Stage 2 EPAs – mandatory

General psychiatry

ST2-EXP-EPA1 – Electroconvulsive therapy (ECT)

Area of practice	General psychiatry			***EPA identification***	ST2-EXP-EPA1
Stage of training	Stage 2 – Proficient			***Version***	v0.10 (BOE-approved 04/05/12)
The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.					
Title	***Demonstrating proficiency in all the expected tasks associated with prescription, administration and monitoring of ECT.***				
Description Maximum 150 words	The trainee is proficient in the modern use of ECT including appropriate: selection and work-up of patients, explanation to the patient and family (or carer where appropriate) and liaison with ward, ECT, theatre and anaesthetic staff. The trainee complies with administrative, legal and documentary requirements. They demonstrate correct administration including electrode placement, seizure monitoring and titration and can manage the course, side effects and complications.				
Fellowship competencies	**ME**	1, 2, 3, 4, 6	**HA**	1	
	COM	1, 2	**SCH**	1, 2	
	COL	1, 2, 3, 4	**PROF**	1, 2	
	MAN	2, 4, 5			
Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Relevant RANZCP guidelines. • Local protocols, procedures, relevant documentation. • Relevant legal aspects including relevant sections of the local Mental Health Act. • Pre-ECT physical, cognitive and psychiatric evaluation. • Indications, situations of higher risk and contraindications. • How to approach special precautions/higher risk (eg. pacemakers, warfarin, intracranial lesions).				

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

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.

</td></tr>
<tr><td>Assessment method</td><td>Progressively assessed during individual and clinical supervision, including three appropriate WBAs.</td></tr>
<tr><td>Suggested assessment method details</td><td>

Case-based discussion.
Mini-Clinical Evaluation Exercise.
Feedback from appropriate sources.

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

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	• 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

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ST2-EXP-EPA2 – Mental Health Act

<table>
<tr><td>Area of practice</td><td colspan="2">General psychiatry</td><td colspan="2">EPA identification</td><td>ST2-EXP-EPA2</td></tr>
<tr><td>Stage of training</td><td colspan="2">Stage 2 – Proficient</td><td colspan="2">Version</td><td>v0.9 (BOE-approved 12/07/12)</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">The application and use of the Mental Health Act.</td></tr>
<tr><td>Description
Maximum 150 words</td><td colspan="5">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.</td></tr>
<tr><td rowspan="4">Fellowship competencies</td><td>ME</td><td>1, 2, 3, 4, 5, 8</td><td>HA</td><td colspan="2">1, 2</td></tr>
<tr><td>COM</td><td>1, 2</td><td>SCH</td><td colspan="2">2</td></tr>
<tr><td>COL</td><td>1, 2, 3, 4</td><td>PROF</td><td colspan="2">1, 2, 3</td></tr>
<tr><td>MAN</td><td>2, 5</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
• 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</td></tr>
</table>

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	• 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.

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ST2-EXP-EPA3 – Risk assessment

<table>
<tr><td>Area of practice</td><td colspan="2">General psychiatry</td><td colspan="2">EPA identification</td><td>ST2-EXP-EPA3</td></tr>
<tr><td>Stage of training</td><td colspan="2">Stage 2 – Proficient</td><td colspan="2">Version</td><td>v0.5 (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">Assessment and management of risk of harm to self and others.</td></tr>
<tr><td>Description
Maximum 150 words</td><td colspan="5">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.</td></tr>
<tr><td rowspan="4">Fellowship competencies</td><td>ME</td><td>1, 2, 3, 4, 5, 7, 8</td><td>HA</td><td colspan="2">2</td></tr>
<tr><td>COM</td><td>1, 2</td><td>SCH</td><td colspan="2"></td></tr>
<tr><td>COL</td><td>4</td><td>PROF</td><td colspan="2">1, 2, 3</td></tr>
<tr><td>MAN</td><td>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
• 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</td></tr>
</table>

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

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ST2-EXP-EPA5 – Cultural awareness

<table>
<tr><td>Area of practice</td><td colspan="2">General psychiatry</td><td colspan="2">EPA identification</td><td>ST2-EXP-EPA5</td></tr>
<tr><td>Stage of training</td><td colspan="2">Stage 2 – Proficient</td><td colspan="2">Version</td><td>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 and manage adults with cultural and linguistic diversity.</td></tr>
<tr><td>Description
Maximum 150 words</td><td colspan="5">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.</td></tr>
<tr><td rowspan="4">Fellowship competencies</td><td>ME</td><td>1, 2, 3, 4, 5, 6</td><td>HA</td><td colspan="2"></td></tr>
<tr><td>COM</td><td>1</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
• 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</td></tr>
</table>

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<table>
<tr><td></td><td>– 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.</td></tr>
<tr><td>Assessment method</td><td>Progressively assessed during individual and clinical supervision, including three appropriate WBAs.</td></tr>
<tr><td>** Suggested assessment method details</td><td>• Case-based discussion.
• Observed clinical activity (OCA) – where a cultural advisor or language interpreter is present.
• Review of a brief written cultural formulation.</td></tr>
<tr><td colspan="2">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.</td></tr>
</table>

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** In NZ, unless the trainee has completed a Maori Clinical team run or is about to do so, we require that they complete the 'Te Iho Assessments' as part of the Cultural Awareness EPA. The assessments are available here: http://www.psychtraining.org/teIho1.html. We suggest that the Case be used for a Case-based Discussion. The completed assessments are emailed to the Director of Training who will confirm their satisfactory completion to the trainee and supervisor. Even if the trainee is doing a Maori team run, the Assessments are excellent preparation for such a run, and are still recommended.

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ST2-PSY-EPA2 – Therapeutic alliance (one of the 3 Psychotherapy EPAs can be left to Stage 3)

<table>
<tr><td>Area of practice</td><td colspan="2">Psychotherapy</td><td>EPA identification</td><td>ST2-PSY-EPA2</td></tr>
<tr><td>Stage of training</td><td colspan="2">Stage 2 – Proficient</td><td>Version</td><td>v0.4 (BOE-approved 08/11/12)</td></tr>
<tr><td colspan="5">The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.</td></tr>
<tr><td>Title</td><td colspan="4">Psychodynamically informed patient encounters and managing the therapeutic alliance.</td></tr>
<tr><td>Description
Maximum 150 words</td><td colspan="4">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.</td></tr>
<tr><td rowspan="4">Fellowship competencies</td><td>ME</td><td>5</td><td>HA</td><td></td></tr>
<tr><td>COM</td><td>1</td><td>SCH</td><td>1,</td></tr>
<tr><td>COL</td><td>1, 2</td><td>PROF</td><td>1, 2, 3</td></tr>
<tr><td>MAN</td><td></td><td colspan="2"></td></tr>
<tr><td>Knowledge, skills and attitude required
The following lists are neither exhaustive nor prescriptive.</td><td colspan="4">Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.
Ability to apply an adequate knowledge base
• 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</td></tr>
</table>

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	• 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.

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ST2-PSY-EPA3 – Supportive psychotherapy (one of the 3 Psychotherapy EPAs can be left to Stage 3)

<table>
<tr><td>Area of practice</td><td colspan="2">Psychotherapy</td><td>EPA identification</td><td colspan="2">ST2-PSY-EPA3</td></tr>
<tr><td>Stage of training</td><td colspan="2">Stage 2 – Proficient</td><td>Version</td><td colspan="2">v0.3 (BOE-approved 08/11/12)</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">Supportive psychotherapy.</td></tr>
<tr><td>Description
Maximum 150 words</td><td colspan="5">The trainee is able to see a patient in a dyadic treatment and use direct measures to ameliorate symptoms and maintain, restore or improve self-esteem, ego functions and adaptive skills. They can develop and implement a psychotherapeutic treatment plan within a comprehensive treatment plan, when required. This includes determining which form of therapy would be suitable for the patient’s needs and awareness of the resources available. The trainee is able to adapt their treatment to the needs of the patient and, where appropriate, incorporate other techniques (eg. techniques borrowed or modified from cognitive–behavioural therapy [CBT], analytic approaches or others) within the underlying supportive approach. The trainee understands the term therapeutic alliance and how to bolster this.</td></tr>
<tr><td rowspan="4">Fellowship competencies</td><td>ME</td><td>1, 3, 4, 5</td><td>HA</td><td colspan="2"></td></tr>
<tr><td>COM</td><td>1</td><td>SCH</td><td colspan="2"></td></tr>
<tr><td>COL</td><td>1, 2</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
• The principle objectives of supportive psychotherapy – to maintain or improve the patient’s self esteem, ameliorate or prevent recurrence of symptoms, improve psychological or ego functioning and enhance adaptive capacities.
• Understands that the practice of supportive psychotherapy is used in many therapeutic encounters.
• The paramount importance of the patient–therapist relationship.
• Indications and contraindications for supportive psychotherapy including grief, bereavement.
Skills</td></tr>
</table>

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

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.

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ST2-PSY-EPA4 – CBT: Anxiety management (one of the 3 Psychotherapy EPAs can be left to Stage 3)

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.				

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	• 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

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Addiction psychiatry

(NB: if trainee has already done one or both Addiction EPAs in previous runs, they should do 2 generic Stage 2 EPAs in a subsequent Addiction run.)

ST2-ADD-EPA1 – Intoxication and withdrawal

<table>
<tr><td>Area of practice</td><td colspan="2">Addiction psychiatry</td><td>EPA identification</td><td>ST2-ADD-EPA1</td></tr>
<tr><td>Stage of training</td><td colspan="2">Stage 2 – Proficient</td><td>Version</td><td>v0.10 (BOE-approved 15/10/12)</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">Management of substance intoxication and substance withdrawal.</td></tr>
<tr><td>Description
Maximum 150 words</td><td colspan="4">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></td></tr>
<tr><td>COM</td><td>1, 2</td><td>SCH</td><td></td></tr>
<tr><td>COL</td><td>1, 2, 3</td><td>PROF</td><td>1, 2</td></tr>
<tr><td>MAN</td><td></td><td colspan="2"></td></tr>
<tr><td>Knowledge, skills and attitude required
The following lists are neither exhaustive nor prescriptive.</td><td colspan="4">Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below.
Ability to apply an adequate knowledge base
• 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>

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

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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

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(NB: if trainee has already done one or both Addiction EPAs in previous runs, they should do 2 generic Stage 2 EPAs in a subsequent Addiction run.)

ST2-ADD-EPA2 – Comorbid substance use

Area of practice	Addiction psychiatry		***EPA identification***	ST2-ADD-EPA2
Stage of training	Stage 2 – Proficient		***Version***	v0.6 (BOE-approved 04/05/12)
The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.				
Title	***Comorbid mental health and substance use problems.***			
Description Maximum 150 words	Integrated assessment and management of a person’s substance use and mental health problems. The trainee demonstrates the ability to assess, conduct appropriate physical and cognitive assessment, formulate, consider differential diagnoses and develop integrated management strategies. They are able to explain the relationship between the person’s substance use and mental health to patients, family and staff. The trainee demonstrates awareness of challenges posed by comorbidity.			
Fellowship competencies	**ME**	1, 2, 3, 4, 5, 6, 7	**HA**	
	COM	1, 2	**SCH**	1, 2
	COL	1, 2, 3, 4	**PROF**	1, 2, 5
	MAN	4		
Knowledge, skills and attitude required The following lists are neither exhaustive nor prescriptive.	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge, skills and attitude described below. **Ability to apply an adequate knowledge base** • Management plan shows appropriate use of services available to persons with comorbidity. • Theories explaining comorbid substance use and other mental health disorders. • Understand the effects of ongoing substance use on diagnostic accuracy. **Skills** • Appropriate assessment of each problem and their interrelatedness (including temporal relationship) for this person. • Appropriate ongoing assessment and diagnostic revision. • Ability to formulate for the patient, their family and colleagues. • Appropriate engagement of family and others in assessment and management.			

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

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

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