***ST1-GEN-EPA5 – Antipsychotic use – this one is mandatory – must do before the end of 1st year***

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|---|---|---|---|
| ***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.

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|---|---|---|---|---|
| ***Title*** | ***Use of an antipsychotic medication in a patient with schizophrenia/psychosis.*** | | | |
| ***Description*** | 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***<br>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.<br>**Ability to apply an adequate knowledge base**<br>• Positive and negative symptoms and cognitive deficits in schizophrenia, the current dominant hypotheses for schizophrenia and their mechanisms.<br>• The antipsychotic effect and other effects of these drugs on thinking and behaviour.<br>• The common time period for the onset of the full antipsychotic effect and issues surrounding polypharmacy.<br>• Pharmacology of antipsychotics and drug interactions.<br>• 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. | | | |

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|---|---|
| | • 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).<br>• Understands options for mode of delivery of antipsychotic treatment, eg. oral/injectable (depot).<br>• The concept of a biopsychosocial approach to treatment.<br>• Issues of informed consent in the chronically mentally ill, ethical issues.<br>**Skills**<br>• Physical and mental state assessment.<br>• Adapts approach to fit the patient's personal and cultural background, mental state and diagnosis.<br>• Establishes rapport, involves patient and where appropriate support network in decision making, risk–benefit analysis and incorporates patient aims in the treatment plan.<br>• Applies the biopsychosocial model in formulation and management including patients with treatment resistance.<br>• Assesses and manages side effects.<br>• Able to give explanations in a way that is understandable and meaningful.<br>• Clear and respectful communication with other staff, both written and verbal. Clear, legible documentation.<br>• Manages discontinuation and recommencement.<br>• Able to manage acute and longer-term treatment.<br>• Applies the principles of rehabilitation psychiatry.<br>**Attitude**<br>• Professional approach to patient and others including respect for the views of the patient and others.<br>• 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.<br>• Case-based discussion.<br>• Mini-Clinical Evaluation Exercise.<br>• Observed Clinical Activity (OCA). |
| **References**<br>GALLETLY C, CASTLE D, DARK F et al. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders. *Aust NZ J Psychiatry* 2016; 50: 410–72. | |
| **Locally funded text:**<br>Stahl's Essential Psychopharmacology: Neuroscientific Basis and Practical Applications (Essential Psychopharmacology Series) by Stephen Stahl | |

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

***ST1-GEN-EPA6 – Providing psychoeducation – this one is mandatory – must do before the end of 1st year***

| | | | |
|---|---|---|---|
| ***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.

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

**References**


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

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

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


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

***ST2-EXP-EPA1 – Electroconvulsive therapy (ECT) – optional – can be done in ST1 to lighten your EPA load in ST2***

| | | | |
|---|---|---|---|
| ***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.

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|---|---|---|---|---|
| ***Title*** | ***Demonstrating proficiency in all the expected tasks associated with prescription, administration and monitoring of ECT.*** | | | |
| ***Description*** | 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).<br>• Equipment.<br>• Knowledge of dosing protocols, titration procedures and procedures for different electrode placements.<br>• Markers of seizure adequacy.<br>• How stigma and history can impact on the acceptance of ECT for the patient and others.<br>**Skills**<br>*General*<br>• Interactions with patients, carers, staff/liaison with anaesthetic staff.<br>• Ability to obtain informed consent/sufficient information from patient/carer if involuntary treatment and where feasible.<br>• Communication with other staff involved with the patient, clear documentation.<br>*Technical*<br>• ECT technique.<br>• Familiar with the use of equipment, airways, mouth guards, ECT machine.<br>• Determining dose/charge.<br>• Thorough knowledge of EEG monitoring.<br>• Cuff monitoring or similar if or as required.<br>• Set dose/charge.<br>• Skin preparation, testing impedance.<br>• Lead placement (examples may include EEG and ECG, treatment leads).<br>**Attitude**<br>• 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***<br>*(these include, but are not limited to, WBAs)* | • Case-based discussion.<br>• Mini-Clinical Evaluation Exercise.<br>• Direct Observation of Procedural Skills (DOPS).<br>• Feedback from appropriate sources.<br>• 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, 2013.

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

THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS. *Position Statement 74: Electroconvulsive Therapy (ECT).* Melbourne: RANZCP, March 2014. Viewed 2 May 2017, <www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/PS-74-PPP-Electroconvulsive-Therapy.aspx>.

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


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

***ST2-EXP-EPA2 – Mental health Act – optional – can be done in ST1 to lighten your EPA load in ST2***

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

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

| | | | | |
|---|---|---|---|---|
| ***Title*** | ***The application and use of the mental health Act.*** | | | |
| ***Description*** | The trainee can apply the provisions of the relevant mental health Act to provide care on an involuntary basis. The trainee provides explanations to patients and their carers, engages them where possible and deals with their concerns. They comply with documentary and administrative obligations. The trainee is aware of the factors which justify involuntary care under the local mental health Act, including the principle that involuntary care must contribute to treatment of mental illness and consequent improvements in autonomy. The trainee seeks to optimise the autonomy of patients receiving involuntary care and promotes pathways to less restrictive care. | | | |
| ***Fellowship competencies*** | **ME** | 1, 2, 3, 4, 5, 8 | **HA** | 1, 2 |
| | **COM** | 1, 2 | **SCH** | 2 |
| | **COL** | 1, 2, 3, 4 | **PROF** | 1, 2, 3 |
| | **MAN** | 2, 5 | | |

***Knowledge, skills and attitude required***

The following lists are neither exhaustive nor prescriptive.

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

**Ability to apply an adequate knowledge base**

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

**Skills**

- Determination of whether or not the patient suffers a mental illness or mental disorder as variously defined in the relevant legislation.
- Assessment of a variety of harms (differing from jurisdiction to jurisdiction) that involuntary treatment may protect a patient or others from. These include harms such as the experience of the symptoms of mental illness, physical harm, dangers to health or safety, diminished ability to care for self and harms associated with the patient's possible deterioration.

| | |
|---|---|
| | • Risk assessment (with risk of harm to self considering self-harm, neglect, exploitation, damage to relationships and reputation; risk of harm to others considering the patient's context and the presence of children) including risk–benefit analysis of enforcing treatment.<br>• Assessment of harms that might be associated with enforcing involuntary treatment, including stigma, loss of rapport and nosocomial suicide.<br>• Assessment of decision-making capacity, as defined in the common law or relevant mental health Act, with respect to the decision to refuse the treatment proposed.<br>• Ability to provide support to a patient who would otherwise lack decision-making capacity.<br>• Ability to identify the mode of safe and effective care that will provide the least restriction on the patient's freedom and human rights.<br>• Ability to identify the mode of treatment that best reflects the person's will and preferences via note of the person's expressed preferences, either currently or in an advance directive, and information gathered from family and friends.<br>• Conflict resolution and ability to negotiate and compromise.<br>• Communication and collaboration with the patient, family and others as necessary, eg. police, emergency services.<br>• Ability to prepare reports and appear before relevant bodies as required by the legislation.<br>**Attitude**<br>• Commitment to providing treatment in the least restrictive setting.<br>• An appropriate regard for the hazards associated with involuntary care and the harms associated with coercive care.<br>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.<br>• Mini–Clinical Evaluation Exercise.<br>• Professional presentation.<br>• Observed Clinical Activity (OCA). |

**References: Relevant to all Australasian jurisdictions**


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

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

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

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


**Relevant to New Zealand**


*Mental Health (Compulsory Assessment and Treatment) Act* 1992 (NZ) [especially ss 2 (definition of mental disorder), 5, 7A,27]. DAWSON J & GLEDHILL K (eds). *New Zealand's Mental Health Act in Practice*. Wellington: Victoria University Press, 2013.


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

***ST2-EXP-EPA3 – Risk assessment – optional – can be done in ST1 to lighten your EPA load in ST2***

| | | | |
|---|---|---|---|
| ***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*** | 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.<br>• Formulate a risk-management plan arising from risk assessment with the multidisciplinary team, with due consideration of clinical, legal and contextual interventions.<br>• Engage patients and carers, be aware of central role of therapeutic relationships, in risk management.<br>• Communicate and collaboratively implement a risk-management plan with the multidisciplinary team.<br>• Work in collaborative and respectful fashion with the multidisciplinary team.<br>• Ability to weigh up pros and cons of particular interventions and show high quality decision-making processes, including use of risk–benefit analyses.<br>**Attitude**<br>• A diligent attitude to obtaining sufficient information from available sources, including carers.<br>• A diligent attitude to communicating information where appropriate to carers and health workers involved.<br>• Appropriate attitude to balancing competing priorities, eg. civil liberties, confidentiality, therapeutic rapport, when managing risk.<br>• Commitment to adopting an evidence-based approach.<br>• Awareness of own limitations and willingness to seek other's opinion when required.<br>• 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.<br>• Appropriate level of diligence in documentation of assessment, decisions and reasoning.<br>• 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.<br>• Mini-Clinical Evaluation Exercise.<br>• Direct Observation of Procedural Skills (DOPS).<br>• Observed Clinical Activity (OCA). |
| **References**<br>THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS. *Risk Basics*. Melbourne: RANZCP, October 2016. Viewed 2 May 2017 <learnit.ranzcp.org/User/Course/Search?query=riskbasics> [member login required]. | |

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

***ST2-EXP-EPA5 – Cultural awareness – optional – can be done in ST1 to lighten your EPA load in ST2***

| | | | |
|---|---|---|---|
| ***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.

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|---|---|---|---|---|
| ***Title*** | ***Assess and manage adults with cultural and linguistic diversity.*** | | | |
| ***Description*** | 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** | | | |

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|---|---|
| ***Knowledge, skills and attitude required***<br>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.<br>**Ability to apply an adequate knowledge base**<br>• Understands the principles of cultural responsiveness.<br>• Understands the impact of culture on verbal and non-verbal communication.<br>• Aware of the barriers and facilitators to the use of interpreters.<br>• Understands the domains of a cultural formulation including an understanding of:<br>– the impact of cultural beliefs on identity<br>– explanatory models of illness |

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

**References**

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

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

**(Additional local information)**

**In NZ we want you to read the information about Maori Mental Health here: http://www.psychtraining.org/Te-Iho-Content-interim.pdf**

**– and discuss this in supervision, as part of achieving this EPA.**

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

***ST2-ADD-EPA2 – Comorbid substance use – optional – can be done in ST1 to lighten your EPA load in ST2 (need DoT's permission to do it – granted!)***

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|---|---|---|---|
| ***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***<br>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***<br>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.<br>**Ability to apply an adequate knowledge base**<br>• Management plan shows appropriate use of services available to persons with comorbidity.<br>• Theories explaining comorbid substance use and other mental health disorders.<br>• Understand the effects of ongoing substance use on diagnostic accuracy.<br>**Skills**<br>• Appropriate assessment of each problem and their interrelatedness (including temporal relationship) for this person.<br>• Appropriate ongoing assessment and diagnostic revision.<br>• Ability to formulate for the patient, their family and colleagues.<br>• Appropriate engagement of family and others in assessment and management. | | | |

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|---|---|
| | • Implementation of a management plan that shows a detailed understanding of the interrelatedness of the comorbid conditions.<br>• Demonstration of advocacy for patients with comorbid substance use problems.<br>**Attitude**<br>• Adopts a non-judgemental, empathic and hopeful approach to the engagement of persons with mental illness and substance use disorder.<br>• Willingness to engage with such persons who are often poorly serviced.<br>• Maintains therapeutic optimism. |
| ***Assessment method*** | Progressively assessed during individual and clinical supervision, including three appropriate WBAs. |
| ***Suggested assessment method details*** | • Case-based discussion.<br>• Observed Clinical Activity (OCA).<br>• Professional presentation – of a specific comorbidity, eg. cannabis and psychosis, anxiety/depression and alcohol. |
| **References**<br>**(Local Auckland reimbursed text)** Drugs & Alcohol Abuse: a clinical guide to diagnosis and treatment – M A Schuckit - Published Plenum Medical Book Co.<br>**John Berks' advice is:** "The standard is the ability to take a good psych history, a good substance history, integrate the two and develop a sensible management plan." | |

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