GHANA COLLEGE OF PHYSICIANS AND SURGEONS

FACULTY OF PSYCHIATRY

CURRICULUM FOR

MEMBERSHIP AND FELLOWSHIP

TRAINING

Revised June 2011

Contents…..…….……..…..…….……..…2

A. General Information

1. Acknowledgement:
    a. This curriculum is an adaptation of the Curriculum of the Egyptian Psychiatric Fellowship and the Curriculum of the Royal College of Psychiatrists, both of which were found very useful.

2. The College and the Faculty
    a. The College of Physicians and Surgeons is Ghana's statutory postgraduate medical college for the training of medical and surgical specialists to the highest level of training to take care of the health needs of the country to the highest level of care. It was established by an Act of Parliament, Act 635 of 2003. The College has two Divisions: Division of Physicians and Division of Surgeons. The Division of Physicians has eight constituent Faculties and Psychiatry is one of these Faculties which were established at the inception of the College.

3. Purpose of curriculum
    a. This curriculum is to guide students to know the extent and limits of the programme of study for the membership and fellowship. It shows the skills, competencies, theoretical knowledge and attitudes the candidate is to develop, the course outline, content and structure, and the method of tuition, method of assessment, resource materials and source of information gathering. It further shows the responsibility of the candidates and gives an overall view of the programme, entry requirements and certification, etc.

4. Rationale of programme
    a. Psychiatric problems are common amongst patients seen in all branches of medicine. Epidemiological studies in many countries show that a large proportion of the society has one diagnosable psychiatric problem or another. In the US Surgeon's general's report (1998) it is estimated that 44% of the population suffer from a recognisable psychiatric disorder. Many studies indicate that one in four persons will suffer a mental illness in his or her life time and at any time one in five has a mental disorder. Studies have shown that 30-40% of patients attending general OPD have a mental disorder or psychiatric comorbidity.
    b. In Ghana the WHO estimates for 2005 were that 10% of the population suffer from one form or the other of mental illness with 650,000 suffering from a major psychiatric illness.
    c. Psychiatric beds form the largest proportion of in-patient beds in the hospital system of many countries. We still have a number of patients roaming on the streets. An estimated one third of all patients on admission in public institutions in Ghana are psychiatric patents.

d. Depression is listed amongst the top five causes of morbidity worldwide and is estimated to have a life time incidence of 20% among females. Orley and Wing (1972) found the prevalence rate of 22.1% among Ugandan women. This may not be different from what prevails in Ghana.
e. The YLD (Year Loss due to Disability) due to mental and neurological disorders In Ghana is 9% while it is 7% for HIV/AIDS.
f. Schizophrenia, one of the most devastating and chronic illnesses of mankind occurs in about 1% of all populations worldwide whilst bipolar disorder occurs in at least 3% of the population.
g. Overall, psychiatric disorders are arguably the largest single group of medical illness in Ghana as in most other countries. They cause considerable morbidity, loss of working hours and are a great burden on families and the economy as a whole.
h. In spite of this widespread prevalence of mental disorders there are very few mental health personnel with current treatment gap being 98% for those who require treatment. Ghana has a severe dearth of psychiatrists, a total of 12 specialists for 24 million population or one to two million population. This ratio is woefully inadequate and requires a major effort towards training many more.
i. Thus most affected people in Ghana currently seek treatment from traditional healers and spiritualists who use various unproven therapies with dire consequences and complications.
j. Psychiatry may be the most exciting discipline within medicine over the next few decades. Long after cancer and infections are subdued psychiatric problems are likely to remain. Though now a high-powered science, psychiatry remains a very clinical and behavioural discipline within medicine. There is a need for Ghana to produce its own cadre against similar professionals elsewhere in the world while being particularly sensitive to local peculiarities.

5. Job description

A Fellow in psychiatry of the College will be a consultant eligible specialist of the highest calibre qualified to act as an independent consultant in general adult psychiatry or the sub-specialty in which he has the special training. A fellow must see himself or herself as:

a. Highly trained professional and clinician for medical treatment of mental disorders who can recognise, manage and prevent mental disorders and promote mental health.
b. Medical Expert in mental health to be able to give informed authoritative advice, answers and reports on mental health issues. He or she may be called upon to give expert advice as witness to the government on mental health issues or even in court.
c. Researcher on mental health issues.

d. Manager of mental health facilities and services and should be able to set up mental health services in an institution, region or district.
e. Scholar who can discuss meaningfully on mental health issues and who is himself or herself desirous of personal development through further self training and seizing any available opportunity to advance his or her knowledge.
f. Mental health advocate.
g. Teacher who can impart knowledge and train others at various levels – nurses, doctors, psychiatrists in training, lay people who require knowledge and skills in mental health, etc.
h. Communicator who is equipped with the skills of sharing knowledge or disseminating his or her findings to his or her peers through conference presentations, publication of papers in respectable and peer review journals. He or she should be able to share knowledge to the general public through media and other means.
i. Collaborator who can effectively work as a team player with other mental health professionals like nurses, clinical psychologists, social workers and occupational therapists.
j. Team leader who can lead a team of other psychiatrists or mental health workers for the implementation of mental health policies and services for the treatment of mental health conditions.

6. Programme goal
    a. The membership in psychiatry aims at producing a specialist to serve the needs of the country.
    b. A member has only one step to become a consultant eligible and should be able to run most programmes of a consultant.

7. Programme objectives
    a. To train specialist psychiatrists in general adult psychiatry with the requisite knowledge, skills, competences and attitudes to serve as specialists in mental health, and who is capable of branching into subspecialty status, eg. after further 2 years training.
    b. To produce people equipped to lead a multidisciplinary mental health team

8. Specific objectives
   At the end of the training the specialist psychiatrist should be able to:
    a. Possess a sound knowledge of behavioural sciences and clinical psychiatry as well as basic psychological treatment methods, have the skills, competences and attitudes to manage psychiatric problems
    b. Recognise, assess, plan and manage a person with psychiatric illness independently

c. Educate other medical personnel including trainee psychiatrists and the general or lay public on mental health issues
d. Plan and carry out research in mental health on his or her own or with others.
e. Communicate effectively with all other mental health professionals.

9. Entry requirements
    a. Basic medical qualification - MB.ChB. or its equivalent
    b. Full registration with the Medical and Dental Council of Ghana
    c. 24 months post graduation clinical experience
    d. Pass an entry examination or possess the appropriate exemption
    e. Pass an interview conducted by the Faculty of Psychiatry for entry into the programme

10. Duration of programme
    a. The basic programme will normally take a duration of three calendar years
    b. Fellowship requires a further 2 years after one year of possessing membership

11. Certification
    a. Candidates must have gone through the three year training period, passed the relevant assessment examinations as prescribed by the Court of Examiners of the College. Candidate will be admitted for examinations only after satisfactory reports of in-training or formative assessments including due completion and countersigning of logbook.
    b. A candidate who has passed the requisite examinations and been admitted to the College after payment of requisite fees will be awarded the College Membership diploma with the College seal and is entitled to use the letters MGCP (Member Ghana College of Physicians) after his or her name.

12. Programme structure
    a. The programme is based on acquisition of knowledge, competency, skills and attitude.
    b. The programme is premised on the fundamental philosophy that medicine in general and psychiatry in particular, is both a science and an art. The science component requires didactic tuition and theoretical knowledge. This will impart the required competency. The art component is apprenticeship which is learnt by following an experienced person, the trainer or trainers. This component will ensure the skills and attitude acquisition.
    c. Every candidate will have a mentor and a supervisor. The supervisor is the trainer on the ground at the facility level. The mentor observes the candidate from afar and ensures the right attitude acquisition and offers career guidance.
    d. The programme will consist of various structured prescribed courses involving lectures, tutorials, clinical work, skills training, supervised research and community or field work.

13. Course description

There shall be two main parts consisting of:

a. Neurosciences and general medicine emphasising on neurology and neurosurgery, behavioural sciences and social sciences. This component is to give a firm grounding in the basic sciences and the biological, psychological and socio-cultural basis of psychiatry. This will ensure appreciation of the fundamentals of psychiatry and the value of research in psychiatry.
b. Clinical psychiatry and essential psychology skills

B. Course outline

14. Subjects of study

The following are subjects for study and knowledge by the candidates.

a. Neuroanatomy
b. Neurophysiology
c. Neurobiochemistry
d. Neuropathology
e. Neuropharmacology
f. Epidemiology
g. Biostatistics
h. Psychology
i. Medical sociology
j. Ethology
k. Ethics
l. Clinical psychiatry
m. Neurology
n. Basic neurosurgery

15. Year one

a. Neuroanatomy
b. Neurophysiology
c. Neurobiochemistry
d. Neuropathology
e. Neuropharmacology
f. Introduction to Psychology
g. Sociology of behaviour
h. Psychopathology
i. Clinical psychiatry I

16. Year two
    a. Clinical psychiatry II
        i. Outpatient care
        ii. Inpatient care
        iii. Emergency psychiatry
        iv. Liaison psychiatry
        v. Community psychiatry
        vi. Forensic psychiatry

    b. Rotations in year two
        i. General adult psychiatry
        ii. Substance abuse
        iii. Internal medicine and neurology
        iv. Neurosurgery
        v. Child psychiatry
        vi. Geriatric psychiatry

17. Year three
    a. Management and administration
    b. Clinical psychiatry III
    c. Liaison psychiatry
    d. Child and adolescent psychiatry
    e. Psychological treatment methods including Cognitive Behaviour Therapy (CBT), counselling, psychotherapy, relaxation training, etc
    f. Community and rehabilitation psychiatry including outreach clinics
    g. Occupational Therapy (OT)
    h. Forensic psychiatry, court attendance and court report writing
    i. Transcultural psychiatry

18. Rotations and rotation sites
    a. First year at Accra Psychiatric Hospital
        i. General adult psychiatry

    b. Second year:
        i. Six months at Pantang Hospital
        ii. Addiction Rehabilitation/Therapeutic Community at Pantang Hospital
        iii. Four months at Korle Bu Teaching Hospital for internal medicine and neurology
        iv. One month at neurosurgery at Korle Bu Teaching Hospital

    c. Third year: Accra Psychiatric Hospital
        i. Management and administration
        ii. Forensic Psychiatry

iii. Psychology skills
iv. Liaison psychiatry
v. Rehabilitation /Occupational Therapy

C. Assessment and Evaluation

19. Assessment and evaluation methods/examinations
    a. Membership exams
    b. Methods of evaluation/ assessment
        i. Formative: in the course of the three years and at the end of the first and second years. Through formative assessment and feedback the supervisor assesses the candidate's areas of weakness and strengths in order to correct him or her. This is workplace based assessment. The components of this assessment shall be:
            a) Log book
            b) Mini CEX (mini-clinical evaluation exercise by which the candidate's clinical skills are assessed)
            c) MCQs
            d) Essay: the supervisor may give some topics for the candidate to prepare or write an essay on.
            e) Clinical
            f) Assessment of clinical expertise in which the supervisor directly observes how the candidate assesses patients
            g) Case-based discussion in which the supervisor engages in discussion with the candidate on a case the candidate has clerked and recorded in the patient's folder. This may be done at ward rounds or the supervisor may call the trainee to discuss at the consulting room
            h) Direct observation of procedural skills in which the supervisor directly observes candidate conducting a procedure, eg, ECT, interviewing, clinical examination, feedback to patients.
            i) Case presentation: a major case presentation at ward rounds or clinical case conference
            j) Journal Club Presentation: the candidate demonstrates his skills in reviewing papers at journal clubs
            k) Assessment of Teaching: candidate's training involves informal teaching of medical students, junior residents, nurses and other health workers. The consultant or supervisor will observe how the candidate effectively teaches or imparts his skills and knowledge to others

l) Leadership skills: supervisor will be looking for how the candidate demonstrates his leadership skills in various leadership roles assigned to him.

m) Time management skills: supervisor observes and gives feedback on candidate's sense of punctuality and how he manages his time with patients, presentations and other relevant areas.

n) Direct observation of non-clinical skills: the supervisor observes the candidate in non-clinical setting and provides feedback in areas such as chairing of meetings, teaching, supervising others or engaging in another non-clinical procedure, academic discussions with peer, how professionally he comports himself in a manner that gives dignity to the profession he is joining.

ii. Summative

1. This will take place at the end of the third year.
2. Format of examination is as follows: three parts -
    a) Theory MCQ's, 100 stems with five questions each and choose the best of the five. Attempt all in 2 hours.
    b) Clinical Exam:
        i. One long case: in forty-five minutes the candidate will take history and examine (physical and mental state) a real patient, compose clinical formulation. This will be followed by thirty minutes of face to face examination of the candidate by a team of three examiners including two internal and one external from a sister postgraduate medical college outside the country. In the thirty minutes the candidate will present his or her findings in fifteen minutes and be quizzed in the next fifteen minutes. The patient may be called to confirm the candidate's history and findings and also for the candidate to demonstrate his assessment and communication skills.
        ii. 2 or 3 short cases of fifteen minutes each in which the candidate will examine the patient in front of the team of examiners constituted as above. It may or may not be the same team. Here the candidate is asked to specifically elicit some features, do a specific mental state examination, etc.

iii. The above two parts may be replaced in the course of time with an Objective Structured Clinical Examination (OSCE).

c) Oral Examination: this will cover every aspect of what the candidate will have studied in the course of the three years including basic neurosciences, identification of brain parts, general and clinical psychiatry, basic psychology, patient management problems, picture identification and interpretation of ancillary investigations like EEG and skull X-Ray. This is also by a three member panel in fifteen minutes.

iii. Marking scheme and pass benchmark

1. The candidate should pass all three parts with at least 50% in each part for an overall pass.
2. The marking will be by close-marking
3. Results are subject to ratification or final approval by the Court of Examiners of the College.

iv. Period and frequency of examinations

1. The summative exam will be held twice a year – March and September.
2. If a candidate fails the examination he or she can re-sit the next six months. However if he or she fails very badly the candidate may be asked to wait for a year to be more fully prepared.
3. There is no limit to the number of times one can sit but the government will withdraw its sponsorship after the third attempt. The training institution may also withdraw the candidate from the institution to make way for other candidates.

D. Teaching and Instructions

20. Method of teaching and instruction

a. Didactic lectures to cover 80 hours for forty topics in the second year of the training. See detailed course content in the second year. The student must attend at least 80% of these lectures.
b. Seminars
    i. Trainer-led
    ii. Candidate-led
c. Clinical conferences and Case presentations
d. Journal clubs
e. Mortality conferences

f. Topic discussions
g. Daily Ward rounds
h. Teaching ward rounds
i. Video demonstrations
j. Clinical demonstrations
k. Sit-in consultations and observations
    i. Candidate will sit in some of his or her trainer's consultations
    ii. Trainer will sit in some of the candidate's consultations
l. Random demonstration of interesting cases as and when available

21. Log book
    a. The candidate will be provided with a log book at the beginning of the training
    b. The candidate should carry the log book with him or her in all training sessions
    c. Candidate should enter his or her procedures, sign and have them counter-signed immediately and not to wait till examinations to have trainers sign from memory
    d. Trainers and supervisors should satisfy themselves that the log book has been adequately completed, that is, the candidate has had requisite training, before they sign up the candidate for summative examination at the end of the third year. Inadequately completed logbook will disqualify a candidate from taking the final examinations at the end of the third year, for it would mean the candidate is not adequately prepared

22. Monitoring and supervision
    a. Each candidate will have a named supervisor who will provide at least one-monthly one-hour supervisory sessions
    b. Monitoring of candidates' programmes will be partly objectified by a log book to be signed by the supervisor as and when the candidate fills them and to be reviewed at least once every month at the monthly supervisory meeting sessions

23. Role of supervisor and mentor
    a. The supervisor is the consultant at the workplace or training institutions where candidate is placed. He or she is the immediate trainer and will offer bedside teaching, direct and indirect supervision of the candidate.
    b. The supervisor is the link between the candidate and the Faculty and will send quarterly (three-monthly) reports to the Faculty on the progress of the candidate
    c. The supervisor should be involved with teaching and training of the trainee at the workplace
    d. Supervisor will be involved with both professional and personal development and will:

i. Provide guidance in acquiring theoretical knowledge
ii. Give approval for attendance at a suitable course
iii. Monitor attendance at approved courses and programmes
iv. Provide guidance on reading
v. Guide discussion of topics or theoretical issues
vi. Conduct formative assessment through giving of essay topics
vii. Perform workplace assessment

e. Supervision of clinical work
    i. Assessment of new cases
    ii. Guidance in care of outpatients
    iii. Review of inpatients
    iv. Sit in at consultations
f. Development of clinical skills
    i. Participation in case conferences
    ii. Training in interviewing
    iii. Formative assessment through Mini CEX
g. Training in research
    i. Critical review of papers
    ii. Attendance at journal clubs
    iii. Training in information technology
    iv. Guidance in selecting research topic
    v. Participation in supervisor's research
    vi. Supervision of research
h. Agenda for monthly one hour one-on-one supervision. Discussion to be trainee-led; supervisors should encourage trainees to bring their own agenda but generally:
    i. Education
        1. Wide ranging discussions around current knowledge and good practice
        2. Feedback on the trainee's development of general techniques such as interview skills, notes-keeping, case presentations and case management
        3. Feedback by the trainer on activities such as ECT, psychological treatments methods and relevance, referrals, research methodology, and audit
        4. Discussion of difficult clinical cases
    ii. Interpersonal skills
        1. Discussions ranging across professional interactions with patients, relatives and staff including self-presentation, attitude and issues of discrimination and discretion
    iii. Managerial skills
        1. Helping the trainee to gain early experiences through participation in local activities including administration

iv. Personal development
    1. An overview of the trainee's current strengths and weaknesses.
    2. Their professional development
    3. Pacing themselves during the training period in terms of examinations, subspecialty experience, research outcomes and conferences
v. Mentorship
    1. Day to day problems including those related to local conditions of service and other relevant personal and domestic arrangements
    2. This may include the trainee's time-management, interpersonal relationships, multidisciplinary team issues, difficulties with supervisor and management of difficult patients
vi. Role modelling – example of good practice
    1. Mutually trusting relationship with a plan and sense of purpose established at the outset
    2. Supervisor well briefed about the trainee's current service and educational activities, especially in relation to the examination
    3. A good working knowledge of the trainee's past experience to enable the supervisor to pitch his teaching in the right area and at the right level

24. Attributes/qualities to develop or enhance
    a. Good interpersonal relationship based on mutual respect
    b. Team player
    c. Managerial skills
    d. Mature discretion
    e. Empathy
    f. Patience and tolerance
    g. Endurance
    h. Ability to work under stress and pressure
    i. Time management
    j. Sensitivity to patient's plight
    k. Sense of urgency
    l. Reading habit
    m. Inquiring and probing mind
    n. Objective, critical and scientific mind
    o. Ability to think in abstract plane
    p. Lateral thinking / thinking outside the box
    q. Assertiveness

25. Skills and competencies
    a. EEG interpretation

b. ECT administration and choice of patients
c. Psychological methods of intervention
    i. Cognitive Behaviour Therapy
    ii. Counselling
    iii. Brief psychotherapy
    iv. Relaxation training
    v. Psycho-education
    vi. Other psychological methods of intervention
d. Doctor-patient interpersonal skills
e. Information gathering skills
f. Information evaluation skills
g. Information giving skills
    i. Ability to explain condition to patient and relatives
    ii. Knowing what, when and how to say it
    iii. Breaking bad news
h. Reporting skills
m. Documentation skills
n. Clinical management skills
o. Learning skills
p. Teamwork skills
q. Critical appraisal skills
r. Interagency communication skills and including referrals and feedback to referred patients
s. Patient assessment skills
t. Research skills
u. Paper/publication writing skills
v. Critical paper appraisal skills
w. Journal review skills
x. Skills for article peer review for a journal
y. Clinical case presentation skills
z. Conference presentation skills
aa. Public speaking skills
bb. Media interaction skills
cc. Advocacy skills

26. Recommended Books and journals
    a. Books
        i. Oxford Textbook of Psychiatry (Michael Gelder, Dennis Gath, Richard Mayou)
        ii. Synopsis of Psychiatry (Kaplan and Sadock)
        iii. Comprehensive Textbook of Psychiatry, Vols. 1 and 2 (Kaplan and Sadock)
        iv. African Textbook of Psychiatry (Ulzen and co)

v. Introduction to Psychology (by Clifford T. Morgan, Richard A. King, John R. Weiss, John Schopler)

b. Journals
    i. British Journal of Psychiatry
    ii. Acta Psychiatric Scandinavica
    iii. African Journal of Psychiatry
    iv. American Journal of Psychiatry
    v. Schizophrenia Bulletin
    vi. Ghana International Journal of Mental Health
    vii. Ghana Medical Journal

27. Resource centres
    a. College library
    b. University of Ghana Medical School library, Korle Bu
    c. University of Ghana Balm library, Legon
    d. Training Institution (Facility or Hospital) library
    e. Internet facilities
    f. Peer support
    g. Personal initiative

28. Peer support
    a. Organise group discussion
    b. Self-tuition among candidates
    c. Share topics for in-depth research and discussion
    d. Support and encourage one another

29. Responsibilities of trainee
    a. A trainee is on study leave and is, therefore, not entitled to annual leave. However the College grants one month leave every year of training which shall be negotiated between the candidate and the training institution
    b. Trainee or candidate must familiarise himself or herself with the requirements and content of curriculum and training
    c. Ensure he or she has been assigned a trainer/supervisor
    d. Ensure attends didactic lectures, at least 80% of them
    e. Attend weekly journal clubs and present according to schedule that will be drawn at the training institution
    f. Attend weekly case presentations and present according to schedule
    g. Attend mortality conferences as organised by the training institution
    h. Join in grand ward rounds
    i. Attend to routine duty, call duties, weekend duties and emergencies as per duty roaster of the institution
    j. Ensure supervisor has quality time monthly one hour one-on one meetings with trainee

k. Ensure he or she fills and supervisor signs the logbook
l. Ensure a sit-in at the consultant's clinic at least three times in the training period
m. Ensure the supervisor sits in at his or her consultation at least two times during his or her training
n. Ensure he or she has opportunity for workplace-based assessment by named supervisor
o. Ensure he or she gets regular feedback from named supervisor
p. Ensure he or she gives regular feedback to the supervisor on how he or she is being supervised or how the program is running
q. Must act professionally at all times and be responsible for his or her patients
r. Must be able to determine when he or she needs to consult superiors and obtain supervisor's input in his or her clinical management
s. Must understand that any breach of professional ethics could be reported to the Medical and Dental Council
t. Must ensure he or she is in good standing with the Medical and Dental Council in terms of renewal of retention and payment of appropriate retention fees.
u. Must have regular contact with their supervisor/trainer to:
    i. agree on educational objectives for each rotation
    ii. develop a personal learning and development plan
    iii. ensure that workplace-based assessments and other means of demonstrating or developing competence are appropriately undertaken
    iv. review examination and assessment progress
    v. regularly refer to their logbook and curriculum to inform discussions about their achievements and training needs
    vi. receive advice about wider training issues
    vii. have access to long-term career guidance and support

E. Course Content

The candidate at various stages of the course, and at any rate at the end of the course, should demonstrate knowledge and ability to apply the knowledge in the following subjects and topics. Some of the topics will be covered by didactic tuition by trainers; others will have to be covered by the candidate through reading or self-tuition and peer support. At any rate by the end of the three years the candidate must demonstrate knowledge and ability to apply knowledge in the following topics.

30. Introduction to Psychiatry

a. Introduction to philosophy, philosophical basis of psychiatry, interrelationship between psychiatry and philosophy, historical development of the relationship between psychiatry and philosophy
    i. What is philosophy, logic and types of logic, inferences and deductions, syllogism, logical fallacies (eg. ad hominim, etc,); subjectivity vrs objectivity, subjective influences in thinking, hair splitting,
    ii. Thinking and types of thinking (straight, logical, rational, dereistic, etc), The value of observation, description, pattern identification, language and accurate description, Ludwig Wittgenstein and linguistic philosophy, Noam Chomsky and language development, relationship between language and cognitive development
    iii. Asking questions, reasonable and right questions, following cues, solution yielding questions
    iv. Mind-brain duality, from philosophers to psychiatrists
b. Scientific basis of psychiatry, relationship and scientific basis
    i. Definition of science, traditional and modern, attributes of science, scientific thinking, methods of science, uses and abuses of science

31. Basic psychology

a. Relationship of psychology to psychiatry
b. Freud, post-Freudians, neo-Freudians, psychoanalysis, its flaws, critiques and contemporary theories
c. Mind and relationship to brain; psychic apparatus
d. Behaviour, theories of behaviour and biology of behaviour
e. Learning and principles of learning; learning theory: classical, operant, vicarious/observational, cognitive models. The concepts of extinction, reinforcement and secondary reinforcement, Learning processes and influences on psychopathology; the concepts of generalization, incubation and stimulus preparedness. Escape and avoidance conditioning; applications of learning theory in clinical settings and behaviour treatments: flooding, systematic desensitisation, reciprocal inhibition, habituation, shaping, and aversion therapy. The impact of various reinforcement schedules. The psychology of punishment. Optimal conditions for observational learning.
f. Personality theory: including rating scales and assessment of personality
g. Sensation, sensory processes and perception; constitutional, environmental and other influences on perception; figure ground differentiation, object and perceptual constancy, set, and other aspects of perceptual organization. Perceptual pathways, from perceptual theory to perceptual disorders -illusions, hallucinations, body image disorders and other psychopathology. Define sensation, types of sensation (traditional and real), define perception and distinguish between the two.

h. Memory and theories of memory: registration, encoding, storage and retrieval or recall and recognition. Primary working memory storage capacity and the principle of chunking; engram; Semantic episodic and skills memories and other aspects of long-term/secondary memory; memory and forgetting; the process of forgetting. Emotional factors and retrieval. Distortion, inference, schemata and elaboration in relation. The relevance of this to memory disorders and their assessment.
i. Thought and thinking: Information processing; mechanism of thinking, the possible relationship with language and language development; Concepts, prototypes and cores. Deductive and inductive reasoning. Problem-solving strategies, algorithms and heuristics.
j. Attention and concentration, basis of serial seven test
k. Cognition and theories of cognitive development
l. Motivation: needs and drives. Extrinsic theories (based on primary and secondary drive reduction) and homeostasis. Hypothalamic systems and satiety. Intrinsic theories, curiosity and arousal; integration and limits; Cognitive consistency. Drive for achievement. Maslow's hierarchy of needs.
m. Emotion: components of emotional response. James-Lange and Cannon-Bard theories, strengths and weaknesses. Cognitive appraisal, differentiation, primary emotions. Emotions and performance.
n. Stress, stressors and stress reactions; physiological and psychological aspects, Situational factors: life events, daily activities of living, conflict and trauma. Vulnerability, coping mechanisms. Locus of control, learned helplessness and learned resourcefulness.

o. States and levels of awareness: Define consciousness, distinguish sleep from unconsciousness or coma, levels of consciousness, Glasgow Coma Scale, unconscious processing. Arousal, attention and alertness. Define sleep. Sleep structure and dreaming, sleep disorders, circadian rhythm or biorhythms and effects of sleep deprivation. Hypnosis and suggestibility. Meditation and trances.

p. Psychological assessment and psychometrics: personality inventory, intelligence tests, depressive inventory, Rosarch, WAIS, etc.

32. Social psychology

a. Attitudes: components and measurement by Thurstone, Likert and semantic differential scales. Attitude change and persuasive communication. Cognitive consistency and dissonance. Attitude-behaviour relationships.
b. Self psychology: self-concept, self-esteem and self-image. Self-recognition and personal identity.
c. Interpersonal issues: person perception, affiliation and friendship. Attribution theory, 'naive psychology' and the primary (fundamental) attribution error.

d. Leadership, social influence, power and obedience. Leadership versus management; Types of social power. Influence operating in small and large groups or crowds: conformity, polarization, and deindividuation. Communicative control in relationships.
e. Communication and Behaviour Change Communication
f. Intergroup behaviour: prejudice, stereotypes and intergroup hostility. Social identity and group membership, group and mob psychology.
g. Aggression: learning theories and aggression, operant conditioning, vicarious learning and aggression, ethnology, frustration and arousal concepts. The influence of television and other media. Family and social backgrounds of aggressive individuals.
h. Altruism, social exchange theory and helping relationships. Interpersonal co-operation.
i. Emil Durkheim and suicide

33. Social science and culture in psychiatry

a. At the completion of training the psychiatrist will be able to demonstrate knowledge of the following:
b. Descriptive terms: social class, socio-economic status and their relevance to psychiatric disorder and health care delivery.
c. The social roles of doctors. Sick role, illness behaviour, help seeking behaviour.
a. Family life in relation to major mental illness, effects of high expressed Emotion.
b. Social and cultural determinants of mental illness, to specific mental health issues, the role of society in addictions. Life events and their subjective, contextual evaluation, community responses to mental illness.
c. The sociology of residential institutions.
d. Basic principles of criminology and penology.
e. Stigma, types of stigma, discrimination and prejudice.
f. Culture and mental health; culture as pathoplastic and as pathogenic; culture, customs and tradition, traditional beliefs and mental disorders, witchcraft belief, health seeking behaviour, traditional healing practices in mental health, funerals and bereavement, role of funerals, widowhood rites, psychological benefits and harm of widowhood rites

34. Human growth and development

At the completion of training, the candidate should be knowledgeable about normal biological, psychological and social development from infancy to old age and to know some disorders associated with abnormal development. The candidate shall know this by learning:

a. 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

b. How the stage of cognitive and emotional development may influence the aetiology, presentation and management of mental health problems
c. Factors that may be associated with vulnerability to mental health problems and protective factors associated with resilience.
d. Developmental issues in relation to the varied cultural and economic backgrounds of patients.
e. Basic frameworks for conceptualizing development: nature and nurture, stage theories, maturational tasks; definitions of maturity. Examination of gene-environment interactions with specific reference to intelligence. Relative influence of early versus later adversities. The relevance of developmental framework for understanding the impact of specific adversities such as traumata. Brief mention of historical models and theories: Freud, Eric Erickson and general psychoanalytic, social-learning, Piaget.
f. Methodology for studying development: cross sectional, cohort and individual studies. Identification and evaluation of influences.
g. Bowlby, attachment theory and its relevance to emotional development, affect regulation and human relationships in childhood and later on. Conditions for secure attachment. Types and clinical relevance of insecure attachment. Early separation and its consequences. Consequences of failure to develop selective attachments. Brief consideration of neonatal maternal 'bonding'.
h. Other aspects of family relationships and parenting practices. The influence of parental attitudes compared with parenting practices. Some aspects of distorted family function: e.g. discord, overprotection, rejection, and enmeshment. The impact of bereavement, parental divorce and intra-familial abuse on subsequent development of the child. Role of domestic violence, child abuse, spousal abuse, child defilement, rape and sexual harassment, short and long term psychological effects and on development. Brief mention of relevance or otherwise of non-orthodox family structure including cultural influences on family and stages of family; interplay of modern nuclear family concept and traditional extended family concept; new structures to replace breaking down traditional structures of security.
i. 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.
j. Cognitive development with critical reference to Piaget's model. The relevance of pre-operational and formal operational thought to communication with children and adults.
k. Basic outline of language development in childhood with special reference to environmental influences and communicative competence

l. Development of social competence and relationships with peers: acceptance, group formation, cooperation, friendships, isolation and rejection. The components of popularity.
m. Moral development
n. Development of fears in childhood and adolescence with reference to age. Possible etiological and maintenance mechanisms.

o. Sexual and sexuality development including the development of gender identity and sexual preferences, normality or otherwise of preferences, culture and sexuality.
p. Adolescence as a developmental phase with special reference to pubertal changes, task mastery, conflict with parents and authority, affective stability and 'turmoil'. Normal and abnormal adolescent development.
q. Adaptations in adult life, such as pairing, parenting, illness, bereavement and loss.
r. Pregnancy and childbirth and their stresses both physiological and psychological.
s. The development of personal (ego-) identity in adolescence and adult life. Work, ethnic, gender and other identities. Midlife 'crises'. Adaptations in adult life, especially to illness.
t. Normal ageing and its impact on physical, social, cognitive and emotional aspects if individual functioning. Social changes accompanying old age.

35. Basic Neurosciences

a. Neuro-anatomy

i. The candidate should be able to draw the brain from all views, lateral, sagital, coronal, etc, and label major parts; the general anatomy of the brain and the functions of the lobes, major gyri including the prefrontal cortex, cingulate gyrus and limbic system; sulci, ventrcles. Basic knowledge of the cranial nerves and spinal chord; vascular system, Circle of Willis.
ii. The anatomy of the basal ganglia.
iii. The internal anatomy of the cortex and temporal lobes including hippocampal formation and amygdala.
iv. The *major* white matter pathways, e.g. corpus callosum, fornix, Papez 's circuit and other circuits relevant to integrated behaviour
v. The types of cell found within the nervous system.
vi. The major neurochemical pathways, including the nigrostriatal, meso limbic and meso cortical dopamine pathways, the ascending noradrenergic pathway from the locus coeruleus, the basal forebrain cholinergic pathway, the brain stem cholinergic pathway, the corticofugal glutamate system and serotonin pathways; the Reticular formation, ascending and descending.

b. Neurophysiology

i. The basic concepts in the physiology of neurones, synapses and receptors, including synthesis, release and uptake of transmitters. A basic knowledge of action potential, resting potential, ion fluxes and channels, neurotransmitters, first, second and third messengers, etc.
ii. The physiology and anatomical pathways of the neural and endocrine systems involved in integrated behaviour including perception, pain, memory, motor function, arousal, drives (sexual behaviour, hunger and thirst), motivation and the emotions, including aggression, fear and stress. Knowledge of disturbances of these functions with relevance to organic and non-organic (functional) psychiatry.
iii. The development and localization of cerebral functions throughout the life span from the foetal stages onwards and their relevance to the effects of injury

at different ages to the brain and to mental function, homunculus. The candidate should be able to draw the corresponding parts of the brain to the body. An understanding of neurodevelopmental models of psychiatric disorders and of cerebral plasticity.

iv. An understanding of the neuroendocrine system, in particular the control of the secretion of hypothalamic and pituitary hormones (by releasing factors and by feedback control) and posterior pituitary function. The main hormonal changes in psychiatric disorders. A basic understanding of neuroendocrine rhythms and their disturbance in psychiatric disorders.

v. A basic knowledge of the physiology of arousal and sleep and with particular reference to noradrenergic activity and the locus coeruleus, reticular formation, reticular activating system; brain waves.

vi. The normal and abnormal EEG (including frequency bands) and evoked response techniques, the brain waves. The applications to investigation of cerebral pathology, seizure disorders, sleep and psychiatric disorders. The effects of drugs on the EEG

c. Neurochemistry

i. Transmitter synthesis, storage and release. Ion channels and calcium flux in relation to this.

ii. Knowledge of receptor structure and function in relation to the transmitters. Pre-synaptic and post-synaptic receptors.

iii. Basic pharmacology of noradrenaline, serotonin, dopamine, GABA, acetylcho-line, excitatory amino acids, 1^{st}, 2^{nd} and 3^{rd} messengers.

iv. Elementary knowledge of neuropeptides, particularly corticotrophin releasing hormone and cholecystokinin and the enkephalins/endorphins.

d. Molecular Genetics

i. Basic concepts: chromosomes, cell division, gene structure, transcription and translation, structure of the human genome, patterns of inheritance.

ii. Traditional techniques: family, twin and adoption studies.

iii. Techniques in molecular genetics: restriction enzymes, molecular cloning and gene probes, Southern blotting, restriction fragment length polymorphisms, re-combination.

iv. Distinction between direct gene analysis and gene tracking. Genetic markers, linkage studies, lod scores.

v. Psychiatric conditions associated with chromosome abnormalities.

vi. Principal inherited conditions encountered in psychiatric practice and the genetic contribution to specific psychiatric disorders.

vii. Prenatal identification and Genetic counselling.

viii. Molecular and genetic heterogeneity. Phenotype/genotype correspondence

ix. DNA and mental health

e. Clinical Psycho-Pharmacology

The trainee will demonstrate knowledge of psychopharmacology. This knowledge will include pharmacological action, drugs used in psychiatry, traditional and newer generation, their classification, clinical indications, side effects, drug interactions, toxicity and appropriate prescribing practice.

i. General principle

1. A brief historical overview of the development of psychotropic drugs. Their classification. Optimizing patient compliance. Knowledge of the placebo effect and the importance of controlling for it. The principles of rational prescribing of psychoactive drug.

ii. Pharmacokinetics

1. General principles of absorption, distribution, metabolism and elimination. Particular reference to a comparison of oral, intramuscular and intravenous routes of administration as they affect drug availability, elimination as it affects the life of the drug in the body and access to the brain through the 'blood-brain barrier'. Applications of these to choice of administrative route and timing of doses. The relationship of culture and ethnicity to pharmacokinetics
2. Relationships between plasma drug level and therapeutic response: the possibilities and limitations of this concept with specific examples such as lithium, antidepressants and anticonvulsants.

iii. Pharmaco-dynamics

1. Synaptic receptor complexity, main receptor sub-types, phenomena of receptor up- and down- regulation, mechanism of tardive dyskinesia.
2. The principal CNS pharmacology of the main groups of drugs used in psychiatry with particular attention to their postulated modes of action in achieving therapeutic affect: at both molecular/synaptic and systems levels. These groups would include 'antipsychotic' agents, drugs used in the treatment of affective disorder (both mood altering and stabilizing), anxiolytics, hypnotics and antiepileptic agents. The relationship of culture, race and ethnicity to pharmacodynamics.
3. Neurochemical affects of ECT.

iv. Adverse drug reactions (ARDs)

1. Understanding of dose-related as distinct from 'idiosyncratic' ADRs.
2. The major categories of ADRs associated with the main groups of drugs used in psychiatry and those associated with appropriate corrective action including drug-drug interactions; in particular metabolic disorders, movement disorders, NMS, TD.
3. The importance of assessing risks and benefits for every individual patient in relation to his medication. Risks and benefits of psychotropic drugs in acute, short- and long-term use including effects of withdrawal.
4. The information database for adverse drug reactions
5. Prescribing of controlled drugs.

36. Ethology

a. Definition, relationship of ethology and psychiatry
b. Lorenz and imprinting,
c. John Bowlby and attachment behaviour,
d. Phylogenetic origins of behaviour,
e. Relationship between separation and depression,
f. Hierarchical and territorial behaviour in aggression, ritualisation,
g. Tinbergen and displacement activities,
h. von Frish and information systems especially in bees.

37. Ethics, mental health legislation and human rights

a. Ethics, morality and moral philosophy,
b. Legality and legitimacy;
c. The four principles of ethics: respect for autonomy, beneficence, non-maleficence and justice;
d. Major ethical theories;
e. Human rights versus peoples' rights, MI Principles (United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care), CRPD (United Nations Convention on the Rights of Persons with Disabilities) and other human rights instruments on mental health
f. Mental health and human rights,
g. Mental health legislation,
h. Other relevant legislations.

38. Epidemiology

a. Definition, quantitative methods,
b. Case identification methods, uses of epidemiology,
c. Epidemiological methods, sample size determination,
d. Ethical considerations and approval seeking, confidence interval uses,
e. Prevalence and incidence rates,
f. Case assessment methods,
g. Reliability and validity,
h. Descriptive studies,
i. Prospective and cohort studies,
j. Case control studies, experimental studies,
k. Community population studies
l. Experimental and research design

39. Biostatistics

a. The role of statistics in psychiatry,
b. Descriptive and inferential statistics,
c. Measures of spread and central tendencies,
d. Measures of variability, standard deviation, variance of intervals
e. Confidence interval,

f. Probability, hypothesis testing, student t test, Z test, chi square, their appropriate applications and interpretations
g. Analysis of Variance (ANOVA),
h. Correlation, correlation coefficient, linear correlation,
i. Multivariate analysis, regression analysis, factor and survival analyses,
j. Pearson r test, Spearman r test, Mann-Whitney U test,
k. Types of errors,
l. Research designs

40. Clinical topics
    a. Psychiatry as a branch of medicine, an applied science
    b. History of psychiatry: world history, West African history, Ghana history; prominent and early names in psychiatry at world, West African and local levels
    c. Psychopathology: the language of psychiatry, signs and symptoms of psychiatric disorders, soft neurological signs
    d. Psychiatric assessment, history taking, mental state examination, different instruments, formulation into biopsychosocial, the 4ps (predisposing, precipitating, perpetuating, protective factors), treatment and prevention;
    e. Psychiatric disorders: anxiety disorders, acute organic (delirium), types and causes, chronic organic (dementia), types and causes, functional psychosis, types and causes, schizophrenia, mood disorders, psychotic disorders, other disorders of psychiatric interests, personality disorders, sleep disorders, eating disorders, psychiatric aspects of epilepsy, substance use disorders, childhood disorders
    f. Gender issues in mental health (women and mental health)
    g. Psychosexual and gender identity disorders
    h. Psychiatric services and management
    i. Psychiatry in relation to medicine and neurology
    j. Child and adolescent psychiatry
    k. Learning disability psychiatry
    l. Liaison psychiatry
    m. Forensic psychiatry
    n. Old age psychiatry
    o. Addiction psychiatry
    p. Social and rehabilitation psychiatry
    q. Transcultural psychiatry
    r. Neuropsychiatry
    s. Neurology
    t. Basic Neurosurgery: brief anatomy of the CNS, speech and other centres of brain, neurosurgical examination, Glasgow Coma Scale, causes and features of raised intracranial pressure, investigations in neurosurgery, CNS abnormalities, hydrocephalus and management, shunting, head and spinal injuries, neurosurgical

infections, brain tumours especially frontal lobe tumours, neurosurgical procedures, head injury, post concussional and contusion syndromes

u. Psychotherapy
v. Psychoanalysis
w. Clinical information management
x. Mental health information management system
y. Leading and managing service development and delivery
z. Community and outreach services

41. Specific Clinical Topics as Didactic Lectures

Two hours per lecture and candidates must attend at least 80 percent of them. Failure to attend 80% or more without justification may lead to the candidate not being signed up for summative examinations at the end of the third year. Some skills, competencies and attitudes are embedded in the topics where relevant to mention

No.	Date	Topic	Consultant/tutor
		Introduction to Psychiatry I: Introduction to philosophy, philosophical basis of psychiatry, interrelationship between psychiatry and philosophy and the historical development of the relationship; What is philosophy, logic and types of logic, inferences and deductions, syllogism, logical fallacies (eg. ad hominim, etc,); subjectivity vrs objectivity, subjective influences in thinking, hair splitting; Thinking and types of thinking (straight, logical, rational, dereistic, etc), The value of observation, description, pattern identification, language and accurate description, Ludwig Wittgenstein and linguistic philosophy, Noam Chomsky and language development, relationship between language and cognitive development; Asking questions, reasonable and right questions, solution yielding questions; Mind-brain duality, from philosophers to psychiatrists; Scientific basis of psychiatry, relationship and scientific basis; Definition of science, traditional and modern, attributes of science, scientific thinking, methods of science, uses and abuses of science.	
1		Introduction to Psychiatry II. Overview, concept of mental health, mental ill-health, mental illness; relative nature of mental health, criteria for threshold for mental illness; illness versus disorder and disease; illness versus sickness; disease versus syndrome; historical development of psychiatry as branch of medicine, world history, West African and Ghana history; Freud and post Freudians.	
2		Aetiology and Models of mental disorders. Aetiology including Genetics, Biochemical –Biogenic amine theories, behavioural, psychosocial factors, life events; Models: Biopsychosocial model versus medical model, behavioural model, supernatural; predisposing, precipitating, perpetuating and protective factors	

3		Classification in Psychiatry including DSM and ICD. Types of psychiatric disorders (nosological classification as clinical, minor, major, other disorders and specific nosological entities), phasing out of term 'neurosis'	
4		Psychopathology (psychiatric symptomatology) as language of psychiatry. Includes soft neurological signs; Brief mention of areas of psychiatry – phenomenology, psychodynamics and experimental/research psychiatry – relating psychopathology to phenomenology (descriptive psychopathology) and psychodynamics (understanding of mental processes) to management	
5		Assessment of the patient. History taking, Mental State and Physical Examination in psychiatry and formulation: Emphasize on areas of similarity and differences between history in physical medicine and psychiatric clerking; role of informants and corroborators; recording of history; rapport establishment and attitude towards patient; time management in clerking through controlling the interview – distinguish between interview and conversation; recognize relevant questions, assessing the reliability of history; role and sequence of chronological development and duration of symptoms; develop probing skills; understanding reasons for resistance in patient/informants in giving accurate history	
6		Diagnostic Instruments in psychiatry: PSE, miniMSE, Computer assisted diagnosis – CATEGO, Global Mental Health Assessment Tool (GMHAT), SCAN; Psychological Instruments: IQ, BDI, Depression-Anxiety Stress Scale, Depression Scale for Children, Stanford-Binet Intelligence Scale, Wechsler Adult Intelligence Scale (WAIS), Wechsler Intelligence Scale for Children (WISC); Personality tests: Thematic Apperception Test (TAT), Rorschach Inkblot Test, Minnesota Multiphasic Personality Inventory (MMPI), 16PF, Myers Briggs Inventory, Draw-a-person test.	
7		Organic Mental Syndromes and Disorders. Acute and chronic, lay concept of 'high fever', symptoms of organicity, different syndromes – delirium, dementia, dysmnesic syndrome, systemic medical conditions with secondary mental effects, Glasgow Coma Scale in impaired consciousness, management including investigations, appropriate medication and dosage in organic conditions, emphasize HIV in both acute and chronic conditions, post concussional and contusion syndromes	
8		Major mental disorders – The schizophrenias. 'Split mind' and historical development, concepts from Kraepelin through Schneider, dementia precox, Bleuler's four A's, current understanding of schizophrenia, schizophrenia across life spectrum, epidemiology.	
9		Major mental disorders – Delusional and other psychotic disorders. Mention must be made of Othello, de Clerambaut, Ekbohm disorders, delusional hypochondriasis; distinguish from schizophrenia	
10		Psychoactive Substance use Disorders. National and international dimension; risk and protective factors (gender, age, education, social status, parenting, religion, peer); types of substance of dependence (should include nicotine and caffeine); neurobiology of addiction, specific neurotransmitters and specific substances of abuse, pathways to addiction, gateway theory; phases of substance use; clinical presentations and	

		spectrum of substance use; intoxication, withdrawal, different management plans (hospitalization versus outpatient care), management, chemotherapy, agonist and antagonists of specific substances, therapeutic community, rehabilitation in substance use disorder management; demand reduction strategies, early detection and prevention strategies; morality versus criminality versus disease nature of addiction, relapsing nature of the disease of addiction; consequences of addiction – social, economic, developmental, medical, psychiatric, drug trafficking and security concerns; Screening inventories including DAST and ASSIST,	
11		Disorders Associated with Alcoholism. Cause, pathophysiology, extent of alcohol use, national per capita consumption, neuropsychiatric syndromes associated with alcohol use; spectrum of alcohol use; concept of 'standard drink', 'unit of drink', 'sensible drink', screening questionnaire (CAGE, ASSIST, AUDIT, MAST, CAST, TWEAK), laboratory markers of alcohol (GGT, AST,ALT, Uric Acid, HDL cholesterol, CDT, 5HTOL, 5HIAA, Acetaldehyde protein adducts, Blood Alcohol, Urine Alcohol, etc); cycle of readiness to change (pre-contemplation, contemplation, decision, action, maintenance, relapse), role of resveratrol in red wine and other antioxidants in alcohol and their role in coronary heart diseases, future possible role in Alzheimer's and other conditions.	
12		Mood (affective) Disorders. Define mood and affect, distinguish between the two; terms associated with these, concept of periodicity, bipolarity and unipolarity; types of mood disorders; gender specific mood disorders; vegetative triad; major depressive disorder, resistant depression, hypomanic and manic spectrum, mixed mood states, post schizophrenic depression, differential diagnosis of mood disorders including medical differentials eg, thyroid dysfunction for mania and depression; cultural coloration of mood disorder presentation and recognition; writing a comprehensive management plan for mood disorder including length of time of treatment; relevant investigations; suicide in depression and assessment of this risk; iatrogenic bipolarity; witchcraft and depression; depression with pseudodementia, role of ECT, chemotherapy and side effects, role of clinical psychologist, occupational therapist and other therapists, eg. Play and drama.	
13		Minor mental disorders – Stress related disorders, Anxiety Disorders. Define anxiety, distinguish between anxiety and fear response, symptoms of anxiety, different anxiety conditions: GAD, panic disorder, phobias, PTSD, OCD); pathophysiology of the different anxiety disorders; culture bound anxiety disorders, age and anxiety; medical conditions presenting as anxiety disorders including thyroid disorders, porphyria, phaeochromocytoma, cardiac arrhythmias; management of anxiety disorders including relaxation and teaching of relaxation techniques, role of benzodiazepines and caution against addiction to them; adjustment disorders: definition, history, clinical features, aetiology, differentials, course and prognosis, treatment	
14		Somatoform Disorders. Clinical features, conversion disorder, pain disorder, body dysmorphic disorder, hypochondriasis; comorbidity with other psychiatric disorders and general medical conditions; features of factitious disorder and malingering compared with somatoform disorders;	

		management,	
15		Dissociative Disorders. Definition, mechanism of dissociation, types of dissociative disorders, fugue state, MPD, possession and trance disorders, distinguish from normal possession and trance states (as in cultural and religious set up)	
16		Sexual and Gender Identity Disorders. Normal psychosexual development of males and females, deviations in normality, channeling of libido, stages of hetero, homosexuality and bisexuality, current concepts of homosexuality and its development, hypo or hyper libido, performance dysfunctions (erectile, ejaculatory, vaginismus, dyspareunia), orgasmic dysfunctions; sexual preference disorders – paedophilia, necrophilia, zoophilia, fetishism, voyeurism, frotteurism, exhibitionism, ego-dystonic homosexuality, sado-masochism; gender identity disorders – transvestism, transsexuality; discuss homosexuality – official (psychiatric) position as normal variation of sexual orientation and historical development of this position, egodystonicity, legal, cultural and moral aspects and human rights perspective; effects of psychotropics on sexual performance and management of this complication; concept of sex addiction and nymphomania. Role and success of CBT in sex and gender identity disorders management	
17		Sleep Disorders. Sleep physiology and anatomy, types and stages of sleep, role of sleep and sleep deprivation in mental health, types of sleep disorders and EEG, psychopathology associated with sleep disorder, primary and secondary sleep disorders, causes and management	
18		Impulse Control Disorders. Impulse: definition, kleptomania, pathological gambling, trichotillomania, pyromania, intermittent explosive disorder, repetitive self-mutilation; aetiology, epidemiology, clinical features, management	
19		Psychosomatic Disorders. Definition, history of psychosomatic theories, developmental psychobiology, current advances, neurophysiology of anxiety, psychoneuroimmuniology, psychocardiology, psychoneuroendocrinology; GI disorders, PU disorders, inflammatory bowel syndrome, obesity, cardiovascular disorders, respiratory disorders, hyperventilation syndrome, asthma, stress and psychiatry.	
20		Personality Disorders. Definition and concept of personality; normal personality traits; define personality disorder and distinguish from personality traits; classification of personality disorders in ICD and DSM; features and diagnostic criteria of the different types of PD; comorbidities and differentials of the different types of PD and distinguishing features of the differentials; theories of aetiology, pathophysiology and psychodynamics; approaches to management, management plan best suited for each type of PD; PD and crime	
21		Suicide, deliberate self-harm (DSH) and assessment of suicide risk. Definition of suicide; acts (and methods) of suicide, epidemiology, types of suicidal behavior, Emile Durkheim, anomie and suicide, causes of suicide, suicide in children and adolescents, recognizing suicide intentions and plans, suicide and the Ghana's criminal code, critique of the code; assessment of risk of suicide; management of suicidal patient; suicide prevention.	

		Deliberate Self Harm (DSH): definition of DSH, acts and methods of DSH, epidemiology, causes, motivation and outcome, assessment of risk and severity, management and prevention; types of DSH including major self mutilation (MSM) and causes of MSM	
22		Violence and other Psychiatric Emergencies. Define and distinguish restlessness, agitation, aggression, violence; define psychiatric emergency as a psychiatric condition requiring prompt and immediate attention; presentation of emergency in suicide, panic, obsessive phobia in OCD, anxiety in schizophrenia, organic brain syndromes, acute exacerbation of schizophrenia, exacerbations in personality disorders, intoxication, delirium tremens, delirium generally, NMS, violence and aggression; immediate interventions, investigations, appropriate medication, role of physical restraint, self-protective techniques, recognition of need for help or referral, how to timely and appropriately call for assistance, how to distract patient's attention while waiting for help; avoid being heroic by personally attempting to disarm or single handedly restrain patient	
23		Child and Adolescent Disorders. Meaning of terms and concepts of child, adolescence, cut off age, seeing the child as barometer of family harmony (evaluation of changes in family and their impact on the child), essentials of developmental psychology, mother-child relationship, bonding and attachment theory, role of child in the family, different manifestations of mental disorders across age, categories of childhood psychiatric disorders and differentials, child abuse, neglect and harm, psychopharmacology in child and adolescence	
24		Mental Retardation and other developmental disorders including autistic spectrum disorders. Definition, epidemiology, clinical features, causes, physical and psychiatric disorders in mental retardation, social and family effects, management of psychiatric and behavior disorder associated; syndromes associated with epilepsy; Autism, Asperger's, Retts	
25		Geriatric Psychiatry (psychiatry of old age). Biology of ageing and social changes associated with ageing; distinguish features of normal ageing from pathological processes in ageing; Alzheimer and other dementias in old age, delusional disorders, secondary effects of loss of function of other organs with ageing resulting in psychological disorders, eg. Sexuality and depression, hence need to explore, depression with pseudodementia, old age and substance use disorder especially alcohol, management remembering that monotherapy and low doses initially is the rule, role of ECT in well chosen cases of old age psychiatry, influence of medical comorbidities	
26		Death, dying and bereavement. Death and dying: thanatology, definitions of death, determination of death, stages of death and dying, mourning practices, near-death experience, caring for the dying, breaking bad news to the dying, fears, goals of treatment, assisted suicide. Bereavement and grief: breaking bad news to the bereaved, normal bereavement reactions, mourning, phenomenology of grief, complicated bereavement, biological perspectives, caring for the bereaved	
27		Psychotherapies. Definition, various psychotherapies, psychodynamic, psychoanalysis, supportive, cognitive and behavior therapies, insight oriented, couples and family therapies, group and individual therapy,	

		psychoeducational interventions, special emphasis on CBT and transactional analysis; combination of psychotherapy with pharmacotherapy, concept of therapeutic alliance, transference, counter-transference, resistance, supportive psychotherapy, therapeutic factors in groups; formulation of management plans including psychotherapeutic intervention, selection of appropriate psychotherapeutic method. Social therapies: social class and psychiatric conditions, relationship between social disintegration and mental illness, concept of therapeutic community, contrasts social therapies and biological psychiatry; role and responsibility of patients in social therapy compared with other methods of therapy, groups most suited for social therapies, how therapeutic community is led, alternatives to therapeutic communities – self groups, telephone, or web-based support services. Occupational therapies, mechanism and principle Art, play, drama, film therapy	
28		Pharmacotherapies and their side effects. Classification of psychotropics - anxiolytics, hypnotics, antipsychotics, traditional and newer generations; pharmacokinetics, mechanism of action, indications and contraindications, dosage, choice of one over the other, unwanted side effects including akathisia, NMS, metabolic disturbances; antiparkinsonian drugs; antidepressants, tricyclic and tetracyclic antidepressants, effect on heart, MAOI, amine precursors, SSRI's, mood stabilizers, antiepileptics, dosage, pharmacokinetics, side effects, basal ganglia and Parkinson's syndrome, limbic and meso-limbic system, nigrostriatal pathway, D1-D5 serotonin receptors, neurotransmitters; management of side effects of pharmacotherapy; cost of medications and affordability.	
29		Tardive Dyskinesia (TD), other movement disorders and their assessment. Use of AIMS (Assessment Instrument for Movement Disorders); mechanism of TD, down dysregulation of synaptic receptors, routine use of anticholinergics and development of TD; gender distribution; treatment; caution in use of antipsychotics and anticholinergics.	
30		Electroconvulsive Therapy. Define ECT; history and development; risk-benefit analysis, informed consent, steps in administration, precautions to take, indications, relative contraindications, straight and modified ECT; use of anaesthesia; complications of ECT; mechanisms of action, patient selection, pre-ECT evaluation, methods of administration, evaluation of therapeutic outcome, management of patients on ECT including medication, controversies and critique of ECT	
31		Legal and Forensic Issues. Definition of Forensic Psychiatry, Interphase between Law, Ethics and Psychiatry; areas of mutual interest between psychiatry and law - Laws relating to ordinary practice (confidentiality, informed consent, human rights issues - autonomy, privacy, dignity, etc, compulsory admission and treatment; Civil laws relating to fitness for some activities - fitness to drive, vote, etc; fitness to care and dispose of properties; testamentary capacity; mentally abnormal offenders; law in relationship to ordinary practice; compulsory admission and treatment; civil laws relating to capacity; mentally ill offenders; psychiatric conditions related to crime; judging criminal responsibility; McNaughton	

		Rule; diminished responsibility; automatism; fitness to plead; mens rea, actus reus; report writing; psychiatrist as witness in court, preparing for the court, addressing the judge in court; Ghana's mental health legislation, historical development, The Criminal Code (Act 29 of 1960, Sections 52 and 57) and criminalization of mental illness – suicide and post partum depression with infanticide.	
32		Neuro-imaging. Principles, structural imaging – CT Scan, MRI; functional imaging – Magnetic Resonance Spectroscopy, PET and SPECT; indications, availability, costs and affordability.	
33		Acquired Immuno Deficiency Syndrome and mental disorders. Psychiatric syndromes in HIV/AIDS, neurobiological syndromes, Psychobiological syndromes, Psychosocial syndromes; Mechanism of syndromes; Psychosocial complications of the chemotherapy including immuno-resuscitated syndrome (IRS); Psychosocial reaction to the fact of treatment per se	
34		Consultation - Liaison Psychiatry. Defines concept, distinguish between consultation (one time task) and liaison (co-management) psychiatry; role of psychiatrist in the general hospital and role of physicians in psychiatric hospitals; psychiatrist's role in issues of dying, death and breaking bad news	
35		Epilepsies: Psychiatric Aspects. Define epilepsy, types; ILAE classification; causes, differentials; EEG findings in epilepsy; psychiatric syndromes in epilepsy; psychiatric complications and effects of epilepsy; significance and content of aura in epilepsies. Management of epilepsy including pharmacotherapy and complications or side effects; psychiatric disorders requiring differentiation from some epilepsies, eg. Complex partial seizures and psychiatric syndromes; epilepsy and IQ; epilepsy and driving	
36		Transcultural Psychiatry. Synonyms of transcultural psychiatry (TCP); psychiatrists and religion – elsewhere versus Ghana; definition of TCP; culture and mental health; definition of culture; justification for and significance of TCP; history of TCP; interrelationship between culture, religion and psychiatry; composition of man – body, mind and soul/spirit; influences of culture over psychopathology and vice-versa (culture as pathogenic or pathoplastic); particular areas of mutual interest – delusions, hallucinations, somatisation disorders, dissociative disorders, culture-bound syndromes; witchcraft belief, spiritual attacks and mental illness; witches camps in Ghana, traditional practices in mental health; types of traditional mental health practitioners; WHO on traditional medicine; mechanism of efficacy of traditional healing; dangers of traditional healing; culture and stigma	
37		Brain Tumours and brain herniations. General psychiatric manifestations and seizures as early signs, frontal lobe meningiomas and gliomas and depression, behavioural disinhibitions and apathy; mixed neuronal and glial tumors, ganglioglioma and dysembryoplastic neuroepithelial tumors (DNET); right sided occipital tumors and visual hallucinations; temporal lobe tumors and irritability, language disturbances, memory lapses; primary brain tumors and metastatic tumors; commonest brain tumor as glioma; intra- and extra– axial tumors causing pressure effects and brain	

		oedema; investigations with CT Scan and MRI, cerebral cysticercosis. Brain herniations: transtentorial herniation, tonsillar and peritonsillar herniation, Subfalcine herniation, Central herniation; causes and consequences.	
38		Dementias and amnesic syndromes. Dementias: definition, clinical features, aetiology, types, management; Alzheimer's, epidemiology, other dementias. Amnesic syndrome. Definition, causes, Wernicke-Korsakov, clinical features, aetiology and pathology, investigations, course and prognosis. Other focal brain lesions: frontal lobe syndrome, temporal lobe, occipital, corpus callosum, brainstem, white matter lesions; the role of thiamine.	
39		Ethics, mental health legislation and human rights. Ethics, morality and moral philosophy; legality and legitimacy (legal justice versus natural justice); the four principles of ethics: respect for autonomy, beneficence, non-maleficence and justice; major ethical theories; human rights versus peoples' rights, MI Principles (United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care), CRPD (United Nations Convention on the Rights of Persons with Disabilities) and other human rights instruments; mental health and human rights; knowledge of mental health legislation in Ghana and its history; other relevant legislations.	
40		Contemporary issues in psychiatry in Ghana. Addressing human resource; funding, stigma and mental health, cultural beliefs and mental health, health-seeking behavior and mental illness, lack of access in mental health, human rights abuse and mental health, mental health advocacy, low prioritization in mental health, institutionalization and challenge of community care, social vices and mental health, substance abuse and rehabilitation centers.	

F. Skills and Competencies

42. **Core Competencies:** the candidate must possess these core competencies by the end of the training:
    a. Patient care
    b. Medical knowledge
    c. Interpersonal and communication skills
    d. Practice based learning and improvement
    e. Professionalism
    f. System-based practice

43. **Specific competencies:** the following list of skills and competencies are required for residents and by the time of completion of the programme they should have been acquired:

a. Ability to assess a patient and produce safe, relevant, available, affordable and cost-effective management plan
b. Ability to assess risk of suicide,
c. Ability to assess risk of dangerousness to self, others or property
d. Familiarity with and appropriate use of current legislation (now mental health decree NRCD 30, 1972) and familiarity with draft mental health bill
e. Familiarity with collateral legislation and relevance to psychiatric practice such as Coroner's Act, Act 18, 1960; Criminal Code, Act 30 (s133), 1960, Act 29, 1960, Ghana Health Service and Teaching Hospitals Act, Act 525, 1996; Traditional Medical Practice Act 2000; etc
f. Familiarity with CRPD and other human rights instruments in mental health, eg. MI Principles
g. Management of severe depressive disorder
h. Management of first episode psychosis
i. Management of schizophrenia
j. Management of alcohol withdrawal, delirium and dependence
k. Management of substance abuse, delirium and dependence
l. Management of bipolar affective disorder
m. Management of the disturbed patient
n. Assessment and management of dementia
o. Familiarity with and appropriate use of modern classificatory system
p. Management of generalised and other anxiety disorders
q. Management of obsessive-compulsive disorders
r. Management of posttraumatic disorders
s. Management of panic disorders with and without agoraphobia
t. Assessment and appropriate referral of cases for specialist clinical psychology services
u. Assessment and appropriate referral to specialist forensic services
v. Assessment and appropriate referral for specialist child and adolescent services
w. Assessment and appropriate referral for specialist learning disability services
x. Ability to do short term brief psychotherapy services under supervision and without supervision
y. See a long term patient for supervised form of psychotherapy
z. Safe and effective administration of ECT
aa. Familiarity with modern day business management techniques
bb. Familiarity with health services management
cc. Safely practice breakaway techniques and approved security and self-defence skills
dd. Device protocol for clinical audit and also for academic research
ee. Ability to interview patients for, and write satisfactory legal and official reports
ff. Satisfactorily perform cardiopulmonary resuscitation

gg. Familiarity with IT systems to the benefit of patient care and research skills
hh. Ability to liaise effectively, courteously and appropriately with professional colleagues involved in the multi-disciplinary care of patients
ii. Ability to introspect about and gain insight into doctor-patient relationship
jj. Ability to recognise, understand, appreciate and detach oneself from patient defence mechanism including identification, transference, counter-transference and denial issues
kk. Ability to recognise one's own defence mechanism and detach from patient objective care, eg. transference, counter-transference and denial issues
ll. Ability to communicate effectively with colleagues, groups, patients, their relatives and carers
mm. Ability to teach effectively
nn. Ability to lead a team
oo. Ability to supervise junior colleagues
pp. Ability to interview through an interpreter and appreciate the barriers in communication
qq. Ability to appreciate and adapt to cross-cultural issues relating to patient

G. ATTITUDES

In the course of the training and by the end of the programme the candidate must have acquired the right attitude expected of a trained professional of that calibre. These attitudes include:

Respects clients, colleagues, subordinates
Neutrality in relating to patient, empathy not sympathy
Strict adherences to ethical code of practice of medicine in general and of psychiatry in particular
Identifies personal biases and prevent their interference with therapeutic alliance and service provision (e.g. transference and counter transference)
Recognise patient's defence mechanisms that will lead to resistance to treatment including denial, transference, rationalisation, and know how to handle them.
Demonstrates tolerance of patient's needs and failure of compliance and resistance
Respects uniqueness/individuality of others with non judgmental attitude; develop the four ethical principles of respect for patients' autonomy, beneficence, non-maleficence and justice
Maintains a positive attitude towards human rights in general and those of the mentally ill in particular, i.e. sees patients as subjects with human rights which should be ensured, protected and fulfilled, and not as objects for sympathy e.g. Patient's right to know about illness, side effects of medication and the right to choose.
Demonstrates a confident stance, stands to challenges, argues logically
Maintains a positive attitude towards continuous education, self directed learning; sees every patient and situation as new opportunity for learning experience.
Knows and is tolerant of his/her realistic limitations both scientific and personal

H. Fellowship Training

44. Objectives

a. To consolidate the knowledge, skills and competencies acquired in the membership training and post membership experience.

b. To produce an experienced Consultant eligible Psychiatrist with leadership, management and research skills in general psychiatry or subspecialty psychiatry

45. Entry Qualifications and selection criteria:

a. Membership of GCPS or a recognised equivalent qualification.

b. Post membership work experience in Ghana for a minimum period of one year, at least six months of which shall be in clinical practice in a psychiatric hospital or general hospital psychiatric unit outside Accra, Kumasi and Cape Coast (Ankaful Psychiatric Hospital)

c. Registration with the Medical and Dental Council of Ghana as a specialist psychiatrist

d. Candidates shall pass a selection interview which shall be conducted in June. Successful candidates shall commence the training in January of the following year.

46. Areas of Subspecialisation:

a. General Psychiatry

b. Child and Adolescent Psychiatry

c. Neuropsychiatry

d. Forensic Psychiatry

e. Consultation-Liaison Psychiatry

f. Addiction Psychiatry

g. Community and Rehabilitation Psychiatry

h. Transcultural Psychiatry

i. Old Age Psychiatry (Psychogeriatrics)

j. Learning Disability Psychiatry

Currently only the General Psychiatry subspecialisation is available. Others will be offered as and when available.

47. Duration of Training: Two years beginning from January to December of the following year.

48. The Training

a. First Year:

i. This will be in a teaching psychiatric hospital in Ghana (Accra, Pantang or Ankaful Psychiatric Hospital).

ii. The candidate will work in a supervised role and consolidate the General Psychiatry experience

iii. Alongside the consolidation of the general psychiatry knowledge and experience, the candidate shall participate in outpatient and inpatient clinical services in the subspecialty area of his or her choice

iv. Attend health administration course at GIMPA (Ghana Institute of Management and Public Administration), Greenhill, Accra.

v. Attend a research methodology and biostatistics course.

vi. Participate in teaching clinical psychiatry to undergraduate and postgraduate medical students

vii. An original research study in a chosen subspecialty of psychiatry or in general adult psychiatry. The chosen research topic and proposal will be approved by the Faculty Board of Psychiatry who will also appoint a research supervisor for the candidate. Within three months of starting the Fellowship the candidate shall submit a topic and proposal for consideration and approval by the Faculty

b. Second Year;

i. General Psychiatry

1. The whole year may be spent in a psychiatric hospital or general hospital psychiatric unit in Ghana or three to six months may be spent in a department of psychiatry in a teaching hospital in a country outside Ghana.

ii. Psychiatric subspecialty: the second year should be spent in a teaching hospital with facilities and human resource for training doctors in the relevant subspecialty in or outside Ghana.

iii. Log-Book: Candidates for the Fellowship shall complete a log-book of training activities throughout the period of training. The completed log-book shall be inspected and duly signed by his or her supervisors as evidence of completed training at least three months before the date of examination.

49. Method of Instruction
    a. There will be no formal didactic tuition.
    b. Instructions will be through journal club, case presentations, ward rounds, candidate-led seminars and topic discussions, participation in research, teaching assignments and other workplace based programmes candidates are to join
50. Research and publication
    a. While it is not mandated to publish within the training period, candidates are encouraged to research and publish at least one paper in a peer review journal before the end of the training. Candidates may be required to participate in supervisor's research programmes
51. Examination

    a. After a minimum of two years training the candidate may present himself or herself for examination.

    b. The examination shall consist of two parts of one hour each:

        i. Viva Voce in the First Hour:

            1. General Psychiatry: 30 minutes

            2. Psychiatric subspecialty of choice as appropriate: 30 minutes

        ii. Thesis defence in the Second Hour

            1. Defence of original research study (thesis). This will have been submitted to the Faculty Chief Examiner at least three months before the date of examination

            2. Two assessors will read the thesis and be part of the panel of examiners.

            3. Four possible outcomes from the thesis defence:

a) Acceptable without modification or requiring only administrative corrections, that is, the corrections can be done at the secretariat

b) Acceptable with minor modifications under a named supervisor and the candidate does not have to present himself for a thesis defence again

c) Referral for substantial modification or rewriting under a named supervisor and the candidate will have to present himself or herself for defence in six months, or the thesis itself was good but the defence was poor and he or she has to come back to defend in six months.

d) Outright rejection: Study was poorly conducted, did not conform to approved design or thesis was poorly written

52. Examiners

a. The examining panel shall consist of three (3) Fellows of the Faculty (including one Fellow who is a subspecialist in the candidate's chosen field of subspecialisation as appropriate).

b. The examiners will have read the thesis in advance as assessors.

53. Examination Outcome:

a. The Faculty court of examiners shall forward the examination results and the examiners' report with their recommendation to the Executive Board of the College for ratification by the College Court of Examiners.

b. The outcome shall be one of the following four:

i. Outright Pass: the candidate passes in the viva voce and the thesis defence without requiring modification in the thesis

ii. Provisional Pass: the candidate passes the viva voce and has minor corrections to do in the thesis. He or she does not have to present himself or herself in the next six months, the correction of the thesis will be under a named supervisor and will be accepted.

iii. Referral in the viva voce: the candidate passes in the thesis or has only minor corrections to do, but he or she fails in the viva voce and will have to present himself or herself in the next six months for the viva voce alone.

iv. Outright referral: the candidate fails in the viva voce and fails in the thesis, i.e. thesis is rejected.

54. Certification:

a. The Successful candidate, upon payment of requisite fees and due admittance to Congregation, shall be presented with the diploma of Fellowship and be entitled to the use of the letters FGCP after his or her name with all the privileges and responsibilities that go with that designation.