

# Higher Specialist Training Handbook

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# Foreword

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Although this is the eighth edition of the *Higher Training Handbook*, it is the first edition produced by the newly constituted Higher Specialist Training Committee; the previous seven editions having been issued under the name of the Joint Committee on Higher Psychiatric Training. This edition brings together the requirements for approval of schemes with the criteria for award of certificates of completion of specialist training, as agreed with the Specialist Training Authority. It also outlines the type of training for which *ad hominem* approval may be sought, explains how assessment procedures should function and recommends how training schemes should be organised. Finally, brief details are given on the application procedure for award of a certificate of completion of specialist training.

The *Handbook* is not intended to cover every aspect of training. If a specialist advisory subcommittee considers that a particular topic needs to be addressed, it produces an advisory paper on the subject. A list of those available currently is given at the end of the *Handbook*.

The provision of health care and medical training is undergoing considerable change at the present time and the *Handbook* requires almost constant amendment. Between editions amendments are published in the *Psychiatric Bulletin* of the Royal College of Psychiatrists.

## Acknowledgements

The preparation of this edition of the *Handbook* was undertaken by Dr Barbara Ballinger, who was honorary secretary from July 1994 until December 1997. She drafted new sections and reviewed and updated elements from the previous edition. Her work on the *Handbook*, and her major contribution to the work of the Committee, are deeply appreciated.

Thanks are also due to Suzanna Gray who coordinated preparation of the *Handbook*.

# Introduction

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Since the last edition of the *Handbook* was published in 1995 there have been major changes in the structure of specialist training in the UK to bring it into line with European Union medical directives. In July 1992 the government established a working party under the chairmanship of the Chief Medical Officer, which included several presidents of Royal Medical Colleges. In line with the recommendations of this group's Calman Report, the European Specialist Medical Qualifications Order 1995 was enacted, which brought into existence the Specialist Training Authority (STA) and the award of certificates of completion of specialist training (CCSTs) as the single means of indicating completion of specialist training. Since 1 January 1997 it has been mandatory for all appointees to National Health Service (NHS) consultant posts to possess a CCST and since that date the College had made numerous recommendations for the award of a CCST.

As a result of the implementation of the European Specialist Medical Qualifications Order 1995 the *Handbook* has been amended to reflect the dual role of the Higher Specialist Training Committee (HSTC) of the Royal College of Psychiatrists, both as the body which sets the standard for training schemes, but also as the body which sets the standard (under the aegis of the STA) for the award of CCSTs.

## **HSTC of the Royal College of Psychiatrists**

The Royal College of Psychiatrists and the Association of University Teachers of Psychiatry (AUTP) agreed at the end of 1997 that the Joint Committee on Higher Psychiatric Training should become a College committee to be known as the HSTC, reporting to the Court of Electors. Its remit remains similar to that of its predecessor, being:

1. To identify the criteria for award of CCSTs.
2. To establish a series of specialist advisory sub-committees (SACs), reporting to it.
3. To advise the subdean (CCSTs) on individual CCST applications.
4. To assess the quality of higher specialist training in psychiatry through the visiting programmes of the SACs.
5. To address manpower issues in conjunction with the deputy registrar for manpower.

At the end of the term of office of the current chairman the chair will thereafter be taken by the dean or his/her nominee. When the HSTC is not chaired by the dean, s/he will be vice-chairman. For the duration of the current chairman's term of office there will be an honorary secretary although this will be reviewed on completion of his term of office.

The membership of the HSTC comprises: two nominees from the College (one nominated by the Court of Electors and one by the University Psychiatry Committee), two from the AOTP, one from the Collegiate Trainees Committee (CTC), one from the Irish Psychiatric Training Committee (IPTC), the five SAC chairmen, four College officers/deputies as *ex officio* members and an observer from the Committee of Postgraduate Medical Deans. All nominations are endorsed by the Court of Electors. The duration of membership, on both the HSTC and its sub-committees, is six years.

There are five SACs covering the following areas: general and old age psychiatry (GOAPSAC), child and adolescent psychiatry (CAPSAC), the psychiatry of learning disability (PLDSAC), forensic psychiatry (FPSAC) and psychotherapy (PTSAC). The membership of each SAC comprises: four nominees from the relevant College faculty, one AOTP nominee, one nominee of the University Psychiatry Committee, one CTC nominee, one from the IPTC (if required) and three co-opted members. GOAPSAC's membership is somewhat different to reflect the range of specialities and sub-specialities covered by the work of the Committee. All nominations to the SACs must be endorsed by the HSTC.

The remit of the SACs is:

1. To assess higher specialist training schemes and to make recommendations thereon to the HSTC.
2. To consider applications for approval of new training placements and trainers.
3. To advise the HSTC on policy matters and give guidance to training programme directors and trainees.

# 1. General information

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## **Aims of higher training**

The principal aim of higher training is to provide a doctor, who has completed basic specialist training and obtained the MRCPsych qualification, with an educational programme which will fit him/her for the independent practice of psychiatry, whether as a consultant in the NHS or as a senior member of an academic department.

The training needs of specialist registrars (SpRs) will differ depending on the type of consultant post to which they aspire. However, all need the opportunity to engage in clinical practice of sufficient diversity and seniority that clinical skills can be developed to the point where proficient independent practice can be achieved and all need to continue with academic pursuits, including participation in original research. All higher trainees need experience in management, teaching, participation in multi-disciplinary teams and they require supervision and guidance to fashion a training programme fitting them for their future career.

The achievement of these aims requires that training occurs in well-organised local schemes which offer a variety of training placements under the supervision of a skilled and interested trainer. During higher training the SpR develops and deepens diagnostic, therapeutic and management skills and moves to increasingly independent practice so that he/she is able to assume a consultant role.

The range of placements in a training scheme should reflect the range of posts available to consultant psychiatrists in the NHS, which may change from time to time. This requires an excess of training placements compared with salary holders so that trainees can be allocated where individual training needs are best served. This is more easily achieved in larger schemes serving a substantial population rather than those based on a hospital or medical school.

The exposure to wide clinical experience, to academic and research work and participation in teaching, management and audit should enable trainees to undertake professional practice informed by a scientific, objective spirit which will enable them to evaluate developments in the speciality throughout their professional lives. They should develop the habit of self-directed learning which will motivate a ready participation in continuing professional development.

## **Higher training scheme**

### *(a) Organisation*

Each deanery should have one or more specialist registrar training committee(s), usually a separate body from the committee overseeing basic specialist training. The pattern will vary between deaneries. While it may sometimes be the case that a deanery has a single committee, it is often better to have separate committees

for the major specialities. Some deaneries may even have a separate committee for each speciality. However, the overriding consideration should be that each scheme relates to a training committee. The postgraduate dean or a designated representative has right of attendance at all training committees.

Membership of training committees should include a chairman (not necessarily a training programme director), organiser(s) of the scheme(s) relating to the committee, a representative of the academic department(s), some consultant trainers and at least one trainee representative. The College's regional adviser will generally attend training committees covering the major specialities. It is desirable that training committees have the services of a professional secretary. Committees should meet at least three times a year and should send copies of their minutes to the postgraduate dean.

It is helpful to trainees and others, including those inspecting training, to have at least one small booklet describing the organisation of the scheme and its placements. This may be done separately for each speciality or the booklet may describe the entire training available in a particular region.

#### *(b) Higher training posts*

The number of SpR posts (i.e. the total number of national training numbers (NTNs)) is related to the likely number of consultant vacancies in the immediate future both in the local region and nationally. The NHS Executive (and its equivalents in Scotland and Northern Ireland) determines this number in each of the psychiatric specialities. The number of NTNs in each region covers clinical SpR posts, flexible training posts, university lecturers with honorary clinical contracts and research trainees. Appointment to SpR posts is by open competition before a properly constituted appointments committee with College, university and higher training committee representation.

Only training gained by doctors holding an NTN may be taken into consideration for award of a CCST. Exceptions to this rule (e.g. locum appointments) are described elsewhere in the *Handbook*.

#### *(c) Higher training placements*

Higher training placements are not intended as permanent posts in a particular clinical service. The allocation of trainees to clinical placements is determined by the training needs of the individual SpR as decided by the SpR, the training programme director and the Higher Training Committee. Particular components of the clinical service will therefore be required for training at a particular time and will change almost continuously. The training needs of the current cohort of trainees may not reflect the present pattern of consultant posts and consultant work. For example, there may be a need for more consultants in substance misuse, old age psychiatry, cognitive/behavioural therapy or neuropsychiatry and existing consultants with these skills are therefore more likely to be trainers than

other consultants. In order that SpRs can obtain appropriate training, it is recommended that there should be an excess of placements over funded posts. No consultant or team should therefore consider that they have the right to a higher trainee. However, an effort should be made to protect academic posts in view of the nature of academic responsibilities, of the need of lecturers to obtain experience in posts outside the academic department and in recognition of the contribution of academic departments to training. Clearly this requires forward planning and it is helpful to consultants and managers if training programme directors and trainees discuss career plans in good time in order to reduce disruption of services.

*(d) Supervision of trainees*

A training consultant should be readily available to the SpR and s/he should hold a regular, weekly, timetabled supervision session where difficult clinical issues, personal, managerial and training matters can be discussed. Towards the end of the placement both trainer and trainee should each write a report which they should send to the training programme director, usually having discussed the reports between themselves. Where, in a single placement, the SpR relates to two consultants, one of them should be designated the main trainer and should be responsible for the weekly supervision session. There should never be more than two trainers for a single placement.

*(e) Clinical experience*

Training placements should be within a good clinical service in which the trainee is given a role matching his/her seniority and experience. The service should provide the opportunity to work in a multi-disciplinary team which includes psychiatric nurses, occupational therapists, psychologists and social workers, and the trainee should, particularly in later years, have the chance to chair clinical meetings and case reviews. Liaison with other hospital specialists, and with general practitioners, including domiciliary consultations, should be available. Experience in emergency psychiatry is of increasing importance, with a growing emphasis on community and domiciliary care.

In addition to this core experience as described in the previous paragraph, some sessions each week (usually two) might be set aside for special clinical interests. For example, for a general psychiatrist these might include liaison psychiatry, perinatal psychiatry, an eating disorder clinic, behaviour therapy instruction or forensic consultations. These different commitments should be carefully timetabled each week. A common distribution of work is six sessions of core placement (including academic time), two sessions of special clinical interest and two sessions of research. An 8:2 sessional arrangement may be appropriate, for example, during the first year of higher training or in some speciality placements. Special interest sessions do not figure in higher training

programmes in child and adolescent psychiatry or psychotherapy; in these specialities appropriate secondments can be arranged to meet individual trainees' particular clinical requirements.

Core placements should last 12 months for a full-time trainee. This gives sufficient time for a realistic clinical experience, allows the completion of treatment programmes and time to build up and close down a clinical service. Subsequent placements should not be 'more of the same', but should be in a different speciality or in a different setting. For example, an SpR in general psychiatry might move from a general service to a substance misuse placement, or to a general service in a different setting, or work in an intensive care unit, or a community/domiciliary care service. The proportion of in-patient, out-patient, day care and community/domiciliary care should vary. Likewise the special interest sessions should change from time to time, thus helping the development of wide clinical experience and therapeutic skills. It may be appropriate for some trainees to include management experience in these sessions or to extend their research sessions for a time. If their career aims require it, it should be possible for trainees to spend a year in another psychiatric speciality: for example, a general psychiatrist may seek a year in psychotherapy or the psychiatry of learning disability. It may be useful also to arrange special interest sessions/secondment outside psychiatry, such as in old age medicine, neuroradiology or neurology. Deaneries may be able to facilitate periods of secondment to, or exchange of placement with, another scheme or deanery.

It must be emphasised that SpR training is not simply an extension of senior house officer work and there should be no 'acting down'. The SpR works more independently and has a greater supervisory and managerial role. The clinical load should not be so heavy that the research, teaching and managerial functions are jeopardised.

#### *(f) Academic training and research*

SpRs must develop the habit and the skills of keeping abreast of developments in basic knowledge and clinical practice which they will carry into their future work as a consultant. Such continuing professional development is strongly recommended for consultants and the necessary habits of mind should be established in the training years. All schemes are required to provide an academic programme specifically for SpRs at a minimum frequency of the equivalent of one session weekly throughout the university term. The consultant responsible for organising this programme should have a link with a university or teaching hospital department and must have adequate time and resources for planning and delivering the programme. SpRs should continue with personal study and reading, attending clinical conferences and journal clubs and should regularly participate in local and national meetings and courses, including those provided by the College.

Increasingly, clinical practice and service organisation and delivery are informed by research studies. A natural reluctance to change impedes the diffusion of advances in knowledge and practice and there is an increasing awareness in the profession of the importance of the ability to judge and assimilate new information. There is probably no better way to obtain insight into these matters than to undertake a piece of original research and the HSTC now requires two sessions each week to be devoted to planning, conducting and communicating the outcome of a research project.

In order to achieve this aim the HSTC advises the appointment of a research tutor or a small research committee who organise a research methods course, identify consultants able to supervise research and regularly review the research progress of each trainee. It is helpful to have peer research meetings where ideas can be discussed, methods criticised, data analysis explored and final presentations made before studies are submitted for publication or presented at outside meetings.

With this support a trainee should be able to conduct a literature search, critically assess published evidence and formulate hypotheses, plan a project and carry it out and then evaluate the results. Some experience of communicating with ethics committees, statisticians and those controlling sources of funding would be gained.

Some schemes have a one-year core placement in research. Such placements are covered by the approval of the scheme as a whole and individual applications for approval of each incumbent is not necessary. However, research undertaken in any other manner cannot count towards higher training unless *ad hominem* educational approval has been granted by the HSTC.

### *(g) Teaching*

Teaching others is important because it not only gives motivation to study and to think critically but it helps to develop a skill which will be required in consultant practice. SpRs should, therefore, be required to teach undergraduates, to supervise junior psychiatrists and to teach other professional groups who view clinical problems from another perspective. SpRs should take part in delivering and organising journal clubs and case conferences.

### *(h) Audit*

It is essential that trainees are exposed to the process of analysing practice, setting standards and auditing practice against these standards. They should be able to use a variety of informational tools to achieve this. The aim is to be able to run an audit as a consultant and trainees should thus have experience of a range of different approaches to audit and to multi-disciplinary audit.

*(i) Management*

SpRs should obtain management experience. This should begin with simple tasks in the clinical, teaching and committee work of the hospital or service. An insight into the work of managers may be gained from attending courses and by shadowing a medical manager. For example, the final month of the core placement could be spent working with a manager. 'Hands on' experience is especially effective, for example, convening a working group, and it may be possible to give a trainee a relevant management task to complete.

*(j) Facilities*

Training is more fulfilling and probably more effective if placements have good facilities. SpRs should have a room of their own, or equivalent suitable personal space, at each point in the scheme with facilities for doing work individually and for storing papers, books and computers securely. Where trainees share a room they must have access to bookable clinical space. There should be ready access to an up-to-date library run by a trained librarian, providing modern methods of information technology. Modern teaching aids, including closed-circuit television, should be available. SpRs should be provided with adequate secretarial help for all aspects of their work, including research. They should also be provided with telephones.

*(k) Safety*

Assessment of the dangerousness of patients and risk assessment are important issues in training. Each scheme should have a written policy on safety which is regularly updated and known to the trainee. It should include details of counselling available to trainees who have been involved in a violent incident. It is helpful if schemes run occasional, brief courses on safety, including breakaway techniques.

*(l) On-call duty*

All SpRs (with the exception of those in psychotherapy) are required to participate in an out-of-hours senior on-call rota, with consultant cover. This should be at a minimum frequency of 1:10 for at least two years, or its equivalent, that is, 70 nights during higher specialist training. The rota should cover relevant specialist services (for example, a forensic SpR should be included in a rota which covers a forensic service). Although psychotherapy SpRs are not required to participate in an on-call rota, it is seen as a good way of maintaining their general psychiatry skills.

## **Duties of the training programme director**

The HSTC has agreed to amend the title of 'scheme organiser' to 'training programme director', in line with the terminology used by postgraduate deans.

The training programme director is a pivotal appointment both within the local higher training scheme and in the relation of the latter to the HSTC. There should be a locally agreed mechanism of appointment. The HSTC must be formally notified of new training programme directors and sent their CVs so that their appointment may be endorsed. There are no rules for the duration of such posts, but the need for continuity in the organisation of the scheme has to be set against the dangers of ossification in a prolonged appointment so that brief and lengthy appointments are both undesirable. A period of appointment between five and eight years is probably about right.

The training programme director carries out his/her duties in active collaboration with the trainers, members of the higher training committee, the university department and the trainees. The appointment therefore requires devotion, endurance, tact, optimism and organisational skill! With the increasing complexity of higher training and the more formal monitoring procedures that are likely to be required the post should have a recognised sessional commitment, at least when the training programme director has to supervise more than a handful of trainees.

The specific tasks of the training programme director include the following:

- (a) Attendance at the meetings of the regional psychiatric higher training committee to report on the scheme and on the performance of trainees: changes, restructuring, successes and problems. He/she should communicate with the postgraduate dean either directly or through a regional committee structure.
- (b) The organisation of HSTC inspection visits and the preparation of the documentation for these. To this end it is wise to review recent approval reports from time to time to ensure that recommendations are being implemented and to ensure that information likely to be required is systematically collected (e.g. the consultant appointments obtained by trainees, higher degrees gained and the publication record of present and recently promoted trainees).
- (c) The preparation of detailed submissions to the HSTC of placements or programmes of training requiring educational approval: for example, new placements in the scheme or the proposed training programmes for flexible trainees or those seeking approval of research appointments.
- (d) Carrying out an individual assessment of each new appointee with the aim of drafting a programme of training consistent with the trainee's needs and career intentions and with current CCST criteria.
- (e) The assessment of trainees at annual intervals (possibly more often during the first year) to monitor the progress of clinical, administrative and academic training including research. These reviews have an important

appraisal function and include written reports from trainee and trainer on the current placement. The timetables for the current and the next placement for each trainee should be checked to ensure that core and special interest experience, research time and regular supervision are appropriately planned and implemented.

- (f) Regular meetings with the trainees as a group to discuss the scheme and its placements.
- (g) Occasional meetings with trainers to discuss the scheme and its further development.
- (h) Being available at other times to offer advice to trainees and to deal with pressing administrative matters.
- (i) Being a member of appointment committees selecting new trainees.
- (j) Taking note of changes in HSTC recommendations published in the *Psychiatric Bulletin* or circulated direct to training programme directors by the HSTC.

## 2. Requirements for approval

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### **Approval of schemes and placements**

All higher specialist training schemes must carry educational approval from the HSTC. This approval covers all constituent placements on the scheme (except those specifically excluded from approval), both those occupied by clinical SpRs and university lecturers. However, it does not cover flexible training programmes or research programmes. Individual educational approval for these must be sought from the HSTC, as described in the next section.

#### *(a) Criteria for approval of schemes*

HSTC approval teams will ensure that a scheme in general terms, as described in the previous section, enables an SpR to gain appropriate training to enable him/her to obtain a CCST. While visitors from the different SACs will apply the core requirements to all schemes, they will also be looking at particular issues relevant to different speciality schemes. Some of these are outlined below.

#### *General/old age psychiatry schemes*

These should include sufficient placements in old age psychiatry to enable all trainees in old age psychiatry to spend at least two years in the speciality in different and contrasting placements and should also be able to offer old age psychiatry training to general psychiatry trainees wishing to spend one year in old age psychiatry. The proportion of NTNPs in general psychiatry and old age psychiatry varies between regions so it is not possible to state the number of placements in old age psychiatry which should be included in each scheme. However, a rough guide is that this figure should be at least 25% of the total number of placements in a scheme.

Each scheme should also include at least one placement in the three sub-specialities of general psychiatry (substance misuse, rehabilitation and liaison) so that SpRs may acquire sufficient training to enable them to obtain an 'endorsement' in one of the sub-specialities. Additionally, it is recommended that schemes have two substance misuse placements, providing exposure to both alcohol and drug misuse.

#### *Child and adolescent psychiatry schemes*

The scheme must enable a trainee to meet the CCST requirements within a three-year period. Trainees must have the experience of working in a variety of placements and with the full range of related disciplines. It is important that a

significant part of training is gained outside a hospital setting, including community settings.

### *Schemes in the psychiatry of learning disability*

All schemes must provide SpRs with the training that will prepare them for the independent practice of psychiatry in a modern learning disabilities service. Schemes must provide training with patients across the whole life span. A wide range of treatments and treatment settings must be available.

### *Forensic psychiatry schemes*

Core training is with mentally disordered offenders in a variety of settings, but should include experience of management of non-offender patients, both in a secure setting and in the community. Training should be available in all treatment methods.

### *Psychotherapy schemes*

At least two specialist psychotherapy consultants must participate in higher training schemes. Other trainers may be designated by the training programme director. Although trainees will specialise in one of the three major branches of psychotherapy, they must receive training in all of them.

## *(b) Approval process*

### *(i) Approval of restructured schemes*

Restructured schemes (or, very occasionally, new schemes) are considered by the HSTC at the request of the training programme director or the postgraduate dean. On receipt of an application the administrative secretary will secure the completed documentation before submission to the appropriate SAC and thereafter to the main committee. Full approval is dependent on a satisfactory report of the visit of inspection to the scheme, normally within 12 months of limited approval.

### *(ii) Approval of established training schemes*

Established schemes are routinely re-inspected by a team composed of a convener from the appropriate SAC, a consultant from a different deanery from the convener and preferably from a different but complementary background, and an SpR who is a member of the Royal College of Psychiatrists (who for preference works in a different region from either of the other two members). Prior to making a visit members of the visiting team receive copies of the submission made by the training programme director.

In the course of the visit, the team meet the trainees, consultant trainers, other teachers, senior academic staff, the postgraduate dean, the regional adviser, those responsible for administering the scheme and the chief executive and medical director of the relevant trust(s). Visits are paid to hospitals and facilities as necessary, although account will be taken of reports of visits undertaken by the relevant deanery to trusts involved in the scheme. At the end of a visit the team prepares a report which is conveyed verbally to the representatives of the scheme visited. The convener then prepares a written report which is returned to the administrative secretary within three weeks and, after it has been checked by the training programme director and by the other visitors for factual accuracy, it is submitted within three months of the visit to the appropriate SAC which discusses the report at its next meeting and may modify it considerably. The SAC has the responsibility of making its reports broadly comparable in approach and standard, and of carefully considering any major decisions before they are taken. It may modify the convener's draft to achieve this. After approval by the SAC the report is submitted to the HSTC itself for final approval. It is then sent to the regional postgraduate dean as a formal report, for circulation to those concerned. The report will contain a decision on the approval status of the scheme and recommendations for improving the quality of schemes, which cover a wide range of topics from the clinical load and supervision of trainees to teaching facilities and adequacy of research support. Some recommendations are mandatory and if approval is to be continued the team will expect to find evidence that they have been implemented when they carry out a subsequent revisit. Other recommendations are made as suggestions for the further enhancement of the scheme.

*(iii) Approval for four years*

Approval is granted for four years to schemes which are regarded as very good by the visiting team at the time of inspection and which, by virtue of facilities, staffing and past record, are likely to remain so until the next visit. When these schemes are revisited after four years it is expected that standards will not only have been maintained but have continued to develop in line with HSTC recommendations published in the *Psychiatric Bulletin*.

*(iv) Approval for less than four years*

Approval for a shorter period is applied to schemes which are not regarded as entirely satisfactory and which require changes to be made before a longer period of approval can be given, or where schemes are undergoing rapid change. A short period of approval may be given when there are great deficiencies in the scheme and changes are urgently required. Where a scheme or post is newly established or changing rapidly the limitation of the period of approval may reflect only the uncertainties surrounding the scheme's status rather than known deficiencies.

An approval report may list required changes which must be implemented in a shorter period than the duration of educational approval granted to the scheme as a whole. In such cases, the training programme director will be required to make an interim report.

*(b) Placements*

*(i) New placements*

Placements on the scheme will be approved at the time of an SAC visit, when details of each placement will be contained in the full documentation. New placements may be added to the scheme because of retirement of trainers or because of developments in the scheme; the training programme director then has to seek approval of each placement from the appropriate SAC. Application should be made on the relevant form, available from the HSTC office.

*(ii) Unapproved placements*

This category is applied to placements for which approval has never been sought or from which approval has been withdrawn. Trainees occupying placements from which approval is withdrawn, will be regarded as occupying an approved placement during their period of tenure but they should rotate elsewhere as soon as possible. Once a placement has lost approval it cannot be used by another trainee.

A comprehensive register of approved training schemes and placements is maintained by the HSTC office.

*(iii) Speciality placements on general/old age psychiatry schemes*

All general/old age psychiatry schemes include placements in all, or some, of the following: psychiatry of learning disability, forensic psychiatry, psychotherapy. Where these placements are approved by GOAPSAC alone they may count towards a CCST in general psychiatry (which may include one year of training in a different psychiatric speciality). In order also to count as a year of training towards a CCST in the second speciality, they must also hold approval from the relevant other SAC. Where a speciality placement on a general/old age psychiatry scheme holds dual approval it may be used as the year of 'common' training required for a dual CCST involving general psychiatry and a second speciality.

Dually approved placements are assessed during SAC visits from both GOAPSAC and the relevant other SAC.

*(d) Trainers*

Consideration of new placements involves scrutiny of the proposed trainer's CV. The SAC will wish to check that the consultant received appropriate higher

training, devotes adequate sessions to the speciality/sub-speciality in which approval is sought and is available for regular supervision. Consultants will normally have been in post at least 12 months before taking on the role of SpR trainer.

The work of higher trainees assumes consultant supervision, including the formal weekly session. Prolonged absence of the training consultant therefore breaches an important condition of training. Where this occurs the trainee should be moved to another placement in the scheme within three months. In some circumstances it may be acceptable that another trainer 'covers' the absent trainer for a limited period. Consultants who are unable to be closely involved in their clinical service (for example because of frequent absence abroad or the assumption of management responsibilities) should withdraw from training.

*(e) University/clinical lecturer posts*

Lecturer posts are covered by the educational approval applying to the scheme in which they function. It is accepted that the balance of activity will be different from clinical SpR posts. The following specific criteria will be applied:

- At least four sessions should be devoted to research and other academic duties.
- At least four sessions must be spent in clinical work. Senior academic appointments usually include consultant responsibility for a clinical service and it is thus important that lecturers have a pattern of clinical experience similar to their SpR colleagues.
- Lecturers must have access to the same range of placements as their SpR colleagues and will rotate at annual intervals. However, where this does not occur and the lecturer remains in a specialist placement, a limit of two years of approved training can be gained in that post.
- Lecturer posts including five or six clinical sessions will lead to award of a CCST after three years. Those involving only four clinical sessions will lead to award of a CCST after four years.
- The minimum 4:4 balance between research/academic and clinical duties may be varied from time to time but this must be the overall balance during the total period of higher training.

*(f) Posts outside the NHS*

There are a small number of placements in private hospitals on approved higher training schemes. These placements have been subject to the same scrutiny as placements in an NHS setting and count towards the training required for a CCST.

There is also higher training in the armed forces, which is subject to formal assessment by the HSTC.

## **Dual training posts**

The organisation of dual training is described below. At the time of going to press the NHS Executive has still to ratify a proposed manpower planning mechanism in relation to dual training.

Trainees holding an NTN in general psychiatry may not follow a dual training programme and general psychiatry SpR posts cannot be advertised as providing dual training. If trainees wish subsequently to follow a training programme leading to award of a dual CCST, they must apply for a post in the second speciality in open competition.

SpR posts in old age psychiatry, the psychiatry of learning disability, forensic psychiatry or psychotherapy may be advertised for dual training with general psychiatry. The NTN will be awarded in one of these four named specialities. The appointments committee must include appropriate representation from both specialities.

Trainees holding an NTN in the four specialities mentioned who are pursuing single CCST training may, during the course of their SpR training, opt to pursue dual training with general psychiatry. They will need to apply and succeed at the next general psychiatry interviews in the deanery, but it will not change their NTN.

Combinations of dual training in child and adolescent psychiatry and another psychiatric speciality are rare. While this continues to be the case, SpRs in child and adolescent psychiatry will be allowed to opt for a dual training programme with the psychiatry of learning disability, forensic psychiatry or psychotherapy provided they are competitively interviewed and there is sufficient training capacity in the second speciality in the deanery. The trainee will retain their NTN in child and adolescent psychiatry.

Dual training programmes involving general psychiatry do not need to be submitted to the HSTC for approval. Programmes involving other combinations of specialities must carry an individual grant of approval from the HSTC.

## **Training requiring individual educational approval**

Training obtained in any type of appointment except those described in the previous chapter must be submitted to the HSTC for *ad hominem* educational approval if it is to count towards the period of higher training required for a CCST. The types of training this applies to are detailed below.

### ***(a) Flexible training and job shares***

Trainees wishing to train flexibly must apply in open competition for an SpR post. If they are appointed, they should then declare their wish to train flexibly. A flexible training programme should be agreed with the training programme director (and submitted to the HSTC for approval) and funding identified by the associate postgraduate dean. Trainees are recommended to contact these key persons well in advance of applying for a post. Trainees may also opt to

move from full-time to flexible training while already an SpR and will similarly require a programme approved by the HSTC and funding from the associate dean's budget. (Different systems pertain in Scotland, Northern Ireland and the Republic of Ireland; details will be available from the relevant postgraduate dean's office.)

Every effort should be made for flexible trainees to have access to placements on the main scheme although, sometimes for geographical reasons, special arrangements may be necessary. They should have access to the same range of special interest experience, teaching, research, on-call and management opportunities. They should attend peer group meetings and receive regular, timetabled consultant supervision.

Criteria for award of CCSTs are expressed in terms of whole years in post. It may therefore be sensible for part-time training placements to extend beyond 12 months in duration so that they are equivalent to 12 months of full-time training. It is recognised that this is difficult to arrange since schemes have an annual rotation date. Where this is not possible it might be necessary to arrange a short placement at the end of the programme in order to complete CCST requirements in full.

Given that most flexible trainees occupy more placements than their full-time colleagues, they gain a wider variety of experience. They are thus not required to include special interest placements in their timetable. Occasionally special interest placements may be provided in the form of a short block of experience as part of a flexible training programme.

Flexible trainees also find it difficult to establish a research project if only one session per week is devoted to research. It is sometimes the case that their research sessions are gathered into a 6- to 12-month full-time block. This arrangement is acceptable to the HSTC.

Educational approval from the HSTC must be granted before a flexible trainee can commence in post. An outline programme for the whole of higher training must be submitted, although only the first two placements must be detailed. All placements must carry educational approval. Application should be made on the relevant form, available from the HSTC office.

SpRs may also job share. Where this is the case there should be no need for them to share the same placement, given that all schemes should have an excess of placements over trainees. The sharing refers to the salary only. Application for educational approval of a job-share training programme must be made on the same basis as SpRs training flexibly.

#### *(b) Research posts*

##### *Approval of four years higher training gained in research*

Honorary higher trainees who occupy a research post for a minimum period of four years will be eligible for recognition of the full period of higher training if the criteria listed below are met:

1. A programme of clinical experience for the whole period of higher training must be specified. Throughout the appointment, there must be four weekly sessions of clinical work in psychiatry unrelated to the research project. Where the number of clinical sessions falls below four, approval for a shorter period will be granted and the trainee required to spend an appropriate period (to be determined by the HSTC) in a clinical higher training post in order to be eligible for award of a CCST.
2. The programme of clinical experience must be tailored to the trainee's needs and include work with the Mental Health Act and other relevant legislation.
3. Clinical work must be undertaken in approved higher training placements on a reduced sessional basis. A programme comprising unrelated sessions in out-patient clinics will not be acceptable.
4. Emergency out-of-hours work must be undertaken for a suitable period and at a sufficient frequency to meet criteria for accreditation.
5. Research and clinical supervision may be given by the same consultant for a maximum period of 12 months only.
6. Trainees must attend the relevant speciality higher training academic programme, participate in the peer group and obtain management and teaching experience.

#### *Approval of one year's higher training gained in research*

One year's recognition of full-time research gained as part of a higher training programme may be granted. A trainee must also spend two years in a full-time clinical higher training post in order to be eligible for award of a CCST.

#### *Approval of between one and four years of higher training gained in research*

The criteria for approval of periods of research of more than one year's duration but less than four will be the same as for approval of four years' experience with the exception that the number of clinical sessions unrelated to the project will be three, or two where the project is clinically based. Clinical work must be undertaken throughout the project. An appropriate period of time in a clinical higher training post will be required in order to render the trainee eligible for award of a CCST.

#### *Approval of research gained prior to appointment to a higher training post*

Recognition as higher training may be granted for a maximum period of one year, provided the experience was undertaken by a post-membership trainee. No clinical work is required during this period. However, where clinical work is undertaken it must be for no more than four sessions a week and must be gained within a higher training scheme. Recognition will not be effective until

appointment to a substantive higher training post (university lecturer or clinical post but not a further research post) which carries an NTN is made. Recognition will not be granted where the trainee already holds recognition of other experience gained prior to appointment to a substantive higher training post.

### *Application procedure*

Application must be made on the relevant HSTC form. The form must be signed by the higher training programme director and the postgraduate dean. Except in the case of post-membership research, the training programme director and postgraduate dean must also confirm that the trainee carries an NTN and was appointed to their research post in open competition.

No research may be considered to contribute to higher training unless educational approval has been obtained from the HSTC.

### *(c) Locum posts*

#### *Consultant locums*

Three months spent in a locum consultant post (or its part-time equivalent) may count towards higher training provided that the post is undertaken in the appropriate speciality, in the final year of training, with the approval of the training programme director and on secondment from a higher training post. Application to the HSTC is not necessary.

#### *SpR locums*

Up to three months spent in a locum post may count towards higher training without application to the HSTC. Recognition as higher training of longer periods may be sought from the HSTC. The post may be in the same scheme as that in which the applicant has obtained a substantive appointment or a different scheme. A series of short-term posts will not be acceptable. Applications should include a job description, confirmation from the trainer that the applicant undertook the same work as substantive incumbents (including two sessions for research and attendance at the academic programme) and confirmation from the organiser of the higher training scheme in which the applicant holds a substantive appointment that his/her locum training has been/will be taken into account in designing their higher training programme. Approval of a maximum period of 12 months (or its part-time equivalent) will be granted. The locum post must be a locum appointment for training (LAT) rather than a locum appointment for service (LAS). The above also applies to fixed-term training appointments (FTTAs).

Training gained in locum SpR and locum consultant posts may count towards the period of higher training required for a CCST. A maximum period of 12 months training gained outside a substantive SpR post in the UK, that is, without an NTN, may count towards CCST training, such as locum appointments, post-

membership registrar posts (see the section on transitional arrangements) and training gained outside the UK.

*(d) Maternity leave and sick leave*

It has recently been agreed that all Royal Medical Colleges will adopt the same policy on maternity leave and sick leave. A total period of three months of either maternity leave or sick leave, or a combination of both, is allowable during the course of higher specialist training. Any further periods of maternity leave or sick leave will necessitate revision of a trainee's CCST date. This new policy relates to periods of maternity leave and sick leave taken from 1 January 1998 onwards.

*(e) Higher training gained outside the UK*

SpRs may seek educational approval from the HSTC of up to one year of training gained outside the UK (note: training in the Republic of Ireland is fully approved for higher training). The place of training abroad must be approved for suitable clinical and academic experience by the appropriate authority in the host country. The applicant must submit: (a) a job description and timetable; (b) evidence of the post's approval status in that country; (c) a CV; and (d) a letter of support from the organiser of the higher training scheme in the UK in which the applicant has been appointed to a substantive SpR post. In line with the scale of reciprocity agreed between the College and the Royal Australian and New Zealand College of Psychiatrists in February 1996, fifth-year registrar posts in Australia or New Zealand may count towards higher training in the relevant psychiatric speciality, on individual application to the HSTC.

It should be noted that, if more than one year of training gained abroad has been taken into account in the award of a CCST (i.e. one year in basic specialist training and one year in higher specialist training), the CCST is not covered by European Union mutual reciprocity agreements.

*(f) Non-consultant grade posts*

In line with the European Specialist Medical Qualifications Order 1995, which is itself based on European Commission medical directives, experience gained in posts other than training posts cannot be recognised as training and thus cannot be taken into account in the award of a CCST.

### 3. Higher training in the Republic of Ireland

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The organisation of higher training in the Republic of Ireland differs in certain respects from that in the UK. The professional body responsible for higher training is the IPTC, which includes representatives from universities, the Irish Division of the Royal College of Psychiatrists, psychiatric specialities, the tutors, and the Department of Health, as well as co-opted trainees. The IPTC seeks and acts on the advice of the HSTC, while itself retaining responsibility for higher psychiatric training in the Republic of Ireland. This relationship works to maintain comparability in higher psychiatric training in the Republic of Ireland and in the UK. The IPTC is represented on the HSTC and on its SACs, and is recognised by the Medical Council for the purposes of granting evidence of satisfactory completion of specialist training.

Statutory responsibility for the regulation of the number and distribution of consultant and senior registrar posts rests with *Comhairle na n-Ospideal* (the hospital council). *Comhairle na n-Ospideal* will not consider the establishment of a senior registrar post until educational approval has been obtained from the HSTC (the reverse of the procedure applied in the UK).

Applications for approval of programmes are processed by the IPTC and forwarded to the HSTC, which then arranges for an approval team to visit and submit a report in the usual way. The final version of this report is sent to the IPTC, which distributes it; generally copies are sent to health boards, local organisers and tutors, the Department of Health and the Postgraduate Medical and Dental Board (the statutory body which promotes and coordinates postgraduate medical and dental education).

Senior registrars are appointed to a national higher training scheme by a national panel appointed by the IPTC which includes representatives of the medical schools, employing authorities and psychiatric specialities. The chairman of the IPTC chairs the national selection panel.

The Local Appointments Commission continues to be responsible for appointments to health board consultant posts. Consultants to private or voluntary hospitals are appointed by local procedures. In general the statutory requirements for consultant appointment are seven years post-qualification with five years in the appropriate speciality, with an MD in psychiatry, MRCPsych, MRCPI in Psychiatry, or the equivalent of one of these.

Enquiries about higher training in the Republic of Ireland should be addressed in the first instance to: The Administrator, IPTC, c/o Corrigan House, Fenian Street, Dublin.

## 4. Annual assessment and award of CCSTs

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Systematic annual assessment of SpRs in higher psychiatric training is central to the award of a CCST. Annual assessment also provides information to the trainee about their progress and their strengths and weaknesses and information to the training programme director for planning of further training, as part of an ongoing appraisal process. The process of annual assessment involves the setting up of an appropriate review panel and a system of collating information for that panel to make its decisions. The first and third annual reviews are particularly critical in that trainees who are not suitable for the speciality should be identified at the first review and counselled appropriately. At the third review, or fourth/fifth review if additional training has taken place, a decision about the award of a CCST will need to be made.

The previous system of annual assessment of higher specialist trainees in psychiatry is described on page 13 of the seventh edition of the *Handbook* under item (e) of the duties of the training programme director as:

*"the assessment of trainees at annual intervals (possibly more often during the first year) to monitor the progress of clinical, administrative and academic training including research. These reviews include written reports from trainee and trainer on the current placement. The timetables for the current and the next placement for each trainee should be checked to ensure that core and special interest experience, research time and regular supervision are appropriately planned and implemented".*

There have been considerable variations between schemes in relation to the degree of formality of these assessments and the nature of annual written records. The postgraduate dean now has a system of review of higher trainees which includes the training programme directors' annual assessment. The review system should have been agreed between the scheme organising committee and the postgraduate dean's office so that appropriate information can be provided to the postgraduate dean and to the Royal College of Psychiatrists to allow a decision to be made about trainees progressing from year to year and ultimately being awarded a CCST. At the conclusion of the annual assessment process the postgraduate dean will complete the relevant record of in-training assessment (RITA) form (Form C – Record of satisfactory progress, Form D – Recommendation for targeted training, Form E – Recommendation for intensified supervision/repeated experience, Form F – Record of out-of-programme experience).

### *Entry into SpR Grade*

In the first three months of the appointment, a training plan should be drawn up. This does not have to be in great detail or specify the precise placements that will be taken; in many cases it will be sufficient simply to specify those objectives

from the list of recommended training experiences that will apply to the individual and any that should be added or dropped. This process, however, will need more care for trainees seeking an out-of-the-ordinary training. If a joint certificate is being sought, this should be explicit. If a speciality interest is being pursued in a three-year training, then other types of experience will obviously need to be reduced. If an academic interest is intended to lead to a very specialist career, then this too should be reflected in the training plan.

The training plan will usually be drawn up jointly by the trainee and the training programme director (or mentor) and sent for approval to the review panel. It must also be submitted to the HSTC for approval if it is for somebody with an honorary contract as SpR (e.g. in a research post) or for a flexible trainee.

### *End of first year*

Particular care should be taken at this assessment, for any reservations about the performance of a trainee should be apparent by now and will need to be made clear. If reservations are serious enough to call into question the trainee's suitability for a consultant appointment eventually, then this too should be made clear so that alternative career plans can be considered. This review should include the postgraduate dean or representative, the trainees' mentor and training programme director; reports should be available (and seen by the trainee) about performance in clinical placements and also from academic supervisors. Any uncertainty should by now be dispelled about whether the proposed plan of training will be sufficient for the eventual award of a CCST if it is satisfactorily carried through – if this is still unclear, the HSTC should decide it. Unsatisfactory performance can lead to advice and remedial action, new objectives for the training plan, repeating the year or advice on alternative career planning.

Information for the annual review should come from the trainee themselves, the trainer who has been involved for the previous year and the training programme director. The trainee should complete a self-assessment schedule based on Part III of the document on completion of specialist training in psychiatry giving a clear indication of what settings they have worked in and what experience they have gained over the previous year in all areas including clinical, research, teaching, management and audit. This document should also include an account of all postgraduate training experiences and will then naturally lead in to the process of recording continuing personal professional development after the award of the CCST.

The Royal College of Psychiatrists' higher specialist training in psychiatry annual assessment form should be completed by the trainer in conjunction with the trainee. This assessment form is based on the educational goals of higher training (pages 32–39), covering general goals, research and audit, teaching and supervisory skills, management skills, core clinical knowledge and skills and appropriate specialist knowledge and skills. The training programme director will add their comments to this document. The trainer's assessment, together

with the training programme director's comments, will then go to the review panel to assist in the annual assessment and finding the necessary information for adjustment of the training experience where problems have been identified. Copies of the documents should be kept by the training programme director, because they will accompany any recommendation from the review panel to the College about the award of a CCST.

#### *End of second year*

The assessment should be along the same general lines as that at the end of the first year; in many cases it will be sufficient for there to be an internal review, that is, without the presence of the external member(s) of the panel. However, any new serious concerns should lead to new objectives and/or advice on meeting them.

#### *Final summative assessment*

Any documents required for final assessment should be submitted at least three months in advance. Their acceptability should be determined at this point. About two months before the third anniversary of appointment (or fourth/fifth for dual training programmes) there is a review of the year's progress, as previously; and in addition the training check-list is completed, the whole course of training is reviewed, and project material (e.g. case book) approved if relevant. When satisfactory, a recommendation for approval is given and forwarded by the dean to the College's deputy registrar. In straightforward cases, the registrar should be able to endorse on behalf of the Court of Electors and forward straight to the STA. The trainee should be able to apply for consultant posts as soon as the recommendation for approval is forwarded; and the endorsement process should be quick enough for the CCST to be awarded by the time of an appointment committee. If cases present problems, further consideration will be needed, the candidate will be informed of delay, the SAC chairman consulted and the case considered by an executive group of the Court of Electors. Once the College has determined that training has been completed satisfactorily, the summary documents go to STA and then to General Medical Council. External review will come from the HSTC accreditation process, especially the site visits, which should audit the process of assessment and appraisal.

## 5. Higher training programmes leading to award of CCSTs in psychiatry

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### **Duration of training**

The total duration of specialist training is six years. Trainees will have completed at least three years of basic specialist training prior to entering higher specialist training, and will have passed the MRCPsych examination (or equivalent).

#### *(a) Single CCSTs*

In order to gain a single CCST an SpR must satisfactorily complete three years of approved higher training (or four in the case of some research and lecturer posts). They will also have acquired the professional attributes, skills in research and audit, teaching, supervision and management and the core knowledge and skills outlined below. Particular note should be made of the following.

#### *General (adult) psychiatry*

Two years must be spent in general psychiatry. One of these years may be in a sub-speciality of general psychiatry (rehabilitation, substance misuse, liaison). Trainees who have satisfactorily completed one year in a sub-speciality may have their entry on the specialist register endorsed accordingly. One year of the training for a CCST in general psychiatry may be spent in another psychiatric speciality. If one or more years in research have been approved as part of CCST training in general psychiatry, a trainee may not also count a year in a speciality placement towards the training required for a CCST.

SpRs may spend part of their higher training in a placement in an emerging field of psychiatry (e.g. neuropsychiatry, eating disorders or perinatal psychiatry). While such training constitutes part of general psychiatry for the purposes of award of a CCST, trainees should be counselled against devoting a major part of their higher training to these fields as they may be unable to demonstrate that they have met the core skills in general psychiatry described in the next section.

#### *Old age psychiatry*

A three-year training period is required. One of these years may be spent in general psychiatry (or one of its sub-specialities) or in any other psychiatric speciality. SpRs who commenced in the grade prior to 1 January 1997 must complete a year in general psychiatry in order to be eligible for a CCST in old age psychiatry.

### *Child and adolescent psychiatry*

All three years must be spent in child and adolescent psychiatry.

### *Psychiatry of learning disability*

Three years of training are required for award of a CCST in the psychiatry of learning disability, of which one year may be spent in general psychiatry or another appropriate psychiatric speciality.

### *Forensic psychiatry*

The three-year period required for award of a CCST in forensic psychiatry must be devoted solely to this speciality.

### *Psychotherapy*

The three-year training programme required for award of a CCST in psychotherapy may not include clinical experience gained in any other speciality.

### *(b) Dual CCSTs*

The Royal College of Psychiatrists and the HSTC accept that trainees should have the option of seeking dual certification. While the minimum duration of higher training for award of a single CCST is three years, there is considerable overlap between some of the psychiatric specialities so that a full six-year training is not required for dual certification. Training should be agreed prospectively and the dual CCST will be awarded on completion of the full programme of training.

The following dual training programmes will be of four years' duration:

- general psychiatry and old age psychiatry
- general psychiatry and the psychiatry of learning disability
- old age psychiatry and the psychiatry of learning disability.

All other programmes will be of five years' duration, to include two years in each speciality and a year in 'common' training. Where the dual programme involves general psychiatry, the common year is likely to be a placement in the second speciality on a general/old age psychiatry scheme. In the following dual programmes the common year is defined as follows:

- Child and adolescent psychiatry and the psychiatry of learning disability: one-year placement in childhood learning disability.
- Child and adolescent psychiatry and forensic psychiatry: one-year placement in forensic adolescent psychiatry.
- Forensic psychiatry and psychotherapy: one-year placement in forensic psychotherapy.

In view of the shorter period of clinical training in each speciality undertaken in a dual training programme, it is unlikely that research can play a part in them (with the exception of general/old age psychiatry). However, the HSTC will consider applications for up to one year spent in relevant research as part of a dual training programme, on an *ad hominem* basis.

*(c) Four-year programmes leading to award of a single CCST*

CAPSAC and FPSAC have agreed a dual training programme which will enable a trainee to apply for a consultant post in forensic child and adolescent psychiatry but will not lead to award of a dual CCST. Details are given in the relevant advisory paper.

It may occasionally also be the case that additional training, possibly in a fourth year, is required for appointment to a particular and highly specialised consultant post. In these circumstances, the trainee will receive a CCST in the appropriate speciality, and not a dual CCST.

**The HSTC reserves the right to consider any individual training programme that varies from the above in order to allow trainees the flexibility to complete an individualised training programme to meet his/her needs.**

### **Educational goals of higher training**

As a general principle, skills acquired in higher training will be at a higher standard than those required for basic training. The goals specified here are broad and general in order to encourage flexibility and prevent restriction of the development of relevant speciality training. For this reason, trainees will also be required to achieve the goals in the speciality in which they seek certification.

All trainees at the time of completion of specialist training should be capable of functioning as autonomous medical specialists with an ability to sustain independent action and decision-making and maintain the quality of clinical work and record-keeping, including physical and psychiatric examination, collection of data from corroborative sources, diagnostic assessment and treatment-planning and library work associated with patients under treatment.

*(a) Professional attributes*

- (i) Honesty and courtesy to patients, relatives, unpaid carers, medical colleagues and other staff of whatever seniority, age or perceived competence.
- (ii) Demonstration of willingness to seek help and learn from colleagues in psychiatry and other disciplines when unsure of correct course in clinical or managerial problems.

- (iii) Calmness with challenging patients, carers, colleagues or team members and a high standard of interviewing skills.
- (iv) Willingness to examine his or her own reactions to patients and others.
- (v) Willingness to speak out when standards fall below expectations and to pursue rectification and advocacy of patients interests.
- (vi) Demonstration of a capacity to replace old knowledge with new, to develop new skills, and adopt new attitudes.

*(b) Research and audit*

- (i) Ability to design, undertake and complete a research project, including the ability to pose relevant research questions, formulate hypotheses, design simple research projects, make statistical evaluations and draw valid conclusions.
- (ii) Maintenance of a system of continuous learning in order to keep abreast of major clinical and research developments.
- (iii) Ability to apply audit principles to his/her own work, to team practice and in a service-wide context.

*(c) Teaching and supervision*

- (i) Ability to supervise the clinical work of psychiatric trainees, both to improve practice and to facilitate their professional development.
- (ii) Teaching psychiatric trainees and staff from other medical and non-medical disciplines through lectures, journal clubs, seminars, small group discussions and problem-oriented learning.

*(d) Management*

- (i) Demonstrate basic competence in time management.
- (ii) Adequate knowledge of trends in management and implications of management structures and systems and resource change within the health service.
- (iii) Ability to develop new services and training through involvement in the setting and monitoring of contracts and advising purchasers.

*(e) Core knowledge and skills*

Knowledge:

- (i) Knowledge of the psychopathology and natural history of common clinical disorders.
- (ii) Knowledge of current methods of management of common clinical disorders, including the theoretical background and practical application of psychological, social and psychopharmacological methods of treatment.

- (iii) Knowledge and understanding of the legal and ethical framework of psychiatric practice, including the working of the relevant Mental Health Act, the duties of the responsible medical officer under the Mental Health Acts and Department of Health instruction and child protection issues and the relevant legislation.
- (iv) Knowledge of the impact of cultural, social and family influences on the genesis, maintenance and management of psychiatric disorders and the cultural aspects of psychiatric practice in a multi-ethnic society.
- (v) Knowledge of other statutory, voluntary and social agencies concerned with the management and care of individuals with a psychiatric disorder.

**Skills:**

- (i) Ability to carry out a clinical assessment, including obtaining a personal history, assessing physical and mental states and obtaining corroborative data.
- (ii) Competence in the application of a range of psychological treatment skills in the relevant area of psychiatric practice and possessing more advanced skills in one or more treatment methods.
- (iii) Competence in the use of relevant psychopharmacological treatments and other physical treatments, including electroconvulsive therapy (ECT) where appropriate.
- (iv) Ability to participate in multi-disciplinary clinical management, including team leadership where appropriate, and ability to coordinate care for people with a psychiatric illness working with other medical, nursing and paramedical staff and statutory and voluntary organisations concerned in the care of people with a mental illness.
- (v) Ability to maintain a system for risk management, including assessment of dangerousness, risk of suicide, self-neglect and abuse.
- (vi) Ability to manage crises, both in health service settings and in the community.
- (vii) Ability to conduct domiciliary assessments.
- (viii) Ability to write court and other clinical and management reports.
- (ix) Ability to maintain therapeutic relationships with patients and a constructive communication with other professionals, dealing competently, tactfully and helpfully with relatives and other carers.
- (x) Competence in the use of information technology in clinical practice and service organisation.

**(a) General (adult) psychiatry**

Knowledge: See the list of core knowledge above.

Skills: See list of core skills above.

*Rehabilitation psychiatry*

Knowledge – see core knowledge, as described above, with particular emphasis on:

- (i) Knowledge of assessment schedules concerning chronic mental illness.
- (ii) Knowledge of assessment of change in such states.
- (iii) Knowledge of psychological techniques used in rehabilitation.

**Skills:**

- (i) Ability to assess components of a chronic disorder, including the patient's strengths and weaknesses.
- (ii) Ability to target and treat priority areas of social, psychological and biological deficits.
- (iii) Ability to identify the needs of patients moving between different environments.

*Liaison psychiatry*

Knowledge – see core knowledge, as described above, with particular emphasis on:

- (i) Knowledge of the efficacy of different forms of assessment of deliberate self-harm and how these might relate to *Health of the Nation*.
- (ii) Knowledge of the prevalence of psychiatric disorder in physically ill patients and the relationship between physical and psychological disorders.
- (iii) Knowledge of different forms of somatisation.
- (iv) Knowledge of the use of antidepressants and other psychotropic medication in the physically ill.

**Skills:**

- (i) Ability to assess and manage deliberate self-harm and teach junior medical and nursing staff to perform such assessments.
- (ii) Ability to assess the psychological component and psychiatric complications in medical illness, including issues relating to death and dying and manage the conditions in conjunction with general hospital doctors and nursing staff where appropriate.
- (iii) Ability to assess and manage neurotic disorders, eating disorders and sexual problems as they present in a general hospital.
- (iv) Ability to assess and manage hypochondriasis, psychogenic pain and abnormal illness behaviour.
- (v) Ability to assess and manage neuropsychiatric disorders and the psychiatric complications of epilepsy.
- (vi) Ability to contribute to discussions at physicians' meetings and encourage and support medical staff and nursing staff in holding private interviews in such a way that the management of psychological problems of patients in general hospitals becomes recognised as an important aspect of patient care.
- (vii) Ability to assess perinatal psychiatric disorders and disorders of the mother/infant relationship.

### *Substance misuse*

Knowledge – core knowledge, as described above, with particular emphasis on:

- (i) Knowledge of pharmaceutical and psychological treatments in substance misuse.
- (ii) Knowledge of the role of primary care teams, other professionals and voluntary organisations in shared care and rehabilitation.
- (iii) Knowledge of the medical and psychiatric consequences of addiction.
- (iv) Knowledge of the schedules for assessment of problem drinking and alcohol addiction.

Skills:

- (i) Ability to assess dependence and addiction to ethanol, narcotics, cannabis, amphetamines, cocaine, glue sniffing and other drugs of abuse.
- (ii) Ability to manage withdrawal states and detoxification.
- (iii) Ability to manage the maintenance of abstinence and other therapeutic goals.
- (iv) Ability to manage maintenance regimes.

### **(b) Old age psychiatry**

Knowledge – core knowledge, as described above, with particular emphasis on:

- (i) Knowledge of the special features of psychiatric disorders presenting in old age.
- (ii) Knowledge of the impact of increasing age on the effects of treatment in the elderly, both physical and psychological.
- (iii) Knowledge of the specialist range of support services available for the elderly mentally ill.
- (iv) Knowledge of the relevant legal issues for the elderly and, in particular, the Court of Protection (England and Wales) and the Accountant of Court and Curator Bonis (Scotland).
- (v) Knowledge of geriatric medicine, neurology, neuroimaging and sensory disorders as necessary for the practice of old age psychiatry.

Skills:

Core skills, as described above, with particular emphasis on multi-disciplinary working and a global approach to management – spanning psychological, medical and social issues.

### **(c) Child and adolescent psychiatry**

Knowledge – core knowledge, as described above, with particular emphasis on:

- (i) Expert knowledge of all forms of psychopathology in childhood and adolescence.

- (ii) Expert knowledge of the implications of mental and physical illness and disability, and personality disorders, for the functioning of parents.
- (iii) Knowledge of, and ability to detect, physical illnesses as they affect children and adolescents and to carry out a developmental assessment.
- (iv) Expert knowledge of theory and practice of psychotropic drug use in childhood and adolescence.
- (v) Knowledge of social organisations (families and larger groups) and ability to consult usefully to institutions, acquired through supervised experience of advice to outside institutions.
- (vi) Knowledge of the impact of cultural, social and family influences on the manifestation of psychiatric disorder in children and adolescents.
- (vii) Knowledge of legal issues relevant to children and adolescents.

Skills – core skills, as described above, with particular emphasis on:

- (i) Ability to assess the quality of parent–child relationships and determine the nature of any interaction needed.
- (ii) Ability to recognise abuse, link with child protection agencies, plan the rehabilitation of abused children and advise on the management of failures in care giving.
- (iii) High level of competence in communication with children and adults.

#### **(d) Psychiatry of learning disability**

Knowledge – core knowledge, as described above, with particular emphasis on:

- (i) Expert knowledge of all forms of psychopathology as they present in people with learning disability.
- (ii) Expert knowledge of psychotropic medication and its effects and use in people with learning disability.
- (iii) Relevant knowledge of, and an understanding of, the work of relevant co-disciplines, for example, child psychiatry, forensic psychiatry, neuropsychiatry and rehabilitation.
- (iv) Knowledge of particular legal issues for people with learning disabilities, especially consent, and Court of Protection (England and Wales) and the Accountant of Court and Curator Bonis (Scotland).

Skills – core skills, as described above, with emphasis on:

- (i) Ability to communicate effectively with people of all degrees of learning disability.
- (ii) Ability to identify factors relevant to the development or maintenance of disturbed behaviour, for example, abuse, bereavement and advice on the management of failures in care-giving.
- (iii) Ability to assess and manage people with pervasive developmental disorder.
- (iv) Ability to manage epilepsy in people with learning disability.
- (v) Ability to identify effects of physical disorders among people with severe learning disability.

- (vi) Ability to identify psychopathology with individuals, families and carers.
- (vii) Ability to work effectively with families, carers and multi-disciplinary groups.
- (viii) Ability to assess competency to consent.

**(e) Forensic psychiatry**

Knowledge – core knowledge, as described above, with particular emphasis on:

- (i) Expert knowledge of the effects of psychopathology on abnormal (including criminal) behaviours including, in particular, aggression and sexual violence.
- (ii) A detailed knowledge of the range of services available to the mentally disordered offender and how to use them.
- (iii) Expertise in mental health legislation and relevant knowledge of criminal and civil law.
- (iv) An understanding of criminological issues, including ethnicity, gender and culture.
- (v) A particular knowledge of the chronic mental disorders, including personality disorder, found in the field of forensic psychiatry and their treatment, both physical and psychological.

Skills – core skills, as previously described, with particular emphasis on:

- (i) Expertise in the use of security as part of treatment.
- (ii) Expertise in the assessment of risk and dangerousness and appropriate communication of advice on this to professional colleagues.
- (iii) Experience in the forensic psychiatric aspects of adolescent psychiatry, learning disability and substance misuse.
- (iv) Expertise in the rehabilitation of patients who present potential risk to others.
- (v) The ability to formulate opinions clearly (both written and verbal) and present them to other professionals, the Home Office and as evidence to the Courts (including mental health review tribunals) and the parole board.
- (vi) The ability to run an in-patient unit and community services in forensic psychiatry, including expertise in the statutory care requirements of detained and restricted patients.

**(f) Psychotherapy**

Knowledge – core knowledge, as described above, with particular emphasis on:

- (i) Expert knowledge of at least one branch of psychotherapy (currently these are psychodynamic/interpersonal, behavioural–cognitive and systems-based psychotherapy) and sufficient familiarity with other branches to know how to match therapy to patient need.

- (ii) Knowledge of group and institutional processes.
- (iii) Knowledge of psychiatric and emotional aspects of medical disorders.
- (iv) Knowledge of the research literature and its methodological strengths and limitations.
- (v) Sufficient self-knowledge to avoid imposing personal solutions to life problems on patients.
- (vi) Recognition of personal limitations and ability to obtain and use supervision.

Skills – core skills, as described above, with particular emphasis on:

- (i) Expertise in at least one branch of psychotherapy and sufficient knowledge about other branches to know the indications and contra-indications in order to match therapy to patient need.
- (ii) Expertise in assessments for psychotherapy, including knowing when to refer.
- (iii) Ability to evaluate the outcome of therapies provided.
- (iv) Expertise in clinical supervision of psychotherapy and psychotherapists.
- (v) Ability to contribute as an expert in psychotherapy to care in mental health and general medical services through consultation and/or joint care of patients.
- (vi) Ability to provide management, leadership and advocacy for specialist psychotherapy services in the NHS.

### **Recommended training experiences**

It is not intended that all trainees should have obtained all of these experiences. All schemes should provide them, but individual trainees will obtain different balances of experience. The following check-lists are provided to help make explicit what training an individual is undertaking and to lead to the judgement as to whether the objectives of training have been met.

#### *(a) Research*

Project – two-page outline.

Supervisor.

Literature reviewed.

Protocol written.

Time made available.

Pilot study performed.

Data collected.

Data analysis.

Written up.

Presented.

*(b) Audit*

Use of information technology.  
Audit meetings.  
Changed practice from audit.

*(c) Teaching and supervisory*

Clinical supervision of trainees.  
Giving lectures.  
Using role play.  
Running small group discussions.  
Using self-directed/problem-oriented learning.  
Conducting seminars.  
Teaching non-medical disciplines.

*(d) Management*

Personnel issues.  
Group management.  
Case load management.  
Service planning.  
Shadow a manager.

*(e) Academic*

Attendance at local, national and international teaching events.  
Attendance at specialist conferences.  
Attendance at higher training courses.  
Presentation of cases.  
Journal clubs.

*(f) Clinical*

These are listed by speciality on the following pages:

**(i) General (adult) psychiatry**

Clinical (settings):

Psychiatric units.  
In-patient wards for acute admissions.  
Intensive care wards.  
Wards for continuing care and rehabilitation.  
Day hospitals.  
Resource centres.  
Hostels of various kinds.

Sheltered workshops.

Out-patient clinics in hospitals and resource centres.

Clinics in general practitioner surgeries.

Home treatment of neurotic illness, acute psychosis and chronic disorders.

Clinical (experience):

*Acute psychiatry*

Assess and manage organic disorders.

Assess and manage non-affective psychosis, using drugs and psychosocial treatments.

Assess and manage mood disorders using ECT, drugs and psychosocial treatments.

Assess and manage neuroses.

Assess and manage personality disorders.

Be familiar with assessment schedules concerning symptoms and signs.

*Rehabilitation psychiatry*

Be familiar with assessment schedules concerning chronic mental illness.

Be familiar with the assessment of change in such states.

Be familiar with psychological techniques used in rehabilitation.

Assess components of a chronic disorder, including the patient's strengths and weaknesses.

Target and treat priority areas of social, psychological and biological defects.

Be able to identify the needs of patients moving between different environments.

*Liaison psychiatry*

Assess and manage deliberate self-harm and teach junior medical and nursing staff to teach such assessments.

Assess the psychological component and psychiatric complications in medical illness and care of the dying and manage these conditions in conjunction with general hospital staff.

Assess and manage neurotic disorders, eating disorders and sexual problems as they present in a general hospital.

Assess and manage hypochondriasis, psychogenic pain and abnormal illness behaviour.

Assess and manage neuropsychiatric disorders and the psychiatric complications of epilepsy.

Contribute to discussions at physicians' meetings and encourage and support medical staff and nursing staff in holding private interviews in such a way that the management of psychological problems of patients in general hospitals becomes recognised as an important aspect of patient care.

Assess and manage perinatal psychiatric disorder and disorders of the mother–infant relationship.

*Substance misuse*

Be familiar with pharmaceutical and psychological treatments in substance misuse.

Be familiar with the role of primary care teams, other professionals and voluntary organisations in shared care and rehabilitation.

Be familiar with the medical and psychiatric consequences of addiction.

Be familiar with the schedules for assessment of problem drinking and alcohol addiction.

Assess dependence and addiction to ethanol, narcotics, cannabis, amphetamines, cocaine, glue sniffing and other drugs of abuse.

Manage withdrawal states and detoxification.

Manage the maintenance of abstinence or other therapeutic goals.

Manage maintenance regimes.

**(ii) Old age psychiatry**

Clinical (settings):

In-patient wards for treatment of functional illness.

Assessment wards.

Continuing care and respite wards.

Joint psychiatric/geriatric wards.

Day hospitals.

Sheltered housing.

Residential care in various settings.

Home assessment and treatment.

Out-patients.

Clinical (experience):

Assess and manage affective psychosis, paraphrenia, hallucinatory states, neurotic disorders and personality disorders in old age.

Assess and manage acute confusional states, and psychiatric complications of physical illness.

Assess and manage dementia of all kinds.

Experience of interviewing mentally impaired elderly subjects, and those with sensory defects.

Experience of obtaining collateral information.

Manage treatment with ECT and a range of psychotropic drugs, including their iatrogenic complications.

Use psychotherapeutic techniques with elderly patients, paying regard to the special developmental tasks of old age, and the need to work with dependency and loss in the individual and the family.

Ensure that the needs of psychiatric and medical treatment are properly balanced and covered.

Assess and manage self-poisoning.  
Assess and manage substance misuse in the elderly.  
Be familiar with assessment schedules for dementia and its differential diagnosis.  
Experience of working in close liaison with other providers of services, including families, social services, the primary care team, geriatric medicine and voluntary agencies.  
Assess the psychological component and psychiatric complications in medical illness, including delirium.  
Be familiar with techniques of neuropsychological testing.  
Have experience of rehabilitation, and the management of problem behaviours in old age.  
Be familiar with the range of community resources which can be deployed to support those with brain failure, and those with mental illness and concurrent physical disability.  
Experience of training other disciplines in the detection and management of psychiatric disorder in old age.

**(iii) Child and adolescent psychiatry**

Clinical (experience):

In-patient and day patient work.  
Out-patient psychiatric team.  
Child guidance unit.  
Pre-school children.  
Adolescents.  
Emotional disorders.  
Conduct disorders.  
Educational difficulties.  
Learning disability.  
Paediatric liaison work.  
Disorders associated with physical illness.  
Neuropsychiatric problems.  
Emergency work.  
Forensic work, including preparation of court reports and experience as an expert witness.  
Consultation.  
Work with residential establishments outside the NHS (e.g. special schools, social service assessment centres).  
Long-term cases.

Clinical (supervised treatments):

Individual dynamic psychotherapy (child).  
Individual dynamic psychotherapy (adolescent).  
Cognitive therapy.

Family therapy.  
Direct behaviour therapy.  
Indirect behaviour therapy.  
Drug therapy.  
Group therapy.

Other special interests:

Project.  
Supervisor.  
Literature review.  
The establishment of project evaluation.

Courses studied:

Child development seminars.  
Child psychiatry seminars.  
Developmental assessment course.  
Therapeutic skills seminars.  
Psychotherapy supervision seminars.  
Journal club.  
Research methodology.  
Teaching skills.

**(iv) Psychiatry of learning disability**

Clinical (settings):

*In-patient units*

Admission and assessment.  
Rehabilitation.  
Long-term care.

*Community*

Out-patients.  
Homes/hostels/group homes, etc.  
Day services.  
Joint work with community teams.  
Educational establishments.

Clinical (cases):

*Adult*

Mild learning disabilities and emotional disorder, behaviour disorder, psychosis, offending.  
Severe learning disability and emotional disorder, behaviour disorder, psychosis.  
Profound and multiple disability.  
Assessment of developmental delay.

*Children*

With moderate learning disabilities.

With severe learning disabilities.

Family dynamics.

Emergency cases.

Clinical (supervised cases):

Management of epilepsy.

Indirect behaviour therapy.

Direct behaviour therapy.

Drug treatments.

Individual psychotherapy.

Group therapy.

Family therapy.

Clinical (special interest experience):

Clinical genetics.

Neuropsychiatry.

Forensic psychiatry.

Child psychiatry.

Paediatrics.

Neurology.

Psychotherapy.

Rehabilitation.

Other courses:

Child development assessment.

Management.

**(v) Forensic psychiatry**

Clinical (significant experience in the following settings):

Medium secure unit.

Special hospital.

Forensic in-patient ward, for example, locked, open, rehabilitation.

Out-patient clinic (including supervision of restricted patients).

Community hostels.

Penal establishments for remand and sentenced prisoners.

Criminal courts.

Mental health review tribunals.

Clinical (some experience in the following settings):

Court diversion schemes.

Civil courts.

Forensic learning disability units.  
Adolescent and child forensic psychiatry services, for example, secure units.  
Victim services.  
Specialist penal establishments, such as, young persons, life-sentenced prisoners, high security, vulnerable prisoner units, care of females, special units.  
Services for the homeless.

Clinical (visits to the following settings):

Home Office.  
Parole board.  
Other special hospitals.  
Other medium secure units.  
Police facilities.  
Therapeutic communities.  
Privately organised forensic services.

Psychotherapy:

A summary of essential experiences is outlined in FPSAC's notes of guidance on psychotherapy training for senior registrars in forensic psychiatry.

Miscellaneous:

Contact with the Mental Health Act Commission  
On-call experience on a senior psychiatric rota which includes responsibility for a forensic unit

#### **(vi) Psychotherapy**

Clinical (experience):

##### *Settings*

Out-patient work.  
In-patient and day patient work.  
Therapeutic community.  
Large group work and the application of psychodynamic principles to communities and institutions.

##### *Assessments*

Assessment for psychotherapy.  
Joint assessments with psychotherapists from different branches of the subject.

##### *Formats*

Individual and joint working.  
Individual, couple, group and family work.

*Durations*

Brief (planned therapy of less than six months duration), medium and long-term cases.

*Frequency*

Appropriate to the branch being taught and congruent with the type of therapy to be practised.

*Range (a representative range of patient problem, diagnosis and severity level)*

Neuroses.

Personality disorders.

Relationship problems.

Borderline and psychotic states.

Psychosomatic disorders.

Traumatic reactions.

*Special experience*

Consultation to individuals, groups and institutions.

Work with psychotherapy and counselling services outside the NHS (e.g. Relate, direct access counselling services, sexual dysfunction clinics, social services, probation).

Child observation.

Pre-school children.

Adolescents.

Child guidance unit.

Learning disability.

Ethnic and other minorities.

Liaison work.

General (adult) psychiatry and rehabilitation.

The elderly.

Disorders associated with physical illness.

Emergency work.

Forensic work.

Nine hundred hours of supervised practice of which 700 should be in the main branch of psychotherapy and 100 in each of the other branches. The three branches currently are psychodynamic/interpersonal, behavioural-cognitive and systems-based psychotherapy. Trainings may adopt an eclectic position, giving equal or near-equal weight to many branches but it is likely that most trainees will major on one. The supervised practice should ensure that a representative range of patients (problem, diagnosis and severity) are seen in a variety of formats (individual, group, couple and family) over a range of durations (brief, medium, and long-term) and frequencies (appropriate to the branch being taught).

Three hundred hours of supervision. Experience of working with three supervisors; supervision should occur both individually and in a group. Allowance may be made for situations such as family therapy where practice and supervision is co-terminous.

Individual psychotherapy.  
Group therapy.  
Cognitive therapy.  
Behaviour therapy.  
Family therapy.  
Supervised assessments (40).  
Supervision of supervision.

Theoretical learning:

400 hours of academic study of which 150 hours should be in direct teaching (seminars/lectures).

Personal self-knowledge:

As appropriate, training therapy for three years in a form(s) that is (are) congruent with the type of therapy to be practised.

Individual therapy.  
Group therapy.  
Family therapy.  
Couple therapy.

Teaching:

Recommended training experiences, as described above, with particular emphasis on:

- (a) Clinical supervision of psychotherapy and psychotherapists.
- (b) As appropriate, the use of audio and video recordings, screen observation and live supervision.
- (c) Participation in multi-perspective (multi-branch) case conferences, journal clubs and research meetings.

Research:

Recommended training experiences, as described above, with particular emphasis on:

- (a) Critical evaluation of the literature in the major branch selected.
- (b) Becoming familiar with the leading issues in psychotherapy as a whole.
- (c) Greater weight may be given to the research element in posts designed to prepare trainees for academic positions.

Courses studied:

Human development.

Mental health.

Cultural variation and influences.

Stigma, discrimination and prejudice.

Key concepts and theoretical principles.

Psychodynamic theory.

Cognitive-behavioural theory.

Small group and systems theory.

Developmental assessment.

Therapeutic skills and techniques.

Ethics, values and philosophy.

Psychotherapy supervision.

Research methodology.

Teaching skills.

Management principles.

## 6. Appendices

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### **Application for the award of a CCST (from 1 January 1997)**

It is the College's responsibility to recommend the award of a CCST to the STA. If the STA supports the College's recommendation, it will issue the CCST and provide details of how to register with the General Medical Council. It is the trainee's responsibility to contact the College for a set of CCST application forms.

In order to apply for a CCST a trainee must complete the College notification form which needs to be countersigned by the postgraduate dean, supported by a RITA Form C and forwarded to the College with a cheque for £100 (single CCST) or £150 (dual CCST) made payable to the Royal College of Psychiatrists. The RITA form should have been signed by both the trainee and the chairman of the Specialist Training Committee as a part of the final assessment process.

If any part of an applicant's higher training was subject to an individual grant of educational approval from the HSTC a copy of the approval letter must be enclosed with the College notification form. Simultaneously, an application for Award of a CCST should be forwarded to the STA, together with a cheque for £250.

It is recommended that trainees aiming for dual certification apply for a dual CCST at the end of their programme; the fees involved will be £400 (one fee of £150 to the College and one of £250 to the STA). Application for two separate CCSTs will cost £700 (two separate fees to the College of £100 each and two to the STA of £250 each).

Further details and advice can be obtained by telephoning the College on 0171 235 2351 x 160. An example of the College notification form is given on the following pages.

## AWARD OF CCST – COLLEGE NOTIFICATION FORM

Department of Postgraduate Educational Services  
The Royal College of Psychiatrists  
17 Belgrave Square  
London  
SW1X 8PG

This form is for use only by those trainees who are nearing completion of their higher specialist training in psychiatry. It should be completed in BLOCK CAPITALS and returned to Carole Pashley at the above address approximately one month before your expected date of completion, where possible. Please note that submission of an incomplete application may cause a delay in the award of your CCST.

Surname:	Forenames:
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Correspondence address (including postcode):
Daytime telephone number:

GMC registration number:
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Primary medical qualification (including date of award and name of university/awarding body):
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Date of passing MRCPsych examination (or equivalent qualification):
---------------------------------------------------------------------

<u>Speciality</u>	<u>Sub-speciality</u>
Child & adolescent psychiatry	Liaison psychiatry
Forensic psychiatry	Rehabilitation psychiatry
General psychiatry	Substance misuse psychiatry
Old age psychiatry	
Psychiatry of learning disability	
Psychotherapy	

I have enclosed a cheque for *(please tick accordingly)*:

£100 (single CCST)

£150 (dual CCST)

*cheques should be made payable to the Royal college of Psychiatrists*

**APPOINTMENTS APPROVED FOR HIGHER SPECIALIST TRAINING**

Title of scheme/s:

<u>Type of Post</u>	<u>Speciality/Sub-Speciality</u>	<u>Location of Appointment</u>	<u>Trainer/s</u>	<u>From</u> <u>To</u>
<u>Example</u>				
Senior	General Psychiatry	ABC Hospital	Dr A Smith	Aug 95
Registrar				Jul 96

**YOU MUST ENCLOSE COPIES OF ANY HSTC APPROVAL LETTERS WHICH  
APPLY TO ANY OF THE ABOVE**

Applicant's signature:

Date:

**YOU MUST NOW ASK YOUR POSTGRADUATE DEAN TO COMPLETE THIS PAGE OF THE FORM. PLEASE ENSURE THAT THIS IS DONE BEFORE YOUR APPLICATION IS SUBMITTED TO THE COLLEGE.**

**CONFIRMATION OF TRAINING FROM THE POSTGRADUATE DEAN**

This is to confirm that the above doctor will successfully complete (or has successfully completed) a higher specialist training programme in one or more of the following psychiatric specialities:

*Please tick accordingly*

Speciality

Sub-Speciality

Child & adolescent Psychiatry

Liaison psychiatry

Forensic psychiatry

Rehabilitation psychiatry

General psychiatry

Substance misuse psychiatry

Old age psychiatry

Psychiatry of learning disability

Psychotherapy

I am able to confirm that the applicant's date of completion of higher training is:

.....

*I will notify the College if there is any change to this confirmation.*

Postgraduate dean's name:

Postgraduate dean's signature:

Date:

**PLEASE ENSURE THAT THE FINAL RITA FORM C: Record of Satisfactory Progress IS SUBMITTED WITH THIS FORM.**

## **Transitional arrangements**

The criteria for award of CCSTs which are described in this *Handbook* apply to trainees who took up an SpR/senior registrar appointment after 31 December 1996. It also applies to doctors in higher psychiatric training prior to that date, with the following exceptions:

1. All approved lecturer posts provided a full higher training in three years, with the exception of those with a specific training limit.
2. All dual training programmes were of four years' duration.

One further concession applies to trainees who were in post-membership registrar posts prior to the end of 'transition' (i.e. 30 November 1996). They may apply to the HSTC for approval of up to 12 months of higher training gained in post-membership registrar posts, whether clinical or research. They will need to provide confirmation from the relevant trainer(s) that their post-membership registrar post(s) were equivalent to higher training in terms of clinical responsibility and supervision, research and participation in an appropriate academic programme. A letter of support from the organiser of the higher training scheme in which the applicant holds a substantive post is also required, together with a CV.

## **Advisory papers**

The five SACs from time to time produce advisory papers. These do not constitute additional requirements for approval but are intended to be helpful in suggesting ways in which various requirements for approval can be met, to give further details on particular types of training or to provide background information.

At the time of going to press the following advisory papers were available:

- CAPSAC: psychotherapy; psychopharmacology; in-patient and day patient care; consultation; developmental psychiatry; adolescent psychiatry; forensic psychiatry; paediatric experience; research; management; clinical audit and information technology; clinical case loads.
- FPSAC: special hospital training; prison experience; psychotherapy.
- PTSAC: the role of personal therapy, criteria for approval of psychotherapy placements on general/old age psychiatry schemes.
- CAPSAC/FPSAC: training for consultant posts in forensic child and adolescent psychiatry.

## **Training for consultants wishing to move speciality**

The College document 'Notes of Guidance for College Representatives on NHS advisory consultant and honorary consultant appointments committees in the UK', April 1997, states:

*“In unusual circumstances, such as a consultant changing speciality or with a EU training, a consultant may not necessarily be on the relevant List of the Specialist Register but may have had additional training as part of their continuing professional development, which is considered to equip them for appointment to a consultant post in another speciality area within psychiatry.”*

The SACs have produced guidelines on further training for consultants wishing to change speciality. Any consultant psychiatrist considering undertaking further training should obtain a copy of the relevant guideline from the HSTC office (some are under revision at the time of going to press). A programme of additional training must be submitted to the HSTC and its successful completion confirmed by the relevant training programme director. Such training is undertaken within the aegis of an approved training scheme on secondment from consultant posts. While it enables a psychiatrist to demonstrate at an appointments committee that they have sufficient training in the speciality to which they wish to move, it does not lead to award of a CCST. This can only occur where the consultant has returned to a substantive SpR post and completed the relevant training. It is recommended that consultants who have completed a programme of further training are appointed to a post in their new speciality in open competition.

Consultants who have completed further training in this manner may be put forward as SpR trainers.

