



RACGP | Rural

The Fellowship in Advanced Rural General Practice (FARGP)

Advanced Rural Skills Training – Curriculum for Mental Health



The Fellowship in Advanced Rural General Practice Advanced Rural Skills Training Curriculum for Mental Health

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Published by:

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Published March 2015

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Acknowledgements

The RACGP Council endorsed this Fellowship in Advanced Rural General Practice Advanced Rural Skills Training Curriculum for Mental Health on 11 March 2015. The RACGP Rural Board would like to thank the many people who provided advice and feedback during the development of this curriculum. In particular, the Board would like to thank Clinical Lead, the late Dr Sharonne Lang, who sadly passed away on 5 March 2015. We also extend our thanks to the RACGP Rural Education Committee and the RACGP staff who have led the efforts to update this curriculum.

The Board is also grateful for the contributions of The Royal Australian and New Zealand College of Psychiatrists and The Australian Psychological Society.

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Introduction

The Fellowship in Advanced Rural General Practice (FARGP) is a qualification awarded by the Royal Australian College of General Practitioners (RACGP) in addition to the vocational Fellowship (FRACGP). The FARGP has distinct pathways for general practice registrars and practising GPs.

The FARGP requirements are:

- completion of the FARGP learning plan and reflection activity
- 12 months in a rural general practice setting
- 12 months of Advanced Rural Skills Training (ARST) in an accredited training post
- completion of the FARGP emergency medicine activities, including satisfactory completion of two advanced emergency skills courses.

In addition to the above, the FARGP community-focused project is an optional activity which provides a valuable opportunity to get to know the community and improve health outcomes.

A core component of the FARGP is the completion of 12 months of Advanced Rural Skills Training (ARST) in an accredited training post. This is designed to augment core general practice training by providing an opportunity for GPs looking to build, refresh or develop more specialised and/or a broader range of skills and knowledge to meet the needs of rural and remote communities.

For more information on the FARGP or advanced rural skills training, visit the website (www.racgp.org.au/education/fellowship/ruraladvantage), email fargp@racgp.org.au or call the RACGP Rural on 1800 636 764.

This curriculum for mental health builds on the strengths of the RACGP's previous Mental Health Advanced Rural Skills Curriculum Statement 2009, outlining a range of knowledge and skills that are valuable in helping GPs to safely and competently provide mental health care in a rural or remote context.

This curriculum offers a different format to the 2009 version by focusing more on competency-based training. It incorporates identified contemporary competencies that complement the GP's traditional skillset, as well as updated information and learning outcomes derived from current general practice evidence and new RACGP initiatives and policies, such as the General Practice Mental Health Standards Collaboration's *Mental health education standards 2014–2016: A handbook for GPs*.

Aim

Mental health can consume a large part of GPs' working hours. With the ever-increasing demands on public mental health facilities and scarcity of specialist psychiatrists in rural Australia,¹ there is a growing need for GPs to have greater skills in the area.

The aim of this curriculum is to provide a framework for the teaching and learning of knowledge, skills and attitudes GPs require to effectively care for patients with a range of mental health issues in environments where face-to-face support from other professionals is often limited.

Rationale

Skill requirements fluctuate throughout a GP's career as they respond to changing community needs, address specific disease or population burdens, ensure practice viability and/or adapt to changes in government policy and environment (such as rural hospital closures).² GPs may have a particular area of interest, a specific service gap in their community, or seek to broaden their generalist skillset through the acquisition of advanced skills. Undertaking ARST enables GPs to extend their expertise in a particular area and/or expand their generalist skillset, and enhance their capability to provide secondary-level care to their community.

Mental health conditions have a significant impact on rural and remote communities, which face unique challenges in accessing mental health specialists (psychiatrists, psychologists, allied health practitioners, psychiatric nurses, etc.). Recent RACGP Rural-led research found the demand for, and use of, advanced mental health skills in rural and remote communities is significant.²

GPs play a crucial role in the provision of mental health services for all Australians. They are exposed to a range of acute and chronic mental health presentations and can be responsible for diagnosis, treatment and ongoing management of care.

In a rural or remote context, GPs may be the only available healthcare workforce, providing the front-line services for mental health issues³ in an environment where specialist support is not immediately available.⁴

It is therefore vital that rural GPs have access to the training and support necessary to meet patient needs in this complex and challenging context. By undertaking ARST in mental health, practising rural GPs and general practice registrars can build their capacity to address these rural challenges, providing high-quality mental health care to their community.

Prerequisites

The FARGP ARST for mental health candidate must:

- have completed at least 12 months of full-time experience in a rural general practice setting before the commencement of this ARST
- be willing to work as part of a team that includes families of patients with mental health issues and allied health professionals in the mental health field
- have satisfied the core curriculum requirements in mental health (refer to *Learning outcomes* section).

Duration, setting and supervision

The requirements for this ARST curriculum must be completed in 12 months (full-time equivalent) in an accredited training post, in accordance with the vocational standards and requirements published by the RACGP.

The ARST post must be in an accredited mental health facility (usually attached to a hospital) in a metropolitan, regional or rural setting. The training post will be under the supervision of a rural GP supervisor/mentor, medical educator and a clinical psychiatrist who is a Fellow of the Royal Australian and New Zealand College of Psychiatrists.

The clinical psychiatrist provides the candidate with a source of clinical expertise, advice and educational support. The rural GP supervisor/mentor is a source of advice on training in the broader context of rural general practice, as well as a professional role model and mentor. The medical educator provides a link back to the regional training organisation (RTO) to inform the candidate about educational activities and overall training requirements.

Practising GPs

The RACGP recognises that doctors who have spent significant time in general practice will already have achieved some of the learning outcomes listed in this curriculum and should therefore be eligible for recognition of prior learning (RPL). A period of three years after FRACGP (full-time equivalent) will qualify a candidate to apply for RPL.

The duration of attachment is 6 months (full-time equivalent). A part-time attachment to a mental health facility would be acceptable for GPs working in rural or remote practice full-time.

The application for RPL should detail how the candidate has achieved these outcomes with, where possible, documentary support. Appropriate documentation could include a letter from a mental health carer or consumer organisation confirming participation, photocopy of de-identified clinical notes demonstrating involvement with an adult guardian, child protection organisation, etc. The outcomes must have been achieved in the past 10 years.

RPL can be applied for the following learning outcomes:

- develop a comprehensive professional referral network (1.2.3)
- collaborate with mental health consumer organisation (3.2.1)
- collaborate with carer organisations (3.2.2)
- describe the differing mental health resources in rural and remote areas (3.2.4)
- increase community awareness of mental health issues as a means of reducing the associated stigma and discrimination (3.3.3)
- manage patient confidentiality (4.1.2)
- define and describe the use of power of attorney and advanced health directives (5.1.2)
- outline the steps required to apply for guardianship (5.1.3)
- outline relevant reporting responsibilities for child protection, domestic violence and substance abuse in your state (5.1.4).

The continuity of care requirement is not applicable to these candidates.

Learning outcomes

These learning outcomes are grouped according to the Five Domains of General Practice.

The terms in italics are defined in the *Range statements* section.

1. Communication skills and the patient–doctor relationship	
Outcome	Performance criteria
1.1 Effective and appropriate communication skills are demonstrated with mental health patients, family members and carers.	<p>1.1.1 Demonstrate focused, flexible and appropriate communication with patients with a mental health issue.</p> <p>1.1.2 Modify communication with mental health patients from culturally and linguistically diverse communities.</p> <p>1.1.3 Modify communication with mental health patients from Aboriginal and Torres Strait Islander backgrounds.</p>
1.2 High-quality holistic healthcare is delivered to people with a mental health issue.	<p>1.2.1 Work as part of a multidisciplinary team to offer safe mental health care to patients with a mental health issue.</p> <p>1.2.2 Manage a complex mental health issue as part of a multidisciplinary team.</p> <p>1.2.3 Develop a comprehensive professional referral network.</p>
2. Applied professional knowledge and skills	
Outcome	Performance criteria
2.1 Take a comprehensive psychiatric history and perform a mental state examination.	<p>2.1.1 Develop rapport with the patient, even in challenging circumstances.</p> <p>2.1.2 Adapt an interviewing technique that encourages the patient to talk and focuses on their strengths.</p> <p>2.1.3 Take accurate and comprehensive patient records and complete relevant documentation as appropriate to the situation.</p> <p>2.1.4 Identify comorbid clinical presentations.</p> <p>2.1.5 Assess associated risk factors.</p> <p>2.1.6 Use the correct phenomenology for mental state examination.</p> <p>2.1.7 Use patient rating scales/outcome tools.</p> <p>2.1.8 Make a diagnosis or give a formulation using a bio-psycho-social model.</p>
2.2 A number of psychological therapies are used appropriately.	<p>2.2.1 Assess the patient and situation as appropriate for cognitive behavioural therapy (CBT).</p> <p>2.2.2 Use CBT appropriately.</p> <p>2.2.3 Describe the benefits of a range of different evidence-based therapies.</p>
2.3 A number of management techniques in relation to the patient with a mental health issue are developed.	<p>2.3.1 Use a recovery-oriented model of care.</p> <p>2.3.2 Employ pharmacotherapy for the full spectrum of mental health issues.</p> <p>2.3.3 Manage psychiatric emergencies.</p> <p>2.3.4 Apply the principles of drug withdrawal and detoxification.</p> <p>2.3.5 Make a plan for relapse prevention and crisis intervention.</p> <p>2.3.6 Demonstrate continuity of care for the long-term health of the patient.</p> <p>2.3.7 Outline the criteria for transfer and safe evacuation of psychiatric patients.</p>

3. Population health and the context of general practice	
Outcome	Performance criteria
3.1 People with a mental health issue who live in rural and remote areas receive appropriate and timely care.	<p>3.1.1 Work effectively with people with <i>mental illness</i> within the current social, cultural and economic influences.</p> <p>3.1.2 Assess and critically analyse the effects of <i>stigma</i> and <i>discrimination</i>, and the impacts these have on an individual, family, and carer.</p> <p>3.1.3 Describe the <i>suicide risk factors</i> in rural areas.</p> <p>3.1.4 Formulate a plan to manage suicide risk.</p>
3.2 Health information is disseminated through relevant networks and organisations.	<p>3.2.1 Collaborate with <i>mental health consumer organisation</i>.</p> <p>3.2.2 Collaborate with <i>carer organisations</i>.</p> <p>3.2.3 Collaborate with non-government organisations that work in the area of mental health.</p> <p>3.2.4 Describe the differing mental health resources in rural and remote areas.</p> <p>3.2.5 Provide ongoing professional development sessions to other rural health professionals, staff, consumers and members of the community.</p>
3.3 Health service provision, policies and activities are initiated and undertaken.	<p>3.3.1 Use relevant guidelines and, where needed, develop new guidelines for health service provision in rural and remote areas that may be missing or in need of reform.</p> <p>3.3.2 Involve consumers and consumer groups, carers and carer groups in developments and initiatives in health service provision.</p> <p>3.3.3 Increase community awareness of mental health issues as a means of reducing the associated stigma and discrimination.</p>

4. Professional and ethical role	
Outcome	Performance criteria
4.1 Ethical practice and behaviour relevant to mental health are applied.	<p>4.1.1 Manage <i>boundaries</i> with patients who are friends, relatives, colleagues or acquaintances.</p> <p>4.1.2 Manage patient confidentiality.</p> <p>4.1.3 Manage <i>personal and family boundaries</i> in the community.</p> <p>4.1.4 Describe how to manage boundary issues related to personal and sexual relationships with current or previous patients.</p>
4.2 Appropriate self-care and reflection is practised.	<p>4.2.1 Identify strategies for establishing, maintaining and improving self-awareness when interacting with patients with a mental health issue.</p> <p>4.2.2 List and discuss <i>self-care strategies</i> that protect and minimise potential personal impacts associated with high levels of disadvantage that occur in a mental health setting.</p>
4.3 Mental health-related professional development is undertaken.	<p>4.3.1 Identify and address professional development needs.</p> <p>4.3.2 Participate in professional development.</p> <p>4.3.3 Interact <i>ethically</i> with external providers.</p> <p>4.3.4 Practice critical self-reflection.</p>

5. Organisational and legal dimensions

Outcome	Performance criteria
<p>5.1 Legal and legislative requirements for mental health are accessed and applied.</p>	<p>5.1.1 Use the relevant Mental Health Act when appropriate.</p> <p>5.1.2 Define and describe the use of power of attorney and advanced health directives.</p> <p>5.1.3 Outline the steps required to apply for guardianship.</p> <p>5.1.4 Outline relevant reporting responsibilities for child protection, domestic violence and substance abuse in your state.</p> <p>5.1.5 Demonstrate <i>professionally acceptable standards</i> of documentation and report writing in the care of psychiatric patients.</p> <p>5.1.6 Outline the protocols for <i>media involvement</i> in a crisis situation.</p>
<p>5.2 Mental health networks are established and supported.</p>	<p>5.2.1 Establish a professional mental health network.</p> <p>5.2.2 Access the metropolitan mental health services for clinical, academic, research, literature, hotline and legal services.</p> <p>5.2.3 Develop and use <i>resources and processes</i> to ensure continuity of care for patients with chronic mental health issues.</p> <p>5.2.4 Outline the range of support services for the carers of people with a mental health issue.</p>

Range statements

These definitions are grouped according to the Five Domains of General Practice.

Communication skills and the patient–doctor relationship

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

Culturally and linguistic diverse communities – can include refugees, visa holders, migrants, people from English and non-English speaking backgrounds, and people with diverse cultural and religious beliefs and practises that include unfamiliar/unconventional/challenging medical beliefs and practises regarding the roles of children, women, men and others in the community (eg. doctors and case managers).⁵ People who are intellectually or hearing impaired should also to be considered.

Aboriginal and Torres Strait Islander peoples – includes people who identify as Aboriginal and/or Torres Strait islander.⁶

Multidisciplinary team – can include GPs, allied health professionals and other medical specialists (occupational therapists, psychologists, psychiatric nurses, social workers, etc.), as well as case managers and cultural advisors.⁵

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

Applied professional knowledge and skills

Challenging circumstances – can make demands on one's abilities, endurance, patience and tolerance. Such patient behaviours could include anger, aggression, mania, violence, agitation and psychosis.

Comorbidity – has implications for aetiology, diagnosis, management and prognosis of mental health conditions. Psychiatric disorders are commonly associated with drug and alcohol problems,⁷ as well as physical health comorbidities (eg. metabolic syndrome).

Risk factors – can include suicide attempts, self-harm, self-neglect, non-compliance, substance misuse, side-effect development, relapse or violence.⁸

Phenomenology – is taken by many authors to be the description of patients' medical signs and symptoms.⁹ Phenomenology in psychiatry means a descriptive account of signs and symptoms that are empirical (opposed to speculative) and detailed (with emphasis on idiosyncratic features of a particular patient).

Bio-psycho-social formulation – factors to consider include biological (disease, physiology); psychological (cognition, behaviour, mood); social (interpersonal, social and occupational, healthcare system, cultural); and presenting, predisposing, precipitating, perpetuating and protective factors. Management of mental health patients is often guided by case formulation as much as diagnosis.⁸

Cognitive behavioural therapy – should include psycho-education, motivational interviewing, behaviour modification, cognitive interventions, cognitive analysis with thought-challenging and cognitive restructuring, relaxation strategies and skills training, eg. problem solving, stress management, etc.¹⁰

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

Recovery-based models of care¹¹ – recovery-oriented mental health practice refers to the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing, and to define their goals, wishes and aspirations.

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

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

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

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

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

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

Emergencies – can include all age groups.

Principles of drug withdrawal and detoxification – can involve medication to minimise drug and/or alcohol withdrawal symptoms, hospital admission, antidepressants, antipsychotics, other drug treatments (eg. naltrexone and methadone), social skill training, group therapy, family therapy, and services for the homeless and employment.⁸

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

Population health and the context of general practice

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

Stigma – can be defined as constituting a label that separates the person from others, the linking of the labelled person to undesirable characteristics, and the rejection and avoidance of the stigmatised person by others.⁸

Discrimination – making a difference in particular cases, as in favour of or against a person or thing.⁹ The person with mental health issue is often discriminated against purely because of the diagnosis.

Suicidal risk factors in rural and remote areas – are well documented in all significant psychiatric textbooks, but these often neglect the easy availability of firearms in rural and remote areas. This risk factor needs to be managed as along with all other suicide risk factors.

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

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

Professional and ethical role

Boundaries – the relationship between a doctor and a patient for the purposes of providing and obtaining treatment is commonly referred to as a doctor–patient relationship. This relationship has boundaries around it and within it. Sexual and non-sexual boundary violations are among the issues that most frequently occur within psychiatry.¹² Doctors should never exploit patients for any sexual advantage, financial gain, or other private purpose.¹³

Personal and family boundaries – can include personal boundaries around disclosing personal information, socialising and forming relationships; family boundaries around disclosing confidential work-related information, protecting family against unwanted attention from patients; and professional boundaries around treating friends and family members.⁵

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

Ethically – core ethical principles include autonomy of the patient; non-maleficence, which is the doctor's duty to avoid inflicting physical or emotional harm on the patient; beneficence, which is to prevent or remove harm and promote wellbeing; and justice, which does not operate in a vacuum, but responds to the ever-changing social, political, religious and legal mores of the moment.¹³

Organisational and legal dimensions

Professionally acceptable standards – medical records are not used by doctors alone, but also by regulatory agencies, by court-ordered subpoena, in malpractice litigation and by patients under the *Freedom of Information Act 1982*. This right of the patient to view their records represents society's belief that the responsibility for medical care has become a collaborative process between doctors and patients.¹³

Media involvement – doctors may comment on mental health generally, but may not offer opinions about patients or a person that is not their patient.¹³

Resources and processes – can include written and recorded notes, copies of referrals, involvement of parents and carers, use of the relevant mental health act where appropriate, screening and recall procedures.⁵

Assessment

General practice registrars

Summative assessment comprises a logbook, a statement by the supervising psychiatrist and an essay on ethics.

Logbook

Each candidate will be supplied with a logbook at the commencement of their attachment. The logbook will need to be with the candidate every day.

Section A

These activities must be recorded in the logbook and signed off by the candidate's clinical supervisor:

- Observation of five psychiatric interviews by a psychiatrist. This must encompass a range of mental health diagnoses, all of which should be recorded in the logbook.
- Performance of five psychiatric interviews with mental state examination and formulation in the presence of a psychiatrist. This must encompass a range of mental health diagnoses, all of which should be recorded in the logbook.
- Participation in a recognised CBT course.
- Undertaking of CBT of appropriate patients under supervision of a cognitive behavioural therapist.
- Weekly supervision meeting with a psychiatrist.
- Monthly supervision meeting with GP mentor/medical educator.
- Attendance at a carer organisation meeting.
- Attendance at a mental health consumer organisation meeting.

Section B

These activities must be recorded in the logbook:

- all patients seen, including:
 - date
 - age
 - gender
 - diagnosis
 - management of comorbid conditions
 - use of a multidisciplinary team.
- ten patients that have been seen regularly for nine or more months.

The logbook should be available to the candidate's medical educator and supervising psychiatrist for review during the ARST attachment.

The logbook will be reviewed by the rural censor at the completion of the attachment.

Statement by supervising psychiatrist

On completion of the attachment, the supervising psychiatrist must sign a document stating the candidate has met all curriculum requirements.

Essay

Candidates must write an essay on ethics as it pertains to psychiatry, including examples from the candidate's time in the attachment. The essay will be reviewed by the rural censor.

Practising GPs

Summative assessment comprises a logbook, a statement by the supervising psychiatrist and an essay on ethics.

Logbook

Each candidate will be supplied with a logbook at the commencement of their attachment. The logbook will need to be with the candidate every day.

Section A

These activities must be recorded in the log book and signed off by the candidate's clinical supervisor:

- Observation of five psychiatric interviews by a psychiatrist. This must encompass a range of mental health diagnoses, all of which should be recorded in the logbook.
- Performance of five psychiatric interviews with mental state examination and formulation in front of a psychiatrist. This must encompass a range of mental health diagnoses, all of which should be recorded in the logbook.
- Participation in a recognised CBT course.
- Undertaking CBT of appropriate patients under supervision of a cognitive behavioural therapist.
- Supervision of meetings with a psychiatrist to be kept in the context of how intensively the candidate undertakes the attachment (full-time or part-time).
- Monthly supervision with a GP mentor is recommended, but not a requirement.

Section B

This activity must be recorded in the logbook:

- all patients seen, including:
 - date
 - age
 - gender
 - diagnosis
 - management of comorbid conditions
 - use of a multidisciplinary team.

The logbook should be available to the candidate's medical educator and supervising psychiatrist for review during the ARST attachment.

The logbook will be reviewed by the rural censor at the completion of the attachment.

Statement by supervising psychiatrist

On completion of the attachment, the supervising psychiatrist must sign a document stating the candidate has met all curriculum requirements.

Essay

Write an essay on ethics as it pertains to psychiatry, including examples from the candidate's time in the attachment. The essay will be reviewed by the rural censor.

Recommended resources

- Therapeutic guidelines: Psychotropic version 7. Melbourne: Therapeutic Guidelines Limited; 2013.
Treatment Protocol Project. Management of mental disorders. Sydney: Treatment Protocol Project; 2004.
- Treatment Protocol Project. Acute inpatient psychiatric care: A source book. Sydney: Treatment Protocol Project; 1999.
- American Psychiatric Association: Diagnostic and statistical manual of mental disorders. Fifth edition. Arlington: American Psychiatric Association; 2013.
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