CMSA

PORTFOLIO OF LEARNING
As required for admission to the FCPsych(SA) Part II examination

Fellowship of the

College of Psychiatrists of South Africa

FC Psych (SA)
Effective JANUARY 2022

From January 2019 only electronic versions of this document will be accepted.
NB! Until this document is configured onto a CMSA electronic platform, candidates are advised to complete them manually and save for electronic uploading as a pdf. Registrars commencing training in 2022 will be required to use only this version of the POL. Registrars already in training may use the relevant sections for rotations that are to be done in 2022 onwards and add on to the sections of the previous POL. Items marked in green are for uploading; the rest of the document contains supporting information.

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SECTION 1

CANDIDATE DETAILS

SURNAME:……FIRST NAMES:.....
ID NUMBER: .....
HPCSA NUMBER:……..TRAINEE POST (N) NUMBER:.....
*TRAINING DATES: COMMENCEMENT:…….
END OF TRAINING:…….....…
HPCSA RECOGNISED TIME (if applicable): ……
UNIVERSITY OF AFFILIATION: .....
.....……
RESIDENTIAL ADDRESS: .....
.....……
PREFERRED POSTAL ADDRESS: .....
.....……
EMAIL ADDRESS:.....
TELEPHONE NUMBER: (Work):…….(Home): ……
CELLPHONE NUMBER:……..
FAX NUMBER:……

UNDERGRADUATE MEDICAL QUALIFICATIONS

UNIVERSITY:……. YEAR:…….

SUCCESSFUL COMPLETION OF PART 1 (MMED PSYCH/FC PSYCH I)

EXAMINATION DETAILS
Exam:
**Month/Year/Subject/s (Paper/s) passed:
.....

.....
.....

*Please refer to the Regulations regarding the completion of the final examination within three (3) years of completing the 4-year training time. Annexure A must be submitted in addition to the POL when applying for the once off concession to sit the examination after this period.
**NB! Part II must be written within 6 years of passing the Part I examination.

SECTION 2

PURPOSE OF THE PORTFOLIO OF LEARNING

What is the Portfolio?

Your portfolio is based on the "**CRITICAL**" Portfolio (***C**ertified **R**ecord of **I**n-service **T**raining **I**ncluding **C**ontinuous **A**ssessment and **L**earning*). It is a professional resource document structured in a flexible format which allows trainees to plan and meet the objectives of the specialty training programme through a *documented* process of work experience, learning and reflection.

Purpose of the portfolio

1. To stimulate students to think consciously and objectively about their own training. (This is known as *reflective* learning). This is its primary purpose.
2. To document the scope and depth of the candidate's training experiences.
3. To provide a record of the trainee's progress and personal development as training proceeds.
4. To provide an objective basis for discussion with the candidate's supervisors about work performance, objectives, and immediate and future educational needs.
5. To provide documented evidence for the CMSA of the quality and intensity of the training the trainee has undergone in readiness to write the FCPsych II examination.

The portfolio is not just a logbook of signed procedures undertaken or witnessed. It should contain the candidate's written reflections and systematic documentation of his/her learning experience, progress towards competence final achievement of entrustment to practice as a psychiatrist. It includes opportunities for candidates to reflect, to explore, to form opinions, and to identify the strengths and areas of improvements needed in their own abilities and knowledge. It provides the facility for trainees to follow their own progress; not only through the training programme, but also towards the learning goals they have set for themselves. In this way the portfolio provides an opportunity to record and document the objective and subjective aspects of training.

Objectives

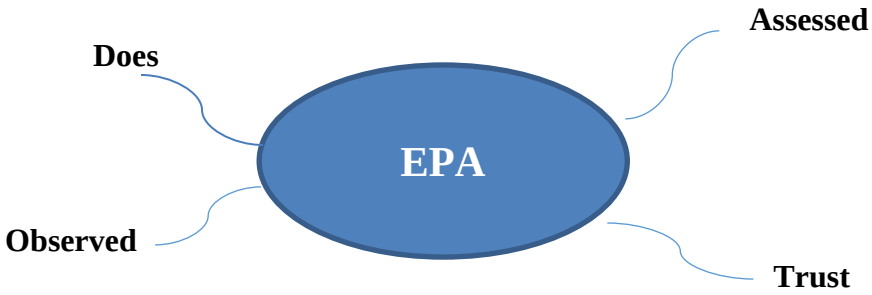
For the trainee, the objectives of the portfolio are to:

- develop a structured learning plan
- identify goals and actions required to achieve the required capabilities (competencies)
- record progress in achieving them
- document personal strengths
- identify areas needing improvement
- reflect on progressive professional development
- encourage good two-way communication with supervisors
- provide documentation of continuous supervision, assessment, review and direction of one's progress.

Competencies can be assessed through **Entrustable Profressional Activities** or **EPAs**.

What are EPAs?

Authentic clinical activities
Tasks that are carried out day-to-day
Units of professional work
Activities that can be assigned, measured and observed
Activities that a supervisor ccan trust a registrar to do independently or unsupervised
A way to teach and assess registrars



Observing a registrar conducting an EPA enables a supervisor to determine the registrar's ability to perform that activity with decreasing supervision and increasing autonomy.
These obervations are known as **Observable Professional Activities** or **OPAs**. OPAs are, therefore, a collection of learning objectives as *activities* that must be *observed* in daily *practice* in order to form entrustment decisions.

Who looks at the Portfolio of Learning?

1. **The candidates**. The primary audiences are the trainees themselves. The document is meant to serve as a learning tool that promotes reflection and good academic time management.
2. **Supervisors**. It is expected that candidates formally meet with their supervisor regularly throughout the training period. At this meeting, supervisors will review the candidate's progress and should use entries in the portfolio as a basis for discussion. This allows a structuring of the supervision process. By referring to and discussing specific areas of learning and experiences, the supervisor is able to provide informed feedback and constructive advice with regard to problems and areas needing improvement and further development. In this way the portfolio structures the supervision process. The portfolio must be made available to the supervisor before the meeting.
3. **The CMSA**. The CMSA requires evidence that learning and training has taken place as part of a structured programme. The portfolio is a critical piece of evidence for this.

This portfolio is a guide and cumulative record of your personal learning, goals, needs, strategies and activities throughout your training programme. The sections in the portfolio are not exhaustive, but rather an indication of the **minimum** that you should be doing. You will learn a great deal more than what is written on these pages. We trust that this will provide you with a positive and valuable learning experience.

Portfolio Completion Criteria

- The Portfolio should always be used in conjunction with the **Regulations** and **Syllabus** for admission to the Fellowship of the College of Psychiatrists of South Africa FC Psych(SA), as may be amended from time to time.
- Entries must always be **legible** and, where indicated, supported by the required **signatories** (Supervising Consultants and Heads of Departments and their contact details). Add pages to each Section as necessary. Ensure that your name appears on every page. It is **essential** that you keep an electronic backup copy of all entries, as well as a printed copy, in case of computer failure or theft.
- Each Rotation will need to be verified by the relevant Head of Department, including the completed "**Record of Procedures Done**" and "**Clinical Practice Rating and Evaluation**" for each Rotation. This process needs to take place at the end of the rotation and not retrospectively.
- The portfolio and supporting certificates and documents must reach the Academic Registrar of the CMSA (together with the relevant assessment fee, if applicable) by closing date of registration for the FC Psych(SA) Part II Examination. Failure to submit the portfolio before this time will result in the candidate not being invited to the examination.
- A readily available electronic copy of the complete POL must be retained by the academic department and the candidate. The College of Psychiatrists will request a copy for the purposes of auditing. Incomplete/outstanding information as they relate to the minimum entry requirements into the final examination may jeopardise your entry into the examination.

SECTION 3

CLINICAL EXPERIENCE

3.1 Learning objectives for clinical rotation as per facility/service

Supervised experience is required during the different specified clinical rotations of a candidate's four years of training. These rotations include:

- a community psychiatric service for a full-time period of not less than three months, or equivalent
- child psychiatric unit or child guidance unit for a full-time period of not less than three months
- at least one year of working in an approved psychiatric hospital or unit

In order to align the teaching objectives with the learning and training activities, assessment opportunities and the expected training/assessment outcomes, specific learning objective(s) for each clinical rotation must be considered. For example, the learning objectives for the rotation in an acute adult psychiatric inpatient unit in an acute general hospital could be:

> *"To achieve the knowledge and core competency outcomes for registrars in their different years of training in an acute adult assessment unit providing inpatient and outpatient care in a general hospital setting, as well as emergency and routine interdepartmental consultation-liaison services and outreach services in a defined drainage area."*

3.2 Schedule of Clinical Rotations

YEAR 1 – Semester 1	
Start date **End date**	
Key Learning objectives/EPAs-min of 8	EPA LEVEL*

YEAR 1 – Semester 2	
Start date **End date**	
Key Learning objectives/EPAs-min of 8	EPA LEVEL*

YEAR 2 – Semester 1	
Start date **End date**	
Key Learning objectives/EPAs-min of 8	EPA LEVEL*

YEAR 2 – Semester 2	
Start date **End date**	
Key Learning objectives/EPAs-min of 8	EPA LEVEL*

YEAR 3 – Semester 1	
Start date **End date**	
Key Learning objectives/EPAs-min of 8	EPA LEVEL*

YEAR 3 – Semester 2	
Start date **End date**	
Key Learning objectives/EPAs-min of 8	EPA LEVEL*

YEAR 4 – Semester 1	
Start date **End date**	
Key Learning objectives/EPAs-min of 8	EPA LEVEL*

YEAR 4 – Semester 2	
Start date **End date**	
Key Learning objectives/EPAs-min of 8	EPA LEVEL*

NB Please indicate if additional training time was completed in the event of extended sick leave or maternity leave.

ADDITIONAL TIME (INCAPACITY/MATERNITY)	
Start date **End date**	
Key Learning objectives/EPAs-min of 8	EPA LEVEL*

***ENTRUSTABLE PROFESSIONAL ACTIVITIES (EPAs) -LEVELS**

Level 1. Is only able to observe it being done; not allowed to practice activity
Level 2. Requires direct supervision to practice activity
Level 3. Requires the presence of senior staff at hand – ready access; supervisor immediately available; findings and decisions must be double checked
Level 4. Can be trusted to practice activity independently/unsupervised – the competent practitioner
Level 5. Good enough to teach/supervise a junior colleague – the specialist

NB!

1. To sit the final examination, all EPAs must have a final minimum rating of '4'
2. Key learning objectives and corresponding entrustable professional activities are to be defined at Departmental level as informed by local clinical rotations
3. All competencies as defined in the regulations must be achieved during the training period AND prior to sitting the final examination.
4. Each of the 7 CANMED competencies must be assessed during the training; although these competencies are integrated into other clinical and professional activities, certification at a minimum level of '4' must be documented.
5. EPA level rating must be done by the supervisor.
6. Where formal workplace based assessments (these can be university specific) have been used to rate the candidate, documentation may be annexed in Section 7B.
7. There should be a progressive increase in the targeted EPA level with the years of training/experience and as relevant to the learning objective.

3.3 Core competencies (Refer to the regulations)

While these sections capture domain specific competencies, it must be noted that the following general professional competencies must be integrated into these rotations:

CANMEDS COMPETENCY FRAMEWORK

- Medical expert/clinical decision maker
  - Interviewing, examination and investigative skills
  - Clinical judgment, integrative and evaluation/assessment skills
  - Clinical problem/diagnostic and management plan formulation
  - Prescription knowledge and skills
  - Knowledge level as required per year of training
  - Risk assessment skills
  - Psychotherapeutic skills and competence
  - Treatment outcomes
- Communicator
  - Presentation skills
  - Interpersonal, communication and listening skills
  - Conveying of information
  - Cultural and spiritual competence
  - Therapeutic relationships
- Collaborator
  - Relationships with MDT members
  - Management of differences and conflict
  - Implementing of management plans
- Manager
  - Organisational skills (duties and services)
  - Leadership skills
  - Database management and clinical audits
  - Resources and time management
  - Practice management systems and clinical governance
- Health advocate
  - Adherence knowledge and skill
  - Advocacy skills and providing health education (patients and families)
  - Cooperation/liaison with other mental health stake holders
- Scholar
  - Practice-based learning (case presentations/discussions, presenting tutorials, lectures, teaching of students)[1]
  - Research and systems-based learning (reading/evaluating scientific papers)
- Professional
  - Quality of patient care
  - Documentation and clinical record keeping
  - Professionalism
  - Ethical practice and conduct

3.4 Child and Adolescent Psychiatry

The Colleges of Medicines of South Africa expects that all psychiatry registrars have an exposure to Child and Adolescent Psychiatry before being allowed to sit for the Part II examination. (*CMSA REGULATION 5.1.5 having satisfactory supervised experience in a child psychiatric unit or child guidance unit recognised for the purpose by the CMSA for a full-time period of* ***not less than 3 months****.)*

<table>
<tr><th>Domain</th><th colspan="2">Item</th></tr>
<tr><td rowspan="9">Core Knowledge</td><td colspan="2">1. Knowledge of common forms of psychopathology in childhood and adolescence</td></tr>
<tr><td colspan="2">2. Knowledge of the implications of mental and physical illness on the functioning of patients and families</td></tr>
<tr><td colspan="2">3. Knowledge of how to carry out a developmental assessment.</td></tr>
<tr><td colspan="2">4. Knowledge of theory and practice of psychotropic drug use in childhood and adolescence</td></tr>
<tr><td colspan="2">5. Knowledge of psychological developmental theory and practice of psychotherapy in childhood and adolescence.</td></tr>
<tr><td colspan="2">6. Knowledge of relevant biological and psychological investigations</td></tr>
<tr><td colspan="2">7. Knowledge of social organisations and institutions (e.g. NGOs, Children’s Homes etc.) and ability to consult usefully to these institutions</td></tr>
<tr><td colspan="2">8. Knowledge of the impact of cultural, social and family influences on the manifestation of psychiatric disorder in children and adolescents.</td></tr>
<tr><td colspan="2">9. Knowledge of legal and ethical issues relevant to children and adolescents</td></tr>
<tr><td></td><td>EPAs</td><td>OPAs</td></tr>
<tr><td></td><td>Assessment and management of :
Attention Deficit Hyperactivity Disorder
Autism Spectrum Disorder
Intellectual Disability and Learning Disorders
Disruptive Behaviour Disorders
Trauma related conditions (e.g. reactive attachment disorders)
Acute Mood and Anxiety disorders
Acute Substance Induced Disorders
Acute management of medically stable and complicated suicide attempts
Acute Psychotic Disorders
ADHD, ASD, Intellectual disability, Tourette’s disorder
Any disorder which can be managed by a general psychiatrist (e.g. uncomplicated depression or ADHD)</td><td>Assess children and adolescents within a developmental framework and including their families , or the commonly encountered mental health problems of their age group.
History from family
History from child/adolescent
Information from other sources
Assessment of family, child, adolescent
Ability to make diagnostic formulation
Perform appropriate additional investigations
Generate and implement a treatment plan
Paediatric psychopharmacological management
Psychological therapies in C&AP e.g.
Play therapy
Parental guidance
Psychoeducation
Supportive psychotherapy
Family therapy</td></tr>
<tr><th>Domain</th><th colspan="2">Item</th></tr>
</table>

Measuring Outcomes	In order to monitor outcomes, trainees will be expected to keep a logbook of all cases seen during their placement in child & adolescent psychiatry. Trainees will be expected to summarise their logbook in preparation for mid-term and end-of-placement reviews. **The onus is on the trainee to provide evidence to support each competency. The trainee should provide evidence that they have had clinical experience of managing patients across a range of diagnostic categories, age ranges and treatment modalities.**
Numbers of cases, assessments, academic presentations	1. 25 new cases involving interviews with parents and children/adolescents per placement [evidence: logbook]
	2. Minimum of 5 joint assessments/ward round presentations/sessions with a member of MDT including feedback from the MDT member (evidence: signed off in log book)
	3. Minimum of at least 1 case where there are child protection concerns and liaison with social agency is required [evidence: logbook]
	4. Minimum of 3 consultation-liaison cases (Evidence: Log book)
	5.1x Observing consultant doing an assessment [Evidence: logbook]
	6.10x case presentations with supervision with feedback from a senior clinician [evidence: Case Presentation Form]
	7.1x Journal Club with feedback from senior clinician [evidence: Journal Club Form]
	8.1x Seminar with feedback from senior clinician [evidence: Assessment of Teaching/Presentation Form]
	9.1x Direct observation by a senior clinician doing an interview/assessment [evidence: Assessment of Clinical Expertise Form]

CERTIFICATION OF COMPLETION OF TRAINING
EPA: Practice of Child and Adolescent Psychiatry

Institution & University			
Dates of rotation(s)		**Duration in months**	
Name of Registrar			
Name of Supervisor			

I. Certification of clinical activities and core competencies
These are the **minimum** requirements. Registrars are encouraged to add additional activities / cases.

1. **Minimum of 20 child and adolescent case interviews**

Date	Case number	Age of patient	Diagnosis	Unit	Hospital

2. **<u>Minimum</u> of 5 joint sessions/ward round presentations with multidisciplinary team as per clinical expertise form**

Date	Case number	MDT team member	EPA Level	Signature

3. **<u>Minimum</u> of 1 observed case with consultant interviewing**

Date	Case number	Consultant	EPA Level	Consultant signature

4. **<u>Minimum</u> of 10 case presentations/supervised cases- supplement with case assessment form from general psychiatry**

Date	Case number	Diagnosis	Consultant	EPA Level	Consultant signature

5. **<u>Minimum</u> of 1x Journal club- supplement with presentation form from general psychiatry**

Date	Journal	Topic	Consultant	EPA Level	Consultant signature

6. **<u>Minimum</u> of 1 seminar – supplement with presentation assessment form from general psychiatry**

Date	Topic	Consultant	EPA Level	Consultant signature

7. **<u>Minimum</u> of 1 x observed case interview- supplement case presentation form from general psychiatry**

Date	Case number	Diagnoses	Consultant	EPA Level	Consultant signature

Certification of Entrustment

I hereby certify that the candidate has met the entrusted professional activities in child and adolescent psychiatry at an overall EPA Level of ……

1. Is only able to observe it being done
2. Requires direct supervision to do it
3. Requires the presence of senior staff at hand – ready access
4. Can be trusted to do it independently – the competent practitioner
5. Good enough to teach/supervise a junior colleague – the specialist

Registrar signature **Supervisor signature**
Date: **Date:**

3.5 **Community Psychiatry and Public Mental Health**

Requirement is a minimum of 3 months, full-time or part-time.
Activities can include, but are not limited to:

- Clinic visits
- Outreach to district (non-specialist) hospitals
- Home visits/Assertive Community Treatment
- Involvement in district mental health teams
- Community-based NPOs
- Service development activities

Domain	Item
Core Knowledge	**Basic clinical knowledge** of general adult and child & adolescent psychiatry. Principles of patient-centeredness; recovery-orientated and palliative mental health care, as well as primary, secondary and tertiary preventive care.
	L**egislation** – Clinical practice implications of MHCA, NHA, Children's Act, Prevention of and Treatment for Substance Use Act.
	Multidisciplinary Team – extends beyond the allied professions to include primary health care staff – medical officers, clinical associates, registered counselors, lay counselors. The patient and their support system also form part of the MDT. Scope of practice, clinical roles and respective support needs of all MDT members need to be understood.
	Non-health government sector – roles and responsibilities of personnel in Social Development, SAPS, Education, Correctional Services; referral pathways and collaborative possibilities between sectors.
	NGO and Community Sector – legal framework, roles and responsibilities of NGO organisations. Transcultural psychiatry and concepts around working with traditional healers, alternative medicine practitioners, faith healers, and faith based organisations

EPA	OPA
Clinical application of: 1. Public Mental Health – basic concepts and service design 2. Mental Health Policy and Service Organization 3. Epidemiology in Psychiatry: 4. Poverty and the Social Determinants of Mental Health 5. Components of a comprehensive mental health service and applying this to the South African context 6. Modalities of Delivery in Community Psychiatry, including the Community Mental Health Team 7. Deinstitutionalisation 8. Mental Health Promotion, Prevention and User Advocacy 9. Practice of Community Psychiatry – a conceptual framework 10. Principles of functional assessment, including disability grant and incapacity assessments	1. Conduct a psychiatric interview of new patients referred to community mental health services, investigate, formulate the case and draft a management plan appropriate to the community setting and resources. 2. To know when to refer new MHCUs in community for admission 3, Liaise with appropriate referral sources, including PHC, medical specialists, hospital and forensic psychiatry, schools, correctional services (for ex-offenders and discharged prisoners), industrial schools, substance use facilities 4. To provide maintenance treatment of common and severe mental disorders. To be able to adjust medication and psychosocial care to meet the needs of the MHCU. Work with family and relevant others in the care of individual patients. 5. Collaborate with PHC, including non-specialist health workers around physical care of severe mentally ill, and to educate

11. Cultural competence, mental health literacy and empowerment 12. Rehabilitation and Recovery	and support care of those with mild to moderate illness by PHC. 6. To understand the advantages and disadvantages of disability grants 7. Be able to write 'treating clinician' letters regarding custodial / legal issues. 8. To develop an understanding of stigma, and advocacy in community. Provide outreach education to local non-health and community-based organisations. Report human rights violations to the MHRB

CERTIFICATION OF COMPLETION OF TRAINING

EPA: Practice of Community Psychiatry and Public Mental Health

Institution & University			
Dates of rotation(s)		**Duration in months**	
Name of Registrar			
Name of Supervisor			

Activities / Outputs:
These are the **minimum** requirements. Registrars are encouraged to add additional activities / outputs.

Item	Specific activity requirements	EPA Level	*(Supervisor's initials)*
1.	Brief (1 page) tabulation of community psychiatry activities including total time spent on each activity.		
2.	Brief (3 page) description of the community psychiatry service components in local area including challenges and proposals for systems improvement.		
3.	1 disability/incapacity assessment report countersigned by consultant.		
4.	1 PowerPoint talk given as part of outreach/support/training to local services/NPOs		
5.	Brief (2 page) description of a service development/improvement activity undertaken by registrar.		
6.	Report on community outreach activity (see format example on p75)		

Certification of Entrustment
I hereby certify that the candidate has met the entrusted professional activities in community psychiatry and public mental health at an overall EPA Level of ……
1. Is only able to observe it being done
2. Requires direct supervision to do it
3. Requires the presence of senior staff at hand – ready access
4. Can be trusted to do it independently – the competent practitioner
5. Good enough to teach/supervise a junior colleague – the specialist

Registrar signature **Supervisor signature**

Date: **Date:**

3.6 **Consultation-Liaison Psychiatry**

These guidelines for the consultation-liaison psychiatry module are to be used in conjunction with the Regulations of the FCPsych (SA), and the associated Portfolio of Learning.

Domain	Item
Core Knowledge	1. An understanding of medically unexplained/ persistent medical symptoms
	2. Anxiety, depression, psychosis, substance use disorders and delirium within medical, surgical and obstetric settings.
	3. The assessment of risk including: non-fatal suicidal behavior, aggression, exploitation and neglect, environmental risk
	4. The various medical and surgical syndromes/disorders that may present with psychiatric and psychological symptoms and signs.
	5. Decision making capacity assessments
	6. The relevant South African legislation (including the Mental Health Care Act, National Health Act, Children's Act, Choice on Termination of Pregnancy Act, Sterilisation Act)
	7. Somatic symptom and related disorders

EPAs	OPAs
Assessment and management of anxiety, depression, psychosis and delirium within medical, surgical and obstetrics settings Assessment and management of risk including non-fatal suicidal behaviour, aggression, exploitation and neglect, environmental risk Approach to medical and surgical syndromes and disorders that may present with psychiatric and psychological symptoms and signs Assessment and management of somatic symptom and related disorders (somatic symptom disorder, functional neurological symptom/conversion disorder, illness anxiety disorder, psychological factors affecting another medical condition) Managing sychiatric issues in palliative care Assessment and management of medically ill special population groups e.g. children and adolescents, geriatric Principals of psychotropic prescribing in medically ill patients Principals of psychotherapy in medically ill patients Identifying and managing ssues related to organ transplant Conducting capacity assessments	1.Be able to carry out a full biopsychosocial assessment of patients, in medical, surgical and obstetric settings, with physical health problems or physical symptoms and mental health symptoms, impaired mental wellbeing, or psychological distress. 2. Be able to diagnose, manage and coordinate complex liaison cases in both in-patient and out-patient settings, including the use of a broad range of psychological, social, environmental and biological interventions. 3. Demonstrate an understanding of emergency, consultation, and liaison styles of working (generic competence). 4. Demonstrate the ability to employ basic management and referral skills. 5. Use one's own authority to optimise medical and surgical management plans. 6. Demonstrate the ability to undertake the basic management of drug/alcohol problems in medical, surgical and obstetric settings including identification and immediate treatment. 7. Collaborate effectively and actively and develop negotiating skills, with medical and surgical colleagues and allied health professionals. 8. Psychotherapeutic skills within the liaison psychiatry setting. 9. Contribute to the development of clinical risk management plans in medical and surgical settings. 10. Work with and support Primary Care in managing complex cases involving multiple undiagnosed symptoms and/or chronic physical illness.

Understanding and clinical application of the relevant South African legislation (including the Mental Health Care Act, National Health Act, Choice on Termination of Pregnancy Act, Sterilisation Act) Assessment and management of feeding and eating disorders Assessment and management of women's mental health issues (psychiatric disorders in pregnancy and the post-partum period, psychiatric disorders related to menopause, premenstrual dysphoric disorder, infertility)	11. Contribute to the development of care packages for patients with long term physical health problems, working with health care staff and social services staff. 12. Active co-ordination and management of patients with specific psychiatric disorders associated with medical & surgical settings e.g. Chronic Fatigue, Fibromyalgia, Irritable Bowel Syndrome, Atypical chest pain, Atypical pelvic pain, Atypical facial pain, Eating disorders, HIV related disorders. 13. Competently manage problems across the age range and the co-ordination of relevant other services as well as identify where clinical audit are required.
Assessment and management of drug and alcohol related problems in medical, surgical and obstetric settings Assessment and management of sexual dysfunction	

CERTIFICATION OF COMPLETION OF TRAINING
Consultation-Liaison Psychiatry

Institution & University			
Dates of rotation(s)		**Duration in months**	
Name of Registrar			
Name of Supervisor			

I. **Clinical Activities**

These are the **minimum** requirements. Registrars are encouraged to add additional activities / cases.

Item	Specific activity requirements	EPA Level	*(Supervisor's signature)*
1. Case Management	5 x new cases referred for inpatient or outpatient management		
2. Report writing	1 x report written following a consultation-liaison psychiatric assessment (this could include reports providing referring clinicians with feedback, referral reports to another clinician or allied health professional or reports following decision making capacity, transplant assessments or other medicolegal assessments in medical settings)		
3. Scholarly activity	1 x Academic case presentation with MDT involvement		
	1 x Journal club/ seminar presentation		

I. Certificate of minimum competencies/EPAs

Item	Competency	EPA Level	(supervisor's signature)
1	Knowledge of medically unexplained/persistent medical symptoms.		
2	Knowledge of somatic symptom and related disorders		
3	Knowledge of anxiety, depression, psychosis, substance use disorders and delirium within medical, surgical and obstetric settings		
4	Knowledge of the assessment of risk including: non-fatal suicidal behavior, aggression, exploitation and neglect, environmental risk		
5	Knowledge of the various medical and surgical syndromes/disorders that may present with psychiatric and psychological symptoms and signs		
6	Ability to perform a decision making capacity assessment		
7	Knowledge of relevant South African legislation		

8	Ability to carry out a full biopsychosocial assessment of patients in medical settings		
9	Ability to confidently diagnose, manage and coordinate complex liaison cases in both in-patient and out-patient settings		
10	Knowledge of psychotropic prescribing in medically ill patients		
11	Knowledge of psychotherapy in medically ill patients		

Certification of Completion of Training

I hereby certify that the candidate has met the entrusted professional activities in consultation liason psychiatry at an overall EPA Level of ……

1. Is only able to observe it being done
2. Requires direct supervision to do it
3. Requires the presence of senior staff at hand – ready access
4. Can be trusted to do it independently – the competent practitioner
5. Good enough to teach/supervise a junior colleague – the specialist

Registrar signature **Supervisor signature**

Date: **Date:**

3.7 **Electroconvulsive therapy**

Domain	Item
Learning objectives	1. Theory of mechanism of action of ECT.
	2. Indications
	3.Contraindications.
	4. Complications and side effects.
	5. Pre-anaesthetic workup.
	6. Legal requirements and ethical issues.
	7. Practical administration of ECT.

DomainEPAs	Item
Skills / core competencies	1. Ability to ascertain indications for ECT in any given patient with regard to clinical diagnosis, urgency and risk assessment.
	2. Ability to indicate and conduct appropriate workup for ECT i.e. blood investigations, ECG and chest x-ray where necessary
	3. Ability to conduct risk assessment in terms of side effects and complication, placement of electrodes, treatment schedules.
	4. Demonstrate satisfactory skill in administering of ECT including need for repeated treatment doses/continued no of sessions/seizure augmentation strategies
	5. Ability to conduct post ECT clinical management, immediately post ECT and within the ward setting, as well as satisfactory record keeping.
	6. A minimum of 1 completed patient (ideally 3) should be presented and include assessment of indications for ECT, administration of 6 sessions of ECT, monitoring of response and follow up. The remaining sessions (minimum of 4) can be done on different patients, but should include clinical assessment for, administration of ECT and monitoring of response.

CERTIFICATION OF COMPLETION OF TRAINING
Electroconvulsive Therapy
ECT ADMINISTRATION LOGBOOK / CERTIFICATION OF COMPETENCE

These are the **minimum** requirements. Registrars are encouraged to add additional sessions/ cases.

Dates of ECT	**Folder/ Initials**	**Indication for ECT**	**Response/ Complications / Comments**	**EPA LEVEL**	**Signature**
Session 1					
Session 2					
Session 3					
Session 4					
Session 5					
Session 6					
Session 7					
Session 8					
Session 9					
Session 10					

*At least six sessions should be a full course of ECT for 1 patient, but more sessions can be added

Registrar self-reflection notes per administration:

1. Patient selection and suitability for ECT
2. Peri-procedure considerations: medication, anaesthetic
3. Monitoring clinical response: immediate, post-anaesthetic, post-course
4. Side-effects/complications
5. Psychopharmacological considerations pre and post ECT

CERTIFICATION OF MINIMUM COMPETENCE IN ECT

I, ……., hereby confirm that Dr ……has fulfilled the ECT training requirements as stipulated in the CMSA regulations:

	EPA/Competency	**Satisfactory** *(Supervisor's initials)*
1	Knowledge of the theory and administration of ECT	
2	Knowledge of ethical and legislative aspects of ECT	
3	Administration of ECT: MINIMUM of 1 (6 sessions) patient; ideally 3 patients) ; minimum of 10 ECT treatments administered	

Registrar signature **Supervisor signature**
Date: **Date:**

3.8 **Forensic Psychiatry**

These guidelines for the forensic psychiatry module are to be used in conjunction with the Regulations of the FCPsych (SA), and the associated Portfolio of Learning.

	Item
Core Knowledge	1. Relevant South African mental health legislation (including Mental Health Care Act, Criminal Procedure Act, National Health Act and Child Justice Act)
	2. The forensic assessment and clinical management process (including the assessment of criminal defendants, risk assessment, and management of State Patients)
	3. Civil matters & litigation issues of relevance to the general psychiatrist (including psychiatric impairment, child custody, contractual and testamentary capacity, curatorship & administratorship, malpractice & negligence)
	4. Special groups in the forensic context (including children, adolescents, women, the elderly, prisoners, victims, impaired health professionals, etc)
	5.Professional skills and ethics (including issues around disclosure, confidentiality, report writing, conflict of interest, dual agency, etc)

EPAs	**Item**
	1. Assessment of criminal defendants in terms of the Criminal Procedure Act
	2. Assessment and management of State Patients in terms of the Mental Health Care Act
	3.Writing of psycholegal reports (including court reports, periodical reports, etc)
	4. Conducting clinical risk assessments, especially in the context of a violent / potentially violent patient
	6. Assessment & management of relevant civil cases (e.g. psychiatric impairment and disability, curatorship, etc)
	7. Working within a forensic multi-disciplinary team

CERTIFICATION OF COMPLETION OF TRAINING
EPA: Forensic Psychiatry Practice

Institution & University			
Dates of rotation(s)		**Duration in months**	
Name of Registrar			
Name of Supervisor			

I. Entrustable professional activities

Item	Specific activity requirements	EPA level	*(Supervisor's initials)*
1. Case Management	1.1. Criminal defendants ("observations"): 3 cases		
	1.2. State Patients: 5 cases		
2. Report writing	2.1. Periodical reports x 5		
	2.2. Reclassification / discharge applications ("mock" report acceptable) x 1		
	2.3. Civil report ("mock" report acceptable) x 1		
3. Scholarly activity	3.1. Journal club (forensic article) x 1		
	3.2. Seminar / tutorial forensic presentation x 1		

II. Certification of *minimum* competencies

Certification of completion of training:

I hereby certify that the candidate has met the entrusted professional activities in forensic psychiatry

1. Is only able to observe it being done
2. Requires direct supervision to do it
3. Requires the presence of senior staff at hand – ready access
4. Can be trusted to do it independently – the competent practitioner
5. Good enough to teach/supervise a junior colleague – the specialist

Registrar signature **Supervisor signature**
Date: **Date:**

3.9 **General Adult Psychiatry**

Domain	Item
Core Knowledge	1. Common mental disorders in adults: epidemiology, aetiology, clinical presentation
	2. Differential diagnosis of common mental disorders
	3. Management strategies of common mental disorders
	4. Legislation pertaining to the management of MHCUs

Core Competencies/EPAs	OPA
Implement the MHCA 17 of 2002	Competent in the clinical and administrative implementation of the relevant sections of the MHCA
Perform a comprehensive specialist psychiatric assessment on culturally diverse adults with mental health problems/mental illness across the lifespan.	Independently and comprehensively assess adult patients-history, mental state and physical examination displaying specialist-level clinical skills.
Construct a biopsychosocial-spiritual/cultural formulation	Integrate information from multiple sources to formulate the case into which relevant predisposing, precipitating, perpetuating and protective factors are highlighted. Competent application of appropriate biological and psychosocial theories to advance an aetiological hypothesis of the clinical presentation.
Generate appropriate differential diagnoses with supporting evidence	Apply and elicit DSM-5 diagnostic criteria to clinical findings to arrive at an appropriate set of differential diagnoses and a provisional/working diagnosis.
Conduct relevant investigations, interpret the results and apply them appropriately in the management.	Develop and document an investigation plan, including appropriate medical, laboratory, radiological and psychological investigations. Interpret the results of investigations in the context of the specific patient. Ability to integrate and interpret clinical findings, results of investigations and collateral information to understand and manage patients.
Accurately assess and manage various types of risk-immediate and future.	Assessment of risk, knowledge of involuntary treatment standards and procedures and how to intervene effectively to minimize risk and implement prevention methods against self harm and harm to others. This includes de-escalation techniques as well as managing highly dangerous situations e.g. armed psychotic patients as well as managing future risk. Ability to apply the relevant legislation e.g. MHCA 2002 apprpriately at all times, with reference to published codes of practice.
Holistic and Comprehensive Acute, Short-and-Long term Management plan	In consultation with the patient, caregivers and relevant stakeholders, formulate a realistic, appropriate and comprehensive management plan for each adult patient. The treatment plan should take into

	account local resources, patient and cultural factors as well as address immediate, short-term as well as long-term therapeutic goals.
Psychopharmacological prescribing and monitoring skills	This includes being able to prescribe safely in contexts of physical and psychiatric comorbidity, drug-drug interactions, side effects, response and laboratory monitoring, adherence and treatment resistance.
Psychosocial management and rehabilitation skills	Develop an appropriate short and longterm psychosocial rehabilitation plan including all stakeholders and in collaboration with a multi-disciplinary therapeutic team, utilizing institution and community resources.
Collaboration, professionalism,leadership and communication skills with staff, patients, families and the public.	Display these competencies in all their clinical and professional interactions.
Clinical report writing	Write reports professionally with relevant information sensitively and accurately reported for the target recipient.

CERTIFICATION OF COMPLETION OF TRAINING

EPA: General Adult Psychiatry Practice

Institution & University			
Dates of rotation(s)		**Duration in months**	
Name of Registrar			
Name of Supervisor			

I. Certification of clinical activities

These are the **minimum** requirements. Registrars are encouraged to add additional activities / cases. It is encouraged that General Adult Psychiatry rotations / exposure be spread out over the 4-year training period. If not possible to do this annually, a **minimum of 3 submissions** as listed below should be made, with one submission from **each training year**.

Departments are encouraged to adopt objective assessment/rating scales for local use. Reflective practice should be done orally or in writing.

1. **Minimum of 25 General adult case managements for each rotation in general adult psychiatry:**
   -Minimum of **10 inpatients** each of whom should have each been followed- up for a minimum of 3 weeks in the ward and of whom, a minimum of **4** have been followed up from inpatient to outpatient care
   -Minimum of **15 outpatients** each of whom should have been seen for a minimum of 3 consecutive visits

Date	Case number	Age of patient	Diagnosis	Unit / Hospital

2. **<u>Minimum</u> of 15 Ward round presentations with multidisciplinary team (equal numbers from each rotation / year of training)**

Date	Case number	Diagnosis	Supervisor feedback/ Rating on objective tool used(specify)	Consultant Signature

3. **<u>Minimum</u> of 1x Journal club- supplement with presentation form from general psychiatry; complete journal club assessment sheet**

Date	Journal	Topic	Consultant	Consultant signature

4. **Minimum of 1 seminar – supplement with presentation assessment/feedback form from general psychiatry; complete seminar assessment sheet**

Date	Topic	Consultant	Consultant signature

5. **Minimum of 1 x observed case interview- supplement case presentation form from general psychiatry**

Date	Case number	Diagnoses	Consultant	Consultant signature

6. **Minimum of 1 x academic/grand round case presentation - supplement case presentation form from general psychiatry**

Date	Case number	Diagnoses	Consultant	Consultant signature

7. **Minimum of 1 x observed family session**

Date	Case number	Diagnoses	Consultant	Consultant signature

8. **Minimum of 1x Written case presentation using the Cultural Formulation Interview in the DSM-5**

Date	Case number	Diagnoses	Consultant	Consultant signature

9. **Minimum of 3 x clinical reports completed on patients managed by the registrar**

Date	Case number	Purpose & Recipient of the report	Consultant	Consultant signature

II. Certification of minimum competencies-For details refer to Annexure X

	Core Competencies/EPAs at Specialist level	EPA Level	Consultant signature
1.	Comprehensive history taking and psychiatric assessment		
2.	Integrated summary and biopsychosocial-cultural/spiritual formulation		
3.	Holistic and Comprehensive Acute, Short-and-Long term Management plan		
4	Risk assessment and management plan		
5.	Psychopharmacological prescribing and monitoring skills		
6.	Record keeping and Clinical Governance Skills		

7.	Collaboration, professionalism, leadership and communication skills with staff, patients, families and the public.		
8.	Clinical report writing		

Certification of Completion of Training

I hereby certify that the candidate has met the entrusted professional activities in general adult psychiatry at an overall EPA Level of ……

1. Is only able to observe it being done
2. Requires direct supervision to do it
3. Requires the presence of senior staff at hand – ready access
4. Can be trusted to do it independently – the competent practitioner
5. Good enough to teach/supervise a junior colleague – the specialist

Registrar signature **Supervisor signature**

Date: **Date:**

3.10 **Geriatric Psychiatry**

These guidelines for the geriatric psychiatry module are to be used in conjunction with the Regulations of the FCPsych (SA), and the associated Portfolio of Learning.

Institution & University			
Dates of rotation(s)		**Duration in months**	
Name of Registrar			
Name of Supervisor			

Domain/EPA	Item
Core Knowledge	1. Normal ageing, neurocognitive assessment and clinical management process
	2. Pharmacological management in elderly patients
	3. Relevant South African mental health legislation (including Mental Health Care Act, Criminal Procedure Act, National Health Act, Older Persons Act)
	4. Civil matters & litigation issues of relevance to the geriatric psychiatrist (including psychiatric impairment, informed consent, contractual and testamentary capacity, curatorship & administratorship, power of attorney, driving, firearms, end of life decisions)
	5. Professionalism and ethics (including issues around disclosure, confidentiality, report writing, conflict of interest, dual agency, etc)

Domain	Item
Learning objectives	1. Competence in neurocognitive assessment of elderly patients
	2. Competence in pharmacological management of elderly patients
	3. Satisfactory knowledge of important mental health legislation & its relevance to geriatric psychiatric practice
	4. Satisfactory knowledge of civil matters & litigation issues of relevance to the geriatric psychiatrist (e.g. psychiatric impairment, etc., as above)
	5.Writing of ordinary clinical reports concerning an elderly psychiatric patient
	6. Self-reflection on learning about challenging medico-legal incidents concerning elderly patients

Domain	Item
Skills / core competencies	1. Ability to assess, diagnose, investigate & manage common geriatric psychiatric cases and problems
	2. Ability to perform neurocognitive assessment of an elderly patient
	3. Ability to write an ordinary clinical report on an elderly patient
	4. Ability to self-reflect on a critical learning experience about a challenging medico-legal incident concerning an elderly patient
	5. Ability to write a report on a challenging medico-legal incident concerning an elderly patient

CERTIFICATE OF COMPLETION OF TRAINING
EPA: Geriatric Psychiatry Practice

Institution & University			
Dates of rotation (s)		**Duration in months**	
Name of Registrar			
Name of Supervisor			

I. Clinical activities

These are the **minimum** requirements. Registrars are encouraged to add additional activities / cases.

Item	EPAs	EPA Level	Completed *(Supervisor's initials)*
1. Directly observed case assessment	1.1. Directly observed comprehensive case assessment of an elderly patient with a neurocognitive disorder or any other psychiatric disorder, observed directly by supervisor, to evaluate registrar's ability to: 1.1.1. Take history 1.1.2. Do mental state examination 1.1.3. Do bedside neurocognitive testing 1.1.4. Discuss management plan that includes: 1.1.4.1. Psychiatric & medical comorbidities 1.1.4.2. Pharmacological management, including drug interactions 1.1.4.3. Psychosocial interventions 1.1.4.4. Rehabilitation		
	1.2. Followed within 2-3 weeks by joint reflection on the directly observed case assessment with the same supervisor		
2. Case report	2.1. Written case report (maximum 2 pages) in which the registrar self-reflects on a critical learning experience about a challenging medico-legal incident concerning an elderly patient, e.g., 2.1.1. Psychiatric impairment 2.1.2. Informed consent 2.1.3. Contractual and testamentary capacity 2.1.4. Curatorship & administratorship 2.1.5. Power of attorney / End of life decisions 2.1.6. Driving, firearms		
	2.2. Inclusion of the above written case report in the Portfolio of Learning		
	2.3. Followed within 2-3 weeks by joint reflection on the written case report with the same supervisor		

II. Certification of *minimum* competencies/EPAs

	Competency/EPA	OPAs	Satisfactory *(Supervisor's initials)*
1	Competence in psychiatric and neurocognitive assessment of elderly patients	**History taking Examination Neurocognitive examination Formulate diagnosis**	
2	Competence in pharmacological management of elderly patients	**Initiate treatment plan by applying knowledge of different classes of drugs and appropriate use in the elderely Know and manage adverse side effects, drug-drug interactions**	
3	Knowledge of important mental health legislation & its relevance to geriatric psychiatric practice	**MHCA application in elderly, capacity to consent to voluntary, assisted or involuntary care, informed consent**	
4	Knowledge of civil matters & litigation issues of relevance to the geriatric psychiatrist	**Impairment, contractual and testamentary capacity, know when to initiate curatorship, power of attorney, assess adequately re use of firearms, driving**	
5	Reporting	**Written clinical report**	

		of elderly patient Writing of report on an elderly patient for medicolegal purposes	

I hereby certify that the candidate has met the entrusted professional activities in geriatric psychiatry at an overall EPA Level of ……

1. Is only able to observe it being done
2. Requires direct supervision to do it
3. Requires the presence of senior staff at hand – ready access
4. Can be trusted to do it independently – the competent practitioner
5. Good enough to teach/supervise a junior colleague – the specialist

Registrar signature **Supervisor signature**
Date: **Date:**

3.11 **Neuropsychiatry**

These guidelines for the neuropsychiatry module are to be used in conjunction with the Regulations of the FCPsych (SA), and the associated Portfolio of Learning.

Domain	Item
Core Knowledge	Functional Neuro-Anatomy
	The Neuropsychiatric assessment and clinical management process (including the beside cognitive testing and)
	Civil matters & litigation issues of relevance to the general psychiatrist (including psychiatric impairment, child custody, contractual and testamentary capacity, curatorship & administratorship, malpractice & negligence)
	Professional skills and ethics (including issues around disclosure, confidentiality, report writing, conflict of interest, etc)

Domain	Item
Learning objectives	Satisfactory knowledge of requesting and interpreting special investigations as related to general psychiatric practice (neuroimaging, EEG)
	Satisfactory knowledge of performing bedside cognitive testing as related to general psychiatric practice
	Assessment & management of relevant neuropsychiatric cases (e.g. psychiatric impairment and disability, curatorship, hereditary illnesses, early cognitive impairment etc)
	Ability to work within a neuropsychiatric multi-disciplinary team

Domain	Item
Skills / core competencies	1. Ability to assess, diagnose, investigate & manage common neuropsychiatric cases and problems

CERTIFICATE OF SATISFACTORY ATTAINMENT OF EPA:
Neuropsychiatry Practice

Institution & University			
Dates of rotation (s)		**Duration in months**	
Name of Registrar			
Name of Supervisor			

I. Clinical activities

These are the **minimum** requirements. Registrars are encouraged to add additional activities / cases.

Item/Domain/EPA	Specific activity requirements/OPAs	EPA LEVEL	*(Supervisor's initials)*
1. Case Management	*X 10 Neuropsychiatric cases*		
	work assessment, curatorship, consultation liaision		
	Counselling patient + family: neurocognitive disorder		
	psychopharmacological issues related to neuropsychiatry: sensitivity to SE, drug-interactions, risk benefit issues (e.g. use of antipsychotics in dementia)		
	integration of the results of comprehensive neuropsychological testing		
2. Examination	Supervisor-observed full neurological examination performed x 2		
	Supervisor observed bedside cognitive testing MOCA, IHDS / MMSE. x1 Testing of cognitive domains of memory, language, attention, executive function, praxis, gnosis.		
	Identification of at least one movement disorder supervisor-observed examination technique to investigate for other movement disorders Parkinsonism, dyskinesias, dystonias etc. x 1		
3. Investigations	Neuroimaging - Differentiation between MRI + CT images Describe and identifyneuropsychiatric pathology x3 Interpreting radiologist's report x 3		
	EEG - Ability to refer correctly for EEG + Interpretation of neurologist's EEG report x 1		
4. Scholarly Activity	Journal club (neuropsychiatry article) x 1 (presentation)		
	Seminar / tutorial neuropsychiatric presentation x 1		

II. Certification of *minimum* competencies/EPAs

	Neuropsychiatry OPAs	EPA Level	Supervisor's initials
1	**Conduct neurological Examination** Motor Sensory Cerebellar Higher cortical function		
2	**Interpretation of Investigations** Special laboratory investigations Neuropsychological reports EEGs CT Scans MRIs		
3	**Complete a comprehensive formulation** Dynamic formulation with DSM-5 and ICD 11		
4	**Develop and implement a holistic management plan** Non pharmacological: psychosocial, neurorehabilitation, OT functional assessment and neurorehabilitation Interactional skills with MDT Communication skills with patient and family Manage relevant medicolegal matters		

I hereby certify that the candidate has met the entrusted professional activities in neuropsychiatry at an overall EPA Level of ……

1. Is only able to observe it being done
2. Requires direct supervision to do it
3. Requires the presence of senior staff at hand – ready access
4. Can be trusted to do it independently – the competent practitioner
5. Good enough to teach/supervise a junior colleague – the specialist

Registrar signature **Supervisor signature**
Date: **Date:**

Psychotherapy

- A psychotherapy logbook is necessary to facilitate the standardization of the training of registrars in psychiatry in South Africa and ensure compatibility with international standards and requirements. The aim of the logbook is thus to formalise and regulate the nature and number of psychotherapy sessions undertaken by registrars as well as supervision.
- Training centres will be required to ensure exposure to patients requiring psychotherapy and provide regular individual supervision or group supervision for registrars. If group supervision is undertaken, no more than 3 registrars should comprise a supervision group, and the presenters should regularly alternate. Psychotherapy trainers and supervisors have to be approved for such purposes by the Head of the Department and must be registered psychiatrists or clinical psychologists. The psychotherapy trainers/supervisors should encourage registrars to discuss their individual training needs during the 4-year training period and individual departments are encouraged to take these needs into consideration when planning rotation placements.
- Registrars have the responsibility to ensure that their training needs are met before they enrol for the final examinations.Registrars are expected to be able to identify patients who are suitable for formal psychotherapy, determine the appropriate psychotherapy modality, and successfully conduct psychotherapy: assessment, treatment and termination phases. Registrars are accountable to their heads of department or the postgraduate training co-ordinator to oversee their logbooks. Registrars should concurrently ensure attendance at lectures and tutorials on basic therapeutic skills and psychodynamic, cognitive behavioural and other psychotherapeutic theories and practice over 6 to 12 months, subject to departmental requirements.
- The expectation is that, at the completion of their training, registrars should be competent in supportive psychotherapy, have had adequate practical exposure to cognitive behavioural therapy, and at least a good theoretical knowledge of the psychodynamic therapies.
- The **Declaration** (Section 9) must be signed before submitting the portfolio to the CMSA.

Psychotherapy training requirements:

There are theoretical and practical components to the training.

A. THEORY

The following subjects should be covered:

1. Basic counselling & listening skills

Basic counselling and listening skills – attention, paraphrasing, clarification, reflection, leading a patient, focussing and summarising.

2. Cognitive Behavioural Therapy (CBT)

- Cognitive Behavioural Model of psychopathology
- Principles of cognitive-behavioural therapy
- Assessment and suitability for CBT
- Principles of Dialectical Behaviour Therapy, main modules
- Assessment and suitability for CBT versus DBT
- Process of cognitive-behaviour therapy
- Initiating the process and the assessment interview
- Educating/socialising the patient to CBT
- Case conceptualisation
- Basics, incorporating:
  - ❖ behavioural principles and techniques
  - ❖ cognitive principles and techniques
- How do cognitive behavioural techniques work?
- Planning and content of sessions
- Use of activity scheduling as a tool in therapy
- Identify and elicit automatic thoughts

- Use of dysfunctional thought record as a tool in therapy
- Identify common cognitive errors in thinking
- Use behavioural techniques as a tool in therapy
- Use of graded exposure/short graduated exposure when working with children and adults with specific phobias.
- Use of exposure and response prevention when working with people with OCD.
- Use of interoceptive exposure when working with people with panic disorder.
- Home assignments, targets, monitoring progress
- Behavioural applications
  - ❖ OCD spectrum disorders
  - ❖ Social phobia, panic disorder, GAD
  - ❖ Trauma and stressor related disorders
  - ❖ Depressive disorders
  - ❖ Sexual disorders
  - ❖ Schizophrenia
  - ❖ Eating disorders, primary insomnia, intellectual disability
  - ❖ Somatic symptom and related disorders
  - ❖ Other appropriate applications

3. Psychodynamic Therapies (incorporating basic therapeutic skills)

- The nature of the unconscious
- Basic therapeutic skills such as forming an alliance, ruptures in the alliance, intersubjective space, establishing / maintaining a therapeutic frame.
- Types of psychotherapy (supportive, exploratory, prescriptive)
- Assessment for therapy (history, suitability etc.)
- Psychodynamic formulation
- How does psychodynamic therapy work (clarification, confrontation and interpretation, working through etc)
- Developmental stages
- Defence mechanisms and resistance
- Transference
- Counter-transference
- How to conduct a session and phases of therapy
- Managing difficult situations (e.g. the silent patient, acting out, termination)
- Analysis of psychotherapy transcripts
- Types of focal psychotherapy
  - ❖ Aim, assessment, indications
  - ❖ Motivation and suitability
  - ❖ Malan, Sifneos +/or Davanloo
- Comorbidity and covariance
  - ❖ Medication, working with family and others
  - ❖ Ethical and moral issues and legal issues
- Introduction to object relations
  - ❖ Freud
  - ❖ Klein
  - ❖ Bowlby (attachment)
  - ❖ Winnicott
- Outcomes of psychotherapy
- Stages of grief and grief work

Note:

- Role play may be used to illustrate some of these points with or without video feedback when this is feasible and consented to by the patient.
- Personal experience of dynamic psychotherapy is encouraged, but optional.

- Interactive practical seminars are suggested to reinforce CBT and dynamic principles in action and application.

4. Family Therapy

- Introduction to types
- Genograms
- Relationship patterns and circularity
- Hypothesising (effect of transitions on relationship patterns and present problems)
- Levels of context (myths, scripts, implicative vs contextual force)
- Values, beliefs, perspectives and cultural context of relationships
- Six categories of circular questions
- Sequential discussion (ecology of ideas)

5. Supportive Psychotherapy

- Support vs supportive therapies (aims and indications)
- Types of supportive therapies (dynamic, Rogers and Rockland)
- Indications and appropriateness in the psychiatric context
- Settings
- Constraints (biological, psychological, social)
- Supportive psychotherapy interventions
- Developing self esteem
- Dealing with affect (emotion)
- Reinforce mature defences
- Nurture positive transference
- Reduce symptoms
- Strengthen psychological functioning
- Strengthen adaptive functioning

6. Group Psychotherapy

- Overview: Types of group psychotherapy (Yalom & others)
- Group therapy techniques
- Optional group psychotherapy experience

B. PRACTICAL

NB! CASES: It is a requirement that **all trainees complete a minimum of 3 therapies; 2 short cases (6-8 sessions*)**, and **one long case** (**16-20 sessions*). Supportive psychotherapy and CBT are essential, the third case may come from either the essential or optional list below.**
SUPERVISION: A **minimum of 30 hours** of supervision over the 4 years is required (can include group supervision). Satisfactory completion and write up of all three cases according to the logbook is required.

***In cases where therapy was terminated prematurely, registrars may be credited with cases up to an absolute minimum of 6 sessions for short cases and 15 sessions for long cases, provided the supervisor and/or training committee are satisfied that the registrar has demonstrated sufficient competency.**

Essential (1 case each of):

- **Supportive psychotherap**y (including grief work and trauma counselling)
- **Cognitive behavioural therapy (CBT)**

Optional :

- Psychodynamic psychotherapy (Brief - Focused)
- Group psychotherapy
- Interpersonal psychotherapy
- Cognitive analytic therapy
- Family therapy
- Dialectical behavioural therapy (DBT)
- Narrative therapy
- Other recognised therapies

PSYCHOTHERAPY CORE COMPETENCIES

The graduate psychiatric training worldwide is currently undergoing a major re-conceptualisation and restructuring with the core competency model forming the basis of training and evaluation. In keeping with the latest developments in training and assessment, core competencies have been defined for each of the psychotherapies. Registrars are expected to display competence in these ***minimum skills*** so as to ensure uniformity across training centres, to ensure an objective standard of training and to assist in the objective evaluation of registrars' levels of competence.

MODULE: Psychotherapy

Domain	Item
Core Knowledge	1. Relevant Theoretical and practical knowledge about Psychodynamic Psychotherapy, including suitability for therapy process and formulation/write up
	2. Relevant Theoretical and practical knowledge about CBT including suitability for therapy, process and case formulation
	3. Relevant Theoretical and practical knowledge about Supportive Psychotherapy including suitability for therapy, process and case formulation/write up
	4. Relevant Theoretical and practical knowledge about Group Psychotherapy including suitability for therapy, process and write up
	5.Professional skills and ethics in psychotherapy (including issues around transference, boundaries etc)

Domain	Item
Learning objectives	1. To obtain satisfactory knowledge of all important psychotherapeutic modalities as they pertain to mental health care users.
	2. To gain basic competence in the process of therapy, including appropriateness of modality chosen
	3. Mastering basic competence in supportive psychotherapy and CBT

Domain	Item
Skills / core competencies	1. Ability to assess and formulate cases from a psycho-diagnostic framework and implement appropriately supportive psychotherapy and CBT.
	2. Assessment, management & associated report-writing of psychotherapy cases
	3. assessment and management of special groups e.g. children, the elderly, patients with difficult personalities
	4. Adequate application of relevant ethical, legal and clinical principles required for general psychological management of psychiatric patients.
	5. Ability to conduct clinical psychological risk assessments, e.g. managing suicidal and other self- harm behaviour

BASIC COUNSELLING SKILLS

Competency requires the ability to:

1. Use a wide range of verbal interventions
    - Minimal encouragers
    - Silence
    - Approval and reassurance
    - Provide information
    - Direct guidance
    - Interpretation
    - Confrontation
    - Nonverbal reference
    - Self-disclosure
2. Clarify
    - Closed questions
    - Open questions
3. Paraphrase
    - Restatement
4. Summarise
5. Reflect

SUPPORTIVE PSYCHOTHERAPY

Competency requires the ability to:

- Assess regressive and adaptive shifts in ego functioning
- Make interventions specifically in support of a patient's ego functions, including defensive operations
- Deliberatively take non-interpretive stance in relation to the defensive operations in a patient
- Recognise internal conflict and help a patient contain it without an emphasis in interpretation
- Be directive, give advice, set limits and educate a patient when appropriate
- Make appropriate manipulations of the environment or take action on behalf of the patient

COGNITIVE BEHAVIORAL THERAPY

Competency requires the ability to:

- State the cognitive model
- Socialise the patient into the cognitive model
- Use structured cognitive model activities (mood check, bridging to prior session, agenda setting, homework review, capsule summaries and patient feedback)
- Identify and elicit automatic thoughts
- State and employ knowledge of cognitive triad of depression
- Use dysfunctional thought record as a tool in therapy
- Identify common cognitive errors in thinking
- Use activity scheduling as a tool in therapy
- Use behavioural techniques as a tool in therapy
- Plan booster sessions, follow-up and self-help sessions appropriately with patients when terminating active therapy
- State the structure of DBT and the distinction from CBT

FAMILY THERAPY

Competency requires the ability to:

1. **Understand and apply the following theoretical concepts**
   - The epistemological underpinnings of family therapy
   - Apply the basic principles of family therapy
   - The systemic framework
   - Understand the impact of systems theory on psychotherapy.
   - Understand pathology in the context of family therapy.

2. **Evaluate, understand and formulate a client's problem(s) according to a family therapy model(s)**
   - To demonstrate effective basic therapeutic skills: active listening, empathy as well as use appropriate verbal and non-verbal communication
   - To understand the problem(s) presented in relation to systemic and family therapy principles
   - To show knowledge of a family developmental cycle
   - To correctly identify a nodal point

3. **Apply an appropriate range of family therapy interventions:**
   - To show a varied knowledge and capacity to implement a range of family therapy interventions
   - To have knowledge of and utilize information and intervention from the broader field of psychology as well as schools that have contributed to the knowledge base of family therapy ie strategic therapy, communications, MRI, etc
   - To demonstrate knowledge regarding normative and non-normative families as well as their developmental and social contexts.

PSYCHODYNAMIC PSYCHOTHERAPY

Candidates must have a thorough understanding of important theoretical concepts and be able to:

- Identify assumptions unique to psychodynamic theory
- Explain usefulness of psychodynamic theory in daily practice even when practicing other modules in therapy
- Be familiar with at least 2 theories that make up psychodynamic theory (theory of Freud being one of them)
- Explain the meaning of the psychodynamic worldview of the unconscious
- List at least six aspects that define psychodynamic theory
- Explain the goal of therapy
- Define main phases encountered during the process of Brief Psychodynamic Psychotherapy
- Explain role of defences and name at least 5. Describe how they would present themselves in therapy
- Have a working understanding of biopsychosocial model of psychodynamic formulation
- Explain principles of psychotherapeutic intervention
- List 5 therapeutic interventions and briefly describe what they are
- List at least 2 cautionary rules in implementing psychodynamic therapy
- Be conversant of the major theories and viewpoints in psychiatry; understand the psychological, social, economic, ethnic, family and biological factors that influence development as well as psychiatric illnesses and treatments
- Describe the concept of professional boundaries. Explain need for these. Explain practically how these would be applied in session

- Be aware of and consider ethical and legal principles as applied to therapeutic relationships
- Have an understanding of the impact that their own cognitive, emotional and behavioural characteristics (personal development) can have on their work, and to have the willingness and ability to change, making appropriate use of supervision and feedback
- Evaluate micro-skills during intake interview and other sessions
- Formulate problem psycho-dynamically using bio-psychosocial model, i.e. predisposing, precipitating, maintaining and protective factors incorporating personal (biological, psychological) factors as well as contextual (cultural factors and stressors in early life)
- Identify and explore defence mechanisms utilised
- Identify therapeutic interventions used
- Identify and explore transference and counter-transference experienced in session.
- Explore boundaries set during and outside of sessions. Examine how this was achieved.
- Recognise when it is appropriate to refer patient to psychodynamic psychotherapist

GROUP THERAPY.

Competencies:

- Basic Counselling skills (micro skills)
- Application and maintenance of relevant ethical standards whilst conducting the group
- Theoretical knowledge of and capacity to apply the Principles of Group Therapy, with specific emphasis on Therapeutic factors and Strategies and Techniques
- Ability to appropriately distinguish the differing roles and responsibilities of a Group Leader and Co-Leader
- Exemplify working knowledge of the Stages of Group Therapy
- formulation and implementation of an appropriate Treatment Plan for the Group in accordance with the presenting group pathology
- Demonstration awareness of critical elements of the group process

COMPETENCIES FOR TRAUMA COUNSELLING

- Demonstrate the ability to select appropriate basic counselling skills and techniques in helping clients to work through the crisis experience
- Demonstrate an understanding of the different models and theories of crisis and trauma counselling
- Demonstrate an understanding of a Trauma Counselling Model.

Learning methods to acquire competencies include:

- Theoretical lessons
- Reading
- E-learning
- Supervised clinical practice
- Peer-group supervision
- Supervision sessions
- Observation and modelling
- Role play
- Discussion with other professionals
- Attendance and presentations at conferences
- Participation in skills-training workshops
- Research
- Evidence-based reviews
- Case presentations
- Write up of cases

Methods that can be utilised to assess attainment of defined competencies:

- Direct observation of therapy-sessions by a supervisor
- Video recording of sessions
- Audio recording of sessions
- Discussion during supervision
- Written and oral presentation of case reports
- Peer-review
- Self-assessment
- Training logbooks
- Examination of the long case (transcript + taped session)

NB! The documentation format may be adapted at university level provided all the minimum requirements are fulfilled. The model used at Wits is included in Annexure C for adaptation and/or adoption by training departments.

Psychotherapy Summary of cases and supervision log

Case No.	Hospital	Group/individual supervision	No. of therapy sessions	No. of supervision sessions	Type of therapy	Supervisor name	Supervisor signature

Supervision record

(Psychotherapy supervision log and record to be completed per session)

Case No: ……. Session no. ….…….

Dr…… Supervisor……..

Date: ……

Feedback on tasks of previous session

_____
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Review of therapy session

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Feedback

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Tasks and/or readings for next session

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…… ……

Signature of supervisor Date

Psychotherapy case summary

(One form to be completed per individual patient at conclusion of psychotherapy. Only the summary is required for submission)

- This summary will form the cover sheet for each of the individual case write ups and will include the detailed supervision log notes.
- Patient initials: …….
- Hospital: …….
- Supervisor: …….
- Type of therapy: ……
- No. of sessions: ……..
- No. of supervision sessions: …..……
- Type of supervision: ..……
- Date/period of therapy: ….…….

Summary of history

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Summary of clinical findings

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Case formulation (based on theory of type of psychotherapy chosen)

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- **Signature registrar: ………………………… Date: …………………………………**
- **Signature supervisor: ……………………… Date: ……………………………….**

CERTIFICATION OF SATISFACTORY COMPLETION OF TRAINING

EPA: Psychotherapy

Institution & University	
Name of Registrar	
Name of Supervisor	

(*To be completed by overall supervisor of psychotherapy training*)

	Comments
Attendance at training activities	
Attendance at supervision sessions	
Participation in learning activities	
Satisfactory completion of training in CBT	
Satisfactory completion of training in Psychodynamic psychotherapy	
Satisfactory completion of training in Supportive Psychotherapy	

EPA LEVEL (min. level of 4 required)

1. Is only able to observe it being done
2. Requires direct supervision to do it
3. Requires the presence of senior staff at hand – ready access
4. Can be trusted to do it independently – the competent practitioner
5. Good enough to teach/supervise a junior colleague – the specialist

1. **Clinical/practical activities**

(Case notes to be retained by registrar / department)

Item	**Specific activity requirements**	**Completed** *(Supervisor's initials)*
1. Case write ups	Short case 1	
	Short case 2	
	Long case	

Certification of Completion of Training

Registrar signature **Supervisor signature**

Date: **Date:**

Statement of Completion of training in psychotherapy by Head of Department

- As evident in this logbook, Dr _____ ,for the purposes of the final examination(s) toward the Fellowship of the College of Psychiatrists, has met the psychotherapy training requirements as detailed in the FC Psych II regulations.
- NAME: _____DATE: _____
- SIGNATURE: _____(Head: Department of Psychiatry)
- NAME OF TRAINING INSTITUTION: _____

SECTION 5

RESEARCH COMPONENT

This includes two components: the completion of a research project, as well as general research knowledge and skill.

5.1 **Research project**. The College of Psychiatrists' Regulations for the admission to the Fellowship - FC Psych(SA), states the research project/report requirement to be:

"Research experience as evidenced by a Head of Department, and supervisor approved, at minimum, first draft of the research report – this must comprise data collection and analysis i.e. a results section, with preliminary content related to the introduction/methods/ discussion and conclusion sections. Research may include case series (but not single case reports) as well as systematic reviews that conform to recognized methods of undertaking such reviews."

NB! The HPCSA requires that the research output be examined at university level to be eligible for registration as a specialist.

5.2 **Research knowledge and skill**. In addition to the completion of a research project as described above, there are also other specified research knowledge, skills and competencies required.

Appendix A on the curriculim blueprint for Part I examination: "Research Methodology & Statistics" - Introduction to Psychiatry specifies two topics:

(1) Research methodology: basic epidemiological principles in psychiatry including: measures of morbidity and risk; types of research study and design; types of bias; case definition, identification and measures; sampling; qualitative methods; principles of evidence-based medicine; and

(2) Statistics: types of data; reliability & validity; types of error; bias; probability and risk; incidence and prevalence; descriptive statistics (measures of central tendency and dispersion); basic analytic statistics (tests of significance; confidence intervals; key parametric and non-parametric tests; tests for differences or association); principles of meta-analyses; principles of qualitative analyses

Appendix F on the curriculum blueprint for the Part II examination identifies research as a module/section of the written examination and includes the following subsections: research concepts; principles of epidemiology; research ethics; study design and protocol development; the research process; biostatistics; writing up results; and critical appraisal. The latter – critical appraisal, can e.g. routinely be assessed at routine journal club meetings (See Section 7B below.)

5.3 **Research milestones schedule**

The following is a proposed schedule to assess research progress during the training period

	Semester 1	**Semester 2**
Year 1	Protocol development	Ethics and postgraduate approval
	Outcome: Protocol approval	
Year 2	Data collection	Data analysis
	Outcome: Data analysis completed	
Year 3	Report writing	Report writing
	Outcome: Completed first draft, evidenced by supervisor and HOD	
Year 4	Submission for examination	Examiners' corrections
	Outcome: MMed degree awarded	

Statement of completion of defined research competencies by Head of Department
As evident in this logbook, Dr _____ has met the stipulated requirements in research knowledge and skills. He/she has: -submitted an examined mini-thesis Y/N -a manuscript that has been accepted for publication in a peer-reviewed journal Y/N -published a manuscript in a peer-reviewed journal Y/N
NAME: _____DATE:_____
SIGNATURE: _____ (Head: Department of Psychiatry)
Training Institution

SECTION 6

POST-GRADUATE LECTURES, MEETINGS, WORKSHOPS, SEMINARS, SYMPOSIA, CONGRESSES AND MODULES RELEVANT TO PSYCHIATRY

(Please note that this refers to activities over and above your regular departmental academic programme)

Date	Topic	Presenter	Event	Venue	Outcome

SECTION 7

ASSESSMENTS AND CERTIFICATIONS LIST

Proformas for internal formative assessments to be submitted for Portfolio of Learning audit purposes. Formative feedback to registrars must be given continually to ensure continuous dveleopment.

Documents can be scanned and uploaded onto Logbox or can be submitted electronically by consultants/trainers. It remains the responsibility of the registrar to submit the document or to ensure that the assessing consultant does the electronic submission.

The Portfolio of Learning defines the MINIMUM requirements for training and does not preclude departments from doing additional training according to individual departmental training programmes and resources.

SECTION A (as in section 3 and 4)

Certificates of completion of training for:

SECTION B

Workplace-based assessments (six-monthly):

Workplace-based assessment of clinical interviewing and skills

- Formative assessments are to be conducted throughout the training period. Their focus is to provide feedback to registrars on their progress towards the attainment of desired levels of knowledge and clinical competency.
- Workplace-based assessments include continuous assessment and feedback (formal and/or informal) on registrars' clinical skills and CANMEDS competencies during the performance of their clinical duties.
- Assessments to be categorized according to entrustable professional activities (EPAs) and scored according to the following 5 levels:

    1. Is only able to observe it being done
    2. Requires direct supervision to do it
    3. Requires the presence of senior staff at hand – ready access
    4. Can be trusted to do it independently – the competent practitioner
    5. Good enough to teach/supervise a junior colleague – the specialist

The provided forms are examples of what is required, but Departments may devise their own assessment methods and more formal tools.

Formal assessments (examples)

At least 6-monthly assessment reports

It is recommended that the following assessments be conducted at least once a semester (twice a year) and that registrars are given feedback on their strengths and deficits. Note that these assessments together incorporate clinical and CANMEDS competencies

- Clinical case presentations (Department specific)
- Journal club presentations
- Seminar presentations

A report on community outreach activity should be submitted once.

DEPARTMENT OF PSYCHIATRY
EPA: PRESENT A SCIENTIFIC JOURNAL ARTICLE(format example)

Name of Registrar **…….**

Semester **…….**

Date of assessment: **……**

Name of Hospital/Module **…….**

Criteria	**Feedback Comments**
Ability to present a synopsis of article	
Ability to identify the key findings or message of the article	
Ability to critically discuss the methodology and interpret the results of the study	
Ability to critically apply the article to the local context	
Presentation skills	
Ability to competently respond to questions	
EPA Level Minimum desired level of 4= can prepare and present without supervision	

Name of Assessing Psychiatrist **…….** **Signature……..…**

Guidelines

- A synopsis of the paper is to be presented i.e.
  - Do not read highlighted excerpts off the original
  - Do summarize the main findings of the paper in your own words.
  - Technical details and fine aspects of methodology and statistics must be fully understood by you and a summary presented.
  - You should be able to clearly explain and respond to any questions.
- At the end of your presentation:
  - State your reasons for choosing the paper
  - Give a brief critical analysis of the merits or limitations of the paper: clinical relevance, robustness of the methodology and data analysis; critique the results.
  - State what you have learnt from article / the relevance / value of the contents, especially to psychiatric practice in South Africa.
- Professionalism and Presentation skills to be displayed:
  - Preparedness
  - Organization of information
  - Presentation skills: verbal/non-verbal skills and use of audio-visual aids
  - Comprehension of the content vs. mere reading

EPA: COMPILE & PRESENT A SEMINAR

Name of Registrar …….

Semester …….

Date of assessment: ……

Name of Hospital/Module …….

Name of Assessing Psychiatrist …….

Signature …….

	Assessment Criterioa	**Feedback Comments**
1	**Subject Research** Is there evidence of adequate research into subject? e.g. appropriate references; in-depth knowledge, current, relevant information	
2	**Content** Has the appropriate information been chosen to achieve the objectives of the presentation? Is the registrar able to collate and summarise relevant information or is there 'copy and paste'?	
3	**Audio-Visual** Have aids been used appropriately in the presentation? e.g. quality of slides, pictures, graphs, etc.	
4	**Oral Presentation** Is the presenter able to communicate effectively? e.g. speech; language; audience contact/rapport/interaction; didactic skills	
5	**Understanding of content and command of knowledge in the chosen area** Shows thorough understanding of content, able to critically discuss related issues, able to competently handle questions and provide clear explanations	
6	**Impact** What is the impact of the presentation? e.g. improving knowledge, changing practice, increasing awareness, etc.	
	EPA LEVEL **Minimum desired level of 4= can compile and present without supervision**	

REPORT ON COMMUNITY OUTREACH ACTIVITY (format example)

1.1.1 State the aim of the activity
1.1.2 Describe the target audience
1.1.3 Describe the activity
1.1.4 Describe the response of the target audience to the activity
1.1.5 Reflections on the activity: effectiveness, appropriateness, learning points for future such endeavors

SECTION 8
DECLARATION BY HEAD OF DEPARTMENT

UNIVERSITY LETTERHEAD

Date

COLLEGES OF MEDICINE OF SOUTH AFRICA

TO WHOM IT MAY CONCERN

Dear Madam/Sir,

RE: FC PSYCH II EXAMS, MONTH YEAR – DR …….

This letter serves to confirm that the above mentioned applicant has successfully completed the requirements stipulated in the regulations and has completed a minimum of 36 months of training for entry to the FC Psych II in terms of:

RECORD OF CLINICAL ROTATIONS & EXPERIENCE: *(certificates of completion of training to be submitted)*	**Check if included**
Child & Adolescent Psychiatry *(for a full-time period of not less than 3 months)*	
Community Psychiatry and Public Mental Health *(for a full-time period of not less than 3 months)*	
Consultation-Liaison Psychiatry	
Forensic Psychiatry	
General Adult Psychiatry	
Geriatric Psychiatry	
Neurology / Neuropsychiatry	
ECT *(A minimum of 1 completed patient (ideally 3) should be presented and include assessment of indications for ECT, administration of 6 sessions of ECT, monitoring of response and follow up. The remaining sessions (minimum of 4) can be done on different patients, but should include clinical assessment for, administration of ECT and monitoring of response.)*	
PSYCHOTHERAPY:	
Psychotherapy training record	
Psychotherapy supervision log	
Psychotherapy case summary (x3) ***NB! CASES**: It is a requirement that **all trainees complete a minimum of 3 therapies; 2 short cases (6-8 sessions*)**, and **one long case (16-20 sessions*). Supportive psychotherapy and CBT are essential, the third case may come from either the essential or optional list below.***	

***SUPERVISION**: A **minimum of 30 hours** of supervision over the 4 years is required (can include group supervision). Satisfactory completion and write up of all three cases according to the logbook is required.*	
Certification of completion of psychotherapy training by supervisor	
Statement of completion of training in psychotherapy by Head of Department	
RESEARCH: (Research experience as evidenced by a Head of Department and supervisor approved, at minimum, first draft of the research report)	
Workplace-based assessments:	
Journal club presentations	
Seminar presentations	
Case/Grand Round presentations	
Report on community outreach activity	
Psychiatry specific attendance certificates	
HOD DECLARATION ON COMPLETION OF TRAINING	

A completed Portfolio of Learning and dissertation with supporting documentation has been submitted to the Department for processing and archiving

Yours faithfully,

……..

Prof (Print Name) ……
Head Of Department/Acting Head
Department Of Psychiatry
Date:

SECTION 9
DECLARATION BY CANDIDATE ON COMPLETION OF TRAINING

I, …….hereby do solemnly declare that all information contained in this PORTFOLIO OF LEARNING is a true, complete and accurate record of my professional experience, education and training from ……. to …… representing the period of training for the FC Psych(SA) qualification.

Signature of Candidate:.....
Name of Candidate: .....
Trainee Number: .....
Date:.....
Signature and name of Academic Head of Department: .....

(OPTIONAL; DEPARTMENT SPECIFIC AND TO BE RETAINED BY DEPARTMENT; NOT FOR SUBMISSION TO CMSA)

ANNEXURE A: FORMAT & GUIDELINES FOR CLINICAL CASE MANAGEMENT

1.1 **Organisation, Presentation and Communication Skills**

When presenting a case the candidate must provide a logical narrative of the patient's story that flows from the main complaint. Please note that the headings below serve only as a guide and the order and content are flexible depending on the patient and the nature of the presenting problem. After hearing a case history, examiners should have a good understanding of the patient's presenting complaint, current situation and relevant background developmental, psychiatric, medical, family and social history. The patient's mental state needs to be described in detail including relevant bedside cognitive testing and a physical examination is essential. Candidates must present a well-integrated summary, case formulation, management plan and the patient's prognosis.

1.2 **History**

Mention any difficulties obtaining the history at the beginning of the presentation and comment on the reliability.

1.3 **Demographics**

- Name
- Age
- Language
- Marital Status
- Number of children
- Employment status, if unemployed: disability grant/pension/medical boarding
- Accommodation: location, formal versus informal housing, number of people residing in dwelling
- Religion
- Handedness
- Context of where patient was seen i.e. inpatient versus outpatient
- Route of referral
- MHCA status

1.4 **Presenting Complaint**

History of the presenting symptoms of the current illness episode, use the patient's own words where possible.

History of Presenting Complaint

Include positive and negative findings:

- Onset of symptoms
- Precipitant/s
- Temporal relationship between precipitant/s (eg substance misuse) and symptoms
- Duration of symptoms
- Evolution of symptoms
- Aggravating and relieving factors
- Associated medical and psychiatric symptoms including screen for DSM criteria symptoms of the current provisional diagnoses
- Response to medication and or therapy
- Systematic Enquiry: Screen for other relevant symptom clusters that may suggest the presence of another disorder eg mood, anxiety, psychotic, eating, substance use, cognitive and personality disorders

1.5 **Past Psychiatric History**

- First illness episode
- First contact with primary care physician, psychiatry, psychology, traditional or spiritual healer
- Previous psychiatric diagnoses
- Number and details of previous illness episodes: precipitants, duration, severity of symptoms, response to treatment, duration of remission
- First admission
- Number and details of admissions: MHCA status, duration, treatments
- Last admission
- Previous pharmacological, psychological and social managements and response to treatment. There should be sufficient detail to enable an assessment of the adequacy of the treatment eg. dose, duration, adverse effects, adherence
- Previous ECT –no. of treatments and response/side-effects
- Psychosocial rehabilitation interventions
- Adherence
- Details of previous suicide attempts and deliberate self-harm

1.6 **Past Medical and Surgical History**

- Neurological conditions: head trauma, epilepsy, delirium, CNS infections
- Non-neurological conditions: diabetes, hypertension, thyroid disease, asthma, TB, HIV, syphilis, cardiac disease, renal failure, liver disease
- Gynaecological/obstetric history; contraception; pregnancy status/LMP
- Previous surgeries
- Known allergies
- Past and current treatments: side effects, adherence

1.7 **Past Drug and Alcohol History**

Current substance misuse problems must be explored in detail in the history of the presenting complaint including onset, precipitant/s, amount, effects, features of abuse and dependence, medical and psychiatric complications, attempts to stop, stage of change.

- Cigarettes: onset, duration, amount (pack years), attempts to stop
- Alcohol: onset, precipitant/s, duration, frequency, amount in units, features of problematic pattern of use, medical and psychiatric complications, attempts to stop, duration of remission
- Other drugs: Specify drugs used, onset, precipitant/s, duration, frequency, amount, features of problematic pattern of use, medical and psychiatric complications, attempts to stop, duration of remission
- Caffeine: amount, duration
- Over the counter medications: onset, precipitant/s, duration, frequency, amount, features of problematic pattern of use, medical and psychiatric complications, attempts to stop, duration of remission

1.9 **Forensic History**

- Cautions, charges, convictions for criminal behaviour
- Prison sentences: charge, duration, probation
- Current court cases pending
- Screen for antisocial behaviour

1.10 **Family History**

- Genogram including parents, siblings, spouse/partners and children
- Deaths: note age and cause
- Medical illness
- Mental illness: suspected symptoms, psychiatric diagnoses, suicide, substance misuse, treatments
- Nature of relationships: Refer to quality of attachment with primary caregivers.

1.11 **Personal History**

The depth and focus of the personal history should be guided by the working diagnosis.

Developmental

- Pregnancy: planned vs unplanned, mother's mental state, substance use, intrauterine infections, duration
- Mode of delivery, complications of labour, neonatal complications
- Milestones
- Illness/ physical trauma
- Abuse, neglect
- Parental separation, parental violence
- Enuresis, encopresis
- Traumatic events

Educational

- Age in grade 1
- Type of schooling
- Primary school
- Secondary school
- Tertiary education
- Problems: academic problems (eg. learning difficulties, failures), bullying, separation anxiety, school refusal, truancy, conduct disorder symptoms, ADHD
- Protective factors: friendships, sports, hobbies, enjoyment of school

Occupational

- First job
- Number of and duration spent in subsequent jobs, reasons for leaving
- Most recent job
- Problems: discrimination, fired, mental and physical health hazards, medical boarding, disability grant

Psychosexual and relationships

- Current relationship status: duration, quality, domestic violence
- Previous relationships: number and average duration, patterns or problems, marriage/separation/divorce
- Sexual orientation
- Sexual problems
- Previous sexual trauma
- Number of sexual partners
- Previous STDs
- Contraception
- Number of pregnancies and complications including antepartum and post-partum psychiatric disorders
- Children

Current Social Circumstances

- Accommodation: water, electricity, overcrowding
- Employment
- Functioning: ADLs and IADL
- Support: family, friends, colleagues, religious organisations, hobbies
- Finances

Premorbid personality

- Self-description
- Hobbies and interests
- Religious affiliation/spiritual beliefs/cultural influences
- Coping skills, reaction to stress

2.0 MENTAL STATE EXAMINATION

2.1 Appearance and Behaviour

- Self-care: grooming, hygiene, nutrition
- Dress
- Cooperation, rapport
- Posture and eye contact
- Involuntary/abnormal movements: tremor, tardive dyskinesia, compulsions, stereotypies, mannerisms, tics, choreiform, athetoid, parkinsonian, catatonia, agitation, psychomotor slowing
- Disinhibition
- Responding to hallucinations

2.2 Speech

- Rate, tone, volume, clarity, grammar, syntax, rhythm

2.3 Mood

- Mood: Describe your impression of the patient's pervasive mood state eg. dysphoric, euthymic, expansive, irritable, labile, elevated, euphoria, depression, anhedonia, alexithymia, anxiety, apathy
- Affect:
    - Describe the most enduring affect during interview
    - Range: e.g. Reactive, restrictive, blunted, flat
    - Stability: e.g. Stable/labile
    - Congruency. Appropriate/inappropriate, congruent/incongruent,

2.4 Thought

- Form: Formal thought disorder- neologisms, word salad, circumstantiality, tangentiality, incoherence, perseveration, verbigeration, echolalia, condensation, irrelevant, loosening of association, derailment, flight of ideas, clang association, blocking,
- Content: overvalued ideas, delusions, preoccupations, ruminations, obsessions, phobias, negative thinking, poverty, passivity phenomena, suicidal ideation

2.5 Perception

- Hallucinations: hypnogogic, hypnopompic, auditory, visual, olfactory, gustatory, tactile, somatic, vestibular, coenesthetic
- Illusions
- Depersonalization
- Derealisation

2.6 Cognition

- Level of consciousness
- Orientation
- Attention and concentration
- Memory: Short and long term
- Language: Expressive and naming functions
- Executive function / Instrumental activities of daily living
- Brief bedside tests as appropriate to case eg. frontal lobes (may include inhibitory function, set-shifting, verbal fluency, abstraction and social cognition), parietal lobes (may include gnosis and praxis, acalculia), temporal lobes (may include memory and receptive language), occipital lobes
  (may include visual agnosia, optic apraxia), and sub-cortical function (movement disorder and processing speed).

2.7 Insight and judgement

- Acceptance and understanding of mental illness, cause, effect on life
- Attitude toward treatment
- Attitude toward admission
- Judgment: An assessment as to how the clinical status/diagnosis impacts upon patient's judgment with emphasis on decisions/actions that have safety implications

2.8 **Physical Examination**

A brief focussed physical examination is essential and must be guided by the history and mental state of the patient. Mention important positive and negative findings.

- General: vital signs, weight, hydration, EPSE, thyroid, dentation, stigmata of HIV, signs of liver disease
- Relevant systems examinations including neurological examination.
- Signs of deliberate self-harm (lacerations, scars, ligature marks etc.)
- Signs of alcohol misuse/intoxication/withdrawal
- Signs of drug misuse/intoxication/withdrawal
- Signs of eating disorder
- Signs of medication side effects
- Signs of thyroid disease
- Signs of HIV
- Signs of syphilis
- Comment on BMI/Metabolic syndrome if relevant

2.9 **Summary**

Synthesize a brief (3-4 sentences) summary of:

- Demographics
- Relevant past psychiatric, medical, substance use, forensic, family, personal
- History of presenting complaint
- Relevant mental state, cognitive testing and physical examination findings

3.0 CASE FORMULATION

3.1 **Diagnostic Formulation**

Diagnosis

Provide a DSM-5 differential diagnosis listing most likely (or principal) diagnosis first and providing motivation for each diagnosis and reasons for discounting differential diagnosis in favour of principal diagnosis. (Do not include DSM-5 Cross-Cutting Symptom Measure Scales, Psychosis Symptom Severity or Alternative Model for Personality Disorders.)

Psychosocial and contextual factors

Add any important psychosocial and contextual factors (See DSM-5 Chapter: Other Conditions that may be a Focus of Clinical Attention). Include under diagnosis if it is a focus of clinical attention and a reason for the current admission, special investigations or management.

3.2 **Disability**

Comment briefly on any difficulties the patient may have in any of the following activities:

- Understanding and communicating
- Getting around
- Self-care
- Getting along with people
- Household activities
- School/Work activities
- Participation in society

3.3 **Risk Assessment and Management** (Immediate and long term, include the reasons for your assessment)

- To Self: suicide, deliberate self-harm, neglect, impulsivity, substance misuse, abscond, non-adherence.
- To Others (staff, patients, family, public): violence, homicide, accidental
- By Others
- Property

3.4 **Aetiological Formulation**-(present as a narrative and try to avoid a checklist, include any relevant cultural factors eg., cultural expression of symptoms, cultural perceptions of illness causation, cultural factors that may be impacting on treatment-seeking and treatment)

- Predisposing factors: biological, psychological, social, cultural
- Precipitating factors: biological, psychological, social, cultural
- Perpetuating factors: biological, psychological, social, cultural
- Protective factors: biological, psychological, social, cultural

3.5 **Management and Prognosis**

Begin with a risk management plan and then discuss an evidence-based immediate, medium term and long-term management plan in the local context taking into account cultural and ethical considerations. Include the role of other members of the multidisciplinary team.

The following framework can be used as guide:

	Setting	**Biological Factors**	**Psychological Factors**	**Social Factors**
Immediate	Inpatient versus outpatient MHCA GP, community health clinic, district hospital, tertiary hospital	Investigations (provide motivation): blood, CSF, urine, ECG, EEG, CT, MRI, PET, X-ray Monitoring: vital signs, bloods Rapid tranquilisation Emergency medical management Detox	Screening tools: eg Beck Depression Inventory, Young Mania Rating Scale, Positive and Negative Syndrome Scale, Hamilton Anxiety Scale, Yale-Brown Obsessive Compulsive Scale, International HIV Dementia Scale Psycho-education Supportive counselling Determine stages of change	Collateral history Social services Housing Care of children, dependants
Medium Term	Inpatient versus outpatient MHCA GP, community health clinic, district hospital, tertiary hospital	Appropriate use of: Antidepressants Antipsychotics Mood stabilisers Hypnotics Anxiolytics Complementary and alternative medicines Dietary plan Monitoring	Appropriate use of: CBT DBT Motivational interviewing Bereavement counselling Support groups	Information regarding community resources, support groups Disability/child care grant application Medical boarding
Long term	Inpatient versus outpatient MHCA GP, community health clinic, district hospital, tertiary hospital	Appropriate use of: Antidepressants Antipsychotics Mood stabilisers Hypnotics Anxiolytics Complementary and alternative medicines Dietary plan Monitoring Adherence	Appropriate use of: CBT DBT Couple therapy Family therapy Group therapy Psychodynamic therapy Support groups	Psychosocial rehabilitation Carer support Occupational therapy Community resources

3.6 **Prognosis**

- Short term
- Long term
- Good and poor prognostic factors
- Consider: support, substance misuse, co-morbidity, insight, adherence, physical illness, family and community influences

ANNEXURE B: SUBMISSION BY CANDIDATES WHO HAVE COMPLETED REGISTRAR TRAINING > 36 MONTHS AGO

C M S A

The Colleges of Medicine of South Africa NPC

Nonprofit Company (Reg No.1955/000003/08)
Nonprofit Organisation (Reg. No. 009-874 NPO)
Vat No. 4210273191

27 Rhodes Avenue, PARKTOWN WEST, 2193

Tel: +27 11 726 7037; Fax: +27 11 726 4036

Website: www.cmsa.co.za
General: Academic.Registrar@cmsa.co.za

JOHANNESBURG OFFICE
EXAMINATIONS & CREDENTIALS

Notice to candidates registering for FCPSYCH Part II after 4 year training has ended

Dear Candidate

Should you be attempting the final FC Psych examination after having completed your four years' of registrar training and are currently outside of an academic post , please take note of the following:

1. You are required to have remained active on the academic and clinical platforms linked to your university.
2. As per the College of Psychiatrists' Fellowship Regulations, should you be attempting this examination more than 3 years after the completion of your formal registrar training, kindly ask your Head of Department to complete the attached motivation.
3. The HOD motivation, together with a **detailed schedule** of your academic involvement since completion of your formal registrar training period, must be submitted to the College of Psychiatrists Council via the CMSA Academic Registrar at least 3 months prior to the examination registration deadline for consideration.
4. Please check that 6 years have not lapsed since passing the FC Psych Part I and that you have complied fully with the portfolio checklist.

President
Prof S Ramlall
September 2021

Motivation to the CMSA to be completed by HoD for candidates outside of an academic training post applying to write the FC Psych Part II examination

Dear HOD,

Please complete this motivation in any instance when a candidate who completed registrar training and left the academic circuit ≥ 3 years ago wishes to apply to write the FC Psych Part II exam.

Name of candidate: _____

University: _____

Completed Part I or MMed primary exams on the following date:_____

Time since completion: _____

(Regulations: Part II must be passed within six years of passing Part I. The Part I is, therefore, valid for six (6) years.)

Exited registrar post on the following date: _____

Time since completing registrar training: _____

*(Regulations: In addition, Part II must be passed within 36 months of **completing** registrar training time (defined as 48 months). The latter requirement will come into effect as of **1 January 2020**.)*

Motivation to allow candidate to sit the Part II examination (provide details of regular and continual participation in all academic and clinical activities since completing registrar training).

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(Regulations effected 1 January 2020: In exceptional circumstances, candidates who do not successfully complete the Part II examination within this period may motivate on the basis of continued active involvement in their department's academic programme, and with support from their HOD, to the College of Psychiatrists for a once off extension to sit the examination <u>once only</u>. If a candidate passes the written component of the Part II examination, but fails the clinical/OSCE/OSPE/practical component, they will be permitted to redo the clinical/OSCE/OSPE/practical component only at the next set of examinations without having to rewrite the written component.)

Please inform the candidate to submit supporting documentation of involvement in the department's academic programme, as well as in supervised clinical activities as detailed in the Portfolio of Learning, from the date of exit of the registrar post. The full POL must also be attached as a single pdf document.

_____ _____

Head of Department Date

APPENDIX C
Wits Psychotherapy Training Documents