RANZCP Supervisor Handbook

Fellowship Program

The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Acknowledgements

Acknowledgement of Country

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) acknowledges Aboriginal and Torres Strait Islander Peoples as the First Nations and the Traditional Custodians of the lands and waters now known as Australia, and Māori as tangata whenua in Aotearoa, also known as New Zealand.

The RANZCP recognises and values the traditional knowledge held by Aboriginal and Torres Strait Islander Peoples and Māori.

The RANZCP honours and pays respect to the Elders, past and present, who weave their wisdom into all realms of life – spiritual, cultural, social, emotional and physical.

Acknowledgement of lived experience

The RANZCP recognises those with lived and living experience of a mental health condition, including community members, members of the College and its staff. RANZCP affirms their ongoing contribution to the improvement of mental healthcare for all people.

This artwork was created by Jordan Lovegrove of the Ngarrindjeri people of the lower Murray River. It is reproduced with the artist's permission.

The two meeting places (concentric circles) are shown as neurons communicating with each other, representing healthy brain functionality. The stars (yellow) represent wellbeing and positive thoughts transmitting throughout the mind.

Document version history

Version	Revision description/reason	Date
V1	First version of CBFP Supervisor Training Manual published on website.	23/08/2012
V2	Document form and structure revised and updated with current information and renamed to the Supervisor Handbook	28/04/2025

Acknowledgments

We thank the Supervisor Project Working Group (SPWG) for their valuable insights and contributions to this document. Specifically, we would like to thank the following SPWG members:

Shane Gill, Lauren Barnett, Emma Schwarcz, Prachi Brahmbhatt, Jacob Alexander, Mathew Coleman, Marshall Watson, Maryssa Portelli, Balaji Motamarri, Matt Brittain, Caroline Roberts, Charles Su and Michael O'Rawe.

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List of Abbreviations

AMC	Australian Medical Council
AOP	Area of Practice
BTC	Branch Training Committee
CbD	Case-based Discussion
CBFP	Competency-based Fellowship Program
CCA – MPR	Clinical Competency Assessment – Modified Portfolio Review
CEQ	Critical Essay Question
CFT	Committee for Training
COE	Confirmation of Entrustment
DOPS	Direct Observation of Procedural Skills
DOT	Director of Training
ECT	Electroconvulsive Therapy
EPA	Entrustable Professional Activity
FEC	Formal Education Course
FTE	Full-time Equivalent
ITA	In-Training Assessment
MCQ	Multiple Choice Question
MEQ	Modified Essay Questions
NZTC	New Zealand Training Committee
OCA	Observed Clinical Activity
PP	Professional Presentation
WBA	Workplace-Based Assessment

Overview

SECTION ONE: OVERVIEW

Message from the President

Dear Supervisors,

As you embark on your crucial role in guiding RANZCP candidates through the Fellowship Program, I commend your commitment to shaping the next generation of mental health professionals. Your dedication ensures that our trainees acquire the necessary competencies to excel in their clinical practice and contribute meaningfully to the field.

As you support a trainee during their participation in the Fellowship Program, you are expected to possess an in-depth understanding of the RANZCP Fellowship curriculum. This knowledge equips you to guide trainees effectively, helping trainees progress through the Fellowship Program. You play a pivotal role in a trainee's development through regular meetings and performance evaluations. Whether through direct or indirect supervision, your guidance empowers trainees to meet the highest standards, exercising their own judgement.

The Supervisor Program Working Group has updated this handbook. It provides essential information on the curriculum and training requirements. Please use this resource throughout your supervisory journey.

Thank you for your unwavering commitment to excellence in psychiatric training. Together, we help to shape the future of mental health care.

Warm regards,

Dr Elizabeth Moore
President

Supervisors

SECTION TWO: SUPERVISORS

Definitions

Supervisor

A supervisor is a psychiatrist or other health professional, formally recognised by RANZCP, who oversees the professional development of a trainee undertaking the Fellowship Program or another RANZCP educational activity.

Supervision

There are many definitions of professional or clinical supervision, including:

- The provision of monitoring, guidance, and feedback on matters of personal, professional and educational development in the context of the doctor's care of patients (Kilminster and Jolly, 2000)
- An event that involves an ongoing professional relationship, between two or more staff members with different levels of knowledge or expertise, to support professional development and to enhance knowledge and skills (Jordan and Shearer, 2019).

For this handbook, supervision refers to a formal alliance between a supervisor and a supervisee, which occurs within the context of a training program of the RANZCP. This guide focuses on information for supervisors acting as the principal supervisor for trainees placed in an accredited training rotation.

In this guide, 'remote supervision' is defined as RANZCP trainee supervision that occurs in accredited training posts that have been designated as suitable for remote supervision for generalist rotations. These training posts can be in medium-sized rural towns, very remote communities (MM4-7) or, for some specific subspecialty rotations, in larger rural towns (MM3). In remote supervision, the principal supervisor works primarily in a different location.

Supervisor information

Each training zone has designated supervisors who have been accredited by the RANZCP to supervise trainees in the workplace. Supervisors must have no more than two trainees under their supervision at one time (Supervision Policy and Procedure, 3.4.2). Supervisors are involved in oversight of clinical work, education and guidance of trainees, as well as providing a path of communication between trainees, the Director of Training (DOT) and the College. In addition, the supervisor has a critical role in the formative and summative assessment of trainees during their rotation, as well as providing targeted learning for trainees who are performing below the standards required by the Fellowship Program, as per the Policies on Progression through Training and Failure to Progress.

Accreditation of supervisors is undertaken by the Branch Training Committee (BTC) or delegated body of the New Zealand Training Committee (NZTC), and the requirements for accreditation differ depending on the type of accreditation sought. All supervisors must be accredited by the RANZCP to supervise trainees or Fellows for the purposes of the Fellowship Program or Certificate of Advanced Training. This includes non-Fellows accredited as a supervisor for a specific aspect of the Fellowship Program, such as psychotherapy, addiction psychiatry or research. There are different application forms for accreditation as a supervisor, depending on whether the applicant is a RANZCP Fellow or a non-RANZCP supervisor.

Supervision accreditation requirements

A principal supervisor is the accredited supervisor who oversees the clinical and training work of a trainee in a particular training post. There are specific requirements for accreditation as a principal supervisor as outlined in the Supervision Policy and Procedure.

Supervisors applying for initial accreditation must submit the application form, attend a Supervisor Training Workshop run by the local Branch Training Committee, and complete any specified Learn It modules. To maintain accreditation, supervisors need to attend at least three peer review sessions every 12 months in which discussion of supervision of trainees is a focus. Supervisors need to apply for reaccreditation every five years and will need to attend a Reaccreditation Workshop.

Supervision sessions

Supervisors should schedule supervision sessions with each trainee, which must cover all aspects of a trainee's work, including after-hours work.

- A minimum of one hour per week of individual supervision must be provided by the principal supervisor. This hour should be regularly scheduled and uninterrupted.
- This supervision hour must take place for 20 weeks per rotation, regardless of the trainee's or principal supervisor's full-time equivalent (FTE) status, i.e. this individual hour per week is still required for part-time trainees.
- Full-time trainees require an additional three hours of supervision per week. For part-time trainees, this additional supervision can be pro rata according to their FTE.
- For trainees in Stage 1, at least one of the remaining minimum of three hours must be conducted as close supervision (either as one-to-one supervision or in a small group with only one other trainee), which occurs outside of ward rounds and case review meetings.
- For all trainees, the other minimum hours can be conducted individually or as a group and can include a clinical meeting where there is an educational opportunity. Staff or clinical meetings where an educational opportunity is not available should not be counted within the total of four hours of supervision.

The core features of supervision

There are three key features to the alliance between supervisor and trainee:

1. Normative: shared responsibility for monitoring safe, ethical and professional practice
2. Educative/formative: shared responsibility for the development of skill, knowledge, attitudes and understanding
3. Supportive/restorative: the provision of a safe space for the trainee to reflect on their experiences and learning during training

Hughes and Pengelly (1997) describe three competing tensions of the supervision process:

1. Managing service delivery (ensuring policies, procedures and protocols of the organisation or of statutes and regulations are followed, and that the quality and quantity of work aligns with the priorities of the service)
2. Facilitating practitioners' professional development
3. Focusing on practitioners' work (allowing the supervisor and supervisee to reflect upon and explore the supervisee's clinical work)

Hughes and Pengelly note that these cannot be regarded separately, and that supervision becomes unsafe if one is ignored or avoided for any length of time.

Responsibilities of supervisors

The key responsibilities of supervisors can be divided into three sections.

1. To ensure effective supervision occurs, supervisors have a responsibility to:

- Understand the requirements of the role and be committed to education and training.
- Maintain a strong working alliance by ensuring supervision occurs regularly in an appropriate context and in a culturally safe way.
- Develop trust through professionalism and leadership.
- Define boundaries by establishing shared goals and preferred styles of supervision and discussing how feedback and disagreements will be managed.
- Ensure culturally safe principles are embedded within training.
- Ensure cultural safety is prioritised by trainees to eliminate culturally unsafe practices that are detrimental to positive health outcomes.
- Be interested in and supportive of the learning and development of the trainee.
- Celebrate successes and highlight what is working well.
- Consider what could be improved or enhanced.
- Model the values they want the trainee to demonstrate with their patients.
- Encourage trainees to consider a patient's support network (family and/or carers) as part of the patient's treatment and recovery.
- Encourage trainees to reflect constructively upon the work presented in supervision.
- Identify the trainee's strengths and utilise these to promote learning.

2. To ensure RANZCP training requirements are met, supervisors have a responsibility to:

- Be familiar with core information, including the RANZCP regulations and curriculum, the College Code of Ethics, and the procedures of the competency-based Fellowship Program.
- Provide initial orientation to the training program to first-year trainees at their institution.
- Review the training requirements and objectives for a rotation with the trainee at the beginning of the rotation.
- Monitor and observe trainees conducting clinical interviews with patients, some of which may be undertaken during supervision time, in the form of Workplace-Based Assessments (WBAs).

- Enable trainees to observe the supervisor conducting diagnostic and therapeutic interviews, with discussion about the interview style and the opportunity to reflect on any clinical and management issues raised.
- Discuss the trainee's performance with the Director of Training (DOT) if required.
- Identify problems needing remediation early, in consultation with the DOT.
- Be available to participate in the trainee's formative WBAs as required.
- Entrust a trainee's Entrustable Professional Activity (EPA) when the trainee has demonstrated they may perform the activity with the stated level of supervision.
- Provide regular formative feedback on the trainee's progress.
- Grade performance of learning outcomes at the midpoint of each rotation on the mid-rotation In-Training Assessment (ITA) form (or earlier and, where necessary, at later points during the rotation), which will be used to identify the trainee's strengths and weaknesses and their progress toward the training objectives of the rotation.
- Complete an end-of-rotation ITA at the end of the trainee's rotation. This must consider the trainee's progress against the relevant learning outcomes and the areas identified in the mid-rotation ITA as requiring further development of the trainee's competence.
- Be familiar with the use of InTrain to document their trainee's performance and to ensure end-of-term ITAs are completed within 60 days of the end of the rotation.
- Understand the educational aims and objectives for the specific training rotation.
- Attend a supervisors' peer review group, or meetings of medical staff where supervision is discussed, three times per year.

3. To ensure appropriate clinical oversight of patient care, supervisors have a responsibility to:

- Create a suitable learning environment for the trainee under their supervision by ensuring a wide range of opportunities are available to the trainee to develop their clinical skills.
- Be aware of the clinical progress of patients under the clinical care of the trainee.
- Attend supervision reliably and be available for clinical consultation and advice.
- Encourage a reflective learning approach and discussion of difficulties, feelings and thoughts related to patient care.
- Encourage a trainee to consider the wider cultural context of the patient.

Aspects to explore during supervision

Supervision must include regular direct supervision of the trainee's clinical work, and may include the following specific areas of focus:

- aspects of the assessment and treatment of people under the trainee's and supervisor's direct clinical care
- psychological understanding
- consultative skills
- ethical standards
- responsibility for other members of the team
- dynamics of the treatment setting
- discussion of other relevant aspects of work in the area of practice
- enhancement of reflective practice in the context of the supervisor/trainee.

Supervision may cover any aspects of the syllabus, learning outcomes or developmental descriptors, as well as the attitudes and skills outlined in the CanMEDS framework.

Supervisor resources and recommended reading

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

The Supervisor Learning Pathway online modules will provide additional information and training for supervisors.

Fellowship

SECTION THREE: RANZCP FELLOWSHIP PROGRAM

Program structure

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

- Stage 1 – 12 months FTE
- Stage 2 – 24 months FTE
- Stage 3 – 24 months FTE

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

Trainees undertake six-month rotations in designated areas of practice (AOPs). These may relate to an age group (e.g. child and adolescent, old age, adult), a setting (e.g. forensic, consultation–liaison), a treatment approach (e.g. psychotherapy), a clinical focus (e.g. addiction, adult acute) or a non-clinical role (e.g. research, education, administration). All rotations and Entrustable Professional Activities have a designated AOP (some rotations
may have more than one AOP).

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

The Fellowship Program outline and the Trainee progress trajectory on pages 15–17 in this handbook provide an overview of the program elements and the key deliverables for trainees to complete at each stage.

Fellowship Program outline	

Fellowship Program overview	• The RANZCP has adopted the seven CanMEDS roles to describe the Fellowship competencies. The Fellowship competencies are end point competencies for all trainees engaged in attaining Fellowship of the College.
	• The program typically requires 60 months full-time equivalent (FTE) to complete.
	  o Stage 1 (12 months FTE)
	  o Stage 2 (24 months FTE)
	  o Stage 3 (24 months FTE)
	• Progression between stages depends on attainment of Fellowship competencies as demonstrated by successful completion of all mandatory assessments AND time spent in rotations.

Formal Education Course	• All trainees must be enrolled in a Formal Education Course. • Stage 1 and 2 syllabuses have been developed to inform Formal Education Courses.
Formative assessment: Workplace-Based Assessments (WBAs)	• WBAs are used for formative assessment of competencies, NEVER as a mechanism to 'mark' or 'pass/fail' – they provide an indicator to both the supervisor and the trainee as to how the trainee is progressing. • Supervisors are required to be competent in conducting WBAs and able to provide the trainee with meaningful and effective feedback. • Supervisors use a minimum of three WBAs to inform their assessment of each EPA. • Trainees are responsible for arranging WBAs with a supervisor. • WBA tools have been selected by the College and include: Mini-Clinical Evaluation Exercise (mini-CEX), Observed Clinical Activity (OCA), Case-based Discussion (CbD), Professional Presentation (PP) and Direct Observation of Procedural Skills (DOPS). • Although OCAs are formative, it is mandatory to do one OCA every 6-month FTE rotation.
Summative assessment: Entrustable Professional Activities (EPAs)	• Progression through training requires trainees to be entrusted to perform specific EPAs to an appropriate standard for the stage of training; these standards are basic, proficient and advanced. • Each 6-month FTE rotation requires two EPAs to be entrusted. • Trainees are responsible for planning their EPAs throughout their training. Please refer to the Trainee Progress Trajectory table. • Fellowship EPAs across all stages DO NOT have to be signed off by a supervisor who has a certificate in the respective area of practice; however, supervisors must be accredited and current.
In-Training Assessment (ITA) mid-rotation forms and end-of-rotation reports	• Formative mid-rotation In-Training Assessment forms must be completed between the supervisor and trainee and should be held in the trainee's record. • Formative mid-rotation ITAs should be completed at the midpoint of the rotation, but may be completed earlier if required. • Summative end-of-rotation ITA reports MUST be submitted to the College head office within 60 days of completion of the rotation.
Summative assessment: Psychotherapy Written Case	• Assesses competence to end-of-Stage 3 standard. • Trainees are required to complete the Psychotherapy Written Case, consisting of one long psychotherapy intervention (minimum of 40 sessions) and an 8000–10,000 word write-up of the case.
Summative assessment: Scholarly Project	• College-approved project of 3000–5000 words must be successfully completed to attain Fellowship. The Scholarly Project is marked at end-of-Stage 3 standard. • Trainees are encouraged to plan their Scholarly Projects, considering the time it will take to complete the project and the availability of their proposed supervisor. • The Scholarly Project Subcommittee governs the conduct and assessment of the Scholarly Project. • Examples of appropriate Scholarly Projects include: a quality improvement Clinical Audit Cycle; a systematic and critical literature review; original and empirical research (qualitative, quantitative, or mixed methods); a case series. • Other Scholarly Projects may be approved on a case-by-case basis. • Trainees may be exempt from undertaking a Scholarly Project if, in the last 10 years, they have demonstrated competency with a substantially comparable project, completed a doctoral, research Masters or Honours thesis in a field relevant to psychiatry, or were a major author of an article published in a recognised peer-reviewed English-language journal relevant to psychiatry.
Summative assessment: MCQ and Written (CEQ and MEQ) Examinations	• The MCQ Examination is set at a Junior Consultant standard, or the expected end-of-Stage 3 standard. • The 3-hour MCQ Examination comprises Multiple Choice Questions (MCQs) and Critical Analysis Problems (CAPs), covering foundational knowledge in psychiatry. Trainees should plan to attempt the MCQ Examination during Stage 2. The MCQ Examination is a 190-minute computer-based exam to be completed at a specialised test centre. • The Essay examinations comprise of a Modified Essay Questions (MEQs) and a Critical Essay Question (CEQ). The Essay examinations have a clinical focus and assesses capacity for critical thinking about clinical practice. • The Written (CEQ and MEQ) Examinations are assessed at the standard expected at the end of Stage 3. • The 50-minute Critical Essay Question (CEQ) examination is a paper-based, handwritten examination completed at a testing centre. • The Modified Essay Question (MEQ) 150-minute examination is a paper-based, handwritten examination completed at a testing centre.
Progression through Training	• Trainees must successfully complete the Fellowship Program's assessments within the time requirements to progress through training towards Fellowship. • The Progression through Training Policy and Trainee Progress Trajectory table detail the mandatory deadlines for the completion of each summative assessment. • The Failure to Progress Policy sets out the requirements for trainees who do not adhere to those deadlines, including the completion of a targeted learning and the requirement to show cause in order to remain in the Fellowship Program after continued unsuccessful attempts of exams, rotations not being passed, extended BITS, and who have not entering targeted learning (including failure to attempt and/or pass by the deadline as well as three or more fails of the same assessment). • This policy also affects trainees who are still not eligible for Fellowship after 13 years (calendar time), trainees on a break in training for 2 years continuously or 5 years in total, and trainees who are not allocated to a training program.

Stage 1 basic

Minimum 12 months FTE accredited training in an approved adult psychiatry training post, of which 6 months is in an acute setting.

Supervision

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

Stage 1 adult psychiatry EPAs:

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

The Stage 1 first 6 months FTE rotation exception rule

A trainee in the first 6-month FTE rotation of Stage 1 may pass that rotation and its corresponding end-of-rotation ITA form before being entrusted with any EPAs. This rule may only be applied in the first 6-month FTE rotation of Stage 1 and cannot be applied in any other Stage or rotation.

Attaining Stage 2 EPAs while in Stage 1:

Trainees should, together with their Director of Training (DOT) and supervisor, refer to the Trainee Progress Trajectory table, and plan for the four Stage 2 general psychiatry EPAs and the three psychotherapy EPAs.

A trainee may also achieve these in Stage 1. In exceptional circumstances, a trainee may, with their DOT's approval, achieve other Stage 2 area of practice EPAs. The expected standard for Stage 2 EPAs remains proficient.

Trainees should familiarise themselves with the following key policy documents:

- Stage 1 Mandatory Requirements
- Progression through Training.

Stage 2 proficient

Minimum 24 months FTE accredited training in an approved training program.

Supervision

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

Mandatory areas of practice

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

Consultation–liaison psychiatry (6 months FTE)

a) Care for a patient with delirium EPA

b) Manage clinically significant psychological distress in the context of a patient's medical illness in the general hospital EPA

Child and adolescent psychiatry (6 months FTE)

c) Develop a management plan for an adolescent where school attendance is at risk EPA

d) Clinical assessment of a prepubertal child EPA

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

Addiction psychiatry

e) Management of substance intoxication and substance withdrawal EPA

f) Comorbid mental health and substance use problems EPA

Psychiatry of old age

g) Behavioural and psychological symptoms in dementia (BPSD) EPA

h) The appropriate use of antidepressants and antipsychotics in patients aged 75 years and over EPA

Elective rotations

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

- Addiction
- Adult
- Psychiatry of old age
- Forensic
- Indigenous
- Other areas of practice as approved by the College

Stage 2 general psychiatry EPAs

Attain by the end of Stage 2, can be attained in Stage 1:

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

Stage 2 psychotherapy EPAs

Two of three must be attained by the end of Stage 2. Can be attained in Stage 1, or third EPA can be attained by end of Stage 3. The third EPA is still assessed against the standard for end-of-Stage 2 training (even if completed in Stage 3). Additionally, if a Stage 2 psychotherapy EPA is completed during Stage 3, it must be in addition to the two mandatory Stage 3 EPAs that must be completed in every 6-month rotation (i.e. it cannot count as one of the two EPAs for a Stage 3 rotation):

1. Psychodynamically informed patient encounters and managing the therapeutic alliance EPA
   a) Supportive psychotherapy EPA

b) Cognitive–behavioural therapy (CBT) for management of anxiety EPA

Trainees should familiarise themselves with the following key policy documents:

- Stage 2 Mandatory Requirements
- Progression through Training.

Stage 3 advanced

Minimum 24 months FTE accredited training in an approved training program.

Supervision

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

Advanced Certificates

Trainees may undertake a Certificate of Advanced Training during this stage.

College-established areas of practice

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

- Addiction
- Adult
- Child and Adolescent
- Consultation–liaison
- Forensic
- Indigenous
- Psychiatry of old age
- Psychotherapies
- Research/academic
- Other areas of practice as approved by the College

EPAs

A minimum of two EPAs should be entrusted at an advanced level for each 6-monthrotation in Stage 3.

Stage 3 FELL (Fellowship) EPAs can be attained in any rotation whereas AOP (area of practice) EPAs can be attained in the relevant area of practice only.

Clinical currency

Trainees may undertake 12 months of research/academic or specialised administrative/managerial training during Stage 3.

Leadership and management

Each Branch Training Committee (BTC) approves the options for formal leadership and management training in their state/country.

Stage 3 psychotherapy

Trainees must provide psychotherapy to a minimum of three patients for at least six sessions each.

Trainees should familiarise themselves with the following key documents:

- Stage 3 Mandatory Requirements
- Progression through Training.

MCQ Exam

Written Examinations (CEQ and MEQ)

Clinical Competency Assessment – Modified Portfolio Review (CCA – MPR)

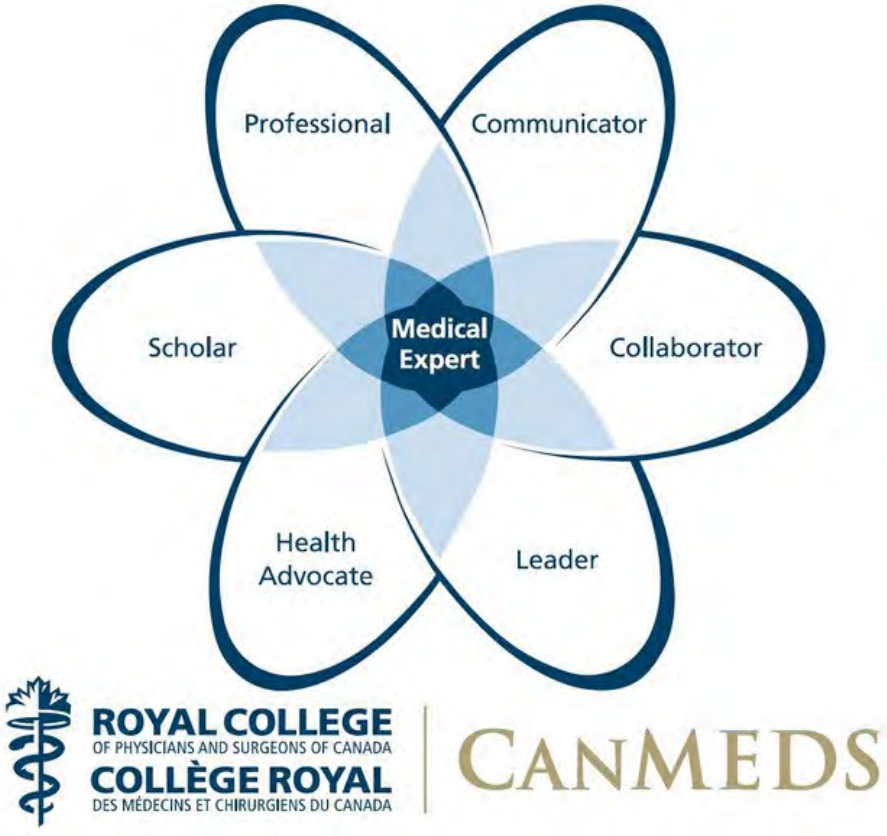
Scholarly Project

Psychotherapy Written Case

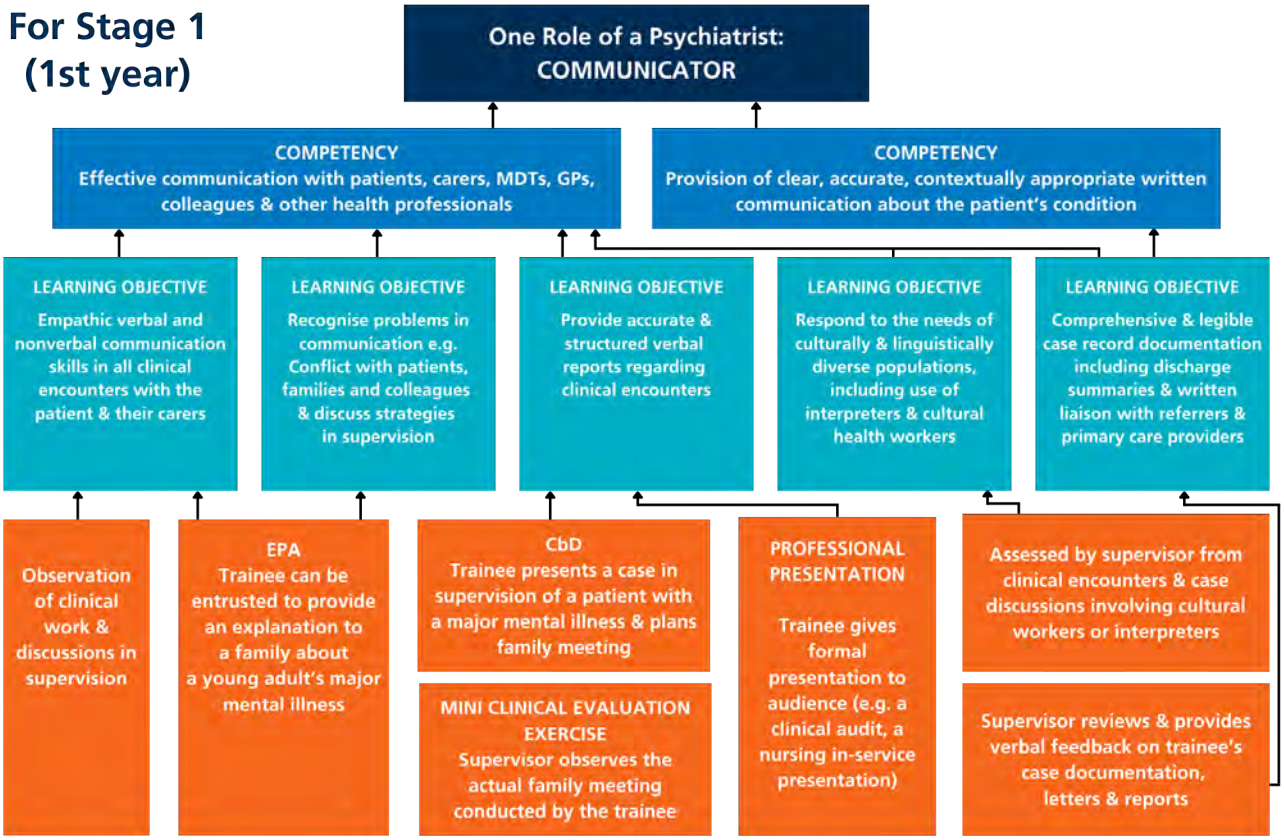
Fellowship competencies

The information in this section is taken from the Fellowship competencies page on the RANZCP website.

The core competencies, as outlined in the Fellowship competencies, broadly define the capabilities expected of all trainees on attaining Fellowship of the College.
The concept of competency-based education, as it relates to the development of objectives for training, is that these objectives, or competencies, should describe the desired outcomes of training, i.e. the knowledge, skills and attitudes expected of learners upon completion of their training. The competencies shown below are end-point competencies for all trainees engaged in attaining Fellowship of the College, defined across the major roles of a doctor, recognising that the range of abilities expected of a doctor in the 21st century extends beyond medical expertise. These Fellowship competencies have been refined into definitive statements of the College's understanding of psychiatry in Australia and New Zealand, described using the CanMEDS roles below.



The diagram below expands on the Fellowship competencies of the 'communicator' role as an example of one competency for one stage of training. It details the ways in which WBAs, EPAs and general supervision may contribute to the achievement of learning outcomes and Fellowship competencies.



Curriculum map

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

Note:

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

The full curriculum maps for both Stage 1 and Stage 2 can be accessed on the RANZCP website.

Syllabus

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

The syllabus is not intended to be prescriptive, and detailed descriptions of content are intentionally excluded to remain consistent with adult learning principles and to reflect the richness and diversity of psychiatry. All areas of knowledge in the syllabus are important; however, not all areas may be expected to be learnt to the same level. As such, a rating system of three categories (Awareness of concepts, working knowledge, and In-depth knowledge) has been used to indicate the depth of knowledge expected at each stage of training.

Entrustable Professional Activities (EPAs) overview

This section provides an overview of the sequencing of EPAs throughout the program.

SECTION FOUR: ASSESSMENTS provides a detailed explanation of EPAs as a form of assessment.

Trainees must attain 16–21 EPAs, within 24 months, by the end of Stage 2. Forward planning is needed to ensure their completion. The expected trajectory can assist the supervisor in planning a trainee's attainment of training elements.

Stage 1

Stage 1 involves a minimum of 12 months FTE training in adult psychiatry, with six months FTE of that time spent in an acute setting. The Stage 1 Mandatory Requirements Policy details requirements for accredited rotations.

By the end of Stage 1, trainees must complete one of the following:

No EPAs in term 1 and the two Stage 1 EPAs in term 2

OR

The two Stage 1 EPAs in term 1 and two Stage 2 generalist* EPAs in term 2

OR

One Stage 1 EPA in each of terms 1 and 2, and a generalist* Stage 2 EPA in term 2.

*Other Stage 2 EPAs may substitute for a generalist Stage 2 EPA with the prior approval of the Director of Training (DOT).

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

In addition to the two mandatory EPAs for Stage 1, trainees are eligible to attain any of the general psychiatry EPAs.

These general psychiatry EPAs are assessed at the standard expected of a trainee at the end of Stage 2, regardless of whether they are attempted in Stage 1 or Stage 2, and may be achieved in any AOP rotation.

Stage 2

General Psychiatry EPAs

By the end of Stage 2, trainees must be entrusted with the following general psychiatry EPAs to progress to Stage 3.

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

Psychotherapy EPAs

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

By the end of Stage 2, trainees must be entrusted with a minimum of two out of three psychotherapy EPAs to progress to Stage 3.

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

Trainees may attain the third psychotherapy EPA in Stage 3. Psychotherapy EPAs may be attained in any AOC rotation.

Stage 2 mandatory rotations with specific EPAs

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

Consultation–liaison psychiatry (mandatory rotation):

1. Caring for a patient with delirium
2. Managing clinically significant psychological distress in the context of a patient's medical illness in the general hospital

Child and adolescent psychiatry (mandatory rotation):

1. Developing a management plan for an adolescent where school attendance is at risk
2. Clinical assessment of a prepubertal child

Additional mandatory EPAs

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

Addiction psychiatry (elective rotation):

1. Management of intoxication and withdrawal
2. Comorbid mental health and substance use problems

Psychiatry of old age (elective rotation):

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

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

Stage 2 elective rotations

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

- addiction
- adult
- forensic
- Indigenous
- psychiatry of old age
- psychotherapies
- research

Note that if any of these elective rotations are undertaken, it becomes mandatory for the two rotation-linked EPAs to be completed (except if it is the second rotation in Stage 2 in that area of practice).

Stage 3

Stage 3 comprises the fourth and fifth years (FTE) of training and is undertaken for 24 months FTE. Trainees in the generalist Fellowship stream must complete 24 months FTE in one or more areas of practice:

- addiction
- adult
- child and adolescent
- forensic
- Indigenous
- psychiatry of old age
- psychotherapies
- research
- academic

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

Certificate of Advanced Training

Trainees may apply and, if successful, enrol in a Certificate of Advanced Training in an area of practice that provides an advanced training certificate.

Assessment

SECTION FOUR: ASSESSMENT

Structure

The assessment standards align with the Australian Medical Council (AMC) accreditation standards and incorporate a range of formats that reflect the objectives of the training program.

Assessment methods include both summative and formative assessments to evaluate trainee progress through the psychiatry training pathway and provide tools for feedback and guidance.

Formative assessments

Workplace-Based Assessments (WBAs)

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

WBAs provide a mechanism for structured and effective feedback that helps trainees and supervisors assess how the trainee is progressing and plan for future learning activities.

As WBAs provide structured feedback for learning, it is helpful for them to be performed early in a rotation, at the midpoint and towards the end. Trainees who would benefit from, or want, more feedback may undertake additional WBAs.

Three WBAs must be completed before each Entrustable Professional Activity (EPA) can be attained. However, this does not mean that if three WBAs have been completed, the EPA must be automatically entrusted. Three WBAs are necessary, but may not be sufficient, for entrustment. A supervisor considers the trainee's performance in their WBAs, along with other evidence from their observed clinical practice, when deciding to entrust an EPA.

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

The Fellowship program has approved five WBA tools:

- Mini-Clinical Evaluation Exercise
- Observed Clinical Activity (OCA)
- Independent Observed Clinical Activity (IOCA)
- Case-based Discussion (CbD)
- Professional Presentation (PP)
- Direct Observation of Procedural Skills (DOPS)

Mini-Clinical Evaluation Exercise

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

Observed Clinical Activity (OCA)

The OCA requires the assessor to observe the trainee engaging in the principal work of undertaking a comprehensive assessment of a patient. This includes taking a patient's history, conducting a mental state and physical examination, making a diagnosis and formulating a treatment plan within one clinical interview session. After the clinical interview, the trainee presents the case to the supervisor, and a discussion about assessment and management occurs. The OCA may be split over two one-hour sessions a week or may be held as a single two-hour session.

Trainees will be assessed on their skills in history taking, examination, formulation and management, and given feedback. The value of an OCA lies in the opportunity it provides for immediate structured feedback on the trainee's performance, further supporting and enhancing their learning.

Case-based Discussion (CbD)

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

Professional Presentation (PP)

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

Direct Observation of Procedural Skills (DOPS)

A DOPS is a concise, validated method of assessment consisting of a supervisor observing a trainee conducting a procedural skill (e.g. psychotherapy, ECT, supervision, physical examination) and providing feedback to the trainee about their performance. The most important part of the DOPS is the feedback given to the trainee.

WBA standard

Each WBA is assessed on a 3-category rating scale. For each item being assessed, the trainee's performance is graded as being either Below, Meets or Above the standard for the end of that stage of training.

For the OCA, there is also a 3-point numerical scale within each category as follows:

Below the standard for end of the stage: 1, 2 or 3

Meets the standard for end of the stage: 4, 5, 6

Above the standard for end of the stage: 7, 8 or 9

The standard for each stage is described in the Developmental Descriptors. Supervisors should use the Developmental Descriptors to help gauge if a trainee is meeting the standards.

The midpoint of the scale ('Meets the standard for end of the stage') is the minimum standard trainees should achieve by completion of each stage. In addition to rating the trainee's performance on the scale, the supervisor or assessor also provides narrative feedback to the trainee, which is the key aspect of WBAs. It is also important to note that not all assessable criteria will be met on each WBA form, as the trainee and assessor should agree on the key skills being assessed.

Trainees are responsible for initiating the WBA process and are responsible for updating their learning plans after each WBA has been completed. Supervisors may initiate the WBA process at appropriate times to support the provision of feedback and to focus on particular aspects of practice.

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

Supervision of clinical work during training is a vital part of the assessment of professional competence. A formative ITA is completed at the midpoint of a trainee's rotation. This provides feedback to the trainee and may be useful in identifying which, if any, areas of a trainee's competencies need improvement.
If the supervisor believes that the trainee is not meeting the required standards, a supportive plan ought to be discussed and agreed upon with the trainee and implemented as soon as possible during a rotation. It is important not to delay this until the end of a rotation.

It is also important that supervisors document the outcomes of these supportive plans accurately on formative and summative mid- and end-of-rotation paperwork. Please see

the related In-Training Assessment Policy and the Progression through Training Policy for further information.

Summative assessments

Entrustable Professional Activities (EPAs)

EPAs are specific activities performed by a trainee that are entrusted by a supervisor. This occurs when a supervisor, using all the data available to them, including the trainee's performance on WBAs, makes an informed decision that the trainee may be trusted to perform the specific task to the required standard with only distant (reactive) supervision.

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

EPAs are entrusted at the following standards:

- Stage 1 – basic level
- Stage 2 – proficient level
- Stage 3 – advanced level

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

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

Two EPAs must be signed off before a trainee may successfully complete a rotation. The only exception is that a trainee in their first 6-month FTE rotation of Stage 1 is not required to be entrusted with any EPAs. Please see the Progression through Training Policy for further information.

In-Training Assessments (ITA) (end-of-rotation)

A summative ITA is completed at the end of each rotation.

Psychotherapy Written Case

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

The psychotherapy

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

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

The written case

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

Scholarly Project

The Scholarly Project may be submitted for assessment during any stage of training. The Project will be assessed at the end-of-Stage 3 standard, regardless of when it is submitted.

Research and topic

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

Project options

A Scholarly Project may take the form of:

- a quality improvement Clinical Audit Cycle
- a critical literature review
- original and empirical research (qualitative, quantitative or mixed methods)
- a case series of three or more patients
- an equivalent other project as approved by the Scholarly Project Subcommittee.

The Scholarly Project must be 3000–5000 words in length. Exemptions and exceptions to the Scholarly Project are further defined in the relevant policy and procedure. The Scholarly Project must be completed and submitted by the deadline.

Multiple Choice Question (MCQ) Examination

The MCQ Examination will test foundational knowledge including, but not limited to, neuroscience, pharmacotherapy, experimental design and critical analysis, history and philosophy of psychiatry, and principles of key psychotherapies. It is set at the standard of the end of Stage 3. The trainee may attempt the exam after they have completed 6 months FTE accredited training (Stage 1). The examination is not a barrier for trainees to enter Stage 2 or Stage 3 of training. The MCQ Examination must be successfully completed by the deadline. Please refer to the MCQ Examination page on the RANZCP website for more information.

Written Examinations (CEQ and MEQ)

The Critical Essay Question (CEQ) and Modified Essay Questions (MEQ) examinations will test knowledge and its application at the level of the end of Stage 3 training. While the trainee may enrol to sit these exams after 18 months of training, it is recommended that they not be attempted until Stage 3. The examinations are not a barrier for trainees to enter Stage 3 of training. The essay examinations must be successfully completed by the deadline. Please refer to the CEQ and MEQ examination pages on the RANZCP website for more information.

Clinical Competency Assessment – Modified Portfolio Review (CCA – MPR)

The CCA – MPR consists of a Portfolio Review assessing the trainee's most recent end-of-rotation In-Training Assessments (ITAs), along with all associated Observed Clinical Activities (OCAs). To be eligible for the CCA – MPR, the trainee must have three end-of-rotation ITAs which cover a training time of at least 15 months FTE, nine months of which must be at Stage 3. The trainee's overall performance in their ITAs and OCAs is assessed against Fellowship competencies and their achievement of the learning outcomes. For the trainee to apply for the CCA – MPR, paperwork associated with end-of-rotation ITAs and OCAs must be successfully completed by the relevant deadline. The eligibility criteria can be found here: Clinical Competency Assessment – Modified Portfolio Review.

- The trainees' grades on all the learning outcomes in the end-of-term ITAs are considered. Supervisors should ensure scores accurately reflect the trainee's clinical performance. A lower score signifies an area for improvement and may serve to promote dialogue and growth.
- An 'unable to comment' grade on an end-of-rotation ITA can have a negative impact on the CCA – MPR process because it removes information from the ITA. Therefore, supervisors and trainees should find ways for various competencies to be demonstrated across the term. Trainees are encouraged to consider the broad areas of psychiatry encountered across their working week, including overtime and working with other health and non-health professionals. These experiences map to these learning outcomes, including the Manager domain. A key goal for supervisors should be to make a genuine grade rather than 'unable to comment' at the end of a rotation.
- Narrative supervisor feedback is also considered in the CCA – MPR. Supervisors need to be thoughtful about writing feedback that is accurate, justified, objective and helpful for the trainee. The feedback should seek to explain the range of grades given for learning outcomes, especially failing grades such as 'inconsistently met' and 'rarely met', or 'unable to comment' grades. Please refer to the CCA Assessment Criteria page on the RANZCP website.

References

REFERENCES

Davys A, Beddoe L (2020) *Best Practice in Professional Supervision, Second Edition: A Guide for the Helping Professions*. UK: Jessica Kingsley Publishers.

Hughes L, Pengelly P (1997) *Staff supervision in a turbulent environment: Managing process and task in front-line services*. London, UK: Jessica Kingsley Publishers.

Jordan SE, Shearer EM (2019) An exploration of supervision delivered via clinical video telehealth (CVT). *Training and Education in Professional Psychology* 13(4).

Kilminster SM, Jolly BC (2000) Effective supervision in clinical practice settings: a literature review. *Medical Education* 34(10).

MacDonald J (2002) Clinical supervision: a review of underlying concepts and developments. *Australian & New Zealand Journal of Psychiatry* 36(1).

Pront L, Gillham D, Schuwirth, LW (2016) Competencies to enable learning-focused clinical supervision: a thematic analysis of the literature. *Medical Education* 50(4).

Rothwell C, Kehoe A, Farook SF, Illing, J (2021) Enablers and barriers to effective clinical supervision in the workplace: a rapid evidence review. *BMJ Open* 11(9).

Policies

List of RANZCP training regulations and policies

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