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**Timetable**

05 January 2017
Topic 1: An Introduction to CAMHS and Developmental Trauma
Lead Facilitator: Dr Anna Gibson

19 January 2017
Topic 2: Neurodevelopmental Disorders: from science to clinical practice
Lead Facilitator: Dr Sam Cortese
Masterclass: Dr Sam Cortese

02 March 2017
Topic 3: Consent to treatment and legal frameworks
Lead Facilitator: Dr Suyog Dhakras
Masterclass: Dr Suyog Dhakras (TBC)

16th March 2017
Topic 4: Recent developments in Eating disorders including changes in classification system DSM 5
Lead Facilitator: Dr Julie Waine

30th March 2017
Presentation of tasks from Eating disorders and functional symptoms
Lead Facilitator: Dr Julie Waine

**Module Leads**

Dr Carlos Hoyos
Consultant Child & Adolescent Psychiatrist
The Orchard Centre
Western Community Hospital Site
Southampton
Tel: 023 8029 6230
CarlosHoyos@solent.nhs.uk

Dr Julie Waine
Consultant Child & Adolescent Psychiatrist
Falcon House
St James Hospital
Locksway Road
Portsmouth
Tel: 02392 684737
julie.waine@nhs.net
Welcome to the Child and Adolescent Psychiatry Module of the Wessex course. As I’m sure you have been informed, the aim of this course is not just to impart the factual knowledge with which you might pass the membership exam, although we will do our best to provide you with some of this, but to provide a firm foundation for your psychiatric practice now and in the future in whichever specialty you choose. An overarching theme of this module is to enable you to consider the relevance of childhood mental health and its impact on development to the current presentation of your patients whether they are working age adults or even older.

We are pleased to be able to introduce you to Child and Adolescent psychiatry and one of the aims of our module is to show you why we think this is the most interesting and satisfying specialty within which to practise.

In addition to the work we will do together, you will be expected to review the Royal College of Psychiatry document:

**A competency based curriculum for specialist training in Psychiatry:Core Module**


and the **Specialist Module on Child and Adolescent Psychiatry with reference to Core Trainees.**

http://www.rcpsych.ac.uk/pdf/CA%20curriculum%20Dec%202010%20(Mar%202012%20Update).pdf

Excerpts from this document can be found in Appendix 1.

From 2015, the membership exam will revert back to two written papers. Human development will be examined in Paper A and clinical topics including Child and Adolescent psychiatry in Paper B. The updated syllabus can be found here.

http://www.rcpsych.ac.uk/traininpsychiatry/examinations.aspx

After completing the CAMHS module you will have begun to

- understand why child mental health is important for adult mental health
- gain the knowledge, skills, attitudes and behaviour necessary to successfully complete a CAMHS placement.

**Objectives**

After completing the CAMHS module you should be able to

1. Take a developmental history
2. Describe the concept of attachment and its relevance for the mental health of children
3. Appreciate the differences in assessment and treatment in CAMHS clinics compared to Adult Mental Health and the reasons underlying this.
4. Describe the diagnostic features of Attention Deficit Hyperactivity Disorder and understand the principals of treatment.
5. Describe the neurodevelopmental differences which can lead to an Autistic Spectrum diagnosis and the principals of intervention.
6. Describe how anxiety and depression may present in a child and in an adolescent and the relevance of somatisation as communication between children and their carers
7. Have an understanding of the complexity of the Criminal justice system with respect to children and how the law interacts with children.
Areas of the MRCPsych syllabus covered but not necessarily taught.

Human Development

At the completion of training, psychiatrists should be knowledgeable about normal biological, psychological and social development from infancy to old age. This is in order to consider:

I. The stages of normal development in order to determine whether an individual’s style of thinking, coping, feeling or behaviour is appropriate for that stage or may be an indication of illness

II. How the stage of cognitive and emotional development may influence the aetiology, presentation and management of mental health problems

III. Factors that may be associated with vulnerability to mental health problems and protective factors associated with resilience

IV. Developmental issues in relation to the varied cultural and economic backgrounds of patients.

Other aspects of family relationships and parenting practices. The influence of parental behaviours compared with parenting practices. Some aspects of distorted family function: e.g. discord, overprotection, rejection, and enmeshment. The impact of bereavement, parental divorce and intrafamilial abuse on subsequent development of the child. Brief mention of relevance or otherwise of non-orthodox family structure including cultural influences on family and stages of family. Individual temperamental differences and their impact on parent-child relationships. Origins, typologies and stability of temperament and the evolution of character and personality. Childhood vulnerability and resilience with respect to mental health.

Adolescence as a developmental phase with special reference to pubertal changes, task excellence, conflict with parents and authority, affective stability and ‘turmoil’. Normal and abnormal adolescent development.

Basic Neurosciences, clinical pharmacology

As relevant to the tasks and case vignettes presented.

Historical background and Context

Children’s psychological distress and mental illness may present as behavioural difficulties this has been known by many generations of adults. In 2010, George Stein published a series “Psychiatry in the Old Testament” in the British Journal of Psychiatry.

Child Psychiatry in the Old Testament

In the Book of Proverbs, the word ‘fool’ denotes a character corresponding to the modern concept of personality disorder (mainly antisocial). Parental grief or depression associated with having a fool as a child is described in three separate entries.

10.10 “A wise child makes a glad father, but a foolish child is a mother’s grief”
17.21 “The one who begets a fool gets trouble, the parent of the fool has no joy”
17.25 “Foolish children are a grief to their father, and bitterness to her who bore them.”

In recent child psychiatry literature, numerous studies replicate this association between maternal depression and having children with conduct disorder.

The management of the more seriously disturbed and delinquent adolescents?

The parents liaised with the local social services (the elders) the solution they came up with is described in Deuteronomy 21:18-21
21:18 “If someone has a stubborn and rebellious son who will not obey his father and mother, who does not heed them when they discipline him, 15Then his father and mother shall take hold of him and bring him to the elders of his town at the gates of the place. Then they shall say to the elders of the town “This son of ours is stubborn and rebellious. He will not obey us. He is a glutton and a drunkard.” Then all the men of the town shall stone him to death. So you shall purge the evil from your midst, and all Israel will be afraid.”


The demonisation of children with undesirable behaviour remains an aspect of today’s society with numerous examples. Whilst stoning is not in the modern therapeutic tool box, the history of interventions for child mental health is interesting. The following is an adapted excerpt from Dora Black’s chapter in Seminars in Child and Adolescent Psychiatry entitled “A brief history of Child Psychiatry” and is well worth reading in its entirety.

The first clinics with a remit to help children with bad behaviour started in Boston in 1920 and spread to the UK as the first place in Europe in 1927. The UK clinic was started in the East End of London by the Jewish Health Organisation. Emmanuel Miller, a psychiatrist was appointed as the honorary director. The clinic consisted of Dr Miller working alongside a psychiatric social worker who had trained in Boston and a psychologist.

In 1933, Dr Miller moved his clinic to the Tavistock and founded its department for the treatment of children and their parents, already recognising the importance of the influence of families on the mental health of their children.

By 1948 and the birth of the NHS, most local authorities had a rudimentary Child Guidance service. By the end of the 1960s, most child psychiatrists were employed by the NHS and working in clinics with educational psychologists, social workers, a few psychotherapists and remedial teachers. The premises were often owned and administrative services provided by the Local Education Authority. There were few hospital sited health clinics per se. Whilst this emphasis on multi-disciplinary treatment had value, the practicalities led to professional isolation amongst the disciplines, the development of a culture of one therapy’s omnipotence and a limited evidence base from which to both counter the above and from which to draw best practice.

Child Guidance services had difficulty in meeting the need, the extent of which was much greater than had been thought. In 1973, Kolvin found that only 1% of children were receiving a service from Child Guidance, yet the prevalence of a definite and functionally impairing child psychiatric disorder was 7-20% (Rutter et al 1970).

Professor Sir Michael Rutter opened the first academic department of Child Psychiatry in 1972 at the Maudsley Hospital. This enabled the initiation of further research but Child and Adolescent psychiatry research is still under-funded by comparison with research into adult mental health disorders.

Landmarks in the history of child psychiatry include

- Kanner’s delineation of infantile autism (1943)
- Robertson’s distressing films of children in hospital (1952, 1958)
- Winnicott’s description of “good enough mothering and the importance of the mother-child relationship (1973)
- Rutter’s epidemiological studies on the Isle of Wight (1970)
- Kolvin’s assessment of treatment strategies. (1973)
- MTA trial of stimulant medication (1999)

In terms of treatment modalities, psychodynamic theory ruled supreme until relatively
recently. Inpatient units for children and adolescents developed after the war although therapeutic schools had been in existence before. Play therapy developed in the United States and was adopted by UK clinics later as have been several other interventions and diagnostic processes in child psychiatry. Today Child and Adolescent Mental Health Services (CAMHS) clinics offer multidisciplinary assessment and treatment with a variety of approaches including CBT and family therapy. Some may also provide dialectical behavioural therapy, cognitive analytical therapy, video interactive guidance as well as individual psychodynamic psychotherapy and group work. The variety of disciplines involved in the work has also expanded, including mental health nurses, occupational therapists, clinical psychologists etc.

The current financial situation of the NHS leaves CAMHS in arguably its most precarious state since the beginning of the Child Guidance service. Organisational and managerial change leaves some aspects of its work open to removal, from the public to the private sector, at a time when few parents with children and adolescents at home can afford the option of private medicine. In some parts of the country, private medical companies, such as Virgincare, have won tenders to provide CAMHS as a core NHS service. The need remains vast. Meltzer et al found 10% of children and adolescents to have a definable disorder yet CAMHS is substantially under-resourced to meet this need. The Health Advisory service report “Together we stand” (1995) recommended the provision of child mental health services in a tiered way and it is often referred to and informed modern service commissioning.

- Tier 1 universal services who see children on a daily basis eg General Practice or schools.
- Tier 2 independent practitioners who advise and educate professionals at tier 1 level such as Primary Mental Health Workers
- Tier 3 specialist CAMHS clinics
- Tier 4 inpatient units usually for adolescents with mental health disorders

An assertive outreach service, designed to decrease the necessity of admission to tier 4, is a recent service development in some parts of the country and may be referred to as tier 3½!

The recent CAMHS review (2008) recommended the discontinuation of these terms stating instead that services should refer to provision for Children’s mental health as Universal, Targeted or Specialist.

Regardless of how services are configured, the mental illness and impairments to functioning in daily life, which children and young people may experience, remain similar to the conditions treated both in Biblical times and the 1920s. Emmanuel Miller was motivated by a desire to enable positive change in the lives of the children and young people he saw and treated. This desire continues for contemporary CAMHS professionals.

Further reading


Suggested General Resources

Textbooks


NICE guidance

Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults. http://www.nice.org.uk/CG72

Nice guidance is also available for the major areas of psychopathology

Others

Mental Health and Growing up Leaflets. Accessed via the Royal College Website

BNF

BNF for children

Websites

www.autisticsociety.org

www.nas.org

Library and IT facilities

You will have access to Library facilities in your own local area and you will be able to use the library at Hawthorn Lodge on course days. You should ensure that you have a NHS Athens account: this is a username and password which allows you to use information resources paid for by the NHS. All NHS staff are entitled to an NHS Athens account.

Your Learning Set will have a laptop, with internet access, to use in the Education Room on course days.

Some useful websites are:

http://www.library.nhs.uk/ and http://www.evidence.nhs.uk/ - locate libraries, search for articles / books / other publications, register for an Athens account, "My Library" facility

http://www.swims.nhs.uk - catalogue of what is available (books, journals, audiovisual, etc) in all libraries in the south west

http://www.medicalresearchservices.nhs.uk/ The Medical Search Initiative has developed electronic tools for use on the desktop, making it much easier for all NHS staff to check details while they are working. The tools created give easy access to reliable sources such as the British National Formulary, Medicines.org.uk and the National Library for Health

Basingstoke, Southampton, Winchester and South West Hampshire:
http://www.hantshealthcarelibrary.nhs.uk/

Dorset:
East Dorset NHS Library Service, Haven Road, Canford Cliffs, Poole
PGMC.library@poole.nhs.uk

Isle of Wight:
library@iow.nhs.uk

Portsmouth:
http://www.porthosp.nhs.uk/library-services.html

Salisbury:
Beechlydene, Fountain Way, Salisbury SP2 7EP
Education Centre, Salisbury District Hospital, Salisbury SP2 8BJ
library.office@salisbury.nhs.uk
Week 1: Developmental Trauma
Dr Anna Gibson, Consultant Child and Adolescent psychiatrist, Havant

Outline of lecture (learning objectives)

What is developmental trauma?
What are the consequences of developmental trauma?
Case studies
Resilience
What about treatment (to include the roles of the team)

Outline of the activity to accompany the keynote lecture.
Case studies for discussion including consideration of relation of symptoms to past experiences, treatment in CAMHS and network.

Tasks:

This is what you have to do:

Choose an article from the following:

- Lest we forget: comparing retrospective and prospective assessments of adverse childhood experiences in the prediction of adult health Reuben et al. 2016
- Risk and resilience trajectories in war-exposed children across the first decade of life Halevi et al 2016
- Moderators of treatment response to trauma-focused cognitive behavioural therapy among youth in Zambia Kane et al 2016
- Early severe institutional deprivation is associated with a persistent variant of adult attention-deficit/hyperactivity disorder: clinical presentation, developmental continuities and life circumstances in the English and Romanian Adoptees study Kennedy et al. 2016

This is what I would expect from you at 9.30 next day:

10 minute presentation of the article with salient points

This is the reason for the task:

Understand some of the recent research into the area of developmental trauma, beginning to apply some of the principles to your understanding of patients
Week 2: Neurodevelopmental Disorders: from science to clinical practice
Dr Samuele Cortese, Senior Lecturer in Child and Adolescent psychiatry, BCC

Outline of lecture (learning objectives)

- Historical evolution of the concept of neurodevelopmental disorders
- Update on the epidemiology and etio-patophysiology of the main neurodevelopmental disorders
- Diagnostic assessment
- Evidence base for the pharmacological and non-pharmacological treatment of neurodevelopmental disorders
- Clinical tips for the management of individuals with neurodevelopmental disorders
- Clinical services for individuals with neurodevelopmental disorders, with a focus on the issue of transition.

Outline of the activity to accompany the keynote lecture.

to gather a detailed neurodevelopmental history in an existing patient with adult psychopathology

Tasks:

This is what you have to do:

“Each person in the group needs to take a neurodevelopmental history from an existing patient with adult psychopathology”

This is what I would expect from you at 9.30 next day:

“You need to be able to present to your colleagues a neurodevelopmental history and discuss how possible neurodevelopmental disorders are related to current problems in 5-10 minutes.”

This is the reason for the task:

“Neurodevelopmental disorders may precede the occurrence of psychopathology in adults and may be, to some extent, a risk factor for future psychopathology. This has been well established in a large body of research for some disorders (such as substance use disorders or antisocial personality disorder) and is currently the focus on increasing research in relation to other disorders (e.g., schizophrenia or eating disorders)”
Week 3: Consent to treatment and Legal Frameworks
Dr Suyog Dhakras, Consultant Child and Adolescent Psychiatrist BCC

Case Study

Michael is 16 and started 6th form college 3 months earlier. He was referred to the local CAMHS team by his GP after he visited him reporting low mood, poor sleep and some suicidal thoughts. He has an older brother who is known to adult mental health with a psychotic illness on a background of Aspergers syndrome. Michael’s college tutor has expressed concern as over the past couple of weeks, Michael’s attendance at college has decreased and Michael can’t account for where he has been. He has also noticed that Michael is a loner at college, his brutally honest manner doesn’t endear him to his peers. He has an interest in Japanese Manga and is a keen member of the GCSE Japanese class.

Michael attends his CAMHS appointment alone, stating that his parents only provide him with a roof over his head, that they are in their mid to late fifties and that he does not want any information shared with them. He proceeds to share his plans for a Columbine style massacre at his college which he will execute alone. He hasn’t told anyone else of his plans. He says he will choose his victims at random, that they will have to justify their existence if they want to live and that he will then decide whether they do or not. He describes a “scientific interest” in experimenting on humans, particularly on the mechanical force that the human ribcage can withstand. He seems to be enjoying relaying his thoughts to you and hasn’t yet decided when he will complete his mission. He says he’s happy with his thoughts of harming others and doesn’t see why the psychiatrist should express concern as his victims would “deserve to die” but he is irritated by his poor sleep and therefore agrees to come back for another appointment.

<table>
<thead>
<tr>
<th>Groups</th>
<th>Task</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Aetiology</td>
<td>What are the diagnostic possibilities for Michael?</td>
</tr>
<tr>
<td>2</td>
<td>Aetiology</td>
<td>Drawing on relevant literature, complete a risk assessment, how would you proceed if he did not turn up for his next appointment?</td>
</tr>
<tr>
<td>3</td>
<td>Intervention</td>
<td>In the context of the possible diagnoses, how should the child and adolescent psychiatrist manage Michael’s care?</td>
</tr>
<tr>
<td>4</td>
<td>Prognosis</td>
<td>Emerging traits of personality disorder is a controversial area. What’s your understanding of the current thinking and how would this influence your management of Michael?</td>
</tr>
</tbody>
</table>

Further reading

Healthy Lives, safer communities. A strategy to promote the health and well-being of children and young people in contact with the youth justice system.
http://dera.ioe.ac.uk/11034/
Support from the start: Working with children and their families to reduce the risks of crime and antisocial behaviour.
http://www.education.gov.uk/research/data/uploadfiles/rr524.pdf
Week 4: Recent developments in Eating disorders including changes in classification system DSM 5
Dr Julie Waine Consultant Child and Adolescent Psychiatrist UHS

Outline of lecture

- Eating disorders through the ages, William Gull, Russell, Morgan et al
- Research evidence re epidemiology with reference to the General Practice Research database
- Assessment with reference to Marsipan/Junior Marsipan guidance and proposed NICE guidance changes
- Eating disorders and autistic spectrum
- Treatment trials including TOUCAN + New Maudsley Model + multifamily systemic therapy

Case vignettes

Learning objectives: By the end of the lecture, core trainees will have an increased knowledge base re factual knowledge and understand broad concepts underpinning treatment including importance of the family.

Outline of the activity to accompany the keynote lecture.

Read the following newspaper article
https://www.theguardian.com/society/2016/aug/06/sisters-eating-disorder-missed-breakfast

Tasks:

This is what you have to do:

In your groups choose between 1) Guardian article & https://www.youtube.com/watch?v=iRim224xFjE 2) animal analogies and other information from the Maudsley Model website or 3) balance risk paper from advances

This is what I would expect from you at 9.30 next day:

10 min presentation to the whole group on whichever resource you chose to process on their behalf. What are the salient features, key points that the group should know from your resource in order to be able to work with and manage patients with eating disorders.

This is the reason for the task:

*Eating disorders have the highest mortality and morbidity of any of the psychiatric illnesses yet as a core trainee, unless working in a specialist unit, there is little exposure to this complex and important area of psychiatry. Trainees need the knowledge, skills and attitudes to manage these patients on a general adult ward and where to find further resources.*
Appendix: Child and adolescent psychiatry

Trainees should play an active part in patient care and not be expected to adopt a passive observer role. The experience should include extensive community experience and include both medical and psychological approaches to treatment.

Not all trainees will have the opportunity to have a post in child and adolescent psychiatry during Core Psychiatry Training. Aspects of developmental psychiatry are important for all psychiatric trainees whatever specialty within psychiatry they subsequently choose. Trainees need to understand child development and the influences that can foster this or interfere with it. To do this they need to understand the bio-psycho-social approach and the varying balance of influences at different stages of development. They need to understand both aberrant development and also how normal development can be disrupted. Whilst this is best learned through clinical experience in a developmental psychiatry post (child and adolescent psychiatry or adult learning difficulties), there will be a few trainees who have to gain these skills in other ways. The knowledge base will come from clinical experience coupled with lectures, seminars and private study including study for examinations. Those who do not get a post in developmental psychiatry are strongly advised to negotiate a clinical attachment during another placement to best prepare them to undertake the child and adolescent WPBAs that they will be expected to achieve during this stage of their training.

All Core Psychiatry Training (CT1-3) trainees are likely to be responsible for seeing young people who present to Accident and Emergency Departments with self-harm whilst they are undertaking out of hours on call duties. This means that they have to understand safeguarding issues and the assessment of risk for these young people. To ensure that they are supported in this, there are competencies appropriate to CT1-3 in safeguarding (Intended Learning Outcome 2) and Managing Emergencies (Intended Learning Outcome 4). In addition, it has become increasingly clear that developmental disorders such as ADHD and autism can continue into adult life and that they have been under-recognised in adulthood. Competence in recognising these disorders is required for all trainees. Depression is an important illness that often starts in adolescence and this is referred to in the ARCP Guide to Core Psychiatry Training.

Core trainees (CT1-3)

The curriculum provides the expectations for all trainees during their training in psychiatry. Core trainees will have responsibility for seeing children and young people when on-call so that they need to obtain competencies to allow them to carry out these duties under supervision. The competencies they need are listed (see 1, p3). Other core trainees will have the opportunity to have a job in child and adolescent psychiatry at some stage during their first three years of core training (usually in the second or third year). For these trainees there are some essential competencies that they should acquire (see 2a, p3) and some that they may acquire; these will depend on their particular job in child psychiatry (see 2b, p3). Whilst there are no requirements to achieve these competencies, trainees should reach the orange level of competency in some (see below).

1) For core trainees who do not undertake a post in child & adolescent psychiatry the following are essential:

- **Competence 1** — Establish and maintain therapeutic relationship (those aspects marked in red and orange below)
- **Competence 2** – Safeguarding (those aspects marked in red and orange below)
- **Competence 3** – Undertaking a clinical assessment (those aspects marked in red and orange below)
- **Competence 4** – Managing emergencies (those aspects marked in red and orange below)
- **Competence 7.2** – ADHD etc, competence 7.3 – autism (those aspects marked in red and orange below)

2a) For core trainees who undertake a child & adolescent psychiatry post

The competences listed under 1 above plus:

- **Competence 5** – paediatric psychopharmacology (those aspects marked in red and orange below)

2b) Depending on their post in child psychiatry, a core trainee may acquire additional competencies in a particular domain e.g. adolescent psychiatry, inpatient child or adolescent psychiatry, paediatric liaison etc. For such experiences there is no requirement of obtaining competencies beyond those listed
above but it is hoped that trainees will aspire to gain competencies, those marked in red and orange for the particular area of practice. They are not expected to be able to work without supervision at this stage of their training.

Aspect Developing Performance

Under Supervision Competent Mastery

7.2 To be able to diagnose and treat neuropsychiatric disorders such as ADHD, Tic Disorders and Tourette Syndrome, and OCD Carry out assessment of child including taking history from multiple sources and observing the child in different settings. Carry out comprehensive assessment of the child including assimilation of reports from other professionals.

Recommend treatments as appropriate including non pharmacological and pharmacological interventions. Diagnose and manage complex presentations of children with significant comorbidities.

Supervision of others in the assessment and treatment process

7.2 Knowledge – Understands range of neuropsychiatric disorders in childhood

• Understanding the clinical features associated with neuropsychiatric conditions

• Understanding the neurobiological basis for neuropsychiatric disorder including neuroanatomy, neurophysiology and neuropsychology

• Knowledge of the differential diagnoses and comorbidities associated with neuropsychiatric disorder

• Understanding of the impact of neuropsychiatric disorder on individual and family development

• Knowledge of the current evidence base for interventions.

7.2 Skills – Understands range of neuropsychiatric disorders in childhood

• Ability to carry out a comprehensive assessment of the child including parental accounts and information from educational professionals as well as direct observation of the patient.

• Ability to liaise with educational professional about the management of the patient in an educational setting

• Ability to assess and diagnose children presenting with a complex picture with comorbid conditions such as autism spectrum disorder, Tourette Disorder, Obsessive Compulsive Disorder and develop a management plan

• Ability to discuss and recommend appropriate psychological and pharmacological interventions

7.2 Behaviours – Understands range of neuropsychiatric disorders in childhood

• As above (See also competency for Learning Disability)

Aspect Developing Performance

Under Supervision Competent Mastery

7.3 To be able to carry out an assessment of an individual with autism spectrum disorder. Contribute to the assessment of a child with autism through history taking and direct observation. Carry out assessment and diagnose autism in non complex cases using standard diagnostic criteria.

Recognise the presence and implications of common comorbid conditions. Carry out assessment of child presenting with complex symptomatology or with significant comorbidities.

7.3 Knowledge – Assesses autism and related disorders

• Understanding of the clinical features of autism

• Understanding of the core deficits in autism and how they impact upon the development of the child and their family

• Knowledge of the causes and development of autism including current and past theories and the evidence base for them

7.3 Skills – Assesses autism and related disorders

• Ability to take a developmental history and identify and follow up on features of autism spectrum disorder

• Ability to diagnose autism using standard diagnostic criteria

• Ability to modulate own behaviour to facilitate interaction with autistic individual

• Ability to recognise and diagnose conditions often comorbid such as learning disability, ADHD, Tourette Syndrome, epilepsy, dyspraxia and mental illness

• Ability to carry out a comprehensive assessment of the child using detailed assessments such as
DISCO, ADI, 3Di, ADOS

7.3 Behaviours – Assesses autism and related disorders

- As above

(See also competency for psychopharmacology, working with networks, learning disability)

Aspect Developing Performance

Under Supervision Competent Mastery

7.4 To be able to contribute to the management plan of an individual with autism spectrum disorder including use of psychotherapeutic and psychopharmacological interventions. Commence and monitor medication as part of a comprehensive treatment plan. Contribute to development and initiation of a multi-agency intervention. Develop and recommend a multi-agency management plan.

Liaise with legal services in relation to child care or forensic issues.

Play a lead role in service development

7.4 Knowledge – Develops management plan for autism spectrum

- Understanding of the range of therapeutic interventions available for children with autism and the evidence base for these

- Understanding of the role of psychopharmacological interventions for children with autism

- Knowledge of the national and local policies in relation to prescribing medications off label or out of their licensed indications

7.4 Skills – Develops management plan for autism spectrum

- Ability to discuss use of psychotropic medications including the full range of side effects in young persons with autism

- Ability to work psychotherapeutically with the family to assist them with creating an environment conducive to the child’s development

- Ability to liaise with other agencies in the management of individual cases as well as development of appropriate services to meet the child’s developmental needs

7.4 Behaviours – Develops management plan for autism spectrum

- As above

(See also Paediatric Liaison)

Aspect Developing Performance

Under Supervision Competent Mastery

7.5 To be able to contribute to the management of neuroepileptic conditions

Awareness of the presentation of seizure disorder as part of the differential diagnosis. Able to recognize seizure disorder and appropriately refer on to paediatric services.

Able to recognize psychiatric comorbidities in children with epilepsy

Able to assess children presenting with non epileptic seizures. Carry out comprehensive assessment of child presenting with seizure disorder or non epileptic seizures and liaise with child health services about ongoing management

7.5 Knowledge – Neuropsychiatric aspects of epilepsy

- The classification of epilepsy and its clinical presentation

- Knowledge of the range of antiepileptic medication in children

- The role of the EEG in children presenting with suspected seizures

- The range of behavioural syndromes associated with epilepsy

- The psychopharmacology of psychiatric disorder and its relationship to seizure disorder

7.5 Skills – Neuropsychiatric aspects of epilepsy

- Ability to carry out a detailed assessment of the child presenting with seizure disorder including interpretation of clinical observation of seizures

- Ability to formulate child’s presentation of non epileptic seizures with families and other professionals with a view to developing a management plan

- Ability to work psychotherapeutically with child and family in cases of seizure disorder and child with non epileptic seizures.

7.5 Behaviours – Neuropsychiatric aspects of epilepsy

- As above