RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

CETC COLLEGE EDUCATION & TRAINING CENTRE

Health for Health Professionals

Enhanced Competencies for Psychiatrists

This document complements:

Guidance and Competencies for the Provision of Services using Practitioners with Special Interest: Royal College of General Practitioners, January 2010

Competency Framework, Faculty of Occupational Medicine, March 2010

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Health for Health Professionals

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Enhanced Competencies for Psychiatrists

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Health for Health Professionals

Enhanced Competencies for Psychiatrists

FOREWARD

Core attributes - good psychiatrists

Patients, their carers, their families and the public need good psychiatrists. Good psychiatrists make the care of their patients their first concern: they are competent, keep their knowledge up to date; are able and willing to use new research evidence to inform practice; establish and maintain good relationships with patients, carers, families and colleagues; are honest and trustworthy, and act with integrity. Good psychiatrists have good communication skills, respect for others and are sensitive to the views of their patients, carers and families.

A good psychiatrist must be able to consider the ethical implications of treatment and clinical management regimes. The principles of fairness, respect, dignity and autonomy are considered fundamental to good ethical psychiatric practice. A good psychiatrist will take these issues into account when making decisions, and will need to pay particular attention to issues concerning boundaries and the vulnerability of individual patients. A good psychiatrist will not enter into a relationship with a patient or with someone who has been a patient.

RCPsych Good Psychiatric Practice, 3rd edition. February 2009.

INTRODUCTION

This document has been commissioned by the Department of Health as part of a programme to develop a framework of knowledge and skills for health professionals who treat other health professionals with mental health, addiction or physical health problems. It complements the document produced by the Royal College of General Practitioners (RCGP) entitled "Guidance and Competencies for the Provision of Services using Practitioners with Special Interest" (January 2010), which was produced in collaboration with the Royal College of Psychiatrists (RCPsych) and the Association of NHS Occupational Health Physicians (ANHOPS), as part of the Health for Health Professionals (HHP) initiative which arose from the White Paper "Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century", published in February 2007.
(http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065946)

This framework describes the competencies expected of psychiatrists who assess, treat, and manage other healthcare professionals as patients, and outlines the educational requirements needed to meet these competencies.

Throughout 2009, a Project Group, nominated by the College, met with representatives from the RCGP and ANHOPS to discuss the competency framework for the three professional groups, as part of the Department of Health (DH) Health for Health Professionals (HHP) programme. The Project Group had the support of Mrs Lynne Christopher, Head of Training, from the College Educational and Training Centre. The Royal College of Psychiatrists convened a separate Competency Group, with a representative membership, to develop enhanced competencies for psychiatrists. This group met in July 2009. There followed a consultation exercise on enhanced competencies for psychiatrists, resulting in this document. The RCPsych document is informed by and complements the documents of the RCGP and ANHOPS.

BACKGROUND

Many doctors and other health professionals are affected by mental health problems and these problems account for much undeclared and unrecognised, but treatable, morbidity. It is important that services are established to meet the health needs of practitioners. Psychiatrists with enhanced competencies are an essential component of such services. Psychiatric expertise should also be deployed in advising and informing educational, training, employment and regulatory bodies. The clinical component of the work with practitioner patients involves extensive confidential communication and joint working. The core alliances within medicine are between General Practice, Occupational Health and Psychiatry. College endorsement of these enhanced competencies establishes legitimacy for this work and enables employment contracts to reflect that commitment.

The Royal College of Psychiatrists has a long history of promoting this work, both at clinical and policy levels. In the 1980s the College was instrumental, through Professors Kenneth Rawnsley and Sydney Brandon, in creating what became the National Counselling Service for Sick Doctors (NCSSD), a confidential volunteer service staffed by interested clinicians, many of whom were psychiatrists. (Rawnsley, 1985; Brandon, 1996; Oxley, 2004). The NCSSD has now been incorporated into the British Medical Association Doctors for Doctors service, whilst a component has transferred to become the College's Psychiatrists Support Service.

Following the Merrison Report into the Regulation of the Medical Profession (HMSO, 1975) the GMC developed its Health Procedures which led, in 1980, to the establishment of a Health Committee and the creation of the post of a Screener for Health (a psychiatrist member of the GMC). The Screener's role was to interpret the information submitted by Medical Examiners and Supervisors about doctors who had a definable clinical condition, and to integrate this information into the work of the Health Committee. The Screener, Supervisors and almost all Examiners were psychiatrists. Virtually all Health Committee cases attracted a psychiatric diagnosis.

The Shipman Inquiry – Fifth Report addressed the protection of the public when a doctor's fitness to practise is compromised by mental health problems, including addictive disorder, and may be an associated factor in criminality. It recommended the separation of adjudication from licensing. The creation of a new GMC as a publicly appointed body means that there has been no psychiatrist member since 2003. The role of the Screener has been replaced by a

body of paid Case Examiners (both lay and medical), only one of who is psychiatrically trained. The health issues presenting to the GMC remain almost exclusively psychiatric in nature.

These changes to the structure function and constitution of the GMC led to the cessation of its role as a representative body. Conduct, health and performance components were amalgamated into a Fitness to Practise Directorate. The investigation of concerns will continue to be a GMC responsibility, but adjudication will pass to the Office of the Health Professions Adjudicator (OPHA) in 2011.

A Health Procedures Review Group headed by Dame Deirdre Hine concluded that the Government and profession should take responsibility for the identification of doctors affected by ill health and should consider the provision of effective, accessible arrangements for intervention, assessment, treatment, rehabilitation and support (Hine, 2005).

The GMC Fitness to Practise Panels are currently assisted by Medical Advisers who are party to the proceedings and are asked to comment, but (unlike the Legal Adviser) are excluded from the Panel's deliberations. As a result, an adjudicating Fitness to Practise Panel may not benefit from psychiatric advice about the relative importance of evidence in complex cases unless all parties are recalled. This added barrier to access was prompted by Judicial Review of a single case, but the universal consequence has been to limit the deployment of psychiatric expertise in the disposal of a case where psychiatric morbidity has been a significant component.

The independent Inquiry into the care and treatment of Dr Daksha Emson, and her three-month old daughter, who died following an extended suicide, highlighted a number of issues which contributed to the tragedy. These included the *stigma of mental illness; being a doctor and a patient; and inadequacies in NHS Occupational Health Services* (North East London Strategic Health Authority, 2003).

The stigma of mental illness

Doctors with mental illness often find themselves in a persecutory and blaming environment, and worry about being scape-goated. Their capacity to contain their vulnerability to illness is often problematic. In an ideal world, it ought to be possible for individuals to be open about any mental health problem, and the working environment should be a culture which enables doctors to be open about their stresses and vulnerabilities. In reality there is often little containment of anxiety generated by sick doctors in terms of institutional/fitness to practise issues, and these doctors worry that any

acknowledgment of their problem has the potential to hinder their career advancement. As "confidentiality is believed to be poor within the health service" doctors with mental health problems are extremely reluctant to attend integrated services, and secrecy and anonymity are inappropriately maintained (NE London Strategic Health Authority, 2003).

Doctor- to - Doctor Consultations

The report acknowledged that, within the provision of specific services for sick doctors, there existed a "grey market", particularly for those doctors with psychological/psychiatric problems, in which there was potential for them to be treated less effectively than "ordinary" patients. Psychiatrists treating doctors require a level of expertise, confidence and authority, which many psychiatrists do not have. Doctors who treat doctors also need a support structure. The identification and development of a cadre of consultant psychiatrists to do this work, set in the context of a supported system, has long been discussed within the Royal College of Psychiatrists. Nationally, small groups of psychiatrists could be linked into a comprehensive network of services and regional support systems working closely with Deaneries and Occupational Health Services (Nuffield Provincial Hospitals Trust, 1996; DH, 1999).

Occupational Health Services

NHS Occupational Health Services have historically been patchy in terms of national coverage, with variable staffing. Most Occupational Health Physicians and Nurses do not have specialist psychiatric training and only limited psychiatric experience. However Occupational Health Services have the potential to enable health professionals with mental health problems to access appropriate support, care and treatment.

Mental Health and Illness in Doctors

Following the publication of the Daksha Emson Inquiry Report, the National Director for Mental Health, Professor Louis Appleby, convened a working group to consider doctors' mental health and ill health. This group worked with key organisations to identify factors that might reduce the risks for doctors becoming unwell, and make it easier for them to access help if they did. The subsequent report, *Mental Health and Ill Health in Doctors* (DH, 2008) acknowledged that there were specific features of mental ill health in doctors that had to be considered when designing and providing care for them. These included high rates of disorder; the tendency to conceal or deny their problems, to present at a late stage and bypass formal channels for help; privileged access to prescription drugs; and the contribution of the working environment to their illness and its potential to delay recovery. The report made a number of recommendations under the following headings:

- Access to information

- Designated care pathways and services
- The role of Occupational Health Services
- Tackling stigma and discrimination
- Healthy working practices
- Reducing stressors in the workplace
- Supporting staff with mental ill health
- Looking after one's own health.

The key principles for the clinical care of doctors with mental health problems were set out as follows:

- Doctors who are ill should be treated first and foremost as patients, not colleagues
- Rules on confidentiality should be strictly observed
- Additional safeguards to ensure privacy of care should be in place
- Doctors should be registered with a local GP
- Doctors treating doctors should have appropriate expertise and seniority
- Out-of-area care should be arranged unless local care is specifically requested
- Doctors should receive the same care and risk management as other patients.

The Chief Medical Officer's report on medical regulation *Good doctors, safer patients* (July 2006) also recognised deficiencies in the provision of care to doctors with mental health and addiction problems and recommended that methodologies should be developed for the assessment of practitioners with mental health and addiction problems and that the NHS should commission a Specialised Addictions Service.

Following the recommendations in the White Paper, *Trust Assurance and Safety – the Regulation of Health Professionals in the 21st Century* (February 2007), the Department of Health directed the National Clinical Assessment Service (NCAS) to work with stakeholders to devise a specification for a pilot service for practitioners with mental health/addiction problems, building on existing good practice in the United Kingdom and abroad.

Royal College of Psychiatrists Expert Working Group and the Proposal for a Practitioner Health Programme

Towards the end of 2006 the Royal College of Psychiatrists and the London Deanery asked Dr Anthony Garelick, consultant psychiatrist, to convene an expert stakeholder working group to advise on how the CMO's proposals might be taken forward. Dr Garelick's expert working group met on a number of occasions from November 2006 to mid-2007 and reached a consensus on what was needed to improve health services for doctors and other healthcare professionals. Stakeholders in the group included the medical Royal Colleges, the Deaneries, the Faculty of Occupational Medicine, the General Medical Council, BMA, NHS Litigation Authority, NHS Employers, the Medical Defence Organisations, and the Sick Doctors' Trust and other professional self-help groups. It also reviewed the Clinicians Health Intervention for Treatment and Support (CHITS) which had previously set out proposals for a UK-wide addiction service for health professionals (Fowlie, 2005; Wilks and Freeman, 2003).

Dr Garelick's expert working group contributed to a Paper on a Proposal for a Practitioner Health Programme, which was published in June 2007 under the auspices of the Royal College of Psychiatrists, NHS London, NCAS and the BMA. The principles of a Practitioner Health Programme (PHP) were outlined as follows:

1. Principle 1 – Protecting the safety of patients
2. Principle 2 – Confidentiality
3. Principle 3 – Taking account of the particular needs of doctors as patients
4. Principle 4 - Enhance the use of local services
5. Principle 5 - Prompt access to specialist services
6. Principle 6 – "Hub and spoke" model
7. Principle 7 - Treatment separate from monitoring
8. Principle 8 - Data collection and evaluation
9. Principle 9 - Responsive to policy initiatives across the UK

The Expert Working Group proposed a service providing effective treatment that would complement GMC procedures for the monitoring of doctors whose health problems gave rise to conditions about their fitness to practise. The Practitioner Health Programme (PHP) was not designed to replace the GMC

procedures, but was envisaged as complementing the role of the National Clinical Assessment Service (NCAS) in assessing the performance of doctors referred to that service. The proposal for a Practitioner Health Programme was accepted by the Department of Health in July 2007.

Proposal for a Prototype Practitioner Health Programme

In January 2008 the National Clinical Assessment Service published its proposal for a prototype Practitioner Health Programme (PHP) in London (NCAS, 2007). This prototype programme, initially a 2-year pilot service, was established for registered medical and dental practitioners living or working within the London Strategic Health Authority area who might present with:

- A mental health or addiction problem (at any level of severity)
- A physical health problem ("where a physical health problem may impact on the practitioner's performance")

The Practitioner Health Programme was established to enhance existing health services for practitioners and was designed to complement, but not replace local health services, existing peer support and GMC/GDC health procedures. It was also designed to draw on good practice in the UK and also the combined experience of similar programmes in America. NCAS commissioned the project, chairs the management group and remains responsible for audit and governance, reporting to the Department of Health. However, it was envisaged that the clinical service to be provided would be separate and distinct from NCAS and other services.

Practitioner Health Programme

The Practitioner Health Programme (PHP) www.php.nhs.uk was commissioned in April 2008, and opened in September 2008. The core service (PHP1) is based at the Riverside Medical Centre, Vauxhall, London and PHP2 secondary care services are based variously at the South London and Maudsley NHS Foundation Trust; the Tavistock and Portman NHS Foundation Trust and Capio Nightingale, all in London, and Clouds House, in Wiltshire. PHP1 saw 184 practitioner patients doctors during its first year of service, 114 (62%) of whom presented with mental health problems; 67 (36%) with an addiction problem and 3 (2%) with a physical health problem (NHS Practitioner Health Programme, 2010). These figures underscore the predominance of mental health problems in this group. The programme has been extremely successful and satisfaction with the service is high, its holistic and confidential nature especially garnering praise.

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Intended Learning Outcomes Areas

1. **Awareness**
2. **Specialist Assessment, Treatment and Management of the Practitioner-patient.**
3. **Risk Assessment/Public Protection**
4. **Regulatory Processes**
5. **Health, Work and Well Being**
6. **Long Term Care/After Care**
7. **Liaison Support Training**
8. **At Organisational Level**
9. **Service Development**
10. **Research and Audit**

Intended Learning Outcome: 1. Awareness
Recognise how mental health, addiction and/or physical health problems may present in the practitioner-patient

Knowledge	Skills	Attitudes demonstrated through behaviours
• Demonstrate knowledge of how mental health and addictions problems can present in the practitioner-patient and in particular the role of the workplace in the initiation and perpetuation of mental health problems • Demonstrate knowledge of the needs of health professionals, including knowledge of epidemiology, natural history, assessment, treatment, prognosis • Demonstrate knowledge of help-seeking behaviour and access to health care by health professionals • Demonstrate knowledge of the full range of treatment models for the management of different mental health and addictions disorders • Demonstrate knowledge of behavioural, social and psychological factors in the disproportionate burden of mental health and addictions disorders found in health professionals • Demonstrate knowledge of the importance of boundary issues when dealing with practitioner	• Raise the issue of mental health/addictions problems sensitively in response to a particular presentation or opportunistically • Provide support and advice to other practitioners on the management of practitioner-patients • Refer practitioner-patients to appropriate treatment services • Minimise the risk of mental health problems/addiction in self • Demonstrate an understanding of the education and training environment for healthcare professionals • Demonstrate an ability to work in an integrated multi-professional team • Demonstrate an understanding of the working environment for healthcare professionals	• Have a non-judgmental attitude • Support and encourage normalisation of mental health discussions by health professionals • Have an awareness of how cultural, sexual, spiritual differences may impact on presentation, assessment and engagement • Awareness of barriers to help-seeking and indirect signs of health/addiction problems

patients • Demonstrate and understanding of the roles of other health professionals		

Intended Learning Outcome: 2. Specialist Assessment, Treatment and Management
To carry out a specialist assessment of the particular needs of the practitioner-patient presenting to treatment; to initiate treatment using a range of therapies/interventions (psychotherapeutic, biological and socio-cultural) and to demonstrate provision of effective evidence-based and high quality care and case management functions

Knowledge	Skills	Attitudes demonstrated through behaviours
• Demonstrate knowledge of clinical conditions and syndromes (mental health and addictions) affecting working age adult patients, and in particular the practitioner-patient • Demonstrate knowledge of the biological, psychological, social and cultural factors which influence the presentation, course and treatment of these conditions in the practitioner- patient • Demonstrate knowledge of the phenomenology and psychopathology of mental health and addictions disorders affecting the working age population and in particular the practitioner-patient • Be familiar with NICE and other good practice guidance with respect to mental health/ addictions • Demonstrate knowledge of psycho-social and pharmacological management of co-morbidity • Demonstrate knowledge of the working environment of the practitioner-patient and its	• Engage with and understand the practitioner-patient, who may have been suffering from a complex and unidentified health problem • Demonstrate the ability to carry out a detailed assessment of a substance misuse disorder in a practitioner-patient • Manage minimisation or under-reporting of problems • Demonstrate a flexible approach to the practitioner-patient and an ability to deal with multiple concurrent problems: physical, mental health, work, employment, education and social. • Elicit appropriate information according to the situation (e.g. in situations of urgency prioritise what is immediately needed) • Elicit the practitioner-patient's view of their problem/situation (both what is said and left unsaid) and show insight into how and when to follow up on "leads" (careful and reflective listening, reframing and summarising as per motivational interviewing techniques) • Frame the needs of the practitioner-patient in the context of their life-time and work-related experiences and their family • Show patience in situations where communication is limited by language or socio-cultural issues • Develop and sustain a therapeutic relationship with the practitioner-patient over the long-term • Develop therapeutic optimism and hope • Formulate a treatment plan where close monitoring,	• Display a non-judgmental, empathic attitude • Display tact and diplomacy • Maintain professional boundaries • Be mindful of vulnerable groups • Show respect for other health care staff • Acknowledge cultural issues • Understand why the practitioner-patient may minimize or under-report their difficulties • Be aware that there can be a strong therapeutic component to supervision

pressures and requirements • Know when to seek advice from other professionals	supervision and strict adherence to the programme is required as part of the back-to-work process • Demonstrate the acquisition of advanced treatment skills • Reflect on and co-ordinate the care of the practitioner-patient, taking into account information and reports from other medical sources (GPs, psychiatrists, occupational health physicians, other doctors, employers, Trusts, Defense Organizations, NCAS, GMC), also family members • Evaluate the outcome of psychological treatments either delivered by self or others and organize subsequent management appropriately • Display the ability to provide expert advice to other health and social care professionals on the psychological treatment and care of the practitioner-patient • Be aware of when, as the treating psychiatrist, one needs support and be able to access this	

Intended Learning Outcome: 3. Risk Assessment/Public Protection
Based on a comprehensive psychiatric assessment be able to demonstrate the ability to assess comprehensively, and document the practitioner-patient's potential for self-harm or harm to others

Knowledge	Skills	Attitudes demonstrated through behaviours
• Demonstrate knowledge of the requirement to protect the safety of patients who may be cared for by the practitioner-patient e.g. addictions, driving offences, work-related issues, complaints etc which may lead to mistakes, misinterpretations, wrong prescribing, clinical errors • Based on a comprehensive psychiatric assessment, demonstrate the ability to assess comprehensively, the practitioner-patient's potential for self-harm, or harm to others; this to include an assessment of risk and the ability to intervene effectively to minimise risk and the ability to implement actions to prevent self-harm and harm to others* • Know from where and from whom to gather information and be assiduous in collecting such information in a professional, reassuring and confidential manner and be aware when such information may be incomplete • Where appropriate use enhanced risk assessment tools (patient-practitioner specific)	• Assess and manage the practitioner-patient with mental illness and/or addiction problems including uncommon conditions, who presents in an emergency • Make a judgement about the most appropriate treatment service for the practitioner-patient, having weighed up their wishes, the need for confidentiality, the severity of illness/disorder, the stability of the mental state and the risks • Demonstrate expertise in applying the principles of crisis intervention in emergency situations • Make care plans in urgent situations where information may be incomplete • Assess suicide risk and make short and long term plans accordingly • Assess the risk that the practitioner- patient poses to others (e.g. patients or public) and make short- and long-term management plans as required (e.g. advice to stop work) • Assess the severity of the problem(s) in the context of predisposing and perpetuating factors at work and home • Understand when to inform regulatory bodies, including GMC, DVLA etc	• Maintain good professional attitudes and behaviour when responding to situations of ambiguity and uncertainty • Be fair and supportive • Be mindful of risk to patients/public (the safety of patients must be the first priority at all times)

• Know the local and national bodies that practitioner-patients can or must engage with to reduce harm to themselves or others • Understand the roles of the Responsible Medical Officer, the Deanery, the GMC/GDC and NCAS • Understand the remediation process		

Intended Learning Outcome: 4. Regulatory Processes
Be able to demonstrate the ability to comply with regulatory frameworks

Knowledge	Skills	Attitudes demonstrated through behaviours
• Demonstrate clear understanding of the regulatory framework, processes and procedures for doctors and dentists including the GMC/GDC Fitness to Practise procedures • Understand the distinction between GMC medical supervision from treatment (legal reasons) • Recognise that there can be a strong therapeutic component to supervision • Demonstrate an understanding that supervising a doctor/dentist for the GMC/GDC is time consuming work which must be carried out meticulously • Know how, when and why to communicate with a network of professionals and workplace supervisors	• Decide when a practitioner patient is unfit to practice and why, and back this up with evidence • Communicate appropriately with a network of professionals and workplace supervisors • Reflect on and co-ordinate the care of practitioner patients, taking into account information and reports from medical sources (GPs, psychiatrists, occupational health physicians, other doctors), employers (workplace reports) and others (GMC, GDC, NCAS) • Utilise effective communication skills during interaction with the practitioner-patient, colleagues and any other relevant individuals in the management of the practitioner-patient • Demonstrate an ability to assess the practitioner-patient's insight into their problem, and its impact on their fitness to practise and ability to cope with a normal workload • Assess the limitations of treatment and the limits of the practitioner-patient's own ability to benefit from treatment	• Maintain a supportive professional attitude to the practitioner-patient despite difficulties faced

Intended Learning Outcome: 5. Health, Work and Well Being
Working in collaboration with the Occupational Health Physician and other professionals, be able to demonstrate the ability to provide health advocacy functions; to carry out a return to work (RTW) assessment and implement this.

Knowledge	Skills	Attitudes demonstrated through behaviours
• Know the Regulatory process, legal framework, employment processes including disciplinary procedures • Know the functions of the BMA and other Trade Unions relevant to health professionals • Have an understanding of the Disability Discrimination Act (1995, amended 2005) and how this Act has been used in the healthcare sector • Understand the role of the Occupational Health Physician • Have detailed knowledge of the roles of the Responsible Medical Officer, the Deanery, NCAS, the GMC/GDC • Know the local and national bodies with which the practitioner-patient must engage in order to reduce harm to themselves and others • Understand the required levels of competence and confidentiality • Understand the remediation process • Have detailed knowledge of the	• Co-ordinate care and information flow between different medical and non-medical parties • Write accurate, concise reports and also present the case of the practitioner-patient where appropriate, mindful of confidentiality issues, conflicts of interest etc • Participate in legal processes (for example, give expert evidence at Tribunals and/or Regulatory Hearings) • Work with OHPs to carry out a return-to work (RTW) assessment • Work with OHPs to develop a RTW programme, including advice on making reasonable adjustments to the job plan • Advise on ill-health retirement/permanent change in working • Recognise when information on the practitioner-patient is incomplete and reflect on who best to contact to augment such information (e.g. in setting up a return to work programme it will be necessary to discuss the practitioner-patient with the OHP, but important information may also be obtained from a previous workplace supervisor, colleagues, Clinical Director) • Balance the strengths and weaknesses of the practitioner-patient and the strengths and weaknesses of the workplace to which they are returning	• Understand boundary issues • Work in a professional and conciliatory manner, be reasonable with all parties involved and provide timely reports

principles of assessing fitness to work • Be aware of the organisational and workplace factors which might need addressing in order to facilitate the safe return to work of a practitioner-patient		

Intended Learning Outcome: 6. Long Term Care and Supervision
Be able to demonstrate case management skills; provide ongoing support, supervision and monitoring when the practitioner –patient returns to the workplace

Knowledge	Skills	Attitudes demonstrated through behaviours
• Knowledge of the roles of the various practitioners involved in the care of the practitioner-patient • Provide on-going case management, supervision and monitoring (e.g. laboratory investigations and tests).	• Work with a multi-professional team in accordance with their roles and responsibilities • Sustain a long standing therapeutic relationship with the practitioner-patient • Arrange and review the results of laboratory tests to monitor compliance • Effectively review work place performance and apply necessary scrutiny to the feedback • Maintain an effective liaison with OH, sharing support and responsibilities as appropriate • Clearly provide both positive and negative feedback • Respond promptly to relapse and identify likelihood of relapse • Able to provide a formulation of a treatment plan • Engender an ability in the practitioner – patient to work under surveillance	• Flexibility • Avoid conflicts of interest awareness / collusion, manipulation, emotional blackmail, other tensions • Maintain a highly professional and ethical stance • Explain boundary and confidentiality issues and actively pay attention to these issues at all times

Intended Learning Outcome: 7. Liaison and Support
To demonstrate the ability to work effectively with a range of colleagues across specialties, including team and collaborative working

Knowledge	**Skills**	**Attitudes demonstrated through behaviours**
• Demonstrate knowledge about the interfaces between adult psychiatry/addictions and other psychiatric specialities, other branches of medicine (especially primary care and occupational medicine) and other service providers*	• Develop and maintain effective relationships with primary care and occupational health services and other care providers, including the voluntary sector and self-help groups (e.g. Alcoholics Anonymous, the British Doctors' and Dentists' Group, Doctor's Helpline etc) so facilitating effective referral mechanisms and educational systems • Share clinical management of the practitioner-patient with other healthcare professionals and work effectively to ensure ongoing communication, to the mutual benefit of the practitioner-patient, their patients and all professionals involved in the treatment process • Prescribe safely, monitor, and where appropriate arrange the full range of physical treatments required to treat the practitioner-patient	• Show confidence in negotiating boundary problems and issues of confidentiality

Intended Learning Outcome: 8. At Organisational Level
To develop appropriate leadership skills

Knowledge	Skills	Attitudes demonstrated through behaviours
• Understand the role of the psychiatrist working with practitioner-patients • Demonstrate a clear idea of the roles of different healthcare professionals working in this field and how best this expertise is integrated in the interests of the practitioner-patient • Demonstrate an understanding of the differing types of leadership • Demonstrate an understanding of the structures of the NHS, social care and professional regulatory organisations • Demonstrate an understanding of organisational policy and practice at a national level in the wider health and social care environment • Demonstrate an understanding of the principles of change management	• Competently manage a service • Work with service managers and commissioners and demonstrate management skills such as understanding the principles of developing a business plan* • Manage change • Manage complaints • Contribute to the interface between the team managing the practitioner-patient and other psychiatric teams, medical teams and service providers by working in a collaborative manner • Demonstrate a range of appropriate leadership and supervision skills • Show clinical and managerial leadership through modelling and mentoring colleagues in the same and other disciplines	• Be available to team members and other agencies for consultation and advice • Work collaboratively with colleagues from a variety of backgrounds

Intended Learning Outcome: 9. Service Development
To demonstrate the ability to develop and manage a comprehensive and integrated network of services (including a virtual network) to meet the needs of the practitioner-patient and fulfil the requirements of "Good Medical Practice" and "Good Psychiatric Practice"

Knowledge	Skills	Attitudes demonstrated through behaviours
Knowledge of the duties of a doctor/dentist registered with the GMC/GDC Knowledge of core attributes of good psychiatrists	• Demonstrate an ability to design and implement programmes for change, including service innovation* • Demonstrate active involvement in service design and development	

Intended Learning Outcome: 10. Research and Audit
Develop the ability to conduct and to complete research and audit in clinical practice

Knowledge	Skills	Attitudes demonstrated through behaviours
• Demonstrate an understanding of research methodology, how to design and conduct a research study • Demonstrate an understanding of the research governance framework • Demonstrate knowledge of sources of research funding	• Carry out a research project and prepare it for publication • Present own research at meetings • Set standards that can be audited • Measure changes in practice • Apply audit principles to own work, to team practice and in a service-wide context	• Work collaboratively • Demonstrate consistent compliance with highest standards • Have a positive attitude to audit • Show willingness to apply continuous improvement and audit principles to own work and practice