Table of Contents

PURPOSE OF THE KNOWLEDGE BASE ... 3
EDUCATIONAL FRAMEWORKS ... 3
CONSTRUCTIVE ALIGNMENT ... 3
MILLER'S PYRAMID OF CLINICAL COMPETENCE ... 4
CANMEDS COMPETENCY FRAMEWORK ... 4
APPLICATION TO STAGES OF TRAINING ... 4
KEY COMPONENTS CLINICAL CONDITIONS, TREATMENT MODALITIES AND SPECIFIC POPULATIONS AND SERVICE CONTEXTS ... 5
PRINCIPLES UNDERPINNING THE KNOWLEDGE BASE ... 5
LIVING DOCUMENT AND UPDATES ... 5
REFERENCES ... 6

SECTION 1: CORE ROLES AND COMPETENCIES ... 7

1.1 PSYCHIATRIC AND MEDICAL EXPERT ... 8

1.1.1 BIOLOGICAL SCIENCES ... 8
STAGE EXPECTATIONS ... 8
1.1.2 PSYCHOLOGICAL SCIENCES ... 9
STAGE EXPECTATIONS ... 9
1.1.3 SOCIAL SCIENCES ... 10
STAGE EXPECTATIONS ... 10
1.1.4 PSYCHIATRIC DIAGNOSIS, FORMULATION, AND CLASSIFICATION SYSTEMS ... 11
STAGE EXPECTATIONS ... 11

1.2 COMMUNICATOR ... 17

INTENDED LEARNING OUTCOME (ILO): ... 17
STAGE EXPECTATIONS ... 17

1.3 COLLABORATOR ... 19

INTENDED LEARNING OUTCOME (ILO): ... 19
STAGE EXPECTATIONS ... 19

1.4 LEADER ... 21

INTENDED LEARNING OUTCOME (ILO): ... 21
STAGE EXPECTATIONS ... 21

1.5 ADVOCATE ... 23

INTENDED LEARNING OUTCOME (ILO): ... 23
STAGE EXPECTATIONS ... 23

DRAFT

1.6 SCHOLAR 25

INTENDED LEARNING OUTCOME (ILO): 25
STAGE EXPECTATIONS 25
1.7 PROFESSIONAL 27
INTENDED LEARNING OUTCOME (ILO): 27
STAGE EXPECTATIONS 27

1.8 CULTURALLY SAFE AND RESPONSIVE PRACTITIONER 13

KEY DEFINITIONS 13
INTENDED LEARNING OUTCOME (ILO): 15
STAGE EXPECTATIONS 15

SECTION 2: CLINICAL CONDITIONS 30

INTRODUCTION 30
GENERAL EXPECTATIONS ACROSS ALL CONDITIONS 31
SPECIFIC STAGE 1 EXPECTATIONS 31
CLINICAL CONDITIONS 32
EMERGENT DISORDERS 37

SECTION 3: TREATMENT CONCEPTS AND MODALITIES 38

INTRODUCTION 38
PRINCIPLES OF SAFE PRESCRIBING 39
PHARMACOLOGICAL TREATMENTS 39
NON-PHARMACOLOGICAL BIOLOGICAL TREATMENTS 41
PSYCHOLOGICAL TREATMENTS 42
SOCIAL INTERVENTIONS 43
RECOVERY MODEL IN PSYCHIATRY 43
PERSON-CENTRED CARE PLANNING 43
INTEGRATING RECOVERY AND PERSON-CENTRED CARE 44
EMERGENT TREATMENT CONCEPTS AND MODALITIES 44
INTRODUCTION 45
GENERAL EXPECTATIONS ACROSS ALL POPULATIONS AND CONTEXTS 46
POPULATIONS 46
SERVICE CONTEXTS 51
EMERGENT AREAS WARRANTING SPECIFIC FOCUS 54

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Introduction to the Knowledge Base Document

This Knowledge Base forms a core component of the **Royal Australian and New Zealand College of Psychiatrists (RANZCP) Fellowship Program Curriculum**. It provides the foundational and advanced knowledge required of trainees as they progress through the stages of training, contextualised to the practice of psychiatry in Australia and Aotearoa New Zealand.

The Knowledge Base is designed to be read in conjunction with other key curricular documents, including the:

- **Program and Graduate Outcomes and Competencies**
- **Entrustable Professional Activities (EPAs)**
- **Teaching and Learning Framework**
- **Curriculum Map**

Ultimately, these documents will be integrated into a single, comprehensive curriculum document.

Purpose of the Knowledge Base

The Knowledge Base outlines what trainees are expected to know, understand, and be able to apply throughout training. It is not a syllabus of facts to memorise, but a guide to the scope and depth of knowledge that underpins safe, effective, recovery-oriented, and culturally responsive psychiatric practice.

By articulating knowledge outcomes in terms of **Intended Learning Outcomes (ILOs)**, the Knowledge Base ensures **constructive alignment** (Biggs & Tang, 2011) where learning outcomes, teaching activities, and assessment methods are aligned to support the development of competence.

Educational Frameworks

Constructive Alignment

The Knowledge Base follows the principle of constructive alignment (Biggs & Tang, 2011). Each Intended Learning Outcome is expressed in terms of what trainees will be able to **do** with knowledge, rather than what they will merely know.

- **ILOs** specify observable performance using action verbs.
- **Teaching and learning activities** provide opportunities for trainees to acquire and practise knowledge.
- **Assessment** evaluates the achievement of ILOs in authentic contexts.

Miller's Pyramid of Clinical Competence

Progression of knowledge and competence is mapped to **Miller's Pyramid** (Miller, 1990). This framework illustrates the developmental trajectory from theoretical knowledge to independent professional practice:

- **Knows** → factual knowledge (e.g., definitions, recall)
- **Knows How** → application of knowledge (e.g., analysis, problem-solving)
- **Shows How** → demonstration of competence (e.g., performing in a supervised context)
- **Does** → independent practice in real clinical settings

Each outcome in the Knowledge Base is mapped to one or more levels of Miller's Pyramid, demonstrating progression from **novice to independent practitioner**.

CanMEDS Competency Framework

The Knowledge Base is organised using the **CanMEDS Physician Competency Framework** (Frank, Snell & Sherbino, 2015), adapted for the RANZCP context. The eight roles are:

1. Psychiatric and Medical Expert
2. Communicator
3. Collaborator
4. Leader
5. Advocate
6. Scholar
7. Professional
8. Culturally Safe and Responsive Practitioner

Application to Stages of Training

The Fellowship training program is divided into three stages; each associated with increasing depth and independence:

Stage 1 (Onboarding to Specialty):
Trainees acquire **foundational knowledge** and begin to demonstrate its application in supervised settings. Outcomes are primarily at the **Knows** and **Knows How** levels.

Stage 2 (Core Training):
Trainees consolidate knowledge and **apply it consistently** in varied clinical contexts, moving towards **Shows How** level outcomes.

Stage 3 (Transition into Independent Practice):
Trainees demonstrate the ability to **apply knowledge adaptively and independently** in complex and uncertain contexts. Outcomes are predominantly at the **Does** level, reflecting readiness for independent practice.

Key Components Clinical Conditions, Treatment Modalities and Specific Populations and Service Contexts

The term **Key Condition (K)** has been used to identify areas under Sections 2 to 4 where trainees are expected to demonstrate applied competence (i.e. in-depth knowledge and skill) versus knowledge and awareness by the completion of training. Depending on future scope of practice and additional advanced training, Fellows will need to plan to develop applied competence for areas not identified as Key as well as expand their level of competence in areas already identified as Key.

Principles Underpinning the Knowledge Base

- **Recovery-oriented practice:** Trainees must demonstrate knowledge that supports person-led recovery, autonomy, and inclusion.
- **Patient-centred and family-centred care:** Trainees must integrate knowledge of models that prioritise the perspectives, values, and goals of patients and their families/whānau, recognising the therapeutic value of collaborative decision-making and shared responsibility for care.
- **Cultural safety:** Trainees must integrate culturally safe and responsive practice, with specific emphasis on working with **Aboriginal and Torres Strait Islander peoples** and **Māori peoples** (Curtis et al., 2019).
- **Trauma-informed care:** Trainees must demonstrate knowledge of the pervasive impact of trauma and principles for creating safe, trustworthy, collaborative, and empowering therapeutic environments.
- **Evidence-based practice:** Trainees are expected to critically appraise and apply current research to guide clinical decision-making.
- **Ethics and human rights:** Knowledge of ethics and rights-based frameworks is central to safe psychiatric practice.
- **Complexity and uncertainty:** Trainees must be prepared to integrate knowledge across biological, psychological, social, cultural, and systemic domains in managing complex cases.

Living Document and Updates

The Knowledge Base is a **dynamic, evolving document**. It reflects current evidence, best practice, and the needs of communities in Australia and Aotearoa New Zealand. Psychiatry is a field that continues to develop rapidly, particularly in areas such as neuroscience, digital health, pharmacological innovations, cultural safety, and recovery-oriented practice.

To ensure it remains relevant and fit-for-purpose, the Knowledge Base will be **reviewed and updated on a regular basis**.

Updates will be informed by:

- advances in scientific and clinical knowledge,
- feedback from trainees, Fellows, consumers, carers, and stakeholders, and
- evolving health and social policy contexts.

Suggestions for revisions or additions to the Knowledge Base are welcomed. Please contact the RANZCP Education team at: **education@ranzcp.org**.

References

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Section 1: Core Roles and Competencies

This section outlines the **core roles and competencies** that underpin the practice of psychiatry across all stages of Fellowship training. These roles are derived from the RANZCP's adaptation of the CanMEDS framework and represent the expectations of psychiatrists as medical specialists, professionals, and leaders within health systems and society.

Unlike "foundational knowledge" which may suggest pre-clinical or entry-level learning, these competencies are **progressive and developmental across the entire training program**. Each role is expressed in terms of outcomes that deepen from **knowledge acquisition (Stage 1)** through to **applied performance (Stage 2)** and **independent role modelling (Stage 3)**.

The eight roles are:

- Psychiatric and Medical Expert
- Culturally Safe and Responsive Practitioner
- Communicator
- Collaborator
- Leader
- Advocate
- Scholar
- Professional

Together, these roles provide a comprehensive framework for psychiatric training and practice. They reflect the College's commitment to:

- person-centred and family-centred care,
- recovery-oriented practice,
- trauma-informed approaches,
- cultural safety and responsiveness,
- and a professional identity grounded in ethics, reflection, and lifelong learning.

Each role is detailed with:

- an overarching **Intended Learning Outcome (ILO)**,
- staged expectations across Stages 1–3,
- alignment to **Miller's pyramid of clinical competence**,
- and references to key frameworks, scholarship, and standards.

This framework ensures that the Fellowship Program produces psychiatrists who are not only clinically competent but also ethically grounded, culturally safe, reflective, and

Together, these outcomes articulate the **scope and depth of knowledge** required for contemporary psychiatric practice in Australia and Aotearoa New Zealand.

1.1 Psychiatric and Medical Expert

The Psychiatric and Medical Expert role is central to the practice of psychiatry, integrating the biological, psychological, and social sciences with diagnostic frameworks and clinical reasoning. It requires trainees to acquire deep and progressive knowledge that informs assessment, formulation, treatment, and communication.

This knowledge must extend beyond factual recall to the ability to **apply and adapt understanding in complex and uncertain contexts**, consistent with **Miller's Pyramid of Competence** (Miller, 1990). Outcomes are staged across training to reflect increasing depth and independence.

1.1.1 Biological Sciences

Intended Learning Outcome (ILO):
Upon completion, trainees will **demonstrate, apply, and critically appraise** knowledge of neuroanatomy, neurophysiology, neuropathology, neuropharmacology, neuroimmunology, and genetics/epigenetics in order to assess, diagnose, and manage psychiatric conditions in clinical practice.

Stage Expectations

- **Stage 1 (Knows):**
  - Define the structure and function of major brain regions, including cortical, subcortical, and limbic systems.
  - Describe the principles of neuronal physiology, including synaptic transmission, neurotransmitter systems, and action potential generation.
  - Identify common neuropathological processes relevant to psychiatry, such as neurodegeneration, infection, or trauma.
  - Explain the basic mechanisms of psychotropic medications.
  - Recall key concepts of genetics, inheritance, and epigenetics in psychiatric disorders.
- **Stage 2 (Knows How / Shows How):**
  - Analyse the role of neurotransmitter systems (e.g., dopamine in psychosis, serotonin in mood disorders, GABA in anxiety disorders).
  - Apply neuropharmacological knowledge to clinical prescribing and monitoring of psychotropics.
  - Interpret the clinical relevance of neuropathological changes (e.g., hippocampal atrophy in PTSD, basal ganglia changes in Huntington's disease).
  - Explain gene–environment interactions and their role in psychiatric vulnerability.
  - Apply knowledge of neuroimmunology to conditions such as autoimmune encephalitis or inflammatory depression.
- **Stage 3 (Does):**
  - Integrate biological sciences into comprehensive biopsychosocial formulations for complex and comorbid presentations.

  - Critically evaluate emerging biological evidence, such as neuroimaging biomarkers or novel pharmacological agents, and apply this to patient care.
  - Communicate complex biological explanations clearly and compassionately to patients, families/whānau, and colleagues.

1.1.2 Psychological Sciences

Indented Learning Outcome (ILO):
Upon completion, trainees will **explain, apply, and integrate** psychological theories and models into psychiatric assessment, formulation, and treatment, demonstrating knowledge across the lifespan and in diverse contexts.

Stage Expectations

- **Stage 1 (Knows):**
  - Describe **attachment theory** and its relevance to development and psychopathology.
  - Recall core concepts of **developmental psychology**, including cognitive, emotional, and social developmental milestones.
  - Define **developmental psychopathology**, including the impact of adverse childhood experiences (ACEs) on later vulnerability.
  - Explain **theories of personality** (psychodynamic, trait-based, and dimensional).
  - Describe principles of **behavioural psychology**, including classical and operant conditioning.
  - Recall models from **cognitive psychology**, including cognitive biases and information processing theories.
  - Outline **learning theory**, including social learning and modelling.
  - Recognise the **phenomenology of grief, bereavement, and loss**, and typical psychological responses.
  - Identify responses to **acute and chronic stress**, including resilience and vulnerability factors.
  - Recall basic principles of **psychometric theory**, including intelligence, personality, and symptom measures.
  - Describe concepts from **health psychology**, including models of adherence, coping, and health behaviour change.
- **Stage 2 (Knows How / Shows How):**
  - Apply attachment and developmental theories to assess clinical presentations (e.g., disorganised attachment in personality disorder).
  - Analyse the role of ACEs and trauma in case formulation.
  - Interpret psychometric assessments, including intelligence testing, personality inventories, and symptom rating scales.
  - Evaluate the application of behavioural and cognitive theories in treatment planning (e.g., CBT for anxiety, behavioural activation for depression).
  - Integrate concepts of health psychology into clinical care (e.g., understanding adherence in psychopharmacology, coping with chronic illness).
- **Stage 3 (Does):**

  - Integrate psychological theories into complex biopsychosocial formulations, adapting across diverse contexts and cultural backgrounds.
  - Apply psychometric testing and theory critically in advanced clinical reasoning.
  - Lead the application of psychological knowledge within multidisciplinary teams, communicating effectively to patients and families.
  - Use trauma-informed frameworks to adapt clinical approaches across settings.

1.1.3 Social Sciences

Intended Learning Outcome (ILO):
Upon completion, trainees will **demonstrate, analyse, and apply** knowledge of social sciences to understand the determinants of mental health, barriers to care, and systemic inequities, and to incorporate these into assessment, formulation, and treatment.

Stage Expectations

- **Stage 1 (Knows):**
  - Define concepts of **social stratification, poverty, and inequality**, and their impact on mental health outcomes and service access.
  - Describe the effects of **race, racism, and systemic discrimination** on mental health and institutional trust.
  - Recall principles of **gender identity and gender diversity**, with emphasis on affirming and inclusive care.
  - Identify the mental health needs of people with diverse **sexual orientations** (LGBTQIA+).
  - Describe the relevance of **culture, identity, and spirituality**, including cultural safety, acculturation, and culturally responsive practice.
  - Outline sociological perspectives on **suicide**, including contagion and cultural influences.
  - Recall the impact of **family and domestic violence**, including coercive control and intergenerational trauma.
  - Define the psychiatric implications of **offending behaviour and sexual violence**.
  - Recognise the long-term psychosocial effects of **childhood abuse and neglect**.
  - Describe the effects of **bullying, harassment, and discrimination**, including within health systems.
  - Identify the experiences and mental health needs of **migrants, asylum seekers, and refugees**.
  - Recognise the influence of **information technologies, social media, and news media** on behaviour, identity, and mental health.
  - Define concepts of **stigma**, including public, structural, and internalised stigma, and their impact on recovery.
  - Recall the effects of **housing instability and homelessness** on mental health.

    - Describe the mental health impacts of **occupational and educational disadvantage**, including unemployment and early school leaving.
    - Identify the role of **social capital and community connectedness** in resilience and vulnerability.
    - Recognise the **psychosocial effects of disasters, terrorism, and pandemics**.
    - Recall the psychiatrist's responsibility to uphold **human rights**, including opposition to torture and inhumane treatment.
- **Stage 2 (Knows How / Shows How):**
    - Apply knowledge of social determinants to analyse clinical presentations.
    - Evaluate the effects of systemic racism and discrimination in case formulations.
    - Incorporate considerations of gender, sexuality, and cultural identity into assessments and care plans.
    - Analyse the role of stigma and disadvantage in limiting recovery.
    - Apply trauma-informed approaches in responding to family violence, abuse, and neglect.
    - Assess the impact of housing, employment, and social capital on treatment adherence and prognosis.
    - Evaluate psychosocial responses to disasters and community trauma in clinical work.
- **Stage 3 (Does):**
    - Integrate social determinants and systemic influences into comprehensive biopsychosocial formulations.
    - Lead advocacy within services for equitable and culturally safe care.
    - Contribute to systemic responses to inequality, stigma, and discrimination at service, community, or policy levels.
    - Uphold human rights principles in all aspects of psychiatric practice, including forensic and institutional contexts.

1.1.4 Psychiatric Diagnosis, Formulation, and Classification Systems

Intended Learning Outcome (ILO):
Upon completion, trainees will **explain, apply, and critically evaluate** psychiatric diagnostic systems (ICD, DSM), case formulation models, and the appropriate use of investigations, psychometric tests, and documentation in assessment.

Stage Expectations

- **Stage 1 (Knows):**
    - Describe the history of psychiatric diagnostic and classificatory systems (ICD, DSM).
    - Outline the principles, benefits, and limitations of classificatory approaches.
    - Identify the purpose of differential diagnosis.
    - Recall approaches to psychiatric interviewing and mental state examination.
    - Describe the role of investigations in psychiatric diagnosis, including:
        - **Pathological tests** (e.g., thyroid function, metabolic panels).
        - **Imaging** (MRI, CT).

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        - **Electroencephalograms (EEG)**.
        - **Electrocardiograms (ECG)**.
        - **Sleep studies**.
        - **Psychometric assessments** (intelligence, personality, symptom rating scales).
    - Recognise the principles of professional psychiatric documentation.
- **Stage 2 (Knows How / Shows How):**
    - Apply ICD and DSM frameworks in developing differential diagnoses.
    - Explain diagnostic reasoning in oral and written case presentations.
    - Use structured approaches to interviewing and mental state examinations.
    - Select and interpret appropriate investigations and psychometric tools.
    - Demonstrate clear and professional documentation of psychiatric assessments.
    - Communicate assessments effectively to supervisors, peers, and multidisciplinary teams.
    - Outline the strengths and limitations of different approaches to case formulation (biopsychosocial, psychodynamic, systemic, cultural).
- **Stage 3 (Does):**
    - Integrate classificatory frameworks with clinical judgement in complex and comorbid presentations.
    - Critically evaluate emerging diagnostic models (e.g., dimensional or transdiagnostic approaches).
    - Apply and interpret investigations and psychometric results in complex cases.
    - Demonstrate excellence in documenting assessments for diverse audiences, including tribunals, courts, and multidisciplinary teams.
    - Lead formulation discussions, applying multiple perspectives (biological, psychological, social, cultural, systemic).
    - Communicate diagnoses and formulations with sensitivity to patients, whānau, and carers.

1.2 Culturally Safe and Responsive Practitioner

Cultural safety is central to psychiatric practice in Australia and Aotearoa New Zealand. It requires psychiatrists to recognise and address power imbalances, systemic inequities, and the ongoing impacts of colonisation, racism, and discrimination. Cultural safety extends beyond knowledge of cultural practices: it demands self-reflection, humility, and responsiveness to the lived experience of patients, families/whānau, and communities.

In the Australian context, psychiatrists must provide care that respects the rights, identity, and wellbeing of Aboriginal and Torres Strait Islander peoples, acknowledging the enduring impact of dispossession, intergenerational trauma, and systemic racism. In Aotearoa New Zealand, psychiatrists must honour Te Tiriti o Waitangi and ensure care is responsive to the needs and rights of Māori as tangata whenua. Cultural responsivity also extends to diverse communities, including those defined by ethnicity, gender identity, sexuality, spirituality, migration experience, and disability.

Key Definitions

- **Cultural Safety**
    - Originating in Aotearoa New Zealand from nursing and midwifery literature (Ramsden, 2002), the term cultural safety has significant importance for First Nations peoples — Aboriginal and Torres Strait Islander peoples in Australia, and Māori in Aotearoa New Zealand.
    - Ahpra –
        - Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities.
        - Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.
    - MCNZ - Council defines cultural safety as:
        - The need for doctors to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery.
        - The commitment by individual doctors to acknowledge and address any of their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided.
        - The awareness that cultural safety encompasses a critical consciousness where healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities.
    - Is determined and defined from the members of the culture not external parties.

- It requires practitioners to examine their own cultural identity, reflect on power dynamics, and take responsibility for delivering care that is defined as safe by the patient, their family/whānau, and community.
- It acknowledges the historical and ongoing impacts of colonisation, systemic racism, and intergenerational trauma, and requires a partnership approach to health care.

- **Cultural Awareness**
    - Refers to knowledge of cultural differences and basic facts about traditions, practices, and beliefs of other cultural groups.
    - It is a starting point, but insufficient on its own, as it risks stereotyping and does not address systemic inequities or practitioner self-reflection.
- **Cultural Competence**
    - Refers to the acquisition of skills, attitudes, and behaviours that enable a practitioner to work effectively across cultural contexts.
    - It often focuses on "doing things the right way" but has been criticised for implying that culture is static and can be mastered.
- **Cultural Humility**
    - Involves an ongoing process of self-reflection and self-critique.
    - Practitioners recognise the limits of their knowledge, remain open to learning from patients and communities, and acknowledge power imbalances in clinical relationships.
- **Cultural Responsivity**
    - Refers to the dynamic ability to adapt care to the cultural needs, identities, and preferences of diverse populations.
    - It requires responsiveness to ethnicity, language, gender identity, sexuality, spirituality, migration experience, and disability, while embedding principles of equity and inclusion.
- **Racism**
    - Racism is a system of structuring opportunity and assigning value based on physical appearance, culture, or ethnicity, which unfairly disadvantages some individuals and communities while advantaging others.
    - It operates at multiple levels:
        - **Individual racism**: prejudiced beliefs or discriminatory behaviours between people.
        - **Institutional racism**: discriminatory policies or practices within organisations and institutions.
        - **Systemic (structural) racism**: the cumulative and compounding effects of societal norms, laws, policies, and historical injustices that produce and reproduce inequities across generations.
        - **Micro-racism**: subtle, everyday forms of racism, often unconscious, expressed through microaggressions (e.g., dismissive comments, stereotyping, assumptions about competence or identity). These can be cumulative and deeply harmful, especially in clinical or workplace settings.
    - In psychiatry, racism in all its forms has profound impacts on mental health, including exposure to trauma, barriers to accessing care, mistrust of services,

and disparities in outcomes. Addressing racism requires both individual reflection and systemic action.

Intended Learning Outcome (ILO):

Upon completion, trainees will **demonstrate, apply, and model** culturally safe and responsive psychiatric practice by engaging in critical self-reflection, addressing systemic inequities, and providing care that upholds the dignity, identity, and rights of Aboriginal and Torres Strait Islander peoples, Māori, and all culturally diverse communities.

Stage Expectations

- **Stage 1 (Knows):**
  - Identify the different forms of racism (individual, institutional, systemic, microracism) and their effects on health and service access.
  - Describe the principles of cultural safety and distinguish it from cultural awareness and cultural competence.
  - Recognise the historical and contemporary impacts of colonisation, racism, and systemic inequities on mental health.
  - Outline the significance of Te Tiriti o Waitangi in Aotearoa New Zealand and the rights of Aboriginal and Torres Strait Islander peoples in Australia.
  - Identify cultural, spiritual, gender, and social diversity and their relevance to mental health care.
  - Describe the role of reflective practice in identifying one's own biases and assumptions.
- **Stage 2 (Knows How / Shows How):**
  - Demonstrate skills in recognising and addressing racism in clinical encounters, service delivery and team contexts.
  - Apply cultural safety principles in psychiatric assessments, formulations, and treatment plans.
  - Demonstrate engagement with Aboriginal and Torres Strait Islander and Māori models of health and healing, in collaboration with cultural advisors, elders, and whānau.
  - Incorporate cultural, spiritual, and identity-based considerations into shared decision-making.
  - Demonstrate responsiveness to the needs of culturally diverse communities, including migrants, refugees, LGBTQIA+ peoples, and those facing systemic discrimination.
  - Engage in reflective practice to address personal bias and power imbalances in clinical encounters.
- **Stage 3 (Does):**
  - Leady system initiatives to challenge and reduce racism, discrimination, and inequity within health systems and society.
  - Role model culturally safe and responsive psychiatric practice in independent clinical work.

- Advocate for service structures that uphold cultural safety and equity in mental health care.
- Lead systemic initiatives to address racism, discrimination, and inequity in health systems.
- Integrate cultural consultation and partnership approaches into complex case management.
- Mentor colleagues and trainees in culturally safe and trauma-informed care, fostering organisational cultures of respect and inclusion.

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1.3 Communicator

Effective communication is a cornerstone of psychiatric practice. Psychiatrists must be able to listen, elicit, and synthesise information from patients, families/whānau, carers, and colleagues, and communicate with clarity, empathy, and respect. Communication involves not only the transfer of information but also the establishment of trust, therapeutic alliance, and shared understanding.

The Communicator role reflects the psychiatrist's ability to use advanced interpersonal and clinical communication skills to conduct assessments, deliver feedback, negotiate treatment plans, and engage with patients and families in culturally safe, person-centred, and trauma-informed ways.

Intended Learning Outcome (ILO):

Upon completion, trainees will **demonstrate, apply, and adapt** advanced communication skills to conduct psychiatric assessments, establish therapeutic relationships, negotiate care, and communicate effectively with patients, families/whānau, carers, and professional colleagues in diverse and complex contexts.

Stage Expectations

- **Stage 1 (Knows / Knows How):**
  - Describe principles of effective communication, including active listening, empathy, non-verbal communication, and rapport building.
  - Recognise the importance of **patient-centred and family-centred communication** in psychiatry.
  - Demonstrate structured psychiatric interviewing, including history taking and mental state examination.
  - Explain the importance of confidentiality, consent, and boundaries in clinical communication.
  - Identify communication strategies for patients across the lifespan, including children, adolescents, older adults, and those with cognitive impairment.
- **Stage 2 (Shows How):**
  - Conduct comprehensive psychiatric interviews, adapting techniques for patients with diverse cultural, linguistic, and social backgrounds.
  - Demonstrate the ability to communicate diagnostic impressions, treatment plans, and risk assessments clearly and sensitively.
  - Engage families/whānau and carers in collaborative discussions, demonstrating respect for their perspectives.
  - Apply trauma-informed communication strategies, recognising the impact of past trauma on engagement.
  - Demonstrate communication strategies for patients across the lifespan, including children, adolescents, older adults, and those with cognitive impairment.

    - Demonstrate skills in managing difficult conversations, including delivering bad news, negotiating disagreement, and addressing complaints.
- **Stage 3 (Does):**
    - Integrate advanced communication skills into all clinical interactions, adapting to complex, high-stakes, or uncertain contexts (e.g., forensic assessments, involuntary treatment, court testimony).
    - Lead communication in multidisciplinary teams, ensuring clarity, inclusiveness, and shared understanding.
    - Role model therapeutic communication for junior colleagues and supervisees.
    - Advocate for communication practices that uphold human rights, recovery principles, and cultural safety.
    - Manage conflict effectively within teams and with patients or families, demonstrating professionalism and respect.

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1.4 Collaborator

Psychiatry is practised within complex health, social care, and community systems. Psychiatrists must work effectively with colleagues in multidisciplinary teams (MDTs), across specialties, and with external agencies. Collaboration requires respect for diverse expertise, recognition of shared responsibility, and the ability to manage interprofessional conflict constructively.

The Collaborator role highlights the psychiatrist's ability **to work in partnership** with patients, families/whānau, carers, colleagues, and services to achieve person-centred, safe, and effective care (Frank, Snell & Sherbino, 2015).

Intended Learning Outcome (ILO):

Upon completion, trainees will **demonstrate, apply, and model** collaborative practices in psychiatry, working effectively within multidisciplinary teams, across service systems, and in partnership with patients, families/whānau, and carers to deliver integrated and recovery-oriented care.

Stage Expectations

- **Stage 1 (Knows / Knows How):**
    - Describe key theories and models of effective teamwork, including those relevant to interprofessional and interdisciplinary collaboration.
    - Describe and demonstrate respect for the roles of different health professionals and community agencies involved in psychiatric care (e.g., psychologists, social workers, nurses, occupational therapists, peer support workers, general practitioners).
    - Recognise the importance of respectful and inclusive communication in MDTs.
    - Identify strategies for engaging families and carers as collaborators in care.
    - Demonstrate knowledge of referral pathways and interagency collaboration.
- **Stage 2 (Shows How):**
    - Actively contribute to MDT meetings and case conferences, integrating psychiatric knowledge with input from other disciplines.
    - Identify and analyse barriers to effective teamwork, including those related to communication, hierarchy, cultural differences, and system fragmentation.
    - Engage constructively with Non-Government Organisations (NGOs), community services, and consumer-led groups, recognising their critical role in recovery-oriented care and social support.
    - Demonstrate collaboration with primary care and community agencies in patient management.
    - Negotiate roles and responsibilities within teams to support coordinated care.
    - Apply collaborative approaches in working with families/whānau, demonstrating recognition of their expertise and perspectives.

    - Address minor interprofessional disagreements constructively, seeking supervision as appropriate.
- **Stage 3 (Does):**
    - Lead and facilitate collaboration across complex systems (e.g., between health, justice, education, and social services).
    - Contribute actively to shared decision-making processes, including case conferences, family meetings, and multidisciplinary reviews.
    - Manage conflict within MDTs or between services professionally and effectively.
    - Role model collaborative practice for peers and supervisees.
    - Advocate for service models that promote integrated, recovery-oriented, and culturally safe care.
    - Demonstrate advanced skills in engaging with families/whānau and carers in decision-making, especially in complex or contested situations.

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1.5 Leader

Psychiatrists are leaders within clinical teams, services, and systems. Leadership encompasses day-to-day responsibilities (such as orienting and supervising junior staff), contributions to service development and governance, and participation in quality improvement and change management. Effective leadership ensures safe, efficient, and equitable delivery of care while modelling professionalism and collaboration.

The Leader role requires psychiatrists to integrate clinical expertise with governance responsibilities, including the science of quality improvement, organisational change, and the incorporation of lived experience perspectives into service design and delivery.

Intended Learning Outcome (ILO):

Upon completion, trainees will **demonstrate, apply, and model** leadership and management skills in clinical and organisational contexts, contributing to safe, effective, equitable, and continuously improving psychiatric services.

Stage Expectations

- **Stage 1 (Knows / Knows How):**
  - Demonstrate understanding of **clinical governance** structures, including risk management, audit, accreditation, and critical review processes.
  - Discuss principles of **organisational change management** and their application in healthcare.
  - Explain the importance of integrating **lived experience perspectives** into governance structures and service design.
  - Identify the psychiatrist's role in supervising junior staff and orienting new colleagues.
- **Stage 2 (Shows How):**
  - Describe the **science of quality improvement** and show how it can be applied to psychiatric services.
  - Arrange the **orientation of new staff** to clinical teams and services.
  - Supervise and support **junior staff members**, ensuring safe delegation of tasks.
  - Apply **relevant organisational policies** in clinical and administrative work.
  - Participate in the development of **service protocols and policies**.
  - Conduct and present **audit and quality improvement cycles**.
  - Demonstrate **open disclosure** following adverse clinical outcomes.
  - Apply principles of **conflict resolution** in professional contexts.
  - Participate effectively in both clinical and non-clinical meetings.
- **Stage 3 (Does):**
  - Lead clinical governance activities, including the reporting and investigation of **adverse outcomes**.
  - Apply principles of **root cause analysis** to critical incidents and patient deaths.

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- Evaluate service performance using outcome measures and contribute to continuous quality improvement.
- Chair meetings effectively, evaluate their performance, and contribute to the development of **terms of reference** for committees.
- Develop, implement, and review **service protocols and policies** in consultation with colleagues and stakeholders.
- Integrate **lived experience perspectives** into service governance and improvement initiatives.
- Lead multidisciplinary teams and services, role-modelling ethical, inclusive, and recovery-oriented leadership.
- Manage complex organisational challenges, balancing individual patient needs with system sustainability.

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1.6 Advocate

Psychiatrists have a responsibility to act as advocates for their patients, families/whānau, carers, and communities. Advocacy is required at the individual level — ensuring that patient rights, dignity, and needs are respected in clinical care — and at the systemic level, addressing inequities, discrimination, and barriers to accessing mental health services.

The Advocate role reflects psychiatry's ethical obligation to promote mental health, protect human rights, and address the social determinants of health. Advocacy should be culturally safe, trauma-informed, and recovery-oriented, ensuring that the voices of people with lived experience guide systems change (Curtis et al., 2019).

Intended Learning Outcome (ILO):

Upon completion, trainees will **demonstrate, apply, and model** advocacy skills at individual, service, and systemic levels to promote equity, human rights, cultural safety, and recovery-oriented mental health care.

Stage Expectations

- **Stage 1 (Knows / Knows How):**
  - Recognise the psychiatrist's role in protecting **human and patient rights**, informed consent, and supported decision-making.
  - Recognise the psychiatrist's role in addressing **social determinants of health** (e.g., poverty, housing, education, discrimination).
  - Identify situations where patients may face barriers to accessing care or may be subject to stigma or discrimination.
  - Explain the ethical foundations of advocacy, including justice, beneficence, and respect for autonomy.
- **Stage 2 (Shows How):**
  - Describe and apply the principles of **advocacy theories**, including:
    - **Rights-based advocacy** (human rights frameworks, legal protections).
    - **Empowerment theory** (supporting agency and autonomy).
    - **Systems advocacy** (addressing structural inequities).
    - **Consumer- and family-led advocacy** (lived experience leadership).
    - **Public health/social determinants model** (reducing upstream risk factors).
    - **Relational advocacy** (therapeutic alliance and trust-building).
  - Advocate for patients within health systems, ensuring timely and equitable access to care.
  - Support families/whānau and carers in navigating health and social services.
  - Identify and challenge stigma and discrimination in clinical settings.
  - Apply principles of **cultural safety** and **trauma-informed care** in advocating for patients from marginalised or vulnerable groups.
  - Collaborate with community agencies and non-governmental organisations to support patients' broader health, rights and social needs.

  - Describe the key advocacy components of relevant mental health policies and laws, and how psychiatrists can influence policy through professional bodies or by engaging with policymakers on issues such as access to services, funding, and human and patient rights.
  - Demonstrate awareness of the mental health impacts of disasters and crisis events, such as natural disasters or pandemics, and why mental health needs may surge and require greater coordination of responses.
- **Stage 3 (Does):**
  - Lead advocacy initiatives at service or community level, addressing systemic inequities in access, quality, or outcomes.
  - Influence policy and service design to ensure mental health systems are equitable and recovery-oriented.
  - Role model advocacy behaviours for peers and supervisees.
  - Partner with consumers, carers, and lived experience representatives in co-designing services and policies.
- Advocate publicly for mental health reform, human rights protections, and reduction of systemic stigma.

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1.7 Scholar

Psychiatrists should be lifelong learners who contribute to the creation, dissemination, and application of knowledge. The Scholar role encompasses critical appraisal, research literacy, teaching and supervision the history and ethical foundations of psychiatry, and the translation of evidence into practice. It requires both an individual commitment to continuous professional development and a responsibility to foster the learning of colleagues, students, and the wider community.

In psychiatry, scholarship is not limited to academic research and teaching; it includes applying evidence-based practice, integrating lived experience perspectives, and teaching within multidisciplinary teams.

Scholarship requires psychiatrists to think critically, reason clinically, and apply evidence judiciously in contexts of uncertainty. Trainees should progressively develop from being recipients of knowledge to becoming producers, evaluators, and teachers of knowledge.

Intended Learning Outcome (ILO):

Upon completion, trainees will **demonstrate, apply, and model** scholarly practices including critical thinking, clinical reasoning, reflective practice, lifelong learning, critical appraisal, evidence-based practice, research engagement, effective teaching and supervision in psychiatry, and the application of historical, ethical and diverse perspectives to contemporary psychiatric knowledge and service delivery.

Stage Expectations

- **Stage 1 (Knows / Knows How):**
  - Describe principles of critical thinking (clarity, logical reasoning, avoiding cognitive bias) and clinical reasoning (hypothesis generation, pattern recognition, analytic reasoning).
  - Outline the hierarchy of evidence and its role in evidence-based practice.
  - Define qualitative, quantitative, and mixed methods research designs.
  - Recognise basic statistical methods and qualitative approaches (e.g., hematic analysis).
  - Identify key milestones in the history of psychiatry, including essential innovations, the development of modern treatments, and the move toward deinstitutionalisation and community-based models of service provision.
  - Recall fundamental learning theories, including reflective practice and communities of practice.
  - Recognise the importance of critical appraisal and lifelong learning.
  - Explain adult learning principles and their relevance to teaching in psychiatry.
  - Demonstrate basic teaching skills in supervised settings (e.g., case presentations).
- **Stage 2 (Shows How):**

  - Apply **critical thinking** and **clinical reasoning** in case formulation, balancing differential diagnoses, evidence, and uncertainty.
  - Use reflective practice to evaluate personal reasoning and decision-making.
  - Analyse historical abuses in psychiatry and apply lessons learned to ethical reasoning.
  - Critically appraise psychiatric and medical education literature, recognising bias and methodological limitations.
  - Apply evidence-based practice by integrating research evidence with clinical expertise and patient values.
  - Conduct a structured literature review (e.g., PRISMA guidelines).
  - Select and justify use of rating scales and instruments in clinical or research settings.
  - Prepare and present research proposals.
  - Participate in research, audit, or quality improvement projects, demonstrating scholarly inquiry.
  - Teach effectively using structured educational approaches, integrating critical appraisal into teaching.
  - Provide constructive feedback in supervised teaching situations.
- **Stage 3 (Does):**
  - Demonstrate advanced clinical reasoning, integrating evidence with contextual knowledge in complex or ambiguous cases.
  - Lead and publish scholarly work (research, service evaluation, education).
  - Demonstrate leadership in evidence-based psychiatric practice, including synthesising research findings into clinical guidelines or service protocols.
  - Critique emerging technologies, including AI in psychiatry, applying critical reasoning to assess risks and benefits.
  - Assess, supervise, mentor, and provide structured feedback to junior trainees, applying adult learning principles and fostering critical thinking, evidence-based and reflective practice in others.
  - Role model scholarly behaviours, critical inquiry and reasoning within clinical teams, contributing to service protocols and clinical guidelines.
  - Apply historical and ethical perspectives and analyse the sequelae of abuses in psychiatry that ensures current systems avoid repeating past harms.
  - Critically evaluate how historical developments have shaped contemporary recovery-oriented, rights-based, and culturally safe practices in leadership and systemic decision-making.
  - Undertake advanced scholarly activity, such as leading research projects, audits, or educational initiatives.
  - Contribute to the academic development of psychiatry through teaching, publication, or conference presentation.

1.8 Professional

Professionalism in psychiatry encompasses ethical practice, integrity, accountability, situational awareness, and a commitment to high standards of care. Psychiatrists must uphold professional responsibilities to patients, families/whānau, carers, colleagues, and society. Professional identity formation develops across training, shaped by reflection, supervision, and mentorship, as well as by the psychiatrist's role in navigating the complexity and uncertainty of mental health care.

Professionalism requires situational awareness — the ability to recognise contextual factors, risks, and interpersonal dynamics that influence safe and effective practice. It also requires responsibility to colleagues: demonstrating respect, collegiality, and active care for the wellbeing of peers and team members. Supporting colleagues in distress, modelling respectful communication, and fostering a culture of safety and compassion are integral to sustainable psychiatric practice.

The Professional role further requires adherence to codes of ethics, human rights frameworks, and professional standards, with an emphasis on culturally safe and trauma-informed care. Trainees must also take an active role in maintaining personal wellbeing, recognising that the psychiatrist's health and behaviour directly impact professional performance.

Intended Learning Outcome (ILO):

Upon completion, trainees will **demonstrate, apply, and model** professionalism by practising ethically, responsibly, and reflectively in diverse psychiatric contexts, while maintaining accountability to patients, communities, colleagues, and the profession.

Stage Expectations

- **Stage 1 (Knows):**
    - Describe principles of professionalism: ethics, confidentiality, informed consent, boundaries, duty of care, situational awareness, respect for colleagues.
    - Identify regulatory/professional requirements: AHPRA, MCNZ, indemnity.
    - Describe the RANZCP Code of Ethics and apply the four principles of biomedical ethics: autonomy, beneficence, non-maleficence, justice.
    - Recognise other ethical frameworks: principlism with expanded principles, virtue ethics, care ethics, deontology, consequentialism.
    - Discuss human dignity, human rights, professionalism, and research ethics in psychiatry.
    - Outline history and development of mental health legislation.
    - Describe the structures of the Australian and New Zealand healthcare systems (Medicare, PBS, NDIS, Health NZ/Te Whatu Ora, PHARMAC).
- **Stage 2 (Knows How / Shows How):**

  - Apply ethical principles in supervised practice, including decision-making, reflective practice, and boundary management.
  - Demonstrate situational awareness and support colleagues in clinical teams.
  - Apply medico-legal requirements: Mental Health Acts, child protection, testamentary capacity, privacy legislation, duty to warn, duty of care.
  - Apply ethical/professional use of digital technologies.
  - Demonstrate knowledge of voluntary assisted dying, supported and substitute decision-making, advance care directives, powers of attorney, and guardianship.
  - Engage with national/state/federal mental health policies and strategies.
  - Apply practical health system processes safely and in compliance with legal requirements: prescriptions, billing, provider/prescriber numbers, compliance requirements.
- **Stage 3 (Does):**
  - Role model professionalism, integrating ethical reasoning, cultural safety, trauma-informed practice, situational awareness, colleague care, and wellbeing.
  - Lead application of ethical frameworks in complex clinical/systemic contexts.
  - Critically reflect on human rights, human dignity, and psychiatry's ethical responsibilities.
  - Apply advanced medico-legal expertise in independent practice, including capacity law and forensic duties.
  - Function independently in the Australian/New Zealand health systems with mastery of clinical, regulatory, and administrative processes.
  - Contribute to peer review, supervision, governance, and policy development.

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Section 2: Clinical Conditions

Introduction

Psychiatric practice requires competence across a wide range of mental health conditions that present in diverse clinical, cultural, and service contexts. This section lists the diagnostic groupings and conditions that all psychiatrists in training are expected to understand and, where relevant, manage during the Fellowship Program.

The scope is deliberately broad, reflecting the complexity of real-world practice and the need for psychiatrists to integrate biological, psychological, social, cultural, and systemic perspectives in assessment, formulation, and management.

The RANZCP Fellowship Program **endorses the use of both DSM and ICD diagnostic systems**, recognising their complementary roles in clinical practice, research, and health system planning. Trainees are expected to be conversant with both frameworks and to apply them critically, with awareness of their strengths, limitations, and cultural implications.

Not every trainee will personally encounter all conditions listed in this section. Some conditions are rare or primarily managed within specific subspecialty contexts. However:

- All trainees are expected to **develop knowledge** of the full range of conditions.
- All trainees must **demonstrate assessment and management skills in the Key (i.e., common) psychiatric conditions**, including **psychotic disorders, mood disorders, anxiety disorders, substance use disorders, personality disorders, trauma-related conditions, and neurodevelopmental disorders**.
- **All trainees are expected to be able to recognise and manage common psychiatric emergencies in both adults and in specific populations such as children/adolescents and older people** (e.g., suicidality, aggression, delirium, acute behavioural disturbance).
- Across the program, trainees should be **exposed to a representative range** of conditions, supported by supervision, teaching, and structured educational resources.

Conditions marked with [K] are considered *Key Conditions*. All trainees are expected to demonstrate applied competence in their assessment and management, beginning from Stage 1 of training.

Progression through training reflects **increasing depth and independence**, mapped to Miller's pyramid:

- **Stage 1:** Trainees acquire knowledge (*Knows*) and apply it under supervision (*Knows How*). For Key Conditions and psychiatric emergencies across the lifespan, Stage 1 trainees are also expected to **demonstrate skills in assessment and initial management under supervision** (*Shows How/Does*).
- **Stage 2:** Trainees consolidate knowledge and skills across the full range of conditions, apply them in more complex and varied contexts, and begin to demonstrate greater autonomy in management (*Shows How → Does under supervision*).
- **Stage 3:** Trainees demonstrate the capacity to **independently assess and manage the full spectrum of psychiatric conditions**, including complex, comorbid, and treatment-resistant presentations, and to provide leadership in multidisciplinary and systemic care (*Does independently*).

General Expectations Across All Conditions

For each condition in this section, trainees should be able to describe:

- **Epidemiology**
- **Biopsychosocial and cultural aetiology**
- **Symptomatology**
- **Phenomenology**
- **Development, course, and prognosis**
- **Assessment** (including MSE, investigations, risk assessment, and cultural formulation)
- **Biopsychosocial and cultural management**
- **Psychiatric and medical comorbidity**

Specific Stage 1 Expectations

By the end of **Stage 1 of Training**, all trainees as a minimum should be able to apply their knowledge to the assessment and initial management of the following urgent or common clinical presentations:

- Acute suicidality
- Delirium
- Self-harm behaviour
- Catatonia
- Medication-related movement disorders, including tardive dyskinesia, acute dystonia, akathisia, and parkinsonism
- Neuroleptic malignant syndrome
- Severe aggression or agitation
- Severe mood dysregulation
- Psychotic states with poor insight

Clinical Conditions

Neurodevelopmental Disorders

- Intellectual development disorders [K]
- Global developmental delay
- Communication disorders
- Autism spectrum disorder [K]
- Attention-deficit/hyperactivity disorder [K]
- Specific learning disorder
- Motor disorders

Neurocognitive Disorders

- Delirium [K] (including sub-syndromal, hypoactive, hyperactive and persistent, as well as delirium superimposed on dementia)
- Major and mild neurocognitive disorders due to:
    - Alzheimer's disease [K]
    - Frontotemporal degeneration [K]
    - Parkinsonism and Lewy body disease [K]
    - Vascular disease [K]
    - Traumatic brain injury [K]
    - Substance/medication use
    - HIV infection
    - Prion disease
    - Huntington's disease
    - Another medical condition
    - Multiple aetiologies
    - Unspecified aetiology

Substance-Related and Addictive Disorders

Substance use, intoxication and withdrawal in relation to:

- Alcohol [K]
- Caffeine
- Cannabis [K]
- Hallucinogens
- Inhalants
- Opioids [K]
- Sedatives, hypnotics or anxiolytics
- Stimulants [K]
- Tobacco [K]
- Other (or unknown) substances

Additional conditions:

- Medication-induced mental disorders
- Gambling disorder [K]
- Other behavioural addiction syndromes
- Disorders related to social media and internet usage [K]
- Neonatal abstinence syndrome
- Fetal alcohol spectrum disorder

Schizophrenia Spectrum and Other Psychotic Disorders

- Delusional disorder
- Brief psychotic disorder
- Schizophreniform disorder
- Schizophrenia [K]
- Schizoaffective disorder [K]
- Substance/medication-induced psychotic disorder [K]
- Psychotic disorder due to another medical condition
- Late- and very-late-onset schizophrenia-like psychoses
- Postnatal psychosis

Bipolar and Related Disorders

- Bipolar I disorder [K]
- Bipolar II disorder [K]
- Cyclothymic disorder
- Bipolar and related disorder due to another medical condition

Depressive Disorders

- Disruptive mood dysregulation disorder
- Major depressive disorder [K]
- Persistent depressive disorder (dysthymia)
- Premenstrual dysphoric disorder
- Substance/medication-induced depressive disorder
- Depressive disorder due to another medical condition
- Perinatal and postnatal mood disorders [K]

Anxiety Disorders

- Separation anxiety disorder
- Selective mutism
- Specific phobia [K]
- Social anxiety disorder (social phobia) [K]
- Panic disorder [K]
- Agoraphobia [K]
- Generalised anxiety disorder [K]
- Substance/medication-induced anxiety disorder
- Anxiety disorder due to another medical condition
- Perinatal and postnatal anxiety disorders

Obsessive–Compulsive and Related Disorders

- Obsessive–compulsive disorder (OCD) [K]
- Body dysmorphic disorder [K]
- Hoarding disorder
- Trichotillomania (hair-pulling disorder)
- Excoriation (skin-picking) disorder
- Substance/medication-induced obsessive–compulsive and related disorder
- Obsessive–compulsive and related disorder due to another medical condition

Trauma and Stressor-Related Disorders

- Reactive attachment disorder
- Disinhibited social engagement disorder
- Post-traumatic stress disorder (PTSD) [K]
- Complex PTSD [K]
- Acute stress disorder [K]
- Adjustment disorders
- Selective mutism

Neurodivergent Conditions

- Autism spectrum disorder [K]
- Attention-deficit/hyperactivity disorder [K]
- Intellectual disability [K]
- Specific learning disorders
- Tourette syndrome and tic disorders

Dissociative Disorders

- Dissociative identity disorder [K]
- Dissociative amnesia
- Depersonalisation/derealisation disorder

Personality Disorders

- General personality disorder
- Paranoid personality disorder
- Schizoid personality disorder
- Schizotypal personality disorder
- Antisocial personality disorder [K]
- Borderline personality disorder [K]
- Histrionic personality disorder
- Narcissistic personality disorder
- Avoidant personality disorder
- Dependent personality disorder
- Obsessive–compulsive personality disorder
- Personality change due to another medical condition

Somatic Symptom and Related Disorders

- Somatic symptom disorder [K]
- Illness anxiety disorder
- Conversion disorder (functional neurological symptom disorder) [K]
- Psychological factors affecting other medical conditions
- Factitious disorder and factitious disorder imposed on another [K]

Feeding and Eating Disorders

- Pica
- Rumination disorder
- Avoidant/restrictive food intake disorder
- Anorexia nervosa [K]
- Bulimia nervosa [K]
- Binge-eating disorder

Elimination Disorders

- Enuresis
- Encopresis

Sleep–Wake Disorders

- Insomnia disorder [K]
- Hypersomnolence disorder
- Narcolepsy
- Breathing-related sleep disorders
- Circadian rhythm sleep–wake disorders
- Parasomnias
- Substance/medication-induced sleep disorder

Sexual Dysfunctions

- Delayed ejaculation
- Erectile disorder
- Female orgasmic disorder
- Female sexual interest/arousal disorder
- Genito-pelvic pain/penetration disorder
- Male hypoactive sexual desire disorder
- Premature ejaculation
- Substance/medication-induced sexual dysfunction

Gender Dysphoria

- In childhood
- In adolescence
- In adulthood [K]

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Gender Incongruence

- In childhood
- In adolescence
- In adulthood [K]

Disruptive, Impulse-Control and Conduct Disorders

- Oppositional defiant disorder [K]
- Intermittent explosive disorder
- Conduct disorder [K]
- Pyromania
- Kleptomania
- Other problematic behaviours (e.g., litigiousness, stalking, fire-setting, aggression)

Paraphilic Disorders

- Voyeuristic disorder
- Exhibitionistic disorder
- Frotteuristic disorder
- Sexual masochism disorder
- Sexual sadism disorder
- Paedophilic disorder
- Fetishistic disorder
- Transvestic disorder

Emergent Disorders

[This section is deliberately left blank. The RANZCP will review the Knowledge Base annually to determine whether any emergent conditions should be included. If so, they will appear here.]

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Section 3: Treatment Concepts and Modalities

Introduction

Effective psychiatric practice requires familiarity with a wide range of treatment modalities. Psychiatrists must integrate biological, psychological, social, cultural, and systemic approaches in a person-centred and recovery-oriented manner.

This section outlines the treatment modalities that trainees are expected to understand and, where relevant, apply during the Fellowship Program.

Not all modalities will be equally available in every clinical setting. However:

- All trainees are expected to **develop knowledge** of the full range of treatment modalities.
- All trainees must **demonstrate applied competence in Key (common) treatments [K]**, including core biological therapies, foundational psychological interventions, and essential social and cultural/systemic approaches.
- All trainees are expected to **work collaboratively with patients, families, carers, and multidisciplinary teams** in selecting and delivering treatments.

Treatments marked with [K] are considered *Key Treatments*. All trainees are expected to demonstrate applied competence in these treatments, beginning from Stage 1 of training.

Progression through training reflects **increasing depth and independence**, mapped to Miller's pyramid:

- **Stage 1:** Acquire knowledge (*Knows*) and apply it under supervision (*Knows How*). For Key Treatments, Stage 1 trainees are also expected to demonstrate skills in their application under supervision (*Shows How/Does*).
- **Stage 2:** Consolidate and broaden therapeutic skills across modalities, apply them in more complex cases, and adapt interventions for comorbidity and diversity (*Shows How → Does under supervision*).
- **Stage 3:** Demonstrate independent practice across the full spectrum of treatment modalities, including advanced, complex, and treatment-resistant cases, and contribute to service-level leadership (*Does independently*).

Principles of Safe Prescribing

Trainees should be able to describe and apply the principles of safe prescribing, including:

- Pharmacokinetics and pharmacodynamics of psychotropic medications [K]
- The role of pharmacogenomics in psychiatry
- Tailoring prescribing to a patient's age, health and cultural background [K]
- Justification of first- and second-line treatments for common psychiatric conditions [K]
- The risks of polypharmacy [K]
- When to consider deprescribing and how to safely withdraw psychotropic medications [K]
- How to safely switch between different psychotropic medications [K]
- The role of complementary medicines and possible risk of drug interactions [K]
- The role of off-label prescribing [K]
- Medication-induced movement disorders and other adverse effects of medication [K]
- Safe prescribing in patients planning pregnancy, during pregnancy, or while breastfeeding [K]
- Methods for improving medication adherence [K]

Pharmacological Treatments

Trainees should be able to describe the mechanism of action, evidence-based indications and contraindications, drug interactions, and adverse effects of the following:

Antipsychotics

- First-generation antipsychotics
- Second-generation antipsychotics [K]
- Clozapine [K]

Antidepressants

- SSRIs [K]
- SNRIs [K]
- Tricyclic antidepressants (TCAs) [K]
- Monoamine oxidase inhibitors (MAOIs)
- Other novel antidepressants

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Mood Stabilisers

- Sodium valproate [K]
- Lithium [K]
- Other anticonvulsants (e.g., carbamazepine, lamotrigine)

Anxiolytics, Sedatives and Hypnotics

- Benzodiazepines [K]

Stimulants and ADHD Medications

- Dexamfetamine [K]
- Methylphenidate [K]
- Lisdexamfetamine [K]
- Atomoxetine
- Clonidine
- Guanfacine

Cognitive Enhancers

- Acetylcholinesterase inhibitors
- Memantine

Substance Use Treatments

- Opioid substitution therapies
- Nicotine replacement therapies [K]
- Relapse prevention agents (e.g., naltrexone, acamprosate, disulfiram)
- Management of acute intoxication and withdrawal [K]

Nutraceuticals

Trainees should:

- Demonstrate knowledge of common vitamins, minerals, herbal supplements, and other bioactive compounds (e.g., omega-3 fatty acids, Vitamin D).
- Describe evidence for nutraceuticals in mood, cognition, and mental health.
- Understand potential benefits, risks, and interactions.
- Discuss their role with patients, ensuring careful monitoring.

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Complementary or Alternative Therapies

Trainees should:

- Discuss patient choices of complementary or alternative therapies, including risks and interactions.
- Assist patients in evaluating evidence.
- Be familiar with common herbal medicines (e.g., St John's Wort, Kava, Valerian).

Novel and Emerging Treatments

- Ketamine
- Medicinal cannabis
- NMDA antagonists
- Psychedelics

Non-Pharmacological Biological Treatments

Neurostimulation

- Electroconvulsive therapy (ECT) [K]
- Transcranial magnetic stimulation (TMS)
- Transcranial direct current stimulation (tDCS)
- Vagus nerve stimulation (VNS)
- Deep brain stimulation (DBS)

Neurosurgery for Mental Disorders

- History of neurosurgery
- Ethical and legal status of neurosurgery
- Emerging neurosurgical treatments

Nutritional Resuscitation

- Principles in underweight patients, including risks and monitoring [K]

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Psychological Treatments

Common Concepts

Trainees should demonstrate understanding and application of:

- Trauma informed care [K]
- Therapeutic alliance, rapport, and common factors in psychotherapy [K]
- Psychological rating scales to measure therapeutic success [K]
- Boundaries, confidentiality, transference, countertransference [K]
- Structuring therapy (frame, contract, session structure) [K]
- Relaxation, mindfulness, grounding techniques [K]
- Safety and care planning [K]
- Containment of distress [K]
- Ending therapy appropriately [K]
- Working with multiple therapists
- Individual, group, couple, and family therapy contexts

Briefer Therapies

- Psychoeducation [K]
- Motivational interviewing [K]
- Supportive psychotherapy [K]
- Cognitive–behavioural therapy (CBT) [K]
- Interpersonal therapy (IPT)
- Acceptance and commitment therapy (ACT)
- Eye movement desensitisation and reprocessing (EMDR)
- Coaching

Longer Therapies

- Dialectical behaviour therapy (DBT)
- Psychodynamic psychotherapy (major schools) [K]
- Trauma-informed therapy

Other Types of Therapy

- Group therapy (major schools)
- Family therapy (major schools)
- Couples therapy (e.g., Gottman Therapy)
- Therapy for sexual disorders
- Contingency management

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- Mutual help programs
- Parenting support and training

Social Interventions

Trainees should be able to outline scope, evidence base, methodology, and use of:

- Stigma and its mitigation [K]
- Mental health literacy and public education initiatives [K]
- Role of social support services (housing, NGOs, accommodation)
- Role of crisis and advocacy groups (e.g., sexual assault, veterans, carers)
- Complex case meetings [K]
- Family meetings [K]

Recovery Model in Psychiatry

The recovery model is a holistic approach prioritising patient goals, strengths, and aspirations rather than focusing solely on symptoms.

Trainees should be able to demonstrate understanding and application of:

- Hope and empowerment [K]
- Self-determination and autonomy [K]
- Strength-based approach [K]
- Social inclusion and community integration [K]

Person-Centred Care Planning

Trainees should be able to:

- Collaboratively set goals with patients [K]
- Respect individual preferences and cultural considerations [K]
- Adapt plans flexibly as circumstances change [K]
- Empower patients as partners in their own care [K]

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Integrating Recovery and Person-Centred Care

Trainees should demonstrate:

- Recognition that each patient's journey is unique [K]
- Application of recovery and person-centred models together [K]
- Care plans that reflect patient goals, preferences, and values [K]

Emergent Treatment Concepts and Modalities

[This section is deliberately left blank. The RANZCP will review the Knowledge Base annually to determine whether any emergent therapies should be included. If so, they will appear here.]

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Section 4: Populations and Service Contexts

Introduction

Psychiatrists are needed to work across diverse populations and service contexts. This work requires flexibility, cultural responsiveness, and adaptability in clinical skills. Trainees must develop competence in working with patients of all ages, cultural backgrounds, genders, and life experiences, and in delivering care across inpatient, community, and specialised settings.

Individual psychiatrists do not work across all settings, and not all trainees will have identical exposure to every setting or population. However:

- All trainees are expected to **develop knowledge** of the full range of populations and contexts.
- All trainees must **demonstrate applied competence in Key Populations and Contexts [K]**, including children and adolescents, older persons, Aboriginal and Torres Strait Islander peoples, Māori, culturally and linguistically diverse (CALD) communities, people with addictions, and those receiving care in acute and community settings.
- Exposure across different service models (e.g., public, private, forensic, rural) is expected to ensure breadth of training.

Contexts marked with [K] are considered Key. All trainees are expected to demonstrate applied competence in these areas, beginning from Stage 1 of training.

Progression through training reflects **increasing scope and independence**, mapped to Miller's pyramid:

- **Stage 1:** Acquire foundational knowledge and demonstrate supervised practice with Key Populations/Contexts (*Knows → Knows How → Shows How*).
- **Stage 2:** Broaden skills across a wider range of populations and contexts, applying them with increasing autonomy (*Shows How → Does under supervision*).
- **Stage 3:** Demonstrate independent, culturally safe, and recovery-oriented practice across the full spectrum of populations and service contexts and provide leadership in system-level care (*Does independently*).

General Expectations Across All Populations and Contexts

For each population or context, trainees should be able to:

- Describe the **epidemiology, prevalence, and service needs**.
- Recognise **cultural, social, systemic, and developmental factors**.
- Adapt assessment, formulation, and management approaches appropriately.
- Demonstrate **culturally safe, recovery-oriented, and trauma-informed practice**.
- Engage effectively with families, carers, and support systems.
- Work collaboratively with multidisciplinary teams.

Populations

Aboriginal, Torres Strait Islander and Māori Peoples

Trainees should be able to:

- Outline the Australian and New Zealand histories of colonisation and invasion [K].
- Explain the ongoing impact of colonisation, intergenerational trauma and racism on mental health and wellbeing [K].
- Outline the history of patient empowerment and carer/whānau advocacy movements [K].
- Demonstrate an understanding of Aboriginal, Torres Strait Islander and Māori world views [K].
- Describe Indigenous models of wellbeing and health [K].
- Discuss cultural practices, customs and social structures, including their impact on psychiatric presentation and intervention [K].
- Describe the principles and importance of working with families, carers, kin and whānau [K].
- Explain systemic and clinician biases in the health system that impact service delivery [K].
- Describe evidence-informed models of care that advance Aboriginal, Torres Strait Islander and Māori mental health [K].

Children, Adolescents and Young People

Trainees should be able to:

- Outline roles and responsibilities in child protection [K].
- Discuss the impact of parental separation, divorce, and parental mental illness on children [K].

- Conduct developmentally targeted interviews and mental state examinations [K].
- Perform family
- interviewing [K].
- Describe developmental and psychometric assessments and interpret clinical instruments.
- Manage children in inpatient and residential treatment settings.
- Assess decision-making capacity in minors [K].
- Apply evidence-based psychological and systemic interventions.
- Collaborate with paediatric services, schools, welfare agencies, and disability services.
- Recognise risks in institutional and out-of-home care [K].
- Anticipate transition challenges to adult care [K].
- Describe common infant mental health presentations, including attachment disorders [K].
- Recognise the impact of substance use on development [K].

Older People

Trainees should be able to:

- Describe the impact of ageism and epidemiological transitions of ageing [K].
- Diagnose and manage elder abuse and exploitation [K].
- Assess the impact of ageing on psychiatric disorders [K].
- Integrate medical assessment and comorbidity into psychiatric care [K].
- Assess occupational function, daily living activities, cognitive capacity, and safety issues [K].
- Recognise the importance of the living environment (squalor, hoarding, accessibility).
- Collaborate with carers, aged care facilities, NGOs and welfare systems [K].
- Apply principles of prescribing and deprescribing in older people.
- Manage end-of-life mental health issues.
- Apply ECT and psychological/behavioural interventions in older people.

People with Addictions and Comorbidity

Trainees should be able to:

- Describe harmful, hazardous and dependent use of prescription and non-prescription substances (opioids, benzodiazepines, pregabalin, cannabis, alcohol, stimulants, hallucinogens, volatile inhalants, ketamine) [K].
- Discuss the psychiatric and medical comorbidities associated with addiction (e.g., Wernicke-Korsakoff, liver disease) [K].

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- Describe the role of investigations (BBV screening, urine drug screens, EEG) and cognitive testing.
- Apply principles of harm minimisation (e.g., needle exchanges, pill testing) [K].
- Discuss public health interventions and relevant government policy.
- Recognise prescribing restrictions and notification requirements [K}.

People with Intellectual and Developmental Disabilities

Trainees should be able to:

- Describe aetiology (genetic, congenital, acquired).
- Assess severity and impact of disability [K].
- Apply person-centred, inclusive and strengths-based practice [K].
- Recognise issues of over- and under-diagnosis and comorbidity.
- Address developmental tasks at key life stages.
- Adapt psychotropic drug regimes appropriately.
- Apply evidence-based behavioural interventions (e.g., positive behaviour support).
- Discuss capacity, consent, supported decision-making, guardianship and treatment legislation.
- Recognise forensic issues in intellectual disability.

Perinatal Populations

Trainees should be able to:

- Assess risk in perinatal psychiatry, including infanticide [K].
- Manage severe mental disorders across pregnancy and postpartum [K].
- Apply safe pharmacological and biological interventions [K].
- Collaborate with perinatal services and supports.
- Manage substance use in pregnancy and puerperium.

Military, Veterans and First Responders

Trainees should be able to:

- Describe the culture of military, veteran and first responder communities.
- Assess risk and weapons safety [K].
- Apply principles of rehabilitation and fitness for work.
- Collaborate with services supporting veterans, service personnel, and their families [K].

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Justice Mental Health (Forensic)

Trainees should be able to:

- Outline the relationship between mental illness and violence [K].
- Describe victimology.
- Understand forensic mental health systems and services.
- Assess and manage risk to others (using tools such as HCR-20) [K].
- Describe therapeutic security and correctional psychiatry.
- Discuss the psychiatrist's role in courts, expert testimony, legal defences, and fitness to plead [K].

Gender Diversity [K]

Trainees should be able to:

- Demonstrate understanding of gender identity and gender diversity, including trans, non-binary and gender-diverse experiences [K].
- Apply affirming and inclusive psychiatric care, consistent with human rights and ethical standards [K].
- Recognise the mental health impacts of stigma, discrimination, and minority stress [K].
- Describe principles of gender-affirming care and multidisciplinary collaboration.
- Understand relevant legal and ethical considerations, including consent and decision-making in youth.

Sexual Diversity

Trainees should be able to:

- Demonstrate understanding of sexual orientation and diversity, including LGBTQIA+ communities [K].
- Recognise the mental health impacts of stigma, homophobia, biphobia, and minority stress [K].
- Apply affirming approaches in psychiatric assessment, formulation, and treatment [K].
- Understand the importance of sexual health, relationships, and identity in holistic care.
- Collaborate with LGBTQIA+ community supports and advocacy organisations.

Multicultural, Migrant, Refugee and Asylum Seeker Populations

Trainees should be able to:

- Describe the mental health impacts of migration, acculturation stress, dislocation, and settlement.
- Recognise the effects of trauma, displacement, detention, and refugee experiences [K].
- Apply culturally responsive care, including the use of interpreters and bicultural workers [K].
- Demonstrate awareness of systemic discrimination, racism, and barriers to accessing services [K].
- Understand relevant immigration and asylum policies and their mental health implications.

People Experiencing Homelessness and Marginalisation

Trainees should be able to:

- Recognise the relationship between housing insecurity, poverty, and mental health [K].
- Assess and manage psychiatric disorders in the context of unstable housing and marginalisation [K].
- Collaborate with housing, social services, and community organisations.
- Describe models of outreach psychiatry and assertive community treatment.
- Advocate for equitable access to care and housing support.

Neurodiverse Populations

Trainees should be able to:

- Demonstrate understanding of neurodivergence, including autism, ADHD, tic disorders, and learning differences [K].
- Apply neuro-affirming approaches that emphasise strengths, not just deficits [K].
- Adapt psychiatric assessments to meet communication and processing needs [K].
- Distinguish between psychiatric comorbidities and features of neurodivergence [K].
- Collaborate with families, educators, and allied health professionals.

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Survivors of Trauma and Torture

Trainees should be able to:

- Recognise presentations associated with exposure to torture, conflict, and persecution [K].
- Demonstrate trauma-informed care that prioritises safety, trust, and empowerment [K].
- Apply culturally appropriate and person-centred interventions [K].
- Recognise the intersection of trauma with refugee, asylum seeker, and CALD experiences.
- Collaborate with specialised trauma and refugee health services.

People in Residential and Institutional Care

Trainees should be able to:

- Recognise the mental health needs of people living in residential aged care, disability services, and custodial institutions [K].
- Describe the systemic risks of neglect, abuse, coercion, and lack of autonomy.
- Adapt psychiatric care to institutional environments, balancing individual care with organisational constraints [K].
- Work collaboratively with institutional staff and services to improve care quality.
- Advocate for human rights, dignity, and least-restrictive alternatives [K].

Service Contexts

Inpatient Services

Trainees should be able to:

- Conduct comprehensive psychiatric assessments in acute inpatient settings [K].
- Manage psychiatric emergencies (e.g., suicidality, aggression, catatonia, delirium) [K}.
- Formulate biopsychosocial treatment plans including pharmacological, psychological, and social interventions [K].
- Apply principles of least restrictive care, seclusion and restraint minimisation [K].
- Collaborate with nursing, allied health, and peer support staff [K].
- Prepare discharge and relapse prevention plans [K].

Community Mental Health Services

Trainees should be able to:

- Manage ongoing psychiatric care in the community, including chronic illness and recovery-oriented practice [K].
- Conduct home visits and community-based assessments [K].
- Work within multidisciplinary teams and community-based service models [K].
- Collaborate with families, carers, and community agencies [K].
- Recognise the role of peer support and advocacy groups [K].

Primary Care and Collaborative Care Models

Trainees should be able to:

- Collaborate effectively with GPs and primary care teams [K].
- Provide psychiatric consultation and shared care [K].
- Communicate clearly with non-psychiatric health professionals [K].
- Support early identification, prevention, and management of common psychiatric disorders in primary care.
- Contribute to integrated chronic disease management.

Emergency and Crisis Services

Trainees should be able to:

- Assess and manage acute psychiatric presentations, including suicidality, aggression, and acute psychosis [K].
- Perform risk assessment and safety planning [K].
- Apply mental health legislation in emergency contexts [K].
- Collaborate with emergency department staff, police, and crisis teams [K].
- Communicate effectively under pressure and resource constraints [K].

Consultation–Liaison Psychiatry

Trainees should be able to:

- Assess the impact of medical illness on psychological health and vice versa [K].
- Recognise psychiatric effects/side effects of medical treatments (e.g., steroids, dopamine agonists) [K].

- Work in medical/surgical environments and adapt communication accordingly [K].
- Provide psychiatric input to multidisciplinary hospital teams [K].
- Address abnormal illness behaviour, demoralisation, and adjustment [K].
- Support staff wellbeing and education in medical settings.

Forensic Psychiatry Services

Trainees should be able to:

- Conduct assessments in custodial and forensic hospital settings.
- Apply knowledge of legal frameworks and forensic orders.
- Assess and manage risk of harm to self and others in forensic settings [K].
- Provide expert psychiatric reports and testimony [K].
- Understand correctional mental health systems and therapeutic security.

Private Psychiatry Practice

Trainees should be able to:

- Understand the structure and funding of private practice (e.g., Medicare, insurance) [K].
- Conduct assessments and ongoing care in private settings [K].
- Manage professional boundaries and conflicts of interest.
- Coordinate with public services when required.
- Navigate ethical and financial considerations unique to private practice.

Rural and Remote Service Delivery

Trainees should be able to:

- Adapt psychiatric practice to small-community life [K].
- Provide care where specialist services may be limited [K].
- Collaborate closely with primary care providers and outreach services [K].
- Use telepsychiatry effectively and safely [K].
- Understand the challenges of service provision in resource-limited contexts [K].

Telepsychiatry and Digital Health

Trainees should be able to:

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- Conduct safe and effective psychiatric assessments via telepsychiatry [K].
- Apply principles of confidentiality, consent, and risk management in digital care [K].
- Adapt communication style for digital interfaces [K].
- Recognise limitations of telehealth and when in-person assessment is required [K].
- Evaluate emerging digital mental health technologies [K].

Specialist Services

(e.g., eating disorders, early psychosis, addictions, neuropsychiatry, intellectual disability, gender services, perinatal psychiatry)

Trainees should be able to:

- Describe the scope and models of care for specialist services.
- Understand referral pathways and collaboration with tertiary services [K].
- Integrate specialist service recommendations into holistic patient care [K].
- Advocate for patient access to specialist care where appropriate [K].

Integrated Care Models and Multidisciplinary Teams

Trainees should be able to:

- Work collaboratively within multidisciplinary teams [K].
- Recognise the value of nursing, allied health, peer support, and carer perspectives [K].
- Demonstrate leadership in shared decision-making and team-based care [K].
- Manage clinical handovers and care transitions safely [K].
- Apply principles of integrated care for complex multimorbidity [K].

Rehabilitation and Recovery Services

Trainees should be able to:

- Understand principles of psychiatric rehabilitation and psychosocial recovery [K].
- Support vocational, educational, and social recovery goals [K].
- Work with rehabilitation teams, NGOs, and supported accommodation services [K].
- Apply long-term relapse prevention and functional improvement strategies [K].
- Promote autonomy, empowerment, and community reintegration [K].

Emergent Areas Warranting Specific Focus

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[This section is deliberately left blank. The RANZCP will review the Knowledge Base annually to determine whether new populations or contexts of psychiatric importance should be included. If so, they will appear here.]

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