PSYCHOTHERAPY TRAINING IN QUEENSLAND UNDER THE 2012 FELLOWSHIP PROGRAM:

A Practical Guide for Queensland Trainees

Adapted from the SA Guide by Dr Jimsie Cutbush

Many thanks to the following authors for developing the original documents:

Paul Cammell: The Guide to Psychotherapy Training

Shane Gill: Psychotherapy Training in SA under the 2012 FP

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1. INTRODUCTION

Training in Psychotherapy is a core component of the RANZCP Fellowship Program. This guide is for trainees in the Queensland Program to assist them in planning how to meet these requirements and develop their skills in psychotherapy.

This guide should be read in conjunction with the RANZCP Fellowship Program regulations, policy and procedure regarding Psychotherapy training, and the Guide to Psychotherapy Training written by Dr Paul Cammell, Chair of the RANZCP Sub-Committee for Advanced Training in Psychotherapy. This Guide is a companion piece for this book.

a. USEFUL LINKS

- Regulations Policy and Procedure for the Psychotherapy Written Case:

https://www.ranzcp.org/Files/PreFellowship/2012-Fellowship-Program/RPP-PSYCHOTHERAPY-WRITTEN-CASE.aspx

- Stage 2 Psychotherapy EPA's:

https://www.ranzcp.org/Files/PreFellowship/2012-Fellowship-Program/EPA-forms/Psychotherapy-EPAs-COE-forms.aspx

- Stage 3 Psychotherapy Requirement Sessions Form:

https://www.ranzcp.org/Files/PreFellowship/2012-Fellowship-Program/Stage-3-Psychotherapy-Sessions-Form-(Reader-extend.aspx

- Advanced Certificate in The Psychotherapies:

https://www.ranzcp.org/Pre-Fellowship/2012-Fellowship-Program/Certificates-of-Advanced-Training/Psychotherapies.aspx

b. CONTACT PEOPLE IN THE QBTC FOR PSYCHOTHERAPY

- Director of Advanced Training, Psychotherapy

Dr Michael Martin elizm@bigpond.net.au
Dr Martin's role is to coordinate the Advanced Training Program in Psychotherapy. He is the person you should contact if they wish to apply for the Psychotherapy Certificate in Stage 3.

- Dr Andrew Christensen achristensen63@gmail.com

Dr Andrew is proxy for Dr Michael Martin at QBTC

2. THE PSYCHOTHERAPY WRITTEN CASE

The Psychotherapy Written Case (PWC) is an important summative assessment. It has two components: the conduct of psychodynamic therapy with a patient for at least 40 sessions, and the submission of a written report describing this that is marked by the Committee for Examinations and must be passed to gain Fellowship. There are detailed regulations about both the experience, which must be supervised, and the Written Case, which are on the website (see the link for this, under "useful links").
https://www.ranzcp.org/Files/PreFellowship/2012-Fellowship-Program/RPP-PSYCHOTHERAPY-WRITTEN-CASE.aspx

The three formative case discussions during the PWC

To encourage reflection on the treatment progress and provide opportunities to receive qualitative feedback, trainees must participate in three formative psychotherapy case discussions with their psychotherapy supervisor during the psychotherapy process. Trainees must submit the three completed psychotherapy case discussion forms to the College with their Psychotherapy Written Case when it is submitted.

Case discussions should occur during the early, middle and late phases of the psychotherapy and should focus on pivotal points or milestones in the therapy process or on treatment dilemmas and/or emerging issues. The supervisor should mark on the Psychotherapy case discussion form the topics covered in each psychotherapy case discussion.

The Case discussion asks the supervisor to provide systematic assessment, on a rating scale as well as in writing, on the areas such as assessment, formulation, risk assessment and management, psychotherapeutic processes and professionalism, including note-keeping. Formative verbal and written feedback on strengths and areas needing improvement are provided. The PWC case discussion form is unique to this task and is different to the usual CBD form. The link is:
https://www.ranzcp.org/Files/PreFellowship/2012-Fellowship-Program/Psychotherapy-case-discussion-form.aspx.

The focus in the first case discussion, in the early phase of treatment, should be on case selection, suitability for the chosen therapy modality, assessment/MSE/diagnosis, risk assessment and initial formulation.

The focus in the second Case discussion, in the middle phase of therapy, should be on the psychotherapeutic process, understanding key episodes in the therapy, reflection on the developing therapeutic relationship, including transference, managing treatment dilemmas (such as boundaries, missed sessions, acting out, resistance etc.) and applying a theoretical framework to the therapy.

The focus in the third case discussion, in the late phase of treatment, should be on reformulation (including an integration of the theoretical model into the understanding of the patient), managing termination, evaluating the outcome of therapy for the patient, reflecting on what the trainee has learnt about the patient in particular and psychotherapy in general, reflecting on the role of supervision and preparing the case for written submission.

a. FINDING A SUPERVISOR

You need to have a supervisor allocated before you commence therapy. This is because your first task will be to discuss an initial assessment of the patient with the supervisor to determine if they are suitable for the PWC. Not all the patients you find who you think are suitable, will be accepted as suitable by your supervisor. Your supervisor might advise you that you should not take the patient on for the PWC. If they do, take this advice, and look for another patient. In this case, your supervisor will give you some direction about what to look for in a suitable patient.

All HHS have supervisors available for provision of psychotherapy supervisor. The arrangements vary; at times it will be a consultant in the service who has an interest in psychotherapy or a consultant employed by the service to provide psychotherapy supervision, or a psychiatrist in private practice who has links with the service. Other trainees receive supervision from psychiatrists in private practice. If you utilize a private psychiatrist you will need to negotiate a fee with them.

In addition, Michael Martin, Director of Advanced Training, Psychotherapy, has provided Postgraduate Training with a list of supervisors, which is available upon request.

Therefore, the first task is to find a supervisor. You may want to do this before you have identified a potential patient, or after you have found a potential patient. I recommend the former, as it can take some time to find a supervisor who is available.

The ideal time to ask for a supervisor is towards the end of first year or the beginning of second year. Most trainees will find that it is best to have completed conducting the therapy during stage 2, i.e. before the end of third year, and to plan to write and submit the PWC report during stage 3 (4th and 5th year). If you plan to find a suitable patient and commence therapy during second year, you then want to have your supervisor in place at the beginning of second year.

If you already have a patient you are considering for therapy, you would present that patient in your first supervision session, which would focus on suitability. You would only set a

contract for therapy with the patient after your supervisor has agreed they are suitable. Your supervisor will also discuss with you how they want supervision to proceed (e.g. hand-written notes vs audio recordings of session material).

If you do not have a patient, your supervisor will talk with you about how to find potential patients and discuss what to look for in a good psychotherapy candidate. You may then arrange to meet again after you have found a potential patient.

It is important to note that supervision does not need to be individual supervision and a group of trainees can meet for group supervision. This can be an advantage, as you can also learn from listening to the therapy undertaken by, and supervision provided to, a colleague. If supervision occurs in a group format, you must have an opportunity to present your patient at least once a fortnight.

Supervision should be for 1-2 hours, recommended to be weekly, but at the minimum fortnightly.

b. FINDING A SUITABLE PATIENT

There are a range of criteria that make some patients more suitable for psychodynamic psychotherapy than others. Your supervisor will discuss this with you when you present a potential patient to them. There are also some relative contraindications you need to consider. It is important to ensure that any risk issues, especially suicidal or self-harming behaviour, are not likely to arise during therapy. Similarly, someone who abuses substances might make a poor candidate for this form of therapy.

There are also some administrative factors are required to make a patient a suitable candidate to be taken on by a trainee for the PWC. These include:

• The patient accepts that you are a trainee, that you will be discussing your therapy with a supervisor (this is required as part of consent).

• The patient accepts that you and they may need to move to undertake therapy in a different location during the course of therapy, as you rotate to different sites.

• The patient accepts that they will need to be a registered client of a public community mental health service.

Sources of suitable patients, that trainees in the past have found helpful, include:

• Patients seen by yourself, when on call and/or working in the ED, who present with a high prevalence disorder underpinned by interpersonal difficulties, their personality style and a background history of past emotional and/or relational problems. This is one reason why it is important to take a good personal history and attempt to make a formulation on patients seen in the emergency setting.

• Patients seen by you in the consultation-liaison setting, where emotional and personality difficulties are relevant to how the person manages their physical illness, and may be amenable to psychotherapy.

• Patients seen by registrar colleagues in the above settings. It is worth informing colleagues that you are looking for a suitable patient, and if your colleagues have already started, or completed, their psychotherapy case they are usually willing to direct suitable patients your way.

• Patients referred to you by supervisor and/or consultant colleagues. It is worth letting consultants with whom you work know that you are looking for a psychotherapy patient. They may have patients referred in their private practice time who may be suitable, who they can then refer to you. Some CYMHS also identify potential psychotherapy patients amongst the parents who attend the clinics with their children. PGT is advised on occasions of possible suitable patients and will provide this information with contact details of the referrer in the weekly e-blast notifications.

• Your supervisor, who is usually a practicing psychotherapist, may have patients referred to them for therapy, but they do not have space in their appointment diary to take them on. They may then refer these patients on to you.

Once you have found a potentially suitable patient, make an assessment and present them to your supervisor. Do not yet promise to commence therapy with the patient or set a contract. Your supervisor may advise you that they are not a suitable patient for a PWC. In this case you have an obligation to make arrangements for the patient to have alternative follow-up, such as through their GP, a Community Mental Health team, or a private psychiatrist. If your supervisor agrees that the patient is suitable, then you can proceed to set a therapy contract and ask the patient to sign the Prescribed Consent Form.

<u>Managing a premature drop-out from therapy:</u>

Unfortunately, on occasion a patient may discontinue therapy part way through, before 40 sessions have been undertaken. You should discuss the drop-out with your supervisor – there may be something to learn from the experience, perhaps about patient suitability or

managing acting out, resistance or transference, that will help you with the next patient. The college has a process which allows consideration of submitting the case with slightly fewer than 40 sessions. You have to submit a request to waive the 40 sessions requirement to the CFT with supporting documentation from your psychotherapy supervisor and QBTC. The Policy and Procedure states the following:

7.1 Termination prior to 40 sessions
There may be unusual and exceptional cases where therapy is terminated just before the planned 40 sessions. Trainees must submit a request to waive the 40 session requirement to the CFT via the College head office. Trainees should include supporting documentation from their psychotherapy supervisor and/or DOT with their requests. The CFT will consider these requests on a case-by-case basis.
Trainees for whom the 40 session requirement is waived must attach written evidence showing that the CFT waived their 40 session requirement to their Psychotherapy Written Case Submission Form. Trainees in this circumstance must still include adequate and convincing discussion in their write-up to demonstrate the required psychotherapeutic principles and practices.

c. *CONDUCTING THE THERAPY*

The College regulations set out rules for this, in some detail, but there are some issues I would like to highlight:

i. Registering the patient with your clinical service

It is essential that the patient you see is registered with a Mental Health Service at which you have clinical privileges. This is essential for you to be indemnified medico-legally for the care of the patient. Therefore this MUST be done. The patient is usually registered with a community team of the HHS with whom you are employed, and where the patient will be seen by you. It is ideal if you maintain this registration and location of therapy, even if you are rotated elsewhere, although it is not always possible. Sometimes the patient can be seen at the site at which you are rotated, and you might need to move the location of therapy when you are rotated. In some cases the patient's registration can also be changed, but in other cases this is not possible. You need to discuss the planned arrangements with the clinical director of each service (where the patient is registered and where you are working) to ensure that the arrangements and clinical governance have the approval of both services. If your patient is registered at a different service, you also need to make sure that the treating team does not precipitously discharge the patient from their service!

In most circumstances you will not be able to continue to see the patient if you are on a break in training, as you would not have cover for indemnity and workplace health and

safety, and you would need to provide for appropriate ongoing care of the patient, and subsequently find another psychotherapy patient.

ii. Deciding where and when to see your patient

Booking a room at your local community Mental Health Team site is an appropriate venue to undertake therapy. You may need to negotiate this with the Treating Psychiatrist and Team Leader if you are not actually working there. Ideally, you can continue this arrangement after rotation to different sites, although this isn't always possible. Some inpatient units have interview rooms that can be booked and would be suitable, although patients tend to find attending an inpatient unit for outpatient therapy somewhat challenging.

It is important that you make a clinical case note entry after each therapy session. This is done on CIMHA (they will have an open episode on CIMHA because you have registered them – see above). This entry can be brief (e.g. "session 29 of psychodynamic therapy for the PWC undertaken") but will need to be longer if a specific issue arises that needs further specific documentation, e.g. a risk issue, or you need to refer the patient to the Treating Team.

iii. Negotiating time away from work to conduct therapy and receive supervision

Trainees are provided with four hours of protected time to attend the FEC during training. However, there is no award provision or College regulation that specifies that a trainee must be given a certain amount of time away from the worksite to conduct psychotherapy or receive supervision. Therefore time taken to conduct therapy and receive supervision is a mutual negotiation you undertake with your supervisor and the clinical team where you work during each rotation. Fortunately, Qld clinical services are supportive of trainees to undertake this requirement, so an arrangement can usually be struck.

The following courtesies should be observed when negotiating an arrangement:

• It would be asking too much of your clinical service to expect your work site to provide you with more than a maximum of three hours of absence from clinical duties for your therapy, supervision and any travel time (in addition to your release for the FEC). This is an expected maximum, not a minimum entitlement, and many busy services and units will be unable to allow you to be absent from your clinical duties for this much time, and might only be able to allow a portion of this. This should be respected, and a compromise solution negotiated. It would be courteous to try to minimise your absence from the work site as much as possible.

• Any arrangement negotiated with one site should not be used as a precedent to demand the same time away from a different site. Similarly, any arrangement negotiated for one trainee should not be used as a precedent by another trainee to demand the same allowance elsewhere. Any negotiated arrangement is unique for that trainee, that site, that supervisor and that rotation, and does not set a precedent for an entitlement.

• It is most appropriate to conduct the actual therapy during rostered hours, as you are providing a clinical service to a registered client of your service. The supervision, which is a training activity for you rather than being part of your clinical duties for your employer, is therefore the most appropriate component to occur out of rostered hours, if your service is unable to accept your absence from normal clinical duties for both components.

• If possible, schedule therapy and/or supervision at either end of the day, to reduce the amount of time absent from work travelling to and from therapy/supervision. Alternatively, timing therapy/supervision to coincide with the start/end of your lunch break may work.

• Some supervisors schedule supervision after hours, e.g. at 0800 – 0900 or at 1700 – 1800. If this works for the supervisor, this is acceptable.

• If you do receive psychotherapy supervision after hours (in part or in full), you SHOULD NOT claim overtime for receiving supervision, as this is a training and not a clinical service activity. Your timesheet should reflect your normal rostered hours, even if some or all of your supervision occurs after rostered hours finish.

• Try to choose a supervisor who you can see relatively close to your worksites, so as to reduce travel time.

• The ideal arrangement is to have a supervisor who works at your own worksite (and a patient you can see at your worksite, or close by). Some supervisors work in the public system but some are in private practice, so you will probably have to travel to their rooms.

• Also, choose a patient who can easily travel to the worksite you will see them, at a time that will suit you and your service. This practical issue is one of the suitability criteria to consider when finding a patient.

iv. Lines of clinical responsibility for your psychotherapy patient

Your PWC supervisor is NOT clinically responsible for your patient's care. They are supervising your learning and your completion of this mandated training activity. They are a training supervisor accredited by the College, not a clinical supervisor. They are not taking

responsibility for the patient's clinical outcome. However, you do take responsibility for your patient's care. Therefore you need to have a clinical supervisor who has a clinical line of responsibility from you to them for the patient. This may be your principal supervisor in the current rotation, or may be the lead psychiatrist at the CMHT site where the patient is seen, or another designated psychiatrist within the LHN. Whoever it is, you need to make sure they are aware that they have this role, and that they have accepted it. If it is your principal supervisor in the current rotation, you should discuss the patient and any clinical issues at an early supervision session in the rotation.

If clinical issues arise for the patient whilst you are seeing them e.g. the patient experiences a mental health emergency, a risk issue emerges, or there is a need for treatment with medication, psychiatric admission or referral to a mental health clinician/service, you should discuss this with the clinical supervisor. You should also discuss these issues with your psychotherapy supervisor, as this will have an impact on the therapy, transference etc. and will need to be discussed in your write up. You should inform your psychotherapy supervisor who the clinical supervisor is, and vice versa, in case they need to contact each other during your therapy.

Whilst you must make at least brief case note entries into CIMHA, you should keep detailed "training notes" of what has happened during therapy and during supervision. These notes will be invaluable when writing up the case. These notes must be kept securely by you during therapy (e.g. in a locked filing cabinet) and destroyed after your case has been submitted and passed. I recommend that you include no identifying information about the patient in these training notes, and use the same deidentification strategies you need to employ for the PWC write up. It may also be prudent not to include identifying information about the patient when presenting to your training supervisor (you need to do so with your clinical supervisor, of course), as this reinforces that your discussions with the training supervisor are NOT about clinical care of the patient. Any clinical information that needs to be retained as a clinical record of the patient's assessment and management, for medico-legal purposes, should be entered into the CBIS record.

d. WRITING UP THE PWC CASE REPORT

i. Some guidelines about the standard required

The PWC is marked against the standard of a "junior consultant". The Fellowship Competencies spelt out in the CbFP (.https://www.ranzcp.org/Pre-Fellowship/2012-Fellowship-Program/About-the-training-program/Fellowship-competencies.aspx), give

some indication as to what this standard is, although these descriptors do not specifically address the standards relevant to the psychotherapy case. The “end of Stage 3” developmental descriptors and learning outcomes, which are more extensive, also give some indication of the junior consultant standard, as “the end of stage 3” is, in effect, the same as “the start of being a consultant”.

The implication of this standard is that it is expected that the write-up demonstrates clinical maturity in its reflection about the process of therapy that occurred. It is acknowledged that the therapy was (usually) conducted during stage 2, in either second or third year, and was the first experience of the trainee in longer course of psychodynamic therapy. Therefore it is not expected that the therapy itself was conducted to the standard of a junior consultant, it is the written report of the therapy, reflecting on what occurred, that must reach this standard. The requirements of the PWC, including de-identification requirements and required format of report can be found within the PWC regulations.

PGT has successful cases available to guide the candidates towards the standard. Please contact the PGT office if you would like to pursue these. (N.B. Plagiarism is a breach of the Code of Ethics and Exam Code of Conduct; these cases as specifically to guide you to the standard).

The marking sheet used by examiners, which articulates the standards applied to the case, can be found at:
https://www.ranzcp.org/Files/PreFellowship/2012-Fellowship-Program/Psychotherapy-Written-Case-marking-sheet-(2016).aspx

Some suggestions about how to demonstrate this junior consultant standard include:

• There is an expectation that the standard of professional English is high. Pay attention to spelling (set the spellcheck on “Australian English”, not “US English”) and grammar. It might be wise to have review of the final draft by someone with skills in professional writing, purely for the purposes of checking the standard of written English. Trainees can use their professional development allowance to hire a professional reviewer for this purpose. Information about professional editing/reviewing services, including a list of professional editors, can be found on the Institute of Professional Editors website: http://iped-editors.org/

• Also, pay attention to formatting in the final written document. This includes the proper use of headings and sub-headings. It is important to ensure that headings to not appear alone at the bottom of a page, with the content commencing at the top of the next page. If this

happens, insert a page break to bring the heading to the top of the next page. Major sections of the write-up, like chapters in a book, should always commence on a new page.

• Ensure that you follow the headings for the marking criteria in the write up, and ensure that you can 'tick off' all domains of the marking criteria in each section of your write up.

• Ensure you avoid unnecessary repetition of history in your report. The case is usually written over a period of time, and sometimes the same information can be unwittingly repeated, which is redundant, wastes words in a crowded word count and frustrates the marker. Also, ensure that all the information upon which the formulation is based is included in the history, and does not appear for the first time in the formulation, have evidence in the history for statements made in the diagnosis, differential diagnosis and formulation.

• Pay attention to the mental state, diagnosis and risk assessment. Whilst the case is meant to showcase the psychotherapy, it is still expected that the history and MSE will be well-written in the standard "Maudsley" format, and the diagnoses should be accurate and justifiable (with appropriate differentials included and discussed). Any risk issues should be articulated and the management plan should address these explicitly.

• Ensure there is a discussion of the suitability of the patient for dynamic psychotherapy. You must acknowledge any relative contra-indications (e.g. substance abuse, a history of acting out and/or suicidal behaviour) and why it was felt these did not preclude the patient from therapy. You should discuss why psychodynamic therapy was chosen as the intervention ahead of other forms of psychotherapy that might have been considered (these must be sound clinical reasons, not because you needed a patient to complete a training requirement).

• You also need to demonstrate an understanding of the particular model of therapy used, particularly in the Management plan, Re- formulation and Discussion. Many trainees are very inexperienced when they commence their case and rely heavily on the model/s used by the psychotherapy supervisor. It is important that you discuss with your supervisor the model/s that they are using and do some reading to gain a better understanding of the model/s, so that you can use this knowledge both in the progress of therapy and supervision, and the write up of the case. While it can be appropriate to use more than one explanatory model in a case, the candidate needs to demonstrate that they understand each model and the conceptual terms in each model, and present these consistently. Some candidates use different models and terms interchangeably with the result that they do not present as understanding the processes involved (e.g. Object Relations Theory and Attachment Theory with terms such as impaired object relations and insecure attachment).

• There is no mandated format for the report of the progress of therapy. However, this is the crux of the case, so must provide a compelling narrative of the content and process of the dynamic therapy over the 40 sessions. There are two main styles:

- Organise the sessions chronologically, e.g. sessions 1-8, 9-15, 16-25 etc.
- Organise the sessions thematically, e.g. “the developing transference”, “managing resistance”, “acting out”, “termination” etc., with each theme covering sessions that overlap chronologically.

The former is probably the easiest to write, and is the most commonly chosen. When dividing up sessions, perhaps try to arrange them such that each group of sessions covers a connecting theme, e.g. “sessions 1-5: setting the frame and gathering further information”, Sessions 6-10: a focus on the relationship with her father”, “sessions 11-20: “recognising and interpreting transference” etc.

• You need to reference the role of the supervisor and what you learnt from supervision continuously throughout the written case. A key point where the role of the supervisor would be highlighted is the discussion about suitability for psychotherapy. You should also comment on your supervisor’s advice when challenging moments in therapy such as when transference, resistance and acting out (e.g. missed sessions) occurred. You should comment on how your supervisor advised you about establishing a secure therapeutic frame, making interpretations, containing the patient’s emotions and managing the termination phase. Finally, you should acknowledge your supervisor’s advice about emerging dynamic themes during therapy, their input into the re-formulation and their direction about further reading to enhance learning.

• The Reformulation is a key component of the case in which you are expected to demonstrate the junior consultant standard. Whilst the initial formulation, made when you first saw the patient, probably in second year, is not expected to be at this standard, the reformulation, constructed at the end of therapy, with input from your supervisor, is expected to be at this standard. It should be sophisticated and should tie together all of the information about the patient’s inner world that emerged during therapy.

• The Discussion is the other key component of the case in which the junior consultant standard should be demonstrated. The discussion represents your mature reflection on the process and content of therapy, as a trainee now thinking like a junior consultant would about this core clinical activity. You should be prepared to acknowledge mistakes made due to your inexperience, and your own emotions and thoughts about the process as you undertook it. You should discuss what you have learnt about psychotherapy and about

psychodynamic theory from this experience. You should reference key literature that has enhanced your learning, but the discussion should be focused on your reflection of the patient and their therapy, and not merely a summary of related articles and book chapters. The discussion should be frequently brought back to the clinical material that has emerged from the case, and to the role of supervision in facilitating your learning.

ADVICE FROM MEMBERS OF THE CASES SUBCOMMITTEE ABOUT PASSING THE PWC

There are resources on the RANZCP website to help trainees understand the standard and how to conduct and write up the case:

- Psychotherapy Written Case webinar available on Learnit [member log-in required] hosted by Dr Paul Cammel, SATPsy Chair, covers: PWC requirements, methodology, how to find suitable patient, supervision, submission and assessment and Q&A.

- Congress 2017 Psychotherapy Written Case Presentation [PDF; 162 KB]Dr Andrew Pethebridge, Chair PWC Subcommittee CFE: How to approach the PWC and 'How to Fail the PWC'.

- The Psychotherapy Written Case in the 2012 Fellowship Program [video; 18.46 min] Following discussions with the Faculty of Psychotherapy, Associate Professor Beth Kotze (Chair, Case History Subcommittee, Committee for Exams) has prepared a video for psychotherapy supervisors, to help them assist trainees in the preparation and submission of the Psychotherapy Written Case. The video will also be useful for trainees. *Also available:* Presentation slides [PDF; 240 KB]

- Psychotherapy Written Case e-module, available on Learn*it* [member log-in required]

- There is also an article written by Dr Mary Frost in 2009 which discusses the key reasons why candidates fail the case submission. Whilst written in 2009, the information is relevant in 2016. The link is: http://apy.sagepub.com/content/17/5/394.full.pdf+html

The following summarizes key points from these resources:

• The assessment, MSE and initial formulation are acknowledged to have been conducted early in training, usually stage2, and are assessed against the Proficient standard (end of stage 2). All other sections are assessed at junior consultant/end of stage 3 standard

• The key domains that have so far had the lowest pass rates have been Assessment, formulation (despite being end of stage 2 standard), management plan and clinical progress. Supervision, communication/liaison and discussion have had the best pass rates. Therefore it is important to ensure the report of the assessment, management and progress of therapy is detailed and comprehensive.

• The competence of the trainee as a therapist is NOT the major focus of the examiner when marking the case. Instead, it is the capacity of the candidate to demonstrate mature reflection and critical evaluation of the process of therapy. The candidate should explicitly acknowledge therapeutic mistakes they may have made during therapy, discussing what they have learnt from this experience of psychotherapy.

• The full psychiatric history should be described. Unsuccessful cases often present a narrative without sufficient information to adequately assess risk or justify diagnoses. Unsuccessful cases often provide a MSE dominated by a discussion of phenomena that were absent (psychosis, specific symptoms), but are deficient in a description of sophisticated mental state observations of what was present in a patient who is relatively well (c.f. patients usually seen with floridly acute illness).

• The formulation needs to provide an explanation of why this person has these problems at this time. Unsuccessful cases often provide a formulation that is a summary of the case, without integration or linkages. An over-reliance on dynamic theory and specific dynamic concepts in the formulation can make it sound generic or theoretical, without being individualised to the patient.

• There is expected to be a thoughtful discussion about suitability for psychotherapy in general) and the chosen model in particular. Unsuccessful cases often do not explicitly acknowledge relative contraindications, and so don't discuss how these were weighed up against the potential benefits of therapy. Risks of therapy and consideration of alternative interventions need to be explicitly addressed.

• The write-up of the progress of therapy is often a weakness in unsuccessful cases. Some candidates simply write a narrative of what was discussed, without demonstrating a recognition and understanding of the psychodynamic processes or demonstrating how interventions based on this model led to therapeutic change. Some candidates fail to integrate the chosen therapy model into the report,

Some candidates struggle to organize what is a vast amount of clinical material into this section. Some describe early sessions in minute detail and then leave only a paragraph to summarize the termination phase. Some candidates fail to edit this section well, and find it hard to leave out material that isn't relevant to the overall story of the case. The candidate should give priority to material that led to key changes for the patient, or created key dilemmas in the progress. The candidate should include direct quotes of what the patient said and what they, as therapist, said in response. Key interpretations that led to insight by the patient should be highlighted. The discussion of the termination phase should demonstrate that therapy concluded when it was appropriate for it to do so, not just because "40 sessions were completed."

• As stated earlier, mature reflection, self-awareness and critical evaluation at the level of a junior consultant are important to demonstrate in the reformulation, the section on the role of supervision and the discussion. The reformulation in particular should incorporate information about the patient's psychological functioning that were learnt during therapy. It should integrate psychodynamic concepts and theory in a sophisticated and patient-centred manner. The discussion should focus on the patient and what has been learnt about psychotherapy and psychodynamic processes from the patient. It should not be a simple review of psychodynamic literature that is divorced from any reference to the patient and therapy undertaken.

ii. When to write up and submit the case

In the past, trainees have often completed therapy, kept their training notes and then commenced the write-up some months, or even years, after the actual therapy. This is not a good idea, as time can lead to a fading of memory. The approach I would recommend is:

• Write up the history, MSE, diagnosis soon after you have gathered it, when you first see the patient. As you do this, if there is any missing information you can clarify this from the patient, as you are still engaged with them in therapy.

• Write up the risk assessment, initial formulation, discussion of suitability and management plan soon after these have been done and discussed with the supervisor, when they are fresh in your mind.

• Some trainees will write up the therapy progress as they go, but there is a benefit in writing up the whole progress of all the 40 sessions in one go at the end, after the completion of therapy. This allows you to write a coherent narrative, especially as many themes emerge and re-emerge over the duration of the therapy. It might also save you effort in writing up early sessions in a patient who drops out of therapy midway through. However, I would construct this narrative, at least in draft form, soon after the completion of therapy, even if you delay writing up the reformulation discussion until later.

• The Reformulation and Discussion, the two components crucial to the junior consultant standard, should be written up as close to submission date as you can. This allows you to have gained sufficient clinical experience and maturity to write these at the junior consultant standard.

This means that you write up different aspects of the case at different times, some at the start of therapy and some just prior to submitting it. The earlier drafts, written during therapy in 2nd or 3rd year, can sit on a hard drive somewhere (with back-ups, just in case), and are revisited when you set about compiling the final case to be written up. You would edit and re-write these earlier drafts so that the whole case reads coherently and is aligned to the junior consultant standard. However, this is a much less onerous effort than trying to write the whole case up from scratch when you decide you need to submit it.

So, when should you write the case up and submit it? The short answer is: **sometime during stage 3**, which is the stage of training at which you are meant to be practicing at the end of stage 3 / junior consultant standard (e.g. all stage 3 ITA's and stage 3 EPA's are assessed against the end of stage 3 standard, as defined in learning outcomes and developmental descriptors). The remediation deadline for the PWC has now been set at 60 months, so you have 8 submission dates in stage 3 available before this.

When in stage 3 you choose to submit depends on your plans to complete other centrally administered assessments. Some trainees may choose to complete the OSCE and Essay paper in 4th year, and leave the PWC and Scholarly project until 5th year, whilst other trainees may do things in the reverse order, or in any other order that suits their own circumstances. The decision about when to write and submit the SP and PWC will be influenced by when you have completed the therapy or research, as those who commenced therapy or their SP later may have little choice but to submit in 5TH year.

Whilst this decision is one for each trainee to make, some advice is:

• Don't leave all your exams until fifth year, or attempt them all at the same time. The MCQ should be completed before the end of stage 2, and two of the other assessments would ideally be completed in fourth year, leaving only two for fifth year.

• It is probably unwise to sit an exam or submit a written report at the very first opportunity in the trajectory, as you are likely to have insufficient clinical experience or knowledge to pass. Equally, do not make the attempt at the very last opportunity before the remediation deadline, as this leaves no chance to resubmit or resit the exam before that deadline arrives. Somewhere in the middle of that range would be wisest.

• Therefore the PWC might be best submitted somewhere between the May submission date of fourth year and the August submission date of fifth year, depending on the timing of other assessments you attempt during this period, and whether or not you have completed therapy by this time.

• An exception to this advice may be if you have a strong desire to enter the Psychotherapy Certificate, and to complete this concurrently with stage 3, so that you gain your certificate and Fellowship at the same time. Since a pass in the PWC is a pre-requisite for entry into the psychotherapy certificate, if the above was your goal, then you would need to submit in third year. However, it is worth bearing in mind that the average time taken to complete the Psychotherapy Certificate is just over four years and that very few trainees manage this within their training, so this goal is not realistic for most trainees anyway. The vast majority will complete the certificate as a consultant/Fellow in any case, so it would not be worth risking a fail in the PWC by submitting it in stage 2 for this reason, when most trainees will not complete the psychotherapy certificate within stage 3 in any case.

• The Forensic Certificate also requires a pass in either the PWC, the Essay Paper or the Scholarly Project to be eligible to apply. Trainees wishing to commence this certificate early in Stage 3 may choose the PWC as the task to attempt prior to the end of Stage 2. However, I gain caution against submitting the PWC, or sitting an exam, before you are truly ready to pass it at the consultant standard.

One suggested example trajectory for sitting exams/submitting cases is as follows, but this is only one guide and each trainee will have their own priorities. The timetable assumes full-time training: part-time trainees and those with BIT's should adjust accordingly.

• Attempt the MCQ in February of third year. This allows you to spend first year gaining clinical experience, without a focus on exams, and then to start second year looking for a psychotherapy case and commencing a scholarly project. The end of second year would then be focused on MCQ preparation and reading psychiatry texts and literature. It also gives you ample time to resit before the end of stage 2 if you are unsuccessful.

• Attempt the Essay Exam in February of fourth year. This allows you to have completed all of the stage 2 rotations, and completed the stage 1 and stage 2 FEC, the syllabus for which forms the basis for the content of the essay exam. If passed, it allows you to then commence the rest of fourth year with this hurdle out of the way.

• Attempt the OSCE exam in September of fourth year. This gives you plenty of time to prepare during fourth year.

• Submit the PWC in February of fifth year. This allows you to spend the time after the OSCE to prepare this report, at the standard of a junior consultant, and gives you space for resubmission in May or August if required.

• Submit the scholarly project in June of fifth year. This allows sufficient time after the PWC submission to prepare this draft, and also allows one further resubmission (October) if unsuccessful, without delaying Fellowship if the resubmission passes.

These dates might need to change if one or more exams are failed, if you have gained an exemption from the Scholarly Project, if you completed your psychotherapy or SP much earlier or later than usual, or if other factors, such as breaks in training for maternity leave etc., need to be taken into account. Every individual must plan their own timetable, and there is no right or wrong trajectory, except that it is very unwise to leave all these exams to the last moment, at the end of fifth year.

iii. Seeking appropriate consultants to review and critique your case drafts

It is important that you have consultants read drafts of your PWC before you submit it. Trainees who submit cases with little or no review by experienced consultant have much lower pass rates than those who obtain extensive feedback. People you should ask to read your case include:

• Your psychotherapy supervisor. This is mandatory, as they need to sign the final case report as an accurate representation of the patient treated. During supervision, your supervisor should have spent some of the time discussing how you will write up the case. Psychotherapy supervisors have usually supervised a lot of trainees and read a lot of cases, and so will give good advice about how to write it up.

• Experienced psychiatrist supervisors in your MHS. This may be your current principal supervisor, or the CTS for your region, or another supervisor with training in psychotherapy.

• You should ensure that you provide the draft to your supervisor with ample time for them to read it, provide some feedback and then for you to incorporate that feedback into your final case. Check the availability of the people reading your case in advance, to allow for leave

and work commitments, and ensure that they have a copy of the PWC marking criteria. As a rule of thumb, give the reviewer at least two weeks to read the case and provide feedback and you at least two weeks to revise the case in response to that feedback. Therefore, handing a draft to a reviewer with only two days before submission date is not giving them or you a chance to give such a review justice, and it is likely to not occur at all.

Don't plan to work on the case at the very last minute, so that you are working until the early hours of the morning of the last submission date finalising your case. Plan to have the case completed at least a week before the submission date, which allows for some last minute unexpected adjustments, if required. The submission dates are advertised well in advance, so there is no need to go “down to the wire”. Some trainees take leave for a week or so to write up the case, but with some forward planning and discipline, this should not be necessary.

If you are unsuccessful in the first submission, do not despair. So far many of cases submitted have failed on first submission, so there is no shame in this outcome. The marker provides you with excellent, focused, specific formative feedback on what you need to do in order to correct problems and bring the case up to a passing standard. These suggestions should be strictly followed in your revision. Again you should have some of the experienced psychiatrists listed above read your revision (also supply them with the marker’s feedback). The same examiner marks your revision, and provided you have properly addressed the deficiencies stated in the first marker’s feedback, you should pass. So far, a large majority of resubmitted cases have passed on the second submission.

Do not change initial sociodemographic and / or clinical data when you re-write a case for resubmission as this would be considered an ethical breach in the CFE code of conduct for examinations. If you have become aware of any circumstances in which such information has changed, you need to discuss this in your re submission.

Given that you often don't get the results and feedback until one or two weeks before the next submission date, it is usually best to resubmit in the submission date 3 months hence, e.g. if submitted in February, the fail is notified in early May, then resubmit in August. The exception is that if there were only one or two deficiencies (e.g. a fail in only one domain), such that a rewrite will not be difficult to achieve in a short space of time, then you could plan to resubmit at the next submission date a couple of weeks later.

e. USE OF VIDEOCONFERENCING FOR SUPERVISION AND THERAPY

The regulations allow some or even all of the supervision to be conducted via videoconference as per the policy and procedures quoted below. This is usually for geographically remote trainees to access suitable supervisors who might not be available for face to face supervision. If this option is to be used, it is important that the videoconference hardware and software used has appropriate fidelity and encryption/security, as confidential information is being exchanged. For these reasons Skype may not be suitable. Fully de-identifying all patient information during the discussion would be advisable if full encryption isn't available.

There needs to be prospective approval of this arrangement (i.e. prior to it commencing), with that approval is delegated to the training program DOT – there is no further approval by CFT required. However, the DOT would need to provide written documentation of this approval to the trainee and the trainee would need to include this with the submitted PWC. She/he would also be expected to incorporate discussion of the issues involved in this form of supervision in their written case. There is no maximum amount of therapy that could be conducted via videoconference – all of it could be done this way; although this is not perhaps ideal, as some sessions of face to face supervision would be advisable.

The relevant section from the regulations is:

3.3 Psychotherapy supervision via telephone or videoconference

A trainee who is unable to access a local psychotherapy supervisor in person may access an accredited psychotherapy supervisor via telephone or videoconference. Psychotherapy supervision must fulfil the requirements as per points 3.1 and 3.2 above, whether conducted in person or via telephone or videoconference systems.

A trainee who has arranged access to a psychotherapy supervisor via telephone or videoconference must apply for prospective approval from their DOT. Approval for psychotherapy supervision via telephone or videoconference will be determined on a case-by-case basis with consideration of the accessibility and availability of local psychotherapy supervision, in addition to supporting documentation provided by the trainee and/or potential psychotherapy supervisor. If approval is granted, it must be documented by the DOT in writing prior to the commencement of the psychotherapy and the trainee must submit this documentation to the College head office attached to their Psychotherapy Written Case Submission Form.

A trainee who has been supervised via telephone or videoconference would be expected to address issues around this form of psychotherapy supervision in the case report as part of the 'Supervision' assessment domain.

The issues the DOT would consider in determining approval would be:

• Whether there was a genuine reason why face to face supervision was impractical or difficult.

• Whether the suggested format of videoconferencing was appropriately secure as to protect patient confidentiality and privacy. I would take advice about this from experts in videoconference techniques.

• Whether the Director of the Service supported the plan, as well as the actual PWC supervisor, and the trainee's principal supervisor.

• Whether the request was for the whole of supervision, or just part of supervision, to be done by videoconference. It would be easier to approve if some of the supervision was planned to occur face to face.

• Whether there was reassurance that for this patient, this trainee and this supervisor, the video conferenced supervision would not adversely affect the learning/training provided to the trainee, or the care provided to the patient.

• That both supervisor and trainee were experienced in the proper use of videoconferencing.
A written request, addressing the above issues, with appropriate support from supervisors(s), should be sent to me at the SAPBTC if a trainee wishes to take this option
The regulations also allow for a component of therapy to be conducted via videoconference, but there are more restrictions with this than on video conferenced supervision.

The regulations state:

4.3 Requests to conduct psychotherapy sessions via videoconference (Refer to Appendix 1)
While the value and role of communication technology in psychotherapy is acknowledged, the use of videoconference facilities is generally not appropriate for the initial stage of learning psychotherapy, where therapeutic alliance and management of risk are being learnt and framed. However, trainees may apply to the Committee for Training (CFT) for approval to conduct a portion of the psychotherapy sessions via videoconference in exceptional circumstances and where the therapy frame and relationship are already established. Applications must be prospective and must be made in writing and submitted via the Training Department at the College head office. Trainees should include supporting documentation from their psychotherapy supervisor and/or DOT with their requests and must address the exceptional circumstances, the impact on the therapeutic relationship and the anticipated number of sessions that would be conducted via these means, as well as the other requirements set out in Appendix 1.
The CFT will consider these requests for approval on a case-by-case basis. Generally, no more than 10 out of 40 sessions, which must be towards the end of therapy, will be approved. Trainees must seek prospective approval for sessions to be conducted via videoconference even when they are in addition to the minimum 40 sessions of psychotherapy. If approval is granted, the trainee must submit the documentation provided by the CFT to the College head office attached to their Psychotherapy Written Case Submission Form. Approval will not be granted for psychotherapy conducted via telephone as this would not allow for the visual cues necessary in learning psychotherapy.

The important points are:

• Prospective approval is granted by application to the Committee for Training in Melbourne – approval is not delegated to the DOT

• Exceptional circumstances must exist that make face-to-face therapy impracticable
• The video conferenced sessions should be in the second half of therapy, and no more than ten sessions
• The QBTC should be asked for support and recommended to CFT.
• You must explicitly discuss the impact of the change to videoconferencing on the therapy, the alliance etc. in the PWC report.

This option is most likely to be used by trainees who commence therapy in one location but are then rotated to a distant location, and so complete therapy via video-conference.

3. THE STAGE 2 PSYCHOTHERAPY EPA'S

a. WHEN AND HOW TO PLAN TO ATTAIN THESE

The three Stage 2 Psychotherapy EPA's are:

- Psycho-dynamically informed patient encounters and managing the therapeutic alliance.
- Supportive psychotherapy
- Cognitive–behavioural therapy (CBT) for management of anxiety

The Stage 2 Psychotherapy EPA's can be entrusted at any time before the end of Stage 2 (end of third year). You are even allowed to attain these during stage 1. However, the standard of competence required is the end of stage 2, regardless of when they are entrusted. Therefore your supervisor in first year may feel that you have not yet reached that standard, and may ask that you defer attainment of these until you are in stage 2. However, you can still undertake WBA's that will inform entrustment during first year, or during any rotation in stage 2.

The requirement is to attain a minimum of two of the three Stage 2 psychotherapy EPA's before the end of Stage 2. The third EPA can be left until stage 3 to be attained. If you choose to do this, the standard of competence required remains the end of stage 2. You can choose any two of the three EPA's to be attained before the end of stage 2.

The Supportive Psychotherapy EPA is probably the EPA that is easiest to reach the required standard earliest in training. Therefore it may be appropriate to consider undertaking WBA's for this in the second half of first year, or in second year, and aiming to attain it in by the end of second year. Opportunities to develop skills in supportive psychotherapy will exist in almost every rotation in stage 1 and 2.

The therapeutic alliance EPA requires experience in psycho-dynamically informed encounters, although you are not required to perform actual psychotherapy – these are utilised during normal clinical work. The expectation is that you will be able to create and manage a therapeutic alliance with patients, including those who are challenging or resistant. You should be able to recognise points of conflict and disjunction and take steps to repair these. These steps should be informed by a familiarity with the evidence base in managing the therapeutic alliance.
There is a specific direction in the EPA to undertake case-based discussion with three different patients in three different settings:

- a patient seen in an emergency situation
- a patient who is described as 'difficult' in an inpatient setting

• a patient managed in the community by the trainee for at least 4 weeks

You may need to thus undertake WBA's for this EPA across several different rotations during stage 2. Therefore, the appropriate time to plan to attain this EPA would be during third year. Opportunities to develop skills in therapeutic alliance should be found in all stage 1 and 2 rotations, including child and adolescent psychiatry.

The third psychotherapy EPA, "CBT for anxiety", is one that should be completed opportunistically, i.e. when you become involved with a patient with anxiety who is suitable for formal CBT, in any stage 2 rotation, you should attempt to undertake this CBT (if possible in your work site) and seek appropriate supervision. This is because finding suitable patients might be challenging, and you should seize the opportunity to provide CBT on a suitable patient if you happen to be involved in their care. There are some special competencies related to CBT techniques that are included in this EPA and so you will need to ensure you undertake formal CBT supervised by an accredited supervisor, for this EPA. This EPA is discussed further, in more detail below. If you do not encounter sufficient patients with anxiety to undertake CBT, complete WBA's and attain this EPA in stage 2, it might become the one that you leave until stage 3 to attain. However, if you do manage to provide CBT to sufficient numbers of patients with anxiety in stage 2, or if you undertake rotations where CBT is a focus, it is an advantage to attain this EPA in stage 2 if you can. In this case it would be wise to still plan to also attain the other two stage 2 psychotherapy EPA's by the end of stage 2. If you can attain all three psychotherapy EPA's in stage 2, this makes one less task required during stage 3, so this is certainly the ideal outcome to aim for if it can be achieved!

It is important to note that you cannot use WBA's undertaken with the patient seen for the PWC for any of the stage 2 psychotherapy EPA's. However, if the patient drops out of therapy prematurely, so that they are thus not used for the PWC, then you are free to use a WBA about that patient (e.g. a case based discussion) for the psychotherapy EPA, such as the therapeutic alliance EPA (e.g. as the patient seen in the community for > 4 sessions). This might be some small consolation for a premature drop-out.

b. RECEIVING APPROPRIATE SUPERVISION

Like all EPA's, the psychotherapy EPA's can be entrusted by any College accredited supervisor. The supervisor does not need to be a psychotherapy practitioner or need special accreditation. This is because the psychotherapy competencies embodied in these EPA's are seen as universal competencies of a general psychiatrist.

Despite the above, you may find that you will benefit from additional supervision, especially for the CBT for anxiety EPA. Whilst most, if not all, supervisors should feel confident to supervise practice and undertake WBA's in supportive psychotherapy and with the therapeutic alliance, not all supervisors will have specific expertise or training in CBT, or be practitioners in this therapy. Therefore, you may need to source specific supervisors who have CBT expertise to genuinely achieve proficiency in using CBT for this group of disorders.

The therapeutic alliance EPA assumes the supervisor has knowledge and skills in psychodynamic principles, but does not require the supervisor to be a psychotherapist or supervise you treating a patient with psychotherapy. If your principal supervisor felt that they did not have the requisite skills or knowledge required to entrust this EPA, you should seek some additional supervision from within your worksite to assist you with this EPA. It is highly unlikely that over the two years of Stage 2 you would not be exposed to supervision from at least one psychiatrist who was comfortable in undertaking WBA's for this EPA and entrusting it. It could be reasonably expected that all supervisors would be comfortable entrusting the supportive psychotherapy EPA.

c. THE CBT: ANXIETY EPA

This EPA deserves some specific comments, as it is the only psychotherapy EPA that requires a course of a specific modality of psychotherapy to be performed, for a specific target symptom. The other two psychotherapy EPA's can be achieved through routine clinical experience and from WBA's undertaken with any patient seen in clinical practice, without psychotherapy being the focus of intervention with that patient.

This EPA entrusts competence in the use of CBT for the symptom of "Anxiety", rather than for an "Anxiety Disorder"

This is an important point. The patient needs to be experiencing anxiety symptoms that are of sufficient severity to be causing distress or dysfunction such that they become a focus for clinical attention. The patient does NOT need to have a formal diagnosis of an anxiety disorder. Instead they may have a primary diagnosis of a mood disorder, psychotic disorder, personality disorder etc., in which anxiety is a significant comorbid symptom, even if it does not qualify as a formal anxiety disorder diagnosis. The patient must still meet suitability criteria for CBT as an intervention, which must be conducted proficiently under supervision.

However, this broadens the range of patients you can manage with CBT and undertake WBA's with for this EPA. This is worth keeping in mind.

There is no specific accreditation for supervisors to entrust this EPA. It is up to each supervisor to reflect on their own skills, experience and training and to decide if they feel comfortable to confirm that a trainee has the knowledge, skills and attitudes defined in this EPA, and they can be entrusted to a proficient standard. If your principal supervisor believes they do have sufficient skills, they can entrust this EPA and if they do, the QBTC and the College will accept the EPA as being attained.

There are some specific skills required for this EPA, and suggested assessments methods, to confirm entrustment of this EPA. These are listed in the EPA as:

• Observe the use of Socratic questioning (including by means of audio or video recordings).

• Review written cognitive–behavioural formulations, provision of specific treatment interventions and assess impact on patient's treatment goals, ensure that need for referral for more targeted treatment or provision of advanced strategies is considered.

• Supervisor may consider use of assessment tools such as the Cognitive Therapy Formulation Scale (CFRS), Revised Cognitive Therapy Scale (CTS-R) or Cognitive Therapy Awareness Scale (CTAS) when reviewing casework, written formulations/treatment planning or observing clinical activities.

The QBTC recommends that your supervisor use at least some of these assessment methods to base their decision to entrust this EPA. If your supervisor does not feel they have the skills and expertise to do this, then you will need to find additional supervision from a CBT practitioner. There are several ways to do this:

• Arrange for a psychiatrist supervisor colleague who is CBT trained and experienced and accessible within the service in which you work, to undertake the supervision required for this EPA, including the WBA's. All HHS's have some psychiatrists and psychologists with these skills, and your local CTS should be able to direct you to them.

• Arrange for a QBTC Non College Fellow approved supervisor, e.g. a psychologist who is CBT trained and experienced and accessible within the service in which you work, to undertake the supervision required for this EPA, including the WBA's. All HHS's have some psychologists with these skills, and your local CTS should be able to direct you to them. A Non college fellow approved supervisor will not be able to complete and sign the EPA- this will need to be done by your principle supervisor in discussion with the CBT supervisor.

• It is worth remembering that supervision can be done in a group format. Even case based discussions can be done in a group format, with trainee colleagues observing your

discussion with the supervisor (and their feedback provided to you). Such group sessions may be most appropriate for discussing conceptualisation, formulation and suitability than the actual conduct of therapy, but this can be discussed with the group supervisor.

The remaining difficulty may be in finding patients, in our low prevalence-focused services, who have anxiety as a clinical problem and are suitable for CBT. This may be a reason why this EPA will be hard for some to attain by the end of stage 2, and why several trainees may need to choose this to be the one to leave until stage 3. However, it still needs to be done, and if you leave it to stage 3, you will need to develop a plan to attain it.

It is worth remembering that CYMHS are more likely to see patients with high prevalence diagnoses, and to use psychotherapy as a primary intervention, including CBT. The WBA's required for this EPA can be undertaken with children or adolescents. When this EPA was first designed in 2013 it did specify that the EPA must be achieved with adults, but this requirement was removed in November 2015 and now it can be attained through experience and WBA's working with children and adolescents. It is also worth considering that patients encountered in medical settings during your C-L term may well have clinically significant anxiety problems that warrant a CBT intervention.

Finally, most adult community teams have at least one, but usually more, psychologists with CBT expertise, and see some patients who are referred with anxiety disorders and are suitable for CBT. If the psychologist is not a College accredited supervisor, they may be able to work with your principal supervisor in the Community Team in order to attain this EPA.

4. THE MANDATORY STAGE 3 GENERALIST PSYCHOTHERAPY EXPERIENCES

a. SUMMARY OF THE REQUIREMENTS

• Trainees must provide psychotherapy to a minimum of three patients for at least six sessions each during Stage 3 of training. These sessions must involve different patients than the person to whom the trainee has provided the 40+ sessions of psychotherapy related to the Psychotherapy Written Case summative assessment. Additionally, the therapy must be provided to patients other than those with whom the trainee has undertaken WBAs leading to the entrustment of any psychotherapy EPAs. The requirement to undertake psychotherapy training with a number of different patients is intended to further enhance the trainee's development of psychotherapy skills.

• The therapy sessions should focus on an established psychotherapy treatment approach for an acceptable treatment indication, as well as involving all of the phases of therapy including: assessment and formulation, contracting and establishment of the treatment frame, review of progress, and working towards termination. There should be awareness of transference and countertransference, plans to deal with barriers to treatment and outcome measurement.

• Trainees must receive individual or group supervision for these psychotherapeutic sessions by a College-accredited supervisor. The psychotherapeutic sessions for each patient must be recorded on a Stage 3 Psychotherapy Sessions Form, which must be signed by the supervisor. The form must be countersigned by the trainee's DOT and submitted to the College head office in order for the completion of the sessions to be entered on the trainee's Training Record.

• Group psychotherapy is an acceptable modality provided that the above criteria can be met. Group sessions count as one session for one patient and cannot be claimed as more than one patient.

The key elements to take note of in these regulations are:

• The patient seen for the PWC and patients seen for WBA's to inform the stage 2 EPA's CANNOT count toward this requirement.

• Patients initially seen for the PWC, but who drop out of therapy after 6 sessions but before 40 sessions, and so are not used for the PWC, CAN be used for this requirement, provided the entire therapy, from start to finish, was undertaken during stage 3 and hadn't commenced during stage 2.

• The four patients seen for structured psychotherapy for the Adult Certificate CANNOT be used for this requirement (i.e. these three patients seen for the generalist requirement must be in addition to those four seen for Adult certificate requirement).

• However, patients seen for the psychotherapy requirements of the AT Certificate in Psychotherapy CAN be used to satisfy this generalist requirement.

• Also, patients seen for the psychotherapy requirements for the Old Age certificate (three patients over 65 y.o. seen for 6 or more sessions) and the Child and Adolescent Psychiatry certificate (nine patient and/or family groups) CAN be used to fulfil this generalist requirement.

• Whilst no specific therapy modality is mandated or excluded, there must be consideration of psychodynamic processes, such as transference. CBT or other structured therapies can be undertaken, but there must be awareness of these issues discussed in supervision.

• Whilst the regulations do not say “treated to completion”, the requirement to involve “all phases of therapy”, including termination, implies a completed therapy. There must be at least six sessions, but many completed therapy courses will require more sessions than this.

• There must be a College-accredited supervisor (i.e. accredited by the QBTC for Stage 3) who signs the form verifying that the experience has been completed. However, the actual supervision can be delegated to another therapist supervisor (see below).

• Group therapy (e.g. family therapy undertaken during a CAP rotation) can count.

b. FINDING SUITABLE PATIENTS

These requirements can be completed at any time during the two years of Stage 3 Training. All three could be undertaken during the same 6/12 rotation, or one patient could be seen in each of three separate rotations. It is likely that there will be at least one rotation, if not more, that you will have clinical involvement with patients who will benefit from a course of psychotherapy. Therefore you should be able to meet this requirement with patients seen as part of your routine clinical work, rather than having to take on patients from outside of your clinical role.
Rotations that should enable exposure to patients suitable for brief (i.e. 6 or more sessions) of psychotherapy (for generalist trainees) include:
- Adult community team rotations

- Emergency Department rotations, if brief therapeutic follow-up of patients seen is part of the role (such as at FMC).

- Some adult inpatient rotations, which include opportunities for formal psychotherapeutic interventions to be done

- Private Hospital Rotations

- Youth Mental Health rotations

- C-L rotations (esp. in the liaison component)

- Forensic rotations, as some patients can be there for extended periods
In addition to opportunities for brief dynamic psychotherapy or CBT, that may present themselves in routine clinical practice, the following are examples of patients that might be suitable for therapy for this requirement, within routine clinical services (this is not an exhaustive list):
- Grief therapy for patients experiencing bereavement or loss as a precipitant psychosocial stressor

- Relationship/interpersonal therapy for patients in whom relational difficulties are a precipitant psychosocial stressor

- Solution-focussed / problem solving therapy for patients in whom a psychosocial crisis is a significant issue, e.g. in someone who has been suicidal.

- Brief therapy aimed at emotional regulation, impulse control and behavioural self-management for patients with a borderline personality, which can be informed by DBT principles but does not need to be a formal DBT course.

- Cognitive therapy for depression. Whilst the CBT-anxiety EPA is specifically for anxiety disorders, depressed patients for whom cognitive therapy is suitable are much more likely to be encountered within routine public mental health work.

- Behavioural activation/activity scheduling for people with depression and other conditions (e.g. chronic psychosis), causing social disability. There would still need to be a discussion of psychological processes, such as transference, use of defences etc., in supervision.

- CBT for chronic hallucinations and/or delusions in people with schizophrenia, which are likely to part of rehabilitation services.

- Motivational enhancement therapy (using motivational interviewing) for people with addiction/substance abuse problems

- Adherence therapy, if conducted as a formal intervention.

Please note that unstructured supportive psychotherapy, which is part of routine outpatient follow-up, or psychoeducation as part of routine care, are NOT sufficient to qualify for this requirement.

c. FINDING APPROPRIATE SUPERVISORS

The only requirement for supervisors is that they be accredited by the QBTC for general supervision of trainees in stage 3. There is no requirement, or process, for special psychotherapy accreditation for this requirement. The standard of competence is that of a general psychiatrist, not a specialist psychotherapist (which is what the Advanced Certificate in Psychotherapy is for). The QBTC expects that the many of the psychiatrists supervising Stage 3 trainees as their principal clinical supervisor will be able to provide supervision for this generalist psychotherapy requirement. Most general psychiatrists use psychotherapy in appropriate patients as part of their clinical practice.

Supervisors can self-select themselves as having sufficient skills or experience to supervise this requirement. Therefore you should check with your supervisor at the start of a stage 3 rotation whether or not they consider themselves sufficiently skilled to supervise you for this requirement. If the supervisor feels they are not sufficiently skilled, they can decline to supervise this requirement – they are not required to supervise psychotherapy if they believe they lack sufficient skills in psychotherapy to do so. If this is the case, you should discuss with your supervisor, or local CTS, what alternative arrangements can be made. They may take the option to delegate supervision to a non-psychiatrist colleague (see below) or they may direct you to another supervisor with psychotherapy skills within your team, work site or HHS. Every region has a number of supervisors who have expertise in psychotherapy. The QBTC has a database of supervisors at each training site who have nominated themselves to be supervisors for this experience.

Delegation of supervision to non-College Fellow accredited supervisors

Whilst a College accredited supervisor must sign the form of completion, and certify that the six or more sessions were completed according to the requirements, the actual supervision of therapy itself can be delegated by them to an experienced non-College Fellow accredited supervisor (e.g. a psychologist or nurse therapist). The College supervisor would remain the formal supervisor of the experience, and would need to communicate with the delegated supervisor at the end of therapy to confirm/verify with them at the end of the therapy that:
- The therapy was completed competently (at the standard of a general psychiatrist, not a specialist psychotherapist) under the supervision of the delegated supervisor

- The therapy was for six or more sessions of an appropriate therapy type that were undertaken for a specific indication.

- The therapy was conducted with a patient of stated gender and age, finishing on stated date,

- The therapy involved all of the phases of therapy including: assessment and formulation, contracting and establishment of the treatment frame, review of progress and working towards termination.

If the delegated supervisor can verify this to the supervisor, the College supervisor can sign the form, under the "supervisor declaration".
In this situation, the College accredited supervisor should meet with the trainee at least twice – prior to commencement of therapy and after completion of therapy. At the first session, the trainee should present the patient and their therapy plan, and suitability should be discussed. If suitable, the supervisor would then recommend the trainee take the patient on for therapy under the supervision of the nominated non-College Fellow supervisor.
The second session, after completion (this can be done during a usual supervision session, if they are also the principal supervisor) would also be after the supervisor's discussion with the delegated supervisor (which might have been over the phone or e-mail). During this session the College supervisor would ensure the trainee found the therapy and supervision a useful learning experience, gain their feedback about the supervisor, discuss any transference issues or other psychodynamic process that they need to be aware of (especially if the supervisor hasn't) and then sign off the form. The College accredited supervisor would retain the clinical line of responsibility for the patient and should also be available to discuss any concerns the trainee has about the patient's clinical state during therapy.

The choosing of a suitable delegated supervisor by the College supervisor does require a formal accreditation process through application to the QBTC.

d. DOCUMENTATION OF COMPLETION OF THIS REQUIREMENT

The Stage 3 Psychotherapy Sessions Form (see link under "Useful links" earlier) needs to be completed for every patient seen that meets this requirement. This means that THREE separate forms will need to be sent in to the College during stage 3 to have this requirement recorded as complete.

Each form must be signed by the College-accredited supervisor (not a delegated supervisor, if one has been used) and then sent to the PGT office, where the DOT, will sign the form and send to the College.

Note that the Form is not a summative assessment, like an EPA. It is also not a formative assessment, like a WBA. It doesn't include any feedback, or a pass/fail grade. It is merely verification that the experience has been completed.
If you are using the same patient and therapy for this requirement as for a certificate requirement (e.g. Psychotherapy, CAP, POA) you will still need to send in the Stage 3 Psychotherapy Sessions Form *as well as any forms that are required to have it recorded for your certificate.* In this case it needs to be signed by the DOAT – Psychotherapy, Dr Michael Martin.

5. THE ADVANCED CERTIFICATE IN THE PSYCHOTHERAPIES

a. OUTLINE OF THE PSYCHOTHERAPY CERTIFICATE REQUIREMENTS

You should discuss the Advanced Psychotherapy Certificate with the DOAT for Psychotherapy, Dr Michael Martin, before applying for this certificate. Michael will provide more detailed information about how supervision of the required therapy experiences is arranged. Some important information to know before applying for this Certificate includes:

• You must have successfully passed the Psychotherapy Written Case to be eligible to apply for this certificate. This will mean that most trainees, who will submit and/or pass the PWC during stage 3, will not be able to commence this certificate at the very beginning of Stage 3. In this case, you should either enter the generalist stream and then apply after the PWC is passed, or commence a different certificate and then apply for dual certificate training when you are eligible for the psychotherapy certificate. However, completing dual certificate requirements whilst simultaneously completing Fellowship examinations in Stage 3 will be potentially onerous, and should only be attempted after careful consideration of the workload demand of this option.

• Experience has shown that the majority of Psychotherapy certificate trainees take more than two years to complete the required supervised psychotherapy experiences, with the average time to completion being four years. The vast majority of trainees who commence in stage 3 will thus complete the certificate as Fellows-in-Training, usually a couple of years after Fellowship. Therefore you should anticipate this and not feel pressured to complete it within the nominal 24 months.

• The requirements for this certificate can be found at:

https://www.ranzcp.org/Pre-Fellowship/2012-Fellowship-Program/Certificates-of-AdvancedTraining/Psychotherapies.aspx

b. ATTAINING STAGE 3 EPA'S WHILST UNDERTAKING THE PSYCHOTHERAPY CERTIFICATE

There are 8 Psychotherapy Certificate EPA's that must be attained in order to achieve this certificate. These are usually confirmed by the Psychotherapy supervisor who is supervising the therapy experiences required by the therapy stream you are undertaking. Whilst you are in Stage 3, you will also be working in generalist rotations and completing the generalist requirements for Fellowship. As a trainee, you must always attain a minimum of two EPA's per 6 month FTE rotation. Whilst in QLD we do have a few dedicated psychotherapy rotations, the vast majority of psychotherapy trainees will work in general adult (or another AOP) rotations during most of their stage 3. There are no mandated rotations for the psychotherapy certificate.

This means that for most psychotherapy certificate trainees their principal supervisor will not be undertaking the WBA's for their psychotherapy EPA's, and will not be confirming the psychotherapy EPA's. They will be undertaking WBA's related to EPA's linked to the Area of Practice (AOP) of that rotation, usually adult psychiatry. Therefore they will usually expect to confirm either adult AOP EPA's or generalist stream EPA's, during the rotation.
Therefore trainees in the Psychotherapy Certificate should expect, during the stage 3 rotation, to attain two EPA's linked to the Area of Practice of the rotation they are in, usually adult or general. WBA's for these will be done with their principal supervisor in the rotation. The mandatory OCA per rotation will be in the AOP of their clinical rotation.
The trainee may also attain one or even more of the Psychotherapy EPA's during the rotation, with WBA's for these done with their psychotherapy supervisor and the EPA entrusted by that supervisor. In this case, these would usually be in addition to the stage 3 adult/general/AOP EPA's attained with their principal supervisor. In this case all 3 or more EPA's should be listed on their ITA, and the COE for the Psychotherapy Certificate EPA's submitted to the Psychotherapy DOAT and the COE's for the AOP/general EPA's submitted to the Stage 3 DOAT. In essence Psychotherapy Certificate trainees should see themselves as generalist trainees who are doing the psychotherapy certificate in addition to the standard fellowship requirements for generalist trainees. Psychotherapy certificate trainees should thus use the Generalist/Fellowship ITA for each rotation, as there is no specific Psychotherapy Certificate ITA.

In some rotations, such as dedicated psychotherapy rotations, it may be possible to achieve the psychotherapy certificate EPA's as the only EPA's attained during that rotation, as the AOP in this case would be psychotherapy. The minority of psychotherapy certificate trainees will be in this position.

There is always a requirement for two EPA's to be submitted with every six month rotation in Stage 3, so each trainee must ensure that between the AOP/general EPA's and any psychotherapy EPA's completed, there is at least two per 6/12 FTE rotation submitted with each ITA. Once you become a Fellow in training only the 8 psychotherapy certificate EPA's need be completed, and the requirement for two every six months (and also for ITA's and OCA's) ceases.

c. COMPLETING PSYCHOTHERAPY CERTIFICATE TRAINING EXPERIENCES WHILST UNDERTAKING STAGE 3 GENERAL PSYCHIATRY ROTATIONS

Each stream of the Psychotherapy certificate requires certain numbers of patients to be treated with psychotherapy, under supervision, provided by supervisors who are accredited by the DOAT in Psychotherapy. Most of these supervisors will not be the principal supervisor for your clinical work in your rotation.

Therefore you will most probably need to arrange this supervision to occur in addition to the supervision provided for your clinical work. Irrespective of what supervision is provided for the certificate, you should still receive an individual hour of supervision from your principal supervisor for the rotation. Supervision for the certificate can contribute to the additional three hours of mandated weekly supervision.

Also, most of the patients you need to provide therapy for will be in addition to the usual clinical work required as part of your rotation. The Psychotherapy DOAT will assist you in identifying suitable patients to treat with psychotherapy for the certificate. If these can be found in your clinical role, this is a bonus, but often they will be sourced from outside your clinical service.

The same rules apply for these patients as for the PWC patient:

- They must be registered with an QLD HHS, with some case entries made about each encounter.
- There must be a nominated psychiatrist within the HHS who acts as the clinical supervisor for that patient.

Also, there will be the same tension related to time taken away from your clinical duties to undertake psychotherapy experiences for your certificate, as there is for the PWC. The same

guidelines apply for this as do for the PWC, about negotiating a courteous arrangement for time take away from clinical duties, namely:

• You negotiate a mutually agreed arrangement with your clinical service.

• There is no mandated entitlement, and how much time will be allowed will vary from site to site.

• A guiding principal is that a maximum of a total of three hours per week of time away from clinical duties (including therapy + supervision + travel time). This is not a minimum entitlement and some sites will only be able to allow a smaller portion of time than this.

• It is best to conduct therapy within rostered hours and so if some component needs to be done outside of rostered hours, this should normally be the supervision.

d. COMPLETING THE PSYCHOTHERAPY CERTIFICATE AFTER OBTAINING FELLOWSHIP

The vast majority of trainees will be unable to provide enough therapy to enough patients during Stage 3 rotations to complete the certificate requirements (sessions/hours of therapy, numbers of patients and attainment of EPA's) as a trainee. This is expected so is perfectly acceptable. In fact it will be easier to complete the required therapy and supervision after becoming a Fellow.

When you become a Fellow you should aim to undertake therapy as part of your rights of private practice and organise your schedule to receive supervision in your own time. As a consultant, you will have to carry your own indemnity if you conduct psychotherapy outside of your rights of private practice, i.e. during your own, non-salaried time, if you establish a part-time or full-time private practice. As a Fellow-in-training in Psychotherapy, you will no longer need to complete ITA's or OCA's, or receive the mandated four hours of supervision per week. However, you will still need to complete any remaining Psychotherapy Certificate EPA's, and undertake at least 3 WBA's with a psychotherapy supervisor to inform attainment of these.

6. PSYCHOTHERAPY TRAINING IN OTHER ADVANCED TRAINING CERTIFICATES

a) ACHIEVING THE ADULT CERTIFICATE PSYCHOTHERAPY REQUIREMENTS

The Certificate of Advanced Training in Adult Psychiatry includes a requirement to provide structured psychotherapy, to completion, for four patients. There is a list of accepted structured psychotherapies, and you can choose any four of these 9or use only one for all four patients). The requirements are provide below, but can also be found at:
https://www.ranzcp.org/Files/PreFellowship/2012-Fellowship-Program/Adult-Certificate/Structured-psychotherapy-requirements.aspx

Structured psychotherapy requirements

Structured psychotherapy requirements for trainees and Fellows completing a 'Certificate of Advanced Training in Adult Psychiatry'.

'Structured therapies' are those where there are defined (sometimes manualised) therapy techniques employed and a specific timeframe for the therapy, in general a brief course of up to about 20 sessions.

Most of these therapies have a growing evidence base for efficacy in high prevalence disorders, but SATAP is prepared to allow inclusion of relatively new therapies of this type such as adherence therapy, cognitive analytic therapy or solution-focused (problem-solving) therapy.
Note that in every instance, the therapy is to be pre-planned, structured carefully with clear goals and timeframe and a verbal contract for therapy arranged with the patient. There must be supervision, either individually or in a small group, on at least a monthly basis.
Suitable therapies in this category include:

• acceptance and commitment therapy
• adherence therapy (as a structured therapy, e.g. as described in the manual by Richard Gray)
• behavioural therapy
• cognitive analytic therapy (CAT)
• cognitive–behavioural therapy (CBT)
• cognitive therapy
• couples or marital therapy
• dialectical behavioural therapy (DBT; if structured and time limited, not the longer-term psychodynamic therapy some patients eventually receive)
• grief therapy (if structured and time limited)
• interpersonal and social rhythm therapy (for bipolar mood disorder)
• interpersonal therapy (IPT; as a structured therapy, e.g. as described in the manual by Klerman and Weissman)
• mindfulness-based cognitive therapy

• motivational enhancement therapy (as a structured therapy, e.g. as described in the manual by William Miller)
• motivational interviewing (if structured as a formal therapy)
• solution-focused therapy (problem-solving therapy).

Notes:
• If the therapy is delivered in a group format, the trainee must be a principal therapist in the group and only one person from the group can be considered as one of the four required patients.
• Unstructured and longer-term psychological interventions are not acceptable for this training requirement (e.g. psychodynamic or psychoanalytic therapy, supportive psychotherapy, psychoeducation, unstructured motivational interviewing or counselling and unstructured family therapy).
• A few other formally structured psychotherapies may be acceptable and will be considered by the SATAP on a case-by-case basis.

Learning goals to guide trainees undertaking this requirement

Attitudes
• Respect for the patient's rights, e.g. autonomy, consent, privacy, confidentiality, boundaries, etc.
• Willingness to actively and openly participate in supervision.

Knowledge
• The theory underpinning the modality of the psychotherapy employed.
• The evidence base for the modality of psychotherapy utilised.

Skills

Assessment of suitability of the patient for that modality of psychotherapy, including (but not restricted to):
• Psychiatric evaluation, with a focus on psychological assessment.
• Psychological formulation of the patient's problem(s) according to the therapy paradigm being considered.
• Considerations of the indications for, and relative contraindications against, psychotherapy in that patient.
• Making an appropriate selection of the psychotherapy modality to be used.

Initiation of therapy, including (but not restricted to):
• Establishing a therapeutic contract – explaining the therapy to the patient and gaining their consent for treatment (including consent for supervision).
• Engagement of the patient and formation of a working alliance.
• Orientation to the model.
• Setting the structure of therapy, e.g. frequency of sessions, venue, duration.
• Setting goals for therapy.
• Planning how the sessions will be conducted according to the school of therapy being offered.
• Choosing appropriate measures to monitor patient progress.

Delivery of therapy, including (but not restricted to):
• Making an appropriate range of formal psychological interventions at appropriate times as appropriate for the chosen modality and faithful to the model.
• Monitoring effectiveness of interventions and adapting therapy in line with progress of therapy.
• Assessing and managing resistance to therapy according to the principles of the specific therapy.

Conclusion of therapy, including (but not restricted to):

- Setting a termination date and managing any anxiety in the patient about termination as it approaches.
- Evaluating (with the patient) whether or not the therapy has been successful and has achieved its goals. This should also involve formal assessments (such as personalised symptom measures or established measures such as the Beck Depression Inventory in cognitive therapy for depression).
- Understanding and discussing in supervision where therapy may have failed to achieve its goals and why this might be the case.
- Arranging for ongoing psychiatric care of the patient, as appropriate.

Important points to understand from this are:

- You CANNOT use the three patients seen for the Stage 3 generalist psychotherapy requirements for this Adult Certificate requirement. Therefore Stage 3 trainees undertaking the Adult Certificate must see a minimum of seven different patients – three for the generalist requirements and four for the adult structured therapy requirement.

- You CANNOT use the patient you treat for the PWC, or any patients for which you undertake WBA's for any of the Stage 2 psychotherapy EPA's, if completed in stage 3

- If you were undertaking a dual certificate, in Adult & Psychotherapy, then you CAN use patients seen for the Psychotherapy Certificate to satisfy this Adult certificate requirement, and vice versa.

- Longer term psychodynamic psychotherapy is specifically excluded, as it is not considered sufficiently structured. A structured form of Brief Dynamic Therapy would be acceptable.

- If you wish to undertake a form of therapy that is not on this list (e.g. Narrative Therapy, Schema Therapy etc.) this may well be appropriate. However you should check with the DOAT for Adult Psychiatry (Jimsie Cutbush) first and you may need to obtain formal approval from the QBTC.

Given that there is a large range of structured psychotherapies to choose from, it should be possible to undertake some, if not all, of these during at least some of your Adult Psychiatry rotations during Stage 3. Many of the patients you see during community rotations, as well as some inpatient rotations, will have one of these therapies as an indicated intervention. The difficulty may be in arranging time to actually undertake this therapy in a busy service, or to arrange supervision from a therapist sufficiently skilled in this therapy modality. You should ensure that such supervision is available before commencing the therapy.

The requirements allow supervision to be provided in a group format, and on no less frequent than a monthly basis. It does not need to be weekly, or on a one-to-one basis. It

may be that several Adult Certificate Trainees can arrange for monthly supervision to be provided to them together, which is not that difficult to arrange.

If therapy is to be provided to patients that are not part of your normal clinical role, but within rostered hours, the same principles apply to this as they do for the PWC or the Psychotherapy Certificate requirements (see these sections). The same guidelines for taking time away from your clinical duties to see the patient or receive supervision also apply, and are summarised as follows:

• The patient must be registered with an QLD Health clinical service, with some case entries made about each encounter.

• There must be a nominated psychiatrist within the HHS who acts as the clinical supervisor for that patient.

• You negotiate a mutually agreed arrangement with your clinical service for time to be spent away from the service.

• There is no mandated entitlement about how much time will be allowed away from your duties, and this will vary from site to site.

• A guiding principal is that a maximum of a total of three hours per week of time away from clinical duties (included therapy + supervision + travel time). This is not a minimum entitlement and some sites will only be able to allow a smaller portion of time than this.

• It is best to conduct therapy within rostered hours and so if some component needs to be done outside of rostered hours, this should normally be the supervision.

• Given the requirement is for monthly supervision, the impact of supervision on clinical duties should be less than other psychotherapy requirements in training.

This requirement is not a formative assessment or a summative assessment – it just needs to be completed. It is not graded and written feedback is not provided on the form you need to complete, which can be found at: https://www.ranzcp.org/Files/PreFellowship/2012-Fellowship-Program/Adult-Certificate/Adult-structured-psychotherapy-form-(Reader-extend.aspx

b) ACHIEVING THE PSYCHOTHERAPY REQUIREMENTS IN OTHER CERTIFICATES

The following Advanced Certificates have specific Psychotherapy Requirements:

Advanced Certificate in Child and Adolescent Psychiatry

Provision of psychotherapy to nine discrete patients/dyads/families/groups for at least six sessions each.

- The patients should include:
    - three patients under 6 years old
    - three patients 6–12 years old
    - three patients 13–18 years old.

- Of the above psychotherapy cases, the following modalities must be completed:
    - three structured, manualised (e.g. CBT, IPT)
    - three dynamic
    - three dyadic or family/group in any model (e.g. mother–infant, family/group).

- Trainees must be supervised by an appropriate supervisor for the particular modality. This could include group supervision.
- If the child and adolescent psychotherapy requirements are complete, then the Stage 3 Fellowship psychotherapy requirement is considered met.

Advanced Certificate in Psychiatry of Old Age

Provision of psychotherapy to three older persons (i.e. > 65 years old) for at least six sessions each.

Note:

• Patients seen for these two Certificate requirements CAN be used to satisfy the Fellowship Generalist Psychotherapy requirement.

• Therefore, if you see six older persons for six sessions of psychotherapy, under supervision, the same patients can be used to complete the Generalist requirement. You would need to submit both the Generalist Psychotherapy Sessions Form and the POA psychotherapy form, but the same patients would be used and the same supervisor would sign both forms. If, however, you saw people younger than 65 to complete this generalist Fellowship requirement earlier in stage 3, and entered the POA certificate half-way through Stage 3, you would then have to see a further six older people with psychotherapy to meet the POA Certificate requirement.

• Any three of the nine patients seen for the CAP certificate requirement could be used for the generalist requirement. Again, both the generalist and CAP certificate psychotherapy forms would have to be submitted separately. Similarly, as above, if you completed this generalist psychotherapy requirement with adult patients prior to entering the CAP certificate, you would need to complete the CAP requirement with nine younger patients.
It is expected that provision of psychotherapy for these requirements would be an integral part of CAP rotations during CAP advanced training, and POA rotations during POA advanced training, so that patients and supervisors should be readily available during the conduct of your clinical work, at least in some of the rotations during the 24 months of certificate training. If, for some reason, you have difficulty completing these requirements you should contact the DOAT CAP Dr David Furrows and POA Dr Gerard Byrne to discuss this and find a solution.