"This prospectus is made under the provisions of the Universities Act, the Postgraduate Institute of Medicine Ordinance, and the General By-Laws No. 1 of 2016 and By-Laws No. 2 of 2016 for Degree of Doctor of Medicine(MD) and Board Certification as a Specialist"

POSTGRADUATE INSTITUTE OF MEDICINE
UNIVERSITY OF COLOMBO, SRI LANKA

POSTGRADUATE COURSE

CONDUCTED BY

THE BOARD OF STUDY IN PSYCHIATRY

FOR

BOARD CERTIFICATION IN CHILD AND ADOLESCENT PSYCHIATRY

2013

BOARD OF STUDY IN PSYCHIATRY

CONTENTS

1. Introduction

The Board of Study in Psychiatry of the Postgraduate Institute of Medicine (PGIM) will conduct a training programme in psychiatry and an examination, the Doctor of Medicine (MD) in Psychiatry examination. The successful trainees can select to follow the programme in one of the two subspecialities ie Child and adolescent Psychiatry or Forensic Psychiatry. This section of the prospectus provides information regarding the regulations and guidelines formulated by the Board of Study (BoS) in Psychiatry and PGIM pertaining to the structure of training programme in Child and adolescent Psychiatry and Board Certification.

2. Mission, Justification and Proposed Outcome

This document is the final proposal for inclusion of Child and Adolescent Psychiatry as a sub-specialty in Psychiatry, leading to Board Certification as Child and Adolescent Psychiatrists. It has taken into account the unique mental health needs of the 0 to 18 years age group that cannot be met through training only in General Psychiatry

The Mission

The mission is to produce a Child and Adolescent Psychiatrist who is competent in working with children adolescent and their families and with health, educational, legal and social agencies and other stakeholders involved in the care of children and adolescents, and to provide optimum care in a responsible and ethical manner.

Justification

The substantial economic and social burden resulting from child mental health problems and disorders is well accepted. Poor service development in Sri Lanka has resulted in a large treatment gap in this age group. The burden largely comes from developmental disorders, anxiety and mood disorders, which are highly prevalent, 20% or more. Further relevance of this fact to children and adolescents is that 50% of these disorders that arise in childhood if untreated continue into adolescence and adulthood. It is also well recognized that much of these problems responds to early intervention and are preventable with appropriate interventions. All these disorders can be reliably diagnosed in preschool age and pervasive developmental disorders as early as infancy. Attachment disorders and disruptive behaviour disorders without successful treatment and support are major risk factors for personality disorders in adults. Childhood disorders impair school learning, lower occupational attainment and quality of life, increase potential for health risk behaviour, substance abuse and suicide. Co-morbidity is also common, worsens the impact of disorder on children, and increases the likelihood of continuity into adulthood. Subspecialty training in Child and Adolescent Psychiatry will produce a group of specialist who are focused on the mental health needs of this population, which cannot be effectively met by a General Psychiatrist.

Proposed Outcome

The Chid and Adolescent Psychiatrist is expected to provide a specialist service to 0-18 year age group with mental health needs. Other functions include giving leadership to a multidisciplinary team of medical and allied health staff, develop services and treatment programmes, work with paediatric and primary health care services, provide education and training to relevant persons, act in a professional manner at all times.

3. Training outcomes at the end of the programme

The programme is designed to provide competency in knowledge, skills and attitude in dealing with mental health problems and disorders in the 0-18 age group. In order to practice the speciality effectively and efficiently, the qualified clinician will keep his/her knowledge up dated and engage in scientific research and audit.

The curricular content given below is incooperated into training activities for a period of two years training in Sri Lanka and one year period at an overseas training centre. The overseas training is expected to provide exposure to interventions where opportunity may have not been available in Sri Lanka. The expected long term outcome of the training programme is to have Child and Adolescent Psychiatrist in adequate numbers working in all Districts and providing services both at hospital and community levels.

4. Training Content and Curriculum

The following is identified as core areas for developing competency. It is assumed here that the trainee embarking on specialist training in Child and Adolescent Psychiatry has already had the adequate grounding in core knowledge and skills in General Psychiatry. The curriculum given below is focused on advanced training in Child and Adolescent Psychiatry.

4.1 Core knowledge

This knowledge should be developed through clinical practice during training, gathered by reading text books and journals, by attending academic events and by actively contributing to journal clubs and other CME activities.

4.1.1 Developmental, biological, psychological, socio-cultural, neurological and medical aspects of mental health and behaviour in children and adolescents. This would include age related behaviour and their variations for Sri Lankan children, factors of aetiological importance in mental and behavioural disorders in children and adolescents.

4.1.2 The full range of mental and behavioural disorders affecting children and adolescents, define their signs and symptoms. These include disorders specific to child and adolescent period in their onset such as hyperkinetic disorders, conduct disorders, mixed disorders of conduct and emotions, emotional disorders with onset specific to childhood (separation anxiety, phobic anxiety, social anxiety, sibling rivalry), disorders of social functioning with onset specific to childhood and adolescence (elective mutism, attachment disorders), tic disorders, other disorders with onset in childhood and adolescence (non-organic enuresis, non-organic encopresis, feeding disorders, stammering), Specific developmental disorders such as pervasive developmental disorders (autism, Rett syndrome, disintegrative disorder), specific developmental disorders of speech and language, scholastic skills and motor functioning, and other developmental disorders of psychological functioning. Adult-like disorders affecting children and adolescents and their special modes of presentation (mood disorders, anxiety disorders, neurotic, stress-related and somatoform disorders, disorders due to psychoactive substance use, behavioural syndromes associated with physiological disturbances and physical factors, deliberate self-harm). Presence of co-morbid disorders in association with a primary disorder is the norm rather than the exception in children and adolescents.

4.1.3 Mental health problems in children and adolescents not amounting to mental disorders, clinically relevant nevertheless due to their impact on the life of the child or adolescent (stress, child abuse, chronic or life threatening physical illness, learning difficulties, life-style problems such as obesity, bereavement, loss and grief etc.).

4.1.4 Structured assessment formats, rating scales, standardized assessment schedules used in child and adolescent psychiatry, developmental assessments in children, assessment of cognitive profiles, family assessment schedules and parent assessment schedules, their theoretical background, their use and shortcomings in terms of content and cultural limitations.

4.1.5 Theoretical basis and models of practice of psychological interventions in individual, family and group interventions [Cognitive Behaviour Therapy, (CBT)], behaviour modification, problem solving therapy, solution focused therapy, creative therapies, play therapy etc.)

4.1.6 Pharmacological treatment - their indications and dosage in relevance to age, practice guidelines, scientific basis for their use in children and adolescents, pharmacokinetics, pharmacodynamics, evidence base for their use, relevance to development and associated co-morbidities in a child, adverse effects and safe practice.

4.1.7 Prevention and early intervention. Theory of universal, indicated and selective prevention; rationale for early intervention from current scientific evidence based knowledge in brain development, developmental processes and continuities of psychopathology.

4.1.8 Paediatric liaison

The range of developmental and psychosocial adversities affecting children and adolescents with chronic illness, life-limiting illness and the psychosocial impact on their families, appropriate interventions to improve resilience and coping and facilitate compliance with treatment regimes, the knowledge of psychiatric and behavioural consequences of drugs commonly used in the treatment of children – steroids, anticonvulsants etc.

4.1.9 Age related development and behaviour of children and adolescent and alterations in these aspects related to child abuse and neglect, long term consequences of child abuse legal framework for child protection and safeguarding children's rights in Sri Lanka.

4.1.10 Ethical issues in the practice of child and adolescent psychiatry and guidelines regarding issues such as informed consent, autonomy, doctor-patient relationship, limits of confidentiality and privacy, respect of rights and legal boundaries.

4.1.11 Multidisciplinary Team concept and working with other agencies, role of different disciplines in child and adolescent mental health care, qualities of effective and efficient leadership in teamwork.

4.2 Skills and attitude development

There are essential skills that need to be acquired during the training programme. These include the following;

4.2.1 Establish and maintain a therapeutic relationship with children, adolescents and their families. Respect privacy and confidentiality. Show sensitivity and understanding regarding concerns expressed by the parents. Gather information in a balanced unbiased manner. Communicate with children and their parents at a level comprehensible by them and facilitate working together for the well being of the child and adolescent. Provide psycho-education in all relevant issues.

4.2.2 Comprehensive history taking, mental state examination and physical examination. Include developmental, socio-cultural, medical, family factors that contribute to the clinical presentation. Gather information from multiple sources. Use of specific techniques such as drawings, diagrams, plays activities and stories to gather information especially from young developmentally delayed children who are not verbally competent. Being aware of altered manner of presentation of psychopathology that is specific to children. Make a risk assessment in relation to potential for self-harm, self-neglect, exploitation by others, school failure, aggression / violence etc. Make comprehensive and legible written or computerised documentation of the information for later reference.

4.2.3 Investigations including ability to carry out psychometric assessment to make a neurodevelopmental assessment in a child with developmental problems or learning difficulties. Request for imaging studies or laboratory investigations where appropriate by providing adequate and relevant information.

4.2.4 Diagnostic formulation and differential diagnosis. Take systemic perspective in making the diagnostic formulation to include key biological, developmental and psychosocial aspects of the clinical presentation, contributory predisposing, precipitating and perpetuating factors, and risk and resilience factors in the child / adolescent. Provide a feedback to child / adolescent and family in a manner comprehensible to them. Write back to the referring agent. Use the diagnostic formulation to inform school and any other relevant agency regarding the child's needs.

4.2.5 Objective oriented treatment planning that would allow objective measurement of outcome. Follow up care, vigilance about ongoing risks and vulnerabilities taking appropriate timely action. Modify and adopt known therapeutic intervention to suit individual child's age and developmental level to obtain optimum outcome and avoid any possible adversities.

4.2.5.1 Use pharmacological treatment with appropriateness and safety in mind and with routine monitoring of relevant physical and psychological parameters.

4.2.5.2 Assess suitability for individual psychological therapy, objectify targets for change and outcome measures, select and implement strategies for intervention and monitor compliance and adversities.

4.2.5.3 Assess suitability for family intervention / group intervention, objectify targets for change and outcome measures, select and implement strategies for intervention and monitor compliance and adversities.

4.2.5.4 Prevention early intervention – early identification, educate and train parents on use strategies for intervention, improve parenting skills and empower parents - in conditions such as developmental disorders, autism, severe behaviour problems, learning difficulties etc.

4.2.6 Comprehensive assessment of children suspected of being abused, neglected or exploited. Specific skills required in the assessment of young children without verbal competence to communicate their experience. Therapeutic intervention in the individual victim and family members. Deal with relevant child protection and legal authorities. Write Court Reports.

4.2.7 Management of psychiatric and behavioural emergencies such as deliberate self harm, violence and other severe behavioural problems, school non-attendance, starvation in anorexia nervosa. Clinical decision making to manage the emergency, ensuring safety of patient and others, pharmacotherapy and psychological / behavioural interventions, organising teamwork and supervision of the patient, monitoring outcome, follow up care and preventive measures.

4.2.8 Respond to requests from Court of Law for assessment of issues regarding custody and access and submit report that answers the confronting questions in a balanced unbiased manner.

4.2.9 Liaison with Paediatrics – provide assessment and guidance on management of psychosocial aspects associated with physical disorders, assess and manage somatisation disorders and abnormal illness behaviour, work cohesively with paediatric teams in patients where joint management is indicated. Clear and relevant communication with the other team members

4.2.10 Skills in examination of physical illness in children and enlisting the support of paediatricians where necessary.

4.2.11 Working with other agencies involved in the care of children and adolescents – relates to providing consultation and guidance to schools, children's homes, probation and childcare services, child protection services, child rights and advocacy groups, parent associations etc.

4.2.12 Teaching and training skills in all aspects of mental health of children and adolescents to a wide range of medical and non-medical groups.

4.2.13 Proficiency in research, select areas for study, seek ethical permission, use appropriate research techniques for data gathering and analysis, write scientific papers and make presentation at academic forums

5. Selection Process for the Training Programme and Guidance for Trainees

The training programme in Child and Adolescent Psychiatry subspeciality falls within the Stage II of training. Trainees who wish to be Board Certified as Child and Adolescent Psychiatrist will select to follow this programme. Successful completion of MD Psychiatry examination is a requirement to enter this programme. The number of trainees selected shall be decided by the BoS in Psychiatry, depending on the vacancies and the cadre approval by the Ministry of Health and availability of training placements.

5.1 Selection Process

The candidates will be selected on the merit based ranking results of the MD Psychiatry Examination. The positions available will be offered to the candidates by the Board of Study in Psychiatry.

The selected candidates would be provided with full and comprehensive details of the training programme. This would be available at the PGIM for perusal by prospective candidates prior to the allocation meeting.

5.2 Guidance through the Training Programme

Once appointed to a training unit in Child and Adolescent Psychiatry for 12 months, the trainee will receive supervision and guidance from the consultant of that unit, who will also monitor the progress of the trainee and provide a written record to the Board of Study in Psychiatry.

6. Training Programme Details and Structure

6.1 Broad objectives of training programme.

6.1.1 Patient care – in multiple settings of outpatient, inpatient, day hospital, paediatric liaison setting and community.

6.1.2 Medical knowledge, skills and attitude

The trainee is expected to keep abreast with current knowledge in child and adolescent psychiatry and mental health, constantly attempt to learn new skills and sharpen existing skills and have a healthy attitude to practice.

6.1.3 Interpersonal and communication skills

The trainees is expected to develop good skills in working with patients and families and the multidisciplinary team

6.1.4 Professionalism

The trainee should at all times be mindful of ethical principles and responsibilities in the areas of doctor-patient relationship, consent for treatment, dealing with families and professional boundaries. Responsibility towards work, commitment, honesty is required. Comprehensive record keeping and good time management are other useful professional skills to develop.

6.1.5 Evidence-based approach to practice

Although this may depend sometimes on availability of resources application of guidelines should be attempted as far as possible.

6.2 Details of logistics

The post MD (Stage II) training in this training programme will be 3 years out of which 2 years of training in a recognised centre in Sri Lanka and minimum of one year in a recognised centre abroad.

6.2.1 Local Training

The selected trainees for the training programme will be appointed as Senior Registrar to the Lady Ridgeway Hospital or other suitable unit in Sri Lanka for a minimum period of 2 years. In addition 12 sessions in paediatric neurology under supervision of a paediatric neurologist will be included. During this period, the trainee is also expected to broaden the experience through liaising with schools, primary health care settings, children's homes and other residential care settings in the community, probation and childcare, rehabilitation centres for children conducted by social services and voluntary organisations, special education settings etc.

6.2.2 Foreign Training

The trainees have to complete one year of training in child and adolescent psychiatry in a overseas unit recognised by the BoS in Psychiatry.

6.3 Research Project

Successfully carrying out a research project, directly relevant to Child and Adolescent Psychiatry is a mandatory requirement to be Board Certified as a Child and Adolescent Psychiatrist. A research protocol should be submitted to the Board of Study in Psychiatry for review and approval, and ethical clearance obtained, prior to commencement. The research should be carried out preferably in Sri Lanka. Approval may be granted for a research conducted abroad if the subject of study is relevant to Sri Lanka. It should be a prospective study, hospital or community based, and preferably an original study rather than a replication. Interventional studies have to be registered with the Sri Lanka Clinical Trials Registry. The supervisor for the research would be the consultant in whose unit the trainee is working. The examination process for the completed research will follow the guidelines set by the Board of Study in Psychiatry.

6.4 Attendance requirements

A trainee would be considered to have successfully completed each training placement by fulfilling the 80% attendance requirement and is certified by the supervising consultant has having performed satisfactorily during the placement in the Progress Reports.

Trainees, who wish to avail themselves of an extended period of leave, including sick, maternity or other leave, are required to inform the Board of Study in Psychiatry and obtain approval for such leave at the earliest available opportunity.

Trainees availing themselves of such leave will be required to fulfil the PGIM requirement of 80% attendance in each training placement to be considered as having successfully completed Stage II of the training programme.

6.5 Portfolio

The trainees are required to start a portfolio. The portfolio will form the basis of the Pre-Board Certification Assessment (PBCA) which is a PGIM pre-requisite for board certification as a specialist (See Section 7.2).

Please see Annexure 6 for guidelines for preparing a Portfolio

6.6 Dissertation

All trainees in Stage II of the training programme are required to complete a research project and submit a dissertation based on the project. Prior to starting on their dissertations the candidates are required to submit a research protocol to the BoS. The Board will appoint an examiner for the protocol. The candidate should begin their research only after approval by the BOS.

The dissertation will be examined by a panel of two examiners appointed by the Board of Study in Psychiatry which may accept the dissertation, suggest suitable amendments before acceptance or reject the dissertation. Trainees should have their dissertations accepted by the Board of Study to be eligible to apply for board certification as a specialist.

6.7 Progress Reports (Record of Training)

At the conclusion of each training placement in Stage II of the training programme, the supervising consultant shall complete a Progress Report for the trainee, indicating whether the trainee has satisfactorily completed that placement. Areas of concern regarding the trainee, if any, which would include any leave of absence from the training programme, should also be recorded. If the supervisor is not satisfied with the trainee's performance, this should be referred to the Board of Study early for appropriate action.

The trainee shall submit the Progress Reports from all training placements, two weeks after the completion of each placement. All progress reports must be submitted to the PGIM prior to application for Board Certification.

See annexure 3

6.8 Pre-Board Certification Assessment (PBCA)

The PBCA has 2 components

6.8.1 Written component

At the successful completion of 3 years of Stage II training, Trainees have to sit for an assessment comprised of MCQ and a SEQ paper.

1. MCQ	30 questions	1 Hour	100 Marks
2. SEQ	2 questions	2 Hours	100 Marks

The MCQ paper will consist of 30 questions of five responses each of the multiple true false type to be answered in one hours. There will be negative marking within each question.

The SEQ paper will consist of 2 questions to be answered in two hours. Each question will be independently marked by two examiners.

Each candidate must obtain minimum of 50% in each component in order to pass the written components of the PBCA. The candidates those who will be unsuccessful will have to sit again after 6 months.

6.8.2 Portfolio viva and oral presentation to the BoS.

A trainee who has passed the written component (6.8.1) may apply in writing to the Board of Study in Psychiatry seeking board certification as a specialist in Child and Adolescent Psychiatry

I. Portfolio Viva

Upon receiving such an application the Board of Study will appoint a panel of examiners who will schedule portfolio viva as required by the PGIM. Assessment of the trainee's portfolio at a viva will constitute a part of the PBCA in Psychiatry.

The panel of examiners appointed by the Board of Study may accept the portfolio or suggest suitable amendments before acceptance.

II. Oral presentation

The trainee should make a presentation of 20-30 minutes duration to the BoS indicating the details of the overseas training and future vision for the development of services in the subspeciality of Child and Adolescent Psychiatry.

Upon successful completion of 6.8.2.i and 6.8.2.ii above the Board of Study shall recommend to the Board of Management of the PGIM that the trainee be considered for board certification as a Child and adolescent Psychiatrist in Sri Lanka..

7. BOARD CERTIFICATION

7.1 Eligibility:

Prospective applicants must satisfy the following requirements:

(a) passed the MD (Psychiatry) examination
(b) Satisfactory completion of Stage II of the training programme, fulfilling the requirements set out in Section 5 & 6
(c) Acceptance of the dissertation
(d) Acceptance of Portfolio
(e) Passed pre-board certification assessment