

Royal College of Psychiatrists WPBA Guide for Core Psychiatry Training

Introduction

This Guide has been written by members of the College Curriculum Committee to help core psychiatry trainees, their trainers and assessors better understand the competencies that should be assessed in Core Psychiatry Training (CPT) and the standards that are required.

It has been written in response to concerns from trainers and College examiners that trainees sitting the College Clinical Assessment of Skills and Competencies (CASC) Examination had not been properly prepared or had left their preparation too late. This appears at least in part due to the fact that the potential for workplace-based assessment (WPBA) to guide learning has not been realised. All too often it appears that trainees are leaving WPBA's to the last week or two of a placement, they are being assessed only in a narrow range of situations and assessors are tending to record overly high marks to trainees. Together, these factors reduce the benefit that trainees can gather from the opportunities for formative feedback that WPBA provides.

Structure of the Guide

Each specialty that contributes to CPT has considered aspects of the CPT Curriculum and provided a sample of typical WPBA scenarios and mapped them against the relevant Intended Learning Outcomes. The scenario describes the competencies that are being assessed and gives an indication of the level of performance expected. Each gives examples of development areas that can be used to guide the formative feedback that the assessor gives the trainee. Some of the examples that are given are similar in format to CASC scenarios; thus the guide may be helpful to candidates preparing for the CASC examination.

Using the Guide

The Guide should be read in conjunction with the CPT Curriculum and the Assessment Blueprint. The ARCP Guide in the Curriculum describes the core competencies that trainees must attain by the end of each year of CPT and it also details the compulsory elements of assessment that trainees should undergo. This Guide is intended to give additional advice to trainees and assessors. The scenarios in the Guide may be used to inform episodes of WPBA or preparation for the CASC exam.

While these scenarios can be used at any time in CPT, some or more suited to a particular stage than to others. For example, the scenarios in general adult psychiatry may all be done in CT1, while those in child and adolescent psychiatry and in learning disability psychiatry should be done in CT2 or 3.



WPBA Guide for Trainers

Contents

- Addiction Psychiatry
- Child and Adolescent Psychiatry
- General Adult Psychiatry
- Learning Disability Psychiatry
- Liaison Psychiatry
- Old Age Psychiatry
- Psychotherapy
- Rehabilitation Psychiatry



CT1 Competencies in

Addiction Psychiatry

WPBA Guide for Trainers

CORE COMPETENCIES IN ADDICTION PSYCHIATRY WPBA GUIDE FOR TRAINERS

Intended learning outcome 1

Be able to perform specialist assessment of patients and document relevant history and examination on culturally diverse patients to include:

- History of present illness.
 - Past medical and psychiatric history.
 - Systemic review
 - Family History
 - Socio-cultural history
 - Developmental History
 - Presenting or main complaint
- History of present illness
Past medical and psychiatric history
Systemic review
Family history
Socio-cultural history
Developmental history

Learning outcome 1-1a

Clinical history

Elicit a complete clinical history, including psychiatric history, that identifies the main or chief complaint, the history of the present illness, the past psychiatric history, medications, general medical history, review of systems, substance abuse history, forensic history, family history, personal, social and developmental history.

Overcome difficulties of language, physical and sensory impairment.

CLINICAL DRUG AND ALCOHOL HISTORY-TAKING COMPETENCY

This WPBA tests the trainee's ability to elicit a systematic drug and alcohol history.

Subsidiary elements:

- Risk assessment.
- Assessment of harms.
- Communication skills.

Trainees should be able to:

- Establish current drug and alcohol use.
- Establish the pattern of drug and alcohol use from initiation to present, including periods of abstinence.
- Elicit key features of dependence, including escalation of use, tolerance, loss of control, craving.
- Explore reasons for relapse after abstinence periods.
- Conduct risk assessment, including injecting behaviour, sharing paraphernalia and accidental overdose.
- Enquire about BBV testing/immunisation.
- Explore psychiatric, physical and social drug and alcohol related harms.

- Understand the importance of collateral information in clinical assessment.

Interview/communication skills

Trainees should be able to:

- Show an appropriate mix of open and close questioning.
- Demonstrate advanced listening skills.
- Use motivational interviewing style to roll with resistance/denial.
- Elicit information in structured and focussed manner.
- Avoid the use of jargon.
- Explore history in compassionate and non-judgmental way.

1-1b Patient examination, including mental state examination and physical examination

Perform a reliable and appropriate examination including the ability to obtain historical information from multiple sources, such as family and other members of the patient's social network, community mental health resources, old records.

Elicit and record the components of mental state examination.

Make a clear and concise case presentation Assess for the presence of general medical illness

ASSESSMENT OF PHYSICAL EFFECTS OF DRUG AND ALCOHOL MISUSE COMPETENCY.

This comes within the remit of the competency - "Assess for the presence of general medical illness". This WPBA tests the trainee's ability to conduct a systematic physical examination of a patient with substance misuse problems.

Trainees should be able to:

- Introduce oneself to the patient.
- Seek consent and explain the procedure.
- Examine general appearance, including nutritional state, self neglect, personal hygiene.
- Examine skin for sweating, infections, injection sites (including neck, groin).
- Examine gait for ataxia.
- Examine eyes for tearing, nystagmus, pupil size, and jaundice.
- Examine nose for rhinorrhoea, nasal septum integrity.
- Examine mouth for dental hygiene, caries.
- Examine cardiovascular system – pulse, blood pressure, heart sounds.
- Examine respiratory system for signs of infection/pulmonary embolism.
- Examine abdomen for signs of hepatitis, constipation.
- Examine neuromuscular system for tremor, muscle wasting.

Communication Skills

Trainees should be able to:

- Show sensitivity in conducting examination.
- Show professionalism and respect.
- Demonstrate empathetic responses.

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CT1 Competencies in

Child & Adolescent Psychiatry

WPBA Guide for Trainers

CT2-3 CORE COMPETENCIES IN CHILD AND ADOLESCENT PSYCHIATRY

WPBA GUIDE FOR TRAINERS

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Intended learning outcome 3: Demonstrate the ability to recommend relevant investigation and treatment in the context of the clinical management plan. This will include the ability to develop and document an investigation plan including appropriate medical, laboratory, radiological and psychological investigations and then to construct a comprehensive training plan addressing biological, psychological and social-cultural domains.

Learning Outcome 3.1 History taking using developmental approach (from parents and child/adolescent where appropriate).

Elicit a complete clinical history from parent and/or child in a “routine case”, including psychiatric and developmental history, that identifies the main or chief complaint, the history of the present illness, the past psychiatric history, medications, general medical history, review of systems, substance abuse history, forensic history, family history, personal, social and developmental history. The trainee should be observed interviewing the parent of a patient who is not previously known to them. This competency will usually be assessed using an Assessed Clinical Encounter (ACE), however sub-components e.g. a mental state examination may be assessed using a mini-ACE. Each trainee should aim to undertake at least one ACE focusing on this competency.

AREAS FOR DEVELOPMENT

| | |
|--|--|
| Questioning style e.g. use of appropriate mix of open & closed questions | |
| Listening and responding appropriately to parent and/or patient | |
| Management of interview, including empathic responses | |
| Appropriate focus on the required task | |
| Fluency of interview | |
| Recognises and prioritises the importance and appropriateness of relevant information offered | |
| Explores history in adequate depth | |
| Explores range of symptoms | |
| Interview shows professionalism including but not limited to avoidance of harmful interaction; shows respect for child’s and carer’s rights; ethical behaviour etc | |

| | |
|--|--|
| GLOBAL MARK NOT ACHIEVED COMPETENCY | |
| SOME COMPETENCY – BUT FURTHER DEVELOPMENT NEEDS IN THIS AREA | |
| COMPETENCY ACHIEVED | |

Learning outcome 3.2 physical examination**"Physical examination of Children"**

This competency will usually be assessed with a mini-ACE. The trainee will normally have heard or taken a case history from the parent. The trainee will also be able to discuss appropriate investigations. Prior to signing the competency, the trainee must be competent in all the following areas.

AREAS OF ASSESSMENT

| | |
|---|--|
| Obtains appropriate consent | |
| Manages the examination with sensitivity to child's anxiety | |
| Uses parent as chaperone appropriately | |
| Basic physical examination of child or adolescent | |
| Can measure blood pressure in a child | |
| Can measure height, weight and head circumference accurately | |
| Can carry out a basic neurodevelopmental examination of the child | |
| Can use and interpret child and adolescent growth charts | |
| Can recognise major dysmorphism | |

GLOBAL MARK

| | |
|--|--|
| NOT ACHIEVED COMPETENCY | |
| SOME COMPETENCY – BUT FURTHER DEVELOPMENT NEEDS IN THIS AREA | |
| COMPETENCY ACHIEVED | |

| |
|---|
| Learning Outcome 2.1 Detects alterations in children’s development that might suggest the child has been maltreated or neglected |
|---|

Discuss a clinical history from parent and/or adolescent focusing on the possibility of “maltreatment or neglect”, including taking a developmental history of attachment and sexual behaviour, and systematic enquiry about anxiety symptoms, poor bladder control, risk taking behaviour, self-harm, substance misuse, poor peer relationships, destructive inter-personal relationships, antisocial behaviour, truanting, poor academic performance. This would normally be done as CBD. Each trainee should aim to undertake at least one CBD focusing on this competency.

AREAS FOR DEVELOPMENT

| | |
|--|--|
| Questioning style has used an appropriate mix of open & closed questions | |
| Evidence in presentation of listening and having responded appropriately to parent and/or patient | |
| Management of interview, including empathic responses | |
| Appropriate focus on the required task | |
| Fluency of interview | |
| Recognises and prioritises the importance and appropriateness of relevant information offered | |
| Explores history in adequate depth | |
| Explores range of symptoms | |
| Interview shows professionalism including but not limited to avoidance of harmful interaction; shows respect for child’s and carer’s rights; ethical behaviour etc | |

| | |
|--|--|
| <u>GLOBAL MARK NOT ACHIEVED COMPETENCY</u> | |
| SOME COMPETENCY – BUT FURTHER DEVELOPMENT NEEDS IN THIS AREA | |
| COMPETENCY ACHIEVED | |

Learning Outcome 4.1 – Psychiatric emergencies in child and adolescent psychiatry

CLINICAL CASE PRESENTATION OF CHILD OR ADOLESCENT EMERGENCY

4.1 “Assessment and management of psychiatric emergencies, including minimising risk to patients, parents and carers, yourself and others.”

This competency will usually be assessed using a Case Based Discussion (CBD) WPBA. A case presentation will usually indicate that a trainee has interviewed the patient. They may or may not have had the opportunity to obtain a collateral history or view the case notes. Prior to signing this competency as completed, the trainee must demonstrate they are competent in all these areas.

AREAS OF ASSESSMENT

| | |
|---|--|
| Range of history explored | |
| Depth of history explored | |
| Range of risk explored | |
| Depth of risk explored | |
| Fluency of presentation | |
| Depth of phenomenology explored | |
| Range of phenomenology explored | |
| Logical and appropriate assessment of differential diagnosis | |
| Collateral information & investigations; significant omissions | |
| Analysis of problems & synthesis of opinion | |
| Prioritisation, recognition of importance and appropriateness of information delivered | |
| Professionalism including but not limited to harmful interaction; failure to respect individual's rights; ethical behaviour etc | |

GLOBAL MARK

| | |
|--|--|
| NOT ACHIEVED COMPETENCY | |
| SOME COMPETENCY – BUT FURTHER DEVELOPMENT NEEDS IN THIS AREA | |
| COMPETENCY ACHIEVED | |

Learning Outcome 7.2 (neuropsychiatry, ADHD) OR 7.3 (Autism)

CLINICAL HISTORY TAKING COMPETENCY IN A PAEDIATRIC NEUROPSYCHIATRY CASE

In a paediatric neuropsychiatry case [alternative, in a case of ADHD or of autism], elicit a complete clinical history from parent and/or child, including psychiatric and developmental history, that identifies the main or chief complaint, the history of the present illness, the past psychiatric history, medications, general medical history, review of systems, substance abuse history, forensic history, family history, personal, social and developmental history". The trainee should be observed interviewing the parent of a patient who is not previously known to them. This competency will usually be assessed using an Assessed Clinical Encounter (ACE), however sub-components may be assessed using a mini-ACE e.g. in the context of a ward review. Each trainee should aim to undertake at least one ACEs focusing on this competency.

AREAS FOR DEVELOPMENT

| | |
|--|--|
| Questioning style e.g. use of appropriate mix of open & closed questions | |
| Listening and responding appropriately to parent and/or patient | |
| Management of interview, including empathic responses | |
| Appropriately focuses on the required task | |
| Fluency of interview | |
| Recognises and prioritises the importance and appropriateness of relevant information offered | |
| Explores history in adequate depth | |
| Explores the relevant range of symptoms including likely comorbidity | |
| Interview shows professionalism including but not limited to avoidance of harmful interaction; shows respect for child's and carer's rights; ethical behaviour etc | |

GLOBAL MARK

| | |
|--|--|
| NOT ACHIEVED COMPETENCY | |
| SOME COMPETENCY – BUT FURTHER DEVELOPMENT NEEDS IN THIS AREA | |
| COMPETENCY ACHIEVED | |

Learning Outcome 13.4 To be able to assess and manage depressive disorders in adolescence

Elicit a complete clinical history from a parent and young person in a typical case of adolescent depression that identifies the main or chief complaints, the history of the present illness, level of risk, the past psychiatric history, medications, general medical history, review of systems, substance abuse history, forensic history, family history, personal, social and developmental history. A Case Based Discussion would normally test this.

AREAS OF ASSESSMENT

| | |
|--|--|
| Range of history explored | |
| Depth of history explored | |
| Range of risk explored | |
| Depth of risk explored | |
| Fluency of presentation | |
| Depth of psychopathology explored | |
| Range of psychopathology explored | |
| Choice of avenues of enquiry, tests or examination including significant omissions | |
| Analysis of problems & synthesis of opinion | |
| Prioritisation, recognition of importance and appropriateness of information delivered | |
| Knowledge of treatment options for depressive and mixed affective disorders in adolescence | |
| The impact of psychosocial factors on adolescent depression including child abuse | |
| Knowledge of comorbidity of depressive disorders including anxiety disorders and conduct disorders | |
| Psychopharmacology of treatments options for depression | |

GLOBAL MARK

| | |
|--|--|
| NOT ACHIEVED COMPETENCY | |
| SOME COMPETENCY – BUT FURTHER DEVELOPMENT NEEDS IN THIS AREA | |
| COMPETENCY ACHIEVED | |

- Knowledge of rating scales and questionnaires used to assess depression and change over time
- Treatment options for comorbid disorders
- Prognostic indicators
- Knowledge of link of self-harm with depression

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CT1 Competencies in

General Adult Psychiatry

WPBA Guide for Trainers

CT1 COMPETENCIES IN GENERAL ADULT PSYCHIATRY

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PARTICULARLY SUITED TO THE FIRST SIX MONTHS

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THESE MAY BE TACKLED IN THE SECOND SIX MONTHS

It is expected that all the above competencies will continue to be developed and more complex cases encountered. However, new competencies will be acquired in the second placement, concerning patient treatment, management and generic leadership and team working skills.

| | |
|---|----|
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LEARNING OUTCOME 1a

CLINICAL HISTORY TAKING COMPETENCY

“Elicit a complete clinical history, including psychiatric history, that identifies the main or chief complaint, the history of the present illness, the past psychiatric history, medications, general medical history, review of systems, substance abuse history, forensic history, family history, personal, social and developmental history”.

The trainee should be observed interviewing a patient who is not previously known to them. This competency will usually be assessed using an Assessed Clinical Encounter (ACE), however sub-components may be assessed using a mini-ACE e.g. in the context of a ward review.

AREAS FOR DEVELOPMENT

| | |
|---|--|
| Questioning style e.g. use of appropriate mix of open & closed questions | |
| Listening and responding appropriately to patient | |
| Management of interview, including empathic responses | |
| Lack of appropriate focus on the required task | |
| Fluency of interview | |
| Prioritisation, recognition of importance and appropriateness of information delivered | |
| Depth of history explored | |
| Range of history explored | |
| Professionalism including but not limited to harmful interaction; failure to respect individual's rights; ethical behaviour etc | |

GLOBAL MARK

| | |
|--|--|
| NOT ACHIEVED COMPETENCY | |
| SOME COMPETENCY – BUT FURTHER DEVELOPMENT NEEDS IN THIS AREA | |
| COMPETENCY ACHIEVED | |

LEARNING OUTCOME 1b

PATIENT MENTAL STATE EXAMINATION COMPETENCY

“Perform a reliable and appropriate mental state examination on a patient.”
(Appearance and behaviour observation, affect, speech, thoughts, abnormal beliefs, abnormal perceptions, suicidality/homicidality, cognition, insight)

The trainee should be observed interviewing a patient who is not previously known to them. This competency will usually be assessed using an Assessed Clinical Encounter (ACE) with learning outcome 1A, however sub components may be assessed using a mini-ACE e.g. in the context of a ward review.

AREAS FOR DEVELOPMENT

| | |
|---|--|
| Questioning style e.g. use of appropriate mix of open & closed questions | |
| Listening and responding appropriately to patient | |
| Management of interview, including empathic responses | |
| Lack of appropriate focus on the required task | |
| Fluency of examination | |
| Choice of avenues of enquiry, tests or examination including significant omissions | |
| Application of cognitive testing | |
| Depth of psychopathology explored | |
| Range of psychopathology explored | |
| Professionalism including but not limited to harmful interaction; failure to respect individual's rights; ethical behaviour etc | |

GLOBAL MARK

| | |
|--|--|
| NOT ACHIEVED COMPETENCY | |
| SOME COMPETENCY – BUT FURTHER DEVELOPMENT NEEDS IN THIS AREA | |
| COMPETENCY ACHIEVED | |

LEARNING OUTCOME 1b

ASSESSMENT OF PSYCHOTROPIC PHYSICAL EFFECTS

“Recognise and identify the effects of psychotropic medication in the physical examination”

This competency is best assessed using a Mini-ACE. The trainee should be observed undertaking a 5-10 minute physical examination of a patient, keeping the patient fully informed of their findings throughout, at the end of the examination they should give a brief summary of the main findings to their assessor.

AREAS FOR DEVELOPMENT

| | |
|---|--|
| Lack of introduction, consent seeking or explanation to patient of procedure. | |
| Inadequate patient history taking e.g. dentures, awareness of involuntary movements | |
| Orofacial examination | |
| Upper limb examination | |
| Lower limb examination | |
| Examination of gait | |
| Truncal stability | |
| Quality of physical examination | |
| Fluency of examination | |
| Management of examination, including empathic responses | |
| Analysis of problems & synthesis of opinion | |
| Professionalism including but not limited to harmful interaction; failure to respect individual's rights; ethical behaviour etc | |

GLOBAL MARK

| | |
|--|--|
| NOT ACHIEVED COMPETENCY | |
| SOME COMPETENCY – BUT FURTHER DEVELOPMENT NEEDS IN THIS AREA | |
| COMPETENCY ACHIEVED | |

LEARNING OUTCOME 1b

THE CLINICAL CASE PRESENTATION

“Make a clear and concise case presentation.”

This competency will usually be assessed using a Case Based Discussion (CBD) WPBA. A case presentation will usually indicate that a trainee has interviewed the patient, they may or may not have had the opportunity to obtain a collateral history or view the case notes. Prior to signing this competency as completed, the trainee must be given the opportunity to be competent in all these areas.

AREAS FOR DEVELOPMENT

| | |
|---|--|
| Range of history explored | |
| Depth of history explored | |
| Range of risk explored | |
| Depth of risk explored | |
| Fluency of presentation | |
| Depth of psychopathology explored | |
| Range of psychopathology explored | |
| Application of cognitive testing | |
| Choice of avenues of enquiry, tests or examination including significant omissions | |
| Analysis of problems & synthesis of opinion | |
| Prioritisation, recognition of importance and appropriateness of information delivered | |
| Professionalism including but not limited to harmful interaction; failure to respect individual's rights; ethical behaviour etc | |

GLOBAL MARK

| | |
|--|--|
| NOT ACHIEVED COMPETENCY | |
| SOME COMPETENCY – BUT FURTHER DEVELOPMENT NEEDS IN THIS AREA | |
| COMPETENCY ACHIEVED | |

LEARNING OUTCOME 2a

THE DIAGNOSTIC FORMULATION

“Be familiar with contemporary ICD or DSM diagnostic systems, with the ability to discuss the advantages and limitations of each. Formulate a differential diagnosis for major presenting problems”.

⌈This competency will usually be assessed using a Case Based Discussion (CBD) WPBA of a case that the trainee has been clinically involved with.

AREAS FOR DEVELOPMENT

| | |
|---|--|
| Lack of appropriate focus on the required task | |
| Fluency of discussion | |
| Factual knowledge of diagnostic classification systems | |
| Analysis of problems & synthesis of opinion | |
| Prioritisation, recognition of importance and appropriateness of information delivered | |
| Professionalism including but not limited to harmful interaction; failure to respect individual's rights; ethical behaviour etc | |

GLOBAL MARK

| | |
|--|--|
| NOT ACHIEVED COMPETENCY | |
| SOME COMPETENCY – BUT FURTHER DEVELOPMENT NEEDS IN THIS AREA | |
| COMPETENCY ACHIEVED | |

LEARNING OUTCOME 2b

THE AETIOLOGY OF PSYCHIATRIC ILLNESS

“Describe the various biological, psychological and social factors involved in the predisposition to, the onset of and the maintenance of psychiatric disorder.

“Integrate information from multiple sources to formulate the case into which relevant predisposing, precipitating, perpetuating and protective factors are highlighted”

This competency will usually be assessed using a Case Based Discussion (CBD) WPBA of a case that the trainee has been clinically involved with.

AREAS FOR DEVELOPMENT

| | |
|---|--|
| Range of biological factors explored | |
| Range of psychological factors explored | |
| Range of social factors explored | |
| Differentiating roles of individual factors | |
| Fluency of presentation | |
| Lack of appropriate focus on the required task | |
| Choice of avenues of enquiry, tests or examination including significant omissions | |
| Analysis of problems & synthesis of opinion | |
| Prioritisation, recognition of importance and appropriateness of information delivered | |
| Professionalism including but not limited to harmful interaction; failure to respect individual's rights; ethical behaviour etc | |

GLOBAL MARK

| | |
|--|--|
| NOT ACHIEVED COMPETENCY | |
| SOME COMPETENCY – BUT FURTHER DEVELOPMENT NEEDS IN THIS AREA | |
| COMPETENCY ACHIEVED | |

LEARNING OUTCOME 3

EXPLANATIONS TO PATIENTS AND CARERS

“Be able to explain to patients, families, carers (and colleagues) the process and outcome of assessment, investigation and treatment or therapeutic plan”

This competency will be assessed by a Mini-ACE – it may be completed in the out patients department, ward setting or during a domiciliary consultation.

AREAS FOR DEVELOPMENT

| | |
|---|--|
| Consideration of obtaining appropriate consent from patient | |
| Appropriate introduction | |
| Management of interview, including empathic responses | |
| Lack of appropriate focus on the required task | |
| Fluency of examination | |
| Completeness of explanation e.g. significant omissions | |
| Prioritisation, recognition of importance and appropriateness of information delivered | |
| Listening and responding appropriately to carer | |
| Professionalism including but not limited to harmful interaction; failure to respect individual's rights; ethical behaviour etc | |

GLOBAL MARK

| | |
|--|--|
| NOT ACHIEVED COMPETENCY | |
| SOME COMPETENCY – BUT FURTHER DEVELOPMENT NEEDS IN THIS AREA | |
| COMPETENCY ACHIEVED | |

LEARNING OUTCOME 4a

CLINICAL RISK ASSESSMENT

“Comprehensively assess immediate and long term risks to patients and others during assessment and treatment.”

This may be assessed by Mini-ACE or CBD. The Areas for development below are described for a Mini ACE

AREAS FOR DEVELOPMENT

| | |
|---|--|
| Questioning style e.g. use of appropriate mix of open & closed questions | |
| Listening and responding appropriately to interviewee | |
| Management of interview, including empathic responses | |
| Lack of appropriate focus on the required task | |
| Fluency of examination | |
| Range of risk explored | |
| Depth of enquiry into risk | |
| Analysis of problems & synthesis of opinion | |
| Prioritisation, recognition of importance and appropriateness of information delivered | |
| Professionalism including but not limited to harmful interaction; failure to respect individual's rights; ethical behaviour etc | |

GLOBAL MARK

| | |
|--|--|
| NOT ACHIEVED COMPETENCY | |
| SOME COMPETENCY – BUT FURTHER DEVELOPMENT NEEDS IN THIS AREA | |
| COMPETENCY ACHIEVED | |

LEARNING OUTCOME 4

FORMULATING A MANAGEMENT PLAN

“Accurately assess the individual patient’s needs and whenever possible in agreement with the patient, formulate a realistic treatment plan for each patient”

This competency may be assessed by using a combination of Mini ACE and CBD. The template below is for a CBD. This competency should be examined on as many occasions as practical during the trainee’s second posting, focusing on different conditions each time.

AREAS FOR DEVELOPMENT

| | |
|---|--|
| Lack of appropriate focus on the required task | |
| Fluency of discussion | |
| Factual knowledge of range of management options | |
| Factual knowledge of depth of management options | |
| Inappropriate decision making for specific patient’s needs | |
| Analysis of problems & synthesis of opinion | |
| Prioritisation, recognition of importance and appropriateness of information delivered | |
| Professionalism including but not limited to harmful interaction; failure to respect individual’s rights; ethical behaviour etc | |

GLOBAL MARK

| | |
|--|--|
| NOT ACHIEVED COMPETENCY | |
| SOME COMPETENCY – BUT FURTHER DEVELOPMENT NEEDS IN THIS AREA | |
| COMPETENCY ACHIEVED | |

LEARNING OUTCOME 4

ASSESSING AND MANAGING AN INCIDENT

“Assess and manage a patient involved in an incident. Provision of reports and documentation relating to incidents. Working with multidisciplinary and multi-agency colleagues to assess and manage incidents. Consider the need for emergency supervision support and feedback for staff, victim, other patients, carers as required.”

This competency may be assessed by using a CBD of a retrospective incident.

AREAS FOR DEVELOPMENT

| | |
|---|--|
| Initial assessment of situation | |
| Safety management of incident | |
| De-escalation management of incident | |
| Team working during incident | |
| Ability to cope under pressure | |
| Prioritisation, recognition of importance and appropriateness of Management | |
| Analysis of problems & synthesis of opinion | |
| Post incident reporting procedure | |
| Emergency support for others | |
| Emergency support for self | |
| Professionalism including but not limited to harmful interaction; failure to respect individual's rights; ethical behaviour etc | |

GLOBAL MARK

| | |
|--|--|
| NOT ACHIEVED COMPETENCY | |
| SOME COMPETENCY – BUT FURTHER DEVELOPMENT NEEDS IN THIS AREA | |
| COMPETENCY ACHIEVED | |

LEARNING OUTCOME 4

USE OF THE MENTAL HEALTH ACT

“Demonstrate an understanding of the contemporary mental health legislation and its local implementation with regard to assessment and treatment of patients, including mentally disordered offenders”

This may be assessed as a mini-ACE (emergency detention) or retrospective CBD. The template below is for a CBD.

AREAS FOR DEVELOPMENT

| | |
|---|--|
| Lack of appropriate focus on the required task | |
| Fluency of discussion | |
| Factual knowledge of mental health law | |
| Analysis of problems & synthesis of opinion | |
| Prioritisation, recognition of importance and appropriateness of information delivered | |
| Professionalism including but not limited to harmful interaction; failure to respect individual's rights; ethical behaviour etc | |

GLOBAL MARK

| | |
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| NOT ACHIEVED COMPETENCY | |
| SOME COMPETENCY – BUT FURTHER DEVELOPMENT NEEDS IN THIS AREA | |
| COMPETENCY ACHIEVED | |

June 2010



CT1 Competencies in

Learning Disability Psychiatry

WPBA Guide for Trainers

CORE COMPETENCIES IN LEARNING DISABILITY PSYCHIATRY WORKPLACE BASED ASSESSMENTS GUIDE FOR TRAINERS

THE INTENDED LEARNING OUTCOMES

Intended learning outcome 1

Be able to perform specialist assessment of patients and document relevant history and examination on culturally diverse patients to include:

Presenting or main complaint

History of present illness

Past medical and psychiatric history

Systemic review

Family history

Socio-cultural history

Developmental history

1-1a Clinical history

Elicit a complete clinical history, including psychiatric history, that identifies the main or chief complaint, the history of the present illness, the past psychiatric history, medications, general medical history, review of systems, substance abuse history, forensic history, family history, personal, social and developmental history.

Overcome difficulties of language, physical and sensory impairment

Aspects of this competency in Learning Disability Psychiatry:

Adaptation of history to account for basic developmental history, schooling; understanding of impact of deficits in cognitive ability including activities of daily living, support required; behavioral history and its impact on carers and other e.g. family members/ other residents; physical history in relation to both underlying syndromes or subsequent ill health, including sensory impairments; history of seizures; identification of major indicators of presence of autistic spectrum disorder.

Ability to elicit information sensitively from family/carers and assessment of the quality of this information.

Communication with PWLD, ability to recognize and adapt to additional communication difficulties associated with other impairment e.g. physical disability, sensory impairments, autistic spectrum disorder.

Not demonstrated

No modification of psychiatric history to include specific aspects of clinical history relating to aspects of LD. Omissions in history of clear relevance to the individual PWLD presented. (e.g. diagnosis of Down Syndrome)

Attempts to engage with carers/ families are insensitive in manner.

Unable to relate to the PWLD as an individual; no attempt at engagement with them, or modify communication.

Some competency but further development needed

Some estimate of level of disability using history of educational attainment, incomplete exploration of activities of daily living. Little exploration of support needs. Inadequate description of behaviour or seizure episodes. Failure to identify key markers of autistic disorder eg language delay, gaze avoidance, stereotypic behaviour. Elicits information from carers, but needs to do so more sensitively. Some attempt to engage with PWLD and recognize potential other impairments.

Achieved competency.

Elicits a full history including basic developmental history, schooling, activities of daily living, support required, basic cognitive assessment with information from carers. Include description of behaviour and seizures. Identifies presence/absence of key features associated with autistic spectrum disorder
Sensitive engagement when eliciting information from parents /carers
Shows sensitive and appropriate attempts to communicate with PWLD, with recognition of other impairments as appropriate.

Intended learning outcome 2

Demonstrate the ability to construct formulations of patients' problems that include appropriate differential diagnoses

1-2a Diagnosis

State the typical signs and symptoms of psychiatric disorders as they manifest across the age range, including affective disorders; anxiety disorders; disorders of cognitive impairment; psychotic disorders; personality disorders; substance misuse disorders; organic disorders; developmental disorders; and common disorders in childhood
Formulate a differential diagnosis for major presenting problems Use the diagnostic system accurately in identifying specific signs and symptoms that comprise a syndrome or disorder
Formulate and discuss differential diagnosis Show an awareness of the advantages and limitations of using a diagnostic system

1-2b Formulation

Describe the various biological, psychological and social factors involved in the predisposition to, the onset of and the maintenance of psychiatric disorder.
Integrate information from multiple sources to formulate the case into which relevant predisposing, precipitating, perpetuating and protective factors are highlighted
Provide explanation to the patient and the family which enables a constructive working relationship.

Aspects of this competency in Learning Disability Psychiatry:

Be able to ascertain the approximate level of learning disability, and the types of skill deficit they may exhibit.

State the features of common syndromes associated with Learning Disability: Down syndrome, Fragile X

State the signs and symptoms of Autistic Spectrum Disorders (the triad of impairments and associated observations including paucity of expression, tics, stereotypical behaviour, language and social interaction).

State the signs and symptoms of seizure types particularly absences, complex partial seizures and generalized seizures.

Demonstrate an understanding of the difficulties of diagnosis of dementia and other psychiatric disorders in people with learning disabilities

Formulate and discuss differential diagnosis with respect to people with Learning Disabilities.

Show an awareness of the limitations of using a diagnostic system in Learning Disabilities

Describe and discuss 'challenging behaviour demonstrate an understanding of the potential causes for this including mental and physical health, communication, sensory, social and environmental factors in behaviour.

Integrate information to make a viable formulations for discussion with patients and carers

Not demonstrated:

Unable to distinguish severe/ profound from mild/moderate LD

Unable to describe any common syndromes associated with Learning Disabilities

Unaware of the autistic triad of impairment and associated features

Description of seizure types limited to generalized seizures

Unable to describe symptoms and signs that might be part of the presentation in a PWLD and dementia ,as distinct from the general population

Only proposes mental illness as a factor in challenging behaviour

Some competency but further development needed:

Able to distinguish severe profound from mild/moderate LD

Able to describe only one common syndrome associated with Learning Disabilities

Partial awareness of the autistic triad of impairments and associated features

Able to describe clearly more than generalized seizures, but partial derference to other types

Able to elicit some of the symptoms and signs of dementia in PWLD and common differential diagnoses

Is able to propose a range of factors associated with challenging behaviour but lacks a systematic approach

Achieved competency.

Able to state simply the types of skills associated with approximate level of learning disability

Able to describe common syndromes associated with Learning Disabilities

Able to outline the autistic triad of impairments and the associated features that might be present on examination in typical cases

Able to describe the range of seizure types that commonly occur in LD

Able to elicit a range symptoms and signs of dementia in PWLD, differential diagnoses particularly in Down syndrome, able to discuss the limitations and difficulties in cognitive assessment

Adopts a systematic and wide ranging approach to the possible factors associated with challenging behaviour, including psychosocial, and makes appropriate suggestion in for the factors in a particular case

Intended learning outcome 3

Demonstrate the ability to recommend relevant investigation and treatment in the context of the clinical management plan. This will include the ability to develop and document an investigation plan including appropriate medical, laboratory, radiological and psychological investigations and then to construct a comprehensive treatment plan addressing biological, psychological and socio-cultural domains

1-3c Treatment planning

- Show a clear understanding of physical treatments including pharmacotherapy, including pharmacological action, clinical indication, side-effects, drug interactions, toxicities, appropriate prescribing practices, and cost effectiveness; Treatment.
- Apply knowledge of the implications of coexisting medical illnesses to the treatment of patients who have psychological disorders
- Accurately assess the individual patient's needs and whenever possible in agreement with the patient, formulate a realistic treatment plan for each patient
- Educate patients, carers and other professionals about relevant psychiatric and psychological issues Monitor patients' clinical progress and re-evaluate diagnostic and management decisions to ensure optimal care Be skilled in multi-agency working
- Show respect for the patient's autonomy and confidentiality while recognising responsibility towards safeguarding others Recognise, value and utilise the contribution of peers and multi-disciplinary colleagues to develop the effectiveness of oneself and others Provide care and treatment that recognises the importance to patients of housing, employment, occupational opportunities, recreational activities, advocacy, social networks and welfare benefits Ensure that the employment of legal powers for detention (or to enforce treatment) balances the duty of care to the patient and the protection of others Be prepared to test out the feasibility and acceptability of decisions

Aspects of this competency in Learning Disability Psychiatry:

- Pharmacotherapy in LD- difference and similarity to general psychiatry.
- Able to demonstrate breadth of thinking around presenting problems; taking into account physical illness and co-existing disabilities (e.g. sensory, seizures, Autistic disorder)well as the patients daily living and social needs.
- Demonstrate an ability to work in a multidisciplinary team and consider problems from a variety of viewpoints including systemic thinking and legal frameworks.
- Demonstrates good communication skills and understanding of the roles of team members.
- Able to translate the above into treatment plans, in multidisciplinary meetings as appropriate, having respect for the views of the PWLD.
- Has an awareness of use of Mental Health Act/Incapacity legislation to underpin treatment plans where appropriate

Not demonstrated –

Trainee is not able to think widely about a management plan to effectively treat/manage a PWLD who presents with mental health concerns, forensic issues, 'challenging behaviour', ASD etc. This could reflect: inexperience in the assessment and diagnosis of common clinical presentations in PWLD; a lack of awareness of communication issues with patients, carers or the Multi professional team; a lack of ability/intuitiveness to access collateral history; little awareness of physical/organic concerns with those with a LD that can influence their mental state/behaviour. Disregards the views of the PWLD.

Some competency but further development needed

The trainee is able to assess and diagnose common presenting problems in LD; prescribe simple relevant treatment (including medication); some liaison with, and awareness of the role of, Multi- professional team members regarding a treatment plan, though may not be fully aware of the range of skills/therapies available . Aware of views of PWLD but does not address this . Is not able to manage complex (multifaceted) cases or those on complex medication regimes.

Achieved competency

The trainee is able to manage complex cases - both routine and emergency, presenting with common problems, and liaises widely with colleagues in Health, SW, Care providers and family. The trainee is very mindful of communication issues and treats the patient with respect. Treatment plans are multidisciplinary where appropriate, well thought out, systemic and take account of immediate, short term and long term management issues. Shows basic knowledge of the CPA as it applies in learning disabilities.

1-4c Mental health legislation

Demonstrate an understanding of the contemporary mental health legislation and its local implementation with regard to assessment and treatment of patients, including mentally disordered offenders Understand and make appropriate use of the Mental Health Act in relation to capacity and consent Apply the legislation appropriately at all times, with reference to published codes of practice

Aspects of this competency in LD Psychiatry:

- Use of contemporary mental health legislation with specific and appropriate reference to the assessment and treatment of PWLD, including offenders.
- Understanding of capacity and consent in PWLD, including legal safeguards as victims and witnesses, as well as patients.

Not Demonstrated

No or little understanding of the contemporary mental health legislation and its local implementation with regard to the assessment and treatment of patients with a learning disability.
No or little understanding of the rights and safeguards afforded by such legislation to patients with learning disability.
No understanding and /or inappropriate use of the mental health act in relation to capacity and consent in patients with a learning disability.

Lack of ability to apply the legislation correctly when assessing and treating people with a learning disability, no or little knowledge of the published codes of practice.

Some Competency but further development needed

Has a working knowledge of the contemporary mental health legislation and its local implementation with regard to the assessment and treatment of patients with a learning disability and can apply this sensitively and compassionately. However lacks knowledge of some of the more subtle dilemmas that may arise when making decisions about the use of the Mental Health Act.

Has a good understanding of the rights and safeguards afforded by such legislation to patients with learning disability but is not always sure of the doctor's duties/role in securing these.

Has a good grasp of the use of Mental Health Act in relation to capacity and consent and usually uses this knowledge in decision making.

Knowledge of application of the correct legislation when assessing and treating people with a Learning Disability and of the codes of practice, usually brings this knowledge to decision making.

Achieved Competency

Has a clear understanding of contemporary Mental Health Legislation in relation to the assessment and treatment of patients with a learning disability and can apply the legislation correctly and consistently

Is aware of the rights and safeguards afforded by such legislation and the doctor's role in promoting and securing these for patients with a learning disability.

Has a thorough understanding of issues around capacity and consent when assessing and treating people with a learning disability and is able to competently apply the correct legislation following the codes of practice.

Has an awareness and understanding of the dilemmas which may arise when making decisions about the use of the mental health act and is able to seek advice appropriately when these arise.

1-4d Broader legal framework

- Define the structure, function and legal implications of medical records and medico-legal reports Demonstrate a knowledge of the relevance of contemporary legislation pertaining to patient confidentiality Awareness of issues surrounding copying correspondence to patients
- Record concisely, accurately, confidentially, and legibly appropriate elements of the history, examination, investigation, differential diagnosis, risk assessment and management plan
- Act in accordance with contemporary codes of practice Be sensitive to the potential conflict between legal requirements and the wishes of the patient
- Complete case records and all forms of written clinical information in a consistent, timely and responsible fashion

Aspects of this competency in Learning Disability Psychiatry:

- Awareness of the above relating to PWLD, and in particular sharing information with other agencies.
- Understanding of implication of legislation re incapacity across a wide range of decisions and the psychiatrists role in this.

- Understanding of ethical dilemmas with respect to incapacity and information sharing.
- Awareness of dilemmas as to use of Incapacity or Mental Health legislation

Not Demonstrated

No awareness of other legislation that is pertinent to protecting the rights of people with learning disability e.g. local incapacity legislation, Disability Discrimination Act, Human Rights Act, Vulnerable adults legislation, Equality Act etc
 No awareness of the ethical dilemmas of information sharing about patients with a learning disability who cannot consent.

Some Competency but further development needed

Has an awareness of current incapacity legislation and when this should be applied to patients with a learning disability.
 Has an awareness of the rights and safeguards which this legislation affords patients with a learning disability.
 Has an awareness of the ethical dilemmas of information sharing about patients with a learning disability who cannot consent.
 Has an awareness of areas where there may be a conundrum about whether to use Mental Health Act or Incapacity legislation.
 Is aware of the other legislation which is pertinent to protecting the rights of people with a learning disability

Achieved Competency

Understands the place of incapacity legislation in providing health and social care to people with a learning disability.
 Is aware of the rights and safeguards which incapacity legislation affords to patients with a learning disability and of the doctor's role in securing these.
 Is aware of the ethical dilemmas in sharing information about patients who cannot consent and is able to use this knowledge in clinical practice.
 Is aware of the dilemmas in deciding whether the Mental Health Act or Incapacity Legislation should be used and is aware when to seek advice regarding this.
 Has a basic knowledge of the other legislation which is pertinent to protecting the rights of people with a learning disability and is able to signpost patients and their carers to this legislation.

Intended learning outcome 9 Demonstrate the ability to work effectively with colleagues, including team working

3–9a Clinical teamwork

Demonstrate an understanding of the roles and responsibilities of team members
 Demonstrate an understanding of the roles of primary healthcare and social services
 Show respect for the unique skills, contributions and opinions of others Recognise and value diversity within the clinical team Be conscientious and work cooperatively.

Aspects of this competency in Learning Disability Psychiatry:

- Understanding of roles of CLDT members and therapists in Learning Disabilities including Speech and Language, Occupational therapists and therapists in the

arts, where available. In particular the range of their therapeutic skills relating to physical, environmental sensory, communicative and psychosocial skills.

- Awareness of the role of psychology, particularly in relation to challenging behaviour and its management
- Understands the different position of community teams in LD and Mental Health, and its implications for the psychiatrist.
- Awareness of the role of social workers as case managers and commissioner, as well as their role in safeguarding of vulnerable adults
- Awareness of the broad philosophies of care for PWLD including mainstreaming, social care lead and the implications for the psychiatrist working in the community
- Demonstrates an understanding of the issue of transition from children's services.
- The above demonstrated by appropriate communications to the team and evidence of appropriate consultation with them during the process of diagnosis, formulation and management of cases.

Not demonstrated

Understanding and communication restricted to nurses and social workers.
Referrals to therapists not considered or generally inappropriate
Unable to articulate the roles of other than nurse and social workers.
Limitation of request for psychological intervention to cognitive assessment
Failure to understand the issues of safeguarding vulnerable adults and the responsibilities of a doctor to inform social service colleagues
Unaware that the structure of the team is dissimilar to community mental health teams; no concept of 'mainstreaming'
Failure to include the team in communications and case reviews as appropriate

Some competency but further development needed

Some work with other disciplines beyond nurses and social workers but lack of knowledge of the role of therapists
Some understanding of the role of psychologist but does not always refer as appropriate/ discuss the appropriateness of referrals
Some understanding of social work role but not always included appropriately in communications
Some understanding of the safeguarding vulnerable adults but unaware of existence of local procedures
Awareness of different service structure and philosophy of services delivery, but unclear
Aware of transition cases but not the wider network within children services.

Achieved competency

Communication and active work with CLDT and other disciplines shown by letter, case review minutes and joint working.
Pattern of appropriate interdisciplinary referrals
Evidence of formal and informal dialogue with team members about the management of a case.
Appropriate involvement and referral to psychology

Appropriate liaison with social work and able to refer to local procedures for safeguarding vulnerable adults
Aware of the social service lead for LD services, the concept of 'mainstreaming' where appropriate; able to articulate some of the implications for the practice of LD psychiatry
Aware of issues for families and professionals within transition to adult services; and make appropriate referrals



CT1 Competencies in

Liaison Psychiatry

WPBA Guide for Trainers

CORE COMPETENCIES IN LIAISON PSYCHIATRY

WPBA GUIDE FOR TRAINERS

CORE TRAINEES

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| LEARNING OUTCOME 1 – CLINICAL HISTORY TAKING | 3 |
| LEARNING OUTCOME 2 – ASSESSMENT OF CAPACITY | 4 |
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LEARNING OUTCOME 1

CLINICAL HISTORY TAKING COMPETENCY

“Carry out a basic MSE identifying specifically:

- *Mood*
- *Psychosis*
- *Delirium*
- *Insight*
- *Understanding”*

This could be done with a new patient, or during a ward review, most commonly using a mini-ACE. Several WPBAs will be required to cover the range and depth of psychopathology

CONSTRUCT

The trainee should be able fully differentiate between overvalued ideas, delusions, illusions and hallucinations, and explore the patient’s health beliefs, expectations and understanding. The trainee should be able to diagnose an acute confusional state, using appropriate questions and tests. Trainees should explore all perceptual areas, and use appropriate questions in order to determine mood disturbance in physically ill patients

AREAS FOR DEVELOPMENT

| |
|---|
| Questioning style e.g. use of appropriate mix of open & closed questions |
| Listening and responding appropriately to interviewee/discussant |
| Management of interview/examination including empathic responses |
| Focus on the required task |
| Fluency of interview/examination/discussion |
| Range of history explored |
| Range of psychopathology explored |
| Depth of enquiry into symptoms and/or psychopathology (signs elicited at examination) |
| Range of cognition tested and appropriate application of cognitive testing |
| Application of cognitive testing |
| Professionalism including but not limited to harmful interaction; failure to respect individual’s rights; ethical behaviour etc |

GLOBAL MARK

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| NOT ACHIEVED COMPETENCY | |
| SOME COMPETENCY BUT FURTHER DEVELOPMENT NEEDS IN THIS AREA | |
| COMPETENCY ACHIEVED | |

LEARNING OUTCOME 1

CLINICAL HISTORY TAKING COMPETENCY

“Carry out a full biopsychosocial assessment of patients, in medical and surgical settings, with physical health problems, physical symptoms and mental health symptoms, impaired mental wellbeing, or psychological distress, including:

- *Systematic documentation of chronology of patient’s medical history including use of time lines*
- *Working with other clinical members of the liaison team*
- *Know the epidemiology and common presentations of psychological problems in medical and surgical settings*
- *Use of appropriate questionnaires to use in medical & surgical settings and their limitations”*

The trainee should be observed interviewing a patient who is not previously known to them. This competency will usually be assessed using an ACE, however sub-components may be assessed using a mini-ACE e.g. in the context of a patient review.

CONSTRUCT

The trainee should be able to take a history in a physically ill patient, or in a patient with medically unexplained symptoms, exploring aspects such as previous medical problems, family illness and associated life events or ongoing stressors. Trainees should focus on the importance of timelines and illness chronology, as well as exploring the patient’s understanding of their illness. Trainees should utilise the full range of available information, such as patient notes, informants and other staff on the ward

AREAS FOR DEVELOPMENT

| |
|---|
| Questioning style e.g. use of appropriate mix of open & closed questions |
| Listening and responding appropriately to interviewee/discussant |
| Management of interview/examination including empathic responses |
| Fluency of interview/examination/discussion |
| Choice of avenues of enquiry, tests or examination including significant omissions |
| Range of history explored |
| Depth of history explored |
| Range of psychopathology explored |
| Depth of enquiry into symptoms and/or psychopathology (signs elicited) |
| Prioritisation, recognition of importance and appropriateness of information delivered and/or management |
| Professionalism including but not limited to harmful interaction; failure to respect individual’s rights; ethical behaviour etc |

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LEARNING OUTCOME 2

ASSESSMENT OF CAPACITY COMPETENCY

“Be able to determine capacity, based on an understanding of the concepts”

This competency will usually be assessed using a mini-ACE. During the post, trainees should demonstrate assessment of several areas of capacity, or attempt to demonstrate changes in capacity in an acutely confused patient over time. The trainee could also discuss their understanding of the assessment of capacity and its consequences in a CBD

CONSTRUCT

The trainee should demonstrate the ability to test capacity, to include demonstration of impairment of the mind, followed by an assessment of the patient’s ability to make a decision. The trainee should also demonstrate that the assessment relates to a specific decision using appropriate open and closed questions, and that capacity can change over time

AREAS FOR DEVELOPMENT

| |
|---|
| Questioning style e.g. use of appropriate mix of open & closed questions |
| Listening and responding appropriately to interviewee/discussant |
| Management of interview/examination including empathic responses |
| Lack of appropriate focus on the required task |
| Fluency of interview/examination/discussion |
| Range of cognition tested and appropriate application of cognitive testing |
| Application of cognitive testing |
| Analysis of problems & synthesis of opinion |
| Prioritisation, recognition of importance and appropriateness of information delivered and/or management |
| Professionalism including but not limited to harmful interaction; failure to respect individual’s rights; ethical behaviour etc |

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LEARNING OUTCOME 3

INVESTIGATION AND TREATMENT COMPETENCY

“Safely use and manage psychotropic medication [in the context of the General Hospital]”

This competency will usually be assessed using a mini-ACE or a CBD in the context of a patient review. It is likely that several mini-ACES will be required to demonstrate a broad understanding of the use of different drug classes in a number of disease areas

CONSTRUCT

The trainee should be able to demonstrate prescribing competence in commonly occurring disease areas, such as liver disease or cardiac disease. Core trainees should demonstrate an awareness of the key problems such as drug interactions and metabolic issues, and demonstrate an ability to identify appropriate sources of information such as the drug card, pharmacist, reference texts such as the BNF and others, as well as seek advice and supervision early. The trainee should demonstrate that they have examined the patient's medical problems and other medication in detail, and examined the existing drug cards. The trainee may also need to identify other drugs as a cause of psychiatric symptoms

AREAS FOR DEVELOPMENT

| |
|---|
| Lack of appropriate focus on the required task |
| Fluency of interview/examination/discussion |
| Choice of avenues of enquiry, tests or examination including significant omissions |
| Range of history explored |
| Depth of history explored |
| Range of risk explored |
| Depth of enquiry into symptoms and/or psychopathology (signs elicited at examination) |
| Extent of physical examination |
| Analysis of problems & synthesis of opinion |
| Prioritisation, recognition of importance and appropriateness of information delivered and/or management |
| Professionalism including but not limited to harmful interaction; failure to respect individual's rights; ethical behaviour etc |

GLOBAL MARK

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| NOT ACHIEVED COMPETENCY | |
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| COMPETENCY ACHIEVED | |

LEARNING OUTCOME 4

RISK ASSESSMENT COMPETENCY

“Carry out an assessment of risk including:

- *Suicide/disturbance,*
- *Exploitation and neglect*
- *Environmental risk”*

This competency will usually be assessed using a mini-ACE, possibly supported by a CBD. This competency will frequently be assessed in A&E by non-consultant assessors – however trainees should ensure that at least one assessment of this competence is carried out by a consultant. Trainees should also demonstrate assessment of risk in contexts other than following deliberate self-harm, such as the assessment of risk in the management of acute confusion in the general hospital

CONSTRUCT

Trainees should be able fully assess risk, taking into consideration danger or risk to others, as well as risks of self-harm, neglect, vulnerability, relapse, and environmental risks. When assessing self-harm, the trainee should consider antecedents, the medical risk of the episode and the risk of recurrence. Trainees will also need to consider the specific aspects of risks on medical and surgical wards, including risks to other staff and patients. Trainees should demonstrate that they ask for support and supervision as appropriate, as well as the need to handover ongoing issues

AREAS FOR DEVELOPMENT

| |
|---|
| Management of interview/examination including empathic responses |
| Lack of appropriate focus on the required task |
| Fluency of interview/examination/discussion |
| Choice of avenues of enquiry, tests or examination including significant omissions |
| Range of history explored |
| Range of risk explored |
| Depth of enquiry into risk |
| Range of psychopathology explored |
| Depth of enquiry into symptoms and/or psychopathology (signs elicited at examination) |
| Analysis of problems & synthesis of opinion |
| Professionalism including but not limited to harmful interaction; failure to respect individual's rights; ethical behaviour etc |

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LEARNING OUTCOME 4

RISK ASSESSMENT COMPETENCY

“Manage psychiatric emergencies including pharmacological and environmental aspects”

This competency will usually be assessed using a mini-ACE, possibly supported by a CBD. This competency will often be assessed by non-consultant assessors – however trainees should ensure that at least one assessment of this competence is carried out by a consultant. There are a wide range of psychiatric emergencies in the general hospital, giving the trainee multiple opportunities for assessment. Trainees should also demonstrate an ability to manage longer term consequences of the emergency once the immediate crisis has passed

CONSTRUCT

Core trainees should demonstrate an understanding of rapid tranquilisation, with consideration of medial risks and safeguards. They should also demonstrate a good understanding of environmental management, and communication with other staff / family caring for the patient. Trainees should demonstrate that they ask for support and supervision as appropriate, as well as the need to handover ongoing issues

AREAS FOR DEVELOPMENT

| |
|---|
| Management of interview/examination including empathic responses |
| Lack of appropriate focus on the required task |
| Choice of avenues of enquiry, tests or examination including significant omissions |
| Range of history explored |
| Range of risk explored |
| Range of cognition tested and appropriate application of cognitive testing |
| Extent of physical examination |
| Quality of physical examination |
| Analysis of problems & synthesis of opinion |
| Prioritisation, recognition of importance and appropriateness of information delivered and/or management |
| Professionalism including but not limited to harmful interaction; failure to respect individual's rights; ethical behaviour etc |

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LEARNING OUTCOME 8

COMMUNICATION WITH PATIENTS, RELATIVES AND COLLEAGUES

“Discuss mental health issues with medical and surgical patients

“Discuss basic management plan with patients”

This competency will usually be assessed using a mini-ACE in the context of a patient review. As this is one of the most important skills in liaison psychiatry, trainees should demonstrate this competence in different contexts, such as dealing with reluctant patients, or in circumstances where communication is difficult, such as in intensive care

CONSTRUCT

The trainee must demonstrate a broad range of listening, talking, interviewing and engaging skills, together with an ability to communicate in plain English, using methods understood by the patient. This may require visual or other aids. The trainee should check the patients understanding of the issues, and allow the patient to seek clarification or ask questions. The trainee should not express any views on the acceptability of the patient’s choices, but offer information in a balanced and supportive way. The Core trainee should demonstrate an understanding of the diagnoses being made and treatments being proposed , sufficient for the patient to make an informed choice

AREAS FOR DEVELOPMENT

| |
|---|
| Questioning style e.g. use of appropriate mix of open & closed questions |
| Listening and responding appropriately to interviewee/discussant |
| Management of interview/examination including empathic responses |
| Lack of appropriate focus on the required task |
| Fluency of interview/examination/discussion |
| Choice of avenues of enquiry, tests or examination including significant omissions |
| Range of history explored |
| Range of risk explored |
| Analysis of problems & synthesis of opinion |
| Prioritisation, recognition of importance and appropriateness of information delivered and/or management |
| Professionalism including but not limited to harmful interaction; failure to respect individual’s rights; ethical behaviour etc |

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June 2010



CT1 Competencies in

Old Age Psychiatry

WPBA Guide for Trainers

CORE COMPETENCIES IN OLD AGE PSYCHIATRY

WORKPLACE BASED ASSESSMENT GUIDE FOR TRAINERS

LEARNING OUTCOME 1

Be able to perform specialist assessment of patients and document relevant history and examination on culturally diverse patients to include:

- **Presenting or main complaint**
- **History of present illness**
- **Past medical and psychiatric history**
- **Systemic review**
- **Family history**
- **Socio-cultural history**
- **Developmental history**

SUGGESTED THEME: ASSESSING AN OLDER PERSON WITH COGNITIVE IMPAIRMENT

SUGGESTED FORMAT: ACE

Aspects of competency

Knowledge: aware of epidemiology and common causes of dementia and able to integrate this knowledge to assessment.

Skills: adopt a dynamic, sensitive approach to interview, using non-technical language. Elicit a complete clinical history, including course and development of symptoms and assessments of risks (e.g. neglect, exploitation), the past psychiatric history, medication, general medical history (including risk factors for dementia), review of systems, substance abuse history, family history, personal, social and developmental history. Overcome difficulties of language, physical and sensory impairment. Able to tolerate repetitive questioning and identify unreliable information.

Attitudes: demonstrates empathy to patient and carer.

Competency not demonstrated

Shows difficulty in engaging with patient with dementia or carer. Significant gaps in assessment resulting in unreliable or inaccurate diagnosis.

Some competencies achieved but further development needed

Generally competent assessment but some gaps or not adapted to the needs of person with dementia.

Achieved competency.

Comprehensive, unhurried and empathic assessment resulting in sound diagnosis and management plan.

Areas for development

| | |
|---|--|
| Questioning style e.g. use of appropriate mix of open & closed questions | |
| Listening and responding appropriately to patient | |
| Management of interview, including empathic responses | |
| Lack of appropriate focus on the required task | |
| Fluency of interview | |
| Prioritisation, recognition of importance and appropriateness of information delivered | |
| Depth of history explored | |
| Range of history explored | |
| Professionalism including but not limited to harmful interaction; failure to respect individual's rights; ethical behaviour etc | |

LEARNING OUTCOME 2

Use effective communication with patients, relatives and colleagues. This includes the ability to conduct interviews in a manner that facilitates information gathering and the formation of therapeutic alliances (core module outcome 8)

SUGGESTED THEME: TAKING A COLLATERAL HISTORY (face-to-face or telephone)

SUGGESTED FORMAT: MINI-ACE

Aspects of competency

Knowledge: knows psychopathology and epidemiology of suspected diagnosis and able to integrate this to prompt informant

Skills: adopt a dynamic, sensitive approach to interview, using non-technical language. Demonstrate interviewing skills, including the appropriate initiation of the interview, the establishment of rapport, the appropriate use of open ended and closed questions, techniques for asking difficult questions, the appropriate use of facilitation, empathy, clarification, and summary statements. Solicit and acknowledge expression of the patients' ideas, concerns,

Attitudes: Demonstrate respect, empathy, responsiveness, and concern for the informant (and patient where present).

Competency not demonstrated

| |
|---|
| Unable to establish rapport with informant. Unable to elicit sufficient information to aid assessment |
|---|

Some competency but further development needed

| |
|--|
| Some information gathered but incomplete- for example due to lack of breadth of questions or lack of clarification |
|--|

Achieved competency.

| |
|---|
| Comprehensive collateral history obtained in sensitive and empathic style |
|---|

Areas for development

| | |
|--|--|
| Questioning style e.g. use of appropriate mix of open & closed questions | |
| Listening and responding appropriately to informant | |
| Management of interview, including empathic responses | |
| Lack of appropriate focus on the required task | |
| Fluency of interview | |
| Prioritisation, recognition of importance and appropriateness of information delivered | |
| Depth of history explored | |

| | |
|---|--|
| Range of history explored | |
| Confidentiality and ethical practise maintained | |

LEARNING OUTCOME 3

Demonstrate the ability to recommend relevant investigation and treatment in the context of the clinical management plan. This will include the ability to develop and document an investigation plan including appropriate medical, laboratory, radiological and psychological investigations and then to construct a comprehensive treatment plan addressing biological, psychological and socio-cultural domains

SUGGESTED THEME: PLANNING INVESTIGATION OF PERSON WITH SUSPECTED DEMENTIA OR DELIRIUM

SUGGESTED FORMAT: CBD

Aspects of competency

Knowledge: awareness of epidemiology and pathology of suspected diagnosis and able to integrate this to plan appropriate investigations. Define the indications for the key investigations that are used in psychiatric practice Define the risks and benefits of investigations, including those of psychotherapeutic and genetic investigations Demonstrate knowledge of the cost effectiveness of individual investigations

Skills: selects investigations appropriate to case; aware of limitations in investigations (e.g false positive results). Able to synthesise results of investigations with clinical presentation. Interpret the results of investigations Liaise and discuss investigations with colleagues in the multi-professional team in order to utilise investigations appropriately

Attitudes: Demonstrate awareness of need to balance use of investigation with appropriate use of resources.

Competency Not demonstrated

Inappropriate investigations relating to case. "scattergun" approach with little heed to resource implications and risks to patient. Safety of patient compromised. Unable to interpret results

Some competency but further development needed

Appropriate investigations selected (possibly with some omissions), and sufficient interpretation to aid diagnosis. Lacks comprehensive approach or awareness of nuances of investigation results

Achieved competency.

Appropriate investigations selected. Able to use results to help rule in (or out) diagnoses.

AREAS FOR DEVELOPMENT

| | |
|--|--|
| Range of investigations considered | |
| Interpretation of test results | |
| Integrates investigations with clinical picture | |
| Lack of appropriate focus on the required task | |
| Prioritisation, recognition of importance and appropriateness of information delivered | |

LEARNING OUTCOME 4

Demonstrate the ability to construct formulations of patients' problems that include appropriate differential diagnoses (core module outcome 2)

SUGGESTED THEME: DIAGNOSTIC FORMULATION AFTER ASSESSMENT OF PERSON PRESENTING TO OLDER ADULTS SERVICES

SUGGESTED FORMAT: ACE

Aspects of competency

knowledge: Be familiar with contemporary ICD or DSM diagnostic systems with the ability to discuss the advantages and limitations of each State the typical signs and symptoms of psychiatric disorders as they manifest across the age range, including affective disorders; anxiety disorders; disorders of cognitive impairment; psychotic disorders; personality disorders; substance misuse disorders; organic disorders; developmental disorders; and common disorders in childhood Formulate a differential diagnosis for major presenting problems

Skills: Undertake a comprehensive assessment of history and mental state with view to formulating differential diagnosis and plan treatment.. Use the diagnostic system accurately in identifying specific signs and symptoms that comprise a syndrome or disorder Formulate and discuss differential diagnosis

Attitudes: . Empathic professional manner. Show an awareness of the advantages and limitations of using a diagnostic system

Not demonstrated

| |
|--|
| Unable to elicit sufficient clinical information or unable to suggest appropriate differential diagnosis or prioritise diagnoses |
|--|

Some competency but further development needed

| |
|--|
| Able to undertake adequate clinical assessment and list appropriate diagnoses, possibly with some omissions. Able to plan management around diagnoses selected |
|--|

Achieved competency.

| |
|--|
| Comprehensive clinical assessment and logical, prioritised list of differential diagnoses. |
|--|

AREAS FOR DEVELOPMENT

| | |
|--|--|
| Lack of appropriate focus on the required task | |
| Questioning style e.g. use of appropriate mix of open & closed questions | |
| Listening and responding appropriately to patient | |
| Management of interview, including empathic responses | |
| Fluency of interview and discussion | |

| | |
|--|--|
| Factual knowledge of diagnostic classification systems | |
| Analysis of problems & synthesis of opinion | |
| Prioritisation, recognition of importance and appropriateness of information delivered | |

LEARNING OUTCOME 5

Develop the ability to carry out specialist assessment and treatment of patients with chronic and severe mental disorders and to demonstrate effective management of these disease states (core module outcome 7)

SUGGESTED THEME: ASSESSING CAPACITY IN A PERSON WITH COGNITIVE IMPAIRMENT

SUGGESTED FORMAT: MINI-ACE

Aspects of competency

Knowledge: Knowledge of Mental Capacity Act (or relevant local legislation) and criteria for assessing capacity

Skills: adopt a dynamic, sensitive approach to interview, using non-technical language. Cover all elements of capacity assessment including assessment of disorder of mind or brain, assessment of patient's ability to understand, retain and weigh all relevant information. Uses adaptive techniques to overcome difficulties in communication

Attitudes: demonstrates empathy to patient.

Not demonstrated

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|---|
| Unable to demonstrate presence or absence of capacity using current legal framework |
|---|

Some competency but further development needed

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|--|
| Asks most questions to determine capacity. Possibly lacking fluency and adaptive approach. |
|--|

Achieved competency.

| |
|---|
| All aspects of assessment covered. Able to synthesise information and make clear judgement of capacity. |
|---|

AREAS FOR DEVELOPMENT

| | |
|---|--|
| Lack of appropriate focus on the required task | |
| Questioning style e.g. use of appropriate mix of open & closed questions | |
| Listening and responding appropriately to patient | |
| Management of interview, including empathic responses | |
| Fluency of interview and discussion | |
| Factual knowledge of components and application of of capacity assessment | |
| Analysis of problems & synthesis of opinion | |

LEARNING OUTCOME 6

Demonstrate the ability to work effectively with colleagues, including team working (core module outcome 9)

SUGGESTED THEME: UNDERSTANDING ROLES OF TEAM MEMBERS IN OLDER ADULTS PSYCHIATRY

SUGGESTED FORMAT: CBD

Aspects of competency

knowledge: aware of different team members (psychologist, OT, social worker, therapist, etc) and their roles within the team and contribution to patient care.

Skills: able to select appropriate profession for relevant tasks

Attitudes: demonstrates respect for individual professional's roles.

Not demonstrated

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|---|
| Lacks understanding of roles of team members or lacks understanding of inter-disciplinary working |
|---|

Some competency but further development needed

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|---|
| Some awareness of roles of team members but may not fully understand contribution each profession may make to patient care. |
|---|

Achieved competency.

| |
|--|
| High level of understanding of roles of professions in patient care. Respects diversity in team. Able to delegate/assign tasks appropriately |
|--|

AREAS FOR DEVELOPMENT

| | |
|--|--|
| Range of disciplines involved in care of patients | |
| Roles of disciplines involved in care of patients | |
| Awareness of background/training /ethos of team members | |
| Able to delegate and assign tasks to appropriate members | |

Other possible WPBAs:

LEARNING OUTCOME

Based on a comprehensive psychiatric assessment, demonstrate the ability to comprehensively assess and document patient's potential for self-harm or harm to others. This would include an assessment of risk, knowledge of involuntary treatment standards and procedures, the ability to intervene effectively to minimise risk and the ability to implement prevention methods against self-harm and harm to others. This will be displayed whenever appropriate, including in emergencies

THEME- assessment of risk (self-harm, neglect, exploitation, abuse)

FORMAT Mini-ACE/CBD

LEARNING OUTCOME

Be able to perform specialist assessment of patients and document relevant history and examination on culturally diverse patients

THEME- assessment of cognition

FORMAT Mini-ACE

LEARNING OUTCOME

Develop the ability to carry out specialist assessment and treatment of patients with chronic and severe mental disorders and to demonstrate effective management of these disease states

THEME- Psychopharmacology in the elderly

FORMAT- CBD

June 2010



CT1 Competencies in

Psychotherapy

WPBA Guide for Trainers

COMPETENCIES IN PSYCHOTHERAPY WORKPLACE BASED ASSESSMENT GUIDE FOR TRAINERS

Intended learning outcome 1

Be able to perform specialist assessment of patients and document relevant history and examination on culturally diverse patients to include:

- History of present illness.
- Past medical and psychiatric history.
- Systemic review
- Family History
- Socio-cultural history
- Developmental History
- Presenting or main complaint History of present illness Past medical and psychiatric history Systemic review Family history Socio-cultural history Developmental history

1-2b Formulation

Describe the various biological, psychological and social factors involved in the predisposition to, the onset of and the maintenance of psychiatric disorder.

Psychotherapeutic aspects of this competency.

The doctor must demonstrate an ability to use psychological understandings of the pathogenic origins and pathoplastic cascade in psychopathology.

COMPETENCY NOT DEMONSTRATED

Unable to give a psychological formulation of the case.

Fails to consider the implications of obvious aetiological factors such as seriously adverse childhood experiences.

No insight into the role of life events in precipitating disease.

No understanding of how current interpersonal difficulties might hinder recovery.

SOME COMPETENCIES ACHIEVED BUT FURTHER DEVELOPMENT NEEDED

Can mention some psychological factors in the genesis and perpetuation of psychiatric illness but fails to integrate these into a fully developed formulation or misses out obvious and important elements.

ACHIEVED COMPETENCY

Able to give a psychological formulation which uses historical information to point to psychological factors that may have predisposed to illness and gives a good account of the causal role of stressors in precipitating illness and shows a good understanding of

how current conflicts and interpersonal difficulties may hinder recovery.

GLOBAL MARK

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|---|--|
| COMPETENCY NOT DEMONSTRATED | |
| SOME COMPETENCIES ACHIEVED BUT FURTHER DEVELOPMENT NEEDED | |
| ACHIEVED COMPETENCY | |

1-3b Investigation
Define the indications for the key investigations that are used in psychiatric practice Define the risks and benefits of investigations, including those of psychotherapeutic and genetic investigations Demonstrate knowledge of the cost effectiveness of individual investigations.

Psychotherapeutic aspects of this competency.

To understand what a psychotherapeutic assessment might add to decision making in relation to diagnosis and treatment and to refer appropriately.

COMPETENCY NOT DEMONSTRATED

Never considers the use of such referrals or makes them indiscriminately.

SOME COMPETENCIES ACHIEVED BUT FURTHER DEVELOPMENT NEEDED

Considers referral to psychotherapy assessment but not clear about the distinction between referring for treatment and referring for assessment or fails to consider referring in cases where this would be evidently useful.

ACHIEVED COMPETENCY

Able to refer both inpatients and outpatients for an assessment in cases such as personality disorder, atypical psychotic symptoms or complex neurotic symptomatology where the opinion of the psychotherapist may assist with diagnosis and management.

GLOBAL MARK

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|---|--|
| COMPETENCY NOT DEMONSTRATED | |
| SOME COMPETENCIES ACHIEVED BUT FURTHER DEVELOPMENT NEEDED | |

| | |
|---------------------|--|
| ACHIEVED COMPETENCY | |
|---------------------|--|

1-3c Treatment planning

Explain the evidence base for physical and psychological therapies including all forms of psychotherapies, brief therapy, cognitive behavioural therapy, psychodynamic therapy, psychotherapy combined with psychopharmacology, supportive therapy and all delivery systems of psychotherapy (that is individual, group and family)

COMPETENCY NOT DEMONSTRATED

Does not know what the evidence base for psychological therapies are beyond the crudest level (such as CBT is a good therapy).

SOME COMPETENCIES ACHIEVED BUT FURTHER DEVELOPMENT NEEDED

Able to mention some treatments which are appropriate in different situations but fails to consider all relevant conditions or omits certain evidence based treatments from consideration.

Understands that alternative treatments may be appropriate in some situations but unsure what these might be.

ACHIEVED COMPETENCY

Can say which psychotherapeutic treatments have a good evidence base in a range of conditions and has rough appreciation of their effect size.

Can consider which treatments to use as second line if there are contraindications to the first line therapy.

Knows the different systems for delivering psychological interventions and can say which are appropriate in different situations.

GLOBAL MARK

COMPETENCY NOT DEMONSTRATED

SOME COMPETENCIES ACHIEVED BUT FURTHER DEVELOPMENT NEEDED

ACHIEVED COMPETENCY

1-3c Treatment planning 2

Apply contemporary knowledge and principles in psychological therapies. Foster a therapeutic alliance with patients With appropriate supervision, commence and monitor therapeutic treatment in patients, based on a good understanding of the mechanisms of their actions Demonstrate the capacity to deliver basic psychological treatments in at least two modalities of therapy and over both longer and shorter durations

COMPETENCY NOT DEMONSTRATED

Has not delivered any psychological treatments, does not use psychotherapeutic techniques or understandings in routine psychiatric practice.

SOME COMPETENCIES ACHIEVED BUT FURTHER DEVELOPMENT NEEDED

Either fails to show sufficient evidence of competency in delivering formal psychotherapeutic treatments or notwithstanding some evidence of having delivered psychological treatments shows deficient understanding or skill in the use of psychotherapeutic principles in routine psychiatric practice.

ACHIEVED COMPETENCY

In normal psychiatric practice is able to use psychotherapeutic principles to understand how to foster a working and collaborative alliance with a patient even where this is complex because of patient characteristics (such as hostility, distrust, learning difficulties, psychotic experience).

Within normal psychiatric practice can implement basic psychotherapeutic strategies where these are helpful (for example giving appropriate psychoeducation, supportive interventions, advice about simple behavioural or cognitive strategies, identification of an interpersonal problem and focus on its resolution, or use of psychotherapeutic principles to understand and manage the reasoning a patient might have for resisting compliance with medication.

In addition demonstrated ability to deliver basic psychological treatments in more than one modality of psychotherapy and over longer and shorter duration of treatment.

GLOBAL MARK

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|---|--|
| COMPETENCY NOT DEMONSTRATED | |
| SOME COMPETENCIES ACHIEVED BUT FURTHER DEVELOPMENT NEEDED | |
| ACHIEVED COMPETENCY | |

2-8a Within a consultation

Demonstrate a knowledge of how to structure the clinical interview to identify the patients concerns and priorities, their expectations and their understanding

Demonstrate interviewing skills, including the appropriate initiation of the interview, the establishment of rapport, the appropriate use of open ended and closed questions, techniques for asking difficult questions, the appropriate use of facilitation, empathy, clarification, confrontation, reassurance, silence and summary statements

Solicit and acknowledge expression of the patients' ideas, concerns, questions and feelings Understand the ways in which patients may communicate that are not directly verbal and have symbolic or unconscious elements Communicate information to patients in a clear fashion Appropriately close interviews

Psychotherapeutic aspects of competency

The capacity to use emotional sensitivity to guide behaviour during the interview and to respond sensitively to the patient's expectations and fears in such situations.

COMPETENCY NOT DEMONSTRATED

Wooden, rigid or inappropriate interview style. Little sensitivity to the needs of patients in interview situations.

SOME COMPETENCIES ACHIEVED BUT FURTHER DEVELOPMENT NEEDED

Can interview a range of patients but has difficulty in subtler aspects of interactions.

Shows uncertainty when dealing with more upset or angry patients.

Unaware of impact of own behaviours on different kinds of patients.

ACHIEVED COMPETENCY

Shows skill in engaging patients who present a range of difficulties to the interviewer such as hostility, distrust, reticence.

Can pick up signs of emotional experience and sensitively elicit emotions and unvoiced thoughts.

Is able to use own reactions to the patient and experiences of emotion during the interview process to provide information about the interpersonal interaction with the patient and to guide the interview process.

Gives information and support to patients in a comprehensible way matched to the patients emotional and intellectual capacities.

GLOBAL MARK

| | |
|---|--|
| COMPETENCY NOT DEMONSTRATED | |
| SOME COMPETENCIES ACHIEVED BUT FURTHER DEVELOPMENT NEEDED | |
| ACHIEVED COMPETENCY | |

6-16a Research techniques

Demonstrate an understanding of basic research methodology including both quantitative and qualitative techniques

Psychotherapeutic aspects of competency

Understands the research base in psychological treatments and demonstrates some understanding of the particular difficulties in conducting research in this area and the methodologies used to overcome these.

COMPETENCY NOT DEMONSTRATED

Little awareness of the key papers and techniques in the field.

SOME COMPETENCIES ACHIEVED BUT FURTHER DEVELOPMENT NEEDED

Some awareness of the research in the field but restricted range or limited understanding

ACHIEVED COMPETENCY

Understands the key methodologies in use – the importance of randomised controlled trials, the use of manualised treatments and the importance of care in relation to placebo control groups in this area.

GLOBAL MARK

| | |
|---|--|
| COMPETENCY NOT DEMONSTRATED | |
| SOME COMPETENCIES ACHIEVED BUT FURTHER DEVELOPMENT NEEDED | |
| ACHIEVED COMPETENCY | |

7-17a Doctor patient relationship

Demonstrate an understanding of all aspects of professional relationships including the power differential between psychiatrists and patients

Demonstrate an understanding of the boundaries surrounding consultation

Demonstrate an understanding of the rights of patients, carers and the public

Demonstrate an understanding of the factors involved when the doctor-patient relationship ends

Psychotherapeutic aspects of competency

Able to understand the emotional and professional tensions that may lead to boundary violations or unethical acts in psychiatric practice in areas such as research, relationships outside professional contacts, and confidentiality.

COMPETENCY NOT DEMONSTRATED

Shows difficulty in understanding the duties of a doctor in relation to patients or, despite understanding these duties does not fulfil them in practice.

SOME COMPETENCIES ACHIEVED BUT FURTHER DEVELOPMENT NEEDED

Maintains overtly competent practice but shows deficient understanding of the more subtle aspects of the dilemmas involved.

May display tendencies to a characteristic boundary difficulty such as sharing personal information with patients.

ACHIEVED COMPETENCY

Understands that pressures to violate boundaries or act unethically can be subtle but that minor infractions can lead to worse difficulties later on.

Able to use the support consultation and oversight of other professionals to assist in maintaining professional standards.

Particularly careful about issues of confidentiality in situations where risk may warrant disclosure of information.

GLOBAL MARK

| | |
|---|--|
| COMPETENCY NOT DEMONSTRATED | |
| SOME COMPETENCIES ACHIEVED BUT FURTHER DEVELOPMENT NEEDED | |
| ACHIEVED COMPETENCY | |

7-17e Recognise own limitations

Demonstrate an appreciation of the extent of one's own limitations and when to ask for advice Recognise the potential benefits of seeking second opinions in advance of problems arising

Psychotherapeutic aspects of competency

Demonstrated capacity to consider that professional activities or difficulties might be influenced by one's own emotional situation or preoccupations.

COMPETENCY NOT DEMONSTRATED

No evidence that the doctor has an awareness of their own emotional state or needs.

SOME COMPETENCIES ACHIEVED BUT FURTHER DEVELOPMENT NEEDED

Recognises own emotional reactions and responses but shows difficulty in acting appropriately as a result.

ACHIEVED COMPETENCY

Able to identify when emotionally in difficulties in a clinical situation and to ask for support or take other appropriate steps to manage emotional responses so as to maintain a good standard of practice.

GLOBAL MARK

| | |
|---|--|
| COMPETENCY NOT DEMONSTRATED | |
| SOME COMPETENCIES ACHIEVED BUT FURTHER DEVELOPMENT NEEDED | |
| ACHIEVED COMPETENCY | |



CT1 Competencies in

Rehabilitation Psychiatry

WPBA Guide for Trainers

CORE COMPETENCIES IN REHABILITATION PSYCHIATRY WORKPLACE BASED ASSESSMENTS GUIDANCE FOR TRAINERS

MANAGING LONG-TERM PSYCHIATRIC ILLNESS

Intended learning outcome 7

Develop the ability to carry out specialist assessment and treatment of patients with chronic and severe mental disorders and to demonstrate effective management of these disease states

Define the concept of quality of life and how it can be measured

Rehabilitation approach to this competency

This competency should show how the trainee understands the importance of quality of life goals in rehabilitation psychiatry and the comprehensiveness of their understanding of what those goals would be and how they could be assessed. This case can best be assessed as a Case Based Discussion but could be based on a mini ACE - "please talk to this patient to evaluate his quality of life"

Not demonstrated

Is not aware of the range of factors in quality of life required to achieve competency and is unable to describe any beyond a few made up on the spot. Does not understand that quality of life goals are important even if psychotic symptoms have not resolved and cannot name any quality of life assessment schedules.

Some competency but further development needed

Shows awareness of the majority but not all of the quality of life factors required to achieve competency. Understands that quality of life is an important goal even without resolution of psychotic symptoms. Unable to name any quality of life assessment schedules.

Achieved competency

Understands that independence of accommodation, employment and training, leisure activities, friendships and intimate relationships, financial independence, spiritual or religious practice, physical wellbeing and satisfying family relationships are the principal factors in quality of life and can list these accurately. Understands that quality of life is an important goal even without resolution of psychotic symptoms. Able to name at least one quality of life assessment schedule such as Lehman's Quality of life Interview or Lancashire Quality of Life Profile.

Intended learning outcome 8

Use effective communication with patients, relatives and colleagues. This includes the ability to conduct interviews in a manner that facilitates information gathering and the formation of therapeutic alliances

Demonstrate interviewing skills, including the appropriate initiation of the interview, the establishment of rapport, the appropriate use of open ended and closed questions, techniques for asking difficult questions, the appropriate use of facilitation, empathy, clarification, confrontation, reassurance, silence and summary statements

Rehabilitation approach to this competency

This would be assessed through an ACE. The essence is to show the ability to communicate with a patient who is engrossed with chronic delusions and hallucinations which may have become part of their understanding of the world.

Not demonstrated

The patient gets into conflict with the patient about their life view. They may view it in purely diagnostic medical terms and see the patient as lacking insight and non-compliant. They show no signs of empathy or of seeing the world through the patients eyes.. They do not get beyond the conflict to gather information of the patients social and psychological sphere. The result may well be the patient saying very little and the doctor giving a very conventional disease interpretation.

Some competency but further development needed

They can engage the patient avoiding conflict about their view of the world but fail to establish an aligned relationship, seeing the patient as unwell and therefore essentially different to "normal People". Whilst getting a full view of the patient's symptomatology they will fail to elicit aspects of the patients normal life, world and reactions.

Achieved competency

They can engage the patient avoiding conflict and forming rapport. They align with the patients view of the world, by circumventing confrontation about its reality respecting it whilst maintaining a full understanding of it as symptom generated. They can gather information on the patients history and test its voracity. They can maintain a mutually respectful relationship whilst holding a position that allows for future testing of beliefs. They encourage the patient to open up so as to elicit the meaning of their symptoms in their life and at the same time eliciting information about the conventional elements of their life and history.

Intended learning outcome 9

Demonstrate the ability to work effectively with colleagues, including team working

Demonstrate an understanding of the roles and responsibilities of team members

Rehabilitation approach to this competency

This will be best demonstrated during a Direct Observation of Non-Clinical Skills but could also be elicited during a CBD. The setting is likely to be a team meeting to discuss a

referral, crisis or Care Plan. The individual will discuss an individual possibly in respect to a crisis, encouraging and hearing the views of different members, testing them appropriately and incorporating them into an understanding of the situation and the formulation of a plan to respond.

Not demonstrated

They will have prejudged the outcome or be unable to pull together a broad understanding of the situation. They will either ignore or argue with other members of the team or conversely simply accept a view from one member uncritically. They will hold an illness model in spite of more sophisticated views being expressed. They may not respect different cultures for eliciting and formulating the agenda.

Some competency but further development needed

They will be able to listen to others views but will assume that they are working from the same training in formulation. They will hear others perspectives but struggle to combine them into a coherent formulation that carries the respect and support of the team. They will encourage emphasis on non-medical aspects such as activity and employment. They will garner information on capacity of the patient to manage their everyday life.

Achieved competency

They will be able to encourage all members of the team to contribute, asking questions to clarify, test views and elicit further information sensitively, incorporating all the views into a broadly accepted understanding and plan of action. They will demonstrate understanding of different cultures and training leading to a unity of view rather than disagreement. They will be able to elicit all aspects of the expertise of the MTD in bringing together a rounded understanding of the patient and their function.

Intended learning outcome 11

Demonstrate the knowledge, skills and behaviours to manage time and problems effectively

Demonstrate a good understanding of clinical priorities

Rehabilitation approach to this competency

During a rehabilitation post they will need to demonstrate the ability to proactively pursue tasks rather than to react to crisis. This will include developing relationships with patients, producing reviews of past notes, developing individual elements of work and reviewing the patient with members of the team at their request. This can best be tested through a CBD towards the end of their post on a patient they have been seeing for some time.

Not demonstrated

They will not have developed a rapport with or an understanding of the patient. They will not have ensured an up to date review is in the notes. They will describe the patient in terms of crisis and medical treatment rather than in terms of a human relationship. They will not understand why they should see the patient if there is not a problem.

Some competency but further development needed

They will have spent some time with the patient whilst not in crisis, have proactively reviewed medication and diagnosis and have developed a good grasp of the patient in the round. They will however still think in terms of reacting to crisis which will often be viewed

in medical terms. They will not fully understand the benefits of proactive engagement in improving quality of life and preventing and managing crisis if it presents.

Achieved competency

They will have seen the patient proactively, taking the time to get to know them and their views through conversation as well as reviewing notes. They will have reviewed medication and diagnosis without a crisis to force a review. They will have met with key members of the team and be able to discuss the patient in team meetings. They will be able to identify likely crisis and explain what measures are in place to avert, identify them early and manage them should they arise.

Intended learning outcome 14

To ensure that the doctor is able to inform and educate patients effectively

Develop an awareness of how established practices may perpetuate and reinforce stigma

Rehabilitation approach to this competency

Best evaluated through a Case Based Discussion of a notes review on a patient who has a long history in the service. The purpose is to understand how the patient has adapted to services, finding ways that engage that service to meet their needs or becoming discouraged and mistrustful. Words such as Schizophrenic, non-compliant and lacking insight will have primacy and behaviour will be described as maladaptive, manipulative and dependent and attention seeking.

Not demonstrated

The patient's problems will be interpreted medically but with understanding of how qualities of the services can modulate this. There will be some understanding that behaviour that causes problems can be developed as a response to procedures and failures. However they will be unable to give these due weight and harness them in the development of a care plan.

Some competency but further development needed

Achieved competency

They will have an extensive knowledge of the patient's involvement with services, understanding how this has developed and understanding behaviour and attitudes as part of the system. They will understand that services often let people down and fail to deliver. They will understand that services that react to crisis generate crisis and that paternalistic services generate dependency. They will understand that behaviour that causes services a problem may be entirely rational from the patient perspective. They will be able to incorporate this understanding in formulations and plans. They will be able to give specific examples.