The Royal Australian & New Zealand College of Psychiatrists

2012 Fellowship Program

EPA Handbook

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

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Document version history

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v0.4	Approved EPA added: ST2-PSY-EPA4.	21/01/13
v0.3	Approved EPAs added: ST2-EXP-EPA5; ST2-CAP-EPA1; ST2-CAP-EPA2; ST2-PSY-EPA1; ST2-PSY-EPA2; ST2-PSY-EPA3; ST2-AP-EPA1; ST2-INDAU-EPA2. Amendments made to EPAs: ST2-ADD-EPA1; ST2-ADD-EPA2; ST2-POA-EPA1; ST2-INDAU-EPA1.	21/11/12
v0.2	Approved EPAs added: ST1-GEN-EPA1, ST2-EXP-EPA2, ST2-ADD-EPA1, ST2-POA-EPA1, ST2-AP-EPA2, ST2-INDAU-EPA1. Amendments made to EPAs: ST1-GEN-EPA2, ST1-GEN-EPA3, ST1-GEN-EPA4.	02/08/12
v0.1	First version of EPA Handbook published on CBFP website.	21/05/12

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Preamble

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

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

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

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

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

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

Standard

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

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

Which EPAs and how many?

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

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

Stage 1

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

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

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

Stage 2

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

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

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

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

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

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

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

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

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

Psychotherapy EPAs

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

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

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

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

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

Stage 3

Stage 3 EPAs are currently in development.

Entrustment process

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

The Fellowship Program uses four WBA tools:

- Case-based discussion (CbD)
- Mini-Clinical Evaluation Exercise
- Observed Clinical Activity (OCA)

- Professional presentation.

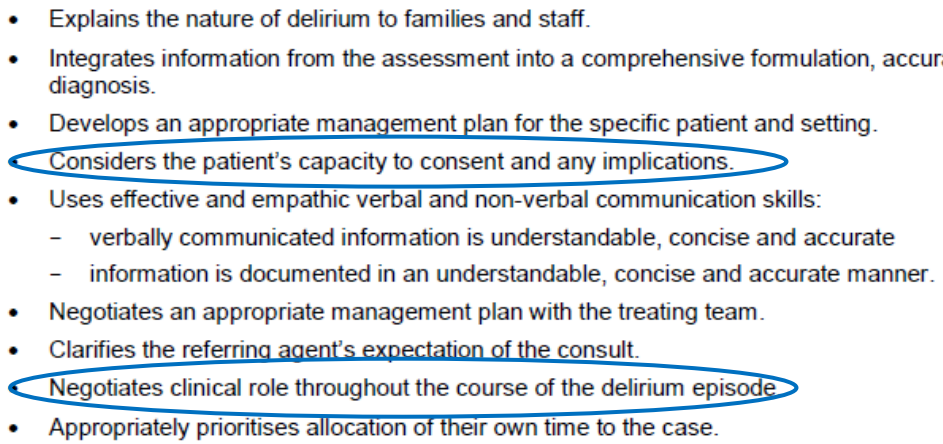
WBAs and EPAs

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

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

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

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



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

Who can entrust an EPA?

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

Rural settings

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

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

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

Confirmation of Entrustment form

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

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

Reference

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

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

Area of practice	*EPA number*	*Title*
Stage 1 EPAs		
Adult psychiatry 12 months adult psychiatry training, 6 months in an acute setting.	ST1-GEN-EPA1	Producing discharge summaries and organising appropriate transfer of care. **No longer required*.**
	ST1-GEN-EPA2	Initiating an antipsychotic medication in a patient with schizophrenia. **Not required for trainees commencing training from mid-2014. Trainees who commenced prior to this date, read below†.**
	ST1-GEN-EPA3	Active contribution to the multidisciplinary team meeting. **No longer required*.**
	ST1-GEN-EPA4	Communicating with a family about a young adult's major mental illness. **Not required for trainees commencing training from mid-2014. Trainees who commenced prior to this date, read below‡.**
	ST1-GEN-EPA5 *(New)*	Use of an antipsychotic medication in a patient with schizophrenia/psychosis.
	ST1-GEN-EPA6 *(New)*	Providing psychoeducation to a patient and their family and/or carers about a major mental illness.
Stage 2 general psychiatry EPAs – may be entrusted during Stage 1, must be entrusted by the end of Stage 2		
General psychiatry Mandatory EPAs to be attained by the end of Stage 2. These general psychiatry EPAs may be attained in any area of practice rotation during Stage 1 or Stage 2 and will be assessed at a proficient (Stage 2) standard.	ST2-EXP-EPA1	Demonstrating proficiency in all the expected tasks associated with prescription, administration and monitoring of ECT.
	ST2-EXP-EPA2	The application and use of the Mental Health Act.
	ST2-EXP-EPA3	Assessment and management of risk of harm to self and others.
	ST2-EXP-EPA4	The safe and effective use of clozapine in psychiatry. **Not required for trainees commencing training from mid-2014. Trainees who commenced prior to this date, read below†.**
	ST2-EXP-EPA5	Assess and manage adults with cultural and linguistic diversity.

Area of practice	*EPA number*	*Title*
Psychotherapy EPAs – may be entrusted during Stage 1		
Psychotherapy	ST2-PSY-EPA1	The provision of psychoeducation in a formal interactive session. **Not required for trainees commencing training from mid-2014. Trainees who commenced prior to this date, read below[‡].**
Trainees must attain two (of three) EPAs by the end of Stage 2: • Therapeutic alliance (EPA2) • Supportive psychotherapy (EPA3) • CBT: Anxiety management (EPA4) The remaining EPA must be attained by the end of Stage 3. These EPAs may be attained in any area of practice rotation and will be assessed at a proficient (Stage 2) standard.	ST2-PSY-EPA2	Psychodynamically informed patient encounters and managing the therapeutic alliance.
	ST2-PSY-EPA3	Supportive psychotherapy.
	ST2-PSY-EPA4	Cognitive–behavioural therapy (CBT) for management of anxiety.
Stage 2 EPAs		
Child and adolescent psychiatry Mandatory rotation, must complete associated EPAs.	ST2-CAP-EPA1	Develop a management plan for an adolescent where school attendance is at risk.
	ST2-CAP-EPA2	Clinical assessment of a prepubertal child.
Consultation–liaison psychiatry Mandatory rotation, must complete associated EPAs.	ST2-CL-EPA1	Care for a patient with delirium.
	ST2-CL-EPA2	Manage clinically significant psychological distress in the context of the patient's medical illness in the general hospital.
Addiction psychiatry Elective rotation. Mandatory EPAs, may be attained in any rotation.	ST2-ADD-EPA1	Management of substance intoxication and substance withdrawal.
	ST2-ADD-EPA2	Comorbid mental health and substance use problems.
Psychiatry of old age Elective rotation. Mandatory EPAs, may be attained in any rotation.	ST2-POA-EPA1	Behavioural and psychological symptoms in dementia (BPSD).
	ST2-POA-EPA2	The appropriate use of antidepressants and antipsychotics in patients aged 75 years and over (or under 75 with excessive frailty).

Area of practice	*EPA number*	*Title*
Adult psychiatry Elective rotation – if undertaken, must complete associated EPAs.	ST2-AP-EPA1	Assess treatment-refractory psychiatric disorders.
	ST2-AP-EPA2	Physical comorbidity.
Forensic psychiatry Elective rotation – if undertaken, must complete associated EPAs.	ST2-FP-EPA1	Violence risk assessment and management.
	ST2-FP-EPA2	Expert evidence.
Indigenous mental health – Australia Elective rotation – if undertaken, must complete associated EPAs.	ST2-INDAU-EPA1	Interviewing an Aboriginal or Torres Strait Islander patient.
	ST2-INDAU-EPA2	Develop a mental healthcare management plan for an Aboriginal or Torres Strait Islander patient.
Indigenous mental health – New Zealand Elective rotation – if undertaken, must complete associated EPAs.	ST2-INDNZ-EPA1	Interviewing a Māori patient.
	ST2-INDNZ-EPA2	Develop a mental healthcare management and recovery plan for a Māori patient.

*Trainees are **no longer required** to achieve ST1-GEN-EPA1 (Discharge and transfer of care) and ST1-GEN-EPA3 (Team meeting) in order to complete Stage 1. Trainees who have already attained either/both of the EPAs will continue to have them reflected on their training record.

†Trainees who have attained **both** ST1-GEN-EPA2 (Initiating an antipsychotic) **and** ST2-EXP-EPA4 (Clozapine), are **not required** to attain ST1-GEN-EPA5 (Antipsychotic use).

Trainees who have **not yet attained** either ST1-GEN-EPA2 or ST2-EXP-EPA4, **must** attain ST1-GEN-EPA5.

Trainees who have attained **either** ST1-GEN-EPA2 or ST2-EXP-EPA4, **must attain either** ST1-GEN-EPA5 **or** the EPA not yet attained.

‡Trainees who have attained **both** ST1-GEN-EPA4 (Communicating with a family) **and** ST2-PSY-EPA1 (Psychoeducation), are **not required** to attain ST1-GEN-EPA6 (Providing psychoeducation).

Trainees who have **not yet attained** either ST1-GEN-EPA4 or ST2-PSY-EPA1, **must** attain ST1-GEN-EPA6.

Trainees who have attained **either** ST1-GEN-EPA4 or ST2-PSY-EPA1, **must attain either** ST1-GEN-EPA6 **or** the EPA not yet attained.

For the detailed EPA requirements, please see the EPA Policy and Procedure available on the** Regulations, policies and procedures **page of the RANZCP website.

The Royal Australian & New Zealand College of Psychiatrists

CONFIRMATION OF ENTRUSTMENT FORM

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

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

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

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

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

Supervisor Name (print) ……

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

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

Supervisor Name (print) ……

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

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

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

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

Director of Training Name (print) ……

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

Stage 1 EPAs – mandatory

Adult psychiatry

ST1-GEN-EPA1 – Discharge and transfer of care (No longer required)

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

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

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

	• Demonstrates knowledge of range of follow-up and community services. • Understands the importance of clinical records in communication. **Skills** • Uses effective and timely verbal and written communication (including electronic communication where appropriate). • Grasps and formulates the essentials of the case and the treatment plan including relapse-prevention and risk-management plans. • Communicates key points of decision making. • Communicates and collaborates effectively with patients and families/carers in organising transfer of care. • Uses tact where required, avoids pejorative language. • Appropriately considers privacy issues and consent. **Attitude** • Willingness to supplement with verbal communication (eg. by phone) when required. • Exhibits a patient-centred approach to care. • Demonstrates willingness to include all appropriate stakeholders in the transfer of care process. • Appropriate respect for the patient, other members of the multidisciplinary team, patient supports and their views.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion.

References

THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS. *Communication between psychiatrists, medical practitioners and other healthcare providers*. Melbourne: RANZCP, 2009. Viewed 24 February 2012, <www.ranzcp.org>.

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

ST1-GEN-EPA2 – Initiating an antipsychotic (Check rules)

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

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

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

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

References

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

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

THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS. *Position statement #37: Policy on mental health services*. Melbourne: RANZCP, 1997. Viewed 24 February 2012, <www.ranzcp.org>.

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

ST1-GEN-EPA3 – Team meeting (No longer required)

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

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

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

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

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

ST1-GEN-EPA4 – Communicating with a family (Check rules)

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

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

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

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

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

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

Ability to apply an adequate knowledge base

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

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

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

ST1-GEN-EPA5 – Antipsychotic use (New)

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

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

Title	***Use of an antipsychotic medication in a patient with schizophrenia/psychosis.***
Description Maximum 150 words	The trainee understands the role and use of antipsychotics, including clozapine, their risks, benefits and alternatives. They are aware of the common and potentially serious side effects, their detection and appropriate management. The trainee adheres to the protocols, documentary and administrative obligations and other aspects of safe initiation, monitoring and treatment. The trainee can engage where possible with the patient, obtaining consent as far as possible, can listen and respond to the patient's concerns and provide explanations in a clear manner. They are aware of the factors that may contribute to non-adherence and those that may improve treatment adherence. They have a respectful and professional attitude towards the patient and other members of the multidisciplinary team.

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

Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Positive and negative symptoms and cognitive deficits in schizophrenia, the current dominant hypotheses for schizophrenia and their mechanisms. • The antipsychotic effect and other effects of these drugs on thinking and behaviour. • The common time period for the onset of the full antipsychotic effect and issues surrounding polypharmacy. • Pharmacology of antipsychotics and drug interactions. • Knowledge of protocols, safe monitoring and side effects (eg. EPSE and metabolic syndrome), including life-threatening side effects (eg. myocarditis, agranulocytosis). Knows how to respond to problems and will appropriately seek

	assistance. • Factors other than non-adherence that can initiate or maintain a relapse, eg. high expressed emotion, illicit drugs, drug interactions (eg. smoking with clozapine and olanzapine). • Understands options for mode of delivery of antipsychotic treatment, eg. oral/injectable (depot). • The concept of a biopsychosocial approach to treatment. • Issues of informed consent in the chronically mentally ill, ethical issues. **Skills** • Physical and mental state assessment. • Adapts approach to fit the patient's personal and cultural background, mental state and diagnosis. • Establishes rapport, involves patient and where appropriate support network in decision making, risk–benefit analysis and incorporates patient aims in the treatment plan. • Applies the biopsychosocial model in formulation and management including patients with treatment resistance. • Assesses and manages side effects. • Able to give explanations in a way that is understandable and meaningful. • Clear and respectful communication with other staff, both written and verbal. Clear, legible documentation. • Manages discontinuation and recommencement. • Able to manage acute and longer-term treatment. • Applies the principles of rehabilitation psychiatry. **Attitude** • Professional approach to patient and others including respect for the views of the patient and others. • Willingness to learn from others involved in the patient's care.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	One WBA could focus on clozapine. • Case-based discussion. • Mini-Clinical Evaluation Exercise.
References ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS CLINICAL PRACTICE GUIDELINES TEAM FOR THE TREATMENT OF SCHIZOPHRENIA AND RELATED DISORDERS. *Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the treatment of schizophrenia and related disorders*. Aust NZ J Psychiatry 2005; 39:1–30.	

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

ST1-GEN-EPA6 – Providing psychoeducation (New)

Area of practice	Adult psychiatry	***EPA identification***	ST1-GEN-EPA6
Stage of training	Stage 1 – Basic	***Version***	v0.2 (EC-approved 14/03/14)

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

Title	***Providing psychoeducation to a patient and their family and/or carers about a major mental illness.***
Description Maximum 150 words	The trainee can provide evidence-based, understandable and relevant information on the nature of a condition, its treatment(s), rehabilitation and recovery that addresses the needs of the patient and their family and/or carers. They are able to establish rapport, listen to and deal empathically with concerns and misconceptions. The trainee can be tactful, sensitive to the possible impact of what they say, and understand the impact of stress or illness on the ability to take in information. They are aware of the phases of grief and coping strategies. The trainee is able to handle the ethical and legal issues around consent, patient autonomy and confidentiality and they have a respectful and professional approach to the patient and their family/carers.

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

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

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

Ability to apply an adequate knowledge base

- The principles and aims of psychoeducation.
- Diagnosis, treatment and course of major mental illness, including individual variability and uncertainty.
- Coping strategies, phases of grief and adjustment.
- The benefit of information in improving compliance and engagement, coping, empowering patients, supporting patients and carers, normalising where appropriate and reducing stigma.
- Principles of recovery-oriented practice.
- Local resources for the patient and family/carers.

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

References

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

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

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

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

Stage 2 EPAs – mandatory

General psychiatry

ST2-EXP-EPA1 – Electroconvulsive therapy (ECT)

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

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

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

	• Issues of concurrent medications. • Adverse events, physiological changes during ECT, memory changes. • Role of anaesthetist, all aspects of anaesthesia pertinent to the psychiatrist. • Physical monitoring (examples may include muscle relaxation, pre-Deep Tendon Knee Reflex [DTKR], fasciculation). • Equipment. • Knowledge of dosing protocols, titration procedures and procedures for different electrode placements. • Markers of seizure adequacy. • How stigma and history can impact on the acceptance of ECT for the patient and others. **Skills** *General* • Interactions with patients, carers, staff/liaison with anaesthetic staff. • Ability to obtain informed consent/sufficient information from patient/carer if involuntary treatment and where feasible. • Communication with other staff involved with the patient, clear documentation. *Technical* • ECT technique. • Familiar with the use of equipment, airways, mouth guards, ECT machine. • Determining dose/charge. • Thorough knowledge of EEG monitoring. • Cuff monitoring or similar if or as required. • Set dose/charge. • Skin preparation, testing impedance. • Lead placement (examples may include EEG and ECG, treatment leads). **Attitude** • Ethical and professional approach to patient, carers and other staff.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion. • Mini-Clinical Evaluation Exercise. • Feedback from appropriate sources.

	• Supervision during ECT sessions. Confidence the trainee has received sufficient training in ECT.

References

ROYAL COLLEGE OF PSYCHIATRISTS. *The ECT handbook: the third report of the Royal College of Psychiatrists' special committee on ECT*. London: RCPsych, January 2004. Viewed 15 February 2011, <www.rcpsych.ac.uk>.

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

THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS. *Clinical memorandum #12: Electroconvulsive therapy*. Melbourne: RANZCP, February 2007. Viewed 15 February 2011, <www.ranzcp.org>.

THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS. *Clinical memorandum #18: Transcranial Magnetic Stimulation*. Melbourne: RANZCP, February 2008. Viewed 15 February 2011, <www.ranzcp.org>.

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

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

ST2-EXP-EPA2 – Mental Health Act

Area of practice	General psychiatry	***EPA identification***	ST2-EXP-EPA2
Stage of training	Stage 2 – Proficient	***Version***	v0.9 (BOE-approved 12/07/12)

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

Title	***The application and use of the Mental Health Act.***			
Description Maximum 150 words	The trainee can apply the provisions of the relevant Mental Health Act to deliver quality psychiatric care. The trainee provides explanations to patients and their carers, engages them where possible and deals with their concerns. They comply with documentary and administrative obligations. The trainee is aware of the factors which justify involuntary care under the local Mental Health Act, including the principle that involuntary care must contribute to treatment of mental illness and consequent improvements in autonomy. The trainee seeks to optimise the autonomy of patients receiving involuntary care and promotes pathways to less restrictive care.			
Fellowship competencies	**ME**	1, 2, 3, 4, 5, 8	**HA**	1, 2
	COM	1, 2	**SCH**	2
	COL	1, 2, 3, 4	**PROF**	1, 2, 3
	MAN	2, 5		
Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • History of mental health legislation. • Psychiatry as an agent of society. • Mental Health Act and its procedure and principles. • Ethical principles of autonomy, freedom from coercion and duty of care to the patient and the community. • Common psychiatric conditions and their treatment. • Awareness of legal and societal consequences of enforced treatment including consideration of stigma. **Skills**			

	• Risk assessment (with risk of harm to self considering self-harm, neglect, exploitation, damage to relationships and reputation; risk of harm to others considering the patient's context and the presence of children) including risk–benefit analysis of enforcing treatment. • Conflict resolution and ability to negotiate and compromise. • Communication and collaboration with the patient, family and others as necessary, eg. police, emergency services. • Ability to prepare reports and appear before relevant bodies as required by the legislation. **Attitude** • Commitment to providing treatment in the least restrictive setting. • An appropriate regard for the hazards associated with involuntary care and the harms associated with coercive care. • Professional approach to patient and others.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion. • Mini–Clinical Evaluation Exercise. • Professional presentation.
References THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS. *Code of Ethics*. Melbourne: RANZCP, 2009.	

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

ST2-EXP-EPA3 – Risk assessment

Area of practice	General psychiatry	***EPA identification***	ST2-EXP-EPA3
Stage of training	Stage 2 – Proficient	***Version***	v0.5 (BOE-approved 04/05/12)

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

Title	***Assessment and management of risk of harm to self and others.***			
Description Maximum 150 words	The trainee can undertake a systematic assessment of the risk of harm to self and others posed by a patient. They can formulate and communicate an appropriate management plan that addresses such risks.			
Fellowship competencies	**ME**	1, 2, 3, 4, 5, 7, 8	**HA**	2
	COM	1, 2	**SCH**	
	COL	4	**PROF**	1, 2, 3
	MAN	4		

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

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

Ability to apply an adequate knowledge base

- Knowledge of evidence-based static and dynamic risk and protective factors for both 'harm to self' (including suicide) and 'harm to others'.
- Knowledge of appropriate biopsychosocial interventions to enhance protective, and minimise risk, factors.
- Awareness of the strengths and limitations of different approaches to assessing risk including: unstructured clinical, actuarial and structured professional judgment approaches.
- Relevant statistical concepts including: sensitivity, specificity, positive predictive value, negative predictive value, 'numbers needed to treat' applied to risk reduction, base rates and ROC Analysis.
- Key legal constructs including standard of care, duty of care.
- High-risk periods for suicide and for harm to others (eg. soon after discharge, early in course of ECT).
- Basic principles of ethical and legal obligations.

Skills

- Formulate an assessment of risk of harm to self and others, including a consideration of evidence-based risk and

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

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

ST2-EXP-EPA4 – Clozapine (Check rules)

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

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

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

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

References

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

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

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

ST2-EXP-EPA5 – Cultural awareness

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

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

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

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

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

	- cultural factors related to psychosocial environment and the impact of cultural factors and expectations on functioning - the relationship between the clinician and the patient. • Understands the distinction between culturally sanctioned beliefs and psychopathology. • Understands the impact of cultural values on recovery-oriented mental healthcare including biological interventions and psychosocial rehabilitation. **Skills** • Able to effectively utilise interpreters in psychiatric interviews. • Adapts approach to psychiatric interview and intervention in a culturally sensitive manner. • Interacts with patients and their families and carers in a manner that is respectful of their cultural values. • Acknowledges the impact of bilateral cultural factors in the interaction between the patient and clinician. • Able to incorporate identified cultural beliefs, values and formulation into management. **Attitude** • Motivated to remain culturally sensitive in approach and interaction with patients, families and carers. • Willingness to be respectful of cultural diversity. • Willingness to learn from cultural advisors and patients from CALD backgrounds about their worldview and health beliefs.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion. • Observed clinical activity (OCA) – where a cultural advisor or language interpreter is present. • Review of a brief written cultural formulation.

References

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

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

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

Psychotherapy

ST2-PSY-EPA1 – Psychoeducation (Check rules)

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

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

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

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

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

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

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

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

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

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

ST2-PSY-EPA2 – Therapeutic alliance

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

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

Title	***Psychodynamically informed patient encounters and managing the therapeutic alliance.***			
Description Maximum 150 words	The trainee can create and manage a therapeutic alliance with patients including those who are challenging or resistant. The trainee will be able to recognise points of conflict and disjunction and take steps to repair these. These steps will be informed by a familiarity with the evidence base in managing the therapeutic alliance.			
Fellowship competencies	**ME**	5	**HA**	
	COM	1	**SCH**	1,
	COL	1, 2	**PROF**	1, 2, 3
	MAN			

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

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

Ability to apply an adequate knowledge base

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

Skills

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

References

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

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

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

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

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

ST2-PSY-EPA3 – Supportive psychotherapy

Area of practice	Psychotherapy	***EPA identification***	ST2-PSY-EPA3
Stage of training	Stage 2 – Proficient	***Version***	v0.3 (BOE-approved 08/11/12)

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

Title	***Supportive psychotherapy.***
Description Maximum 150 words	The trainee is able to see a patient in a dyadic treatment and use direct measures to ameliorate symptoms and maintain, restore or improve self-esteem, ego functions and adaptive skills. They can develop and implement a psychotherapeutic treatment plan within a comprehensive treatment plan, when required. This includes determining which form of therapy would be suitable for the patient's needs and awareness of the resources available. The trainee is able to adapt their treatment to the needs of the patient and, where appropriate, incorporate other techniques (eg. techniques borrowed or modified from cognitive–behavioural therapy [CBT], analytic approaches or others) within the underlying supportive approach. The trainee understands the term therapeutic alliance and how to bolster this.

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

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

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

Ability to apply an adequate knowledge base

- The principle objectives of supportive psychotherapy – to maintain or improve the patient's self esteem, ameliorate or prevent recurrence of symptoms, improve psychological or ego functioning and enhance adaptive capacities.
- Understands that the practice of supportive psychotherapy is used in many therapeutic encounters.
- The paramount importance of the patient–therapist relationship.
- Indications and contraindications for supportive psychotherapy including grief, bereavement.

Skills

- Establishes and maintains a positive therapeutic alliance and interacts with the patient in an empathic, respectful, direct,

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

References

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

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

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

ST2-PSY-EPA4 – CBT: Anxiety management

Area of practice	Psychotherapy	***EPA identification***	ST2-PSY-EPA4
Stage of training	Stage 2 – Proficient	***Version***	v0.3 (BOE-approved 10/01/13)

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

Title	***Cognitive–behavioural therapy (CBT) for management of anxiety.***			
Description Maximum 150 words	The trainee can manage anxiety in general adult psychiatric patients. The trainee demonstrates an ability to assess anxiety and employ basic management skills such as psychoeducation, structured problem solving and de-arousal strategies to a proficient level.			
Fellowship competencies	**ME**	1, 3, 4, 5, 6, 7	**HA**	
	COM	1, 2	**SCH**	2
	COL	1, 2	**PROF**	1, 3
	MAN			

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

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

Ability to apply an adequate knowledge base

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

Skills

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

	• Use of that collaborative understanding of maintaining cycles to identify targeted interventions to break the cycle. These may include: cognitive challenging, mindfulness, graded exposure, exposure and response prevention, etc. • Implement basic management strategies such as relaxation training, basic cognitive challenging and structured problem solving. • Identify the need, and make appropriate referrals, for expert provision of more advanced CBT strategies. **Attitude** • Working as a co-therapist with the patient as their own therapeutic agent. • Scientist practitioner.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Mini-Clinical Evaluation Exercise. • Case-based discussion. • Observe use of Socratic questioning (including by means of audio or video recordings). • Review written cognitive–behavioural formulations, provision of specific treatment interventions and assess impact on patient's treatment goals, ensure that need for referral for more targeted treatment or provision of advanced strategies is considered. • Supervisor may consider use of assessment tools such as the Cognitive Therapy Formulation Scale (CFRS), Revised Cognitive Therapy Scale (CTS-R) or Cognitive Therapy Awareness Scale (CTAS) when reviewing casework, written formulations/treatment planning or observing clinical activities.

References

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

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

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

For supervisors (including assistance in assessing competence):

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

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

Child and adolescent psychiatry

ST2-CAP-EPA1 – Manage an adolescent

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

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

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

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

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

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

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

ST2-CAP-EPA2 – Prepubertal child

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

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

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

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

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

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

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

Consultation–liaison psychiatry

ST2-CL-EPA1 – Delirium

<table>
<tr><td>Area of practice</td><td colspan="2">Consultation–Liaison psychiatry</td><td>EPA identification</td><td colspan="2">ST2-CL-EPA1</td></tr>
<tr><td>Stage of training</td><td colspan="2">Stage 2 – Proficient</td><td>Version</td><td colspan="2">v0.4 (BOE-approved 04/05/12)</td></tr>
<tr><td colspan="6">The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.</td></tr>
<tr><td>Title</td><td colspan="5">Care for a patient with delirium.</td></tr>
<tr><td>Description
Maximum 150 words</td><td colspan="5">The trainee can assess, make an accurate diagnosis, conduct appropriate physical and cognitive assessment and describe the evidence for the use of a specific management strategy. They are able to communicate the concept of delirium to patients and families within the general hospital setting. The trainee demonstrates awareness of challenges posed by a consultative model of care provision where a patient is not under the direct care of the psychiatrist.</td></tr>
<tr><td rowspan="5">Fellowship competencies</td><td>ME</td><td>1, 2, 3, 4, 5, 6, 7, 8</td><td>HA</td><td colspan="2">1</td></tr>
<tr><td>COM</td><td>1, 2</td><td>SCH</td><td colspan="2">1, 2</td></tr>
<tr><td>COL</td><td>1, 2, 3, 4</td><td>PROF</td><td colspan="2">1, 2, 3, 4</td></tr>
<tr><td>MAN</td><td>4, 5</td><td colspan="3"></td></tr>
<tr><td></td><td colspan="5"></td></tr>
<tr><td>Knowledge, skills and attitude required
The following lists are neither exhaustive nor prescriptive.</td><td colspan="5">Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.
Ability to apply an adequate knowledge base
• Considers appropriate use of mental health and other relevant legal frameworks.
• Understands additional resources, eg. special nurses, out-of-hours psychiatry review.
• Understands most suitable setting for patient care.
• Accesses, appraises and applies best level of evidence.
Skills
• Comprehensive assessment, including:
- appropriate cognitive tests
- laboratory/relevant investigations</td></tr>
</table>

	- collateral history - medication review. • Explains the nature of delirium to families and staff. • Integrates information from the assessment into a comprehensive formulation, accurate diagnosis and differential diagnosis. • Develops an appropriate management plan for the specific patient and setting. • Considers the patient's capacity to consent and any implications. • Uses effective and empathic verbal and non-verbal communication skills: - verbally communicated information is understandable, concise and accurate - information is documented in an understandable, concise and accurate manner. • Negotiates an appropriate management plan with the treating team. • Clarifies the referring agent's expectation of the consult. • Negotiates clinical role throughout the course of the delirium episode. • Appropriately prioritises allocation of their own time to the case. • Identifies possible stigma surrounding delirium. • Demonstrates effective conflict resolution skills, as needed. **Attitude** • Models and encourages a non-judgemental approach to the patient. • Takes on teaching opportunities as they arise in the case. • Treats the patient and referring team with respect. • Seeks appropriate supervision.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion. • Mini-Clinical Evaluation Exercise. • Direct observation. • Feedback from appropriate sources.
References	

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

ST2-CL-EPA2 – Psychological distress

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

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

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

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

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

Ability to apply an adequate knowledge base

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

Skills

- Explains the nature of psychological distress and its origins to patients, families and staff and engages the relevant persons in a negotiated management plan.

	• Exercises good judgement in the allocation of resources for the optimal care of the patient, family and ward milieu. • Comprehensive assessment, including consideration of: - premorbid psychological functioning - social and cultural setting - prognosis - loss - normal/abnormal illness behaviour - physiological disturbance. • Integrates information from the assessment into a comprehensive formulation, accurate diagnosis and differential diagnosis. • Develops an appropriate management plan for the specific patient and setting. • Uses effective and empathic verbal and non-verbal communication skills: - verbally communicated information is understandable, concise and accurate - information is documented in a sensitive, understandable, concise and accurate manner. • Negotiates an appropriate management plan with the treating team. • Clarifies the referring agent's expectation of the consult. • Negotiates clinical role throughout the course of the treatment episode. • Appropriately prioritises allocation of their own time to the case. • Identifies possible stigma surrounding psychological distress. • Advocates for the adequate provision of health information to the patient and family. • Recognises any abnormal treatment behaviour. • Proposes strategies for resolving disputes/disagreement. **Attitude** • Models and encourages a non-judgemental approach to patients, including patients with previous mental illness and/or personality disorder.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion. • Mini-Clinical Evaluation Exercise. • Direct observation.

	• Feedback from appropriate sources.
References	

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

Addiction psychiatry

ST2-ADD-EPA1 – Intoxication and withdrawal

<table>
<tr><td>Area of practice</td><td colspan="2">Addiction psychiatry</td><td>EPA identification</td><td colspan="2">ST2-ADD-EPA1</td></tr>
<tr><td>Stage of training</td><td colspan="2">Stage 2 – Proficient</td><td>Version</td><td colspan="2">v0.10 (BOE-approved 15/10/12)</td></tr>
<tr><td colspan="6">The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.</td></tr>
<tr><td>Title</td><td colspan="5">Management of substance intoxication and substance withdrawal.</td></tr>
<tr><td>Description
Maximum 150 words</td><td colspan="5">The trainee can assess substance intoxication and substance withdrawal and effectively and safely manage these conditions. The trainee demonstrates an ability to identify critical concepts in the medical emergency management of intoxication and is able to plan a withdrawal regimen from the relevant substance(s). This involves assessment (psychiatric and medical), initiation of psychotropic medications within safe limits to facilitate supported withdrawal to completion of detoxification and arrangement of appropriate follow-up.</td></tr>
<tr><td rowspan="4">Fellowship competencies</td><td>ME</td><td>1, 2, 3, 4, 5, 6, 7</td><td>HA</td><td colspan="2"></td></tr>
<tr><td>COM</td><td>1, 2</td><td>SCH</td><td colspan="2"></td></tr>
<tr><td>COL</td><td>1, 2, 3</td><td>PROF</td><td colspan="2">1, 2</td></tr>
<tr><td>MAN</td><td></td><td colspan="3"></td></tr>
<tr><td>Knowledge, skills and attitude required
The following lists are neither exhaustive nor prescriptive.</td><td colspan="5">Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.
Ability to apply an adequate knowledge base
• Knowledge of medical complications associated with intoxication from common substances including alcohol, cannabis, benzodiazepines, caffeine, psychostimulants and opioids.
• Knowledge of appropriate medical management to reduce risk of harm.
• Knowledge of commonly utilised protocols for managing detoxification from alcohol, benzodiazepines, cannabis, nicotine, psychostimulants and opioids.
• Ability to integrate detoxification with ongoing treatment.
• Knowledge of basic pharmacology as it relates to medications utilised in withdrawal, including the potential for interaction with other medications/substances.</td></tr>
</table>

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

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

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

ST2-ADD-EPA2 – Comorbid substance use

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

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

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

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

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

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

Ability to apply an adequate knowledge base

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

Skills

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

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

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

Psychiatry of old age

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

<table>
<tr><td>Area of practice</td><td colspan="2">Psychiatry of Old Age</td><td>EPA identification</td><td>ST2-POA-EPA1</td></tr>
<tr><td>Stage of training</td><td colspan="2">Stage 2 – Proficient</td><td>Version</td><td>v0.7 (BOE-approved 12/07/12)</td></tr>
<tr><td colspan="5">The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.</td></tr>
<tr><td>Title</td><td colspan="4">Behavioural and psychological symptoms in dementia (BPSD).</td></tr>
<tr><td>Description
Maximum 150 words</td><td colspan="4">The trainee can perform a comprehensive assessment of an older person with dementia presenting with behavioural and psychological symptoms and develop a comprehensive care plan.</td></tr>
<tr><td rowspan="4">Fellowship competencies</td><td>ME</td><td>1, 2, 3, 4, 5, 6, 7, 8</td><td>HA</td><td>1</td></tr>
<tr><td>COM</td><td>1, 2</td><td>SCH</td><td>2</td></tr>
<tr><td>COL</td><td>1, 2, 3, 4</td><td>PROF</td><td>1, 2, 3</td></tr>
<tr><td>MAN</td><td>1, 2</td><td colspan="2"></td></tr>
<tr><td>Knowledge, skills and attitude required
The following lists are neither exhaustive nor prescriptive.</td><td colspan="4">Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.
Ability to apply an adequate knowledge base
• Size of the problem (epidemiology), impact on carers and services.
• Access and availability of services.
• Clinical manifestations of BPSD.
• Contributing and aetiological factors (eg. biological, psychological, social, environmental and cultural).
• Biopsychosocial treatment of BPSD (eg. identification and management of delirium, infection, pain, constipation, sensory impairment, fatigue, care needs, psychiatric symptoms, carer stress and restraint).
• Interventions for patients, family and carers, including staff of residential aged care facilities.
• Environmental approaches to management (dementia friendly unit design), role of activity, music, etc.
• Role and risk–benefit of antidepressants, antipsychotics (including in dementia with Lewy bodies and Parkinson’s dementia), mood stabilisers, sedatives, cholinesterase inhibitors. Note the poor response of some behaviours</td></tr>
</table>

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

	• Willingness to educate others either formally or informally. • Ethical principles. • Recognising when a palliative care approach is appropriate in dementia. • Person-centred care. • Recognising limitations of medications and their place within a broader treatment approach.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion. • Mini-Clinical Evaluation Exercise. • Observed Clinical Activity (OCA). • Professional presentation.
References INTERNATIONAL PSYCHOGERIATRIC ASSOCIATION. The *IPA complete guides to behavioral and psychological symptoms of dementia (BPSD): Specialists guide*. Northfield: IPA, 2012.	

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

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

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

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

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

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

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

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

Ability to apply an adequate knowledge base

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

Skills

- Assess
  - psychiatric and medical diagnoses

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

References

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

Stage 2 EPAs – elective

Adult psychiatry

ST2-AP-EPA1 –Treatment-refractory psychiatric disorders

<table>
<tr><td>Area of practice</td><td colspan="2">Adult psychiatry</td><td>EPA identification</td><td colspan="2">ST2-AP-EPA1</td></tr>
<tr><td>Stage of training</td><td colspan="2">Stage 2 – Proficient</td><td>Version</td><td colspan="2">v0.7 (BOE-approved 15/10/12)</td></tr>
<tr><td colspan="6">The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.</td></tr>
<tr><td>Title</td><td colspan="5">Assess treatment-refractory psychiatric disorders.</td></tr>
<tr><td>Description
Maximum 150 words</td><td colspan="5">The trainee can assess patients with a range of treatment-refractory psychiatric disorders (with refractory defined as the failure of at least three different pharmacological agents with each being trialled for an adequate length of time at an adequate dose). These disorders may include bipolar disorder, schizophrenia, major depression, obsessive–compulsive disorder, etc. The trainee can develop a biopsychosocial management plan for them considering detailed case review, treatment timeline, organic aetiologies, psychosocial factors, Axis II factors and second opinions.</td></tr>
<tr><td rowspan="4">Fellowship competencies</td><td>ME</td><td>1, 2, 3, 4, 5, 6, 7</td><td>HA</td><td colspan="2">1</td></tr>
<tr><td>COM</td><td>1, 2</td><td>SCH</td><td colspan="2"></td></tr>
<tr><td>COL</td><td>1, 2, 3, 4</td><td>PROF</td><td colspan="2">1</td></tr>
<tr><td>MAN</td><td>2, 4</td><td colspan="3"></td></tr>
<tr><td>Knowledge, skills and attitude required
The following lists are neither exhaustive nor prescriptive.</td><td colspan="5">Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.
Ability to apply an adequate knowledge base
• Demonstrates knowledge of biological, psychological and social factors that may render a person’s mental illness refractory to treatment.
• Demonstrates knowledge of the definitions and controversies of treatment-refractory disorders.
• Demonstrates knowledge of evidence-based interventions in treatment-refractory psychiatric disorders.
• Demonstrates knowledge of what constitutes adequate trials of treatment for treatment-refractory psychiatric disorders.</td></tr>
</table>

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

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

ST2-AP-EPA2 – Physical comorbidity

Area of practice	Adult psychiatry	***EPA identification***	ST2-AP-EPA2
Stage of training	Stage 2 – Proficient	***Version***	v0.4 (BOE-approved 12/07/12)

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

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

	effects (EPSE) and drug toxicity. **Attitude** • Acknowledge limitations of own knowledge and skill to enable appropriate referral to other medical and non-medical professionals in order to coordinate and optimise overall treatment. • Proactive in approach to detection and management of physical comorbidities and sequelae of psychiatric treatment.
Assessment method	Progressively assessed during individual and clinical supervision, including three appropriate WBAs.
Suggested assessment method details	• Case-based discussion. • Mini-Clinical Evaluation Exercise.
References	

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

Forensic psychiatry

ST2-FP-EPA1 – Violence risk assessment

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

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

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

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

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

Ability to apply an adequate knowledge base

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

Skills

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

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

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

ST2-FP-EPA2 – Expert evidence

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

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

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

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

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

Indigenous mental health – Australia

ST2-INDAU-EPA1 – Interviewing a patient

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

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

Title	***Interviewing an Aboriginal or Torres Strait Islander patient.***			
Description Maximum 150 words	The trainee can use an interview with an Aboriginal or Torres Strait Islander patient to conduct a psychiatric assessment, develop rapport and build a therapeutic alliance. They can adapt their communication style to take into account barriers to communication between a psychiatrist and an Aboriginal or Torres Strait Islander patient. The trainee is able to create a culturally safe context for the interview including use of appropriate environments and presence of appropriate supports (which may include an Aboriginal and Torres Strait Islander mental health worker). The trainee can use the interview to diminish stigma around both mental illness and government health services.			
Fellowship competencies	**ME**	1, 2, 3	**HA**	1
	COM	1	**SCH**	2
	COL	1, 2, 3	**PROF**	1, 2
	MAN			
Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Understands the concept of cultural safety. • Understands the role of an Aboriginal and Torres Strait Islander mental health worker (cultural interpreter). • Understands cultural aspects of verbal and non-verbal communication. • Understands historical knowledge and context of the patient's community and how this may impact on the patient's presentation or the manner in which they relate to the interviewer. • Knowledge of cultural belief systems including an awareness that cultural beliefs may be misunderstood as psychiatric			

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

References

THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS. *Module 1: Interviewing an Aboriginal or Torres Strait Islander patient*. Melbourne: RANZCP, October 2014. Viewed 20 November 2014, <www.ranzcp.org/Publications/E-learning>

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

ST2-INDAU-EPA2 – Management plan

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

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

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

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

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

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

THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS. *Module 2: Developing a mental health management plan for an Aboriginal or Torres Strait Islander patient*. Melbourne: RANZCP, October 2014. Viewed 20 November 2014, <www.ranzcp.org/Publications/E-learning>

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

Indigenous mental health – New Zealand

ST2-INDNZ-EPA1 – Interviewing a Māori patient

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

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

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

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

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

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

Ability to apply an adequate knowledge base

- Understand how colonisation processes have impacted on Māori cultural identity and the fragmentation of traditional customs, language and disconnection with lands and the implications this may have on presentation.
- Recognise that Māori are a heterogeneous group from different areas with different dialects and customs.
- Understand the role of the Treaty of Waitangi and the implications for Māori health and wellbeing, particularly with regard to Articles 2 and 3.
- Understand that knowing where the tangata whaiora (consumer) is from (ie. tribal area) is an important tool in engagement and forming a therapeutic alliance.
- Understand the different Māori cultural nuances of interaction in the doctor–patient relationship, eg. tāngata whaiora not making eye contact as a sign of respect or feelings of whakamā (shame)/feeling stink.

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

References

OAKLEY BROWNE MA, WELLS JE & SCOTT KM, eds. *Te Rau Hinengaro: the New Zealand mental health survey*. Wellington: Ministry of Health, 2006.

Glossary

hauora – health and wellbeing.

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

mihi – speech of greeting, acknowledgement, tribute.

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

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

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

te reo Māori – the Māori language.

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

whakatau – a welcome or welcome speeches.

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

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

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

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

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

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

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

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

Knowledge, skills and attitude required

The following lists are neither exhaustive nor prescriptive.

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

Ability to apply an adequate knowledge base

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

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

References

Glossary

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

hauora – health and wellbeing.

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

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

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

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

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

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

te reo Māori – the Māori language.

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

whakapapa – genealogy, lineage, descent.

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

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

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Stage 3 EPAs – to be developed

In development – coming soon