RACGP

Rural General Fellowship (FRACGP-RG)

Additional Rural Skills Training (ARST) Curriculum for Mental Health

Rural Generalist Fellowship (FRACGP-RG): Additional Rural Skills Training (ARST) Curriculum for Mental Health

Disclaimer

The information set out in this publication is current at the date of first publication and is intended for use as a guide of a general nature only and may or may not be relevant to particular patients or circumstances. Nor is this publication exhaustive of the subject matter. Persons implementing any recommendations contained in this publication must exercise their own independent skill or judgement or seek appropriate professional advice relevant to their own particular circumstances when so doing. Compliance with any recommendations cannot of itself guarantee discharge of the duty of care owed to patients and others coming into contact with the health professional and the premises from which the health professional operates.

Accordingly, The Royal Australian College of General Practitioners Ltd (RACGP) and its employees and agents shall have no liability (including without limitation liability by reason of negligence) to any users of the information contained in this publication for any loss or damage (consequential or otherwise), cost or expense incurred or arising by reason of any person using or relying on the information contained in this publication and whether caused by reason of any error, negligent act, omission or misrepresentation in the information.

Recommended citation

The Royal Australian College of General Practitioners. Rural Generalist Fellowship (FRACGP-RG): Additional Rural Skills Training (ARST) Curriculum for Mental Health. East Melbourne, Vic: RACGP, 2024.

The Royal Australian College of General Practitioners Ltd
100 Wellington Parade
East Melbourne, Victoria 3002

Tel 03 8699 0414
Fax 03 8699 0400
www.racgp.org.au

ABN 34 000 223 807

Published August 2024

We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

ID-5750

Contents

Introduction

The Rural Generalist Fellowship (FRACGP-RG) is a qualification awarded by The Royal Australian College of General Practitioners (RACGP) in addition to the vocational Fellowship (FRACGP). Completion of a minimum 12 months of Additional Rural Skills Training (ARST) in an accredited training post is an essential component of training towards the RG Fellowship. This additional training is designed to augment core general practice training by providing an opportunity for rural general practitioners (GPs) to develop additional skills and expertise in a particular area and enhance their capability to provide secondary-level care to their community.

This curriculum sets out the competencies that candidates are required to develop to complete ARST in Mental Health. It also provides a framework for the teaching and learning of the critical knowledge, skills and attitudes that rural generalists require to effectively care for patients with a range of mental health issues in rural and remote environments, where face-to-face support from other professionals is often limited.

Objectives

GPs play a crucial role in the provision of mental health services for all Australians. They are exposed to a range of acute and chronic mental health presentations and can be responsible for diagnosis, treatment and ongoing management of care. Mental health conditions have a significant impact on rural and remote communities, which face unique challenges in accessing mental health specialists (ie psychiatrists, psychologists, psychiatric nurses and other mental health workers). This means that rural GPs often provide the front-line service for mental health problems in their communities. Demand for, and use of, additional mental health skills in rural and remote communities is significant.

It is therefore vital that rural GPs have access to the training and support necessary to meet patient needs in this complex and challenging context. By undertaking ARST in Mental Health, candidates will develop the knowledge, skills and confidence to address their unique rural challenges, provide high-quality mental healthcare to their community, and be an advisory resource in mental health to other GPs. A long-term outcome of this will be improved equity of access to skilled practitioners in mental health and better healthcare for rural Australians.

Prerequisites

ARST in Mental Health can only be undertaken after the Hospital Training Time component of FRACGP has been completed. To give candidates a rural general practice context to the learning, and provide a better understanding of where their additional skills will be practised, it is strongly recommended (but not mandatory) that they have completed at least 12 months full-time equivalent (FTE) of community rural general practice terms before starting the ARST. However, the RACGP recommends that candidates work closely with their training team to plan the best training pathway for their individual circumstances.

Duration

This ARST in Mental Health requires a minimum of 12 months (FTE) in an accredited training post, in accordance with the vocational standards and requirements published by the RACGP. Candidates must demonstrate satisfactory achievement of outcomes as per the curriculum.

Context for the FRACGP-RG ARST Curriculum for Mental Health

The ARST post must be in an accredited mental health facility. This will usually be attached to a hospital or community mental health service, and may be in a metropolitan, regional or rural setting. A teaching post accredited for at least 12 months of training with the Royal Australian and New Zealand College of Psychiatrists (RANZCP) will generally be suitable but candidates must ensure that their training post has been accredited by the RACGP for mental health training before commencement. Ideally, a mental health training post will include community-based components, such as outreach clinics to rural and remote locations, including tele-psychiatry services.

The mental health issues GPs encounter in rural areas cover the broad spectrum from prevention and raising community awareness, through to serious mental illness. Rural communities also have their own particular culture due to differences in geography, demographics, socio-economic status, resources and infrastructure. Rural GPs are often confronted with challenging mental health problems in relatively isolated communities without immediate specialist backup. As such, rural GPs need to acquire a range of skills to provide the services that their city-based colleagues might refer on.

With the diversity of rural practice, during the training post candidates must be exposed to a wide range of clinical presentations and clinical interventions that will equip them to meet the needs of their individual communities. To achieve this outcome and fulfil the full range of curriculum requirements, it may be necessary for the candidate to split their training across a number of different facilities. It may also be necessary to undertake one or more short-term secondments to learn specific skills.

The emphasis of this ARST in Mental Health is on the acquisition of relevant clinical skills and experience. Candidates will engage in self-directed learning under the supervision of a Fellow of the RANZCP who is a clinical psychiatrist who participates in a general medicine roster. Registrar candidates will be supported by a GP medical educator. A rural GP mentor is recommended as an additional source of advice on training in the broader context of rural general practice, as well as a professional role model and support person.

The role of the GP mentor includes:

- acting as GP role model, mentor and support person
- observing the candidate's performance and provide regular feedback and assistance in general practice settings, where appropriate
- contributing to the assessment of the candidate, where appropriate.

The GP medical educator provides a link back to the training team to inform the candidate about educational activities and overall training requirements. Their role is to:

- provide advice and assistance regarding training needs, learning activities and completion of training requirements
- assist in the development, implementation and evaluation of learning materials
- assist in access to learning opportunities
- contribute to formative assessment of the candidate and monitor progress.

The clinical psychiatrist provides the candidate with a source of clinical expertise, advice and educational support. Their role is to:

- provide supervision in the clinical setting

- facilitate access to clinical learning opportunities
- demonstrate clinical skills and procedures
- observe the candidate's performance and provide regular feedback and assistance
- conduct regular teaching sessions
- monitor candidate progress and contribute to formative assessments
- report on progress in completing assessment requirements.

An independent or alternate assessor is someone with similar qualifications as the supervisor who will contribute to formative assessment of the candidate. They should be a Fellow of the RANZCP, who is a clinical psychiatrist who participates in a general medicine roster, or a Fellow of the RACGP or ACRRM with additional skills in mental health.

A combination of teaching methods is used, taking into account the specific clinical context and learning environment. Teaching and supervision methods strongly emphasise the acquisition of knowledge and skills in practice settings. Through demonstration, observation and interactive teaching methods, candidates are challenged to perform, reflect upon and assess their competence in applying the clinical knowledge and skills described in the curriculum.

Teaching methods may include:

- practice-based demonstration by supervisors
- practice-based observation and feedback on candidate performance
- group discussion, activities, case studies and presentations
- role-play or simulated scenarios illustrating challenging clinical situations
- online learning modules
- simulation of clinical presentations
- specific courses and workshops
- audio-visual and web-based presentations
- research projects
- regular meetings with supervisors
- access to continuing professional development workshops
- presentation of educational sessions to other staff or community groups
- journal articles and web-based resources
- development of teaching skills through teaching of junior medical staff and medical students.

Candidates are expected to determine the depth and extent of education and training required in consultation with their supervisors and document this as part of their training plan.

Content of the FRACGP-RG ARST Curriculum for Mental Health

The following content list provides guidelines for the candidate and the supervisors regarding topics to be covered during training. This is a non-exhaustive list of desirable knowledge and skills to meet the mental health needs of rural communities. It is anticipated that this list may be adapted to address the particular learning goals of candidates and the particular context in which the training is conducted.

The content is organised under the following headings:

1. Acute presentations
2. The nature of rural communities
3. The scope of mental illness
4. Practical skills
5. Resource management
6. Self-care

1. Acute presentations

- Early warning signs of mental illness and early intervention
- Identification of comorbid presentations
- Legal reporting responsibilities in child sexual abuse, domestic violence, substance abuse
- Performing a mental state examination
- Principles of using standardised patient rating scales
- Psychiatric emergency – crisis intervention skills
- Taking a mental health history
- Therapeutic modalities and regimes

2. The nature of rural communities

- Boundary issues in being a rural mental health professional
- Confidentiality in small communities
- Gun legislation and mental health crisis
- Mental health protocols and guidelines
- Protocols for media management in crisis situations
- Safe evacuation and transfer processes – protocols and guidelines
- Working with special needs groups, including women, perpetrators, domestic violence, carers

3. The scope of mental illness

- Dysfunctional personalities/families

- Mental health promotion
- Philosophy of mental health
- Social and cultural influences on mental health
- Spectrum of mental health problems

4. Practical skills

- Communication skills – listening, cross-cultural, empathy
- Communicating with children and adolescents
- Conducting a positive consultation using empowering techniques
- Counselling skills and essential techniques
- Identifying one's own limitations and knowing when to refer
- Mental health assessment
- Positive and negative transference
- Principles of detoxification and withdrawal
- Principles of, and exposure to, different types of therapies (eg family, group, relationship, bereavement and cognitive behavioural therapy)
- Principles of sexual counselling, including survivors of sexual abuse and transgender issues
- Process for critical incident stress debriefing

5. Resource management

- Developing a professional network
- Multidisciplinary teamwork, shared care and case management
- Principles of adult learning / educational sessions
- Program development
- Protocols for home visiting
- Respite care and support systems for carers
- Resources and how to access them in rural areas
- State legislation, power of attorney, child protection, guardianship
- Tele-psychiatry facilities
- Using translators to conduct a consultation

6. Self-care

- Balancing caseload and demands
- Establishing personal support network, including debriefing access
- Identifying personal strengths and vulnerabilities
- Managing a busy general practice as a mental health professional
- Professional development strategies
- Stress management

Learning outcomes and performance criteria

The **RACGP curriculum for Australian General Practice 2022** bases lifelong teaching and learning on the five domains of general practice. The domains represent the critical areas of knowledge, skills and attitudes necessary for competent, unsupervised general practice. They are relevant to every general practice patient consultation and form the foundation of the skills of rural GPs. Candidates undertake this ARST in Mental Health in conjunction with the **RACGP Curriculum for Australian General Practice 2022**. Subsequently, this curriculum is designed to detail the additional knowledge and skills that GPs completing their ARST in Mental Health are required to develop in order to provide comprehensive mental healthcare in rural and remote communities. The five domains are:

1. Communication and the patient–doctor relationship
2. Applied professional knowledge and skills
3. Population health and the context of general practice
4. Professional and ethical role
5. Organisational and legal dimensions

By the end of this ARST in mental health, the candidate will have expanded upon the assumed level of knowledge of the vocational registrar in these areas.

Note: Italicised terms in the following tables are defined in the next section, titled 'Range statements'.

1. Communication skills and the patient–doctor relationship

Learning outcomes	Performance criteria
1.1 Communicate effectively and appropriately with mental health patients, family members and carers	1.1.1 Demonstrate focused, flexible and appropriate *communication* with patients with a mental health issue 1.1.2 Modify communication with mental health patients from *culturally and linguistically diverse communities* 1.1.3 Modify communication with mental health patients from *Aboriginal and Torres Strait Islander* backgrounds 1.1.4 Modify communication with children and adolescents 1.1.5 Develop rapport with the patient, even in *challenging circumstances* 1.1.6 Adapt an interviewing technique that encourages the patient to talk and focuses on their strengths
1.2 Provide high-quality, holistic healthcare to patients with mental health issues	1.2.1 Communicate clearly and professionally with other members of a multidisciplinary team 1.2.2 Engage effectively in case management meetings

2. Applied professional knowledge and skills

Learning outcomes	Performance criteria
2.1 Take a comprehensive psychiatric history and perform a mental state examination	2.1.1 Make accurate and comprehensive patient records and complete relevant documentation as appropriate to the situation 2.1.2 Identify *comorbid* clinical presentations 2.1.3 Assess associated *risk factors* 2.1.4 Use the correct *phenomenology* for mental state examination 2.1.5 Use patient rating scales / outcome tools 2.1.6 Make a diagnosis and/or give a formulation using a *bio-psycho-social* model
2.2 Appropriately use a number of psychological therapies	2.2.1 Assess the patient and situation as appropriate for *cognitive behavioural therapy* (CBT) 2.2.2 Use CBT *appropriately* 2.2.3 Use alternative evidence-based *therapies* where appropriate
2.3 Use a number of management techniques in relation to the patient with a mental health issue	2.3.1 Use a *recovery-oriented model of care* 2.3.2 Employ pharmacotherapy for the full spectrum of mental health issues 2.3.3 Manage psychiatric *emergencies* 2.3.4 Apply the *principles of drug withdrawal and detoxification* 2.3.5 Make a plan for relapse prevention and crisis intervention 2.3.6 Demonstrate *continuity of care* for the long-term health of the patient 2.3.7 Use appropriate transfer and safe evacuation processes for psychiatric patients

3. Population health and the context of general practice

Learning outcomes	Performance criteria
3.1 Provide appropriate and timely care to people with a mental health issue who live in rural and remote areas	3.1.1 Work effectively with people with mental illness within the current social, cultural and economic influences 3.1.2 Assess and critically analyse the effects of stigma and discrimination, and the impacts these have on an individual, family and carer 3.1.3 Describe the suicide risk factors in rural and remote areas 3.1.4 Formulate a plan to manage suicide risk
3.2 Disseminate health information through relevant networks and organisations	3.2.1 Collaborate with *mental health consumer organisations* 3.2.2 Collaborate with *carer organisations* 3.2.3 Collaborate with non-government organisations that work in the area of mental health
3.3 Support the use and development of mental health services in rural and remote areas	3.3.1 Use relevant guidelines and, where needed, develop new guidelines for mental health service provision in rural and remote areas 3.3.2 Involve consumers and consumer groups, carers and carer groups in developments and initiatives in health service provision

4. Professional and ethical role

Learning outcomes	Performance criteria
4.1 Deliver professional and ethical care to patients with mental health issues	4.1.1 Manage *boundaries* with patients who are friends, relatives, colleagues or acquaintances 4.1.2 Manage patient confidentiality 4.1.3 Manage *personal and family boundaries* in the community
4.2 Practise self-care and reflection	4.2.1 Use effective strategies for establishing, maintaining and improving self-awareness when interacting with patients with a mental health issue 4.2.2 Use effective *self-care strategies* that protect and minimise potential personal impacts associated with high levels of disadvantage that occur in a mental health setting
4.3 Demonstrate a commitment to mental health-related professional development	4.3.1 Identify and address professional development needs 4.3.2 Participate in professional development 4.3.3 Interact *ethically* with external providers 4.3.4 Practise critical self-reflection
4.4 Promote mental wellbeing in rural communities	4.4.1 Provide professional development sessions to other rural health professionals 4.4.2 Provide education sessions for members of the rural community 4.4.3 Promote and implement good mental health practices to staff, patients and community
4.5 Facilitate collaboration and coordinated care	4.5.1 Work effectively as part of a *multidisciplinary team* to help ensure continuity of care to patients with a mental health issue 4.5.2 Develop and use a comprehensive *professional referral network* 4.5.3 Provide leadership in supporting the multidisciplinary team, in particular, in debriefing and conflict resolution

5. Organisational and legal dimensions

Learning outcomes	Performance criteria
5.1 Work within professional and legislative requirements and guidelines	5.1.1 Use the relevant Mental Health Act when appropriate 5.1.2 Follow state-based reporting requirements for child protection, domestic violence and substance abuse 5.1.3 Notify relevant authorities as required 5.1.4 Demonstrate *professionally acceptable standards* of documentation and report writing in the care of psychiatric patients
5.2 Establish and support mental health networks and	5.2.1 Establish a professional mental health network 5.2.2 Use a range of appropriate regional and metropolitan mental health services 5.2.3 Use a range of clinical, academic and research resources 5.2.4 Develop and use *resources and processes* to ensure continuity of care for patients with chronic mental health issues 5.2.5 Use support services for the carers of people with a mental health issue
5.3 Use relevant protocols	5.3.1 Follow the appropriate protocols for home and hostel visiting 5.3.2 Follow local transfer and safe evacuation processes and protocols for psychiatric patients 5.3.3 Access the protocols for *media involvement* in the management of crisis situations

Range statements

The following statements and definitions are offered to improve the understanding of key terms used throughout the learning outcomes and performance criteria. These terms are not definitive and need to be considered in local contexts. They are grouped according to the five domains of general practice.

Communication skills and the patient–doctor relationship

Communication – This can include listening, speaking, looking for non-verbal communication, and written, phone and tele-psychiatry facilities.

Culturally and linguistic diverse communities – This term can include refugees, visa holders, migrants, people from English and non-English speaking backgrounds, and people with diverse cultural and religious beliefs and practices that include unfamiliar/unconventional/challenging medical beliefs and practices regarding the roles of children, women, men and others in the community (eg doctors and case managers). People who are intellectually or hearing impaired should also be considered.

Aboriginal and Torres Strait Islander – This term includes people who identify as Aboriginal and/or Torres Strait islander.

Challenging circumstances – These are situations that make demands on one's abilities, endurance, patience and tolerance. Such challenging circumstances may be related to patients presenting with anger, aggression, mania, violence, agitation and psychosis.

Multidisciplinary team – This can include GPs, allied health professionals and other medical specialists (occupational therapists, psychologists, psychiatric nurses, social workers, Aboriginal and Torres Strait Islander health workers), as well as case managers and cultural advisors.

Professional referral network – This can include individuals and groups of professionals who offer treatment, management, advice, support, information and advocacy to patients, their families and carers. Professionals can include people who work in the medical, legal, social and community sectors.

Applied professional knowledge and skills

Comorbid – Comorbidity has implications for aetiology, diagnosis, management and prognosis of mental health conditions. Psychiatric disorders are commonly associated with drug and alcohol problems,[1] as well as physical health comorbidities (eg metabolic syndrome).

Risk factors – This can include suicide attempts, self-harm, self-neglect, non-compliance, substance misuse, side-effect development, relapse or violence.[2]

Phenomenology – This is taken by many authors to be the description of patients' medical signs and symptoms.[3] Phenomenology in psychiatry means a descriptive account of signs and symptoms that are empirical (opposed to speculative) and detailed (with emphasis on idiosyncratic features of a particular patient).

Bio-psycho-social formulation – Factors to consider include biological (disease, physiology); psychological (cognition, behaviour, mood); social (interpersonal, social and occupational, healthcare system, cultural); and presenting, predisposing, precipitating, perpetuating and protective factors. Management of mental health patients is often guided by case formulation as much as diagnosis.[2]

Cognitive behavioural therapy – This should include psycho-education, motivational interviewing, behaviour modification, cognitive interventions, cognitive analysis with thought-challenging and cognitive restructuring, relaxation strategies and skills training (eg problem solving, stress management).[4]

Appropriately – CBT is practised by the candidate with the supervision of a psychologist or psychiatrist who is qualified in the area.

Therapies – These may include dialectical behaviour therapy, family therapy, group therapy, interpersonal therapy and mindfulness-based cognitive therapy.

Recovery-oriented models of care[5] – Recovery-oriented mental health practice refers to the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing, and to define their goals, wishes and aspirations.

Recovery-oriented practice encapsulates mental healthcare that recognises and embraces the possibilities for recovery and wellbeing created by the inherent strength and capacity of all people experiencing mental health issues; maximises self-determination and self-management of mental health and wellbeing; and assists families to understand the challenges and opportunities arising from their family member's experiences.

The lived experience and insights of people with mental health issues and their families are at the heart of recovery-oriented culture. The concept of recovery was conceived by, and for, people living with mental health issues in order to describe their own experiences and journeys, and to affirm personal identity beyond the constraints of their diagnoses.

Recovery-oriented approaches recognise the value of this lived experience and bring it together with the expertise, knowledge and skills of mental health practitioners, many of whom have experienced mental health issues in their own lives or in their close relationships.

Recovery-oriented approaches challenge traditional notions of professional power and expertise by helping to break down the conventional demarcation between consumers and health professionals. Within recovery-oriented paradigms, all people are respected for the experience, expertise and strengths they contribute.

Recovery-oriented approaches focus on the needs of people who use services, rather than on organisational priorities.

Emergencies – An emergency is any acute disturbance of behaviour that, if left unmanaged, could lead to harm (either to the individual or others).

Principles of drug withdrawal and detoxification – This can involve medication to minimise drug and/or alcohol withdrawal symptoms, hospital admission, antidepressants, antipsychotics, other drug treatments (eg naltrexone and methadone), social skill training, group therapy, family therapy, and services for the homeless and employment.[2]

Continuity of care – This is the uninterrupted care of a patient with a chronic mental health issue over a long period of time.

Population health and the context of general practice

Mental illness – This is any illness as defined by the most up-to-date version of the *Diagnostic and statistical manual of mental disorders* (DSM).

Stigma – Stigma can be defined as constituting a label that separates the person from others, the linking of the labelled person to undesirable characteristics, and the rejection and avoidance of the stigmatised person by others.

Discrimination – This means making a difference in particular cases, as in favour of or against a person or thing.[3] The person with a mental health issue is often discriminated against purely because of the diagnosis.

Suicide risk factors in rural and remote areas – Such risk factors are well documented in all significant psychiatric textbooks, but these often neglect the easy availability of firearms and dangerous chemicals in rural and remote areas. These risk factors need to be managed along with all other suicide risk factors.

Mental health consumer organisations – These are voluntary organisations commonly run by people with mental health issues. Ask before attending their meetings and, when present, listen, and advise and teach if asked.

Carer organisations – These are voluntary organisations for parents and carers of people with mental health issues. Ask before attending their meetings and, when present, listen, and advise and teach if asked.

Professional and ethical role

Boundaries – The relationship between a doctor and a patient for the purposes of providing and obtaining treatment is commonly referred to as a doctor–patient relationship. This relationship has boundaries around it and within it. Sexual and non-sexual boundary violations are among the issues that most frequently occur within psychiatry.[6] Doctors should never exploit patients for any sexual advantage, financial gain or other personal purpose.[7]

Personal and family boundaries – These can include personal boundaries around disclosing personal information, socialising and forming relationships; family boundaries around disclosing confidential work-related information and protecting family against unwanted attention from patients; and professional boundaries around treating friends and family members.

Self-care strategies – These are activities that ensure the doctor remains well physically, spiritually and emotionally.

Ethically – Core ethical principles include autonomy of the patient; non-maleficence, which is the doctor's duty to avoid inflicting physical or emotional harm on the patient; beneficence, which is to prevent or remove harm and promote wellbeing; and justice, which does not operate in a vacuum, but responds to the ever-changing social, political, religious and legal mores of the moment.[7]

Organisational and legal dimensions

Professionally acceptable standards – Medical records are not used by doctors alone, but also by regulatory agencies, by court-ordered subpoena, in malpractice litigation and by patients under the Freedom of Information Act 1982 (Cth). This right of the patient to view their records represents society's belief that the responsibility for medical care has become a collaborative process between doctors and patients.[7]

Media involvement – Doctors may comment on mental health generally, but may not offer opinions about patients or a person that is not their patient.[7]

Resources and processes – These can include written and recorded notes, copies of referrals, involvement of parents and carers, use of the relevant Mental Health Act where appropriate, and screening and recall procedures.

Assessment

Satisfactory completion of the ARST in Mental Health will be assessed by a combination of workplace-based assessment (WBA) approaches during the candidate's 12-month (FTE) placement in an accredited training post.

WBA is a recognised approach to assessing medical practitioners in training in the actual workplace, and WBA assists with training, as well as assessment. To achieve this requirement, WBAs assess a diverse range of attributes, including clinical competencies, domains and skills. Further details about WBA and how it is applied in ARST assessment can be found in the **AGPT Registrar Training Handbook** and the **Rural Generalist Training Handbook**.

The following WBA assessment tools will be used to assess the candidate's competency in this ARST in Mental Health:

- logbook
- three random case note analysis sessions reviewing a minimum of three cases per session
- two supervisor reports, one completed at six months and one at completion of 12 months of training (FTE)
- two Mini-Clinical Evaluation Exercise (Mini-CEX) sessions, with a minimum of three cases per session
- two case-based discussion sessions (candidate submits four cases and is assessed on two each session).

Each task is described in more detail below.

Logbook

Candidates will be required to maintain a logbook throughout their training. A component of maintaining this logbook involves reflecting on self-identified learning needs. The range of skills that are logged, and any proposed professional development in this area, should take into consideration the community requirements.

This logbook will need to be regularly reviewed by the supervisor and reviewed by the medical educator at each medical educator meeting.

Random case notes analysis

Candidates will be required to undertake three random case note analysis sessions in which a minimum of three cases are reviewed per session. Using patient notes that are randomly selected, the assessor will review the quality of case notes as well as explore the candidate's clinical decision making, management and therapeutic reasoning.

The first of these random case notes analysis sessions should be completed by the supervisor in months two to four (FTE) of the training. The second session should be completed by an alternative assessor in months four to six (FTE). The third session should be completed in months seven to eight (FTE) by the supervisor.

Supervisor reports

The candidate and their supervisor will meet half-way through the training (eg at six months for full-time training) and at the end of the training period (eg at 12 months for full-time training) to complete a supervisor report.

These reports should provide a global assessment of performance against the outcomes outlined in this curriculum. The candidate and supervisor will meet to discuss the candidate's performance, identify areas for further learning and development, and ensure that the candidate is progressing adequately in their training. Progression, or lack thereof, should be documented and discussed, with the intent of formulating a plan to remediate any gaps identified either through additional learning, or experiences, or a combination of both.

Mini-CEX

Candidates will be required to undertake two Mini-CEX sessions in which a minimum of three cases are observed per session. The assessor will observe the candidate conducting a consultation with real patients and provide feedback about their performance.

The first of these Mini-CEX sessions should be completed by the supervisor in months two to four (FTE) of the training. The second session should be completed by an alternative assessor in months seven to eight (FTE).

Case-based discussions

Candidates will be required to undertake two case-based discussion sessions. The candidate will be required to submit four cases and will be assessed on two cases for each session. The assessor will explore the candidate's case management and clinical reasoning alongside their medical knowledge.

The first of these case-based discussion sessions should be completed by an independent assessor in months four to six (FTE) of the training. The second session should be completed by an independent assessor in months nine to 11 (FTE).

Recommended learning resources

- American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th edn. Arlington: American Psychiatric Association, 2013.
- Bateman A, Brown D, Pedder J. Introduction to psychotherapy: An outline of psychodynamic principles and practice. 4th edn. New York: Routledge, 2010.
- Blashki G, Judd F, Piterman L. General practice psychiatry. Sydney: McGraw-Hill Australia, 2006.
- Bloch S, Singh BS. Foundations of clinical psychiatry. 3rd edition. Melbourne: Melbourne University Press, 2007.
- Davies J. A manual of mental health care in general practice. Canberra: Commonwealth Department of Health, 2003.
- Harden M. Cognitive behavior therapy: Incorporating therapy into general practice. Aust Fam Physician 2012;41(9):668–71.
- Therapeutic guidelines: Psychotropic version 7. Melbourne: Therapeutic Guidelines Limited, 2013.
- Treatment Protocol Project. Acute inpatient psychiatric care: A source book. Sydney: Treatment Protocol Project, 1999.
- Treatment Protocol Project. Management of mental disorders. Sydney: Treatment Protocol Project, 2004.

References

1. The Royal Australian College of General Practitioners. The RACGP curriculum for Australian general practice 2022. East Melbourne, Vic: RACGP, 2022
2. Johnstone E, Cunningham Owens D, Lawrie S, McIntosh A, Sharpe M, editors. Companion to psychiatric studies. 8th edn. Edinburgh: Churchill Livingstone, 2010.
3. Spitzer M, Uehlein F, Schwartz M, Mundt C, editors. Phenomenology, language and schizophrenia. New York: Springer-Verlag, 2011.
4. The General Practice Mental Health Standards Collaboration. Mental health training standards 2020–22: A guide for GPs. Melbourne: GPMHSC, 2019.
5. Department of Health. A national framework for recovery-oriented mental health services: Guide for practitioners and providers. Canberra: DOH, 2013
6. American Psychiatric Association: Diagnostic and statistical manual of mental disorders. 5th edn. Arlington: American Psychiatric Association, 2013.
7. Sadock, B, Sadock, V, Ruiz, P. Kaplan and Sadock's synopsis of psychiatry: Behavioral sciences/clinical psychiatry. 11th edn. Philadelphia: Wolters Kluwer/Lippincott Williams and Wilkins, 2017

List of acronyms and initialisms

ARST	Additional Rural Skills Training
FRACGP	Fellow of the Royal Australian College of General Practitioners
FRACGP-RG	Royal Australian College of General Practitioners Rural Generalist Fellowship
FTE	full-time equivalent
GP	general practitioner
Mini-CEX	Mini-Clinical Evaluation Exercise
RACGP	Royal Australian College of General Practitioners
RANZCP	Royal Australian and New Zealand College of Psychiatrists
WBA	workplace-based assessment

Healthy Profession.
Healthy Australia.

RACGP