The NFPT & the emerging architecture of training & fellowship

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Outline

- The vision
- The design logic
- The curriculum architecture
  - The outcomes of Fellowship
  - The developmental pathway
  - The learning framework
  - The assessment framework
  - The progression framework
- Where to next?

A Vision for the Fellowship Program

- The Fellowship Program develops psychiatrists for Australia and Aotearoa New Zealand
  - They are clinically expert
  - They are committed to delivering patient-centred, high-quality care.
  - They practise collaboratively
  - They are equipped to meet evolving mental health needs
    - through culturally safe care, accountability, reflective practice, and meaningful engagement with communities.
- In doing so, the Program honours psychiatry's social contract
  - advancing the public good
  - strengthening public trust in our profession.

The Fellowship program will have an explicit design logic

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The design logic

Design foundation

Design Constraints

Design Tensions

Values & Principles

Limits design must respect

To be negotiated where principles collide

Design Values

Why we are redesigning Fellowship

OUR PURPOSE & COMMITMENTS

Why we are redesigning Fellowship – Our Design Purpose

Fellowship exists to make a difference.

Improving Outcomes
Better outcomes for people, families and communities.

Professional Identity
Psychiatrists as specialist medical practitioners.

Social Contract
Ethical, rights-respecting practice in the best interests of patients and society.

Cultural Safety
Equity and lived experience embedded through training and assessment.

Future Readiness
Preparing psychiatrists for tomorrow's health system, not yesterday's training model.

Our purpose drives our work.
It is the reason we are redesigning Fellowship.

How we will approach the redesign – Our Design Commitments

We make these commitments to each other and our community.

Capability-based
We design around integrated professional capability demonstrated in authentic clinical practice.

Consistent but flexible
We maintain common outcomes and standards while allowing multiple pathways to Fellowship.

Co-designed
We design with Fellows, trainees, educators and people with lived experience.

Our commitments guide how we design, decide and deliver together.

Design Principles

The practical rules that follow from those values

OUR DESIGN PRINCIPLES

How we design the Fellowship to deliver on our values

THEME 1: WHAT WE DESIGN AROUND

1	**Start with impact.**	Every design decision should improve outcomes for people, families, communities and society.
2	**Design around capability.**	Build integrated professional capability for specialist psychiatric practice.
3	**Learn through practice.**	Organise learning around authentic clinical work in real practice settings.

THEME 2: HOW LEARNING DEVELOPS

4	**Design one coherent learning system.**	Connect education, learning, support, assessment & progression into one coherent educational system.
5	**Standardise outcomes, not pathways.**	Enable multiple pathways while maintaining common outcomes, standards and fairness.
6	**Design for developmental progression.**	Ensure a structured pathway with increasing responsibility and complexity.
7	**Develop important capabilities longitudinally across the Fellowship.**	Design for deliberate, sustained development of capabilities that span all phases.
8	**Use assessment to advance learning and support judgement.**	Ensure assessment informs learning, supports entrustment, & drives progression decisions.

THEME 3: HOW THE PROGRAM IS IMPLEMENTED

9	**Design for educational and operational feasibility.**	Ensure the program is achievable, sustainable and equitable across workforce, services and settings.

THEME 4: HOW THE PROGRAM ENDURES

10	**Build for adaptation, not redesign.**	Create a durable Fellowship architecture that evolves with evidence, needs and practice.

These principles explain how we deliver on our purpose and commitments in every major design decision.

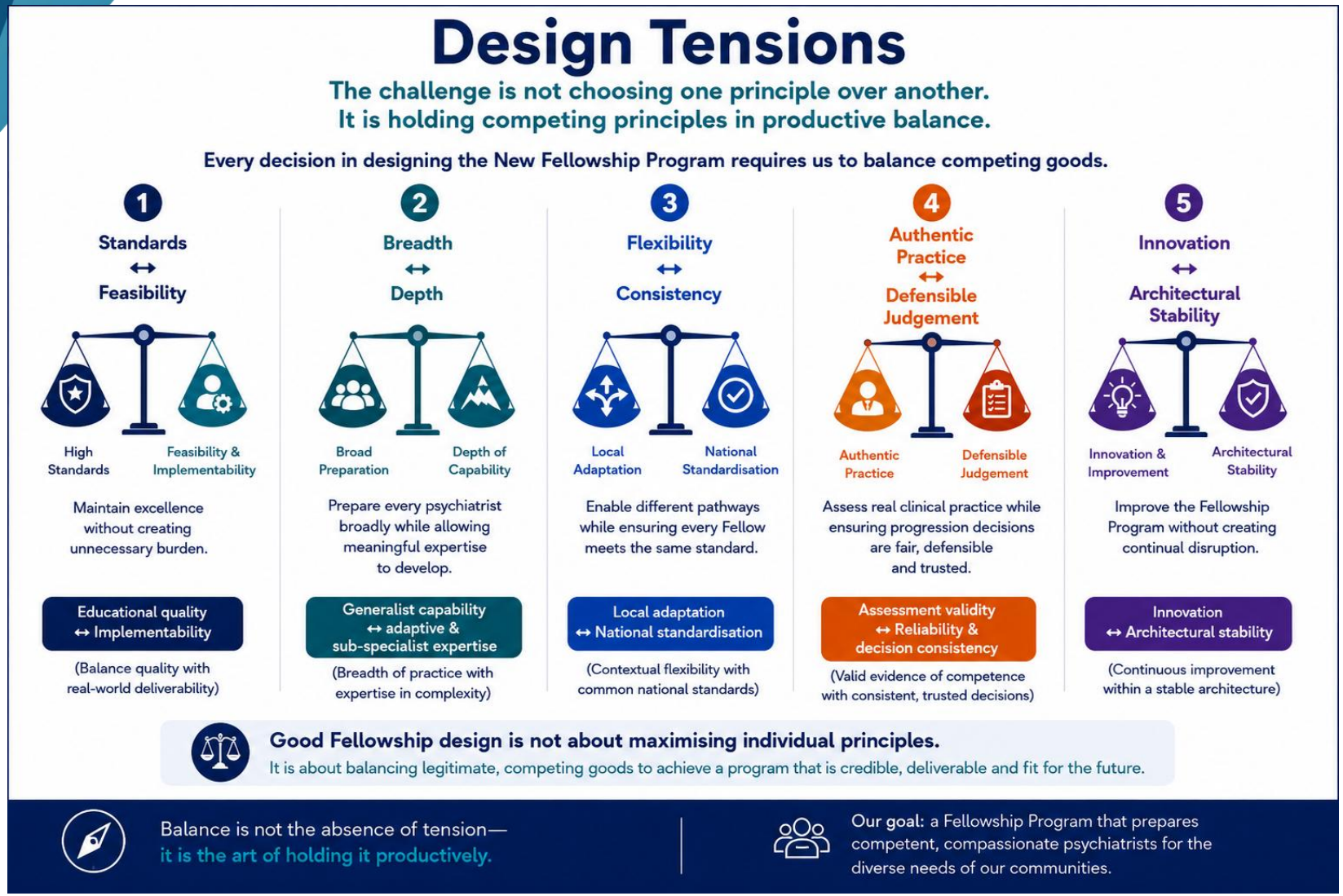
Design constraints

The limits design must respect

- Protect professional standards
  - Be trusted by the public and profession
- Be deliverable in 5 years
  - Allow for pursuit of special interests in depth
    - eg. Certificates of Advanced Training
  - Allow for breadth
- Be accreditable
- Be implementable

Design tensions

Where principles collide



The Fellowship program will have an explicit curriculum architecture

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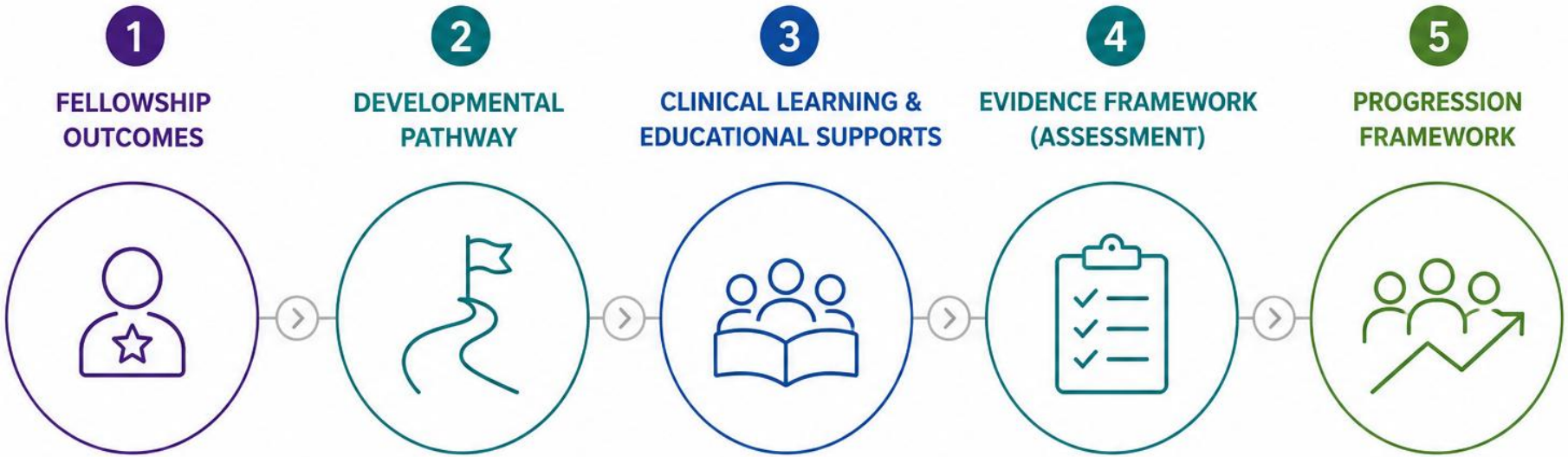
Prototype Fellowship Curriculum

A coherent educational system for developing specialists psychiatrists.



1. Fellowship will signify a set of outcomes

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Readiness for independent specialist practice

- For independent specialist psychiatric practice:
  - Safely & ethically
  - In complexity
  - In a range of real-world settings
  - With sound clinical judgement
  - In the service of patients, families, communities and systems

Not: time served, rotations completed, forms submitted

But: capability demonstrated, judgement trusted, standards met

A common professional identity

- A psychiatrist is a medical specialist in mental illness who combines therapeutic and culturally responsive clinical practice with practice in systems and professional formation to improve mental health & equitable care for people and communities.

Capability Framework

How does identity find expression across the breadth of psychiatric work?

2. Fellowship training will follow a developmental pathway

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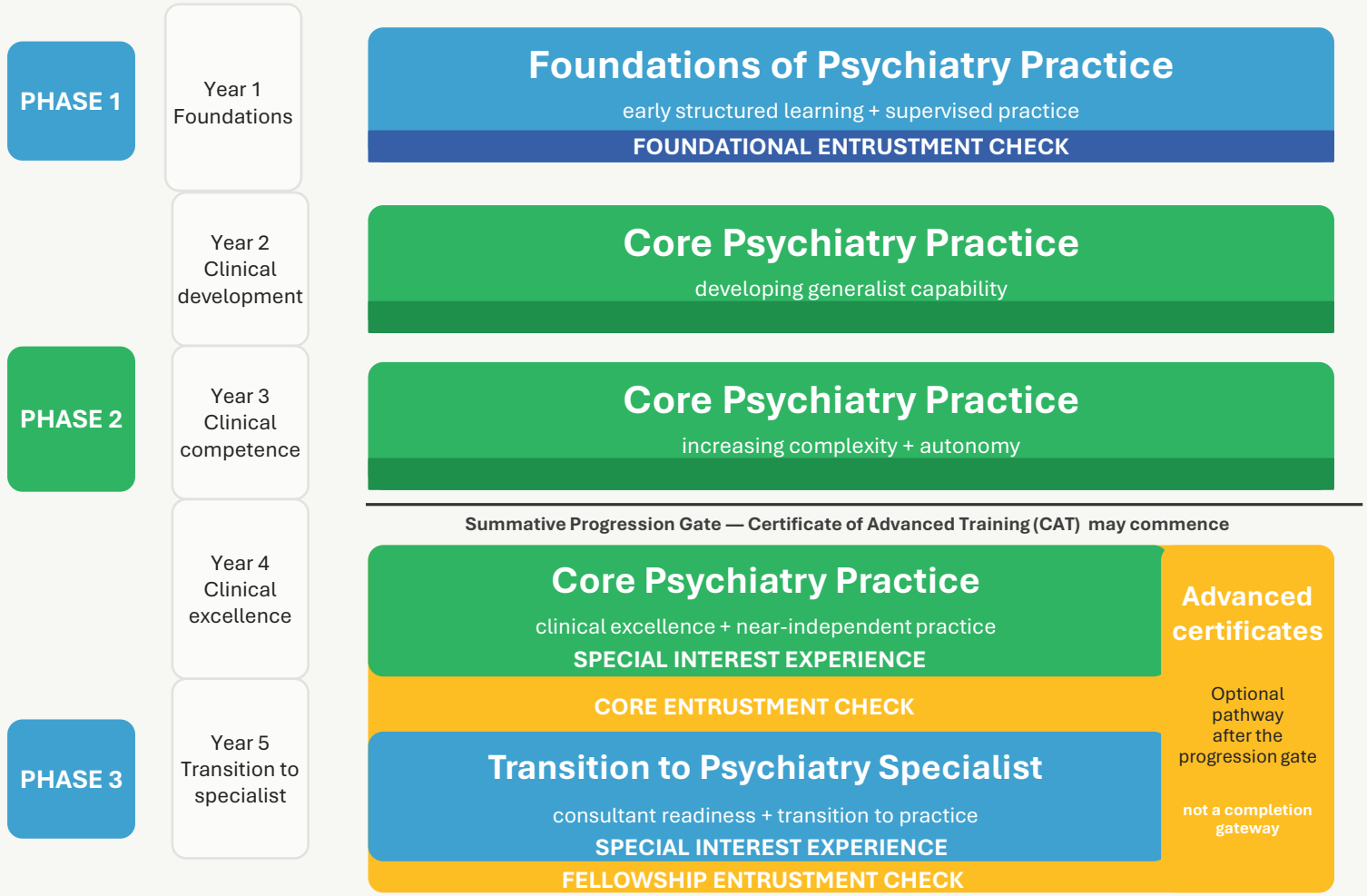
Prototype Curriculum Architecture- developmental pathway

Phases, EPA spine, longitudinal capability strands and advanced development



EPAs define the work to be entrusted. Capability strands describe how the psychiatrist develops and performs that work over time. Recurring dimensions are mandatory criteria applied across relevant EPAs.

3. Clinical Experience & Educational Supports

How will learning & development occur?

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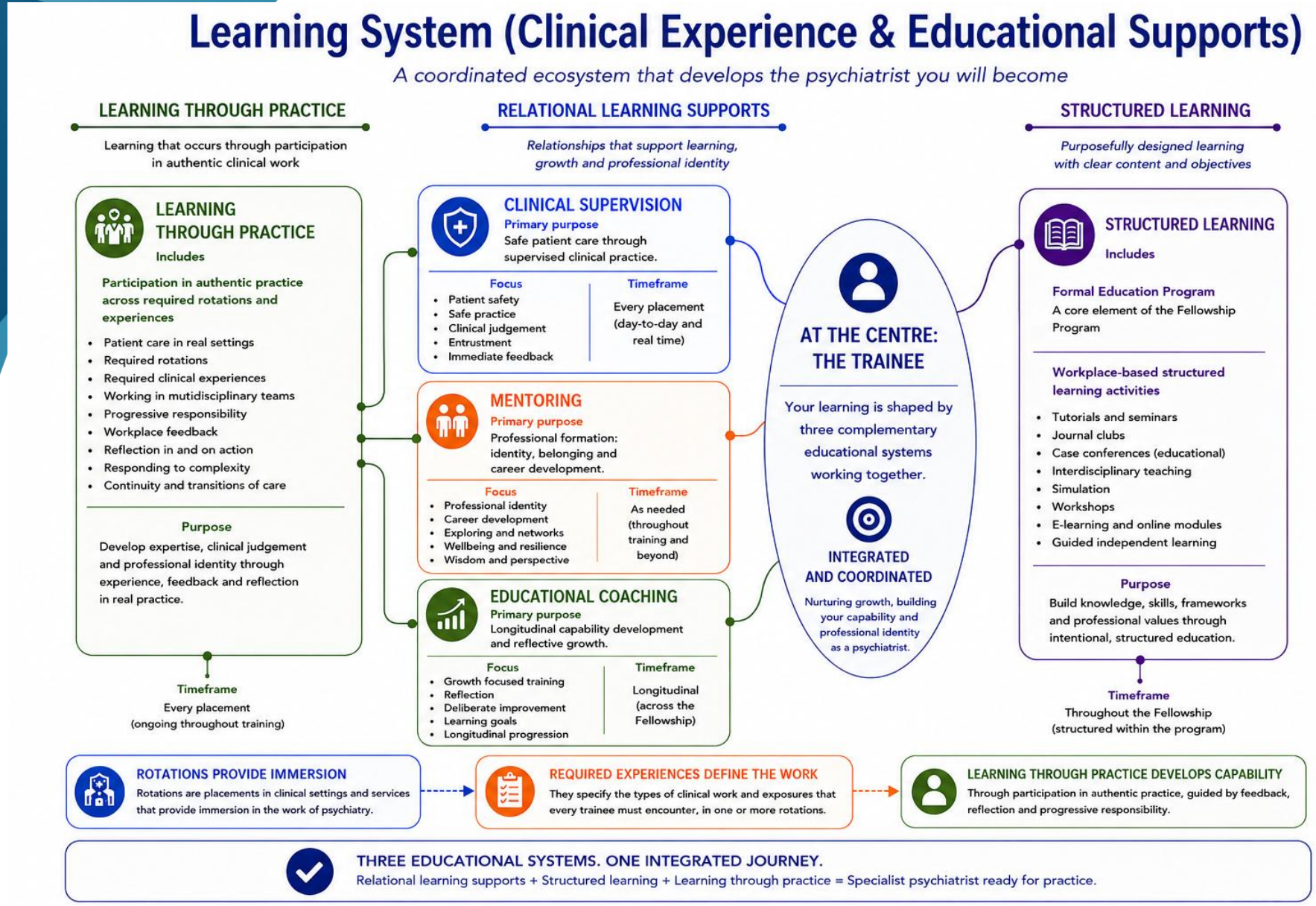
Educational Supports in Specialist Psychiatry Training



Ensuring breadth through experiences & settings

What happens to mandatory rotations?

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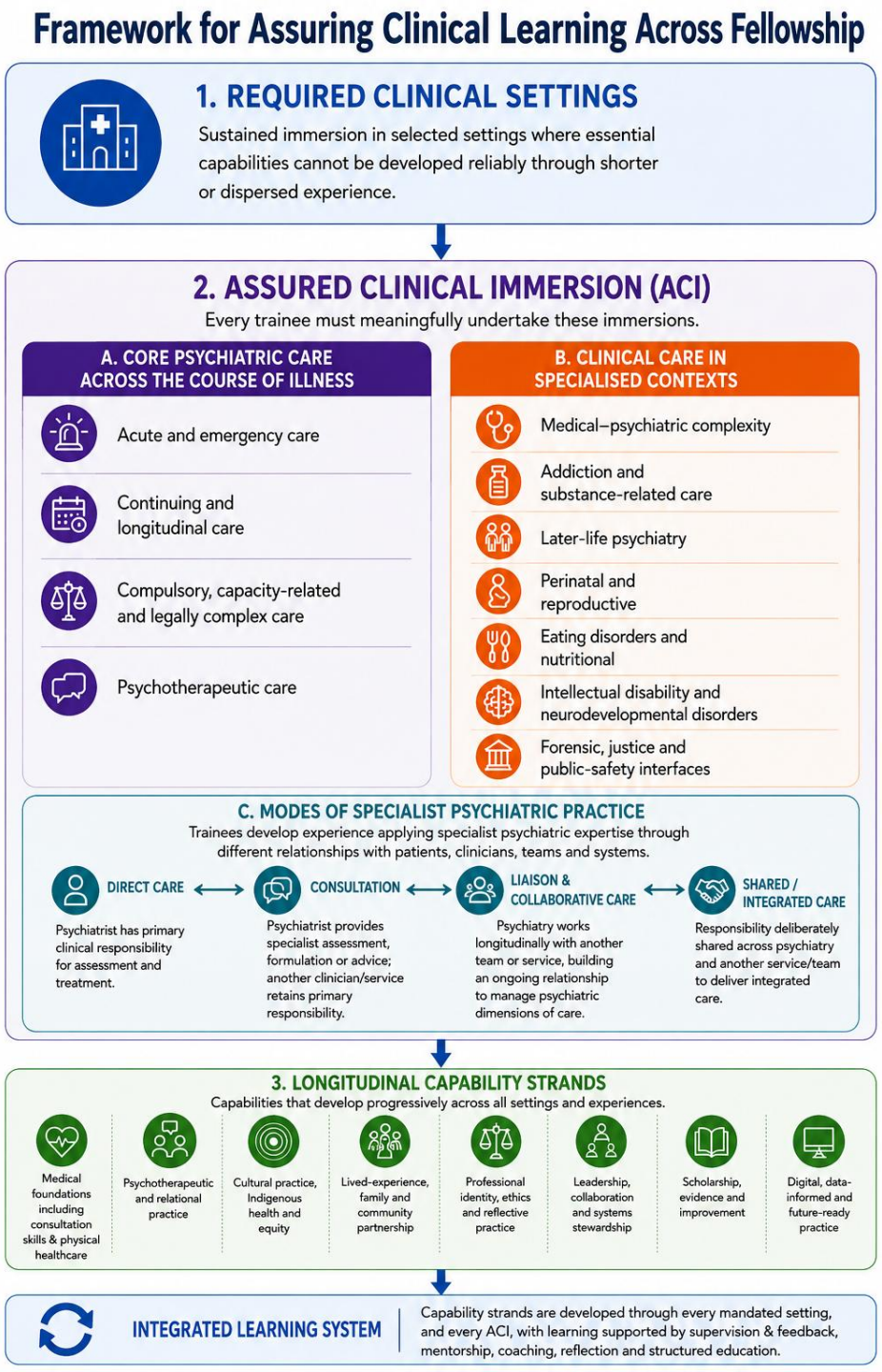
Framework for Assuring Clinical Learning Across Fellowship



Why keep or discard mandatory rotations?

5-tests approach

- A mandatory rotation should exist only where all five tests are met:
  1. The learning is essential for all psychiatrists.
  2. The learning requires immersion in a particular clinical ecology, not just exposure to a patient group.
  3. The competence cannot be reliably developed or assessed through other experiences.
  4. The requirement can be delivered equitably across metropolitan, regional, rural, remote, public, private, Australian and Aotearoa New Zealand contexts.
  5. The educational benefit justifies the opportunity cost.

Layer 1: Mandatory Rotation

Required setting	Why it matters	Key Capabilities Developed
Child, adolescent/youth & family psychiatry	The CAP rotation provides a unique developmental, family & systems-based learning environment that cannot be reliably replicated elsewhere. Trainees integrate developmental assessment, family work, attachment, child protection, education, legal and interagency perspectives into the assessment and management of children and young people. Underpin psychiatric practice across lifespan. Capabilities cannot be developed in other rotations. Require immersive, supervised clinical experience within multidisciplinary CAMHS & ICYMHS	• Developmental assessment and formulation • Family assessment and family work • Attachment-informed and relationship-centred practice • Recognition and management of childhood adversity, developmental trauma and child protection concerns • Assessment and management of neurodevelopmental disorders • Collaboration across families, schools, health, disability, child protection and justice systems • Consent, capacity and legal responsibilities for minors • Psychopharmacology in children and adolescents • Developmentally appropriate engagement and communication with children, young people and families • Management of transitions between child and adult mental health services

Layer 2: Assured Clinical Immersion

- **Areas of practice in which every trainee must actively participate**
  - demonstrate capability, potentially across multiple settings.
- **Encounter alone is insufficient.**
  - The trainee must perform meaningful clinical work, not merely see a case.
- **It requires a distinctive clinical approach.**
  - Eg developmental adaptation, family work, medical monitoring or specialist prescribing.
- **It involves defined systems or relationships.**
  - Eg. disability services, obstetrics, paediatrics, nutrition teams, schools or justice agencies.
- **It is vulnerable to omission in ordinary training.**
  - Without explicit assurance, some trainees may complete training with little substantive experience.
- **Failure to develop the capability would materially limit general specialist practice.**
- **Evidence can be specified.**
  - For example, observed assessments, case-based discussions, treatment planning, longitudinal involvement or supervised clinical activity.

ASSURED CLINICAL IMMERSION

These experiences should be achieved over the course of training and mapped across multiple rotations and settings, ensuring exposure to diverse populations, contexts and models of care.

CLINICAL EXPERIENCE TO BE ASSURED (Assured Clinical Immersion – ACI)	WHY IT MATTERS (What the experience develops)	EXAMPLES OF WHERE IT MAY BE ACHIEVED (Settings and contexts)
CLUSTER 1 — Core psychiatric practice across the lifespan and course of illness		
Child and adolescent psychiatric practice*	Develops developmentally informed psychiatric practice, including assessment and treatment within family, relational and broader systems.	Child and adolescent mental health services; paediatric settings; school and youth services; family and systemic therapy services; emergency departments; community and inpatient units.
Broad adult psychiatric practice	Provides the foundation of general psychiatric practice across common, severe and complex mental disorders.	Adult inpatient & community services; outpatient care; primary care; private practice; consultation–liaison; rehabilitation; crisis services.
Later–life psychiatric practice	Builds capability in the assessment and management of mental disorders in older adults, including cognitive and neuropsychiatric conditions.	Older persons' mental health services; general adult services; aged care; memory clinics; rehabilitation; inpatient and community settings.
Psychotherapeutic & relational care	The therapeutic relationship is a core instrument of psychiatric practice.	Supervised psychotherapeutic practice; longitudinal relationships; community & private practice; personality disorder & trauma services; family work; group programs; application in acute & continuing care.
Acute, emergency & after–hours psychiatry	Develops timely judgement, crisis management and safe decision–making under pressure and uncertainty.	Emergency departments; psychiatric triage; crisis teams; acute inpatient units; consultation–liaison; after–hours / on–call work.
Continuing, rehabilitation & longitudinal care	Psychiatry requires therapeutic relationships over time and recovery–oriented care across transitions.	Community mental health; rehabilitation services; continuing–care teams; private practice; psychother–apy; older persons' & child/youth services; primary care–linked models.
Compulsory, capacity–related & legally complex care	Ensures psychiatrists can exercise statutory powers safely while upholding rights, autonomy and public protection.	Inpatient, community & emergency settings; tribunals; forensic; older persons' & child/youth services; capacity & consent assessments; restrictive practice governance; mental health legislation.
CLUSTER 2 — Specialised clinical contexts and interfaces		
Medical–psychiatric complexity	Manages the interaction between physical illness and mental illness.	Consultation–liaison in general hospitals; ED; ICU; oncology; transplant; neurology; perioperative settings; primary care.
Addiction & substance–related care	Integrated management of substance use with mental health.	Specialist addiction services; consultation–liaison; emergency; inpatient & community services; dual–diagnosis programs; youth, perinatal, forensic & primary care.
Perinatal, reproductive & parent–infant mental health	Care across pregnancy, birth and early parenthood.	Perinatal services; mother–baby units; consultation–liaison; obstetric & maternity services; community & adult psychiatry; child & family services; primary care.
Eating disorders & severe nutritional compromise	Management of serious eating disorders, medical risk and family dynamics.	Specialist eating–disorder services; child & youth services; adult inpatient & community care; consultation–liaison; EDs; medical & paediatric services; family–based treatment programs.
Intellectual disability, autism & other neurodevelopmental conditions	Neurodevelopmental differences affect presentation, communication, diagnosis & treatment across the lifespan.	Child & youth services; adult community psychiatry; disability & specialist neurodevelopmental services; consultation–liaison; forensic, inpatient & community settings.
Forensic, justice & public–safety interfaces	Psychiatrists work where mental illness, offending, risk & public safety intersect.	Forensic mental health & correctional settings; courts; community forensic services; emergency & acute services; supervised assessment of violence risk & fitness to plead.

MODES OF SPECIALIST PSYCHIATRIC PRACTICE

(How specialist expertise is applied)

Trainees develop experience applying specialist psychiatric expertise through different relationships with patients, clinicians, teams and systems. These modes cut across all ACIs and settings.

DIRECT CARE
Psychiatrist has primary clinical responsibility for assessment and treatment.

CONSULTATION
Psychiatrist provides specialist assessment, formulation or advice; another clinician/service retains primary responsibility.

LIAISON & COLLABORATIVE CARE
Psychiatry works longitudinally with another team or service, building an ongoing relationship to manage psychiatric dimensions of care.

SHARED / INTEGRATED CARE
Responsibility is deliberately shared across psychiatry and another service/team to deliver integrated care.

CULTURAL PRACTICE, INDIGENOUS HEALTH & EQUITY* | Developed and evidenced across all required clinical experiences.

Includes cultural safety, humility & responsiveness; working with Aboriginal, Torres Strait Islander & Māori peoples and communities; engaging interpreters & cultural advisers; addressing racism & inequity; adapting care to cultural & community contexts; partnering with families, carers & lived experience.

* Longitudinal across all experiences.

Note: ACIs are developed across multiple rotations and settings and in all modes of specialist psychiatric practice.

* Child and adolescent psychiatric practice is also assured through the required clinical setting.

Sub-specialist experiences & providing depth

What happens to the CATs?

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Considerations for sub-specialist training

- **What belongs within Fellowship?**
  - Which advanced capabilities should every Fellow develop?
  - Which capabilities should remain optional or post-Fellowship?
- **When should advanced training occur?**
  - During or following Fellowship?
  - Across both, depending on the capability?
- **What should Faculties and Sections reconsider?**
  - Purpose and outcomes of CATs.
  - Is a two-year CAT the only appropriate model?
  - Should recognition become more flexible and modular?
  - Relationship to workforce needs & lifelong professional development.

Future possibilities for exploration

- Flexible advanced learning pathways.
- Stacked or modular credentials.
- Micro-credentials for defined areas of practice.
- Certificates recognising broader programs of advanced capability.
- Recognition of advanced practice undertaken after Fellowship.

4. The Assessment or Evidence Architecture

How will learning & development occur?

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Assessment Framework

Single integrated hybrid assessment system: programmatic and summative, front-loaded, with no external examinations in the final year.

Work-based assessment

- Formative WBAs / AFL
- EPA entrustment decisions by clinical supervisors
- Multiple sources and longitudinal evidence
- Supports feedback, progression and remediation

External written assessment

- Core knowledge
- Clinical reasoning
- Evidence application
- Summative external assessment

External clinical assessment

- Blueprinted and mapped to outcomes / AOL
- Assures standards
- Summative, external and front-loaded
- Limited number of attempts
- Independent benchmarking of clinical capability, reasoning, communication and readiness for progression toward Fellowship

Reflective portfolio

- Evidence of attainment and capabilities
- Narrative evidence over time
- Threshold learning linked to EPAs

Balanced workplace judgement + independent assurance + reflection

Notes: AFL: Assessment for learning AOL: Assessment of learning EPA: Entrustable Professional Activity PCP: Progression and remediation support
Design intent: avoid assessment creep by aligning assessment to outcomes and emphasising narrative portfolio evidence rather than tick-box accumulation.

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The Scholarly Project

- The proposed direction would be to retain:
  - critical appraisal;
  - formulation of a meaningful question;
  - appropriate method;
  - analysis and interpretation;
  - communication of scholarly work;
  - evidence of the trainee's own contribution.
  - Acceptable pathways might include research, quality improvement, service evaluation, evidence review, educational scholarship or implementation work.

Psychotherapy

- Psychotherapy will be embedded in the New Fellowship Program
  - The vision
    - a psychiatrist is a medical specialist who can practice independently, in complexity & across a range of settings.
  - The core capabilities
    - clinical treatment, relational and cultural, judgement, systems, professional formation
  - Curriculum architecture
    - incl. EPAs & longitudinal capabilities
  - Assessment framework
    - incl. reflective portfolio & WBAs
  - Learning architecture
    - mandatory experience
- The proposed direction would be to retain:
  - a substantial supervised psychotherapy experience;
  - evidence of psychotherapeutic formulation and relational competence;
  - reflective use of supervision;
  - credible evidence of actual practice.

DEVELOPING PSYCHOTHERAPEUTIC CAPABILITY ACROSS FELLOWSHIP

A LONGITUDINAL CAPABILITY STREAM

Psychotherapeutic capability develops progressively through staged learning, supervised practice, reflection and multiple sources of evidence.

1 FOUNDATIONS Year 1

PURPOSE
Develop the therapeutic capabilities expected of every psychiatrist.

CAPABILITIES
- Therapeutic alliance
- Supportive psychotherapy
- Engagement & communication
- Shared decision-making
- Reflective practice

LEARNING & PRACTICE
- Workplace practice
- Observation
- Supervision
- Introductory teaching

EVIDENCE
- Workplace observations
- Supervisor reports
- Reflective discussions
- Portfolio evidence

2 DEVELOPING CAPABILITY Year 2

PURPOSE
Extend psychotherapeutic capability into developmental, family, cultural and systemic practice.

CAPABILITIES
- Developmental formulation
- Family work
- Systemic practice
- Working with carers
- Indigenous ways of healing
- Cultural and relational practice

LEARNING & PRACTICE
- Child & Adolescent Psychiatry
- Family work
- Multidisciplinary practice
- Community settings

EVIDENCE
- Workplace assessments
- Case discussions
- Supervisor reports
- Portfolio evidence

3 MANDATORY SUPERVISED PSYCHODYNAMIC PRACTICE Years 3–4

PURPOSE
Develop psychodynamtic capability through sustained supervised psychotherapeutic practice.

MINIMUM REQUIREMENT
≥ 50 supervised psychotherapy sessions

PSYCHOTHERAPEUTIC CAPABILITIES
- Psychodynamic formulation
- Therapeutic alliance
- Reflective use of self
- Therapeutic boundaries
- Rupture and repair
- Transference
- Countertransference
- Sustained therapeutic work
- Termination

LEARNING SUPPORTS
- Weekly supervision
- Reflective practice
- Formal psychotherapy teaching
- Peer case discussion

EVIDENCE (MULTIPLE SOURCES)
- Supervisor reports
- Therapy log
- Longitudinal reflective entries
- Observed case discussions
- Brief written syntheses
- Portfolio evidence

4 TRANSITION TO SPECIALIST PRACTICE Years 4–5

PURPOSE
Deepen psychotherapeutic capability according to future practice.

EXAMPLES OF ADVANCED PSYCHOTHERAPEUTIC PRACTICE
- CBT
- DBT
- MBT
- ACT
- IPT
- Family Therapy
- Group Therapy
- Trauma-focused therapies
- Indigenous healing approaches
- Digital psychological therapies

LEARNING ENVIRONMENTS
Specialist clinical settings, community programs, private practice and advanced training opportunities.

EDUCATIONAL SUPPORTS ACROSS ALL YEARS

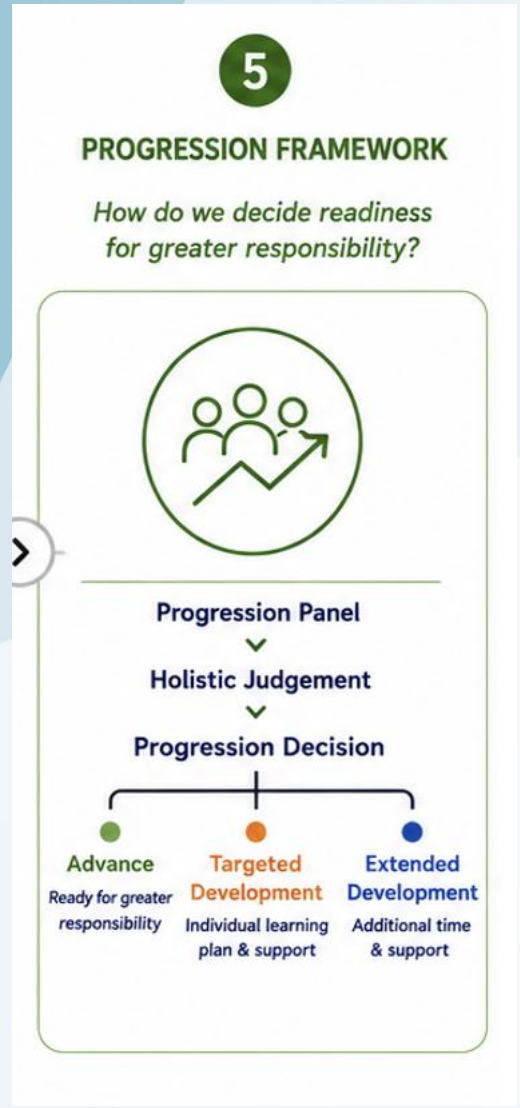
Supervision | Reflective practice | Case discussion | Formal teaching | Portfolio evidence | Professional development

Every Fellow develops psychotherapeutic capability through staged learning, sustained supervised practice and multiple sources of evidence collected across Fellowship.

Progression decisions are based on the totality of evidence over time.

5. The Progression Architecture

A framework for judgement



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Progression Decisions

- Draw on several forms of evidence
  - **workplace performance evidence**: repeated observations of the trainee undertaking authentic clinical work;
  - **EPA evidence**: judgements about the level of supervision required for important professional activities;
  - **knowledge and clinical examination results**;
  - **required clinical experiences** and evidence of breadth;
  - **supervisor reports and multisource feedback**;
  - a **reflective developmental portfolio**, showing how the trainee has used feedback, addressed gaps and developed over time.
- Evidence reviewed longitudinally
- Collective progression decisions
- Outcomes more nuanced than pass or fail

Bringing it all together

Stable core, adaptive edges

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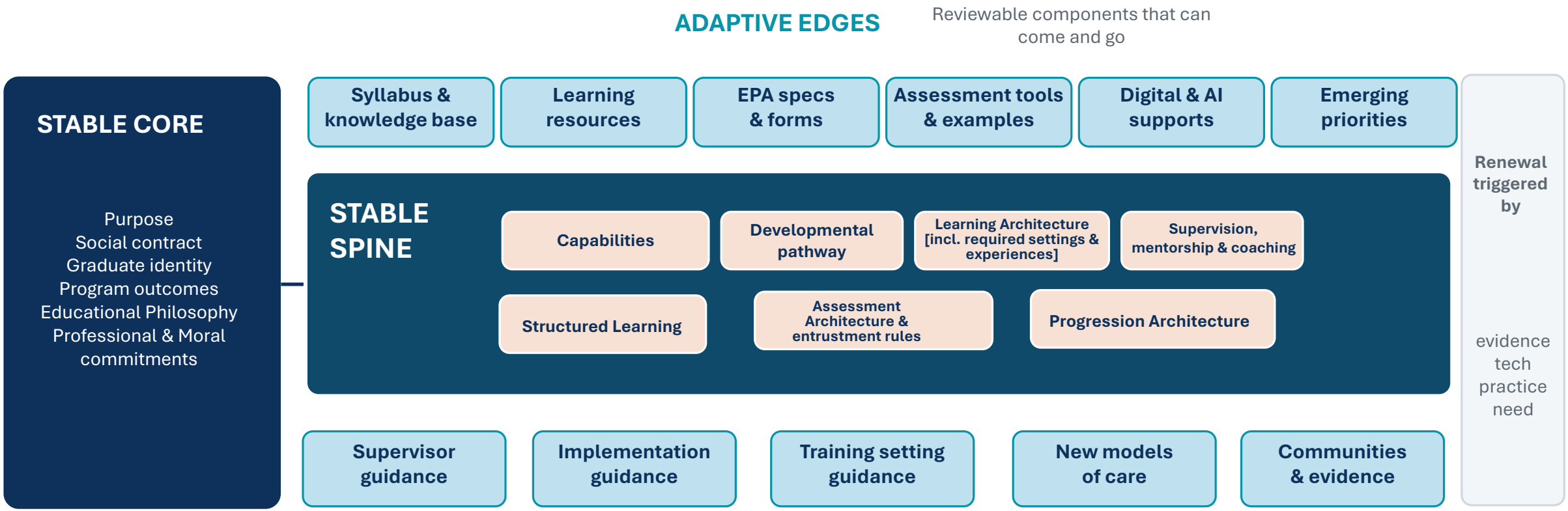
An adaptive governance architecture for the FRANZCP

What must endure is protected; what must evolve can be refreshed without destabilising the program.



The core defines what the program stands for; the spine says how it is held together; the edges say what can be refreshed over time