RANZCP Child and Adolescent Advanced Certificate

Guideline for a reduced duration or alternative clinical experience to mandatory six-month FTE inpatient rotation including guidance for accreditation of expanded settings for competition of mandatory inpatient rotation.

The Royal Australian & New Zealand College of Psychiatrists

Introduction

Inpatient, residential and partial hospitalisation (day patient) care are part of the spectrum of care and intervention in child and adolescent mental health disorder. Inpatient care presents the most intensive and acute component of that spectrum. Psychiatric admission of children is uncommon representing less than 7% of the total MH inpatients (Pottick , McAlpine, & Andelman, 2000). Inpatient services are the costliest element, estimated to account for almost half of the cost of annual mental health treatment for children and adolescents (Burns & Taube, 1990). Moreover, despite considerable efforts to develop alternative types of care, there are children and adolescents for whom inpatient psychiatric care remains appropriate (Pottick , McAlpine, & Andelman, 2000).

Only a small proportion of child psychiatrists work in inpatient units and residential settings, but all child psychiatrists will potentially come into clinical contact with patients and families who may require such care. The RANZCP Certificate training program for Child and Adolescent Psychiatry, like most international CAP training programs, includes a mandatory minimum inpatient training experience (Perkes, et al., 2022). For many trainees the acuity and risk issues inherent in an intensive care setting assist in development in competency in relation to these presentations in other settings. Opportunities also exist to develop skills in managing the milieu and to develop skills in leading the MDT. By the completion of Advanced Training in Child and Adolescent Psychiatry (ATCAP) a trainee must complete a 6-month FTE training rotation in a dedicated child and/or adolescent mental health inpatient unit and must demonstrate competency in relation to inpatient care of children with mental health disorder.

Trainees with previous equivalent training experiences within a child and/or adolescent inpatient or residential setting can apply for Recognition of Prior Learning. This experience cannot be considered where it has occurred during Stage 1 or 2 RANZCP Fellowship training.

Trainee can apply to SATCAP through their Director of Advanced Training in Child and Adolescent Psychiatry (DOATCAP) for consideration of a reduced duration or alternative experience to the mandatory inpatient experience. Applications will be considered where extraordinary circumstances exist, and completion of the requirement would create significant hardship. A trainee may wish to apply for a reduction in the FTE requirement or alternate experience. Where the inpatient experience would be less than 3 months FTE (including part-time applications) a trainee should apply for an alternate experience. Delegated approval by DOATCAP will be reviewed by SATCAP. Progress in the alternate experience would be reviewed at three months (or equivalent marker of a mid-point of the experience) and on completion. The DOATCAP will provide feedback to SATCAP upon completion.

SATCAP is also supportive of accreditation of a wider range of inpatient and residential settings that can provide sufficiently equivalent experiences to meet the outlined competencies for the mandatory Cert CAP mandatory inpatient experience. For example, child and adolescents with mental health problems admitted to a paediatric unit with consultation and liaison care provided be a CAMH MDT is likely to be suitable. The DOAT CAP support is required for the accreditation.

Guidance for accreditation of a training post for mandatory inpatient rotation

Accreditation of training posts is undertaken by Branch Training Committees. Dedicated child and adolescent mental health inpatient or residential units are reviewed by DoAT to ensure that they meet the requirements for the ATCAP mandatory inpatient experience. This allows them to confirm trainee completion of the mandatory inpatient experience.

DoAT may accept that an inpatient experience can be completed where children and/or adolescents are managed in inpatient settings other than a dedicated mental health unit. It must be demonstrated that

1. The unit can provide experiences that support the development of the articulated inpatient rotation competencies
2. There is child and adolescent psychiatry leadership in the management of the mental health presentation. For example, the patients are admitted under a child and adolescent psychiatrist or jointly with a medical team.
3. There is the capacity for multidisciplinary intervention for admitted patient
4. That the equivalent duration of experience is available (i.e. not less than 3 months FTE exposure).

Guidance for completion of inpatient experience of reduced duration

1. Application reduction in duration of inpatient experience (not less than 0.5FTE)

    a. Completion of inpatient experience 0.5FTE or greater can be granted by DOATCAP contingent on satisfactory ITA by inpatient supervisor.
    b. Completion inpatient experience at not less than 0.5FTE for 6 months (or not less than 3 months FTE) may be granted provided the DOATCAP is in support of the application and contingent upon inpatient supervisor documentation that the experience has allowed the trainee to gain required level of inpatient competence (referencing the inpatient competency documentation)

Guidance for completion of an alternative to the required inpatient experience

If you wish to request an alternative clinical experience to the ATCAP mandatory inpatient rotation you are required to make a written request to SATCAP through your DoATCAP. This can be approved by your DoAT pending SATCAP review. The experience must be with 0-18-year-old age group. The experience may occur over a single rotation or multiple rotations.

The written request should include:

1. A written outline of your argument for an alternative experience including:
    a. Explanation for why mandatory inpatient rotation is not possible or creates hardship. Hardship may include professional, service-based and/or personal explanations.
    b. Summary of proposed alternative experience and how this would provide sufficient interaction with systems where children and adolescents with mental health problems might be managed within an inpatient setting
2. A proposal outlining visits to, or observation within, a suitable CAP inpatient unit(s). Ideally this should be with the inpatient unit providing care for child and young people in your area and/or training jurisdiction
3. Map the proposed alternative experience to the existing Cert. ATCAP expected competency development during inpatient rotation competencies (See below)
4. Specifically address how you plan to compete ST3-CAP-AOP-EPA5

You should discuss your application with your principal supervisor, CAMHS/CYMHS clinical director and DoAT prior to the submission.

You must document how the inpatient rotation competencies can be met through your proposed alternative experience and what actions you will take to achieve and demonstrate these competencies. The competencies are available on the RANZCP website: Description of expected competency development during inpatient rotation. The competencies assist trainees, clinical services, DoATCAP and SATCAP determine whether a particular post meets the requirements for

accreditation as Cert. CAP mandatory six-month inpatient experience required. They map expected competencies required for child and adolescent psychiatrists working in inpatient settings. A trainee may wish to consult with the consultant child and adolescent psychiatrists working at the inpatient units likely to be involved in the trajectory of care of patients in their training jurisdiction to determine how these, and any other relevant competencies might be best achieved.,

	RANZCP Stage 3 Cert CAP Inpatient Rotation Required Competencies	**Outline how your proposed alternative experience will enable you to meet the *and demonstrate* competencies**
1	Conduct a relevant assessment (including mental state and physical examination) for the inpatient setting through collecting and collating and synthesizing a range of information from multiple sources.	
2	Develop a working diagnosis and relevant differential diagnoses that relates to a formulation of strengths and deficits/difficulties and leads to prioritized recommendations for intervention within the inpatient setting. *Experience in an inpatient setting supports trainees to develop skill of quick succinct and prioritised formulations and targeted management plans relevant to risk and facilitating appropriate durations of inpatient care. Inpatient settings are often the place where trainees have opportunity to manage young people presenting with low prevalence disorders.*	
3	Evaluate a young person's risk to self and other and the impact of admission on such risk. *Developing skills in bridging the gap between capacity for acute hospitalization and inpatient management of risk and that which can be managed safely by family and support systems in the community*.	
4	Enhance safety in inpatient settings by developing, negotiating, implementing and evaluating individual risk management plans including where management might involve the use of coercive intervention is such as seclusion, restraint and sedation.	
5	Evaluate the relevance of a variety of therapeutic modalities to patient care within the inpatient settings including family and group interventions. *This includes the role of nursing interventions.*	
6	Demonstrate skills in evidence based psychopharmacological treatments in urgent and dangerous situations *(including rapid tranquilization)*.	
7	Utilize an analysis of the benefit, limitations and adverse impacts of managing different developmental ages and clinical presentations in inpatient, residential and partial hospitalization settings to make decisions about the about role of admission to inpatient and residential settings in the longitudinal management.	
8	Apply of the principles of recovery focused care for young people and their families as relevant to inpatient care.	
9	Work in compliance with mental health and other relevant legislation including that United Nations Convention on the Rights of the Child, Children's Protection, Family Law, Young Offenders and Education Acts in the management of young persons and their family. *Opportunities to be involved with young people referred for and*	

	experiencing involuntary treatment, exposure to mental health tribunals, opportunities to write medical reports under supervision	
10	Plan and implement a discharge plan that is mindful of the need for liaison with less restrictive levels of care.	
11	Evaluate the systemic functioning of the inpatient unit and articulate the impact of milieu in the care of inpatients. Act to attend to problems in the milieu that impact adversely on inpatient care (or have the potential to). *This includes strategies for managing cohorts/groups of young people together*	
12	Demonstrate capacity to provide clinical leadership to an inpatient multidisciplinary team (*including demonstration of the knowledge, skills and attitudes associated with completion of CAP-AOP-EPA 5).*	
13	Collaborate to enhance the care of young people with mental health presentations and disorder at the interface of inpatient care with other agencies including • wider hospital system such as emergency departments, paediatric units and general hospital settings • wider child and youth mental health services including the private sector and non-government organisations • the child protection sector • the adult mental health sector.	
	Additional Comments (*for example: any previous relevant experience, proposed primary supervisor and any ancillary supervisors who may be completing WBA associated with development of competency)*	

References

Burns, B., & Taube, C. (1990). Mental Health Services for Adolescents: Background Paper for US Congress, Office of Technology Assessment's Adolescent Health Project. Washington, DC, US Congress. *Office of Technology Assessment*.

Perkes, I., Eggleston, M., Jacobs, B., McEvoy, P., Fung, D., & Robertson, P. (2022). The making of child and adolescent psychiatrists in Australia and New Zealand. *ANNZJP*, Vol 56(8) 899-904.

Pottick , K., McAlpine, D., & Andelman, R. (2000). Changing Patterns of Psychiatric Inpatient Care for Children and Adolescents in General Hospitals, 1988-1995. *American Journal of Psychiatry*, 157:1267–1273.

Revision Record

Contact		**Project Officer, Education and Training**	
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