The Royal Australian & New Zealand College of Psychiatrists

2012 Fellowship Program

Supervisor Manual

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Glossary of Terms

AMC	Australian Medical Council
BOE	Board of Education
BTC	Branch Training Committee
CBFP	Competency-based Fellowship Program
CFT	Committee for Training
COE	Confirmation of Entrustment
DOT	Director of Training
EPA	Entrustable Professional Activity
FEC	Formal Education Course
FTE	Full Time Equivalent
ITA	In-Training Assessment
OCA	Observed Clinical Activity
OCI	Observed Clinical Interview
OSCE	Objective Structured Clinical Examination
RANZCP	Royal Australian and New Zealand College of Psychiatrists
WBA	Workplace-based Assessment

List of Appendices

Stage 1 syllabus

Stage 2 syllabus

Developmental Descriptors

Mini-Clinical Evaluation Exercise template

Observed Clinical Activity (OCA) template

Case-based Discussion (CbD) template

Professional Presentation template

Stage 1 Mandatory Requirements Policy

Progression through Training Policy

Failure to Progress Policy

Section One Overview

Foreword

This manual has been produced to guide and support supervisors to assist trainees through their psychiatry training pathway in the College's 2012 (competency-based) Fellowship training program. Each section has been written to address all areas of the program and includes an outline of what is required of you in your role as a supervisor. It is important to note that there is recommended reading that accompanies the manual to increase your readiness in the role.

The information contained in the following pages is frequently updated in line with policy and procedural changes and should only be considered correct as of December 2012. Any updates will be included in the online manual, located on the College website and you are encouraged to check regularly to ensure you have the latest version.

As the principal organisation representing the medical speciality of psychiatry in Australia and New Zealand we recognise the importance of the supervisor in the training program and welcome your feedback and advice to continually improve this manual and the College website. Please provide your feedback to: training@ranzcp.org

Competency-based training

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand. The College has a key role in training, examining and awarding the Fellowship of the College to medical practitioners.

The (competency-based) Fellowship Program (CBFP) began as a project in 2007 to redevelop the five-year RANZCP Fellowship training program to address issues associated with workforce shortages and increasing demands in the area of mental health. The program is underpinned by international best practice benchmarks in specialist medical education, incorporating a competency-based approach and adult learning principles in a more effective and efficient outcome-oriented framework, with the broad aims of increasing flexibility, improving examination pass rates and decreasing the time taken to complete training while retaining high standards in accordance with community expectations.

The project is overseen by the Board of Education (BOE) and has involved considerable contribution across the College membership. The Chair of the BOE also reports regularly to the General Council of the College.

The RANZCP (competency-based) Fellowship Program will be implemented for new trainees in December 2012 in New Zealand and in January 2013 in Australia.

In summary, the 2012 Fellowship training program will move to a competency-based approach that is:

- based on the CanMEDS model
- built upon the defined Fellowship Competencies
- based on the principles of continuous improvement
- fit for purpose
- designed to improve pass rates and reduce delays with progression
- in line with new developments in medical education.

Key Differences

Some important differences between the 2003 and 2012 programs are as follows:

Curriculum	The new curriculum is based on the acquisition of key competencies. In the new program, the curriculum is aligned, with integration between outcomes, learning opportunities and assessments. It is underpinned by current best practice approaches in adult education, including notions of lifelong learning, self-reflection, and workplace-based assessment.
Structure	The previous program comprised basic (3 years) and advanced training (2 years). The new program comprises three stages: Stage 1 (year 1; basic level), Stage 2 (years 2 and 3; proficient level), Stage 3 (years 4 and 5; advanced level).
Supervision	Feedback between supervisor and trainee is more formalised in the new program, particularly in-training formative feedback (using Workplace-based Assessments). Supervisors' work practices will change, but there will be no changes to the time allocations for supervision.
Assessments	**Workplace-based Assessments (WBAs):** This assessment type has been added to the program. It is a formative assessment that is performed in the workplace. It replaces the informal formative feedback processes of the previous program. **Entrustable Professional Activities (EPAs):** This assessment type has been added to the program. It is a summative assessment that is performed in the workplace. It replaces many of the experiences required in the previous program. EPAs are one of the mechanisms by which a trainee's competence is measured throughout the 60 months. **Psychotherapies:** Psychotherapy EPAs have been added to the program. They replace the briefer interventions (short cases) required in the previous program. The Psychological Methods Case History remains from the previous program and has been renamed the Psychotherapy Written Case. The First Presentation Case is no longer required. **In-Training Assessment (ITA) forms and reports:** The ITA Forms and Reports replace the mid-rotation report and end-of-term report, respectively. **Scholarly Project:** This assessment has been added to the program. It was added in recognition of the fact that psychiatrists must be capable of scholarly evaluation of their practice. **Written exam:** In the previous program, the written exam was assessed at an end of basic training standard. In the new program, it is assessed at a junior consultant standard. **Clinical exams:** Clinical examinations, the Observed Clinical Interview (OCI) & Objective Structured Clinical Examination (OSCE), are held in Stage 3 and are to be set to a Junior Consultant standard.
Pass rates	Curriculum alignment is intended to improve pass rates in the new program. In particular, alignment of formative and summative assessments will better prepare trainees. A competency-based training system will also mean that trainees in difficulty can be identified and assisted earlier in the training process.

Section Two Duties of Supervisors

Supervisor Information

Each training institution has designated supervisors who have been accredited by the RANZCP to guide trainees in the workplace. Generally, supervisors should have no more than two trainees under their supervision at one time. Supervisors are involved in teaching and supervising trainees as well as providing a path of communication between trainees and the local Head of Department and Director of Training (DOT). In addition, the supervisor has a critical role in the formative and summative assessment of trainees and in assisting trainees who are performing below the standards required by the Fellowship Program, as per the Policies on Progression through Training and Failure to Progress.

Supervision Requirements

Supervision sessions with each trainee should be scheduled and must cover all aspects of a trainee's work, including after-hours work.

For full-time trainees, clinical supervision must be maintained at a minimum of four hours per week over 40 weeks. Of these hours, a minimum of one hour per week must be individual supervision of a trainee's current clinical work, and should be uninterrupted.

For part-time trainees, this hour of individual, uninterrupted supervision is required in full; however the remaining three hours of supervision per week must be on a pro-rata basis (minimum).

For trainees in Stage 1, there are further supervision requirements: of the four supervision hours per week, at least two per week must be closer supervision outside ward rounds and case review meetings.

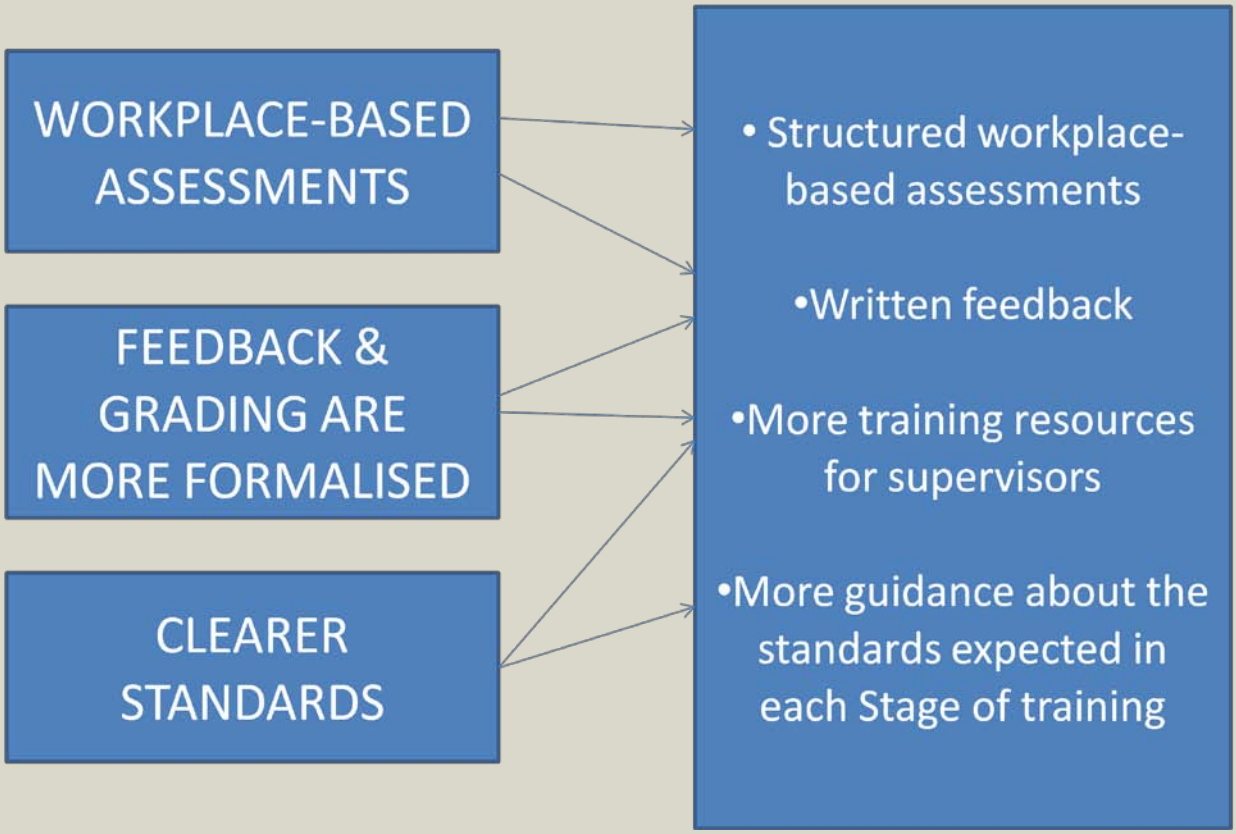
Duties of Supervisors

Supervisors are to:

- be familiar with core information, inclusive of the RANZCP regulations and curriculum, the College Code of Ethics and the procedures of the competency-based Fellowship Program
- understand the basic requirements of the role and be committed to education and training
- provide initial orientation to the training program to first year trainees at their institution
- provide leadership and modelling
- monitor and observe trainees with patients, peers and other medical staff on a regular basis
- encourage trainees to consider a patient's support network (family and/or carers) as part of the patient's treatment and recovery
- reflect constructively upon the work presented in supervision
- discuss the trainee's performance with the DOT if required
- discuss strategies to overcome any weaknesses in performance with the trainee concerned
- identify problems needing remediation early, and consult the DOT
- ensure availability to participate in the trainee's formative Workplace-based Assessments (WBAs) as required

- sign off a trainee's EPA only when confident the trainee can conduct an activity with distant supervision
- be responsible for completing a trainee's formative mid-rotation In-Training Assessment (ITA) Form to provide feedback to the trainee
- be responsible for completing a trainee's summative end-of-rotation ITA Report and assist the trainee in ensuring that it reaches the College within 60 days
- be interested and supportive of the trainee
- understand the educational aims and objectives for the specific training rotation
- attend reliably and be available for clinical consultation
- attend a supervisors' peer review group three times per year, and present at one of these meetings (minimum) or at a meeting of medical staff where supervision is discussed

Some aspects of supervision have changed to fit the competency-based approach to training (see diagram below).



Supervisor Resources & Recommended Reading

A key component of competency-based education is the active role of the trainee, sharing responsibility with their supervisor for their learning. Supervisors will be expected to provide frequent and accurate formative feedback to guide the trainee's participation in the educational process. All DOTs and supervisors will require training and support to effectively implement the program and embed the concepts and educational imperatives of competent performance within training.

Training resources for DOTs and supervisors are available from the 'Resources' section of the website:
http://www.ranzcp.org/Resources/Assessment-resources-for-Fellows/2012-Fellowship-Program-Assessor-resources.aspx

Program documentation can be found under the 'Pre-Fellowship' section of the website. All College Regulations, Policies & Procedures governing the new program can be found in a consolidated document on the RANZCP website.

In particular, supervisors are encouraged to be familiar with the following documents:

- Stage 1 Mandatory Requirements Policy (see Appendices)
- Progression through Training Policy (see Appendices)
- Failure to Progress Policy (see Appendices)
- Trainee Progress Trajectory (see Section Three)
  The 'Trainee Progress Trajectory' is a useful one-page diagram to support the understanding of the above policies.
- EPA Handbook
  The Preamble section of the EPA Handbook provides a good introduction to EPAs and the entrustment of them.

Program Structure

The RANZCP (competency-based) Fellowship Program takes 60 months full-time equivalent (FTE) and is divided into three stages.

Stage 1 – 1 year FTE (year 1)

Stage 2 – 2 years FTE (years 2 and 3)

Stage 3 – 2 years FTE (years 4 and 5)

Progression through each stage is dependent on a trainee demonstrating competent performance across all Fellowship Competencies. This is shown by the successful completion of the required formative and summative assessments and meeting the time requirements for each stage. The Progression through Training Policy outlines the deadlines for completion of each element of the Fellowship Program. Trainees who do not meet these requirements will be placed on a Failure to Progress pathway, which is outlined in the Failure to Progress Policy.

Whilst the competency-based Fellowship Program has been designed to remain flexible to the needs of both the trainee and supervisor, as well as the opportunities provided by each rotation, the program has been designed to be undertaken in steps. The diagram on the following page details the trajectory of a trainee's progress throughout the Stages of Training.

The *2012 (competency-based) Fellowship Outline* and the *Trainee Progress Trajectory* on the following three pages provide an overview of the program elements and the key deliverables for trainees to complete at each stage. Please check that the version is current as this document is updated. As with all documents embedded within this manual, the latest version can always be downloaded from the RANZCP website: http://www.ranzcp.org/Pre-Fellowship/2012-Fellowship-Program/About-the-training-program.aspx

2012 (competency-based) Fellowship Program Outline	

2012 (competency-based) Fellowship Program overview	• The RANZCP has adopted the seven CanMEDS roles to articulate the Fellowship Competencies. The Fellowship Competencies are end point competencies for all trainees engaged in attaining Fellowship of the College.
	• Typically 60 months full time equivalent (FTE) to complete.
	• Implementation begins:
	  ○ Stage 1 (1st year): 1 December 2012 (NZ); 1 January 2013 (Australia)
	  ○ Stage 2 (2nd and 3rd years): December 2013
	  ○ Stage 3 (4th and 5th years): December 2015.
	• Transition of existing trainees will not occur before 2014.
	• Progression between stages depends on attainment of Fellowship Competencies as demonstrated by successful completion of all mandatory assessments AND time spent in rotations.

Formal Education Course	• All trainees must be enrolled in a Formal Education Course. • Stage 1 and 2 syllabi developed to inform Formal Education Courses.

Incorporation of the 2003 regulations training experiences into the 2012 Fellowship Program	• The following experiences are embedded in the Fellowship Competencies and demonstrated by successful achievement of the Learning Outcomes (assessed on the summative end of rotation In-Training Assessment Report):
	  ○ Ethical conduct and practice
	  ○ Working with people with mental illness, their families and carers
	  ○ Working with non-government and other community organisations
	  ○ Longitudinal management of patients with enduring psychiatric illness
	  ○ Working with patients from culturally and linguistically diverse backgrounds.
	• Branch Training Committees (BTCs) continue to provide learning opportunities to help trainees achieve the Learning Outcomes.
	• Requirement to undertake a specified number of activities per year to meet working with consumers and carers, non-government and other community organisations training objectives has been removed.

Summative assessment: Psychotherapies	• Competence to a proficient level in psychotherapies demonstrated by end of training. • Trainees are required to complete the Psychotherapy Written Case, consisting of one long psychotherapy intervention (~ 1 year or 40 sessions) and a 5,000 – 10,000 word write up of the case. Trainees will be encouraged to undertake this by the end of Stage 2. The case will be assessed at Junior Consultant standard. • Trainees are encouraged to treat low acuity/high prevalence disorders. • In addition to the Psychotherapy Written Case, trainees are required to be entrusted with three of the four Psychotherapy EPAs by the end of Stage 2; the fourth must be attained by the end of Stage 3, also to a standard of Proficient.
Summative assessment: Scholarly Project	• College-approved project of 3,000 - 5,000 words must be successfully completed to attain Fellowship, which will be marked at Junior Consultant standard. • Trainees will be encouraged to undertake the Scholarly Project earlier, rather than later, in training and should aim to submit their Proposal/Method Outline for approval in Stage 2. • A Scholarly Project Subcommittee has been established to govern the conduct and assessment of the Scholarly Project. • Examples of appropriate Scholarly Projects include: a quality assurance project or clinical audit; a systematic and critical literature review; original and empirical research (qualitative or quantitative); a case series. • Other Scholarly Projects may be approved on a case-by-case basis.
Formative assessment: Workplace-based Assessments (WBAs)	• WBAs are used for formative assessment of competencies, NEVER as a mechanism to 'mark' or 'pass/fail' – they provide an indicator to both the supervisor and the trainee as to how the trainee is going. • Supervisors are required to be competent in conducting WBAs and able to provide the trainee with meaningful and effective feedback. • Supervisors will use a minimum of three WBAs to inform their assessment of each EPA. • Trainees are responsible for arranging WBAs with a supervisor. • WBAs tools have been selected by the BOE and include: Case-based Discussion (CbD), Mini-Clinical Evaluation Exercise, Observed Clinical Activity (OCA), and Professional Presentation.
Summative assessment: Entrustable Professional Activities (EPAs)	• Progression through training requires trainees to be entrusted to perform specific EPAs to an appropriate standard for the stage of training; these are Basic, Proficient and Advanced. • Each 6-month FTE rotation requires two EPAs to be entrusted. • Trainees are responsible for planning their EPAs throughout their training. Typically, 3 to 5 are recommended. Please refer to the Trainee Progress Trajectory. • Fellowship EPAs across all Stages DO NOT have to be signed off by a supervisor who has a Certificate in the respective area of practice; however, supervisors must be accredited and current.
In-Training Assessment (ITA) mid-rotation forms and end-of-rotation reports	• Formative mid-rotation In-Training Assessment Forms should be held in the trainee's record. • Summative end-of-rotation In-Training Assessment Reports MUST be submitted to the College in Melbourne within 60 days of completion of the rotation.

Summative assessment: Examinations	• Written examination is to be set at a Junior Consultant standard
	  ○ Sat by trainees at threshold of Stage 2 and 3 (years 3 & 4) – although trainees are allowed to sit the written exam from early Stage 2, this is not recommended.
	  ○ Not a barrier to entering Stage 3 of training; nor a barrier to sitting either of the Clinical Examinations.
	• OCI - Observed Clinical Interview examination - Trainees must pass 2 out of 3 OCIs to successfully complete the examination.
	• OSCE - Objective Structured Clinical Examination – Trainee is assessed over 12 stations.
	The Clinical examinations are held in Stage 3 and are to be set at a Junior Consultant standard.

Progression through Training	• Trainees must successfully complete the Fellowship Program's assessments within the time requirements to progress through training towards Fellowship. • The Progression through Training Policy and Trainee Progress Trajectory detail the mandatory deadlines for the completion of each assessment. • The Failure to Progress Policy sets out the requirements for trainees who do not adhere to those deadlines, including the completion of a remedial plan and the requirement to show cause in order to remain in the Fellowship Program after continued failure (including failure to attempt and/or pass by the deadline as well as three or more fails of the same assessment). ○ This policy also affects trainees who are still not eligible for Fellowship after 13 years (calendar time), trainees on a break-in-training for 2 years continuously or 5 years in total and trainees who are not allocated to a training program.

Stage 1 Basic

12 months FTE – first intake December 2012.
Minimum 12 months FTE accredited training in approved Adult Psychiatry training post; 6 months in an acute setting.

Supervision

- Minimum 4 hours/week for 40 weeks, of this:
  - 2hrs/week outside ward rounds and case review.
  - Minimum 1 hour individual supervision of clinical work.
- WBAs will typically occur in supervision time.
- EPAs may or may not be formally signed off in supervision time.

Stage 1 General Psychiatry EPAs:

1. Producing discharge summaries and organising appropriate transfer of care.
2. Initiating an antipsychotic in a patient with schizophrenia.
3. Active participation in the multidisciplinary team meeting.
4. Providing an explanation to a family about a young adult's major mental illness.

Attaining Stage 2 EPAs while in Stage 1:
Trainees should, together with their Director of Training (DOT) and Supervisor, refer to the 'Trainee Progress Trajectory' and plan for the 5 Stage 2 General Psychiatry EPAs and the Psychotherapy EPAs. The trainee may also achieve these in Stage 1.

In exceptional circumstances, the trainee may with their DOT's approval, achieve other Stage 2 Area of Practice EPAs.
The expected standard remains Proficient.

Trainees should familiarise themselves with the following key policy documents:

- Progression through Training
- Stage 1 Mandatory Requirements

The Royal Australian & New Zealand College of Psychiatrists

Stage 2 Proficient

24 months FTE – first intake December 2013.
Minimum 24 months FTE accredited training in an approved training program.

Supervision

- Minimum 4 hours/week for 40 weeks annually.
- 1 hour/week individual supervision of clinical work.

Mandatory Areas of Practice

Mandatory area of practice rotations and Stage 2 EPAs (must be entrusted by end of Stage 2):

- **Consultation–Liaison Psychiatry (6 months FTE)**

EPAs:

a) Care for a patient with delirium.
b) Manage clinically significant psychological distress in the context of a patient's medical illness in the general hospital.

- **Child & Adolescent Psychiatry (6 months FTE)**

EPAs:

c) Develop a management plan for an adolescent where school attendance is at risk.
d) Clinical assessment of a prepubertal child.

Trainees will achieve competent performance to a proficient level in the following areas of practice, which are achieved through entrustment of specific EPAs to a proficient standard:

- **Addiction Psychiatry**

EPAs:

e) Management of intoxication and withdrawal.
f) Comorbid mental health and substance use problems.

- **Psychiatry of Old Age**

EPAs:

g) Behavioural and psychological symptoms in dementia (BPSD).
h) The appropriate use of antidepressants and antipsychotics in patients aged 75 years and over (or under 75 with excessive frailty).

Written Exam (Junior Consultant Level)

Elective rotations

Trainees will also undertake two elective 6-month (FTE) rotations in the following areas of practice, achieving competence to a proficient standard demonstrated by EPAs:

- Addiction
- Forensic
- Psychiatry of Old Age
- Other areas of practice as approved by the BOE
- Adult
- Indigenous
- Rural

Stage 2 General Psychiatry EPAs. Attain by the end of Stage 2, can be attained in Stage 1:

1. Demonstrating proficiency in all the expected tasks associated with prescription, administration and monitoring of ECT.
2. The application and use of the Mental Health Act.
3. Assessment and management of risk of harm to self and others.
4. The safe and effective use of clozapine in psychiatry.
5. Cultural competence.

Stage 2 Psychotherapy EPAs. Attain 3 of 4 by the end of Stage 2, can be attained in Stage 1. 4th to be attained by end of Stage 3:

1. The provision of psychoeducation in a formal interactive session (Mandatory).
2. Psychodynamically informed patient encounters and managing the therapeutic alliance (Mandatory).
3. Supportive psychotherapy (Choice).
4. CBT (Choice).

Refer to the Trainee Progress Trajectory and the EPA policy and procedure for EPA timing.

Stage 3 Advanced

24 months FTE – first intake December 2015.
Minimum 24 months FTE accredited training in an approved program.

Supervision

- 4 hours per week for 40 weeks annually.
- 1 hour/week individual supervision of clinical work.

Advanced Certificates

Trainees may apply and, if successful, enrol in a Certificate of Advanced Training in a College-established Area of Practice.

College-established Areas of Practice

Trainees can complete 24 months FTE in a single area of practice.
Trainees will achieve competent performance to an advanced level in either a single or multiple areas of practice:

- Addiction
- Child & Adolescent
- Forensic
- Psychiatry of Old Age
- Research/Academic
- Other areas of practice as approved by the BOE
- Adult
- Consultation–Liaison
- Indigenous
- Psychotherapies
- Rural

EPAs

A minimum of two EPAs should be entrusted at an advanced level for each rotation in Stage 3.

Clinical currency

Trainees who undertake 12 months of research/academic or specialised administrative/managerial training during Stage 3 must continue to maintain currency in an area of clinical psychiatry.

Observed Clinical Interview (OCI)

Objective Structured Clinical Examination (OSCE)

Trainee Progress Trajectory in the (competency-based) Fellowship Program

Supporting document for Policy on Progression through Training and Policy on Failure to Progress

The Royal Australian & New Zealand College of Psychiatrists

INTENDED TO PROVIDE TRAINEE WITH A BASELINE AGAINST WHICH THEIR PROGRESS WILL BE MONITORED TO ENSURE A STEADY PROGRESSION

	STAGE 1		STAGE 2				STAGE 3			
FTE MONTHS *:	**6**	**12**	**18**	**24**	**30**	**36**	**42**	**48**	**54**	**60**
ROTATION EPAs	ITA with associated 2 EPAs †	ITA with associated 2 EPAs	ITA with associated 2 EPAs	ITA with associated 2 EPAs	ITA with associated 2 EPAs	ITA with associated 2 EPAs	ITA with associated 2 EPAs	ITA with associated 2 EPAs	ITA with associated 2 EPAs	ITA with associated 2 EPAs
STAGE 2 GENERAL PSYCHIATRY EPAs x 5		1 of the 5 e.g.: Clozapine	1 of the 5 e.g.: Risk	1 of the 5 e.g.: ECT	1 of the 5 e.g.: Mental Health Act	1 of the 5 e.g.: Cultural Competency				
STAGE 2 PSYCHOTHERAPY EPAs x 4 **STAGE 2 x 3** **STAGE 3 x 1**	1 of the 4 e.g.: Psycho education (MANDATORY§)		1 of the 4 e.g.: Therapeutic alliance (MANDATORY§)		1 of the 4 e.g.: Supportive Psychotherapy (CHOICE OF§)			1 of the 4 e.g.: CBT (CHOICE OF§)		
ADDITIONAL MANDATORY STAGE EPAs				2 ADD EPAs (If not elective rotations)		2 POA EPAs (If not elective rotations)				**{TBA}**
WRITTEN EXAM							WRITTEN EXAM **PASS**	R = 46	SC = 54	
OCI EXAM									OCI **PASS** R = 54	SC = 60
OSCE EXAM									OSCE **PASS** R = 54	SC = 60
SCHOLARLY PROJECT					PROPOSAL / METHOD OUTLINE				SCHOLARLY **PASS** ‡ R =54	SC = 60
PSYCHOTHERAPY WRITTEN CASE							WRITTEN CASE **PASS** ‡	R = 46	SC = 54	

* = Months of accredited training time

† = There is an exception for attaining the EPAs for the first rotation only

‡ = Allow time for marking

§ Psychotherapy EPAs: Trainee must attain 3 of the 4 Psychotherapy EPAs by the end of Stage 2. These are the Psychoeducation and Therapeutic Alliance EPAs and either CBT or Supportive Psychotherapies as the third. The fourth one will be attained by the end of Stage 3, still to a proficient standard.

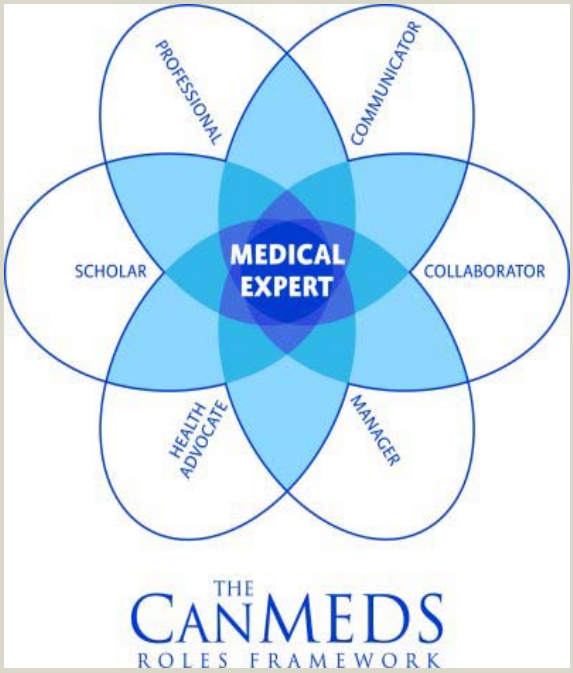
R = Remedial plan (mandatory)

SC = SHOW CAUSE to Committee for Training (mandatory)

Fellowship Competencies

Please note, the following section is an extract from the 'Fellowship Competencies' page on the RANZCP website.

The core competencies, as outlined in the *Fellowship Competencies* **Table 1** below, broadly define the capabilities expected of all trainees on attaining Fellowship of the College. The concept of competency-based education, as it relates to the development of objectives for training, is that these objectives, or competencies, should articulate the desired outcome of training, i.e. the knowledge, skills and attitudes expected of learners upon completion of their training. The competencies listed in the table are endpoint competencies for all trainees engaged in attaining Fellowship of the College, defined across the major roles expected of a doctor in the 21st century, recognising that contemporary expectations of the range of abilities of the doctor extends beyond that of being medical experts. These Fellowship Competencies have been refined into definitive statements iterating the College's understanding of psychiatry in Australia and New Zealand, described through the CanMEDS roles below.



Medical Expert

As Medical Experts, psychiatrists perform comprehensive, culturally appropriate psychiatric assessments with patients of all ages. Fundamental to the practice of psychiatry is the ability to perform and report thorough mental state examinations, integrating all available information to accurately formulate and diagnose patient conditions, subsequently providing an evidence-based biopsychosociocultural management plan, mindful of the impacts on patients' physical health. Demonstrable skills in psychotherapeutic, pharmacological, biological and sociocultural interventions are requisite. Psychiatrists define and review patient outcomes, revising management as appropriate based on this review, and are committed to early intervention and recovery. Medical expertise is supported by the application of contemporary research, psychiatric research and treatment guidelines, as well as the application of mental health and related legislation in patient care.

Communicator

As Communicators, psychiatrists communicate effectively with a range of patients, carers, multidisciplinary teams, general practitioners, colleagues and other health professionals, using their interpersonal skills for the improvement of patient outcomes. Communication skills range from the ability to provide clear, accurate, contextually appropriate written communication about patients' conditions, to being able to enter into dialogue about psychiatric issues with the wider community.

Collaborator

As Collaborators, psychiatrists are able to work effectively with other psychiatrists, within multidisciplinary teams and with other health professionals, whilst working within relevant health systems and with government agencies. Psychiatrists are also able to work respectfully with patients, families, carers, carer groups and non-government organisations.

Manager

As Managers, psychiatrists are able to work within clinical governance structures in healthcare settings, providing clinical leadership, and are able to work within management structures within the healthcare system; the ability to critically review and appraise different health systems and management structures is also requisite. Psychiatrists prioritise and allocate resources efficiently and appropriately, with the facility to perform appropriate management and administrative tasks within the healthcare system, applying health and other relevant legislation where appropriate. Psychiatrists also incorporate an awareness and application of information and communication technology (ICT) into their practice.

Health Advocate

As Health Advocates, psychiatrists use their expertise and influence to advocate on behalf of individual patients, their families and carers, as well as more broadly on an epidemiological level. Psychiatrists lessen the impact of mental illness through their understanding, and application, of the principles of prevention, promotion and early intervention.

Scholar

As Scholars, psychiatrists are committed to lifelong learning, with the ability to critically appraise and apply psychiatric and other health information for the benefit of patients. Psychiatrists are able to transfer information to colleagues, other health professionals, students, patients, families and carers and are able to facilitate the learning of colleagues, trainees and other health professionals, contributing to the development of mental health knowledge.

Professional

As Professionals, psychiatrists' commitment to their patients, profession and society is demonstrated through their adherence to ethical conduct and practice, complying with all relevant regulatory requirements, at all times comporting themselves with integrity, honesty, compassion and respect for diversity. Psychiatrists actively engage in reflective practice, giving due consideration to feedback received from others. Psychiatrists are expected to contribute to the profession beyond their commitment to patient care, whilst mindful of the necessity of maintaining a responsible equilibrium between personal and professional priorities in the pursuit of sustainable practice and well-being.

Table 1

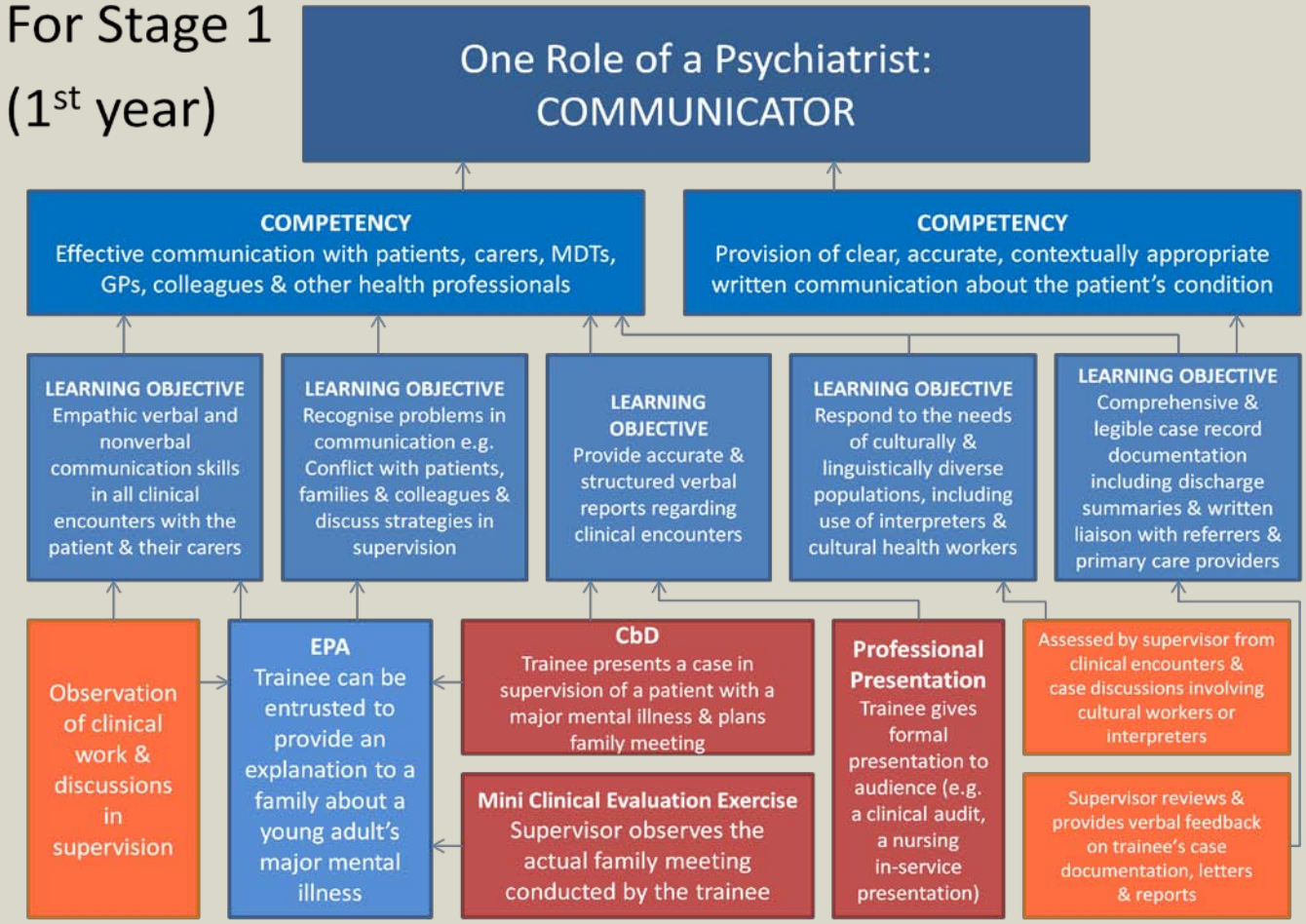
Fellowship Competencies

CanMEDS Role	
Medical Expert	
1.	Conduct a comprehensive, culturally appropriate psychiatric assessment with patients of all ages
2.	Demonstrate the ability to perform and report a comprehensive mental state examination, which includes cognitive assessment
3.	Demonstrate the ability to integrate available information in order to formulate the patient's condition and make a diagnosis according to ICD or DSM
4.	Develop, negotiate, implement and evaluate outcomes of a comprehensive evidence-based biopsychosociocultural management plan (appropriately revise)
5.	Demonstrate skills in psychotherapeutic, pharmacological, biological and sociocultural interventions to treat patients with complex mental health problems
6.	Demonstrate the ability to integrate and appropriately manage the patient's physical health with the assessment and management of their mental health problems
7.	Demonstrate the ability to critically appraise and apply contemporary research, psychiatric knowledge and treatment guidelines to enhance patient outcomes
8.	Demonstrate the ability to appropriately apply mental health and related legislation in patient care
Communicator	
1.	Demonstrate the ability to communicate effectively with a range of patients, carers, multidisciplinary teams, general practitioners, colleagues and other health professionals
2.	Demonstrate the ability to provide clear, accurate, contextually appropriate written communication about the patient's condition
Collaborator	
1.	Demonstrate the ability to work respectfully with patients, families, carers, carer groups and non-government organisations
2.	Demonstrate the ability to use interpersonal skills to improve patient outcomes
3.	Demonstrate the ability to work effectively with other psychiatrists, within multidisciplinary teams and with other health professionals
4.	Demonstrate the ability to work within relevant health systems and with government agencies

Manager	
1.	Demonstrate the ability to work within clinical governance structures in health care settings
2.	Demonstrate the ability to provide clinical leadership within management structures within the health care system
3.	Demonstrate awareness of the importance of review of and critical appraisal of different health systems and governance/management structures
4.	Demonstrate the ability to prioritise and allocate resources efficiently and appropriately
5.	Demonstrate the ability to perform appropriate management and administrative tasks within the health care system
Health Advocate	
1.	Demonstrate the ability to use expertise and influence to advocate on behalf of patients, their families and carers
2.	Demonstrate the ability to understand and apply the principles of prevention, promotion and early intervention to reduce the impact of mental illness
Scholar	
1.	Demonstrate commitment to life long learning
2.	Demonstrate the ability to educate and encourage learning in colleagues, other health professionals, students, patients, families and carers
3.	Contribute to the development of knowledge in the area of mental health
Professional	
1.	Demonstrate ethical conduct and practice in relation to patients, the profession and society
2.	Demonstrate integrity, honesty, compassion and respect for diversity
3.	Demonstrate reflective practice and the ability to use and provide feedback constructively
4.	Demonstrate the ability to balance personal and professional priorities to ensure sustainable practice and well being
5.	Demonstrate compliance with relevant professional regulatory bodies

The diagram below expands on the Fellowship competencies of the 'communicator' role as an example.

It details the ways in which Workplace-based Assessments (WBAs), Entrustable Professional Activities (EPAs) and general supervision can contribute to the achievement of learning outcomes and Fellowship competencies.



Curriculum Map

The curriculum map illustrates the competencies, learning outcomes and syllabus for each stage of the Fellowship program. The map also identifies a range of possible learning and teaching options, including tools for assessing the achievement of outcomes and competencies.

Note:

- The learning and teaching options listed are not an exhaustive or prescriptive list.
- The list is a guide for Directors of Training, supervisors and Branch Training Committees to use for supervision and training advice.
- The curriculum map is used by Formal Education Course (FEC) providers to review and align their course curriculum.

The diagram below is a small extract of the Stage 1 curriculum map; the full curriculum maps of both Stage 1 and Stage 2 can be accessed on the RANZCP website:

http://www.ranzcp.org/Pre-Fellowship/2012-Fellowship-Program/About-the-training-program/Program-development-history.aspx

RANZCP CBFP Mapping grid 2012 STAGE 1

Competency Role - Medical expert	**Learning Outcomes**	**Syllabus Refer to Stage 1 Syllabus for more information**	**Range of Learning & Teaching options**	**Assessment**
Conduct a comprehensive, culturally appropriate psychiatric assessment with patients of all ages	Conduct an organised psychiatric assessment with a focus on: • History taking • Psychiatric interview skills • Risk assessment • Phenomenology	Interviewing & Assessment: - Basic principles of interviewing - MSE - Phenomenology - Appropriate medical assessment and investigations - Use of collateral sources - Impact of cultural context - Risk assessment Social psychiatry Knowledge of specific disorders and normal development Assessment of psychiatric emergencies	Formal Education Course (FEC) Introductory cultural competence: workshop/ Web based /DVD Clinical placement Supervision Case based discussions Direct observation of other health professionals Video & feedback of interviews Role play	Mini-Clinical Evaluation Exercise. OCA CBD ITA report x 2
Demonstrate the ability to perform and report a comprehensive mental state examination, which includes cognitive assessment	Conduct an organised psychiatric assessment with a focus on: • MSE with relevant physical and cognitive examination Obtaining collateral history from other sources	Interviewing & Assessment: - MSE - phenomenology - appropriate medical assessment & investigations Neurosciences relevant to cognitive assessment and knowledge of specific disorders	FEC DVD Clinical placement Presentation of cases during team meetings (ST1 GEN EPA 3) Supervision OCA Direct observation of other health professionals Video & feedback of interviews	Mini-Clinical Evaluation Exercise. OCA CBD ITA report x 2 ST1 GEN EPA 3
Demonstrate the ability to integrate available information in order to formulate the patient's condition and make a diagnosis according to ICD or DSM	Accurately construct a differential diagnosis for common presenting problems, using a diagnostic system (DSM, ICD)	Formulation Knowledge of normal development & basic psychology (trauma, early development, grief & loss) Genetics & inheritance Risk assessment Diagnosis & classification Impact of cultural context	FEC OCA Case based discussion (Review of notes and letters) Case history ST 1 GEN EPA 4 ST1 GEN EPA3 Professional presentation	Mini-Clinical Evaluation Exercise. OCA CBD ITA report x 2 ST1 GEN EPA 3 ST1 GEN EPA4 Professional presentation

Syllabuses

The purpose of the syllabuses is to define the knowledge base that underpins the acquisition of competencies required for progression between stages. The content outlined in the syllabus documents is intended to inform knowledge acquisition across clinical, informal and formal education settings, as well as self-directed learning in accordance with the competency-based framework.

The syllabuses are not intended to be prescriptive, and detailed descriptions of content are intentionally excluded in order to remain consistent with adult learning principles and to reflect the richness and diversity of psychiatry. All areas of knowledge in the syllabuses are important, however not all areas could be expected to be learnt to the same level. As such, a rating system of three categories (*Awareness of Concept; Working Knowledge; & In-depth Knowledge*) has been utilised to indicate the depth of knowledge expected at each Stage of training.

For more information, please see the syllabuses in the Appendices section, or click on the link below.

Stage 1 syllabus

Stage 2 syllabus

****Stage 3 syllabus is currently in development****

Entrustable Practice Activity (EPA) Overview

This section provides an overview of the sequencing of EPAs throughout the program. Section Four – Assessments *provides a detailed explanation of EPAs as a form of assessment.*

Trainees must attain 20 – 24 EPAs by the end of Stage 2, therefore forward planning is needed to ensure their completion. Much thought and consideration has gone into developing the structure of the program, and as such the expected trajectory is useful to assist with planning a trainee's attainment of training elements.

Stage 1

Stage 1 involves a minimum of 12 months FTE training in Adult Psychiatry, with 6 months FTE of that time spent in an acute setting. The Stage 1 Mandatory Requirements Policy details requirements for acceptable rotations (see Appendices).

The first intake for Stage 1 in the (competency-based) Fellowship Program will be December 2012 for New Zealand and January 2013 for Australia.

By the end of Stage 1, trainees must attain the following four mandatory EPAs in order to progress to Stage 2:

1. Producing discharge summaries and organising appropriate transfer of care.
2. Initiating an antipsychotic medication in a patient with schizophrenia.
3. Active contribution to the multidisciplinary team meeting.
4. Providing an explanation to a family about a young adult's major mental illness.

These four EPAs are assessed at the Stage 1 standard – 'Basic'. Trainees must complete three Workplace-based Assessments (WBAs) before an EPA can be achieved. WBAs are formative assessment tasks that are used by the supervisor and trainee to assess the trainee's progress, provide feedback and plan the next learning steps. Together with other data regarding the trainee's progress, the WBAs help inform the entrustment of EPAs.

In addition to the four mandatory EPAs for Stage 1, trainees are eligible to attain any or all of the General Psychiatry EPAs required for the successful completion of Stage 2.

These General Psychiatry EPAs are assessed at the standard expected of a trainee at the end of Stage 2, 'Proficient', regardless of whether they are attempted in Stage 1 or Stage 2 and may be achieved in any Area of Practice rotation.

General Psychiatry EPAs

By the end of Stage 2, trainees must be entrusted with the following general psychiatry EPAs in order to progress to Stage 3. These EPAs may be achieved in any area of practice rotation during Stage 1 or Stage 2 according to opportunity:

1. Demonstrating proficiency in all the expected tasks associated with prescription, administration and monitoring of ECT.
2. The application and use of the Mental Health Act.
3. Assessment and management of risk of harm to self and others.
4. The safe and effective use of clozapine in psychiatry.
5. Cultural competence.

Psychotherapy EPAs

As with the General Psychiatry EPAs, the Psychotherapy EPAs are assessed at the standard expected of a trainee at the end of Stage 2, 'Proficient', regardless of the stage in which they are attempted.

By the end of Stage 2, trainees must be entrusted with three (of four) psychotherapy EPAs in order to progress to Stage 3. During Stage 1 or Stage 2, trainees are eligible to attain:

1. The provision of psychoeducation in a formal interactive session.
2. Psychodynamically informed patient encounters and managing the therapeutic alliance.

By the end of Stage 2, trainees must have completed the two EPAs above and choose one of the following to attain:

3. Supportive psychotherapy.
4. Cognitive-behavioural therapy (CBT) for management of anxiety.

Trainees must attain the remaining (fourth) psychotherapy EPA by the end of Stage 3, which will be assessed at a proficient level. Psychotherapy EPAs may be attained in any area of practice rotation.

Stage 2

Stage 2 is the second and third years of training and takes 24 months (FTE). The first intake of trainees into Stage 2 will be in December 2013 for New Zealand and January 2014 for Australia.

Stage 2 Mandatory Rotations with specific EPAs

In addition, trainees must be entrusted with two EPAs for each 6-month FTE rotation they undertake in Stage 2 (rotation-based EPAs). The EPAs are area of practice specific, thus trainees must attain:

Consultation–Liaison Psychiatry (mandatory rotation):
1. Care for a patient with delirium.
2. Manage clinically significant psychological distress in the context of a patient's medical illness in the general hospital.

Child & Adolescent Psychiatry (mandatory rotation):
1. Develop a management plan for an adolescent where school attendance is at risk.
2. Clinical assessment of a prepubertal child.

Additional mandatory EPAs

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

Addiction Psychiatry (elective rotation):
1. Management of intoxication and withdrawal.
2. Comorbid mental health and substance use problems.

Psychiatry of Old Age (elective rotation):

3. Behav**io**ural and psychological symptoms in dementia (BPSD).
4. The appropriate use of antidepressants and antipsychotics in patients aged 75 years and over (or under 75 with excessive frailty).

Trainees can achieve these EPAs during an elective rotation to these Areas of Practice, or alternatively when opportunity arises (i.e. in any area of practice rotation).

Stage 2 Elective rotations

Trainees will also undertake two elective 6 months (FTE) rotations in the following areas of practice, achieving competence to a proficient standard demonstrated by EPAs:

- Addiction
- Adult
- Forensic
- Indigenous
- Psychiatry of Old Age
- Rural
- Other Areas of Practice as approved by the BOE

Stage 3

Stage 3 is the fourth and fifth years of training and takes 24 months FTE.

The first intake of trainees into Stage 3 will be in December 2015 for New Zealand and January 2016 for Australia.

Stage 3 EPAs are currently in development and will be available in 2013.

Trainees in the generalist Fellowship stream must complete 24 months FTE in a single or multiple Areas of Practice:

- Addiction
- Adult
- Child & Adolescent
- Forensic
- Indigenous
- Psychiatry of Old Age
- Psychotherapies
- Research/Academic
- Rural
- Other Areas of Practice as approved by the BOE

A minimum of two EPAs must be entrusted at an advanced level for each rotation in Stage 3. If a trainee decides to undertake 12 months or more of research/academic or specialised administrative/managerial training in Stage 3, they must continue to maintain currency in an area of clinical psychiatry.

Certificates of Advanced Training

Trainees may apply and, if successful, enrol in a Certificate of Advanced Training in a College-established area of practice.

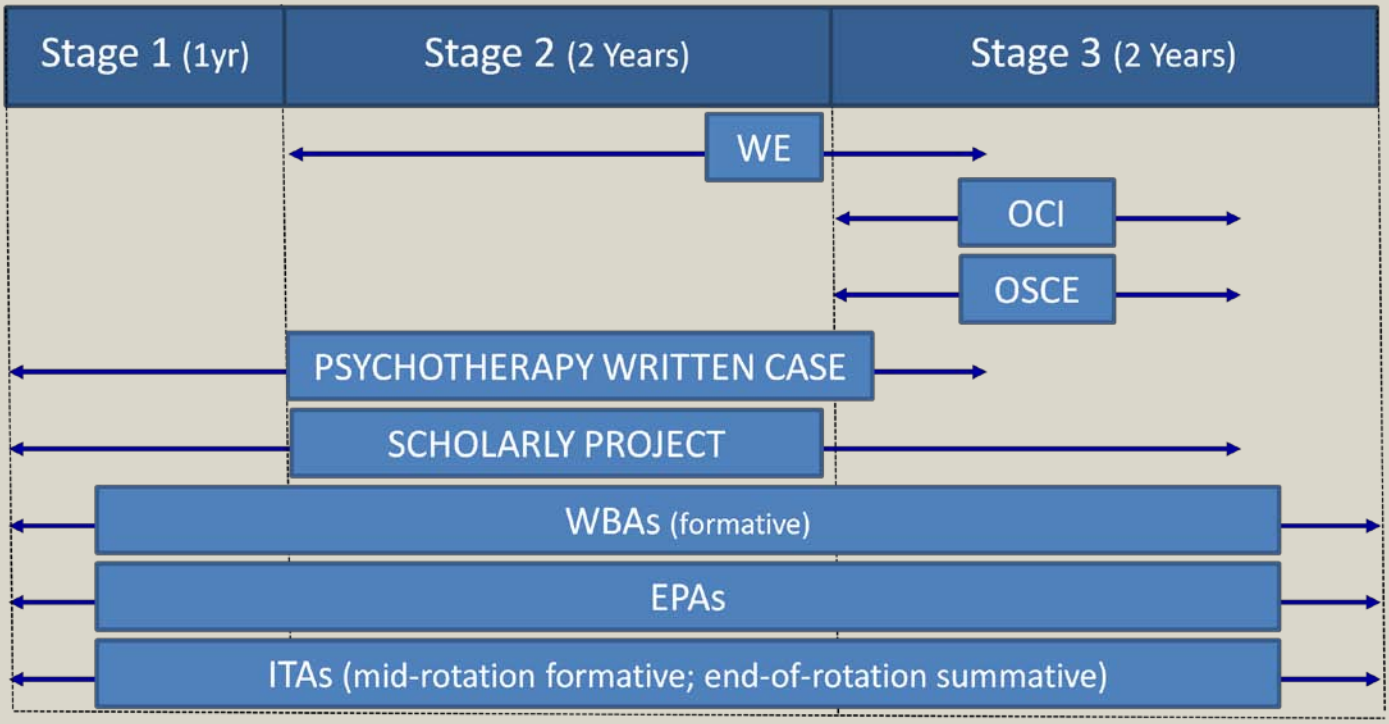
Further EPA Information

To see the detailed EPAs and their respective Confirmation of Entrustment (COE) forms, please see the EPA forms page on the RANZCP website:
http://www.ranzcp.org/Pre-Fellowship/2012-Fellowship-Program/Training-forms/EPA-forms.aspx

Structure

The assessment standards are set in line with the Australian Medical Council (AMC) accreditation standards and incorporate a range of formats reflective of the objectives of the training program. Assessment methods include both summative and formative assessment to evaluate trainee progress through the Psychiatry training pathway and provide tools for feedback and guidance.

The diagram below details the timing of assessments in the 2012 Fellowship program.



WE = Written Examination
OCI = Observed Clinical Interview
OSCE= Objective Structured Clinical Examination

WBAs = Workplace-based Assessments
EPAs = Entrustable Professional Activities
ITAs = In-training Assessments

Formative Assessments

Workplace-based Assessments (WBAs)

Competency-based training is dependent on trainees demonstrating the knowledge, skills and attitudes needed for safe practice. WBAs are an effective way to assess competence in an authentic work setting.

WBAs provide a mechanism for structured and effective feedback, which helps both trainees and supervisors assess how the trainee is progressing and plan for future learning activities. Although they require a process, they do not need additional supervision time, and this added structure allows supervisors to focus on specific areas when giving feedback and judgement to trainees.

As WBAs provide structured feedback for learning, it's helpful for WBAs to be performed early in a rotation, at the mid-point and towards the end. Trainees who would benefit from, or want, more feedback can undertake additional WBAs.

Three WBAs must be completed before each Entrustable Professional Activity (EPA) can be attained. However, this does not mean that if three WBAs have been completed that the EPA has been attained, as WBAs and EPAs are not directly linked. A supervisor considers the trainee's performance in their WBAs, along with other evidence, when deciding to entrust an EPA.

The program does not explicitly state which WBA tools must be used in a rotation, or per EPA. However, each EPA offers suggestions for which WBAs tools are most appropriate.

The Fellowship training program has approved four WBA tools, which are included as Appendices:

- Mini-Clinical Evaluation Exercise
- Observed Clinical Activity (OCA)
- Case-based Discussion (CbD)
- Professional Presentation

Mini-Clinical Evaluation Exercise

The Mini-Clinical Evaluation Exercise is a concise method of assessment requiring a supervisor or another assessor to observe a trainee in a clinical encounter with a real patient and then provide feedback to the trainee about their performance. The feedback related to the trainee should concentrate on their performance of agreed specific clinical tasks rather than on their general performance.

Observed Clinical Activity (OCA)

The OCA requires trainees to be observed for the duration of an initial assessment with a patient. Trainees will then be assessed on pre-identified skills and given feedback. It is similar in structure to the RANZCP summative assessment, the Observed Clinical Interview (OCI).

The OCA allows the assessor to be present as the trainee engages in the principal work of psychiatry practice, for example, taking a patient's history, conducting a patient examination, making a diagnosis and formulating a treatment plan, within one clinical interview session. The value of this instrument for the trainee lies in the opportunity it provides for immediate structured feedback on their performance, further supporting and enhancing learning, and aids in preparation for the summative OCI in Stage 3 of training.

Case-based Discussion (CbD)

This is a discussion based on existing case notes to assess a trainee's clinical reasoning and decision making, the integration of medical knowledge within case management and their ability to document this. The most important part of the CbD is the feedback given to the trainee. CbD uses case-based learning strategies to assess trainee case management of particular patients.

Professional Presentation

The Professional Presentation tool requires an assessor to observe a trainee giving a professional presentation to various audiences and provide feedback to the trainee about their performance. The feedback should concentrate on the trainee's performance of specific presentation skills rather than on their general performance.

WBA Standard

Each WBA is assessed on a 9-point rating scale. For each item being assessed, the trainee's performance is either:

Below the standard for **end of the Stage**, which is a rating of 1, 2 or 3

Meets the standard for **end of the Stage**, which is a rating of 4, 5, 6

Above the standard for **end of the Stage**, which is a rating of 7, 8 or 9.

The standard for each Stage is described in the Developmental Descriptors, and supervisors should use the Developmental Descriptors to help gauge if a trainee is meeting the standards.

The mid-point of the scale – 'Meets standard for end of Stage' – is the standard trainees should aim to achieve **on completion of each Stage**. In addition to rating the trainee's performance on the 9-point scale, the supervisor/assessor also provides feedback comments to the trainee, which is a key aspect of WBAs.
It is also important to note that not all assessable criteria will be met on each WBA form, instead the trainee and assessor should agree on the key skills being assessed.

Trainees are responsible for initiating the WBA process and are responsible for retaining the forms and updating their learning plans after each WBA has been completed. Supervisors may initiate the WBA process at appropriate times to support the provision of feedback and also to focus on particular skills and aspects of practice. DOTs should view a copy of the WBA forms when signing each EPA's Confirmation of Entrustment form.

In-Training Assessment (ITA) Form (mid-rotation)

Supervision of clinical work during training is a vital part of the assessment of professional competence. A formative mid-rotation ITA form is completed at the midway point of a trainee's rotation. This provides feedback to the trainee and can be useful in informing which, if any, areas of a trainee's competence need improvement. Should the supervisor have grounds to believe that the trainee is not meeting the required standards, a remedial process is to be commenced as soon as possible during the course of a rotation, which can include devising a remedial plan in discussion with the trainee. It is important not to delay discussion and initial remedial interventions until the end of a rotation, at which point it is too late to provide assistance. It is also important that supervisors document remedial issues accurately on formative and summative mid- and end-of-rotation paperwork. Please see the related In-Training Assessment Policy and the Progression through Training Policy for further information.

Summative Assessments

Entrustable Professional Activities (EPAs)

EPAs are specific activities that a trainee must demonstrate their ability to perform with only distant (reactive) supervision. They are a way for trainees to demonstrate their competence.

Generally, the activities entrusted by EPAs have been chosen because they are tasks that are of high importance for daily practice, or are high-risk or error-prone tasks. In addition, they are tasks that are exemplary of a number of CanMEDS roles.

A trainee attains an EPA when a supervisor, using all the data available to them including the trainee's performance on WBAs, can make an informed decision that the trainee can be trusted to perform the specific task to the required standard with only distant (reactive) supervision. This also means that the trainee is experienced enough to ask for additional help in a timely manner when assistance is required.

EPAs are entrusted at the following standards:

- Stage 1 – Basic level
- Stage 2 – Proficient level
- Stage 3 – Advanced level

Note that the standard of an EPA is set at the stage of training in which it is designed to be entrusted, irrespective of the stage in which the trainee attempts it. For example, a Stage 1 trainee who attempts to achieve a Stage 2 general psychiatry EPA must be assessed at the proficient level, not at the basic level. These standards are detailed in the Developmental Descriptors, which describe the standards trainees must meet to be considered at the appropriate level for each Stage.

EPAs are a summative assessment, and may or may not be formally signed off in supervision time, depending on what activity is being entrusted. Supervisors, trainees and DOTs must sign a Confirmation of Entrustment (COE) form for each EPA to verify attainment.

To see the detailed EPAs and their respective COE forms, please see the EPA forms page on the RANZCP website:
http://www.ranzcp.org/Pre-Fellowship/2012-Fellowship-Program/Training-forms/EPA-forms.aspx

Two EPAs must be signed off before a trainee can successfully complete a rotation. In exceptional cases, a trainee in their first 6-month FTE rotation of Stage 1 may conditionally pass that rotation before being entrusted with two of the mandatory Stage 1 EPAs. Please see the Regulations, Polices & Procedures document on the RANZCP website for further information.

In-Training Assessment (ITA) Report (end-of-rotation)

Supervision of clinical work during training is a vital part of the assessment of professional competence. A summative end-of-rotation ITA report is completed at the end of each rotation. Please see the Progression through Training Policy for further information.

Psychotherapies Written Case

The Psychotherapy Written Case assessment comprises both the provision of psychotherapy and the writing and submission of a related case report.

The psychotherapy

Trainees must treat a person, under supervision, using psychological methods for at least 40 sessions. During the therapy process, trainees must participate in three formative psychotherapy case discussions with their psychotherapy supervisor to encourage reflection on treatment progress and provide opportunities to receive qualitative feedback.

There may be unusual and exceptional cases where a patient terminates therapy just prior to completion of the planned 40 sessions. Trainees can submit a request to waive the 40 session requirement to the Committee for Training (CFT). The CFT will consider and approve these requests on a case-by-case basis.

The written case

Trainees must write and submit a case report, detailing their assessment and subsequent management of a person using psychological methods over at least 40 sessions, for summative assessment by the Case History Subcommittee. The report must be between 8000 - 10 000 words in length. The assessment domains and further submission information are defined in the relevant policy and procedure.

The Psychotherapy Written Case is not a barrier for trainees to enter Stage 3 of training; however, it must be completed and submitted by the deadline stated in the Progression through Training Policy and the Trainee Progress Trajectory.

Scholarly Project

The Scholarly Project can be submitted for assessment during any Stage of training; however, the Project will be assessed at Fellowship standard regardless of when it is submitted. Trainees must pass the Scholarly Project assessment to be eligible for Fellowship.

Research and Topic

Trainees may select their own Scholarly Project topic based on their own research interests in an area relevant to psychiatry or mental health. The Scholarly Project must be based on novel research, and may be used to satisfy the research requirements of a Certificate of Advanced Training where applicable.

Project Options

A Scholarly Project may take the form of:

- a quality assurance project or clinical audit
- a systematic and critical literature review
- original and empirical research (qualitative or quantitative)
- a case series
- an equivalent other project as approved by the Scholarly Project Subcommittee.

The Scholarly Project must be 3000–5000 words in length. Exemptions and exceptions to the Scholarly Project are further defined in the relevant policy and procedure. The Scholarly Project must be completed and submitted by the deadline stated in the Progression through Training Policy, which is available in the Appendices.

Written Examination

The written examination will test knowledge and its application at a junior consultant level. The written examination is designed to be attempted at the threshold of Stage 2 and 3. The trainee may attempt the exam at any point in Stage 2, but too early is not recommended. The written examination is not a barrier for trainees to enter Stage 3 of training; however, the written exam must be successfully completed by the deadline stated in the Progression through Training Policy, which is available in the Appendices.

Observed Clinical Interview (OCI) Examination

The OCI examination attempt rules have not changed. Trainees are required to pass two of three OCIs to successfully complete the OCI examination. Trainees can attempt the OCI examination in Stage 3. The OCI examination consists of five important domains – data gathering, data content, mental state examination, formulation and management plan. The OCI examination standard is set at the level of junior consultant. The OCI examination must be successfully completed by the deadline stated in the Progression through Training Policy, which is available in the Appendices.

Objective Structured Clinical Examination (OSCE)

Trainees are eligible to sit the OSCE in Stage 3. The OSCE consists of 12 stations (cases) and is a broad assessment of the core competencies required for a graduating psychiatrist. The OSCE is set at a junior consultant level. The OSCE must be successfully completed by the deadline stated in the Progression through Training Policy, which is available in the Appendices.

Key parameters for transition

Please note that there will be no transition occurring in 2013.

A number of key decisions were made as to how the College will transition to the new competency-based 2012 Fellowship Program. These are as follows:

1. Trainees are not to be disadvantaged.
2. The 2012 Fellowship Training Program must have a clearly defined 'Failure to Progress' Policy.
3. As trainees are not to be disadvantaged, certain trainees, on a case-by-case basis, may need exemptions from the requirements of the Failure to Progress Policy to facilitate transition. For example, if the Written Exam has been failed 3 times, a trainee could not be transitioned and immediately thereafter be placed on the 'Failure to Progress' pathway.
4. The two training programs shall not exist side-by-side indefinitely.
5. There must be provision for voluntary transition, where appropriate and possible.

The *Transition Matrix* below shows how the elements of the 2003 program equate to the 2012 Fellowship program and will used to assist the transition process. Please note, the *Transition Matrix* is designed to be viewed in A3 format, and can be downloaded from the RANZCP website:
http://www.ranzcp.org/Files/ranzcp-attachments/PreFellowship/2012-Fellowship-Program/Transition-matrix.aspx

Approach

The 2012 competency-based Fellowship Program's Stages are being implemented sequentially. The Stages of the new program are being rolled out in line with the progression of a (full-time) trainee commencing in December 2012/January 2013. i.e.:

STAGE	Year	New Zealand	Australia
1	Year 1	1st December 2012	1st January 2013
2	Years 2 and 3	1st December 2013	1st January 2014
3	Years 4 and 5	1st December 2015	1st January 2016

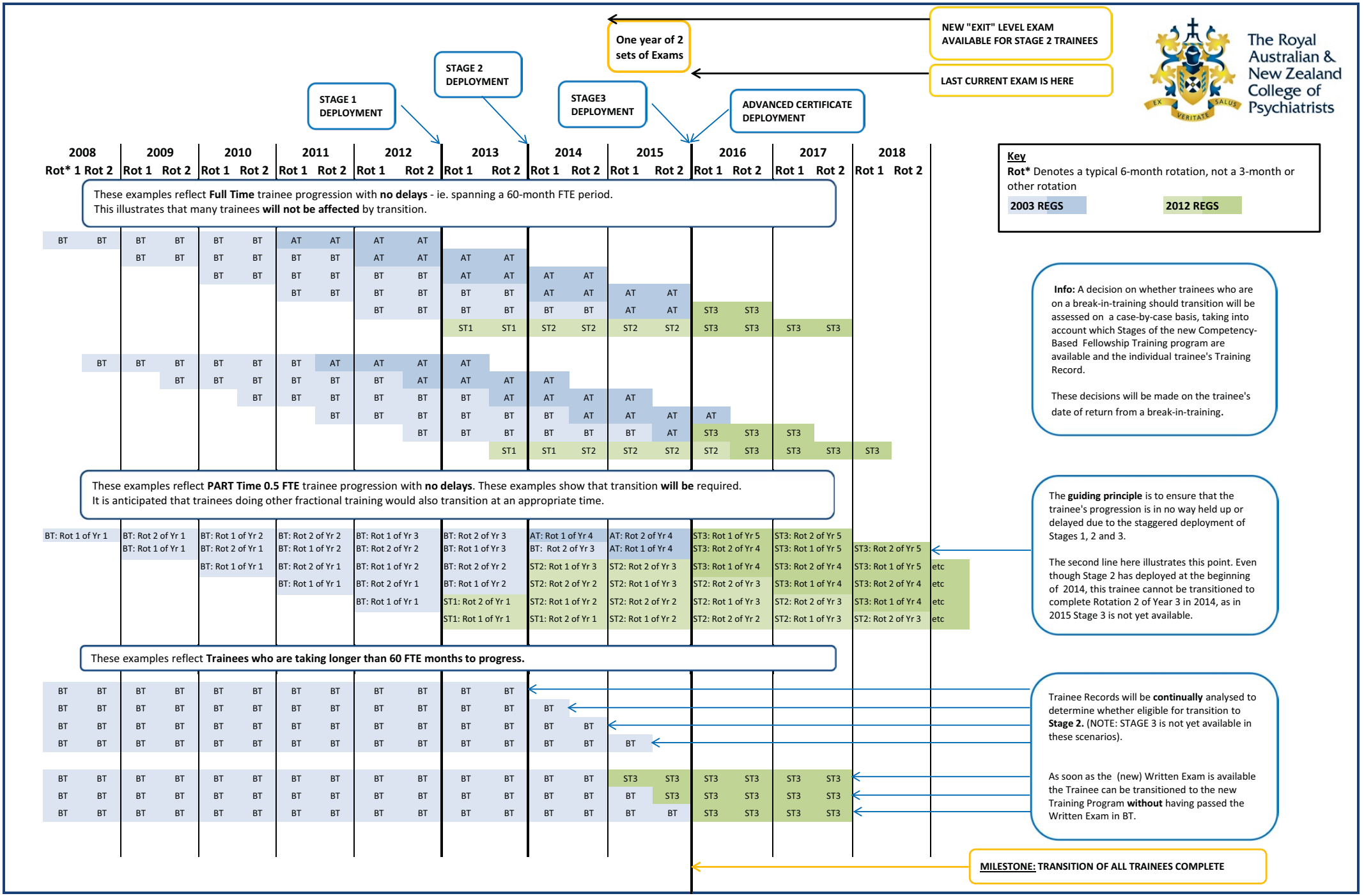
The transition process will happen in a stepwise fashion to coincide with the roll-out of the Stages of the competency-based Fellowship Program.

Transition Timeline

Trainees who are registered in the 2003 Fellowship Training Program will transition to the new 2012 competency-based Fellowship training program by 2015. The end of 2015 is when a full-time trainee who started the 2003 Fellowship Training Program in 2011 would finish, assuming no break-in-training or hold ups. However, a full-time trainee who began training in 2012 under the 2003 regulations will be required to transition to the 2012 competency-based Fellowship Training Program in their final year of training.

The same timelines do not apply for a trainee who is **not** full-time. This is demonstrated in the second portion of the *Transition Timeline* which shows the progress of a 0.5 FTE trainee. A 0.5 FTE trainee starting in 2011 can expect to transition to the 2012 competency-based Fellowship Training Program at the beginning of 2014.

The *Transition Timeline* below can be downloaded in A3 format from the RANZCP website:
http://www.ranzcp.org/Files/ranzcp-attachments/PreFellowship/2012-Fellowship-Program/Transition-timeline.aspx


NEW "EXIT" LEVEL EXAM AVAILABLE FOR STAGE 2 TRAINEES
One year of 2 sets of Exams
LAST CURRENT EXAM IS HERE
The Royal Australian & New Zealand College of Psychiatrists
STAGE 1 DEPLOYMENT
STAGE 2 DEPLOYMENT
STAGE3 DEPLOYMENT
ADVANCED CERTIFICATE DEPLOYMENT
2008 Rot* 1 Rot 2
2009 Rot 1 Rot 2
2010 Rot 1 Rot 2
2011 Rot 1 Rot 2
2012 Rot 1 Rot 2
2013 Rot 1 Rot 2
2014 Rot 1 Rot 2
2015 Rot 1 Rot 2
2016 Rot 1 Rot 2
2017 Rot 1 Rot 2
2018 Rot 1 Rot 2
Key
Rot* Denotes a typical 6-month rotation, not a 3-month or other rotation
2003 REGS
2012 REGS
These examples reflect Full Time trainee progression with no delays - ie. spanning a 60-month FTE period.
This illustrates that many trainees will not be affected by transition.
Info: A decision on whether trainees who are on a break-in-training should transition will be assessed on a case-by-case basis, taking into account which Stages of the new Competency-Based Fellowship Training program are available and the individual trainee's Training Record.
These decisions will be made on the trainee's date of return from a break-in-training.
These examples reflect PART Time 0.5 FTE trainee progression with no delays. These examples show that transition will be required.
It is anticipated that trainees doing other fractional training would also transition at an appropriate time.
The guiding principle is to ensure that the trainee's progression is in no way held up or delayed due to the staggered deployment of Stages 1, 2 and 3.
The second line here illustrates this point. Even though Stage 2 has deployed at the beginning of 2014, this trainee cannot be transitioned to complete Rotation 2 of Year 3 in 2014, as in 2015 Stage 3 is not yet available.
These examples reflect Trainees who are taking longer than 60 FTE months to progress.
Trainee Records will be continually analysed to determine whether eligible for transition to Stage 2. (NOTE: STAGE 3 is not yet available in these scenarios).
As soon as the (new) Written Exam is available the Trainee can be transitioned to the new Training Program without having passed the Written Exam in BT.
MILESTONE: TRANSITION OF ALL TRAINEES COMPLETE

RANZCP COMPETENCY-BASED FELLOWSHIP PROGRAM TRANSITION MATRIX FROM BASIC TRAINING TO STAGES 1 AND 2

2003 FELLOWSHIP REGULATIONS

BASIC TRAINING COMPONENTS	Writtens Barrier	Clinical Barrier	AT Barrier	CERTIFICATE Barrier	Transition Rules
Registration & Enrolment					
Trainee Registration	Y	Y	Y	Y	Not affected by Transition
Formal Education Course	Y	Y	Y	Y	Not affected by Transition
Annual Basic Experiences (1 each FTE year, 3 by end of 36 months)					**Annual Basic Experiences rules:**
Ethical Practice	N	Y	Y	Y	If Trainee FTE < 12 months,
- 1 activity each FTE year					THEN requirement to have any on record is waived.
People with Mental Health Problems and Mental Illness Experience	N	Y	Y	Y	If Trainee FTE ≥ 12 Months and < 24 Months
- 1 activity each FTE year					THEN Trainees Current record must incl YR 1
Carer Experience	N	Y	Y	Y	If Trainee FTE ≥ 24 Months and < 36 Months
- 1 activity each FTE year					THEN Trainees Current record must incl YR 1 & 2
NGO & Other Community Organisation Experience	N	Y	Y	Y	If Trainee FTE ≥ 36 Months
- 1 activity each FTE year					THEN Trainees Current record must incl YR 1, 2 & 3
Basic Experiences (by end of 36 Months)					
Mental Health of Aboriginal or Torres Strait Islanders or Maori	N	Y	Y	Y	If Current ---> credit 2 Indigenous EPAs *
- either 3 month FTE rotation OR Experience					AND **Cultural Competency EPA**
					If a 3 month FTE rotation was done, additionally credit the time
Psychiatry of Old Age	N	Y	Y	Y	If Current ---> credit 2 POA EPAs *
- either 3 month FTE rotation OR Experience					If a 3 month FTE rotation was done, additionally credit the time
Addiction Psychiatry	N	Y	Y	Y	If Current ---> credit 2 ADD EPAs *
- either 3 month FTE rotation OR Experience					If a 3 month FTE rotation was done, additionally credit the time
ECT Training - 10 treatments	N	Y	Y	Y	If Current ---> credit **ECT EPA** *
Psychotherapy Experience (40 months and **5** Brief Interventions)	N	Y	Y	Y	If Current ---> then credit (Note: Operational Complexity***)
No direct correlating item in Basic Training					If Trainee FTE ≥ 18 Months
					THEN credit **Clozapine EPA** *(remember to have a rule re date of credit)*
Basic OR Advanced Experiences					
Rural Mental Health	N	N	N	N	If Current --> credit 2 Rural EPAs, but NO rotation time
- either 3 month FTE rotation OR 15 outreach day visits					If a 3 month FTE rotation was done, then credit the time
					If not done, then that is acceptable in order to transition.
Continuity of Care	N	N	N	N	Not a pre-requisite for a Trainee in Basic Training to successfully transition
- 6 cases across 9 months					
Rotations (36 months FTE), each one is minimum 6 months FTE					
Adult	N	Y	Y	Y	If Trainee has ≥ 6 Months Adult FTE
					THEN credit rotation AND Discharge Summary EPA & Ward Round EPA.
Adult Acute	N	Y	Y	Y	If Trainee has ≥ 6 months Adult Acute FTE,
					THEN credit rotation AND Antipsychotic Med EPA & Diagnostic Expl EPA
					If Trainee has BOTH of the above
					THEN credit the **Mental Health Act EPA** (Current Regulation 8.5 (v))
					AND the **Risk EPA** (Current Regulation 8.5 (iii))
Child and Adolescent	N	Y**	Y	Y	If Current ---> credit rotation & 2 CAP EPAs *
Consult-Liaison	N	Y**	Y	Y	If Current ---> credit rotation & 2 CL EPAs *
Choice of 2 additional College established AOP:					
Addiction	N	Y**	Y	Y	If Current ---> credit rotation & 2 ADD EPAs *
Adult	N	Y**	Y	Y	If Current ---> credit rotation & 2 AP EPAs *
Forensic	N	Y**	Y	Y	If Current ---> credit rotation & 2 FP EPAs *
Indigenous	N	Y**	Y	Y	If Current ---> credit rotation & 2 IND EPAs *
Old Age	N	Y**	Y	Y	If Current ---> credit rotation & 2 POA EPAs *
Rural	N	Y**	Y	Y	If Current ---> credit rotation & 2 RUR EPAs *
General Additional					If Current ---> credit rotation, but NOT any EPAs.
Examinations and Case Histories					
First Presentation Case History	N	Y	Y	Y	Although nothing directly equates to Scholarly Project, the trainee cannot be disadvantaged, hence the credit is given
Psychological Case History / Methods	N	N	Y	Y	If Current ----> retains currency date *
Written Examination	n/a	Y	Y	Y	If Current ----> retains currency date *
Clinical Examination	n/a	n/a	Y***	Y***	If Current ----> retains currency date *

2012 FELLOWSHIP REGULATIONS

TRAINING COMPONENTS FOR STAGE 1 AND STAGE 2		Writtens Barrier	Clinical Barrier	ST 3 Barrier	CERTIFICATE Barrier
<same>		Not applicable, as the Written Examination now takes place in STAGE 2 or by the end of the 1st rotation of STAGE 3	Not applicable, as the Clinical Examinations (OSCE and OCI) now takes place in STAGE 3	Y	Y
<same>				Y	Y
Incorporated into the FCs & LOs as signed off on the ITA Report	PROF1, PROF2			n/a	n/a
Incorporated into the FCs & LOs as signed off on the ITA Report	ME1, ME6			n/a	n/a
Incorporated into the FCs & LOs as signed off on the ITA Report	COM1, COL1, HA1, SCH2			n/a	n/a
Incorporated into the FCs & LOs as signed off on the ITA Report	COL1, COL4, MAN1, MAN3			n/a	n/a
Covered in Stage 2 Syllabus	ME1, COM1, COL1, COL2, PROF2.			n/a	n/a
Cultural Competency EPA				Y	Y
Trainee must attain the 2 POA EPAs (not necessary to do within a POA rotation)				Y	Y
Trainee must attain the 2 ADD EPAs (not necessary to do within an ADD rotation)				Y	Y
Trainee must attain the ECT EPA				Y	Y
4 x Stage 2 Psychotherapies EPAs (Psychoeducation, Therapeutic alliance, Supportive psychotherapy, CBT)				Y	Y
Treatment with Clozapine EPA				Y	Y
Rural Health no longer mandatory. Trainee may electively undertake the rotaion & EPAs.				n/a	n/a
Incorporated into the FCs & LOs as signed off on the ITA Report	ME4			n/a	n/a
"Basic Adult" rotation with 2 EPAs				Y	Y
"Basic Adult Acute" rotation with 2 EPAs				Y	Y
Application of the Mental Health Act EPA				Y	Y
Risk Assessment EPA				Y	Y
6 Month FTE Rotation with 2 EPAs				Y	Y
6 Month FTE Rotation with 2 EPAs				Y	Y
6 Month FTE Rotation with 2 EPAs				Y	Y
6 Month FTE Rotation with 2 EPAs				Y	Y
6 Month FTE Rotation with 2 EPAs				Y	Y
6 Month FTE Rotation with 2 EPAs				Y	Y
6 Month FTE Rotation with 2 EPAs				Y	Y
6 Month FTE Rotation with 2 EPAs				Y	Y
Scholarly Project (3,000 - 5,000 words)				N *	N *
Psychotherapy Written Case (5,000 - 10,000 words)				N	N
Written Examination				n/a	n/a
Clinical Examination				n/a	n/a

N * Trainee may submit at any point in the Fellowship Program, but it is assessed at a standard of Fellowship.

***** **CURRENCY** is determined as documented under the 2003 Regulations in **LINK 19.**
Date attained remains as per original date of attainment, NOT as per date Trainee is transitioned. Should a trainee loose currency at a future point AFTER successful transition to CBFP 2012, then the component is (re) attained according to the latest CBFP requirements at the time, unless notified differently by the CFT in writing

Operational Complexity * ** with regards to Psychotherapies - we do not receive the paperwork until all interventions have been completed. The processes around this will need to be examined in further detail at a later point

Y** Under the existing Regulation for Clinicals, the Trainee must have completed a minimum of 30 FTE months of BT (i.e.: 5 of 6 Rotations), before attempting Clinical Examinations

Y*** Under the existing Regulation for entry to AT the Trainee may commence AT without having passed Clinicals. However, no more than 6 FTE months will be credited until the Clinical Examination has been passed. In addition, the Trainee is NOT eligible to enrol for a Certificate course.

APPENDICES

Stage 1 syllabus

Document version history

Version N°	*Revision description/reason*	*Date*
v1.4	Reformatted (content numbered)	28/06/12
v1.3	Updated with content identified during Stage 1 blueprinting	23/04/12

Preamble

This document has been prepared with the intent of providing a syllabus for learning for Stage 1 of the Competency-Based Fellowship Program (CBFP). The syllabus intends to define, for trainees and educators, the knowledge base that underpins the acquisition of competencies in Stage 1 and that is required for progression to Stage 2. The content outlined below is intended to inform knowledge acquisition across clinical, informal and formal education settings as well as self-directed learning in accordance with the CBFP framework.

The syllabus is not intended to be prescriptive. Accordingly, in order to be consistent with the principles of adult learning and to reflect the richness and diversity of psychiatry, detailed descriptions of content are intentionally excluded. This also allows for advances in psychiatric knowledge and changing paradigms. It is recognised that local training schemes and Formal Education Courses (FECs) will provide greater levels of specification.

The syllabus is indicative of the breadth of knowledge required. All areas in the syllabus are important and need to be covered; however, not all areas could be expected to be learnt to the same level. To help trainees, FEC coordinators, supervisors and other educators, a rating system has been utilised to indicate the depth of knowledge expected.

Depth of knowledge as appropriate for Stage 1 (not importance of knowledge)	
AC	Awareness of concepts
WK	Working knowledge
IDK	In-depth knowledge

It is expected the rating system also reflects the learning opportunities available to trainees in the first stage of training. The rating currently attributed to each area in the syllabus affects Stage 1 training only and the rating may change as training progresses.

Content

1	**Interviewing and assessment**		
	1.1.1	Basic principles of interviewing	IDK
	1.1.2	Mental state examination (MSE)	IDK
	1.1.3	Phenomenology	IDK
	1.1.4	Appropriate medical assessment and investigations	IDK
	1.1.5	Use of collateral sources	IDK
	1.1.6	Impact of cultural context	IDK
	1.1.7	Risk assessment	IDK
	1.1.8	Formulation	IDK
2	**Assessment and management of psychiatric emergencies**		IDK
3	**Diagnosis and classification**		
	3.1.1	Systems of classification (ICD, DSM)	IDK
	3.1.2	Principles and problems	WK
	3.1.3	History of development of diagnosis and classificatory systems in psychiatry	AC
4	**Basic sciences**		
	4.1.1	Neurosciences (relevant to the clinical syndromes…)	WK
		4.1.1a Neuroanatomy	WK
		4.1.1b Neurophysiology	WK
		4.1.1c Neurochemistry	WK
	4.1.2	Genetics and inheritance	AC
5	**Treatments in psychiatry**		
5.1	Social psychiatry		
	5.1.1	Principles of the recovery philosophy	AC
	5.1.2	Principles of stigma, mental health literacy, the role of public education initiatives	AC
	5.1.3	Role of social support services (housing, accommodation, non-governmental organisation [NGO] sector individual and group supports)	AC
	5.1.4	Role of non-medical individual and group counselling supports, eg. rape crisis services, veterans' support services	AC
	5.1.5	Role of consumer and advocacy groups	AC
5.2	Biological		
	5.2.1	Principles of psychopharmacology and prescribing	IDK
	5.2.2	Antipsychotics	IDK

	5.2.3	Antidepressants	IDK
	5.2.4	Mood stabilisers	IDK
	5.2.5	Anxiolytics	WK
	5.2.6	Electroconvulsive therapy (ECT)	WK
5.3	Psychological		
	5.3.1	Basic principles of psychological interventions (including non-specific factors)	IDK
	5.3.2	Understanding the principles and application of:	
	5.3.3	Supportive psychotherapies	IDK
	5.3.4	Psychodynamics	WK
	5.3.5	Cognitive–behavioural therapy (CBT)	AC

6 Critical appraisal and basic statistics

6.1.1	How to evaluate a scientific paper in psychiatry	WK
6.1.2	Fundamentals of statistics relevant to psychiatry	WK
6.1.3	Understanding study designs (quantitative and qualitative)	AC

7 Basic ethics

7.1.1	Ethics of involuntary treatment	IDK
7.1.2	Boundary issues	IDK
7.1.3	Issues of the exercise of power in psychiatry	IDK
7.1.4	Privacy and confidentiality	IDK
7.1.5	Distribution of healthcare	AC
7.1.6	Relationship with pharmaceutical companies	AC

8 Professionalism

8.1.1	Importance of personal ethics and integrity	IDK
8.1.2	Importance of maintaining professional standards	IDK
8.1.3	Importance of maintaining personal wellbeing	IDK

9 Mental health and related legislation

9.1.1	Relevant local mental health legislation		IDK
9.1.2	Responsibilities under the Mental Health Act		IDK
9.1.3	Principles underpinning mental health legislation		WK
9.1.4	Other health legislation (common law)		
	9.1.4a	Duty-of-care	WK
	9.1.4b	Enduring power of attorney	AC
	9.1.4c	Guardianship	AC
	9.1.4d	Advance health directives	AC

10 Normal development across the lifespan

10.1.1	Adolescent	WK
10.1.2	Adult	WK
10.1.3	Early attachment	AC
10.1.4	Infant	AC
10.1.5	Child	AC
10.1.6	Old age	AC

11 Basic psychology

11.1.1	Responses to trauma (including early-developmental trauma)	WK
11.1.2	Grief and loss	WK
11.1.3	Group theory and group dynamics	WK
11.1.4	Principles of adult learning	AC
11.1.5	Personal learning style	AC
11.1.6	Learning and related theories	AC
11.1.7	Basic principles of cognitive and behaviour therapy	AC

12 Cultural competence

12.1.1	Impact of cultural factors in clinical practice	WK

13 Patients, families and carers

13.1.1	History of patient empowerment and ‘consumer’ and carer movements	AC
13.1.2	Understanding the principles and importance of working with patients, families and carers	AC

14 Specific disorders

In Stage 1, trainees are expected to acquire knowledge of the following aspects of the disorders listed below:

Epidemiology, aetiology (biopsychosocial, cultural), symptomatology, course, assessment, management (biopsychosocial, cultural), psychiatric and medical comorbidities, differential diagnoses.

14.1	Organic psychiatry	
14.1.1	Delirium	WK
14.1.2	Dementia	AC
14.2	Substance dependence	
14.2.1	Acute intoxication	WK
14.2.2	Withdrawal	WK
14.3	Psychosis	
14.3.1	Schizophrenia spectrum disorders	IDK
14.4	Mood disorders	
14.4.1	Bipolar disorder	IDK
14.4.2	Depressive disorders	IDK
14.5	Anxiety disorders	
14.5.1	Panic and phobias	WK
14.5.2	Responses to adversity and trauma (adjustment disorders and post-traumatic syndrome)	WK
14.5.3	Generalised anxiety disorder (GAD)	AC
14.5.4	Obsessive–compulsive disorder (OCD) spectrum	AC
14.6	Personality disorders	
14.6.1	Borderline	IDK
14.6.2	Anti-social	WK
14.6.3	Narcissistic	WK

Appendix

AC – Awareness of concepts

Advance health directives

Basic principles of cognitive and behaviour therapy

Child (normal development)

Cognitive–behavioural therapy (CBT)

Dementia

Distribution of healthcare

Early attachment (normal development)

Enduring power of attorney

Generalised anxiety disorder (GAD)

Genetics and inheritance

Guardianship

History of development of diagnosis and classificatory systems in psychiatry

History of patient empowerment and ‘consumer’ and carer movements

Infant (normal development)

Learning and related theories

Obsessive–compulsive disorder (OCD) spectrum

Old age (normal development)

Personal learning style

Principles of adult learning

Principles of stigma, mental health literacy, the role of public education initiatives

Principles of the recovery philosophy

Relationship with pharmaceutical companies

Role of consumer and advocacy groups

Role of non-medical individual and group counselling supports, eg. rape crisis services, veterans’ support services

Role of social support services (housing, accommodation, non-governmental organisation [NGO] sector individual and group supports

Understanding study designs (quantitative and qualitative)

Understanding the principles and importance of working with patients, families and carers

WK – Working knowledge

Acute intoxication

Adolescent (normal development)

Adult (normal development)

Anti-social personality disorder

Anxiolytics

Delirium

Duty-of-care

Electroconvulsive therapy (ECT)

Fundamentals of statistics relevant to psychiatry

Grief and loss

Group theory and group dynamics

How to evaluate a scientific paper in psychiatry

Impact of cultural factors in clinical practice

Narcissistic personality disorder

Neuroanatomy

Neurochemistry

Neurophysiology

Neurosciences (relevant to the clinical syndromes…)

Panic and phobias

Principles and problems (of diagnosis and classification)

Principles underpinning mental health legislation

Psychodynamics

Responses to adversity and trauma (adjustment disorders and post-traumatic syndrome)

Responses to trauma (including early-developmental trauma)

Withdrawal

IDK – In-depth knowledge

Antidepressants

Antipsychotics

Appropriate medical assessment and investigations

Assessment and management of psychiatric emergencies

Basic principles of interviewing

Basic principles of psychological interventions (including non-specific factors)

Bipolar disorder

Borderline personality disorder

Boundary issues

Depressive disorders

Ethics of involuntary treatment

Formulation

Impact of cultural context

Importance of maintaining personal wellbeing

Importance of maintaining professional standards

Importance of personal ethics and integrity

Issues of the exercise of power in psychiatry

Mental state examination (MSE)

Mood stabilisers

Phenomenology

Principles of psychopharmacology and prescribing

Privacy and confidentiality

Relevant local mental health legislation

Responsibilities under the Mental Health Act

Risk assessment

Schizophrenia spectrum disorders

Supportive psychotherapies

Systems of classification (ICD, DSM)

Use of collateral sources

Stage 2 syllabus

Document version history

Version N°	*Revision description/reason*	*Date*
v0.12	Updates to items A12.1.6 and B3.1.2; reformatted (content numbered)	28/06/12
v0.11	Updated with content identified during Stage 2 blueprinting	10/05/12

Preamble

This document has been prepared with the intent of providing a syllabus for learning for Stage 2 of the Competency-Based Fellowship Program (CBFP). The syllabus intends to define, for trainees and educators, the knowledge base that underpins the acquisition of competencies in Stage 2 and that is required for progression to Stage 3. The content outlined below is intended to inform knowledge acquisition across clinical, informal and formal education settings as well as self-directed learning in accordance with the CBFP framework.

The syllabus is not intended to be prescriptive. Accordingly, in order to be consistent with the principles of adult learning and to reflect the richness and diversity of psychiatry, detailed descriptions of content are intentionally excluded. This also allows for advances in psychiatric knowledge and changing paradigms. It is recognised that local training schemes and Formal Education Courses (FECs) will provide greater levels of specification.

The syllabus is indicative of the breadth of knowledge required. All areas in the syllabus are important and need to be covered; however, not all areas could be expected to be learnt to the same level. To help trainees, FEC coordinators, supervisors and other educators, a rating system has been utilised to indicate the depth of knowledge expected.

Depth of knowledge as appropriate for Stage 2 (not importance of knowledge)	
AC	Awareness of concepts
WK	Working knowledge
IDK	In-depth knowledge

It is expected the rating system also reflects the learning opportunities available to trainees in the second stage of training. The rating currently attributed to each area in the syllabus affects Stage 2 training only and the rating may change as training progresses.

It is important to note that the syllabus outlines knowledge that all trainees must acquire in Stage 2 of training, regardless of which area of practice rotations they undertake.

Content

A Generalist knowledge and general psychiatry

The following content represents generalist knowledge that should be applied across different areas of practice. This section builds on that acquired in Stage 1 and also covers areas of knowledge not addressed in the specific area of practice sections. The rating reflects the depth of knowledge required at Stage 2.

A1 Interviewing and assessment

A1.1.1	Interviewing with sensitivity, including but not limited to, sensitivity to culture, sexual orientation, intellectual abilities and developmental stage	IDK
A1.1.2	Understanding the importance of synthesising informant and corroborative histories and documented histories with direct assessment	IDK
A1.1.3	Understanding the components and limitations of risk assessment, including issues in specific populations, eg. infants, children and adolescents, older people	IDK
A1.1.4	Understanding the concept and challenges of interviewing and assessing the mental state of people with complex communication needs including intellectual, developmental and other disabilities (cognitive, sensory and motor)	WK

A2 Assessment and management of psychiatric emergencies IDK

A3 Diagnosis and classification

A3.1.1	Systems of classification (ICD, DSM)	IDK
A3.1.2	Principles and problems	WK
A3.1.3	History of development of diagnosis and classificatory systems in psychiatry	AC

A4 Basic sciences

A4.1.1	Neurosciences (relevant to the clinical syndromes…)	IDK
	A4.1.1a Neuroanatomy	IDK
	A4.1.1b Neurophysiology	IDK
	A4.1.1c Neurochemistry	IDK
A4.1.2	Genetics and inheritance	WK

A5 Management in psychiatry

A5.1 Social

A5.1.1	Principles of the recovery philosophy	WK
A5.1.2	Principles of stigma, mental health literacy, the role of public education initiatives	WK
A5.1.3	Role of social support services (housing, accommodation, non-governmental organisation [NGO] sector individual and group supports)	WK
A5.1.4	Role of non-medical individual and group counselling supports, eg. rape crisis services, veterans' support services	WK
A5.1.5	Role of consumer and advocacy groups	WK

A5.2 Biological

A5.2.1	Principles of psychopharmacology and prescribing	IDK
A5.2.2	Antipsychotics	IDK
A5.2.3	Antidepressants	IDK
A5.2.4	Mood stabilisers	IDK
A5.2.5	Anxiolytics	IDK
A5.2.6	Electroconvulsive therapy (ECT)	IDK
A5.2.7	Management of physical sequelae and complications of psychiatric illnesses and their treatment	IDK
A5.2.8	Transcranial magnetic stimulation	AC

A5.3 Psychological

A5.3.1	Principles of psychological interventions (including non-specific factors)	IDK
A5.3.2	Understanding the role of, and evidence-based indications for, the major modalities of psychotherapy (supportive, psychodynamic, cognitive–behavioural, interpersonal, family, group and couples)	WK

A5.4 Population

A5.4.1	Principles of promotion, prevention and early intervention strategies	AC
A5.4.2	Awareness of at-risk groups	AC
A5.4.3	Understanding the burden of mental illness	AC

A6 Critical appraisal and basic statistics

A6.1.1	How to evaluate a scientific paper in psychiatry	IDK
A6.1.2	Fundamentals of statistics relevant to psychiatry	WK
A6.1.3	Understanding study designs (quantitative and qualitative)	WK

A7 Ethics

A7.1.1	Capacity	IDK
A7.1.2	Ethics of coercive treatment	IDK
A7.1.3	Boundary issues	IDK
A7.1.4	Issues of the exercise of power in psychiatry	IDK
A7.1.5	Privacy and confidentiality	IDK
A7.1.6	Relationship with industry	IDK
A7.1.7	End-of-life decisions (including do not resuscitate (DNR) orders)	WK
A7.1.8	Child protection	WK
A7.1.9	Ethics of duality and conflicts of interest	WK
A7.1.10	Distribution of healthcare resources	AC

A8 Professionalism

A8.1.1	Importance of personal ethics and integrity	IDK
A8.1.2	Importance of maintaining professional standards	IDK
A8.1.3	Importance of maintaining personal wellbeing	IDK

A9 The law

A9.1.1	Principles underpinning mental health legislation	IDK
A9.1.2	Understanding relevant local legislation as it applies to specific groups of patients, eg. forensic, child and adolescent, addiction	IDK
A9.1.3	Responsibilities under the Mental Health Act	IDK
A9.1.4	Relevant common law principles, eg. capacity, necessity, duty-of-care, duty-to-warn	IDK
A9.1.5	Knowledge of mandatory reporting requirements (including ethical considerations and health practitioner's context)	WK
A9.1.6	Testamentary capacity	WK
A9.1.7	Advance health directives	WK
A9.1.8	Supported and substitute decision making, eg. guardianship and administration, enduring power of attorney	WK
A9.1.9	Understanding the role of an expert in legal proceedings (including report writing and giving evidence)	AC
A9.1.10	Principles of psychiatric defences and fitness to plead/stand trial	AC

A10 Normal development across the lifespan

A10.1.1	Attachment, infant, child, adolescent, adult, old age	IDK

A11 Children of parents with mental health disorders

A11.1.1 Understanding the issues/problems facing children of parents with mental illness and/or addiction	WK
A11.1.2 Knowledge of strategies to assist children of parents with mental illness and/or addiction	WK

A12 Psychology

A12.1.1 Group theory and group dynamics	IDK
A12.1.2 Learning and related theories	WK
A12.1.3 Personality theory	WK
A12.1.4 Developmental psychology	WK
A12.1.5 Cognitive psychology	WK
A12.1.6 Psychometric assessment	AC

A13 Cultural competence

A13.1.1 Impact of cultural factors in clinical practice	WK
A13.1.2 Psychiatry in a multicultural context	WK
A13.1.3 Impact of migration	WK

A14 History

A14.1.1 History of psychiatry as it informs current psychiatric practice	WK
A14.1.2 History of patient empowerment and ‘consumer’ and carer movements	WK

A15 Specific disorders

In Stage 2, trainees are expected to acquire knowledge of the following aspects of the disorders listed below:

Epidemiology, aetiology (biopsychosocial, cultural), symptomatology, course, assessment, management (biopsychosocial, cultural), psychiatric and medical comorbidities, differential diagnoses.

A15.1	Organic psychiatry	IDK
A15.2	Psychosis	
	A15.2.1 Schizophrenia spectrum disorders	IDK
A15.3	Mood disorders	
	A15.3.1 Bipolar disorder	IDK
	A15.3.2 Depressive disorders	IDK
A15.4	Anxiety disorders	IDK
A15.5	Personality disorders	IDK
A15.6	Dissociative disorders	WK
A15.7	Sleep disorders	WK
A15.8	Perinatal disorders	WK
A15.9	Eating disorders	WK
A15.10	Impulse control disorders	WK
A15.11	Sexual disorders	WK

B Consultation–Liaison psychiatry

B1 Interviewing and assessment

B1.1.1	Principles of interviewing, history gathering and documentation in the general medical setting	IDK
B1.1.2	Specialised cognitive testing	IDK
B1.1.3	Focused medical assessment and investigations in the medically ill	IDK

B2 Systemic issues in Consultation–Liaison psychiatry

B2.1.1	Role of Consultation–Liaison psychiatrist	WK
B2.1.2	Models of care in the general medical setting (consultation versus liaison)	WK

B3 Treatments in psychiatry

B3.1 Social

B3.1.1	Stigma associated with mental illness in the general hospital setting	IDK
B3.1.2	Advocacy when the patient is under another clinician's care	WK

B3.2 Biological

B3.2.1	Principles of psychopharmacology and prescribing in the medically ill patient, eg. patients on multiple medications, patients with impaired organ function	IDK
B3.2.2	Psychiatric and neuropsychiatric sequelae of medical conditions and their treatments	WK
B3.2.3	Analgesia	AC

B3.3 Psychological

B3.3.1	Principles of psychological interventions in the Consultation–Liaison setting	IDK
B3.3.2	Application of psychological techniques (eg. conflict resolution) to the patient and the treating team	WK
B3.3.3	Containing distress	WK

B4 Normal development across the lifespan

B4.1.1	Impact of medical illness on normal development	WK

B5 Psychology

B5.1.1	Abnormal illness behaviour	IDK
B5.1.2	Sick role	IDK
B5.1.3	Responses to trauma and medical illness (including chronic medical illness)	WK
B5.1.4	Demoralisation	WK
B5.1.5	Grief and loss	WK

B6 Cultural competence

B6.1.1	Impact of cultural factors in the general medical setting, eg. different understandings of the need to inform the patient	WK

B7 Specific disorders in consultation–liaison psychiatry

In Stage 2, trainees are expected to acquire knowledge of the following aspects of the disorders listed below:

Epidemiology, aetiology (biopsychosocial, cultural), symptomatology, course, assessment, management (biopsychosocial, cultural), psychiatric and medical comorbidities, differential diagnoses.

B7.1	Organic psychiatry	
B7.1.1	Delirium	IDK
B7.1.2	Epilepsy	WK
B7.1.3	Acquired brain injury	WK
B7.1.4	Psychiatric illness due to general medical conditions (including side effects of treatments)	WK
B7.2	Psychiatric disorders in the medically ill	IDK
B7.3	Somatoform disorders	
B7.3.1	Pain disorders	WK
B7.3.2	Somatisation disorder	WK
B7.3.3	Conversion disorder	WK
B7.3.4	Hypochondriasis	WK
B7.4	Factitious disorder and malingering	WK

C Child & Adolescent psychiatry

C1 Interviewing and assessment

C1.1.1	Basic principles of interviewing children and adolescents	IDK
C1.1.2	Mental state examination of the child or adolescent	IDK
C1.1.3	Appropriate medical assessment and investigations	IDK
C1.1.4	Use of collateral sources	IDK
C1.1.5	Family interviewing	IDK
C1.1.6	Developmental assessment	IDK

C2 Treatments in psychiatry

C2.1 Biological

C2.1.1	Principles of psychopharmacology and prescribing in children and adolescents	IDK
C2.1.2	Antipsychotics	IDK
C2.1.3	Antidepressants	IDK
C2.1.4	Mood stabilisers	IDK
C2.1.5	Anxiolytics	WK
C2.1.6	Psychostimulants and other treatments for Attention deficit hyperactivity disorder (ADHD)	AC
C2.1.7	Awareness of the use of, and limited evidence for, complementary and alternative treatments	AC

C2.2 Psychological

C2.2.1	Principles of psychological interventions (including non-specific factors)	WK
	C2.2.1a Family therapy	WK

C3 Psychology

C3.1.1	Responses to trauma (including early-developmental trauma)	WK
C3.1.2	Grief and loss	WK
C3.1.3	Interpretation of behaviour checklists	WK
C3.1.4	Learning and related theories	AC
C3.1.5	Psychometrics	AC

C4 Patients, families, carers and systemic issues in Child & Adolescent psychiatry

C4.1.1	Understanding principles of working with patients, families and carers	WK
C4.1.2	Working with schools, welfare agencies, physical health services	WK

C5 Specific disorders in child & adolescent psychiatry

In Stage 2, trainees are expected to acquire knowledge of the following aspects of the disorders of childhood and adolescence listed below.

Epidemiology, aetiology (biopsychosocial, cultural), symptomatology, course, assessment, management (biopsychosocial, cultural), psychiatric and medical comorbidities, differential diagnoses.

C5.1	Internalising	WK
C5.2	Externalising	WK
C5.3	Neurodevelopmental disorders	WK
C5.4	Somatic	WK

D Addiction psychiatry

D1 Interviewing and assessment

D1.1.1	Knowledge and synthesis of the interaction between substance use and psychiatric symptoms/disorders	IDK
D1.1.2	Physical effects of substance use, eg. Korsakoff's syndrome, hepatitis	WK
D1.1.3	Investigations specific to substance use, eg. blood-borne viruses, urine drug screening (UDS)	WK
D1.1.4	Specific cognitive testing, eg. executive function testing	WK

D2 Treatments in psychiatry

D2.1.1	Integrated approach to the treatment of co-existing problems, especially comorbid post-traumatic stress disorder (PTSD) and other anxiety disorders, mood disorders and psychosis	IDK
D2.1.2	Knowledge of harm-minimisation strategies and public health interventions, eg. needle exchanges	WK
D2.1.3	Knowledge of interaction between drugs of abuse and treatment of psychiatric disorders	WK

D2.2 Social

D2.2.1	Stigma associated with addiction	WK
D2.2.2	Advocacy	AC
D2.2.3	Knowledge of special populations, eg. indigenous people	AC

D2.3 Biological

D2.3.1	Relapse prevention pharmacotherapy, eg. anti-craving drugs	WK
D2.3.2	Opioid substitution therapies	WK
D2.3.3	Knowledge of pharmaceutical drug misuse (including over-the-counter medications)	AC

D2.4 Psychological

D2.4.1	Motivational interviewing	WK
D2.4.2	Contingency management	WK
D2.4.3	Mutual help programs, eg. Alcoholics Anonymous (AA)	WK
D2.4.4	Acceptance and commitment therapy	AC

D3 Substance use across the lifespan

D3.1.1	Substance use in young people and in older people	WK
D3.1.2	Substance use in pregnancy/puerperium	WK
D3.1.3	Impact of substance use on normal development (including dementia)	WK
D3.1.4	Neonatal abstinence syndromes	WK

D4 Specific disorders in addiction psychiatry

In Stage 2, trainees are expected to acquire knowledge of the following aspects of the disorders listed below:

Epidemiology, aetiology (biopsychosocial, cultural), symptomatology, course, assessment, management (biopsychosocial, cultural), psychiatric and medical comorbidities, differential diagnoses.

D4.1	Substance-induced disorders	
	D4.1.1 Substance-induced mood disorders, anxiety disorders	IDK
	D4.1.2 Substance-induced psychosis	IDK
D4.2	Substance dependence and physical illness	WK
D4.3	Substance dependence	
	D4.3.1 Alcohol	IDK
	D4.3.2 Nicotine	IDK
	D4.3.3 Cannabis (including its relationship with psychosis)	IDK
	D4.3.4 Amphetamine-type stimulants	IDK
	D4.3.5 Hallucinogens	WK
	D4.3.6 Opioids	AC
	D4.3.7 Inhalants	AC
D4.4	Pharmaceutical drug misuse/abuse/dependence	
	D4.4.1 Prescribed medications	WK
	D4.4.2 Over-the-counter medications	WK
D4.5	Drug stabilisation	
	D4.5.1 Acute intoxication	IDK
	D4.5.2 Withdrawal, knowledge of rating scales and their limitations	IDK
D4.6	Gambling	WK
D4.7	Pain assessment and management options	
	D4.7.1 Chronic pain and substance use	WK
D4.8	Personality disorders	
	D4.8.1 Personality disorders in the addiction setting	WK

E Forensic psychiatry

E1 Interviewing and assessment

E1.1.1	Assessment and management of risk of harm to others	IDK

E2 Other

E2.1.1	The relationship between mental illness and violence	WK
E2.1.2	Therapeutic security and levels of security in psychiatric facilities	WK
E2.1.3	Forensic mental health systems and services	AC
E2.1.4	Correctional psychiatry	AC

E3 Specific disorders in forensic psychiatry

In Stage 2, trainees are expected to acquire knowledge of the following aspects of the disorders listed below:

Epidemiology, aetiology (biopsychosocial, cultural), symptomatology, course, assessment, management (biopsychosocial, cultural), psychiatric and medical comorbidities, differential diagnoses.

E3.1	Personality disturbance in a forensic setting	WK
E3.2	Problematic behaviours	
E3.2.1	Litigiousness	AC
E3.2.2	Stalking	AC
E3.2.3	Paraphilias	AC
E3.2.4	Fire-setting	AC
E3.2.5	Aggression	AC
E3.3	Victimology	AC

F Psychiatry of Old Age

F1 Interviewing and assessment

F1.1.1	Psychiatric assessment of older adults	IDK
F1.1.2	Neuroimaging in older people (including an appreciation of the range of normal findings in older people on CT and MRI structural scans)	IDK
F1.1.3	Functional assessment (including ADL/IADL function and issues of risk particularly relevant to the older person, such as falls)	IDK
F1.1.4	Assessment of social situation, eg. suitability of living environment, accessibility, social support, elder abuse and exploitation, severe domestic squalor, hoarding	IDK

F2 Treatments in psychiatry

F2.1 Biological

F2.1.1	Electroconvulsive therapy (ECT) as applied to older people	IDK
F2.1.2	Principles of psychopharmacology and prescribing in older people (including treatments for physical illnesses, with an emphasis on psychopharmacology in people aged 75 and over)	IDK
F2.1.3	Biological treatments in dementia (including the use of cognition enhancers)	WK

F2.2 Psychological

F2.2.1	Principles of behavioural and psychological interventions in older people	WK

F3 Patients, families, carers and wider systems

F3.1.1	Interaction with residential aged care facilities, non-governmental organisations (NGOs), eg. Alzheimer's Australia and Alzheimers New Zealand	WK
F3.1.2	Community services for older people, eg. home help, domiciliary nursing, meals on wheels, etc.	WK
F3.1.3	Income support, public housing, disability services for older people	WK
F3.1.4	Health and welfare support for older veterans	WK

F4 Specific disorders in psychiatry of old age

In Stage 2, trainees are expected to acquire knowledge of the following aspects of the disorders listed below:

Epidemiology, aetiology (biopsychosocial, cultural), symptomatology, course, assessment, management (biopsychosocial, cultural), psychiatric and medical comorbidities, differential diagnoses.

	F4.1.1	Awareness of how ageing and functional impairment associated with ageing affects treatment outcomes, including the speed of response to treatment	WK
F4.2	Organic mental disorders		
	F4.2.1	Dementias	IDK
	F4.2.2	Very-late-onset (> 60 years) schizophrenia-like psychoses	IDK
	F4.2.3	Effects of ageing in people with early-onset (< 40 years) and late-onset (40–60 years) psychotic disorders	IDK
	F4.2.4	Amnestic disorder	WK
F4.3	Personality disorders in older people		
	F4.3.1	Presentation of personality disorders in later life	WK
	F4.3.2	Pathoplastic effects of personality dysfunction on Axis I disorders in later life	WK

G Psychotherapies

G1 Interviewing and assessment

G1.1.1	Principles of assessment for all psychotherapy approaches	IDK
G1.1.2	Understanding general factors to rapport building, therapeutic alliance, frame and contract setting in psychotherapy and issues of confidentiality and boundaries (including boundary violations and personal disclosure) specific to psychotherapy	IDK
G1.1.3	Formulation – psychodynamic approaches and other approaches compatible with the other models of psychotherapy	IDK

G2 Treatments in psychiatry

G2.1 Psychological treatments

Understanding the theories, indications and evidence base for the following modalities:

G2.1.1	Supportive therapies	IDK
G2.1.2	Family therapy (major schools)	WK
G2.1.3	Cognitive and behavioural therapies	WK
G2.1.4	Interpersonal therapy (IPT)	WK
G2.1.5	Psychodynamic therapies (major schools)	WK
G2.1.5a	Historical perspective and context of different schools	WK
G2.1.6	Group therapy (major schools)	AC
G2.1.7	Couples therapy	AC

H Indigenous Australians/Māori mental health

H1 Interviewing and assessment

H1.1.1	Interviewing with cultural sensitivity	IDK

Issues relating to:

H1.1.2	Familiarity with the Australian and New Zealand history of colonisation/invasion and the ongoing impact for Indigenous people today	WK
H1.1.3	Familiarity with the Indigenous world view, often contrasted as being holistic in comparison with the more categorical 'Western' world view	WK
H1.1.4	Specific cultural practices, customs and social structures and their impact on mental illness presentation and intervention	AC

I Rural psychiatry

I1 Interviewing and assessment

I1.1.1	Telepsychiatry	AC

Issues relating to:

I1.1.2	Impact of small community living on presentation of mental illness and intervention	AC
I1.1.3	Working autonomously, and in partnership with, limited community support services	AC

J Psychiatry of Intellectual & Developmental Disabilities

J1.1.1	Specific issues of assessment of people with intellectual disabilities, including mental health and behaviour, relevance of severity of intellectual disability	WK
J1.1.2	Consideration of the aetiology of the disabilities in the patient, whether congenital and/or acquired, and relevance to the clinical presentation	WK
J1.1.3	Specific issues of management, including adapted psychotropic drug regimens and importance of long-term developmental perspective	WK

K Perinatal psychiatry

K1.1.1	Specific issues of assessment and management in this population	WK
K1.1.2	Risk assessment (including risk of infanticide)	WK
K1.1.3	Use of pharmacology in this population	WK

Appendix

AC – Awareness of concepts

Acceptance and commitment therapy

Advocacy (Addiction psychiatry)

Aggression

Analgesia

Awareness of at-risk groups

Awareness of the use of, and limited evidence for, complementary and alternative treatments (Child & Adolescent psychiatry)

Correctional psychiatry

Couples therapy (Psychotherapies)

Distribution of healthcare resources

Fire-setting

Forensic mental health systems and services

Group therapy (major schools) – Psychotherapies

History of development of diagnosis and classificatory systems in psychiatry

Impact of small community living on presentation of mental illness and intervention

Inhalants

Knowledge of pharmaceutical drug misuse (including over-the-counter medications)

Knowledge of special populations, eg. indigenous people

Learning and related theories (in Child & Adolescent psychiatry)

Litigiousness

Opioids

Paraphilias

Principles of promotion, prevention and early intervention strategies

Principles of psychiatric defences and fitness to plead/stand trial

Psychometric assessment (Generalist knowledge)

Psychometrics (in Child & Adolescent psychiatry)

Psychostimulants and other treatments for Attention deficit hyperactivity disorder (ADHD)

Stalking

Telepsychiatry

Transcranial magnetic stimulation

Understanding the burden of mental illness

Understanding the role of an expert in legal proceedings (including report writing and giving evidence)

Victimology

Working autonomously, and in partnership with, limited community support services

WK – Working knowledge

Acquired brain injury

Advance health directives

Advocacy when the patient is under another clinician's care (Consultation–Liaison psychiatry)

Amnestic disorder

Anxiolytics (in Child & Adolescent psychiatry)

Application of psychological techniques (eg. conflict resolution) to the patient and the treating team

Awareness of how ageing and functional impairment associated with ageing affects treatment outcomes, including the speed of response to treatment

Biological treatments in dementia (including the use of cognition enhancers)

Child protection

Chronic pain and substance use

Cognitive and behavioural therapies (Psychotherapies)

Cognitive psychology

Community services for older people, eg. home help, domiciliary nursing, meals on wheels, etc.

Consideration of the aetiology of the disabilities in the patient, whether congenital and/or acquired, and relevance to the clinical presentation (Psychiatry of Intellectual & Developmental Disabilities)

Containing distress

Contingency management

Conversion disorder

Demoralisation

Developmental psychology

Dissociative disorders

Eating disorders

End-of-life decisions (including do not resuscitate (DNR) orders)

Epilepsy

Ethics of duality and conflicts of interest

Externalising disorders

Factitious disorder and malingering

Family therapy (in Child & Adolescent psychiatry)

Family therapy (major schools) – Psychotherapies

Fundamentals of statistics relevant to psychiatry

Gambling

Genetics and inheritance

Grief and loss

Grief and loss (in Child & Adolescent psychiatry)

Hallucinogens

Health and welfare support for older veterans

Historical perspective and context of different schools (of psychotherapy)

History of patient empowerment and 'consumer' and carer movements

History of psychiatry as it informs current psychiatric practice

Hypochondriasis

Impact of cultural factors in clinical practice

Impact of cultural factors in the general medical setting, eg. different understandings of the need to inform the patient (Consultation–Liaison psychiatry)

Impact of medical illness on normal development

Impact of migration

Impact of substance use on normal development (including dementia)

Impulse control disorders

Income support, public housing, disability services for older people

Interaction with residential aged care facilities, non-governmental organisations (NGOs), eg. Alzheimer's Australia and Alzheimers New Zealand

Internalising disorders

Interpersonal therapy (IPT) – Psychotherapies

Interpretation of behaviour checklists

Investigations specific to substance use, eg. blood-borne viruses, urine drug screening (UDS)

Knowledge of harm-minimisation strategies and public health interventions, eg. needle exchanges

Knowledge of interaction between drugs of abuse and treatment of psychiatric disorders

Knowledge of mandatory reporting requirements (including ethical considerations and health practitioner's context)

Knowledge of strategies to assist children of parents with mental illness and/or addiction

Learning and related theories

Models of care in the general medical setting (consultation versus liaison)

Motivational interviewing

Mutual help programs, eg. Alcoholics Anonymous (AA)

Neonatal abstinence syndromes

Neurodevelopmental disorders

Opioid substitution therapies

Over-the-counter medications

Pain disorders

Pathoplastic effects of personality dysfunction on Axis I disorders in later life

Perinatal disorders

Personality disorders in the addiction setting

Personality disturbance in a forensic setting

Personality theory

Physical effects of substance use, eg. Korsakoff's syndrome, hepatitis

Prescribed medications

Presentation of personality disorders in later life

Principles and problems (of diagnosis and classification)

Principles of behavioural and psychological interventions in older people

Principles of psychological interventions (including non-specific factors) – in Child & Adolescent psychiatry

Principles of stigma, mental health literacy, the role of public education initiatives

Principles of the recovery philosophy

Psychiatric and neuropsychiatric sequelae of medical conditions and their treatments (Consultation–Liaison psychiatry)

Psychiatric illness due to general medical conditions (including side effects of treatment)

Psychiatry in a multicultural context

Psychodynamic therapies (major schools) – Psychotherapies

Relapse prevention pharmacotherapy, eg. anti-craving drugs

Responses to trauma (including early-developmental trauma) – in Child & Adolescent psychiatry

Responses to trauma and medical illness (including chronic medical illness) – Consultation–Liaison psychiatry

Risk assessment (including risk of infanticide)

Role of Consultation–Liaison psychiatrist

Role of consumer and advocacy groups

Role of non-medical individual and group counselling supports, eg. rape crisis services, veterans support services

Role of social support services (housing, accommodation, non-governmental organisation (NGO) sector individual and group supports)

Sexual disorders

Sleep disorders

Somatic disorders (in Child & Adolescent psychiatry)

Somatisation disorder

Specific cognitive testing, eg. executive function testing

Specific issues of assessment and management in this population (Perinatal psychiatry)

Specific issues of assessment of people with intellectual disabilities, including mental health and behaviour, relevance of severity of intellectual disability

Specific issues of management, including adapted psychotropic drug regimens and importance of long-term developmental perspective (Psychiatry of Intellectual & Developmental Disabilities)

Stigma associated with addiction

Substance dependence and physical illness

Substance use in pregnancy/puerperium

Substance use in young people and in older people

Supported and substitute decision making, eg. guardianship and administration, enduring power of attorney

Testamentary capacity

The relationship between mental illness and violence

Therapeutic security and levels of security in psychiatric facilities

Understanding principles of working with patients, families and carers

Understanding study designs (quantitative and qualitative)

Understanding the concept and challenges of interviewing and assessing the mental state of people with complex communication needs including intellectual, developmental and other disabilities (cognitive, sensory and motor)

Understanding the issues/problems facing children of parents with mental illness and/or addiction

Understanding the role of, and evidence-based indications for, the major modalities of psychotherapy (supportive, psychodynamic, cognitive–behavioural, interpersonal, family, group and couples)

Use of pharmacology in this population (Perinatal psychiatry)

Working with schools, welfare agencies, physical health services

IDK – In-depth knowledge

Abnormal illness behaviour

Acute intoxication

Alcohol

Amphetamine-type stimulants

Antidepressants

Antidepressants (in Child & Adolescent psychiatry)

Antipsychotics

Antipsychotics (in Child & Adolescent psychiatry)

Anxiety disorders

Anxiolytics

Appropriate medical assessment and investigations (in Child & Adolescent psychiatry)

Assessment and management of psychiatric emergencies

Assessment and management of risk of harm to others (Forensic psychiatry)

Assessment of social situation, eg. suitability of living environment, accessibility, social support, elder abuse and exploitation, severe domestic squalor, hoarding

Basic principles of interviewing children and adolescents

Bipolar disorder

Boundary issues

Cannabis (including its relationship with psychosis)

Capacity

Delirium

Dementias

Depressive disorders

Developmental assessment

Effects of ageing in people with early-onset (< 40 years) and late-onset (40–60 years) psychotic disorders

Electroconvulsive therapy (ECT)

Electroconvulsive therapy (ECT) as applied to older people

Ethics of coercive treatment

Family interviewing (Child & Adolescent psychiatry)

Focused medical assessment and investigations in the medically ill

Formulation – psychodynamic approaches and other approaches compatible with the other models of psychotherapy

Functional assessment (including ADL/IADL function and issues of risk particularly relevant to the older person, such as falls)

Group theory and group dynamics

How to evaluate a scientific paper in psychiatry

Importance of maintaining personal wellbeing

Importance of maintaining professional standards

Importance of personal ethics and integrity

Integrated approach to the treatment of co-existing problems, especially comorbid post-traumatic stress disorder (PTSD) and other anxiety disorders, mood disorders and psychosis

Interviewing with sensitivity, including but not limited to, sensitivity to culture, sexual orientation, intellectual abilities and developmental stage

Issues of the exercise of power in psychiatry

Knowledge and synthesis of the interaction between substance use and psychiatric symptoms/disorders

Management of physical sequelae and complications of psychiatric illnesses and their treatment

Mental state examination of the child or adolescent

Mood stabilisers

Mood stabilisers (in Child & Adolescent psychiatry)

Neuroanatomy

Neurochemistry

Neuroimaging in older people (including an appreciation of the range of normal findings in older people on CT and MRI structural scans)

Neurophysiology

Neurosciences (relevant to the clinical syndromes...)

Nicotine

Normal development across the lifespan (attachment, infant, child adolescent, adult old age)

Organic psychiatry

Personality disorders

Principles of assessment for all psychotherapy approaches

Principles of interviewing, history gathering and documentation in the general medical setting

Principles of psychological interventions (including non-specific factors)

Principles of psychological interventions in the Consultation–Liaison setting

Principles of psychopharmacology and prescribing

Principles of psychopharmacology and prescribing in children and adolescents

Principles of psychopharmacology and prescribing in older people (including treatments for physical illnesses, with an emphasis on psychopharmacology in people aged 75 and over)

Principles of psychopharmacology and prescribing in the medically ill patient, eg. patients on multiple medications, patients with impaired organ function

Principles underpinning mental health legislation

Privacy and confidentiality

Psychiatric assessment of older adults

Psychiatric disorders in the medically ill

Relationship with industry

Relevant common law principles, eg. capacity, necessity, duty-of-care, duty-to-warn

Responsibilities under the Mental Health Act

Schizophrenia spectrum disorders

Sick role

Specialised cognitive testing

Stigma associated with mental illness in the general hospital setting

Substance-induced mood disorders, anxiety disorders

Substance-induced psychosis

Supportive therapies (Psychotherapies)

Systems of classification (ICD, DSM)

Understanding general factors to rapport building, therapeutic alliance, frame and contract setting in psychotherapy and issues of confidentiality and boundaries (including boundary violations and personal disclosure) specific to psychotherapy

Understanding relevant local legislation as it applies to specific group of patients, eg. forensic, child and adolescent, addiction

Understanding the components and limitations of risk assessment, including issues in specific populations, eg. infants, children and adolescents, older people

Understanding the importance of synthesising informant and corroborative histories and documented histories with direct assessment

Use of collateral sources (in Child & Adolescent psychiatry)

Very-late-onset (> 60 years) schizophrenia-like psychoses

Withdrawal, knowledge of rating scales and their limitations

CBFP Developmental Descriptors

The following table contains the Developmental Descriptors for use in the Competency-Based Fellowship Program. The Developmental Descriptors are behavioural descriptors for the Fellowship Competencies.

The descriptors articulate how the overarching Developmental Trajectory applies for each of the Fellowship Competencies at the Basic, Proficient and Advanced level. The descriptors chart the anticipated developmental trajectory of trainees' performance as they progress towards Fellowship. It is recognised that the behaviours described in the Developmental Descriptors do not represent the exclusive range of behaviours, and are provided only as a guide.

These descriptors are intended to provide supervisors and trainees with a reference point for defining performance standards. It is anticipated that the descriptors will be of use as criteria supporting workplace-based assessments and guiding the provision of formative feedback to trainees.

The Developmental Trajectory illustrates the broad changes expected of trainees' practice as they progress through training:

Basic	Proficient	Advanced
Low level of independence		High level of independence
High level of supervision		Low level of supervision
Completes straightforward tasks		Completes complex tasks

Aspect of Practice	BASIC End of Stage 1	PROFICIENT End of Stage 2	ADVANCED End of Stage 3
Assessment ME 1*	Conducts a standard assessment of a patient with typical psychiatric disorders, but requires supervision to elicit all necessary data and to understand the significance of data obtained.	With supervision, performs a detailed and comprehensive assessment of a patient presenting with typical and atypical features.	Performs a detailed and comprehensive assessment of a patient presenting with complex or multiple problems, or in special groups.

History Taking ME 1*	Follows recommended framework for history taking. Hypothesis-driven for simple problems. Requires supervision to clarify important positive and negative features from the history and for accuracy and interpretation of mental state examination. Demonstrates adequate assessment of risk.	History taking is targeted according to the patient's presentation and is hypothesis-driven. Uses supervision to enhance understanding of relevant issues, including in-depth analysis of risks.	History taking is appropriate to setting, focused and hypothesis driven. Sophisticated understanding of immediate and long-term risks of the individual case.
Sociocultural ME 1, 3*	Identifies key sociocultural issues relevant to the psychiatric assessment. Requires supervision to deepen understanding.	Integrates sociocultural issues and patient's needs into the psychiatric assessment. Uses supervision to enhance understanding.	Generates a sophisticated sociocultural formulation and applies this formulation to the treatment plan of the patient.
Mental State Examination ME 2*	Conducts and presents a thorough MSE, assessing the key aspects of observation of appearance, behaviour, conversation and rapport, affect and mood, thought (stream, form, content, (normal and abnormal), perception, cognition, insight and judgement. Able to perform some targeted cognitive assessments correctly. Succinct presentation of the MSE (and cognitive assessment) with accurate use of phenomenological terms and appropriate positive and negative findings. *(OCI marking sheet just below standard)*	Conducts and presents a thorough, relevant and succinct MSE, with accurate use of phenomenological terms and appropriate identification of positive and negative findings. Performs an accurate cognitive assessment targeted to the patient's presentation that provides useful information. Interprets findings of cognitive assessments correctly and can discuss their application.	Conducts and accurately presents a tailored MSE in complex patients, in a variety of settings and for a variety of reasons. Approach is organised and efficient. Decides on the importance of a cognitive assessment, chooses the most appropriate tests and performs them in a meaningful manner that provides useful information targeted to the patient's presentation. *(Surpasses the standard on ECE MARKING SHEET)*
Formulation ME 3*	Produces an accurate BPS[1] formulation and requires supervision to link salient factors.	Able to identify and succinctly summarise important aspects of the history, using a BPS framework, and develop hypotheses as to how these factors interacted such that the patient now presents with the problems identified. Clearly demonstrates an understanding of the individual	Sophisticated integration of information on complex or unusual cases into a BPS formulation.

[1] BPS refers to the Biopsychosocial Model described by Engel (Engel G.L. (1977), *The Need for a New Medical Model: A Challenge for Biomedicine*, Science, 196: 129 – 136), which includes cultural and spiritual dimensions within the social domain

		before them (i.e. tailored and not generic formulations). Hypotheses should be based on recognised psychological, social and biological theories and, where extant, evidence. Such theories and evidence that the candidate relies upon should be accurately described and applied in a manner that demonstrates a deeper level of understanding. These hypotheses should inform management recommendations. Uses supervision to assist and learn from this process.	
Information Gathering ME 3*	Under supervision, describes, gathers and integrates additional information acquired from other sources and places this information into a chronological and developmental perspective.	Uses supervision to gather and integrate information from all agencies involved, including external professionals, into overall assessment and formulation. Identifies gaps and inconsistencies in information and develops a plan to address these.	Gathers and integrates complex information from all relevant sources, accurately evaluates the quality and accuracy of information and appropriately uses all information to inform the assessment and management plan. Seeks additional missing information and clarifies inconsistent information efficiently.
Vulnerability and Resilience ME 3, 4*	Describes vulnerability and resilience factors but requires supervision to incorporate these into the formulation and management plan.	Analyses vulnerability and resilience factors but may require supervision to incorporate these into formulation and management plan in complex or multisystem presentations.	Theorises vulnerability and resilience factors in the comprehensive formulation and applies these to the management plan with highly complex and novel presentations. Identifies peer or supervision support when required.
Management Plan ME 4*	Describes a basic management plan that is driven by the formulation, but requires supervision to ensure a tailored approach. Requires supervision to re-evaluate and adapt the management plan according to patient response or guide referral to other professionals or agencies during the course of management.	Develops and negotiates the design of a comprehensive management plan that addresses issues identified in the formulation. Monitors therapeutic alliance and response to the management plan, including the balance of benefits and side effects of treatments/therapies, can adjust the plan accordingly as required.	Designs a comprehensive management plan for complex or unusual cases. The trainee can hypothesise the potential therapeutic alliance difficulties, and the barriers to treatment. The trainee describes the anticipated treatment response for a condition and can speculate about potential problems arising during care. The trainee elaborates discharge/termination arrangements in advance and these are tailored to the patient's

			condition and specific needs.
Follow Up ME 4*	Follows procedures for appropriate follow up and transfer of care to primary or other carers. Some supervision might be required.	Tailors the follow up care arrangements to the patient's presentation and arranges transfer of care in an accurate, succinct and timely manner.	Designs follow up care arrangements and transfer of care with clear direction of potential problems that can occur in the care plan.
Investigations ME 5*	Identifies and can interpret routine / standard range of haematological biochemical tests other investigations (including neuro-imaging) involved in routine psychiatric care. May require support to prioritise interventions and interpret abnormal results.	Justifies the selection of investigations, and demonstrates ability to prioritise these in a hierarchy of essential to least important. Demonstrates cost-benefit reasoning in the selection of investigations. Requires assistance to prioritise interventions in more complex situations.	Initiates consultation and support to manage complex and unfamiliar clinical problems. Reflects on limitations and value of interventions in care of patients
Diagnostic Procedures ME 6*	Identifies and undertakes routine diagnostic procedures including physical examination, laboratory tests, and questionnaires. Requires assistance with interpretation.	Justifies selection of diagnostic procedures and interprets results.	Independently undertakes and interprets relevant investigations and physical examination in a resource effective and ethical manner.
Critical Appraisal ME 7*	Identifies principles of evidence-based practice to guide the development a management plan for routine or uncomplicated presentations, with aid of supervisor.	Independently applies evidence-based management principles in routine cases. Uses supervision to identify gaps in theoretical knowledge in more complex cases.	Critically evaluates available scientific evidence to Guide the development of the management plan.
Integrate Information ME 7*	Identifies appropriate ways of obtaining relevant basic science and clinical information to augment understanding. Requires support to evaluate source of information. Also requires support to integrate newly acquired knowledge with prior learning and apply to clinical practice.	Incorporates relevant clinical information and evaluates its sources, requiring minimal support to integrate this with prior learning and application to practice.	Critically evaluates and integrates medical, developmental, psychological and sociological information and its sources, and applies this appropriately to practice.
Legislation ME 8*	Describes mental health and related legislation but may need assistance in its application to individual cases.	Applies mental health and related legislation accurately and independently in routine and difficult cases.	Trainee is fully aware of responsibilities under mental health and related legislation. Appreciates the strengths and weaknesses of mental health and related legislation and able to use independently.
Obtaining Information	Gathers relevant information from other informants with guidance from supervisor, in a	Gathers relevant information from other professionals and informants to inform	Reflects on the relevance of information obtained from other professionals to generate a complete

COM 1*	professionally sensitive manner.	assessment, recognising confidentiality, bias and other variables	and sophisticated understanding of complex cases.
Communicate Management Plan COM 1*	Communicates a basic but safe management plan to patient and caregivers but requires supervision to ensure flexibility of approach.	Communicates a comprehensive management plan to patient and caregivers. Adopts a maintenance focus including psychoeducation, early warning signs, access to treatment and patient self-evaluation.	Effectively communicates management plan and discusses its acceptability with the individual and family/carer. Contemplates potential barriers and negotiates flexible alternatives as required.
Rapport COM 1*	Interacts effectively with patient and caregivers, with supervision. May at times be somewhat overly technical or elaborate, or be more active or directive or passive than the situation ideally requires, but still maintains adequate rapport. Indentifies core components of rapport establishment and common barriers for poor establishment of rapport.	Adapts interactions to the individual patient and caregivers to facilitate establishment of rapport, mindful of the background of the patient and caregivers, with minimal supervision.	Independently tailors interactions according to the developmental stage and background of the patient and caregivers. Can self-evaluate establishment and maintenance of rapport in the therapeutic environment.
Documentation COM 2*	Follows institutional/organisational procedures to produce written information. Written information may be somewhat over-inclusive or lacking detailed information.	Demonstrates the ability to produce more sophisticated documentation, such as complex reports and clinical reviews, under supervision. Shows discernment in selection of content, and tailors documentation to intended audience.	Produces complex clinical documentation (such as medico legal reports, briefs about critical incidents etc) with minimal input from supervisor. For example, produces a sophisticated report that provides salient and integrated information and plan that can also be used by others. Documentation is succinct and professional.
Interagency COM 2*	Identifies and communicates effectively with agencies involved in patient care with supervision.	Liaises and negotiates with relevant agencies, justifying shared care, with minimal support.	Recognises complex issues related to liaison and contributes to higher level discussion or interagency working groups.
Working Alliance COL 1*	Establishes and maintains rapport and engagement of families/carers in straightforward cases but requires supervision to improve competence in this area. For example, requires assistance to select content with reference to possible positive and	Establishes and maintains rapport, and engages each family member in the assessment process but seeks supervision to further enhance this skill. Less supervision required in complex situations. For example, level of assistance to select content with reference to possible positive and negative	Establishes and maintains an effective working alliance with the patient and relevant others, in complex/difficult situations. For example, selects content with reference to possible positive and negative implications for patient and caregivers.

	negative implications for patient and caregivers.	implications for patient and caregivers will depend on complexity and prior experience.	
MDT COL 3*	Identifies key roles, values and responsibilities of professionals in the multidisciplinary team. Participates in the multidisciplinary team with assistance of supervisor.	With minimal supervision, promotes good multidisciplinary team function, effectively taking leadership role in routine multidisciplinary team meetings when indicated, and can negotiate complex issues.	Effectively leads complex multidisciplinary team meetings when indicated, for example in critical incidents, and actively encourages contributions from all members of the multidisciplinary team to promote efficient and effective multidisciplinary team function.
Systems Theory COL 3*	Identifies important dynamic systems-related issues impinging on team functions in supervision.	Explains how systems theory is relevant to multidisciplinary team function and shows awareness of intrapersonal issues that may affect multidisciplinary team functioning.	Works with multidisciplinary team to prevent, negotiate and resolve conflict and other issues within multidisciplinary team independently but seeks support where indicated.
Psychiatrist Role COL 3*	Distinguishes key roles, and responsibilities of psychiatrists in the health care system from other mental health professionals	Describes the range of roles and responsibilities of psychiatrists in the health care system.	Describes more complex roles and responsibilities of psychiatrists in the system of care, including psychiatrists' role in conflict of interest situations in the organisation and sponsorship
Liaise with Psychiatrists COL 3*	Liaises appropriately and effectively with the supervisor, psychiatrists, including the on-call psychiatrist.	Liaises effectively with psychiatrists with minimal supervision in complex clinical situations.	Liaises effectively with psychiatrists in complex clinical situations.
Recruitment COL 3/4*	With supervision, identifies and recruits additional services appropriately.	Recruits other professionals appropriately to contribute to management.	Demonstrates an ability to prioritise the use of additional resources, according to patient need.
Role of Key Agencies COL 4*	Identifies key agencies and can describe services provided.	Describes in detail the roles and responsibilities of key agencies and identifies a broad range of additional agencies.	Describes the roles and responsibilities of a wide range of agencies and has a sophisticated approach to utilising their services.
Service Provision Gaps COL 3/4 & MAN	Identifies major gaps in service provision and integration and reflects on this within the context of supervision	Identifies gaps in service provision and integration and can minimise the impact in most circumstances with supervision	Identifies gaps in service provision and integration in relation to complex patients and communicates the impact on the family and patient using local relevant clinical governance structures.

2*			
Consultation COL 4*	Provides effective consultation to other health professionals and agencies around individual patient care or broader systemic issues affecting the well being of populations.	Provides consultation to relevant agencies and can develop both individual comprehensive management plans and systemic interventions with minimal supervisory support	Consults effectively to multiple agencies around complex individual presentations and systemic issues
Professional Role MAN 1*	Describes and adheres to the trainee role within the clinical line of responsibility.	Explains the role of the trainee within the system and the learning environment.	Performs a professional role within the system, acknowledging limitations of responsibility, the ability to tolerate and manage uncertainty, and participates in organisational governance processes.
Systemic Issues MAN 1*	Identifies systemic issues impacting on patient care at a personal and clinical level with supervision.	Identifies issues but needs assistance to identify at what level intervention would be most effective within current the governance structure.	Describes principles of change management and change processes and with supervision can proactively contribute to change in a manner that advances mental health care
Clinical Leadership MAN 2*	Identifies the clinical leadership role of a psychiatry trainee, including whilst on-call	Participates effectively as a junior leader at the local hospital level, with guidance and support.	Participates effectively in committees and meetings in all roles. Able to participate in committees concerning service development and planning, capacity enhancement, financial and human resource allocation.
Quality Improvement MAN 3*	Describes the principles of quality assurance.	Articulates the principles behind design, critical review and development of systemic quality evaluation processes.	Participates in the design, development and critical review of systemic quality improvement.
Service Development MAN 2, 4*	With assistance, identifies and describes the impact of resource allocation on wider health systems.	With supervision identifies gaps in service provision and critically discusses service development and planning, capacity enhancement and human resource allocation. Shows an understanding of funding for services.	Takes a leadership role in discussions regarding development and planning, capacity enhancement and human resource allocation. Shows a sophisticated understanding of funding for services.
Resource Allocation	Under supervision, describes the costs, benefits and risks of psychiatric care.	Analyses the balance of costs, benefits and risks of psychiatric care.	Management plans take account of cost/risk/benefit analysis to influence resource allocation.

MAN 4*			
Documentation MAN 5*	Accurately documents the case assessment, formulation and management plan, with supervision. Requires supervision to assist with integration of information.	Accurately documents sophisticated case assessments, formulations and management plans.	Autonomously completes documentation requirements, and is able to provide supervision to ensure others fulfil their documentation obligations.
Clinical Responsibilities MAN 5*	Reliably attends to required clinical responsibilities.	Reliably attends to required clinical responsibilities and, with assistance, manages complex and unfamiliar situations.	Meets work demands responsibly and in a timely manner in complex and unfamiliar clinical situations.
Patient and Systems Engagement HA 1*	Engages with individual patient and the more immediate systems with supervision to provide quality care.	Engages with individual patient and multiple systems with supervision to positively influence outcomes.	Engages with individual patient and multiple systems to positively influence outcomes.
Advocacy Groups HA 1*	With support, identifies the relevance of advocacy groups and their role in supporting patient and caregivers. Actively seeks and evaluates local and regional groups and makes recommendations with support.	Actively links patient and caregivers to relevant local and/or regional advocacy groups.	Actively links patient and caregivers to relevant local and/or regional advocacy groups, encourages development of advocacy groups.
Prevention and Promotion HA 2*	Integrates principles of prevention and health promotion to planning and service provision in mental health services with supervision.	Integrates principles of prevention and health promotion to planning and service provision in mental health services. With supervision can apply these to wider systems.	Integrates principles of prevention and health promotion to planning and service provision in mental health settings and wider systems.
Epidemiology HA 2*	Describes basic epidemiology and identifies sources of epidemiological data relevant to clinical decision making.	Demonstrates the application of epidemiology to clinical practice. With supervision critically reviews epidemiological data to judge how this influences interventions in service provision and at a societal level.	Critically reviews and applies relevant epidemiological data to inform clinical decision making and service provision for individuals and societies.

Knowledge Gaps SCH 1*	Requires individual supervision to help identify deficiencies in relevant knowledge and skills, and ways to remedy these deficiencies.	Uses supervision to identify areas of knowledge deficiency and review the existing literature to enhance understanding.	Identifies gaps in own knowledge, generate new questions for study and evaluates obtained knowledge.
Reflection SCH 1 PROF 3*	Actively engages and participates in supervisory relationship to identify learning needs and develop appropriate action plans, and evaluates these periodically.	Collaboratively uses supervision to develop reflective practices to ensure ongoing learning and professional development.	Establishes and participates reflectively in peer and mentoring relationships to ensure ongoing learning and professional development.
Teaching SCH 2, COM 1*	Communicates at a level and in a manner that can be comprehended by familiar audiences.	Communicates at a level and in a manner that can be comprehended by most audiences.	Communicates at a level and in a manner that can be comprehended by the audience being addressed.
Learning Needs Assessment SCH 2*	Identifies the learning needs of others but may require support to prioritise these. With supervision, selects content and, guided by best teaching practices, develops an effective educational strategy.	Reflects on and prioritises the learning needs of others. Develops effective educational strategies with support.	Reflects on and prioritises the learning needs of others and develops tailored educational strategies.
Supervision SCH 1, 3*	Describes the essential components and value of clinical supervision.	Critically appraises the components of the supervisory relationship, and limitations to the supervisory process.	Develops supervisory skills through formal training.
Scholarly Activity SCH 3*	Describes research approaches, such as study design, methodology, and conducting literature reviews.	Identifies an area of practice appropriate for scholarly investigation and refine plans with supervision.	Creates a scholarly project through planning, data gathering, analysis, and presentation.
Consent and Confidentiality PROF 1*	Identifies the principles and limits of obtaining consent and keeping confidentiality, using supervision in complex clinical situations.	Applies the principles and limitations of obtaining consent, including performance of capacity assessment, and keeping confidentiality in clinical practice.	Justifies decision making regarding consent and confidentiality in challenging clinical scenarios.
Boundaries PROF 1*	Follows guidelines to maintain personal and interpersonal boundaries in clinical practice and uses supervision to enhance understanding and to	Ensures appropriate personal and interpersonal boundaries in clinical practice, seeking supervision	Maintains and ensures appropriate personal and interpersonal boundaries, utilising peer review group to assist in decision making in more difficult or

	apply theoretical knowledge to clinical situations.	in complex situations.	complex countertransferential situations.
Ethics PROF 1*	Identifies relevant ethical principles but will need support to resolve conflicting priorities to guide action.	Identifies relevant ethical principles but can resolve these in familiar situations and will seek support where complexity exists.	Identifies relevant ethical principles but can resolve these in most situations. Identifies and seeks support, including peer review, to consolidate ethical decision making.
Quality of Care PROF 1, 2*	Follows institutional guidelines to deliver high quality care with integrity, honesty, compassion and respect for diversity.	Evaluates quality of care and identification of potential for error and incorporates this into continuing practice improvement.	Challenges and intervenes to improve quality of care.
Reflection on Limitations PROF 3*	Identifies the importance of ongoing self-reflection in clinical practice and discusses the limitations of their expertise during supervision.	Reflects on limitations of their practice and expertise through ongoing self-audit and seeks supervision to address limitations or to develop a safe alternative approach.	Safely operates within required scope of practice and expertise, identifies ramifications of limitations to their expertise and seeks appropriate support.
Time Management PROF 4*	Using supervision, external structures and regulations, balances patient care, service requirements and personal well-being.	Applies time management skills and prioritisation that fulfils personal and clinical interests and duties.	Displays flexible time management skills that generate sustainable work-life balance.
Others' Unprofessional Behaviour PROF 5*	Distinguishes between professional and unprofessional behaviours and discusses this with the supervisor or other appropriate authority.	Identifies and, with support, addresses unprofessional behaviours in others.	Identifies and addresses unprofessional behaviours in others.
Regulatory Requirements PROF 5*	Identifies professional regulatory requirements and can follow required procedures.	Complies with relevant professional regulatory requirements, and identifies other professional guidelines and codes of conduct.	Complies with relevant professional regulatory requirements, analyses and incorporates other professional guidelines and codes of conduct into clinical practice.

References

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McAllister, S., Lincoln, M., Ferguson, A., & McAllister, L. (2010). *Assessment of performance in practicum*. In L. McAllister, Paterson, M., Higgs, J., & Brithell, C. (Eds), Innovations in allied health fieldwork education: A critical appraisal (pp.247-260). The Netherlands: Sense Publishers.

McAllister, S., Lincoln, M., Ferguson, A., & McAllister, L. (2010). *Issues in developing valid assessment of speech pathology students' performance in the workplace*. International Journal of Language & Communication Disorders, 45(1), 1-14.

Mini-Clinical Evaluation Exercise WBA

Trainee Name:	Program Name:
Stage: 1 2 3 Rotation: 1 2 3 4	Date of assessment:

Brief description of the case:
Learning Outcomes being assessed:
EPA/other: EPA standard of assessment: Basic Proficient Advanced

Please indicate the activity in which the assessment has taken place:

☐ Assessment of a psychiatric emergency (acute psychosis)	☐ Management of a psychiatric emergency (acute psychosis)
☐ Clinical review	☐ Management of a high prevalence psychiatric condition
☐ Assessment of a high prevalence psychiatric condition	☐ Management of a low prevalence psychiatric condition
☐ Assessment of a low prevalence psychiatric condition	☐ Management of a severe and enduring mental illness
☐ Assessment of response to treatment	☐ Management of a psychiatric emergency (suicidal feelings and acts)
☐ Assessment of a severe and enduring mental illness	☐ Obtaining informed consent
☐ Assessment of a psychiatric emergency (suicidal feelings and acts)	☐ Other (specify):

*Please rate the following aspects of the assessment on the scale below. (n/a = not applicable) *see Developmental Descriptors document as a guide to standards and to inform feedback. Point 5 on the scale represents the expected standard* ***on completion of the trainees current Stage*** *of training.*

			Below standard for end of Stage			Meets standard for end of Stage			Above standard for end of Stage		
1.	History taking process	n/a	1	2	3	4	5	6	7	8	9
2.	History taking content	n/a	1	2	3	4	5	6	7	8	9
3.	Mental state examination skills	n/a	1	2	3	4	5	6	7	8	9
4.	Physical examination skills	n/a	1	2	3	4	5	6	7	8	9
5.	Communication skills	n/a	1	2	3	4	5	6	7	8	9
6.	Data synthesis	n/a	1	2	3	4	5	6	7	8	9
7.	Organisation/Efficiency	n/a	1	2	3	4	5	6	7	8	9

What aspects were done well?	**Suggestions for areas of improvement**

Agreed action/goals:

Assessor's Name:	Assessor's Position:
Assessor's Signature:	Date: RANZCP ID:
Trainee's Signature:	Date: RANZCP ID:

WBA - Mini-Clinical Evaluation Exercise

The Royal Australian & New Zealand College of Psychiatrists

INTRODUCTION

The Mini-Clinical Evaluation Exercise is a RANZCP approved Workplace-based Assessment (WBA) tool. The primary purpose of this tool is to promote learning for a trainee by providing structured feedback on performance within an authentic workplace context. The feedback to the trainee relates directly to their performance against a set of developmental descriptors for **the end of their stage of training**. The purpose of this approach is to provide educationally driven opportunities for trainees to assess their progress against a set of developmental descriptors. These descriptors encapsulate the standard that the College requires of trainees at the point of progression to the next developmental stage of training. The descriptors outline basic, proficient and advanced skill levels and are viewed as a continuum along which the trainee must progress.

What is a Mini-Clinical Evaluation Exercise?

The Mini-Clinical Evaluation Exercise is a concise, validated method of assessment requiring an assessor to observe a trainee in a clinical encounter with real patients and provide feedback to the trainee about their performance. The feedback related to the trainee should concentrate on their performance of agreed specific clinical tasks rather than on their general performance.

Where does it take place?

The Mini-Clinical Evaluation Exercise is conducted in the workplace.

Who is involved?

An assessor, a trainee and a consumer. The trainee is responsible for arranging an assessor and an appropriate case for the formative assessment to occur. WBAs not being undertaken with the primary supervisor must be approved by them.

Choosing an encounter

Ideally, the consumer who has agreed to participate should be new to the trainee, or the task for assessment has as yet not been undertaken. If possible, the assessor should be familiar with the issues the consumer has presented with. The trainee should be mindful of the choice of encounters so that by the end of the training period, they have been assessed over a range of clinical activities and settings.

Activities for assessment (examples)

Stage 1 activities		Stage 2 activities
• Mental state examination	• Risk assessment	• MSE (CAP)
• Bedside neurocognitive assessment	• Talking to families	• Physical examination (cardiometabolic syndrome)
• Physical examination – CVS; EPSE		• Interpret investigations and institute appropriate action plan
• Medication side effect assessment		• Working effectively with carers/families
• Consenting a consumer to treatment		• Risk assessment and management plan institution including in AOPs
• Interpreting investigations		

Assessment criteria

The Mini-Clinical Evaluation Exercise is intended to assess trainees' ability in the following Fellowship Competencies:

- History taking process
- Mental state examination
- Communication skills
- Organisation/efficiency
- History taking content
- Physical examination skills
- Data synthesis

Each Mini-Clinical Evaluation Exercise may cover more than one competency. Areas of focus should be identified in advance.

Feedback session

The feedback aspect of the Mini-Clinical Evaluation Exercise is the most important purpose of the assessment. The feedback will focus on the strengths and weaknesses of the trainee's performance, and will, through self-reflection, also inform their further learning and skill development.

PROTOCOL

The trainee is responsible for driving this process, including when a Mini-Clinical Evaluation Exercise will occur, and arranging all of the administration required. This includes providing the assessor with the Mini-Clinical Evaluation Exercise feedback form.

1. The trainee and assessor discuss competencies to be assessed during the encounter.

2. The Mini-Clinical Evaluation Exercise will take place within the regular supervision time, allowing ample time for:
    - observation of the trainee by the assessor during a clinical encounter (15-20 minutes)
    - discussion and feedback session immediately after the clinical encounter (10-15 minutes)
    - an opportunity for self-reflection is strongly encouraged
    - the assessor to rate the trainee's performance using the Mini-Clinical Evaluation Exercise form (5-10 minutes).

3. The assessor takes no part in the encounter unless intervention is necessary for the consumer's safety
4. The assessor rates the trainee's performance using the 9-point scale on the Mini-Clinical Evaluation Exercise form. The mid-point of this scale (5) represents the expected standard to be achieved at the end of each stage of training (see table below).
    - *Please note: not all assessment criteria on the form are required to be rated during each Mini-Clinical Evaluation Exercise assessment. Not applicable criteria are rated with the n/a option.*

Table 1. Standard guide for rating scale – *see Developmental Descriptors document for more detail*

Trainee Stage	Below Standard for end of Stage (1 2 3)	Meets Standard for end of Stage (4 5 6)	Above Standard for end of Stage (7 8 9)
Stage 1 Basic	Below Basic level as described in developmental descriptors.	At Basic level as described in developmental descriptors.	Above Basic level. Moving towards the standard of a Proficient trainee.
Stage 2 Proficient	Below the standard of Proficient trainee. Meets standard of a Basic trainee.	Meets the standard of a Proficient trainee as described in developmental descriptors.	Above the standard of Proficient trainee. Moving towards the standard of an Advanced trainee.
Stage 3 Advanced	Below standard for Advanced trainee. Meets standard of a Proficient level trainee.	Meets the standard of an Advanced trainee as described in developmental descriptors.	Above the standard for an Advanced trainee.

Please note: standards are at the level expected **on completion of Stage**. Mini-Clinical Evaluation Exercises conducted at the beginning of a Stage may typically include ratings of below "Meets Standard". The purpose of this approach is to provide educationally driven opportunities for trainees to assess their progress against a set of developmental descriptors that are set at the point of progression to the next developmental stage of training. The descriptors outline basic, proficient and advanced skill levels and are viewed as a continuum along which the trainee must progress.

- Immediately following the presentation, the assessor discusses their comments and ratings on the form, providing the trainee with feedback on their performance.

- Constructive and useful feedback is given to the trainee on certain points:
    - areas that were especially good are highlighted
    - areas that need improvement are indicated and discussed
    - Further / future improvement plans are developed.
- The assessor makes feedback comments; the cumulative weight of these comments helps determine a defensible judgment of a trainee's competence. Both the assessor and trainee sign the form.

- The trainee is responsible for retaining the Mini-Clinical Evaluation Exercise form, updating the learning plan where required, and ensuring supervisors and DOTs have access to them on request. Assessors may also hold a copy.

Observed Clinical Activity (OCA) WBA

Trainee Name:	Program Name:
Stage: 1 2 3 Rotation: 1 2 3 4	Date of assessment:

Brief description of the case/clinical task:
Learning Outcomes being assessed:
EPA/other: EPA standard of assessment: Basic Proficient Advanced

Please rate the following aspect of the observed clinical activity on the scale below. (n/a = not applicable) **see Developmental Descriptors document as a guide to expected standards and to inform feedback. Point 5 on the scale represents the expected standard* ***on completion*** *of the trainee's current Stage of training.*

			Below standard for end of Stage			Meets standard for end of Stage			Above standard for end of Stage		
1.	History taking process	n/a	1	2	3	4	5	6	7	8	9
2.	History taking content	n/a	1	2	3	4	5	6	7	8	9
3.	Mental state examination skills	n/a	1	2	3	4	5	6	7	8	9
4.	Physical examination skills	n/a	1	2	3	4	5	6	7	8	9
6.	Data synthesis	n/a	1	2	3	4	5	6	7	8	9
7.	Management plan	n/a	1	2	3	4	5	6	7	8	9

What aspects were done well?	**Suggestions for areas of improvement**

Agreed action/goals:

Assessor's Name:	Assessor's Position:
Assessor's Signature:	Date: RANZCP ID:
Trainee's Signature:	Date: RANZCP ID:

WBA - Observed Clinical Activity (OCA)

The Royal Australian & New Zealand College of Psychiatrists

INTRODUCTION

The Observed Clinical Activity (OCA) is a RANZCP approved Workplace-based Assessment (WBA) tool. The purpose of this tool is to promote learning for a trainee by providing structured feedback on performance within an authentic workplace context.

What is an OCA?
Similar in structure to the RANZCP summative assessment, the Observed Clinical Interview (OCI), the Observed Clinical Activity (OCA) formative assessment requires trainees to be observed for the duration of an initial assessment with a patient. The trainee will be assessed on a series of competencies and provided with immediate feedback. The OCA will usually be split into two sessions, please refer to the protocol in this document for further details.

The OCA allows the assessor to be present as the trainee engages in the principal work of psychiatry practice, for example, taking a patient's history, conducting a patient examination, making a diagnosis and formulating a treatment plan, within one clinical interview session. The value of this instrument for the trainee lies in the opportunity it provides for immediate structured feedback on their performance, supporting and enhancing learning, and preparation for the summative OCI in Stage 3 of training.

Where does it take place?
The OCA is conducted during a clinical encounter, with the assessor observing the trainee. WBAs not being undertaken with the primary supervisor must be approved by them.

Who is involved?
The assessor must be clinically competent in the area of the patient's problem(s). Assessors need to be familiar with the OCA assessment process.

Activities for assessment (examples)

Stage 1 activities	Stage 2 activities
• Change in functioning • Assessment and management of high prevalence disorder • Assessment and management of low prevalence disorder	• Assessment and management of patient with co-morbidity • Area of practice OCA's

Assessment criteria
Within the clinical observed interview, the trainee will be assessed on their ability to conduct a psychiatric interview, synthesise information and formulate a management plan based on the available information.

The OCA is intended to examine trainees:

- history taking process and content
- mental state and relevant physical examination skills
- data synthesis
- management plan development skills.

Feedback session
The feedback will focus on the strengths and weaknesses of the trainee's performance, and will, through self-reflection, also inform their learning and skill development. Over time this will also assist in preparation for the summative OCI's.

PROTOCOL

The trainee is responsible for planning and arranging all of the components required to undertake the OCA.

1. The trainee makes arrangements with an assessor to carry out the Observed Clinical Activity (OCA). WBAs not being undertaken with the primary supervisor must be approved by them.

2. The trainee nominates the clinical case ensuring the breadth of requisite competencies can be assessed. Ideally the patient chosen will be new to the trainee, allowing for a comprehensive interview.

3. The observed clinical encounter will run for 50 minutes and is followed by thinking time, the presentation, viva and feedback with the assessor.

4. A full OCA requires two 1 hour sessions. The first OCA session should include feedback from the assessor immediately following the observed interview. The feedback will only be for those aspects relevant to the observed clinical encounter. The second session should occur as soon as practicable (no longer than a week) after the first session.

	OCA (session 1)
Clinical interview	50 min
Post-interview feedback	10 min
Thinking time/self reflection	Own time
	OCA (session 2)
Presentation of Assessment & Viva	20 min
Presentation of Plan & Viva	20 min
Feedback	10 min
Total	**110 min**

5. The assessor will observe all aspects of the clinical encounter, rating the trainee's performance on a 9-point scale on the OCA form, with corresponding feedback written for each item. The mid-point (5) of this scale represents the expected standard to be achieved **on completion** of each stage of training (see table below). In addition, the assessor makes feedback comments; the cumulative weight of these comments helps determine a defensible judgment of a trainee's competence at **their** stage of training.

    - *Please note: not all assessment criteria on the form are required to be rated during each OCA assessment. Not applicable criteria are rated with the n/a option.*

Table 1. Standard guide for rating scale – *see Developmental Descriptors document for more detail*

Trainee Stage	Below Standard for end of Stage (1 2 3)	Meets Standard for end of Stage (4 5 6)	Above Standard for end of Stage (7 8 9)
Stage 1 Basic	Below standard for Basic trainee.	At Basic level as described in developmental descriptors.	Above Basic level. Moving towards the standard of a Proficient trainee.
Stage 2 Proficient	Below the standard of Proficient trainee. Meets standard of a Basic trainee.	Meets the standard of a Proficient trainee as described in developmental descriptors.	Above the standard of Proficient trainee. Moving towards the standard of an Advanced trainee.
Stage 3 Advanced	Below standard for Advanced trainee. Meets standard of a Proficient level trainee.	Meets the standard of an Advanced trainee as described in developmental descriptors.	Above the standard for an Advanced trainee.

Please note: standards are at the level expected **on completion of Stage**. OCAs conducted at the beginning of a Stage may typically include ratings of below "Meets Standard". The purpose of this approach is to provide educationally driven opportunities for trainees to assess their progress against a set of developmental descriptors that are set at the point of progression to the next developmental stage of training. The descriptors outline basic, proficient and advanced skill levels and are viewed as a continuum along which the trainee must progress.

6. Following the clinical encounter the trainee presents their assessment to the assessor. This consists of a summary of the salient features of the case, an assessment of gaps in the history, other essential information required, a formulation, diagnosis and differential diagnosis. This is followed by a viva of clarification questions from the assessor. The trainee is then invited to present their proposed management plan, again followed by a viva of clarification questions.

7. Following the trainee's presentation of the case, the assessor is required to complete their rating of the trainee and add additional feedback to the OCA form.

8. The assessor should make their judgments only on those competencies and behaviours observed during the OCA, rather than inferring performance from other areas.

9. Once the discussion is complete, the assessor provides detailed feedback to the trainee. Ample time for feedback needs to be factored in, to occur within clinical supervision time.

10. Constructive and useful feedback is given to the trainee on certain points:
    - areas that were especially good are highlighted
    - areas that need improvement are indicated and elaborated on
    - potential ideas to gain further experience and skill in the areas requiring development are discussed.

11. The trainee and assessor discuss and agree upon next steps to progress learning. Both the assessor and trainee sign the form.

12. The trainee is responsible for retaining the OCA form, updating the learning plan where required, and ensuring that supervisors and DOTs have access to them on request. Assessors may also retain a copy.

Case-based Discussion WBA

Trainee Name:	Program Name:
Stage: 1 2 3 Rotation: 1 2 3 4	Date of assessment:

Brief description of case:
Learning Outcomes being assessed (please use terms from prescribed list in the *Learning Outcomes* document):
EPA/other: EPA standard of assessment: Basic Proficient Advanced

Please indicate the activity in which the assessment has taken place

☐ Assessment of a psychiatric emergency (acute psychosis)	☐ Management of a psychiatric emergency (acute psychosis)
☐ Clinical review	☐ Management of a high prevalence psychiatric condition
☐ Assessment of a high prevalence psychiatric condition	☐ Management of a low prevalence psychiatric condition
☐ Assessment of a low prevalence psychiatric condition	☐ Management of a severe and enduring mental illness
☐ Assessment of response to treatment	☐ Management of a psychiatric emergency (suicidal feelings and acts)
☐ Assessment of a severe and enduring mental illness	☐ Obtaining informed consent
☐ Assessment of a psychiatric emergency (suicidal feelings and acts)	☐ Other (specify):

*Please rate the following aspects of the case discussion on the scale below. (n/a = not applicable) *see Developmental Descriptors document as a guide to expected standards and to inform feedback. Point 5 on the scale represents the expected standard* ***on completion of the trainee's current Stage of training*** *.*

			Below standard for end of Stage			Meets standard for end of Stage			Above standard for end of Stage		
1.	Clinical record keeping	**n/a**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
2.	Clinical assessment	**n/a**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
3.	Risk assessment and management	**n/a**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
4.	Medical treatment	**n/a**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
5.	Investigation	**n/a**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
6.	Referral	**n/a**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
7.	Follow-up, care planning & transfer of care	**n/a**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
8.	Professionalism	**n/a**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
9.	Clinical reasoning	**n/a**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**

What aspects were done well?	**Suggestions for improvement**

Agreed action/goals:

Assessor's Name:	Assessor's Position:
Assessor's Signature:	Date: RANZCP ID:
Trainee's Signature:	Date: RANZCP ID:

WBA - Case-based Discussion

INTRODUCTION

The Case-based Discussion (CbD) is a RANZCP approved Workplace-based Assessment (WBA) tool. It is a formative tool with the primary purpose of promoting learning for trainees by providing structured feedback on performance in "real world" settings during regular supervision time.

What is a CbD?

A discussion based on existing case notes and other written correspondence to assess a trainee's clinical reasoning and decision making and the integration of medical knowledge within case management, and their ability to document this. The most important part of the CbD is the feedback given to the trainee.

Where does it take place?

The CbD is conducted during regular supervision time in a meeting between an assessor and trainee regarding a consumer under their care. WBAs not being undertaken with the primary supervisor must be approved by them.

Choosing an encounter

The trainee should ideally have had the opportunity to manage a number of patients prior to arranging their CbD. At least four cases need to be selected by the trainee for the assessor to choose from. One case will be reflected upon on in the review according to the CbD assessment criteria. The purpose of the process is to develop learning outcomes to assist the trainee in their professional development.

Who is involved?

An assessor familiar with the use of the CbD assessment process who is able to provide formative feedback to the trainee. WBAs not being undertaken with the primary supervisor must be approved by them.

Learning Outcome (examples)

Stage 1 activities	Stage 2 activities	
• Relevant mental health legislation • Acute management / Psychiatric emergency • Safe Prescribing • Cultural and Linguistically Diverse persons assessment and management • Consumer / Carer/ NGO • Risk assessment • Writing style and legibility	• Report writing • Formulation • Acute management in Area of Practice (CL, CAP, ADD)	• Safe prescribing (CL, CAP, POA) • Cultural and Linguistically Diverse persons assessment and management • NGO

Assessment criteria

CbD is intended to assess a trainee's clinical reasoning and decision making and the integration of medical knowledge within case management at their stage of training.

- Clinical record keeping: Legible, structured, signed, clear and comprehensible with no important omissions.
- Clinical assessment: Diagnostic skills based on appropriate evidence from, for example, history, examination and investigations; appropriate diagnosis and differential diagnosis.
- Risk assessment and management: Appropriate risk assessment linked to an appropriate management plan.
- Medical treatment: Focussed and appropriate investigations and interpretation of the results.
- Investigation: Includes talking to relatives, carers and any other appropriate third parties.
- Referral: Understanding the need for referral reflecting a considered approach to understanding their skill base and the need for consultation.
- Follow-up, care planning and transfer of care: The trainee makes considered, safe, collaborative and well recorded and communicated plans for follow-up care.
- Professionalism: Appropriate professional standards demonstrated in all aspects of the case.
- Clinical reasoning: Good, logical clinical reasoning and appropriate decision-making.

Feedback session

The feedback aspect of the CbD is the most important purpose of undertaking the assessment. The feedback given to the trainee following each encounter will be concentrated around their performance of the clinical task identified for assessment. The feedback will focus on the strengths and weaknesses of the trainee's performance and will, through self-reflection, also inform their learning and skill development.

PROTOCOL

The trainee is responsible for planning when a Case-based Discussion (CbD) will occur, in consultation with the assessor, and arranging all of the administration required.

1. The trainee makes arrangements with an assessor to carry out the CbD.
2. The trainee selects four cases where they have had direct clinical responsibility for the consumers care. These should incorporate some but not necessarily all of the following (depending on the focus of the CbD); assessment, mental state, physical examination and cognitive testing, synthesis of information and/ or formulation and management plans. The notes are brought to their assessor for discussion.
3. The CbD should be undertaken within an appropriate office or working space that lends itself to privacy, to carry out a detailed conversation between trainee and assessor.
4. The assessor chooses one of the four cases for the trainee to explain in detail.
5. The trainee discusses the selected case with the assessor. This discussion should take between 15 and 20 minutes.
6. When required the assessor prompts the trainee on further discussion points.
7. The feedback session should occur immediately after the discussion within the one hour weekly supervision time. The total time required for the CbD and feedback session will usually be 30-40 minutes.
8. Constructive and useful feedback is given to the trainee on certain points:
   - areas that were especially good are highlighted
   - areas that need improvement are indicated and discussed
   - further / future improvement plans are developed.
9. The assessor rates the trainee's performance using the 9-point scale on the CbD form. The mid-point of this scale (5) represents the expected standard to be achieved (see table below) **on completion of each Stage** (1, 2 or 3) of training. In addition, the assessor makes feedback comments; the cumulative weight of these comments helps determine a defensible judgment of a trainee's competence at **their** stage of training.
   - *Please note that not all assessment criteria on the form are required to be rated during each Case-based Discussion. Not applicable criteria are rated with the n/a option.*

Table 1. Standard guide for rating scale – *see Developmental Descriptors document for more detail*

Trainee Stage	Below Standard for end of Stage (1 2 3)	Meets Standard for end of Stage (4 5 6)	Above Standard for end of Stage (7 8 9)
Stage 1 Basic	Below Basic level as described in developmental descriptors.	At Basic level as described in developmental descriptors.	Above Basic level. Moving towards the standard of a Proficient trainee.
Stage 2 Proficient	Below the standard of Proficient trainee. Meets standard of a Basic trainee.	Meets the standard of a Proficient trainee as described in developmental descriptors.	Above the standard of Proficient trainee. Moving towards the standard of an Advanced trainee.
Stage 3 Advanced	Below standard for Advanced trainee. Meets standard of a Proficient level trainee.	Meets the standard of an Advanced trainee as described in developmental descriptors.	Above the standard for an Advanced trainee.

Please note: standards are at the level expected **on completion of Stage**. Case-based Discussions conducted at the beginning of a Stage may typically include ratings of below "Meets Standard". The purpose of this approach is to provide educationally driven opportunities for trainees to assess their progress against a set of developmental descriptors that are set at the point of progression to the next developmental stage of training. The descriptors outline basic, proficient and advanced skill levels and are viewed as a continuum along which the trainee must progress.

10. The trainee and assessor discuss and agree upon next steps for progress, and both sign the form.
11. The trainee is responsible for retaining the CbD form, updating the learning plan as required, and ensuring that supervisors and DOTs have access to them on request. The assessor may also wish to hold a copy.

Guidance for discussion

This guide is intended to provide direction for the supervisor in eliciting further information from a trainee to support the CbD. It may also guide the trainee to understand important focal points for the discussion regarding their case.
The assessment must commence from the trainee's entry in the case notes. There is no other set structure for the discussion but the following prompts may be used as a guide. Discussion is not limited to these questions, and others may be used to prompt a focused discussion about the case, at the supervisor's discretion.

- General
  - 'Please tell me about this meeting/visit/appointment' or
  - 'Please tell me about your approach to the patient's presenting problem' or
  - 'What were the key points about this meeting/visit/appointment?'
- Assessment/diagnosis
  - 'What specific features led you to this impression/conclusion or diagnosis?' and/or
  - 'What other conditions have you considered/ruled out?'
  - Investigation/referrals
  - 'What specifically led you to choose these investigations?' and/or
  - 'Were there any other investigations or referrals that you considered?'
  - 'I see that you have written down a number of different investigations – how did you think the results would help you work out what was going on and what you needed to do?'
- Management
  - 'What specific features led you to the management/therapy that you chose?' and/or
  - 'Were there any other treatments that you thought about or ruled out?'
  - 'I see that you have decided to treat the patient with …. – talk me through how you decided to prescribe that regime and what the alternatives were you considered?'
  - 'What was going through your mind when you wrote that management plan? Just talk me through your thought process'
  - 'You have referred to treatment guidelines to help with ….. – tell me a bit about how you used the treatment guidelines to help plan management and whether there were any aspects that didn't fit in this case?'
- Follow-up/care plan
  - 'What decisions were made about follow-up (to this entry)?' and
  - 'What were the factors that influenced this decision?'
  - 'You have written down that you were going to ask Dr …… for their advice – what specifically did you want to discuss with them, why was it important in this case, how did their advice help and what did you learn from it?'
- Monitoring chronic illness
  - 'In your care of X, have you discussed the monitoring of their progress?' and/or
  - 'Do you think that there are some monitoring strategies that would be appropriate?' and/or
  - 'Have you discussed any health promotion strategies, e.g. alcohol use, diet, etc?'
- Individual patient factors concerning context of care
  - 'Was there anything particular/special about this patient that influenced your management decisions?' (e.g. demography, psychosocial issues, past history, current medications and treatment? And/or
  - 'On reflection, is there anything about this patient that you wish you knew more about?'
- Care setting
  - 'Is there anything about the setting in which you saw the patient (e.g. home, ward, accident and emergency department) that influenced your management?' and/or
  - 'In considering this case, what changes would improve your ability to deliver care to this patient?'

Professional Presentation WBA

Trainee Name:	Program Name:
Stage: 1 2 3 Rotation: 1 2 3 4	Date of assessment:

Presentation Title:
Brief description of the Presentation:
Learning Outcomes being assessed:
EPA/other: EPA standard of assessment: Basic Proficient Advanced

Please indicate the activity in which the presentation has taken place:

Journal Club ☐	Clinical Audit ☐	Grand Round ☐
Case Presentation ☐	In-service Presentation ☐	Community education ☐

Please indicate the audience/s and setting/s in which the presentation has taken place:

Journal Club ☐	Carer ☐	In-service ☐
Grand Round ☐	NGO ☐	Other (specify):
Consumer ☐	Community ☐	

*Please rate the following aspects of the professional presentation on the scale below. (n/a = not applicable) *see Developmental Descriptors document as a guide to expected standards and to inform feedback. Point 5 on the scale represents the expected standard **on completion** of the trainee's current Stage of training.*

			Below standard for end of Stage			**Meets standard for end of Stage**			**Above standard for end of Stage**		
1.	Introducing the topic	**n/a**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
2.	Setting material in context	**n/a**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
3.	Analysis and critique	**n/a**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
4.	Presentation and delivery	**n/a**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
5.	Answering questions	**n/a**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
6.	Quality of educational content	**n/a**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**

What aspects were done well?	**Suggestions for areas of improvement**

Agreed action/goals:

Assessor's Name:	Assessor's Position:
Assessor's Signature:	Date: RANZCP ID:
Trainee's Signature:	Date: RANZCP ID:

WBA - Professional Presentation

The Royal Australian & New Zealand College of Psychiatrists

INTRODUCTION

The Professional Presentation is a RANZCP approved Workplace-based Assessment (WBA) tool. It is a concise method for formative evaluation of trainees within training, requiring an assessor to observe a trainee giving a professional presentation. The primary purpose of this tool is to promote learning through the provision of immediate structured feedback on their performance within an authentic workplace context to enhance learning. The tool is designed to allow feedback on *specific* presentation skills rather than on their general performance alone.

The feedback to the trainee relates directly to their performance against a set of developmental descriptors for **the end of their stage of training**. The purpose of this approach is to provide educationally driven opportunities for trainees to assess their progress against a set of developmental descriptors. These descriptors encapsulate the standard that the College requires of trainees at the point of progression to the next developmental stage of training. The descriptors outline basic, proficient and advanced skill levels and are viewed as a continuum along which the trainee must progress.

Where does it take place?

The Professional Presentation assessment tool can be used in Journal Clubs, case presentations, community education presentations, clinical audits, grand round presentations and in-service presentations. Example audiences include: the wider community, consumers, carers, or clinician audiences.

Choosing a presentation

Psychiatrists are required to present in multiple forums to broad audiences and represent the profession and their employers in these contexts. The trainee should choose WBA presentations so that, by the end of the training period, they have been assessed over a range of settings and topic areas.

Activities for assessment (examples)

Stage 1 activities	Stage 2 activities
• Case presentation • Topic presentation • Nursing in service presentation	• Clinical audit • Case presentations • Consumer / carer/ NGO

Assessment criteria

The assessment will record performance relative to the following.

- Introducing the topic
- Setting material in context
- Analysis and critique
- Presentation and delivery
- Answering questions
- Quality of educational content

Feedback session

The feedback aspect of the Professional Presentation is the most important purpose of the assessment. The feedback will focus on the strengths and weaknesses of the trainee's performance, and will, through self-reflection, also inform their further learning and skill development.

- The trainee elects participation in a presentation opportunity and organises room bookings, invitations and a private room for the feedback session to occur following the presentation.

- Whether a Journal Club session or a Grand Round presentation, developing a presentation is a significant piece of work requiring the trainee to ensure ample preparation time prior to undertaking the Professional Presentation.

- The trainee arranges for a College accredited assessor to be in attendance during the entire presentation. WBAs not being undertaken with the primary supervisor must be approved by them.

- The Professional Presentation session is expected to run for at least 30 minutes. This includes the presentation and interaction/discussion time with the audience.

- The assessor rates the trainee's performance using the 9-point scale on the Professional Presentation form. The mid-point of this scale (5) represents the expected standard to be achieved at the end of each stage of training (see table below).
    - *Please note: not all assessment criteria on the form are required to be rated during each Professional Presentation assessment. Not applicable criteria are rated with the n/a option.*

Table 1. Standard guide for rating scale – *see Developmental Descriptors document for more detail*

Trainee Stage	Below Standard for end of Stage (1 2 3)	Meets Standard for end of Stage (4 5 6)	Above Standard for end of Stage (7 8 9)
Stage 1 Basic	Below Basic level as described in developmental descriptors.	At Basic level as described in developmental descriptors.	Above Basic level. Moving towards the standard of a Proficient trainee.
Stage 2 Proficient	Below the standard of Proficient trainee. Meets standard of a Basic trainee.	Meets the standard of a Proficient trainee as described in developmental descriptors.	Above the standard of Proficient trainee. Moving towards the standard of an Advanced trainee.
Stage 3 Advanced	Below standard for Advanced trainee. Meets standard of a Proficient level trainee.	Meets the standard of an Advanced trainee as described in developmental descriptors.	Above the standard for an Advanced trainee.

Please note: standards are at the level expected **on completion of Stage**. Professional Presentations conducted at the beginning of a Stage may typically include ratings of below "Meets Standard". The purpose of this approach is to provide educationally driven opportunities for trainees to assess their progress against a set of developmental descriptors that are set at the point of progression to the next developmental stage of training. The descriptors outline basic, proficient and advanced skill levels and are viewed as a continuum along which the trainee must progress.

- Immediately following the presentation, the assessor discusses their comments and ratings on the form, providing the trainee with feedback on their performance.

- Constructive and useful feedback is given to the trainee on certain points:
    - areas that were especially good are highlighted
    - areas that need improvement are indicated and discussed
    - Further / future improvement plans are developed.
- The assessor makes feedback comments; the cumulative weight of these comments helps determine a defensible judgment of a trainee's competence. Both the assessor and trainee sign the form.

- The trainee is responsible for retaining the Professional Presentation form, updating the learning plan where required, and ensuring that supervisors and DOTs have access to them on request. Assessors may also hold a copy.

Education Training Policy

Stage 1 Mandatory Requirements

The Royal Australian & New Zealand College of Psychiatrists

Approval Date:	General Council GC2012/4 – R58 (18 November 2012)
Review Date:	July 2014
Policy Number:	7.1 – Permanent number to be assigned
Risk Assessment:	High
Related Regulation:	7.1

Contents

1. Policy on Stage 1 Mandatory Requirements
2. Policy Statement
3. Purpose
4. Policy Details

4.1 Rotation Requirements

4.1.1 Setting

1. Policy on Stage 1 Mandatory Requirements

This policy describes the mandatory requirements for College trainees in Stage 1 of the (competency-based) Fellowship Program, as governed by the RANZCP Fellowship Regulations 2012.

2. Policy Statement

Stage 1 of the (competency-based) Fellowship Program requires the mandatory completion of a minimum of 12 months' full-time equivalent (FTE) accredited training in College-accredited Adult Psychiatry training posts, 6 months of which must be in an acute setting.

The completion of Stage 1 requires trainees to attain and demonstrate competence in psychiatry to a basic standard as defined by the Developmental Trajectory.

3. Purpose

This policy defines the requirements for the successful completion of Stage 1 training within the (competency-based) Fellowship Program in a clear and transparent manner.

4. Policy Details

4.1 Rotation Requirements

Trainees in Stage 1 must complete a minimum of 12 months' full-time equivalent (FTE) accredited training in College-accredited Adult Psychiatry posts.

4.1.1 Setting

Six months FTE of this training must be completed within an acute setting.

4.2 Training Posts in an Adult Psychiatry Area of Practice

Training in Stage 1 Adult Psychiatry posts will focus on the core basic psychiatry skills. It must also involve working with people with a wide range of mental health problems and mental illness.

Training posts in Adult Psychiatry may involve public and private psychiatry experiences.

4.2.1 Inclusive of Youth Mental Health

The Adult Psychiatry Area of Practice requirement for Stage 1 is inclusive of Youth Psychiatry posts that focus on the core basic psychiatry skills.

4.2.2 Exceptions to Adult Psychiatry Training Posts for Stage 1

Occasionally, exceptions may be necessary to the Adult Psychiatry Area of Practice requirement for a Stage 1 Training Post. Any such exception must be carefully structured and utilise an educationally equivalent post.

The use of an educationally equivalent post for Stage 1 must be on an exceptional basis and will be approved and managed by the relevant Branch Training Committee (BTC) or under that BTC's oversight and delegation as part of the accreditation process.

A post deemed to be educationally equivalent to an Adult Psychiatry post must focus on the core basic psychiatry skills and must successfully undergo the accreditation process for a Stage 1 training post.

4.3 Knowledge Required

By the end of 12 months' FTE training within Stage 1, a trainee should have attained the knowledge base defined in the Stage 1 syllabus.

This knowledge base underpins the acquisition of competencies in Stage 1 and is mandatory for trainee progression to Stage 2.

4.4 Fellowship Competencies

As detailed in the Fellowship Competencies Policy and Procedure (X.X), the College has adopted a set of Fellowship Competencies that map back to the CanMEDS roles underpinning the Fellowship Program. Trainee progression through the stages of training is dependent on the attainment of competent performance across the Fellowship Competencies, demonstrated by the successful completion of all assessments.

4.4.1 Developmental Descriptors

The Developmental Descriptors provide guidance on the skill level expected of trainees at the end of each stage of training as per the Developmental Trajectory (basic, proficient and advanced levels). The Developmental Descriptors articulate how each standard level applies for each of the Fellowship Competencies and provide a reference point for defining performance standards.

4.4.2 Learning Outcomes

The Learning Outcomes prescribe the minimum expectations of what trainees will need to attain in their rotations in order to meet the Fellowship Competency requirements across the stages of training.

The Stage 1 Learning Outcomes must be attained by trainees in order for them to progress to Stage 2.

The Learning Outcomes are tracked on the In-Training Assessments, described in section 4.10.

4.5 Supervision

4.5.1 General Supervision Time Requirements

As specified in the Policy and Procedure on Supervision (X.X), clinical supervision of trainees must be maintained at a minimum of four hours per week over 40 weeks for full-time trainees.

Of these hours, a minimum of one hour per week must be individual supervision of a trainee's current clinical work. While this hour is required in full for all trainees, the other three hours of supervision per week must be on a pro-rata basis (minimum) for part-time trainees.

4.5.2 Stage 1-specific Supervision Requirements

Additionally, of the four supervision hours per week, at least two per week must be closer supervision outside ward rounds and case review meetings for Stage 1 trainees. This is further detailed in the Policy and Procedure on Supervision (X.X).

4.6 Workplace-based Assessments

Workplace-based Assessments (WBAs) provide a mechanism for structured and effective feedback in the assessment of competence in typical work settings. Detailed information can be found in the Policy and Procedure on Workplace-based Assessments (15.1).

4.6.1 Formative Assessments

As described in the Regulation, Policy and Procedure on Workplace-based Assessments (15.1), the (competency-based) Fellowship Program utilises WBAs as formative assessment tools.

WBAs are set and assessed at the standard expected by the end of the designated stage of training, as per the Developmental Trajectory.

4.6.2 Approved WBA Tools

Four WBA tools have been approved for use within the (competency-based) Fellowship Program. These are the following:

- Case-based Discussion (CbD)
- Mini-Clinical Evaluation Exercise
- Observed Clinical Activity (OCA)
- Professional Presentation.

4.6.3 Minimum Requirement

Trainees must complete a minimum of three WBAs to form the evidence base for each required Entrustable Professional Activity (EPA), which is described further in section 4.7.

4.7 Entrustable Professional Activities

4.7.1 Summative Assessments

Entrustable Professional Activities (EPAs) are summative assessments that trainees are required to successfully complete in order to progress through the stages of training.

As detailed in the Policy and Procedure on EPAs (8.1), EPAs are set and assessed at the standard expected by the end of the designated stage of training. Trainees must be able to demonstrate competence to a basic standard at the end of Stage 1, as per the Developmental Trajectory.

4.7.2 Stage 1 Mandatory EPAs

There are four mandatory EPAs that a trainee must achieve in Stage 1. The mandatory EPAs for Stage 1 are the following:

1. Producing discharge summaries and organising appropriate transfer of care.
2. Initiating an antipsychotic medication in a patient with schizophrenia.
3. Active contribution to the multidisciplinary team meeting.
4. Communicating with a family about a young adult's major mental illness.

4.8 EPAs and Rotations

Each 6-month FTE rotation in the (competency-based) Fellowship Program requires the achievement of two specified EPAs, as described by the Regulation on Rotations (17.2). These EPAs are recorded on the In-Training Assessments (described in section 4.10) for each rotation and must be achieved for trainees to be eligible to pass an end-of-rotation In-Training Assessment Report and its corresponding rotation.

Therefore, trainees must achieve two of the mandatory Stage 1 EPAs (listed in point 4.7.2) in each 6-month Adult Psychiatry rotation.

4.8.1 The Stage 1 First 6 Months FTE Exception Rule

A trainee in the first 6-month FTE rotation of Stage 1 may conditionally pass that rotation and its corresponding In-Training Assessment Report before being entrusted with two of the mandatory Stage 1 EPAs. This will apply only in cases in which:

- the supervisor indicates a 'pass' on the ITA Report
- the trainee has undertaken the required minimum number of formative WBAs for the rotation.

Trainees must achieve all four mandatory Stage 1 EPAs before successfully completing Stage 1.

This rule is applicable only to trainees in their first 6-month FTE rotation of Stage 1 and cannot be applied in any other Stage or rotation. This rule allows for flexibility during a period of adjustment for trainees entering psychiatry training.

4.8.2 EPAs and Progression

Trainees will not be able to progress to Stage 2 until they have been entrusted with all four Stage 1 EPAs.

4.9 Eligibility to Achieve Stage 2 General Psychiatry EPAs

In addition to the four mandatory EPAs for Stage 1, trainees in Stage 1 are eligible to be entrusted with any or all of the five General Psychiatry EPAs required for the successful completion of Stage 2. Therefore, these EPAs are also tracked on the Stage 1 In-Training Assessments for record-keeping purposes; however, their achievement or lack thereof does not affect the ability of a trainee to pass or fail a Stage 1 In-Training Assessment Report.

These Stage 2 General Psychiatry EPAs will be assessed at the competence standard expected of Stage 2—a proficient level of competency as per the Developmental Trajectory—regardless of whether they are entrusted to a trainee in Stage 1 or Stage 2.

4.9.1 No Bearing on Stage 1 Mandatory EPAs

The achievement of the Stage 2 General Psychiatry EPAs does not fulfil or replace the requirement for trainees to complete all four mandatory Stage 1 EPAs.

4.9.2 Stage 2 General Psychiatry EPAs Eligible for Achievement in Stage 1

The five Stage 2 General Psychiatry EPAs that trainees are eligible to be entrusted with in Stage 1 are the following:

1. Demonstrating proficiency in all the expected tasks associated with prescription, administration and monitoring of ECT.
2. The application and use of the Mental Health Act.
3. Assessment and management of risk of harm to self and others.
4. The safe and effective use of clozapine in psychiatry.
5. Cultural competence.

Trainees in Stage 1 are not required to attempt nor achieve the above Stage 2 General Psychiatry EPAs while they are in Stage 1.

4.10 Eligibility to Achieve Stage 2 Psychotherapy EPAs

Trainees in Stage 1 are eligible to achieve two specified Psychotherapy EPAs that are required for the successful completion of Stage 2. Their achievement or lack thereof does not affect the ability of a trainee to pass or fail a Stage 1 end-of-rotation ITA Report. Nor does their achievement in Stage 1 fulfil or replace the requirement for trainees to achieve all four mandatory Stage 1 EPAs.

These Stage 2 Psychotherapy EPAs will be assessed at the competence standard expected of Stage 2—a proficient level of competency—regardless of whether they are achieved during Stage 1 or Stage 2.

The two Stage 2 Psychotherapy EPAs that trainees are eligible to be entrusted with in Stage 1 are the following:

1) The provision of psychoeducation in a formal interactive session.
2) Psychodynamically informed patient encounters and managing the therapeutic alliance.

Trainees in Stage 1 are not required to attempt nor achieve the above Stage 2 General Psychiatry EPAs while they are in Stage 1.

4.11 EPA Exceptional Circumstances

In exceptional circumstances, a Director of Training (DOT) may determine that a Stage 1 trainee is eligible to be entrusted with specific Stage 2 EPAs other than the General Psychiatry and Psychotherapy EPAs described in the preceding statements. This approval would be granted on a case-by-case basis and must follow the eligibility guidance outlined in the Entrustable Professional Activities Procedure.

4.12 In-Training Assessments

Each trainee will be assessed on their progress throughout each rotation on two In-Training Assessments (ITAs).

Each stage of training will utilise a specific end-of-rotation ITA Report (summative) and mid-rotation ITA Form (formative). Further detail can be found in the Policy and Procedure on In-Training Assessments (16.1).

In addition to maintaining a portfolio of their WBA forms and copies of all EPA forms, trainees must maintain copies of all ITAs (formative and summative).

4.12.1 Mid-Rotation ITA Form

The ITA Form is the mid-rotation formative assessment for each rotation. The ITA Form is used to provide feedback to the trainee on their progress in the rotation and to highlight any potential progress concerns, as well as plans required to address these concerns.

The ITA Form must be held by the trainee's DOT, and will be forwarded to the College as required.

4.12.2 ITA Report

The ITA Report is the end-of-rotation summative assessment that indicates to the College Training Department what information should be recorded on the trainee's Training Record for each rotation.

The ITA Report indicates whether or not the required EPAs have been entrusted and which WBAs were used to inform them, provides a record of the supervisor's assessment of the trainee's performance for each Stage 1 Learning Outcome, and indicates whether the trainee has passed or failed the overarching summative assessment for that rotation.

4.12.3 Timely Receipt of an ITA Report

The ITA Report for each rotation must be signed by the trainee's DOT and received by the College Training Department within 60 days of the completion of a rotation. The trainee is responsible for ensuring that it is signed by the DOT and for ensuring its submission.

- The non-receipt of a signed ITA Report by this time will result in the delay being noted on the trainee's Training Record. The trainee will be sent correspondence noting the late ITA Report and reminding the trainee that its continued non-receipt by 30 days from the date on which the correspondence is sent will result in a failed ITA Report and rotation unless exceptional circumstances have been accepted by the College on a case by case basis. Further detail can be found in the In-Training Assessment Policy and Procedure (16.1).
- Trainees are responsible for knowing the requirements of the Fellowship Program and of this policy. Non-receipt of correspondence from the College does not invalidate the trainee's obligation to adhere to the requirements it presents.

4.12.4 Failed ITA Report

A failed ITA Report, which corresponds to a failed rotation, will require the trainee to complete a remedial plan developed by the trainee's DOT in conjunction with the trainee. Further detail can be found in the Policy and Procedure on Remedial Plans (X.X) and in the Policy and Procedure on Progression through Training (6.1).

Time spent in a failed rotation does not count towards a trainee's minimum required 60 months' FTE accredited training time.

- Therefore, time spent in a failed Adult Psychiatry Stage 1 rotation does not count towards a trainee's minimum required 12 months' FTE accredited training in Stage 1.
- Time spent during the successful completion of a rotational remedial plan is credited towards a trainee's Training Record and is included in the minimum required 60 months' FTE accredited training time (and 12 months' FTE accredited training in Stage 1 where applicable).

4.13 Successful Completion of Stage 1

Trainees who have successfully passed and submitted the ITA Reports for 12 months' FTE training in accredited Stage 1 rotations and who, as part of the requirements for Stage 1, have been entrusted with the four mandatory Stage 1 EPAs are eligible to continue to Stage 2 of the Fellowship Program.

4.14 Review of Decisions

Any request by a trainee for review of a decision in relation to an unsuccessful rotation or other element of Stage 1 should follow the formal education review process (X.X).

5. Monitoring, Evaluation and Review

The Board of Education (BOE) shall implement, monitor and review the Policy and report on anomalies and issues as these arise.

This policy will be reviewed biennially and updated as required.

6. Definitions and Abbreviations – to include the term and its meaning

Basic Standard	The standard as per the Developmental Trajectory that must be attained and demonstrated by the end of Stage 1.
BOE	The College Board of Education
BTCs	Branch Training Committees – For the purposes of this document, this collective term is inclusive of all Branch Training Committees and the New Zealand Training Committee.
CanMEDS Framework	The CanMEDS Framework, adopted by the Royal College of Physicians and Surgeons of Canada in 1996, is utilised by this College in the development and intent of the (competency-based) Fellowship Program. "CanMEDS is an educational framework identifying and describing seven roles that lead to optimal health and health care outcomes: medical expert (central role), communicator, collaborator, manager, health advocate, scholar and professional." (Royal College of Physicians and Surgeons of Canada, 2011).
College	The Royal Australian and New Zealand College of Psychiatrists
College-accredited	Accredited as part of the responsibility delegated to the Branch Training Committees (BTCs) and undertaken in accordance with the Accreditation of Training Programs: Standards for Accreditation.
Decision	Any direction, affirmation or registration of opinion, in response to a request for special consideration, in which a decision is intended to, or does affect, the progression of a candidate pursuant to the Regulations.
Developmental Descriptors	Describes the skill level expected of trainees at the end of each stage of training. These can be used by supervisors to help determine if a trainee is performing at the appropriate standard as per the Developmental Trajectory. The Developmental Descriptors are not designed to be an exhaustive list and are not intended to replace a supervisor's best judgement. See Associated Documents.
Developmental Trajectory	The Developmental Trajectory illustrates the broad changes expected of trainees' practice as they progress through training through basic, proficient and advanced levels. See Associated Documents (Developmental Descriptors).
DOT	Director of Training. Also applicable to Director of Advanced Training within the context of this policy.
EPAs	Entrustable Professional Activities: summative assessment components of the Fellowship Program.

Failure to Progress	The process that facilitates the identification, support and, potentially, the exit of underperforming and/or non-progressing trainees from the Fellowship Program.
Fellowship Competencies	Fellowship Competencies outline the College's understanding of psychiatry in Australia and New Zealand through the CanMEDS roles, and state the demonstrable endpoint competencies for all trainees engaged in attaining Fellowship of the College. See Associated Documents.
FTE	Full-time equivalent
ITA	In-Training Assessment: formative and summative assessment components of the Fellowship Program.
Learning Outcomes	Learning outcomes for each stage of training (contributing to attainment of each of the Fellowship Competencies). These are the minimum expectations of trainees and will be assessed in the In-Training Assessments. See Associated Documents.
OCI Examination	Observed Clinical Interview: one of the two clinical examinations in the Fellowship Program.
OSCE	Objective Structured Clinical Examination: one of the two clinical examinations in the Fellowship Program.
Psychotherapies Written Case	A summative assessment component of the Fellowship Program.
Remediation	A process in which trainees who have not successfully completed program requirements are assisted, counselled, supported and monitored through the completion of remedial plans.
Scholarly Project	A summative assessment component of the Fellowship Program.
Stage	Training under the RANZCP Fellowship Regulations 2012 falls into three Stages (Stage 1, Stage 2 and Stage 3), which can be defined as basic, proficient and advanced training as per the Developmental Trajectory.
Trainee Progress Trajectory	See Associated Documents and the Progression through Training Education Training Policy
Training Record	The record kept by the College of a trainee's progress on all required components of the Fellowship Program.
WBAs	Workplace-based Assessments: formative assessment components of the Fellowship Program.

7. Associated Documents

7.1 Regulation: 7.1 Stage 1 Rotation Requirements Education Training Regulation

6.1 Progression through the Stages of Training Education Training Regulation

8.1 Entrustable Professional Activities Education Training Regulation

12.1 Supervision in Training Posts Education Training Regulation

15.1 Workplace-based Assessments Education Training Regulation

16.1 In-Training Assessment Report Education Training Regulation

7.2 Policy:
8.1 Entrustable Professional Activities Education Training Policy
6.1 Progression through Training Education Training Policy
12.1 Supervision in Training Posts Education Training Policy
15.1 Workplace-based Assessments Education Training Policy
16.1 In-Training Assessment Report Education Training Policy
X.X Fellowship Competencies Education Training Policy
X.X Remedial Plans Education Training Policy

7.3 Procedure:
7.1 Stage 1 Rotation Requirements Education Training Procedure
6.1 Progression through Training Education Training Procedure
8.1 Entrustable Professional Activities Education Training Procedure
12.1 Supervision in Training Posts Education Training Procedure
15.1 Workplace-based Assessments Education Training Procedure
16.1 In-Training Assessment Report Education Training Procedure
X.X Fellowship Competencies Education Training Procedure
X.X Remedial Plans Education Training Procedure

7.4 Forms :
In-Training Assessment Form (mid-rotation)
In-Training Assessment Report (end-of-rotation)
Workplace-based Assessment (WBA) Form
Entrustable Professional Activity (EPA) Form

7.5 Other:
Trainee Progress Trajectory
Fellowship Competencies
Developmental Descriptors
Learning Outcomes

8. References N/A

DOCUMENT CONTROL

Responsible department: Education	Responsible position: Senior Policy Officer	Version: 0.9
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REVISION RECORD

Date	Version	Revision description

Education Training Policy

Progression through Training

The Royal Australian & New Zealand College of Psychiatrists

Approval Date: General Council GC2012/4 – R58 (18 November 2012)

Review Date: July 2014

Policy Number: 6.1 – Permanent number to be assigned

Risk Assessment: High

Related Regulation: 6.1

Contents

1. **Policy on Progression through Training**

This policy sets out the requirements for a trainee's successful progression through the (competency-based) Fellowship Program.

2. Policy Statement

The Progression through the Stages of Training Regulation states that trainee progression is dependent on:

- the attainment of the required level of competence across the roles (Medical Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar and Professional as per the CanMEDS Framework)
- the successful completion of the assessments required for that stage of training.

This policy further details the timing of these competency requirements that trainees must successfully complete to be eligible for Fellowship of the College through the (competency-based) Fellowship Program.

3. Purpose

This policy sets out the requirements for progression through training under the RANZCP Fellowship Regulations 2012 and ensures transparency and fairness in the application of these requirements.

This policy will present the Trainee Progress Trajectory for progression through the Fellowship Program. This trajectory details the mandatory deadlines for completion of training components to adequately plan for and maintain required trainee progress.

This policy does not set out the requirements for trainees who fail to adhere to the Trainee Progress Trajectory. The Failure to Progress Regulation, Policy and Procedure, which should be read in conjunction with this policy, detail these requirements (19.1).

4. Policy Details

4.1 Deadlines within the Fellowship Program

4.1.1 Deadline

Deadlines within the Fellowship Program are based on accredited training time.

While a deadline states the mandatory completion date for a specific component of the Fellowship Program, it is not a barrier within the program. That is, a deadline does not inhibit the progression of a trainee in itself.

Unmet deadlines, however, will require a trainee to be managed under the Failure to Progress Policy and Procedure (19.1) and may lead to a trainee's exit from the Fellowship Program.

4.2 Trainee Responsibilities

As adult learners, trainees in the Fellowship Program are responsible for their own progress in line with the Trainee Progress Trajectory and must take into account the time required for enrolling in, sitting and marking each assessment in order to successfully meet each deadline. Trainees will maintain copies of their own Fellowship Program forms.

Trainees who anticipate that they will not be able to meet a deadline as required are advised to seek support from their Director of Training (DOT) prior to the deadline.

4.3 Trainee Communication

Trainees will receive correspondence from the College in relation to their progress in the Fellowship Program. Trainees may seek clarification from College staff on the correspondence received and on the Fellowship Program regulations, policies and procedures. However, it is the responsibility of the trainee, to ensure they have an understanding of the RANZCP Fellowship Regulations 2012 and the deadlines required under these regulations and policies.

4.4 Training Time

The Fellowship Program requires a minimum of 60 months' full-time equivalent (FTE) accredited training. This accredited training will be divided as:

- a minimum of 12 months' FTE accredited training in Stage 1
- a minimum of 24 months' FTE accredited training in Stage 2
- a minimum of 24 months' FTE accredited training in Stage 3.

4.5 Entrustable Professional Activities

4.5.1 EPAs and Rotations

Each 6-month FTE training rotation in the (competency-based) Fellowship Program requires the achievement of two specified Entrustable Professional Activities (EPAs), as described by the Policy on Rotations (17.2). These EPAs are recorded on the In-Training Assessment Report for each rotation and must be achieved for trainees to be eligible to pass that In-Training Assessment (and hence, the rotation). This is described further in section 4.6.

4.5.2 EPAs and Stages

Trainees must be entrusted with all mandatory EPAs for a stage (including rotation-based and stage-based EPAs) before progressing to the next stage of the Fellowship Program. A trainee cannot move to a higher stage without first attaining the required competencies of a more basic level.

- Trainees must consider and plan for the number of EPAs that they must be entrusted with before they can successfully complete a stage of the Fellowship Program. Guidance on the minimum and maximum number of EPAs expected to be achieved per 6 months' FTE accredited training (in addition to the mandatory rotation-based EPAs) is outlined in the Entrustable Professional Activities Procedure (8.1).

4.5.3 EPA Deadlines

The mandatory EPAs for each stage must be achieved by the time the trainee has completed 1.5 times the minimum training time requirement for the stage (as detailed in point 4.4). Therefore:

- the Stage 1 EPAs must be achieved by the time the trainee has completed 18 months' FTE accredited training in Stage 1
- the Stage 2 EPAs must be achieved by the time the trainee has completed 36 months' FTE accredited training in Stage 2
- the Stage 3 EPAs must be achieved by the time the trainee has completed 36 months' FTE accredited training in Stage 3.

Failure to achieve the mandatory EPAs by the time requirements above will result in a requirement for the trainee to show cause to the Committee for Training (CFT) as to why they should be able to continue towards Fellowship as set out in the Failure to Progress Policy and Procedure (19.1).

4.6 Training Rotations and In-Training Assessments

4.6.1 In-Training Assessment

Trainees will be assessed on their progress throughout each rotation on two In-Training Assessments (ITAs): the formative ITA Form (mid-rotation) and the summative ITA Report (end-of-rotation).

4.6.2 In-Training Assessment Report Submission to College

The end-of-rotation ITA Report indicates to the College Training Department the information to be recorded on the trainee's Training Record for each rotation. The ITA Report must be submitted within the stipulated time requirements at the end of each rotation to the College Training Department in order for that rotation to be credited on the trainee's Training Record.

The ITA Report must be signed by the trainee's DOT and be received by the College's Training Department within 60 days of the completion of a rotation. The trainee is responsible for being aware of the requirement to submit this form.

- non-receipt of a signed, completed ITA Report by the deadline will result in a failed ITA Report and rotation unless exceptional circumstances have been accepted by the College on a case by case basis. Further detail can be found in the In-Training Assessment Policy and Procedure (16.1).

4.6.3 Failing an In-Training Assessment Report and Rotation

A failed ITA Report indicates rotation failure. An ITA Report and its corresponding rotation will be failed by any of the following:

- the supervisor indicating a 'fail' on the ITA Report

- the trainee failing to achieve both of the mandatory EPAs for the rotation (two EPAs are mandatory for a 6-month FTE rotation)
- the trainee failing to complete the minimum required formative Workplace-based Assessments (WBAs) linked to the mandatory EPAs for the rotation (a minimum of three WBAs are required for each EPA)
- the non-receipt of the ITA Report by the stipulated time requirements as per point 4.6.2.

4.6.4 The Stage 1 First 6 Months FTE Exception Rule

A trainee in the first 6-month FTE rotation of Stage 1 may conditionally pass that ITA Report, and therefore the corresponding rotation, before achieving two of the mandatory Stage 1 EPAs. This is to occur on an exceptional basis and will apply only in cases in which:

- the supervisor indicates a 'pass' on the ITA Report
- the trainee has undertaken the required minimum of formative WBAs for the rotation.

Trainees must achieve all four mandatory Stage 1 EPAs before successfully completing Stage 1.

This rule is applicable only to trainees in their first 6-month FTE rotation of Stage 1 and cannot be applied in any other Stage or rotation. This rule allows for flexibility during a period of adjustment for trainees entering psychiatry training.

4.6.5 Initial Remedial Process

A possible rotation and ITA Report failure, as identified during the rotation by a trainee's supervisor in discussion with the trainee's DOT, will require the trainee to commence an initial remedial plan to assist them in making better progress prior to the end of the rotation. Further detail can be found in the Remedial Plans Policy and Procedure (X.X).

4.6.6 Credit for Training Time

Time spent in a failed rotation does not count towards a trainee's minimum required 60 months' FTE accredited training time.

Time spent during the successful completion of a rotational remedial plan is credited towards a trainee's Training Record and is included in the minimum required 60 months' FTE accredited training time.

4.6.7 Remediation for Unsuccessful Rotations

A failed end-of-rotation ITA Report will require the trainee to complete a formal remedial plan of a minimum of 3 months in duration. Further detail can be found in the Remedial Plans Policy and Procedure (X.X).

4.7 Written Examination

4.7.1 Eligibility

The written examination may be attempted once the trainee has successfully completed Stage 1. It will be assessed at the standard of a Junior Consultant.

4.7.2 Deadline

The written examination is expected to be attempted and passed by the time the trainee has completed 46 months' full-time equivalent (FTE) accredited training.

- Failure to do so will require the development of a formal remedial plan to support the trainee in passing the written examination. Further detail can be found in the Failure to Progress Policy and Procedure (19.1).
- Continued failure to pass the written examination by the time the trainee has completed 54 months' FTE accredited training will result in a requirement for the

trainee to show cause to the CFT as to why they should be able to continue towards Fellowship. Further detail can be found in the Failure to Progress Policy and Procedure (19.1).

4.7.3 Remediation for Two Unsuccessful Attempts

For every two failed attempts at the written examination, the trainee must complete a remedial plan as per the Policy and Procedure on Remedial Plans (X.X).

4.7.4 Correlation with Clinical Examinations

The written examination is not a barrier to a trainee's eligibility for the clinical examinations; however, its deadline for completion occurs earlier than those of the clinical examinations.

4.7.5 Correlation with Certificate of Advanced Training Programs

The written examination is not a barrier to a trainee's eligibility to be accepted into a Certificate of Advanced Training Program.

4.8 Clinical Examination: Observed Clinical Interview Examination

4.8.1 Eligibility

The Observed Clinical Interview (OCI) examination may be attempted once the trainee has successfully completed Stage 2. It will be assessed at the standard of a Junior Consultant.

4.8.2 Deadline

Trainees must successfully complete two out of a possible three OCIs within two consecutive OCI cycles to pass the OCI examination.

The OCI examination is expected to be attempted and passed by the time the trainee has completed 54 months' FTE accredited training.

- Failure to do so will require the development of a formal remedial plan to support the trainee in passing the OCI examination. Further detail can be found in the Failure to Progress Policy and Procedure (19.1).
- Continued failure to pass the OCI examination by the time the trainee has completed 60 months' FTE accredited training will result in a requirement for the trainee to show cause to the CFT as to why they should be able to continue towards Fellowship. Further detail can be found in the Failure to Progress Policy and Procedure (19.1).

4.8.3 Remediation for Two Unsuccessful Attempts

For every two failed attempts at the OCI examination, the trainee must complete a remedial plan as per the Policy and Procedure on Remedial Plans (X.X).

4.8.4 Correlation with Certificate of Advanced Training Programs

The OCI examination is not a barrier to a trainee's eligibility to be accepted into a Certificate of Advanced Training Program.

4.8.5 Correlation with the OSCE

The OCI examination is not a barrier to a trainee's eligibility to attempt the OSCE.

4.9 Clinical Examination: Objective Structured Clinical Examination

4.9.1 Eligibility

The Objective Structured Clinical Examination (OSCE) may be attempted once the trainee has successfully completed Stage 2. It will be assessed at the standard of a Junior Consultant.

4.9.2 Deadline

The OSCE is expected to be attempted and passed by the time the trainee has completed 54 months' full-time equivalent (FTE) accredited training.

- Failure to do so will require the development of a formal remedial plan to support the trainee in passing the OSCE. Further detail can be found in the Failure to Progress Policy and Procedure (19.1).
- Continued failure to pass the OSCE by the time the trainee has completed 60 months' FTE accredited training will result in a requirement for the trainee to show cause to the CFT as to why they should be able to continue towards Fellowship. Further detail can be found in the Failure to Progress Policy and Procedure (19.1).

4.9.3 Remediation for Two Unsuccessful Attempts

For every two failed attempts at the OSCE, the trainee must complete a remedial plan as per the Policy and Procedure on Remedial Plans (X.X).

4.9.4 Correlation with Certificate of Advanced Training Programs

The OSCE is not a barrier to a trainee's eligibility to be accepted into a Certificate of Advanced Training Program.

4.10 Scholarly Project

4.10.1 Eligibility

The Scholarly Project may be submitted for assessment at any time once the trainee has enrolled in the Fellowship Program. It will be assessed at the standard of a Junior Consultant.

Trainees must submit their Scholarly Project proposal to their Branch Training Committee (BTC) as per the Scholarly Project Policy and Procedure (13.1).

4.10.2 Deadline

The Scholarly Project is expected to be attempted and passed by the time the trainee has completed 54 months' full-time equivalent (FTE) accredited training.

- Failure to do so will require the development of a formal remedial plan to support the trainee in passing the Scholarly Project assessment. Further detail can be found in the Failure to Progress Policy and Procedure (19.1).
- Continued failure to pass the Scholarly Project by the time the trainee has completed 60 months' FTE accredited training will result in a requirement for the trainee to show cause to the CFT as to why they should be able to continue towards Fellowship. Further detail can be found in the Failure to Progress Policy and Procedure (19.1).

4.10.3 Remediation for Unsuccessful Submissions

After two failed submissions of the Scholarly Project, the trainee must complete a remedial plan as per the Policy and Procedure on Remedial Plans (X.X).

4.10.4 Correlation with Certificate of Advanced Training Programs

The Scholarly Project is not a barrier to a trainee's eligibility to be accepted into a Certificate of Advanced Training Program.

4.11 Psychotherapies Written Case

4.11.1 Eligibility

The Psychotherapies Written Case may be submitted for assessment once the trainee has successfully completed Stage 1. It will be assessed at the standard of a Junior Consultant.

4.11.2 Deadline

The Psychotherapies Written Case is expected to be attempted and passed by the time the trainee has completed 46 months' full-time equivalent (FTE) accredited training.

- Failure to do so will require the development of a formal remedial plan to support the trainee in passing the Psychotherapies Written Case assessment. Further detail can be found in the Failure to Progress Policy and Procedure (19.1).
- Continued failure to pass the Psychotherapies Written Case by the time the trainee has completed 54 months' FTE accredited training will result in a requirement for the trainee to show cause to the CFT as to why they should be able to continue towards Fellowship. Further detail can be found in the Failure to Progress Policy and Procedure (19.1).

4.11.3 Remediation for Two Unsuccessful Submissions

After two failed submissions of the Psychotherapies Written Case, the trainee must complete a remedial plan as per the Policy and Procedure on Remedial Plans (X.X).

4.11.4 Correlation with Certificate of Advanced Training Programs

The Psychotherapies Written Case is not a barrier to a trainee's eligibility to be accepted into a Certificate of Advanced Training Program.

4.12 Exceptional Circumstances

Where relevant, the DOT may recommend in writing to the College that a trainee receive a specified amount of extra time for the completion of an assessment(s) due to exceptional circumstances. The DOT does not have the authority to determine when a case is exceptional or to grant an extension; this will be done by the CFT on a case by case basis.

4.13 Three Fails of the Same Assessment

The processes for trainees who have failed three attempts at any summative assessment component of the Fellowship Program are set out in the Failure to Progress Policy and Procedure (19.1).

5. Monitoring, Evaluation and Review

The Board of Education (BOE) shall implement, monitor and review the policy and report on anomalies and issues as these arise.

This policy will be reviewed biennially and updated as required.

6. Definitions and Abbreviations

BOE	The College Board of Education
BTCs	Branch Training Committees – For the purposes of this document, this collective term is inclusive of all Branch Training Committees and the New Zealand Training Committee.

CanMEDS Framework	The CanMEDS Framework, adopted by the Royal College of Physicians and Surgeons of Canada in 1996, is utilised by this College in the development and intent of the (competency-based) Fellowship Program. "CanMEDS is an educational framework identifying and describing seven roles that lead to optimal health and health care outcomes: medical expert (central role), communicator, collaborator, manager, health advocate, scholar and professional." (Royal College of Physicians and Surgeons of Canada, 2011).
College	The Royal Australian and New Zealand College of Psychiatrists
Deadline	The mandatory completion date for a specific component of the Fellowship Program.
Decision	Any direction, affirmation or registration of opinion, in response to a request for special consideration, in which a decision is intended to, or does affect, the progression of a candidate pursuant to the Regulations.
DOT	Director of Training. Also applicable to Director of Advanced Training within the context of this policy.
EPAs	Entrustable Professional Activities: summative assessment components of the Fellowship Program.
Failure to Progress	The process that manages the identification, support and, potentially, the exit of underperforming and/or non-progressing trainees from the Fellowship Program.
Fellowship Competencies	Fellowship Competencies outline the College's understanding of psychiatry in Australia and New Zealand through the CanMEDS roles, and state the demonstrable endpoint competencies for all trainees engaged in attaining Fellowship of the College.
FTE	Full-time equivalent
ITA	In-Training Assessment: formative and summative assessment components of the Fellowship Program.
Junior Consultant	A Junior Consultant is a recently qualified Fellow of the College.
OCI	Observed Clinical Interview: one of the two clinical examinations in the Fellowship Program.
OSCE	Objective Structured Clinical Examination: one of the two clinical examinations in the Fellowship Program.
Psychotherapies Written Case	A summative assessment component of the Fellowship Program.
Remediation	A process in which trainees who have not successfully completed program requirements are assisted, counselled, supported and monitored through the completion of remedial plans.
Scholarly Project	A summative assessment component of the Fellowship Program.
Stage	Training under the RANZCP Fellowship Regulations 2012 will fall into three Stages (Stage 1, Stage 2 and Stage 3), which can be defined as basic, proficient and advanced training.

Trainee Progress Trajectory	See Associated Documents
Training Record	The official record kept at the College Headquarters of a trainee's progress on all required components of the Fellowship Program.
WBAs	Workplace-based Assessments: formative assessment components of the Fellowship Program.

7. Associated Documents

7.1 Regulation: 6.1 Progression through the Stages of Training Education Training Regulation
19.1 Failure to Progress Education Training Regulation

7.2 Policy: 19.1 Failure to Progress Education Training Policy
X.X Remedial Plans Education Training Policy

7.3 Procedure: 6.1 Progression through the Stages of Training Education Training Procedure
19.1 Failure to Progress Education Training Policy
X.X Remedial Plans Education Training Policy

7.4 Forms : In-Training Assessment Form
In-Training Assessment Report
Remedial Plan Form

7.5 Other: Trainee Progress Trajectory

DOCUMENT CONTROL

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Education Training Policy

Failure to Progress

The Royal Australian & New Zealand College of Psychiatrists

Approval Date: General Council GC2012/4 – R58 (18 November 2012)

Review Date: July 2014

Policy Number: 19.1 – Permanent number to be assigned

Risk Assessment: High

Regulation: 19.1

Contents

1. **Policy on Failure to Progress**

This policy sets out the process to support and manage trainees who may be failing to progress within the (competency-based) Fellowship Program.

2. **Policy Statement**

The (competency-based) Fellowship Program, as governed by the RANZCP Fellowship Regulations 2012, aims to ensure that all who are awarded the qualification of Fellowship have attained the level of competence required by the Fellowship Program in the practice of psychiatry. Consequently, the Fellowship Program must also offer a mechanism to address trainees who remain in training without progressing towards the qualification of Fellowship within the required time constraints.

The Failure to Progress Policy should be read in conjunction with the Progression through Training Policy (6.1) and will facilitate the process of identifying, assisting and, potentially, exiting trainees that do not meet the Fellowship Program competency and progression requirements.

Processes in relation to the Failure to Progress Policy will be implemented in a fair and transparent manner.

3. **Purpose**

This policy sets out the requirements for trainees who have not complied with the mandatory deadlines set out by the Progression through Training Regulation, Policy and Procedure (6.1). Trainees who fail to meet a specified requirement and/or deadline for a program element will be managed by this policy through a transparent, fair and equitable Failure to Progress process.

Trainees enrolled under the RANZCP Fellowship Regulations 2012 are required to be aware of and adhere to the mandatory deadlines for the elements of the Fellowship Program.

4. Policy Details

4.1 Responsibility in the Failure to Progress Process

4.1.1 Trainee Responsibilities

Trainees are required to fulfil the training requirements of the (competency-based) Fellowship Program, as declared in the signed Training Agreement required for enrolment in the Fellowship Program. As part of this agreement, trainees must keep the College informed of their current contact and medical registration details.

As described by the Progression through Training Policy (6.1), trainees in the Fellowship Program are responsible for their own progress and must comply with the Fellowship Program deadlines set out in the Trainee Progress Trajectory. Trainees in the Fellowship Program must take responsibility for the facets of a summative assessment 'pass,' including the time required for enrolling in, sitting and marking each assessment in order to successfully meet each deadline.

Trainees are required to maintain copies of their own Fellowship Program forms. Trainees are responsible for submitting Fellowship Program forms in a timely manner to avoid consequences of their late/non-submission.

Trainees are responsible for communicating with their Director of Training when exceptional circumstances occur. In exceptional circumstances, individual education plans and progress trajectories can be defined that will support the attainment of competencies through the summative elements of the program in a more flexible manner. Trainees will maintain ongoing communication with their Director of Training in these circumstances.

Trainees are responsible for understanding of the requirements of this policy and all other regulations, policies and procedures underpinning the Fellowship Program. Trainees are responsible for adhering to the mandatory deadlines and the required Failure to Progress processes where appropriate.

4.1.2 Directors of Training Responsibilities

Directors of Training (DOTs) will endeavour to contact and to support a trainee to whom the Failure to Progress policy applies. If a remedial plan is required, the DOT must ensure its development together with the trainee in accordance with the Remedial Plans Policy (X.X). A principal supervisor may support the trainee in the implementation of a remedial plan; however, the DOT holds the overarching responsibility in relation to remedial plans, as per the Remedial Plans Policy.

The DOT may make a written recommendation to the Committee for Training that a trainee's particular circumstances are exceptional and that the trainee requires added flexibility to the trainee's individual Trainee Progress Trajectory. Recommendations will be considered on a case by case basis.

4.1.3 Committee for Training Responsibilities

The Committee for Training (CFT) will review and consider a DOT's written recommendation for flexibility to a trainee's individual Trainee Progress Trajectory due to exceptional circumstances affecting the trainee. The CFT will decide whether to grant any recommended extensions for individual trainee progress.

As outlined in the procedure, the CFT will review relevant written submissions by a trainee who is required to show cause as to why they should remain in the Fellowship Program. The CFT will consider the cause shown by the trainee and, in addition, any recommendation or advice from the DOT.

The CFT may determine that a trainee has not failed to progress and will work with the trainee and the relevant DOT to return the trainee to the trajectory towards Fellowship.

If the CFT determines that a trainee has failed to progress, they will forward this as a recommendation to the Fellowship Attainment Committee for review.

4.1.4 Fellowship Attainment Committee Responsibilities

The Fellowship Attainment Committee (FAC) will review a recommendation made by the CFT that a trainee has failed to progress. The FAC will then make a recommendation in accordance with the usual committee reporting structure as to whether or not the trainee should be managed under the Exit from Training Policy. Further detail on this process can be found in the Exit from Training Policy (19.2).

4.2 Trainee Communication

The College will correspond directly with a trainee who has not progressed in accordance with the stipulated time requirements of the Trainee Progress Trajectory.

4.2.1 Written Communication

The College will issue relevant correspondence to trainees who have not maintained progress towards Fellowship in line with the Progression through Training Policy (6.1). This correspondence will indicate the required action to manage a trainee's progress at that time, as presented within this policy.

4.2.2 Non-Receipt of Communication

The College will endeavour to communicate to trainees where appropriate. However, trainees are responsible for knowing the requirements of the Fellowship Program and of this policy. Non-receipt of correspondence from the College does not invalidate the trainee's obligation to adhere to the requirements it presents.

4.3 Failure to Adhere to Deadlines

4.3.1 Progress Expected

A trainee who has not passed a summative assessment component of the Fellowship Program by the deadline, as specified in the Progression through Training Policy (6.1), will be required to develop a formal remedial plan with their DOT.

4.3.2 Communication from the CFT

The College will send correspondence to the trainee with a copy to the DOT, reminding the recipients of the requirements of this policy.

- The correspondence will also provide an opportunity for the DOT to recommend in writing that the trainee receive a specified extension for the completion of the assessment (and possibly, for other assessments) for exceptional circumstances. As outlined in point 4.1.2 and 4.1.3, the DOT does not have the authority to determine when a case is exceptional or to grant an extension; this is done by the CFT on a case by case basis.

4.3.3 Remedial Plan Required

The trainee and DOT must identify a remedial plan for the attainment of the summative assessment and send the remedial plan to the College Training Department.

The College Training Department must receive the documentation within 60 days of the letter's date so that the trainee's Training Record can be updated and future correspondence is managed effectively. Further detail can be found in the Remedial Plans Policy and Procedure (X.X).

4.4 Requirement to Show Cause for Continued Failure

4.4.1 Progress Required

A trainee who has continued to fail to pass a summative assessment component of the Fellowship Program will be required to show cause to the CFT as to why they should be able to continue towards Fellowship. The deadline by which the requirement to show cause is applicable for each component is stated in the Progression through Training Policy (6.1).

4.4.2 Communication from the CFT

The College will communicate to the trainee this requirement by sending correspondence to the trainee, with a copy to the DOT. A trainee who wants to continue towards Fellowship with the College must show cause for this in writing to the CFT within 60 days of the date of correspondence.

- The correspondence will also provide an opportunity for the DOT to recommend in writing to the CFT that the trainee receive a specified amount of extra time for the completion of the assessment (and possibly, for other assessments) in exceptional cases.

4.4.3 Show Cause to the CFT

The trainee must show cause in writing in order to be considered able to remain in the Fellowship Program by the CFT. The cause shown should include any relevant reasons for the non-attainment of the competency by the mandatory deadline and any mitigating circumstances and an educational plan to pass the assessment by a specified time.

The CFT must receive the cause in writing from the trainee within 60 days of the letter's sent date to enable the review and consideration process to commence. The CFT will consider all relevant information provided.

4.4.4 CFT Considers Any Cause Shown

The CFT will consider any cause shown in writing from the trainee. The CFT will then make a recommendation as to whether a trainee has failed to progress or not, based on the relevant information provided, assessment and progression evidence and any cause shown.

The CFT may determine that the trainee has not failed to progress, and will work with the trainee and the relevant DOT to develop an educational plan to assist the trainee in successfully completing the competencies within determined time requirements, thereby returning the trainee to the trajectory towards Fellowship.

The CFT may make the recommendation that the trainee has failed to progress, and will forward their recommendation for the trainee to be exited from the Fellowship Program to the FAC for review.

4.4.5 Fellowship Attainment Committee Review

The FAC will review the recommendation of the CFT that a trainee has failed to progress in the Fellowship Program and should be exited from the program.

The FAC will forward its recommendation in accordance with the usual committee reporting structure as to whether the FAC upholds the CFT recommendation and recommends the application of the Exit from Training Policy to the trainee, or the FAC opposes the CFT recommendation. If the FAC opposes the CFT recommendation that the trainee has failed to progress, the FAC will recommend that the CFT is directed to work with the DOT and trainee to develop a plan to return the trainee to the trajectory towards Fellowship by a specified time.

4.5 Other Failures to Progress

4.5.1 Three or More Fails of the Same Assessment

After three failed attempts of any summative assessment component, regardless of timing, the requirements in point 4.4 above will be followed.

The trainee must show cause in writing to the CFT as to why they should be able to continue towards Fellowship, even if the trainee is within the timeframes mandated for the component(s) on the Trainee Progress Trajectory.

4.5.2 Break-in-Training

After a 2-year continuous break-in-training, a trainee's DOT may determine that the trainee requires additional formative assessments/training. The College must be informed of this decision.

If a trainee does not complete any additional formative assessments/training required by their DOT after a break-in-training of 2 years or more, if a trainee does not return from a break-in-training as scheduled and is not contactable for 6 calendar months, or if a trainee's total break-in-training time is greater than 5 years, the process in point 4.4 above will be followed. The trainee must show cause in writing to the CFT as to why they should be able to continue towards Fellowship.

4.5.3 Trainees not Allocated to a Program

If a trainee not allocated to a training program as per the Failure to Progress Procedure, the process in point 4.4 above will be followed. The trainee must show cause in writing to the CFT as to why they should be able to continue towards Fellowship even though they are no longer in contact with a training program.

4.5.4 Training Maximum

A trainee who is still not eligible for Fellowship after 13 years (calendar time) in the Fellowship Program, including any breaks-in-training or part-time training, must adhere to the process in point 4.4 above. The trainee must show cause in writing to the CFT as to why they should be able to continue towards Fellowship.

4.6 Review of Decisions

Any request by trainees for review of a decision in relation to Failure to Progress should follow the formal education review process (X.X) and may be subject to the RANZCP Reconsideration and Appeals Policy.

5. Monitoring, Evaluation and Review

The Board of Education (BOE) shall implement, monitor and review the policy and report on anomalies and issues as these arise.

This policy will be reviewed biennially and updated as required.

6. Definitions and Abbreviations

BOE	The College Board of Education
Break-in-training	A trainee's College-approved interruption to training, which includes the required break-in-training fee to maintain their training record.
College	The Royal Australian and New Zealand College of Psychiatrists
Deadline	The mandatory completion date for a specific component of the Fellowship Program as stated in the Progression through Training Policy.
Decision	Any direction, affirmation or registration of opinion, in response to a request for special consideration, in which a decision is intended to, or does affect, the progression of a candidate pursuant to the Regulations.
DOT	Director of Training. Also applicable to Director of Advanced Training within the context of this policy.
Trainee Progress Trajectory	See Associated Documents
Failure to Progress	The process that manages the identification, support and, potentially, the exit of underperforming and/or non-progressing trainees from the Fellowship Program.
Fellowship Competencies	Fellowship Competencies outline the College's understanding of psychiatry in Australia and New Zealand through the CanMEDS roles, and state the demonstrable endpoint competencies for all trainees engaged in attaining Fellowship of the College.
ITA	In-Training Assessment: formative and summative assessment components of the Fellowship Program.
Remediation	A process in which trainees who have not successfully completed program requirements are assisted, counselled, supported and monitored through the completion of remedial plans.
show cause	The process by which a trainee must provide written support for their case to continue in the Fellowship Program to the CFT.
stage	Training under the RANZCP Fellowship Regulations 2012 will fall into three Stages (Stage 1, Stage 2 and Stage 3), which can be defined as basic, proficient and advanced training.
Training Agreement	The agreement that the trainee must make with the College Headquarters upon enrolment in the Fellowship Program.
Training Record	The official record kept at the College Headquarters of a trainee's progress on all required components of the Fellowship Program.

7. Associated Documents

7.1 Regulation: 6.1 Progression through the Stages of Training Education Training Regulation
19.1 Failure to Progress Education Training Regulation

7.2 Policy: 6.1 Progression through the Stages of Training Education Training Policy
X.X Remedial Plans Education Training Policy
19.2 Exit from Training Education Training Policy

7.3 Procedure: 6.1 Progression through the Stages of Training Education Training Procedure
19.1 Failure to Progress Education Training Procedure
X.X Remedial Plans Education Training Procedure
19.2 Exit from Training Education Training Procedure

7.4 Forms : Correspondence Templates
Remedial Plan Form
Show Cause to CFT Form

7.5 Other: Trainee Progress Trajectory

DOCUMENT CONTROL

Responsible department: Education	Responsible position: Senior Policy Officer	Version: 0.9
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REVISION RECORD

Date	Version	Revision description