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CAPSAC Advisory Papers

Introduction

The Higher Specialist Training Handbook contains a comprehensive summary of the educational goals of higher training, including the professional attributes and the core knowledge and skills to be expected of consultant in any psychiatric speciality (pp32-24). The Handbook also includes a list of the training experiences recommended for all trainees (pp39-40), and for child and adolescent psychiatry trainees in particular (pp43-44).

The advisory papers that follow have been produced by the Child and Adolescent Specialist Advisory Committee (CAPSAC) of the Higher Specialist Training Committee of the Royal College of Psychiatrists. First introduced in 1995, each section expands on the learning objectives detailed in the Higher Specialist Training Handbook.

These papers are somewhat less prescriptive than the previous edition, with more emphasis on the objectives that trainees must achieve and less on the exact time spent on particular training experiences that must be provided. It is recognised that there are many ways of organising training to achieve these objectives and that programme directors, consultant trainers and trainees must be allowed some flexibility in organising training. Nevertheless the core training objectives set out in the HSTC Handbook must be achieved if trainees are to be awarded a CCST. Appendix I draws on examples of good practice in programme organisation to provide some advice about the overall organisation of training. Balancing breadth against depth of experience is a challenging task and it is expected that the same scheme will produce trainees with different levels of expertise in different areas despite all having achieved the same core objectives. It is crucial that award of a CCST is not be seen as being the end point of training. The breadth of training provided should be a platform for further training and development at consultant level.

CAPSAC will use the guidance in these papers, as well as the recommendations in the Handbook, when visiting higher specialist training schemes to assess the quality of training offered. With the greater emphasis placed on trainees working with trainers to decide on how best to achieve learning objectives, it is essential that Programme Directors ensure that all trainees have copies both of the HSTC Handbook and these Advisory Papers.

Professional Attributes of the Consultant Child & Adolescent Psychiatrist

The purpose of higher specialist training is to produce someone capable of functioning as a consultant child and adolescent psychiatrist. This is a complex task; the general attributes described in the HTSC Handbook (pp32-33) are, of course, as relevant to child and adolescent psychiatrists as they are to all other consultant psychiatrists. There is however, a danger that in attending to individual learning objectives the overall purpose of training is lost. The acquisition and integration of the learning objectives described in these advisory papers should produce individuals who can demonstrate high level ability in the following areas:

• Consultant child and adolescent psychiatrists, by virtue of their training will have, in addition to their medical background and training, an expertise in child development,
developmental psychopathology and diagnosis, assessment and treatment of clinical problems that will enable them to deal with a range of very complex presentations. This ability to apply multiple perspectives: biological, psychological and social, is a key feature of the consultant child and adolescent psychiatrists’ contribution to child and adolescent mental health services. The consultant’s role will include the containment and management of anxiety in colleagues and other professionals when confronted with complex and challenging situations, as well as clinical management of the problems presented by children, young people and their families.

- Consultant child and adolescent psychiatrists must be able to provide clinical leadership and exercise managerial authority within multidisciplinary teams and within trusts when required. However, consultants will not have leadership responsibilities in all settings, in which they work, and must be able to function in teams where the consultant psychiatrist is not, automatically, the clinical leader of the team. The multidisciplinary nature of child mental health work, places a particular emphasis upon the consultant child and adolescent psychiatrist to seek and respect the experience and expertise of non-medical and medical colleagues. Fulfilling the role of an autonomous medical specialist is a particular challenge when the context of child and adolescent psychiatric work necessitates an ability to collaborate with colleagues (medical and non-medical) from other disciplines and other agencies in a positive way for the benefit of patients.

- Consultant child and adolescent psychiatrists must be life long learners. Award of a CCST represents the completion of one stage of training but the beginning of another. The knowledge, skills and attitudes acquired during higher specialist training must be seen as a foundation for further learning. Knowledge about effective practice is changing and increasing rapidly, the implications for continuing professional development are substantial and require the consultant to identify their own learning needs and pursue them vigorously.

- Consultant child and adolescent psychiatrists must also be prepared for an unknown future. They must be able to provide leadership for their discipline, be able to teach the next generation of trainees, and engage in research and audit to ensure that best practice continues to be developed. They must be able to contribute to the development of services and act as an advocate for their client group.
CHILD AND ADOLESCENT PSYCHIATRY: GENERAL ISSUES FOR TRAINING

Introduction

To gain a comprehensive training in all aspects of general child and adolescent psychiatry in three years, trainees must have experience of working with the full age range from pre-school children to adolescents, in a variety of settings (including multidisciplinary teams). Trainees must take part in routine and out-of-hours emergency work under consultant supervision. All trainees must receive at least one hour of face-to-face supervision per week with their named educational supervisor. A formal academic training programme should support the practical, clinical training. General learning objectives for all psychiatrists and for child and adolescent psychiatry are set out in the HSTC Handbook but are also summarised below.

Learning Objectives

1. Knowledge in biological, psychological and social developmental changes at different stages of childhood and adolescence.
2. Knowledge of individual, family and wider environmental influences on the development of psychopathology and resilience.
3. Knowledge of the variety of ways in which emotional, behavioural, and developmental problems can be related to physical disorder and the physical presentation of disorder.
4. Knowledge of the theoretical bases and principles of the major models of psychological treatments, and of the therapeutic indications, pharmacokinetics and pharmacodynamics of psychoactive medications.
5. Knowledge of the relevant local legislation affecting children, for example, Children Act, Mental Health Act, Children's Hearing Legislation etc.
6. To develop a high level of skill in engaging and communicating with children, adolescents and parents.
7. To carry out a full psychiatric assessment of a child or young person and, where appropriate make a formal psychiatric diagnosis using recognised classificatory systems, for example ICD 10 or DSM IV
8. To carry out risk assessments of young people presenting with self-harming behaviour, drug abuse and threatening or violent behaviour.
9. To gain expertise in the assessment and treatment of parenting skills and deficits to be able to develop appropriate management and therapeutic plans.
10. To gain experience in the full range of treatment modalities (including consultation to other professionals) available to the specialty, and the indications for these.
11. To gain skills in working in multidisciplinary teams and communicating with other relevant agencies, for example Social Services, Education, Police and Courts.

Core Experience

All placements will contribute to training in general child and adolescent psychiatry, although most will also provide experience in one or more of the areas described in the following advisory papers. General child and adolescent psychiatry experience should include:
• Experience in developing skills in the assessment, formulation and treatment of all the main psychiatric disorders encountered in children and adolescents, sensitive to the ethnic origin and cultural background of children and families.
• Regular supervision of one hour per week or pro rata equivalent*.
• Experience of working as a part of a multidisciplinary team.
• Opportunities for appropriate liaison with, and consultation to primary care, social services, education and voluntary sector organisations.
• Experience in assessing and making appropriate management decisions in out of hours crisis situations when supporting agencies are operating at minimum staffing. CAPSAC recommend that a minimum on-call experience should be participation in a one-in-five rota for one year, or the pro-rata equivalent. Consultant on-call cover should be available and on-call experience included in regular supervision discussions.
• Supervised training in office procedures and administration for example, letter and report writing, recording of patient activity statistics, maintenance of records etc.

Caseload

Full time trainees would normally be expected to have a clinical caseload of between 20-30 cases at any one time and to have had some direct responsibility for the assessment/treatment of between 50-75 new cases each year. It is recognised that there may be good reasons for variations outside of these limits at some times and in some placements depending on the nature of the placement. However, significant variations over long periods would be a matter of some concern.

Facilities

• Trainees must have either their own room or their own desk in a shared room. If the latter, there must be adequate storage space for personal files, notes etc, a telephone, and easily accessible bookable clinical space.
• Trainees must have access to an adequate library and where, on some placements, the local library has limited child and adolescent psychiatry holdings or is some distance away, a bench library must be provided in the placement.
• Trainees must be able to carry out a basic physical examination when indicated and facilities for this must be provided. This must be on site at in-patient units.

* Supervision: The HSTC has agreed that "educational supervision must be provide for one hour weekly by the trainer, must be consistently on an individual basis and take place during the working day." Joint supervision with an SHO is not acceptable except on an occasional ad hoc basis to discuss issues of relevance to both the SpR and the SHO.

Over the course of a placement supervision should normally cover the following areas: Theoretical approaches to clinical management, practical management of cases and caseload, detailed supervision of specific sessions, teaching of others, research issues, careers and training matters, service management and medical politics, personal guidance, and the
supervision process. Clinical supervision matters are likely to predominate but the balance of time afforded to different topics will change with the differing needs of different trainees.
PSYCHOTHERAPEUTIC APPROACHES TO TREATMENT

Introduction

Psychotherapeutic approaches include the knowledge, skills and attitudes essential for most aspects of interpersonal working by psychiatrists and in the broadest sense form the context for all interventions and the basis for therapeutic work for the majority. Specifically, this includes an understanding of a range of theoretical models and of assessment and treatment techniques, and provides a framework for thinking about all aspects of service provision for children, adolescents, their families and the other systems within which they are found. This area of training more perhaps than any other in these papers, is one in which trainees may enter higher training with existing skills, where skills developed in one area may be utilised in another, and where acquisition of further skill and knowledge will continue after higher training is complete.

Learning Objectives

1. Knowledge of the theoretical bases and principles of major models of therapy in current use. This is to enable use of a variety of conceptual frameworks so that an understanding of the individuals and families who come to services may be achieved, which takes into account their feelings, behaviour, cognitions and relationships.
2. A high level of skill in engaging and communicating with children, adolescents and parents such that trainees may take part in a psychiatric assessment and any subsequent treatment.
3. Experience of work in each of the core approaches. Three broad levels of experiences and skill (defined below) are recognised as objectives for higher trainees. The level reached will depend on a number of factors including pre-existing training, career intention, skill and interest with more substantial skills i.e. ‘basic competence’ in at least two areas.
4. An appreciation of the place of different treatment approaches, what makes them applicable and acceptable to different individuals and families, for which conditions they are most suitable, the evidence of their efficacy, and judgement and flexibility in ensuring patients are referred appropriately where the skills of another or different professional are required.
5. An ability to use supervision to reflect upon the content and process of psychotherapeutic work, including an understanding the role of the trainee’s own experiences and assumptions may play in the context of such work and an understanding of the way in which personal and professional life issues of the clinician may have an impact upon interactions in the workplace.
6. An understanding of the purpose and practice of supervision of therapeutic work of all kinds. Skills in supervision of staff members and trainees in their clinical work generally and therapeutic work specifically, with a recognition of the limit of specific skills.
Three broad levels of experience and skill:

Level 1  **Basic experience** includes understanding of the conceptual model of the area and supervised experience with patients but without substantial skills to apply the modality.

*All trainees are expected to achieve Level 1 competence of the core approaches with children and adolescents listed below.*

Level 2  **Basic competence**: as Level 1 but with more substantial clinical experience and supervision, resulting in a degree of skill in application such that the trainee would be competent to provide treatment using this approach.

*All trainees are expected to achieve Level 2 competence in at least two areas.*

Level 3  **Specialist competence** includes Levels 1 & 2 and reaches higher levels of knowledge and skill, in a particular therapeutic modality that may include either a degree or UKCP registration.

*Level 3 is unlikely to be achieved exclusively during the course of higher training. Trainees should be encouraged to consider such a goal to the extent that it is consistent with the other objectives of child and adolescent higher training and in consideration that this training may be completed during the trainee’s subsequent career as a consultant.*

Core Experience

For Level 1, ‘basic experience’ this should include study of the theoretical bases, observations of skilled practitioners, direct clinical experience and supervision (all of which should be recorded in the learning log) of the following approaches:

- Individual non-directive psychotherapy.
- Individual behavioural therapy with children and with parents for a child patient.
- Family systems therapy
- Cognitive therapy
- Group therapy

**Theory** should encompass a range of ages and developmental stages, and should include academic seminars in major theoretical areas.

**Experience** should include an opportunity to work with the same patient for a period of several months and preferably longer.

**Supervision** may include input from a range of professionals and should include a range of different techniques (individual, group, live, video and audio feedback, process recording).
CONSULTATION & LIAISON

Introduction

Consultation is a shared exploration with other professionals of problems and possible solutions in which the consultant facilitates the problem solving process for another professional or group. The consultant does not take responsibility for the case and often has not had previous face-to-face contact with the subject of the consultation. Its nature is likely to depend on the theoretical model of the consultant, but an understanding of systemic process forms the basis of many consultation experiences. Consultation can take various forms and typically is in relation to social services or educational establishments or to groups of professionals. An element of staff training as well as problem solving may be involved.

Liaison Work describes contact with professionals for the purposes of sharing assessment, information and undertaking planning in relation to specific cases in a particular agency or unit of organisation. The specific area of paediatric liaison is discussed elsewhere.

Learning Objectives

1. To understand the criteria and goals of consultation i.e. to facilitate understanding and not to direct the professionals seeking consultation.
2. To be able to facilitate the work of other professionals through acquisition of skills specific to the liaison and consultative processes: these include listening skills, information seeking and giving, decision making and the ability to summarise and clarify.
3. Knowledge of group and organisational behaviour, including a systemic perspective and an understanding of issues of role clarity and specificity.
4. To be able to demonstrate skills in presentation of a child psychiatric perspective to other professionals and disciplines, and in integrating this perspective with other ones.

Core Experience

Consultation
• Individual or group learning about theoretical and practical aspects of consultation.
• Observation of consultation carried out by others with opportunity to discuss content and process in supervision.
• Directly supervised and supported experience of consultation to other professionals about a case
• Observing a consultation to a staff group.

Liaison
• Throughout higher training, trainees should undertake liaison with a range of agencies/units including education, social services and the voluntary sector.

Optional Experiences

Consultation to a range of different establishments and professionals.
PSYCHOPHARMACOLOGY

Introduction

Trainees should be competent in the use of all the major groups of drugs used in child and adolescent psychiatry, while recognising that their use only ever forms part of an integrated treatment plan.

Learning Objectives

1. To demonstrate knowledge of the therapeutic indications, pharmacokinetics and pharmacodynamics of psychoactive medications. This involves knowledge of premedication work-up, toxicity, side effects (both short and long), drug interactions and half-life of such drugs.
2. To be aware of the necessity to obtain and document the informed consent of the child and/or parent/guardian (as clinically appropriate).
3. To know how to monitor and document side effects using standardised methods and/or clinical observation.
4. To demonstrate knowledge of those medications that may cause behavioural or psychiatric symptoms.

Core Experience

Training must be organised such that trainees gain first hand experience in talking with both child and parents about the proposed treatment regimen, and then in the use of:

- Major tranquillisers in the treatment of psychotic conditions
- Antidepressants and/or mood stabilisers in the treatment of depression alone or as a co-morbid feature of other illnesses, whether psychiatric or medical, e.g. Epilepsy, Juvenile Diabetes, etc.
- Psychostimulants and the other medications in the treatment of the hyperkinetic syndrome alone or occurring as co-morbid condition
- Other medication used in child psychiatry e.g. Clonidine, anticonvulsants, etc.
LEGAL ASPECTS OF CHILD & ADOLESCENT PSYCHIATRY

Introduction

Child psychiatrists have an important part to play in the assessment and management of children and teenagers who come into contact with the law. They may become involved because of concerns about child protection or following antisocial and risk taking behaviour. Child and adolescent psychiatrists are also called upon to carry out assessments of risk and dangerous behaviour in youths with mental illness or suspected mental illness.

Learning Objectives

1. Knowledge about relevant legislation and court systems in relation to children and adolescents (in Scotland this includes the Children’s Hearing System).
2. To identify the nature and scope of assessments required and the conditions under which such assessments should be accepted.
3. To assess children and their families where child abuse is suspected
4. To undertake risk assessments of dangerous behaviours in youths with mental illness or suspected mental illness.
5. To prepare reports for the court and present evidence in court.
6. To assess and consult to other agencies in relation to could mental health and the law.

Core Experience

Child Protection
- Assessment of children and adolescents where abuse and neglect is suspected.
- Collaborative work with other agencies, for example, Social Services, police and NSPCC etc.
- Participation in multidisciplinary child protection conferences
- Management and treatment of abused children and those who present with sexually abusive behaviour
- Attendance at seminars/workshops on presenting evidence in court.
- Reviewing written reports, writing reports for the court and advising professionals on the best action with regard to a child’s mental health.
- Opportunities to attend a court hearing and observe an experienced child and adolescent psychiatrists giving evidence, and where possible give evidence in court with a trainer present.

Conduct Disorder & Delinquency
Over and above the standard experience and seminars on conduct disorder and delinquency, experience should include:

- Psychiatric assessment of children and teenagers whose antisocial and risk taking behaviour, including sexual offending, result in some form of legal action.
• Assessment of the risk of dangerous behaviour and management thereof, often in collaboration with other agencies, for example, Social Services, Youth Offender Teams etc.

Optional Experiences

• Attendance at a unit such as a secure unit, for children or teenagers with severe antisocial and risk taking behaviour.
• Attendance at specialist forensic adolescent centres
• Involvement with Youth Offender Teams (YOTs), Court Diversion Schemes etc.
• Trainees who intend to specialise in forensic work will need more specialist training. The Higher Specialist Training Committee can provide guidelines on a four-year training in Forensic Child and Adolescent psychiatry, and on a five-year training leading to dual accreditation in Child & Adolescent and Forensic Psychiatry.
PAEDIATRIC LIAISON

Introduction

Sick children represent a vulnerable group for the development of emotional and behavioural problems, and their illness may be the source of considerable stress for their parents and siblings. In addition, children are particularly prone to present psychological problems with physical symptoms or with the exacerbation of existing illness. The identification and management of such problems demand collaboration between paediatricians and child psychiatrists, in both hospital and community settings, and defines the task of paediatric liaison.

Learning Objectives

1. To demonstrate effective co-operation with paediatricians and other members of the paediatric multi-disciplinary team.
2. To demonstrate knowledge of the variety of ways in which emotional, behavioural, and developmental problems can be related to physical disorder and the physical presentation of disorder.
3. To be alert to the possibility of organically based psychiatric disorder, and to facilitate its management.
4. To be able to assess and manage somatisation disorders, abnormal illness behaviour, and cases of unexplained physical symptoms
5. To be able to advise on the psychiatric aspects of chronic illness, life-threatening disease, physical disability, and trauma (e.g. road traffic accidents), and to participate in the management of these conditions.
6. To be able to manage cases of deliberate self-harm and other psychiatric emergencies that present in the A+E department or on the ward.
7. To participate in the identification and management of cases that arouse child protection concerns within the paediatric setting.

Core Experience

Clinical

- Experience within the paediatric setting, both in-patient and outpatient, with the types of cases cited above.
- Experience of working in a child mental health team that has developed links with a paediatric department.
- Attendance at regular multi-disciplinary liaison meetings (with paediatricians, nursing staff, social workers etc.).

Education

- Participation in and attendance at case presentations and other joint teaching meetings held in the paediatric setting.
- Experience of teaching medical staff such as junior doctors, nurses, A+E staff.
Optional Experiences

- The development of close liaison links with a particular clinical department.
- Joint consultations/clinics with a paediatrician.
- Experience of co-ordinating the running of one aspect of the liaison service.
- Experience in developing and completing at least one audit project.
- The opportunity to undertake research in the area of paediatric liaison.
NEUROPSYCHIATRY AND DEVELOPMENTAL DISORDERS

Introduction

Neuropsychiatric and developmental disorders occur in complex conditions resulting from genetic and environmental insults on the brain, with concomitant impairments in neurological, cognitive and intellectual functions, as well as increased risks of developmental psychopathology. Often the mechanisms involved are only partially and poorly understood. The assessment, diagnosis and treatment of psychiatric disorder in the context of a brain disorder pose special difficulty due to modifications in the manifestation of disorders as well as their response to traditional treatments. Of special relevance to developmental neuropsychiatrists are the pervasive developmental disorders, because of their wide-ranging impact on cognitive, social and intellectual functions and the associated stereotyped and repetitive interests and maladaptive behaviours.

Learning Objectives

1. Knowledge of the key aspects of physical (including brain), cognitive, intellectual and social development and an understanding of the genetic and environmental contributions to normal and abnormal child development.
2. Knowledge of the epidemiology and aetiology of developmental and neuropsychiatric disorders, their presentation at different stages of childhood and the treatment and management options available.
3. Knowledge of the common co-morbid conditions and the role of physical problems, neuroepileptic disorders and family reactions and dysfunctions in contributing to the child’s difficulties.
4. Knowledge of the structure and organisation of services for children with these conditions, including the role and responsibilities of education and social services in fostering the development and supporting the care of children with these disorders, and the related legal issues as they pertain to management.
5. To be able to assess a child’s developmental status to a clinically relevant level of accuracy so as to be able to understand clinical problems and their presentation within a developmental context.
6. To be able to contribute to the psychiatric assessment, diagnosis and treatment of children with brain disorder, as well as children with general, specific and pervasive developmental disorders, and evaluate, diagnose and treat associated psychopathology.

Core Experience

• Direct clinical experience in the assessment, diagnosis and treatment of children with complex developmental disorders and neuropsychiatric conditions
• Experience of working within a multidisciplinary context through attachments either to child development centres, child learning disability services or child neuropsychiatry clinics and units (attachments will vary according to the particular model of service organisation at the training centre).
• Experience of multi-agency consultation and liaison.
• Assessing and contributing to the diagnosis of children with the full range of developmental disorders (specific, general and pervasive) and the commonly related neuropsychiatric and behavioural disorders.
• Participation in community-based assessments of children with these disorders through home and school visits.
• Supervision by a child psychiatrist or other medical specialist as long as they have the appropriate expertise and clinical involvement in services for children with these conditions.

Optional Experiences

• Attend paediatric and paediatric neurology clinics to extend experience and develop sufficient skills to be able to contribute to the assessment and treatment of children with seizure disorders and epileptic syndromes.
• An extended attachment to dedicated neuropsychiatric unit or service for more in-depth training and experience.
• Supervised experience of forensic psychiatry in the context of a neuropsychiatric and/or developmental disorder.
• An attachment to a learning disability service
• Consultation to a residential unit/school for children with neuropsychiatric/developmental disorders.
IN-PATIENT & DAY-PATIENT CARE

Introduction

In-patient and day-patient care of children with severe psychiatric disorder forms an essential component of a comprehensive child and adolescent mental health service. All trainees must have direct experience of such services in order that they are able to make use of this type of specialist facility for the maximum advantage of their patients.

Learning Objectives

1. Make judgements about the suitability of different forms of day and residential treatment facilities for children and adolescents and make appropriate referrals to specialist units.
2. Describe the advantages and scope of intensive treatment approaches within residential and day care settings.
3. Use appropriately relevant legislation such as The Children Act and The Mental Health Act as applied to children with severe mental disorders.
4. Work constructively and collaboratively as part of a multidisciplinary team delivering psychiatric treatments for serious psychiatric disorder.
5. Demonstrate competence in the assessment, management and treatment of serious psychiatric disorder.

Core Experience

- Experience in an in-patient or day-patient unit is essential. Furthermore the trainee must be an integral part of the running of the unit and be regularly involved in making management decisions. The placement should normally be for one year and for a minimum of four to five sessions per week. This is not for administrative convenience but to ensure sufficient opportunities for the trainee to be involved in management decisions, to enable the trainee to observe developments over time, and to facilitate flexibility about the use of these and remaining clinical sessions. On occasion six months full-time experience (i.e. 7 sessions per week after time for research and the academic programme) may be more appropriate for particular trainees.
- Where trainees have a day unit rather than an in-patient unit placement, Programme Directors must ensure that all the objectives above; particularly Objectives 4 & 5 are achieved. Trainees who experience only Day Unit placements must have experience of the multidisciplinary management of serious psychiatric disorder.
- Trainees must have the opportunity to visit other day and in-patient units as part of their placement.

Optional Experiences

- In-patient or day-patient experience is usually best gained in the later stages of training.
- For trainees who wish to become consultants in in-patient or day-patient units it is suggested that Programme Directors approach Regional Postgraduate Deans in order to
secure a one-year extension to training. It is recommended that such trainees complete at least two years attached to at least two different day- or in-patient units.
ACADEMIC PROGRAMMES

Introduction

The rapid growth of knowledge in child and adolescent psychiatry and sciences basic to it mean that a carefully organised programme is required. The programme must encourage self-directed learning as preparation for lifelong learning. The programme will inform the trainees and enable them, in combination with other training opportunities, to carry out varied tasks in their current and future posts. The Academic Programme should comprise a minimum 30 sessions per year.

The broad aims of the Academic Programme are to enable trainees to acquire a detailed knowledge of:

- Child and adolescent psychiatric disorders including the range of developmental processes and risk and protective factors associated with their onset, persistence and desistance.
- The way in which this knowledge can facilitate healthy child development and underpins treatment and prevention of child and adolescent psychiatric disorders.

Learning Objectives

1. To know the main findings from research in child and adolescent psychiatry and relevant findings from child development including knowledge of classic studies as well as a selection of more recent studies.
2. To acquire knowledge of research methods sufficient to appraise research reports in child development and child psychiatry, and know the main steps required in carrying out research.
3. To be able to link this knowledge to the acquisition of appropriate attitudes and skills, including awareness that lifelong learning is needed.

Core Experience

- An integrated course of reading seminars on child development and child and adolescent psychiatry, that will address biological, psychological, epidemiological and socio-cultural issues. This should show how developmental processes may be linked to specific psychopathologies e.g. aggression to conduct disorder and delinquency, and the relevance for intergenerational transmission of antisocial behaviour. Equally important is the interrelation between biological and psychosocial processes e.g. link between brain damage, psychopathology and poor social adjustment. Seminars need to balance the developmental perspective with focus on particular stages of development, e.g. infancy, middle childhood, and adolescence.
- A course of seminars on treatment approaches in child and adolescent psychiatry, including psychopharmacology. Knowledge of the current evidence-base of all treatment approaches, including comparison between them, which can underpin clinical decision-making.
- Courses and workshops on research methods, to include research design, instruments of research and practical issues in doing research, and critical appraisal skills.
- Courses and workshops on practical skills such as teaching and courtcraft.
• Case presentation seminars where more than one consultant is present.
The academic programme should be organised to provide as much coherence as possible between its components such as training in psychological treatments and seminars in child development. For example it is desirable to offer the reading seminars on infancy development, including attachment, during the psychodynamic psychotherapy course. Journal meetings are also useful adjuncts to the core programme but cannot substitute for it.

Programme Directors are encouraged to make use of existing local courses to meet the objectives above, for example, teaching skills or research methods courses at local Universities or PG Deaneries. It is not expected that all components of the Academic Programme necessarily have to be delivered by child & adolescent psychiatrists.

No part of the academic programme is optional. Programme Directors should ensure that the Academic programme is formally evaluated and the results of such evaluation used to inform the future development of the programme.
**RESEARCH & SCHOLARSHIP**

**Introduction**

Research plays an important part in the training of child and adolescent psychiatrists. They need to be aware of advances in basic science and in evidence-based practice, and should be able to critically evaluate their own work. For these reasons two sessions per week should be set aside for research training and experience.

1. **Research training for trainees wishing to pursue a clinical career**

Experience and training in research are essential for those wishing to pursue a clinical career. All NHS consultants need to be able to understand and apply research findings and many will be research active.

**Learning Objectives**

1. Ability to pose a research question, develop this into a hypothesis, design a protocol capable of testing this hypothesis, understand statistical evaluations and draw valid conclusions.
2. Ability to appraise the strengths and weaknesses of research carried out by others.
3. Ability to bring an evidence based approach to their own practice.

**Core Experience**

- Participation in a supervised quantitative or qualitative research project or literature review.
- Supervised experience in writing up a paper, thesis, literature review or research report.
- Training in the use of computerised databases.
- Training in research methods and protocol design.
- Training in the evaluation of published research.
- Access to specialist statistical support, a library that carries the major scientific journals and computerised databases.
- Attendance at local and national research meetings and presentation of research at these meetings.

**Optional Experiences**

- A period spent in full-time research.
- Exposure to research advances in subjects of relevance to child psychiatry such as structural and functional imaging, genetics, and cognitive psychology.
2. **Research training for trainees wishing to pursue an academic career**

The development of child psychiatry has emphasised the need for academics who will conduct specialised research as well as teaching duties. Trainees who wish to pursue an academic career should have a no less thorough clinical training than other specialist registrars. However, the content and location of their training programme will have to take into account the need to develop both their research and teaching skills. The clinical academic’s range of clinical experience may therefore differ from that of SpRs who intend to become consultants. The research progress of clinical academics will normally be reviewed and supervised by the local academic department.

**Learning Objectives**

As for child and adolescents who wish to pursue a clinical career, plus:

1. Ability to conduct a substantial research project, make statistical evaluations, and submit the results for publication.

**Core Experience**

- Time spent in full time quantitative or qualitative research.
- Access to the core training experiences that are available to trainees who wish to pursue a clinical career (see above).

**Optional Experiences**

- Supervised experience in refereeing research grants or papers.
- Time spent in another academic department.
- Supervised experience in applying for research funds.
- Experience in supervising research staff.

**Organisation of Research Training**

Within each scheme there should be a research co-ordinator with responsibility to oversee the research carried out by trainees on that scheme, agree on the nature of the research to be carried out, allocate supervisors, monitor progress of research, and review submitted research. This person should have overall responsibility for ensuring that trainees produce a piece of research or literature review that is well thought through, feasible (i.e., capable of producing results before the completion of training) and adequately supervised. He or she could also audit access by trainees to journals, computers and research methods courses on behalf of the Programme Director.

At the end of the first year trainees should be required to produce a brief statement of their research plans for discussion with the research co-ordinator. Experience in research may be obtained in different ways. Some trainees will conduct their own research project. Others
will join existing local research programmes. At this stage, a decision can be made for some trainees to opt for a literature review project on a topic of relevance to child psychiatry.

Writing up is an important part of research. Therefore during the final year of training SpRs should submit to the research co-ordinator evidence of their research activity. This should comprise:

- a paper that has been published or submitted for publication, or
- an essay structured in the same way as a review in a major journal, or
- a thesis submitted for a higher degree, or
- a research report.

If the research co-ordinator feels that all learning objectives relating to research and scholarship have been achieved before the three years of training is concluded, then the trainee can either undertake further research work, or negotiate with the programme director to use his or her research sessions for other relevant clinical training.

Flexible Trainees

Two sessions per week for research for some part time trainees may interfere with the ability to make full use of the opportunities of the clinical placement. In such circumstances, flexible trainees should discuss with their research co-ordinator whether it would be more appropriate to have series of placements with no research time followed by a purely research placement.
TEACHING & SUPERVISION

Introduction

 Consultant child & adolescent psychiatrists will need to have the skills to teach a range of undergraduate and postgraduate students from a variety of professional disciplines. They will also be called on to make presentations of clinical and research material. They therefore need to be familiar with a range of teaching, learning and assessment methods. In addition, most consultants will be called on at some stage in their careers to supervise junior staff, including supervision of their teaching. It is therefore essential that all trainees acquire knowledge and skills in relation to teaching and supervision.

Learning Objectives

1. Organise teaching sessions in a variety of formats (for example, lecture, small group, role play, problem based learning)
2. Construct learning objectives that are clear, relevant, achievable and measurable
3. Compare and contrast appraisal and assessment
4. Complete a structured assessment of another’s performance and deliver constructive feedback on that performance
5. Describe appropriate types of assessment for knowledge and skills based objectives
6. Appraise their own performance in supervising another

Core Experience

- In order to achieve these objectives all trainees should attend some formal teaching on how to teach. This may be part of the local academic programme or may make use of courses run by, for example, the local University and/or Postgraduate Deanery.
- All trainees should also have the experience of having their teaching observed by an experienced teacher.
- Trainees should have the opportunity to supervise some of the work of another trainee. If there are no junior SHOs to supervise, the possibility of supervising part of the work of trainees from other disciplines should be explored, and or SpRs supervising each other.
- All teaching and supervising experience should in turn be supervised by the consultant trainer or some other consultant on the rotation appointed for that purpose

Optional Experiences

- Trainees may wish to set up peer review of their teaching activities.
- Trainees contemplating an academic career should be encouraged to develop a portfolio of teaching and learning experiences.
MANAGEMENT, AUDIT & INFORMATION TECHNOLOGY

Introduction

Consultant child and adolescent psychiatrists will need sufficient management skills to be leaders in service development as well as effective clinicians. They will need to be able to use resources effectively and work with professionals from different backgrounds within and outside the NHS.

Learning Objectives

1. Knowledge of contemporary NHS structures, including the role of purchasers and providers such as Trusts and GP’s; the organisation of postgraduate training including the role of the regional Deans; organisations outside the NHS such as the Royal College of Psychiatrists, GMC, Medical Schools etc and their relationship with the NHS; central and local government structures and responsibilities, especially social services, and relevant interagency structures; the voluntary sector; the main forces shaping demand for and influence on health services.
2. The ability to generate a short and long term strategy, and link day-to-day activities to this. Understanding of service planning including knowledge of business cycle and developing a business case. Understanding effective resource use for strategic purposes.
3. To have functional/operational skills and knowledge, regarding accessing information and using resources. This will include familiarity with audit, and information feedback to change clinical practice and develop services. The uses of IT to support audit, quality control and service development.
4. Familiarity with recruitment, equal opportunities, appraisal and the need for continuing professional development for all disciplines in mental health.
5. An understanding of the principles of clinical governance, risk management and accountability.
6. Development of team leadership skills, to be effective with clinical colleagues, and develop teams, influence colleagues and delegate appropriately.
7. Self-management, to include effective self-presentation, time management, the ability to use ones own initiative, and appropriate ethical awareness.
8. An ability to keep and maintain appropriate clinical records and communicate effectively with other relevant professionals.

Core Experience

- Participation in a management course.
- Completion of an audit project.
- Basic use of word processing, databases and statistical packages are essential for management and also research training. This will require access to a computer at each placement and access to relevant online databases via the Internet from at least one site.
- Other objectives can be achieved using a variety of strategies, including a combination of academic or didactic sessions, for example, reading seminars, skills sessions, role play, shadowing managers or participation in service planning, and the use of supervision and appropriate involvement in clinical teams and departments.
Optional Experiences

Some higher trainees may wish to obtain greater competence and experience of management and familiarity with the relevant structures and processes. This can be achieved by acquiring greater knowledge of 1, and more experience regarding goals 2 and 3. Relevant experiences might include closer involvement with Trust managers and clinical directors, purchasers or involvement with other organisations such as the Department of Health.
Appendix I: The Organisation of Training

The requirement for higher trainees to achieve all of the recommended learning objectives within a three-year training period places great demands on programme directors, consultant trainers and trainees. All must work together if training programmes are to function effectively to deliver high quality training that is structured enough to deliver the core training required and flexible enough to meet the individual needs of trainees.

Programme directors must have sufficient sessions agreed in their job plans to enable them to carry out the many tasks required of them (a list is given on pp14-15 of the Handbook). In most programmes it is recommended that the Programme Director set up a training committee to assist with the management of training. The committee should include trainer and trainee representatives. Specific tasks such as organisation of the Academic Programme and supervision of SpR research should be delegated to named individuals.

In some large schemes, individual members of the training committee have taken lead responsibility for defining and organising experience in some of the areas outlined in the enclosed advisory papers (for example the psychotherapies, paediatric liaison, teaching etc.). The requirement to review all trainees and their training programmes is time consuming. CAPSAC recommends that two reviews take place in each one-year placement and that detailed learning objectives for future training are agreed. At least one of these reviews should take place at the placement base and both should involve the trainer as well as the trainee. Some Programme Directors on large schemes have delegated some of these reviews to Associate Programme Directors who then report back to the Programme Director. This not only reduces the burden on the Programme Director but introduces a component of `training' for potential future Programme Directors.

The clinical placement, usually of one year’s duration in a multidisciplinary team, is likely to remain at the heart of higher training for a number of reasons.

- This placement, with a single main educational supervisor, gives trainees an opportunity to develop a relationship in supervision in which progress in all of the components of higher training can be discussed, monitored and reviewed in a holistic way, notwithstanding the fact that specific components of training may be the subject of more detailed supervision elsewhere.

- The clinical component of these major placements should also enable the trainee to work with a range of patients for a sufficient length of time for them to study the progress of disorders and their treatment over time.

- The relationship with a group of professionals in the team (including the educational supervisor) provides an opportunity to examine the functioning of various professional systems and their interaction with each other and child and adolescent disorders. The interpersonal and management skills required by consultants in all aspects of these professional relationships, can also be observed over a period of time.
However, the need to provide a sufficient range of clinical experience within the three years allowed for training means that clinical placements which provide no more than “good, general out patient child and adolescent psychiatry” will not be able to meet all the requirements of modern trainees. Instead, placements must be developed that provide good general experience alongside more specialist experience. Programme Directors and trainees must start to plan training in a proactive way from the moment that trainees start their training to ensure that all training objectives can be fulfilled. A typical individual training programme might look as follows:

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Out-patient child mental health team 1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>including work in family therapy team</td>
</tr>
<tr>
<td></td>
<td>Neurodevelopmental psychiatry for 6 months</td>
</tr>
<tr>
<td></td>
<td>Paediatric liaison for 6 months</td>
</tr>
<tr>
<td></td>
<td>5 sessions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>In patient adolescent unit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>including taking on one patient for supervised individual psychotherapy</td>
</tr>
<tr>
<td></td>
<td>Legal aspects of psychiatry for 6 months</td>
</tr>
<tr>
<td></td>
<td>2 sessions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 3</th>
<th>Out patient child mental health team 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Including group work, CBT and some consultation</td>
</tr>
<tr>
<td></td>
<td>Management training</td>
</tr>
<tr>
<td></td>
<td>1 session</td>
</tr>
</tbody>
</table>

This programme is given as an illustrative example. It is not expected that all training will follow this pattern. With this kind of programme it is possible for schemes to deliver the necessary learning objectives for trainees but only if training is actively managed. This includes ensuring that there is sufficient variety of training placements and sufficient variation within placements for trainees needs to be met. Many trainees will have gained some relevant experience at SHO level prior to entering higher specialist training. This experience should be taken into account when specifying training objectives for any placement, and prior learning used as a foundation for higher training. However, experience at SHO level cannot be a substitute for specialist registrar training.