accurate and succinct account if asked. They are sufficiently aware of the diagnostic and treatment aspects, progress and discharge planning. The trainee is respectful of the knowledge, experience and opinions of other team members and is able to assist in the coordination of the team to improve patient care.			
Fellowship competencies	**ME**	1, 2, 3, 4	**HA**	
	COM	1, 2	**SCH**	1, 2
	COL	3, 4	**PROF**	1, 2, 3
	MAN	2, 4		
Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Awareness of the multiple functions of the multidisciplinary team meeting (eg. coordination, handover, allowing all members to contribute, enhance communication and team work, address concerns, monitor progress to goals, supervision, teaching, personal development of medical and non-medical staff). • Basic knowledge of biopsychosocial diagnosis and treatment. • Basic understanding of the different needs in different phases of patient treatment, including rehabilitation. • Familiarity with the important aspects of their patient's file, history, treatment and progress. **Skills** • Able to grasp what is most important for diagnosis, treatment and progress. • Clear communication.			

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	• Can engage with the team in a productive and positive way. • Can prioritise, summarise and clarify including, when appropriate, communicate who is doing what and why. • Clear record keeping. • Ability to implement plans decided on at the meeting. **Attitude** • Reasonably punctual. • Available and approachable. • Prepared, good organisational skills, efficiency. • Respectful of other's views. • Attitude of lifelong learning.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion. • Observed Clinical Activity (OCA) – with subsequent discussion of the case in the multidisciplinary team meeting. • Professional presentation (eg. detailed case presentation in multidisciplinary team meeting). • Feedback from appropriate sources. • Direct observation.
References THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS. *Code of Ethics*. Melbourne: RANZCP, 2009.	

COL, Collaborator; COM, Communicator; HA, Health Advocate; MAN, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

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ST1-GEN-EPA3 – Team meeting (COE form)			
Area of practice	Adult psychiatry	***EPA identification***	ST1-GEN-EPA3
Stage of training	Stage 1 – Basic	***Version***	v0.8 (BOE-approved 12/07/12)
Title	***Active contribution to the multidisciplinary team meeting.***		
Description	The trainee can contribute to multidisciplinary team meetings as they are well informed about their patients and able to provide an accurate and succinct account if asked. They are sufficiently aware of the diagnostic and treatment aspects, progress and discharge planning. The trainee is respectful of the knowledge, experience and opinions of other team members and is able to assist in the coordination of the team to improve patient care.		

Please refer to the EPA handbook's preamble for a more detailed description of the EPA assessment process. The corresponding EPA contains the knowledge, skills and attitude that must be demonstrated by the trainee in order to be entrusted with this activity.

ENTRUSTING SUPERVISOR DECLARATION

In my opinion, this trainee can be trusted to perform the activity described with only distant (reactive) supervision. I am confident the trainee knows when to ask for additional help and will seek assistance in a timely manner. The trainee has completed three related WBAs in preparation for this activity.

Supervisor Name (print) ……..…….....

Supervisor RANZCP ID: …….. Signature ……..... Date …….....

PRINCIPAL SUPERVISOR DECLARATION *(if different from above)*

I have checked the details provided by the entrusting supervisor and verify they are correct.

Supervisor Name (print) ……..…….....

Supervisor RANZCP ID: …….. Signature ……..... Date …….....

TRAINEE DECLARATION

I have completed three related WBAs in preparation for this activity. I acknowledge that this is a RANZCP training document only and cannot be used for any other purpose.

Trainee name (print) ……..... Signature ……..... Date .....

DIRECTOR OF TRAINING DECLARATION

I verify that this document has been signed by a RANZCP-accredited supervisor.

Director of Training Name (print) ……..…….....

Director of Training RANZCP ID: …….. Signature …… Date …….....

ST1-GEN-EPA4 – Communicating with a family

Area of practice	Adult psychiatry	***EPA identification***	ST1-GEN-EPA4
Stage of training	Stage 1 – Basic	***Version***	v0.8 (BOE-approved 16/03/12; amended 12/07/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***Communicating with a family about a young adult's major mental illness.***
Description Maximum 150 words	The trainee (where possible) establishes rapport, listens to and deals empathically with a family's concerns and misconceptions. Their explanations of severe mental illness, symptoms and management are clear and relevant and address the needs of the patient and family. The trainee can recognise high expressed emotion yet think beyond the immediate reactions to bad news or recent stress. They have a basic understanding of the likely psychological impact on carers, the phases of grief and coping mechanisms. The trainee is able to handle the ethical and practical aspects of informed consent in the mentally ill, supporting and appropriately mobilising their patient's support network and balancing the needs of the patient and carer(s). They have a respectful, professional and ethical approach to the patient and their family.

Fellowship competencies				
	ME	1, 3	**HA**	1
	COM	1	**SCH**	2
	COL	1, 2	**PROF**	1, 2
	MAN			

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.

Ability to apply an adequate knowledge base

- Diagnosis, treatment and course of major mental illness, individual variability and uncertainty. The biopsychosocial importance of early treatment. A basic grasp of the biopsychosocial approach to understanding and treatment including cultural factors where relevant.
- Local resources for the family and patient.
- Impact on patient and carers, stages of grief and coping strategies.

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	Skills • Translate experience and theoretical knowledge into an explanation that is clear, succinct and understandable, emphasising what is important to the patient and family. • Tact – an ability to express things in a way that is helpful to the family, patient and their ongoing interaction. This may include conflict resolution, ability to work with psychological reactions and interactions. • Ability to deal with individuals under stress. • The ability to document important information clearly with tact and respect. • Ability to balance the needs of carers and family. • Ability to negotiate issues of consent in the mentally ill. • Willingness to advise caregivers of where they may seek further support or help if required, tactful awareness of boundary issues involved. **Attitude** • Professional approach to patient and family.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion. • Mini-Clinical Evaluation Exercise. • Direct observation. • Feedback from appropriate sources.
References The Royal Australian and New Zealand College of Psychiatrists. Melbourne: RANZCP, 15 February 2012. Viewed 24 February 2012, <www.ranzcp.org>.	

COL, Collaborator; COM, Communicator; HA, Health Advocate; MAN, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

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ST1-GEN-EPA4 – Communicating with a family (COE form)			
Area of practice	Adult psychiatry	***EPA identification***	ST1-GEN-EPA4
Stage of training	Stage 1 – Basic	***Version***	v0.8 (BOE-approved 12/07/12)
Title	***Communicating with a family about a young adult's major mental illness.***		
Description	The trainee (where possible) establishes rapport, listens to and deals empathically with a family's concerns and misconceptions. Their explanations of severe mental illness, symptoms and management are clear and relevant and address the needs of the patient and family. The trainee can recognise high expressed emotion yet think beyond the immediate reactions to bad news or recent stress. They have a basic understanding of the likely psychological impact on carers, the phases of grief and coping mechanisms. The trainee is able to handle the ethical and practical aspects of informed consent in the mentally ill, supporting and appropriately mobilising their patient's support network and balancing the needs of the patient and carer(s). They have a respectful, professional and ethical approach to the patient and their family.		

Please refer to the EPA handbook's preamble for a more detailed description of the EPA assessment process. The corresponding EPA contains the knowledge, skills and attitude that must be demonstrated by the trainee in order to be entrusted with this activity.

ENTRUSTING SUPERVISOR DECLARATION

In my opinion, this trainee can be trusted to perform the activity described with only distant (reactive) supervision. I am confident the trainee knows when to ask for additional help and will seek assistance in a timely manner. The trainee has completed three related WBAs in preparation for this activity.

Supervisor Name (print) ……..…….....

Supervisor RANZCP ID: …….. Signature ……..... Date …….....

PRINCIPAL SUPERVISOR DECLARATION *(if different from above)*

I have checked the details provided by the entrusting supervisor and verify they are correct.

Supervisor Name (print) ……..…….....

Supervisor RANZCP ID: …….. Signature ……..... Date …….....

TRAINEE DECLARATION

I have completed three related WBAs in preparation for this activity. I acknowledge that this is a RANZCP training document only and cannot be used for any other purpose.

Trainee name (print) ……..... Signature ……..... Date .....

DIRECTOR OF TRAINING DECLARATION

I verify that this document has been signed by a RANZCP-accredited supervisor.

Director of Training Name (print) ……..…….....

Director of Training RANZCP ID: …….. Signature …… Date …….....

ST2-EXP-EPA4 – Clozapine

Area of practice	General psychiatry	***EPA identification***	ST2-EXP-EPA4
Stage of training	Stage 2 – Proficient	***Version***	v0.9 (BOE-approved 04/05/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***The safe and effective use of clozapine in psychiatry.***			
Description Maximum 150 words	The trainee can balance the risks, benefits and alternatives of clozapine. They can engage and involve the patient and relevant supports to elicit informed consent. The trainee is aware of the patient's aims in treatment and can deal with their concerns. They adhere to the protocols, documentary and administrative obligations and other aspects of safe initiation and monitoring. This includes the common and potentially serious side effects and their management. The trainee can integrate the use of clozapine with rehabilitation. They are able to appropriately communicate to, and work with, other professionals addressing mental health, physical health and lifestyle, including the multidisciplinary team, the patient's GP, and where appropriate, physicians and others.			
Fellowship competencies	**ME**	1, 2, 3, 4, 5, 6, 7, 8	**HA**	1, 2
	COM	1, 2	**SCH**	1, 2
	COL	1, 2, 3, 4	**PROF**	1, 2, 3
	MAN			
Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Indications for clozapine and alternatives. • Benefits of using clozapine, eg. suicidality reduction, cognitive, extrapyramidal symptoms, efficacy for positive symptoms, perhaps improved negative symptoms, quality of life, functioning. • Contra-indications to clozapine, eg. history of bone marrow disease, cardiopulmonary collapse, uncontrolled epilepsy, alcohol, severe concurrent disease (cardiac, renal, liver). • Serious complications – agranulocytosis, severe neutropenia, myocarditis, myopathy.			

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	• Can follow protocols/safe monitoring (knows/will check), eg. FBC, glucose/lipids/weight/cardiac. Knows how to respond to problems and will appropriately seek assistance. • Drug interactions (knows important ones; knows to check). • Interaction with tobacco. • Assessment and management of common side effects. • Issues of informed consent in the chronically mentally ill, ethical issues. • Management of discontinuation and recommencement. **Skills** • Applies the biopsychosocial model in formulation and treatment of medication resistance. • Applies the principles of rehabilitation psychiatry. • Assessment and management of common side effects. • Establish rapport, involve patient and where appropriate support network in decision making, risk–benefit analysis and tolerance of some uncertainty. • Communicate and collaborate with the supervisor, multidisciplinary team, GPs and others as needed. Ability to work with and coordinate others involved. • Advocate for patients where needed. • Ability to assess the extent and impact of deficit symptoms on presentation, quality of life, compliance and work with a patient suffering from deficit symptoms to optimise outcome as far as possible. • Management of discontinuation and recommencement. **Attitude** • Professional approach to patient and others. • Appropriate respect for views of patient and others. • Willingness to learn from others involved in the patient's care.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion. • Mini-Clinical Evaluation Exercise.

References

THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS. *Code of Ethics*. Melbourne: RANZCP, 2009.

The Royal Australian and New Zealand College of Psychiatrists. Melbourne: RANZCP, 15 February 2012. Viewed 24 February 2012, <www.ranzcp.org>.

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COL, Collaborator; COM, Communicator; HA, Health Advocate; MAN, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

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ST2-EXP-EPA4 – Clozapine (COE form)			
Area of practice	General psychiatry	***EPA identification***	ST2-EXP-EPA4
Stage of training	Stage 2 – Proficient	***Version***	v0.9 (BOE-approved 04/05/12)
Title	***The safe and effective use of clozapine in psychiatry.***		
Description	The trainee can balance the risks, benefits and alternatives of clozapine. They can engage and involve the patient and relevant supports to elicit informed consent. The trainee is aware of the patient's aims in treatment and can deal with their concerns. They adhere to the protocols, documentary and administrative obligations and other aspects of safe initiation and monitoring. This includes the common and potentially serious side effects and their management. The trainee can integrate the use of clozapine with rehabilitation. They are able to appropriately communicate to, and work with, other professionals addressing mental health, physical health and lifestyle, including the multidisciplinary team, the patient's GP, and where appropriate, physicians and others.		

Please refer to the EPA handbook's preamble for a more detailed description of the EPA assessment process. The corresponding EPA contains the knowledge, skills and attitude that must be demonstrated by the trainee in order to be entrusted with this activity.

ENTRUSTING SUPERVISOR DECLARATION

In my opinion, this trainee can be trusted to perform the activity described with only distant (reactive) supervision. I am confident the trainee knows when to ask for additional help and will seek assistance in a timely manner. The trainee has completed three related WBAs in preparation for this activity.

Supervisor Name (print) ……

Supervisor RANZCP ID: …….. Signature ……. Date …….....

PRINCIPAL SUPERVISOR DECLARATION *(if different from above)*

I have checked the details provided by the entrusting supervisor and verify they are correct.

Supervisor Name (print) ……

Supervisor RANZCP ID: …….. Signature ……. Date …….....

TRAINEE DECLARATION

I have completed three related WBAs in preparation for this activity. I acknowledge that this is a RANZCP training document only and cannot be used for any other purpose.

Trainee name (print) ……..... Signature ……..... Date .....

DIRECTOR OF TRAINING DECLARATION

I verify that this document has been signed by a RANZCP-accredited supervisor.

Director of Training Name (print) ……

Director of Training RANZCP ID: …….. Signature …… Date …….....

ST2-PSY-EPA1 – Psychoeducation

Area of practice	Psychotherapy	***EPA identification***	ST2-PSY-EPA1
Stage of training	Stage 2 – Proficient	***Version***	v0.4 (BOE-approved 08/11/12)

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

Title	***The provision of psychoeducation in a formal interactive session.***
Description Maximum 150 words	The trainee can provide comprehensive, organised, accurate (evidence-based where possible) and relevant information for patients and/or their carers (family, other professionals, non-government organisations) in one-on-one formal discussions or in groups. Possible topics might include the nature of a relevant condition, its treatment(s), rehabilitation, impact on patients and carers, coping strategies, developing skills and accessing available resources. Potential harms of the treatment or failure to treat can be described. The trainee has a demonstrated ability to provide information in an understandable way, taking into account the capacity and needs of their audience including the impact of stress or illness on the ability to take in information. They can be sensitive to the time information is provided and tactful, being aware of the possible impact of what they say. When required, they can show a sensitive awareness of relevant legal issues and issues around patient autonomy, confidentiality, family and individual aspects of coping with an illness and they demonstrate a professional, ethical and scholarly attitude.

Fellowship competencies				
	ME	5	**HA**	
	COM	1	**SCH**	1, 2
	COL	1, 2	**PROF**	1, 2
	MAN			

Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • The benefit of information in improving compliance and engagement, coping, empowering patients, supporting patients and carers, normalising where appropriate and reducing stigma. • Coping strategies, phases of grief and adjustment. • Some knowledge of family and group dynamics and counselling skills as required.

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	• The likely needs of the relevant audience. • Practical knowledge of the topic of the session. • Awareness of the topic from the perspective of the audience and/or willingness to ask. • Principles of recovery oriented practice. • The principles and aims of psychoeducation. **Skills** • Tailors information to the needs and capacity of the audience. • Engages the audience. • Takes a practical approach based on the experiences of those involved. • Uses understandable language. • Acknowledges and manages emotional distress in a way appropriate to the context. • Demonstrates active listening and promotes an interactive environment. • Bolsters coping strategies that reduce the risk of relapse and recurrence. • Wherever possible, instils hope and a sense of being supported. • Demonstrates an awareness of cultural issues and an ability to work within them if required. • Appropriately negotiates relevant ethical and legal issues including patient autonomy, consent, privacy, confidentiality, conflicting needs. **Attitude** • Respectful and non-judgemental; empowering patients, their families or caregivers. • Committed to reducing stigma. • Ethical, professional. • Attitude of lifelong learning.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Mini-Clinical Evaluation Exercise. • Professional presentation (eg. a presentation to a consumer group). • Case-based discussion.

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References

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COLOM F. Keeping therapies simple: psychoeducation in the prevention of relapse in affective disorders. *Br J Psychiatry* 2011; 198: 338–40.

RUMMEL-KLUGE C & KISSLING W. Psychoeducation in schizophrenia: new developments and approaches in the field. *Curr Opin Psychiatry* 2008; 21:168–72.

COL, Collaborator; COM, Communicator; HA, Health Advocate; MAN, Manager; ME, Medical Expert; PROF, Professional; SCH, Scholar

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ST2-PSY-EPA1 – Psychoeducation (COE form)			
Area of practice	Psychotherapy	***EPA identification***	ST2-PSY-EPA1
Stage of training	Stage 2 – Proficient	***Version***	v0.4 (BOE-approved 08/11/12)
Title	***The provision of psychoeducation in a formal interactive session.***		
Description	The trainee can provide comprehensive, organised, accurate (evidence-based where possible) and relevant information for patients and/or their carers (family, other professionals, non-government organisations) in one-on-one formal discussions or in groups. Possible topics might include the nature of a relevant condition, its treatment(s), rehabilitation, impact on patients and carers, coping strategies, developing skills and accessing available resources. Potential harms of the treatment or failure to treat can be described. The trainee has a demonstrated ability to provide information in an understandable way, taking into account the capacity and needs of their audience including the impact of stress or illness on the ability to take in information. They can be sensitive to the time information is provided and tactful, being aware of the possible impact of what they say. When required, they can show a sensitive awareness of relevant legal issues and issues around patient autonomy, confidentiality, family and individual aspects of coping with an illness and they demonstrate a professional, ethical and scholarly attitude.		

Please refer to the EPA handbook's preamble for a more detailed description of the EPA assessment process. The corresponding EPA contains the knowledge, skills and attitude that must be demonstrated by the trainee in order to be entrusted with this activity.

ENTRUSTING SUPERVISOR DECLARATION

In my opinion, this trainee can be trusted to perform the activity described with only distant (reactive) supervision. I am confident the trainee knows when to ask for additional help and will seek assistance in a timely manner. The trainee has completed three related WBAs in preparation for this activity.

Supervisor Name (print) ……..…….....

Supervisor RANZCP ID: …….. Signature ……..... Date …….....

PRINCIPAL SUPERVISOR DECLARATION *(if different from above)*

I have checked the details provided by the entrusting supervisor and verify they are correct.

Supervisor Name (print) ……..…….....

Supervisor RANZCP ID: …….. Signature ……..... Date …….....

TRAINEE DECLARATION

I have completed three related WBAs in preparation for this activity. I acknowledge that this is a RANZCP training document only and cannot be used for any other purpose.

Trainee name (print) ……..... Signature ……..... Date .....

DIRECTOR OF TRAINING DECLARATION

I verify that this document has been signed by a RANZCP-accredited supervisor.

Director of Training Name (print) ……..…….....

Director of Training RANZCP ID: …….. Signature …….. Date …….....