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**ANNUAL REPORT****2002**

This report outlines the annual activities of the UEMS Section for Psychiatry and the European Board of Psychiatry. The report includes: Section and Board meetings held; new members/countries joining and members departing during the year; working groups' activities and reports finalised; new initiatives and collaboration with other organisations.

**1. Section and Board meetings**

This year's 22<sup>nd</sup> Spring Section and Board meeting held in **Thessaloniki, Greece**, (26-28 April 2002) was very well organised by Prof Andreas Parashos and Prof Andreas Rabavilas of the Hellenic Psychiatric Association. The 23<sup>rd</sup> Autumn meeting, held in **Palma de Mallorca** (4-6 October 2002), was very successfully organised by Prof Manuel Gómez-Beneyto of the Spanish Association of Neuropsychiatry and Dr Miquel Roca Benasar of the Spanish Society of Psychiatry.

**2. Members**

During 2002 the following new members joined the Psychiatric Section and Board of UEMS:

<b>Name</b>	<b>Representing</b>	<b>Replacing</b>
Prof Nils Lindfors	Swedish Psychiatric Association	Prof Hans Ågren
Prof Michal Hrdlicka	Czech Psychiatric Association	Prof J Raboch
Prof Jacek Bomba	Polish Psychiatric Association	Prof Andrzej Piotrowski (passed away on 18 <sup>th</sup> November 2001)
Prof László Tringer	Hungarian Psychiatric Association	Prof Janos Furedi
Dr Torben Lindskov Hansen	Danish Psychiatric Association	Dr Helle Aggernæs
Dr Eva Pálová	Slovak Psychiatric Association	Dr A Rakus
Dr Françoise Mathys	Society of Flemish Neurologists and Psychiatrists	Prof Paul Lievens
Dr Brendan Cassidy	Permanent Working Group	Dr Andrew Carney

**3. Reports from the Working Groups****a) Psychotherapy**

Dr Lindhardt (Denmark) presented the results of the psychotherapy survey undertaken by her working group. Replies were received from 18 countries: Austria, Belgium, Croatia, Cyprus, Denmark, Finland, France, Germany, Greece, Ireland, Malta, The Netherlands, Norway, Poland, Portugal, Slovenia, Spain, Sweden, and the United Kingdom.

The results were as follows:

1. Psychotherapy was an integrated part of training in 14 countries
2. Germany, Sweden, Norway, Austria, Hungary, Ireland, Denmark, Slovenia and UK had a national curriculum for psychotherapy training for psychiatrists
3. Therapeutic experience with a specific number of hours was compulsory in three countries and it was highly recommended in five countries
4. Psychotherapy was a structured part of clinical training in psychiatric hospitals in seven countries
5. Psychotherapy training took place in specific training centres in eight countries
6. Teachers' qualifications were required in seven countries and not required in three

7. Psychotherapy was authorised as an independent profession, in various ways, in seven countries whereas eight countries did not have any formal authorisation
8. Ten countries formulated national plans for psychotherapy
9. Thirteen countries required trainees to obtain a basic health professional status before entering psychotherapy training, whereas in five countries anyone could train as a psychotherapist regardless of their professional background
10. In ten countries, psychiatrists were automatically recognised as psychotherapists, regardless of training received
11. In a further ten countries, psychotherapy training did not involve any mandatory experience with psychopathology
12. In seven countries, psychotherapy training could be paid for from social security funds
13. The following professions would have their psychotherapy training covered by public funds:
  - (a) Psychiatrists in 12 countries
  - (b) General practitioners in 7 countries
  - (c) Other professions authorised as psychotherapists in 7 countries
  - (d) Any profession in 2 countries
14. Funding for psychotherapy was limited by diagnosis, length of training and the basic profession of a trainee
15. Funding was adequate to the needs of psychotherapy only in five countries
16. Practising psychotherapists were required to register in seven countries

#### **b) Profile of a Psychiatrist**

Since Dr Charles Smith (Ireland) has left the Section and Board, Dr Roelof ten Doesschate (The Netherlands) was nominated to chair this working group. This working group formed a number of sub-groups to work on different aspects of the profile which will constitute the full profile of a psychiatrist. The group will continue to report at future meetings.

Dr ten Doesschate reported that the group had been working on a document for some time with an extensive help from Dr James Strachan (UK) who put the report into good English. The working group will continue its work until the report is ready for wider circulation.

Stemming from the October 2002 Palma meeting, discussion on transcultural issues it was agreed to introduce the issue of cultural diversity into the profile.

#### **c) Mental Health Services Profile**

Dr Joseph Saliba (Malta) reported that he received replies from Belgium, Czech Republic, Malta, Norway, Finland, Slovenia, and UK, but there was as yet insufficient information provided to start analysing the questionnaire. The difficulty lay in the complexity of the questionnaire, which included regional information on both public health information and statistics, and clinical aspects of mental health provision. Although the fully completed questionnaire would be a very useful source of information, some delegates pointed out that it was often impossible to obtain reliable data at regional level.

It was reported that the WHO had recently published a similar report by Dr Korkeila, Secretary of the Finnish Psychiatric Association, looking at health indicators rather than service provision. However, the information collected was not as specific or accurate as that intended in the present survey.

It was acknowledged that, due to the complexity of the field, great national diversity and unique historical background in each country it would be impossible to produce a uniform set of recommendations that could be taken up by all the countries. Nevertheless, a reliable description of services provided in each country would make a very useful comparative study that could help some countries in improving their services. It was also suggested that some questions should be simplified and the overall number of questions reduced to ten-twelve, concentrating more perhaps on ascertaining the type of services available in each country, not necessarily in quantitative terms. The simplified questionnaire could then be put to the whole group to assess the feasibility of obtaining the data.

The results of this survey could provide the Section and Board with enough leverage to approach the WHO with official UEMS recommendations for national governments based on professional expertise. This course of action was agreed.

Stemming from the discussion on transcultural and gender issues during the October 2002 meeting in Palma it was agreed to address these in the questionnaire.

#### **d) Supervision**

At the April 2002, Thessaloniki meeting, Prof Cornelius Katona (UK) reported on the January 2002 draft of the Supervision in Psychiatry paper which included comments received from the working group members. Following further work done at the meeting, the working group had finalised the document which Prof Katona circulated to all delegates for distribution within their national associations and comments by the deadline at the end of July 2002 and preparation of the final report for discussion and approval at the autumn 2002 meeting in Palma. At the latter meeting, the final version was approved for distribution to all delegates and circulation within their associations.

#### **e) Visitation of Training Schemes**

At the April 2002 Thessaloniki meeting, Prof Joost Schudel (The Netherlands) reported on the working group's progress with the second draft of the training scheme visitation questionnaire, to be used by national associations to assess their own training schemes. The revised version was distributed to the working group members with a view to putting it to a practical test. Comments were sent to Prof Schudel who prepared the final version for the autumn 2002 meeting in Palma.

At the latter meeting, Prof Schudel informed delegates that his working group had finalised its work on the training scheme assessment questionnaire. The final version of the questionnaire, which had been circulated to all delegates and comments implemented, was approved and will be reviewed in two years time. It was circulated to all delegates as well as directly to the Presidents of national associations.

Arrangements were also made for Prof Schudel to attend an assessment visit in the UK and for Dr Strachan to attend one in The Netherlands where they would both use the questionnaire for assessment and report on this exercise at the Spring 2003 Limassol meeting.

Prof Schudel reminded delegates of the decision not to conduct routine assessment visits to individual training centres but to encourage national associations to organise their own training scheme assessment programmes using this questionnaire. Only in exceptional circumstances and on an express request would the Board organise an assessment visit to a training centre.

### **4. CME and Task Force on CME**

At the April 2002 Thessaloniki meeting, Dr Lindhardt and Prof Gómez-Beneyto reported on a meeting they attended in November 2001 called by the UEMS Secretariat to discuss the development of CME in different countries, the issue of medical specialities in Europe and the role of EACCME and the Specialist Sections and Boards. The main concern was the composition of the EACCME and the lines of communication between the Council and the Sections, since these were only consulted on request, and did not have any influence on who approved specialist professional events. The Section officers proposed that a Task Force on CME be established in order to promote closer links between the EACCME and the Section and to take a leading role in CME.

The issue of CME became prominent last year when several international organisations expressed their interest in providing CME accreditation. During the Section and Board's meeting in Ljubljana, Prof Goran Sedvall, President of the AEP, had presented the AEP point of view on CME. As a result, a joint working group with members from the AEP and the Section for Psychiatry had been set up to accredit CME courses run during the AEP congress in Stockholm this year. The group met in Frankfurt a few months earlier and Prof Gómez-Beneyto had presented the Section and Board's position on CME, stating that as a professional European body comprising senior psychiatrists representing their countries, the Section and Board should be the main player in providing CME accreditation. This was generally accepted.

The group developed an evaluation form for assessing the quality of courses offered and were present in Stockholm to make their own observations. In addition, a joint meeting between the AEP, WHO, WPA and the UEMS Section of Psychiatry took place in Stockholm in May 2002 where a proposal for a close collaboration between these organisations was discussed.

It is the Board's view that the main role of the Section's Task Force on CME should be to promote, supervise and control the quality of the European CME. This will help to alleviate the danger of CME being influenced by the pharmaceutical industry, which would inevitably lead to disproportionate progress of biological psychiatry. Another important aspect of CME is the multidisciplinary approach in mental health that necessitates a type of CME that is inclusive of other disciplines. It is also important to consider accessibility to CME in some countries, both from the linguistic and geographical point of view.

The current working group on CME will be maintained and will report directly to the Task Force. The role of the working group Chairman, Prof Peter König (Austria), will be to carry out specific tasks outlined within the broad policies drawn up by the Task Force. The Section already had support from Prof Michael Musalek (Austria), AEP representative to UEMS, in taking the lead on CME.

The Section also discussed the aims and functions of the Task Force on CME. In many countries CME is still the only option so the Task Force will be mainly concerned with CME. It could act as a PR body, seeking co-operation with other relevant associations, lobbying, promoting, supervising contents of CME, and so on. It will not deal with accreditation or provision of CME. The working group members could base their work on CME/CPD documents provided by their national associations, e.g. the CPD Policy of the Royal College of Psychiatrists.

Prof Katona emphasised that the Section should have a much more important role in defining guiding principles than simply assessing individual courses and allocating points. He suggested that the Task Force should concentrate on providing guidelines to national associations on the best ways to support their individual members' CME which might involve redefining some educational principles and objectives so as to have assessable objectives relevant to the individual's job. This would enable the Section to produce guidelines for national associations on how to organise CME for their own members.

At the October 2002 Palma meeting, Dr Lindhardt and Prof Gómez-Beneyto gave a short outline of a recent developments in collaboration between psychiatric associations and also reported on the first meeting of the CME Task Force which took place in Copenhagen on 20th June 2002.

The Task Force was composed of two representatives from each of the organisations involved. During the first meeting the UEMS Section was represented by Prof Fritz Hohagen (Germany) and Dr Lindhardt. The Task Force met again on 16<sup>th</sup> September 2002, when the Section was represented by Prof Gómez-Beneyto and Prof Katona. The AEP was represented by Prof Henning Sass and Prof Sedvall, the WHO by Dr Wolfgang Rutz, Director of Mental Health Europe, and the WPA by Dr Brian Martindale, Western European Zone representative and Dr Marianne Kastrup, representing the Northern European Zone.

The Task Force aims to establish specific areas of overlap between the organisations and to identify possible fields for co-operation. To facilitate the development of the identity of a European psychiatrist and the quality of care in mental health service, education needs to be high on the agenda therefore CME and CPD seem to be the appropriate initial area to focus on. The national associations confirmed their support for setting up of the Task Force, whereas the EACCME, whilst in principle agreeing with the idea of European co-operation, did not support the establishment of the Task Force.

Notwithstanding this, the main Task Force set up a working group on CME (regarded as the main priority) chaired by Prof Gómez-Beneyto for one year. The working group included Prof Kastrup, Prof Sass and Prof Gómez-Beneyto. The working group set out its work in three steps:

- updating the information on how CME was run in each European country
- developing guidelines on how CME applied to psychiatry

- possibly setting up a European accreditation committee (an aim difficult to attain due to financial constraints and because of doubts about the group's authority to develop such a committee)

As its first task, the working group developed a questionnaire on CME, sent out to all National Psychiatric Associations, following which the group will concentrate on developing specific guidelines on ethical issues, the balance between social, psychological and biological training, etc.

It will also be very important for the Task Force to determine clearly its position as independent of the pharmaceutical industry and any other organisations attempting to enter the field of CME for financial gain. Prof König reminded the delegates that the Section's working group on CME had some time ago drawn up guidelines on CME participation and the involvement of pharmaceutical industry in CME. The Task Force working group will meet again in June 2003 in Vienna to continue its work.

Prof Gómez-Beneyto indicated that, since the overall responsibility for European accreditation rested with the European Council, authorised by the national medical associations, it might prove problematical were the Task Force to create its own accreditation committee. However, he did not envisage any contention between the Task Force and the European Council as far as collecting information on CME and drafting the guidelines were concerned.

Prof Katona emphasised the importance of setting up and following the right plan of action in that the decision whether or not to establish an accreditation committee should be postponed until it was clear that agreement could be reached on principles based on the information collected throughout Europe.

It was agreed that Dr Lindhardt should write to the Presidents of all national associations represented on the Section and Board informing them of the new Task Force on CME.

Prof König reported that the CME working group he chaired had formed two sub groups:

- to work on updating and expanding the current CME guidelines
- to draw up points of interest/collaboration with the European Task Force on CME.

Prof König and Prof Katona would draw up a revised version of the current CME guidelines which would be circulated for comments and the updated version submitted for discussion at the meeting in Limassol in Spring 2003.

## **5. Survey of Undergraduate Teaching in Psychiatry**

At the April 2002 Thessaloniki meeting, Prof Katona submitted his report based on information provided by the delegates from the Czech Republic, Finland, Malta, The Netherlands, Spain and the United Kingdom. It was difficult to assess the usefulness of the material as the majority of delegates did not reply and the level of detail in the reports submitted differed from country to country. The Board was invited to discuss whether or not the survey of undergraduate teaching was a valid project for the Board and if so, the best method to achieve optimal results, since a questionnaire was not necessarily suited, since most countries had several medical schools without a single body overseeing psychiatric training. Since the primary reason for this survey had been to produce a set of recommendations on requirements for entry to specialist training in psychiatry, subsequent discussion centred around issues of how to assess what could be regarded as essential teaching in psychiatry.

It was agreed to follow a proposal, put forward by Prof Katona, to adapt the WPA base undergraduate curriculum and initially produce a set of UEMS recommendations which could then be circulated to delegates for comments. Once approved by the Board, an official report could be sent to national associations. Even though in most countries, national associations did not have the authority to influence medical schools, such an official statement could be useful in helping some national associations to persuade the decision-making bodies.

The working group consists of Prof Gómez-Beneyto, Dr Hansen, Prof Zihlerl, Prof Tringer and Prof Hohagen, chaired by Prof Katona. At the October 2002 Palma meeting, Prof Katona reported that this working group were making three recommendations to the Board:

- that the Board support the WPA document on undergraduate teaching
- a short summary of principles for undergraduate teaching in regard to teaching psychiatry be produced by Prof Gómez-Beneyto for consideration by the working group at the next meeting
- to undertake some research into the attitudes of medical students towards psychiatry at the beginning and at the end of their medical training.

It was agreed that the WPA document would be circulated to the delegates for consultation within their own associations. The proposal for a survey of attitudes to psychiatry was supported. Prof Katona would devise a brief questionnaire, circulate it to his working group and then ask each delegate to identify one participating university in their country, in most cases the academic representative to the Section and Board.

## **6. Implementing QA Recommendations in Member States**

At the April 2002 Thessaloniki meeting, Dr Karl-Otto Svärd (Sweden) reported on the existing QA recommendations, approved in Budapest in April 1998, which advised all National Psychiatric Associations (NPAs) to draw up QA policies, develop QA activities, identify areas of priority, draft QA guidelines, establish QA working groups at a local/clinical level, and ensure that documentation recording activities and outcome measures was in place. The deadline specified was 2000.

The QA Working Group drafted a follow-up questionnaire to assess the process of implementation in each country. Seventeen replies were received and the following results emerged regarding the five recommendations:

- I. to establish working groups on QA and draft QA policy: implemented in 6 countries; policy drafted in 7 countries
- II. to identify areas of priority: implemented in 11 countries;
- III. to formulate clinical guidelines: implemented in 11 countries;
- IV. to set up local QA working groups: implemented in 10 countries;
- V. to draft QA recording documentation: implemented in 8 countries.

Dr Svärd posed the two following questions for discussion:

- Are the recommendations still valid?
- How to proceed with further implementation?

It was noted that although the majority of NPAs supported the recommendations, they had little influence on quality control, which in most countries was a government responsibility. The main obstacles were often financial and sometimes political, when recommendations from national associations, although welcome by national authorities, had very little impact on the state of affairs.

Suggestions were made to clarify quality standards, because unless quality was clearly defined it would be difficult to assess whether or not the targets recommended by the Section were being reached. One way to resolve this issue would be to draw up guidelines on quality standards from a professional standpoint. This could be a useful tool in countries where national quality control did not agree with professional recommendations. In today's societies where professionals seemed increasingly isolated from decisions made by politicians, it was important for the profession to be able to make an evidence-based statement. It was agreed that the current recommendations were simply a framework for national associations to utilise to produce their own guidelines.

After further discussion, the current QA recommendations were re-approved to be circulated again to NPAs for appropriate action with an implementation deadline for 2004. The document would be revised again in 2005.

## **7. Quality Assurance of Training**

At the April 2002 meeting in Thessaloniki, Dr Svärd tabled for approval the final draft of this checklist document for quality assurance in psychiatric training. The work, which commenced at the April 2001 meeting in Ljubljana, had led to a first draft discussion at the October 2001 meeting in Prague and following circulation for comments, the document was revised with extensive help from Dr Strachan. The report will be reviewed in 2004.

At the October 2002 meeting in Palma, Dr Svärd informed delegates that the approved document had been circulated by email. The recommendations, together with the questionnaire on training schemes, would now be circulated by post to all delegates and their NPAs on UEMS Board headed paper with a request for implementation.

## **8. Chapter 6 of the Charter on Training – a review strategy**

At the October 2002 meeting in Palma, Dr ten Doesschate reminded the delegates that since the requirements for training in psychiatry set out in Chapter 6 of the Training Charter (approved in 2002) were due for review every two years, the delegates were required to consult their associations to elicit feedback on the current requirements.

It was important that the EFPT, WPA and AEP should also contribute to the review. Chairs of the working groups which prepared specific components of Chapter 6, e.g. biological psychiatry, community and social psychiatry, psychotherapy, were also asked to review their report and submit their comments.

They were asked to be particularly mindful of the issue of cultural diversity and ethnicity so as to emphasise that professional competencies should include cultural awareness and sensitivity to ethnic issues. It was agreed for Dr Lindhardt to contact Dr Kastrup of WPA, who had a special interest in transcultural psychiatry for a short paragraph which could be incorporated. Prof Levent Küey (Turkey), WPA representative for Southern European Zone, informed the meeting of the recently approved WPA cultural curriculum for psychiatry which was meant as a short guide covering the core competencies in cultural diversity which should be included in psychiatric training. It was agreed to circulate the document which could be useful as background reference material to be used in the review. Prof Katona noted that the issue of cultural diversity did not relate solely to training or practice, but also had a great impact on assessment methods. He suggested the drawing up guidelines for national associations to encourage cultural awareness across the whole of their work.

Dr ten Doesschate will compile comments and prepare a reviewed version for discussion at the Spring 2003 meeting in Limassol.

Prof Fritz Hohagen said that the review of the training requirements gave the Board an excellent opportunity to carry out a survey throughout Europe to ascertain whether the training requirements were being implemented in national training centres. He suggested that the Presidents of national associations be informed that the Board was planning to carry out such a survey and that the national representative, in co-operation with his or her association provide a list of training centres which could be approached. Trainees' opinions should also be sought to get a full picture of training. Dr O'Boyle (Ireland) emphasised that the national representatives should be personally involved in this exercise to ensure that the survey was not ignored. National representatives were expected to take a lead in this survey but a direct contact with the Presidents would help to strengthen the communication with national associations and to improve their awareness of the UEMS.

Summarising the discussion, Prof Gómez-Beneyto said that it was important for the Board to find out whether its work towards harmonisation of training in Europe had any effect. The questionnaire developed by Prof Hohagen and used in Germany would be adapted for use by the Board and a draft would be circulated for comments and further discussion at the Spring 2003 meeting in Limassol.

## **9. Glossary to the Charter on Training**

At the April 2002 Thessaloniki meeting, Dr Saliba (Malta) reported that he received replies from seven countries and had inserted the comments received into the document for discussion. Each definition with proposed amendments was discussed at length and the finalised document approved.

Stemming from the October 2002 Palma meeting discussion on transcultural issues in relation to revision of Chapter 6 of the Charter on Training, it was agreed to add a definition of transcultural psychiatry to the glossary.

## **10. Gender Issues in Psychiatric Training**

At the October 2002 meeting in Palma, Dr Lindhardt, following a request for advice, raised the issue of whether the gender in psychiatric training was addressed in any way throughout Europe. Several country delegates made a number of useful comments ranging from those where there were optional or mandatory courses and a section for residents on gender-specific issues in psychiatry (eg UK, The Netherlands, Turkey) or a section for women's rights or gender issues within the NPA (eg Germany, Turkey) to those where the majority of psychiatrists were female (eg Finland, Ireland, Cyprus) and those where gender issues were not addressed or totally neglected (eg Austria, Greece, Slovenia, France, Sweden, Switzerland, Romania).

Prof Gómez-Beneyto suggested that the issue of cultural diversity and ethnicity should be addressed in the imminent review of the Charter of Training. Guidance in this matter should be most welcome for some countries where cultural diversity was not yet properly addressed. The issue of gender should also be extended beyond training as it impacted on other aspects of psychiatry and mental health. It should be taken up by both the working group on the Charter review and that on the profile of a psychiatrist. Gender issues would also be relevant to the recruitment working group in terms of tackling gender balance in the profession and could also be introduced as one of the questions in the Mental Health Services Profile questionnaire.

## **11. Skill-Based Objectives for Specialist Training in Old Age Psychiatry**

At the October 2002 meeting in Palma, Prof Katona submitted the WPA document for information and to obtain the Board's support for it in principle. Unlike UK, most countries did not recognise old age psychiatry as a speciality or sub-speciality. The document was a result of co-operation between the WPA and WHO in developing a curriculum for old age psychiatry as a sub-speciality. It was widely circulated for consultation and most feedback received was positive. The WPA is seeking UEMS support for the curriculum as a framework which could be used by individual countries to develop their own training in old age psychiatry. Prof Katona suggested that it would be very helpful to find ways to deliver this curriculum to individual countries through co-operation between the University of London, where he worked, which was trying to develop distance learning courses in old psychiatry and partner universities elsewhere in Europe. Such a collaboration project could then obtain funding from the Erasmus Programme. He urged those interested in developing such a partnership to contact him personally.

Prof Gómez-Beneyto replied that the Board could only discuss the document in terms of its usefulness to training and Dr Lindhardt confirmed that, in her view, the discussion whether or not the UEMS should support the development of old age psychiatry as a separate sub-speciality, which was by no means settled, should not be taken up during the Board's meeting. Nonetheless, she thought that the Section could support this particular document as a framework for those countries that wished to develop old age psychiatry, but not as a policy statement in favour of sub-speciality development. This was agreed.

## **12. Recruitment in Psychiatry**

At the October 2002 meeting in Palma, Prof König drew the delegates' attention to the fact that over the recent years there had been a steady decline in the number of medical doctors in general, and specifically psychiatrists, in most EU member states. He suggested the Section and Board should consider the possibility of drawing up a set of recommendations for governments on how to entice young doctors into psychiatry and what incentives could be put in place to make the profession more

attractive. Prof König, Prof Katona and Dr Vincent Martin (Belgium) agreed to put together a written proposal for a new working group on recruitment.

### **13. Child Psychiatry**

Prof Gómez-Beneyto reported that the Ministry of Health in Spain had submitted a draft project on psychiatric training for comments by both psychiatrists and paediatricians. The main comments from psychiatrists stipulated the inclusion of child psychiatry in basic psychiatric training, whereas paediatricians agreed with the project's proposal which would allow a paediatrician to become a child psychiatrist after completing one and a half years of training in child psychiatry. The president of the UEMS Section for Child Psychiatry and Psychotherapy had written a letter supporting the position of the Spanish Association of Neuropsychiatry in this matter. Delegates supported Prof Gómez-Beneyto request for a similar letter from this Section and Dr Lindhardt (President) would be writing to the Spanish Association of Neuropsychiatry.

### **14. Support for Delegates from Eastern European Countries**

Financial support for delegates who could not afford to attend meetings was discussed at the October 2002 meeting in Palma. Dr Lindhardt said that the delegates should consider the budgetary situation as well as possible eligibility criteria, noting that some less affluent countries were already making an effort to attend despite their economic difficulties. Perhaps, those who did not see such effort worthwhile did not regard the work of the Section and Board as relevant to their national circumstances. She suggested that the matter of seeking funds for attending the Section and Board's meetings should be left to individual associations to resolve. She would be happy to support, if necessary, any application for such funding from the EU but the initiative must come from the applicant.

Replying to Prof Katona's question, whether the Section and Board would be willing to help delegates from countries which could not afford to apply for EU funding to attend, she confirmed this, however the initiative must come from the applicant. It was agreed that the President of the Section would write to those representatives who rarely attended the meetings to find out whether their non-attendance was due to financial hardship to inform them of the possibility of applying for EU funds and to assure them of the Section's support should they start any such initiative.

### **15. Website Update**

At the April 2002 meeting in Thessaloniki, Mrs Carroll (UK), Administrative Secretary to the Section and Board, reported that recent attempts to have the Section and Board's approved reports published on the relevant page of the UEMS website were unsuccessful. Dr Leibbrandt, Secretary General of the UEMS, strongly advocated for Sections and Boards to set up and run directly their own separate websites to avoid long delays due to time constraints and heavy workload.

Initial discussion showed that there was consensus that if such a website were to be set up, it should be professionally done, providing links to national associations, the UEMS site and any other useful relevant sites. Discussion fora were also mentioned as a useful feature for the site. The group considered employing the Royal College of Psychiatrists' web designer, which might cut the costs.

The Treasurer suggested that the final decision regarding increased subscriptions might have to be reached at the next meeting. It was agreed to discuss the exact layout and functions at the next meeting and for Mrs Carroll to prepare a proposal for the next meeting detailing different options available.

At the following meeting in Palma, quotes from two outside website design agencies and the Publications Dept at the Royal College of Psychiatrists were considered. The College's quote was the most favourable, but it was emphasised that the website should not in any way be linked to the College's own site and should have its own domain name submitted to specific search engines. It was very important that the site was constructed using the latest technology available world-wide, so that, should the administration of the Section and Board be moved to any other member association the maintenance of the website would easily be transferred to the new site. It was agreed to accept the offer from the College subject to a formal contract drawn up by the Treasurer which would include a detailed timetable and a deadline for completion of the project.

## **16. Prescribing of Medication by Psychologists**

At the April 2002 meeting in Thessaloniki, Dr Saliba briefly outlined, for information, an article published by Deborah Josefson from Nebraska, USA, in the British Medical Journal earlier this year (BMJ 23 March 2002 324:698). The article described the new law introduced in New Mexico allowing psychologists to prescribe drugs to patients suffering from a mental disorder. Psychologists with a doctoral degree would be issued a limited licence allowing them to prescribe drugs for two years under a doctor's supervision after undergoing an additional 450 hours training, a 400 hour practical test and looking after 100 patients under medical supervision before passing a national exam. They could then apply for an independent licence. The main arguments for this had been a limited number of psychiatrists in New Mexico and a higher than average suicide rate among young people. Psychiatrists arguing against the new law claimed the additional training requirements imposed on psychologists were not sufficient to ensure the safety for patients and could lead to people with psychiatric disorders being given "second class citizen" status, rendering them the only group of patients who could be treated by practitioners with no training in the physiology, pathophysiology, and pharmacology of the body as a whole.

Prof Gómez-Beneyto gave a further example of tensions between psychiatrists and psychologists in his country where a psychiatrist had been suspended from practice for a year for allowing psychologists to take patient's history during their first visit. In Spain, a patient referred by a GP for specialist psychiatric treatment should always be seen by a psychiatrist in the first instance. Only after the initial contact with a psychiatrist could a patient be referred to a psychologist for a psychotherapy treatment.

Prof Gómez-Beneyto said that articles like this further contributed to the growing tensions between the two professions and the Section and Board should consider whether or not to take action in the matter. It was agreed that further discussions should be deferred to the Working Group on the Profile of the Psychiatrist.

## **17. Israel Psychiatric Association – request to join the UEMS**

Dr Lindhardt reported that after the AEP congress in Stockholm she received a formal request from the Israeli Psychiatric Association to join the UEMS Section and Board of Psychiatry. At Dr Lindhardt's invitation for comments, the following points were made:

- The meeting should focus on the enlargement criteria which the Section and Board would use in the future rather than on one particular request.
- The Section and Board need to be careful to preserve the balance between the Western and Eastern European countries to ensure that issues affecting both of those groups were equally represented.
- The Section and Board must determine the basis on which individual countries could be allowed to join the group, which was supposed to represent Europe. It might be necessary to define the concept of Europe as an entity.
- If the European Commission wants to promulgate good practice in medicine and encourage harmonisation in training to raise the standards in countries with limited resources, the UEMS should welcome countries that were in the wider definition of Europe. This could require restructuring of meetings in the future, but the Section and Board should follow the World Health Organisation's view of Europe in the wide sense.
- The main aim of UEMS is the harmonisation of training to allow the free movement of medical specialists within the EU. The Section and Board should consult the UEMS Management Council regarding membership policy.
- The Section and Board must follow the UEMS Statutes which clearly indicated that there were 29 members – 18 full members and 11 associate members.
- Each international federation has different regional groupings which reflected its international policy. The Section and Board might introduce a three-tier membership, i.e. full or associate in respect of their position in the EU and observer status to other countries as specified in WHO or WPA European zones.
- The Section and Board need to regulate what is allowed under each respective status, i.e. whether associate members could participate in working groups drawing up recommendations for full members of the European Union.

- The group would probably not be able to work efficiently in promulgating good practice in training if it was allowed to grow too large.
- It is important to determine whether criteria for acceptance should be based on geographical boundaries or whether other factors could be taken into consideration. Countries like Egypt, are very interested in European training and could also at some point seek membership as might Asian countries.

Prof Gómez-Beneyto summarised the discussion pointing out that there were three areas which needed to be defined, namely:

- criteria for accepting new members
- the role of associate members
- the size of the Section and Board.

It was agreed that Dr ten Doesschate would contact Dr Leibbrandt, Secretary General of the UEMS, for clarification of the issue. Dr Lindhardt would then reply formally to the request from Israel accordingly. The Officers would also prepare, for the next meeting, a draft proposal of regulations concerning the procedures for the enlargement of the Section and Board.

## **18. UEMS Management Council Matters**

### **a) Section and Board Representation**

This matter, discussed in April in Thessaloniki, was first mentioned in Prague in October 2001 and concerned the proposal from the Management Council to allocate five seats on the Council to representatives of Section and Board constituencies (groups of related specialities). Originally, there were five groupings and psychiatry was put in a group of independent specialities together with dermatovenerology, occupational medicine, ophthalmology, physical medicine, public health, stomatology and facial surgery. Dr Lindhardt wrote to Mr Hide, Chair of the Council's working party dealing with the issue, and Prof Peter Hill, President of the UEMS Section of Child and Adolescent Psychiatry and Psychotherapy suggesting that psychiatry and child and adolescent psychiatry should form a single constituency. Dr Pylkkänen (Finland) who attended the Management Council meeting in Basel in October 2001 where the matter was discussed had also approached Mr Hide to express his concern about the group's specialist make up. Psychiatry was now placed in the same group as neurology and anaesthesiology. The Section and Board's representatives on the Council would be elected annually on a rotating basis at the May meeting, with appointments being renewable up to a maximum of four consecutive terms of one year. Dr Strachan who attended a meeting of all UK representatives to UEMS Sections in London chaired by Mr Hide in January 2002 also expressed his concern at the new arrangement which, although an improvement on the previous one, was still far from satisfactory and should be reconsidered. It was still difficult to understand how an anaesthetist could represent interests of psychiatry and vice versa.

It was agreed that it was perhaps too late to change anything and the Section should accept the arrangement to see if it was workable. It should however be reviewed after the initial two years. In the meantime, the Section should try to negotiate with the other two Sections to be the first representation on the Council. It would give the Section time to come up with a more favourable solution for psychiatry with evidence to back it.

Dr Sontag (France) reported that the issue of representation on the Management Council was not discussed at the last Child and Adolescent Psychiatry Section meeting. It was agreed that it was important to find out how the decision to join paediatrics and gynaecology was reached and that another letter would be sent to Prof Hill to discuss the issue and to urge maintaining close links between the two Sections. Prof Katona mentioned guidelines drawn up by the Royal College of Psychiatrists dealing with boundaries between the child and adolescent and adult psychiatry and suggested that UEMS could produce a similar document. Such an exercise might bring the two groups together.

### b) New Doctors' Directive

Dr Pylkkänen reported that the Management Council had discussed the important EU Commission proposal for a new Doctors Directive that would replace all existing sectoral directives and abolish the Advisory Committees for each of the medical specialities. It also dealt with the issue of recognition of professional qualifications. Currently, there were seven professional Advisory Committees, one of which dealt with medicine. The new proposal would place all seven Advisory Committees into one.

Article 20 of the new proposal suggested that 17 specialities (psychiatry being one of them) recognised in each of the EU member states would continue to have the automatic recognition of qualifications. For all other specialities, the host country would have to evaluate training and qualifications on a case by case basis. The member states would be required to set up an administrative body called 'Co-ordinator' to collect information relevant to the application of the migrating doctor. The UEMS was against the new proposal but it did not have enough impact to influence the change. The only agents who might successfully oppose the proposed directive were the national governments who would have to bear the costs. Dr Pylkkänen suggested that national psychiatric associations should try to lobby their own governments.

## **19. Feedback from Delegates: April 2002, Thessaloniki**

### Denmark

Dr Hansen reported that he was involved in the work on revising the syllabus for postgraduate training. The revision was based on the report from the National Board of Health but the working group involved with this project was also consulting the UEMS recommendations which would be applied where appropriate. It had led to establishing a number of new Associate Professor positions in all specialities.

### UK

In response to a request from Prof König for advice regarding specialist examinations in other countries, Prof Katona described two initiatives currently in progress. One was a set of guidelines by the College (still in early draft form) on aptitude assessment of trainees before they were awarded their Certificate of Completion of Specialist Training (CCST). The document is based on assessment records, learning outcomes and capability indicators. The second initiative came from the UK Academy of Royal Colleges and Faculties that was calling for harmonisation of specialist examinations across medical specialities in the UK. Prof Katona was involved in the project and said that the specialist examinations in psychiatry would have a considerable influence in the final document.

Prof Katona also reported on current changes in the way specialist training was organised in his country. Although still at a consultative stage, it is almost certain that a new body, Medical Educational Standards Board, will replace the existing Specialist Training Authority (STA). This will significantly shift the power from the specialist associations which heavily influence STA decisions towards the government which will control the new Standards Board. In practical terms, this will mean that the government will dictate the training curricula and training standards. This seems to follow a general trend in Europe where control is being taken away from specialists and taken over by politicians.

### Hungary

Prof Tringer said that the specialist examination in his country consisted of three parts:

- written test (which a candidate has to pass to go on to the second stage)
- oral test
- written analysis of a patient case history

The topics for the examinations are published beforehand so candidates are familiar with the level of knowledge expected of them. Guidelines for psychiatry and psychotherapy examinations are also published. During discussion it became apparent that some sort of consensus statement on assessment of trainees would be extremely useful.

He also reported that specialist training in his country was by law the responsibility of university faculties. Selected hospitals are accredited for training by universities. Following UEMS guidelines the length of training has been recently extended from four to five years.

#### Belgium

Dr Martin reported that his country introduced a new requirement for psychiatric trainees whereby 12 months training in child and adolescent psychiatry was mandatory.

#### Slovenia

Prof Zihlerl reported that his country had followed the UEMS recommendation to extend psychiatric training from 3 to 5 years.

#### Portugal

Dr Varandas reported the same development in his country where psychiatric training was extended from 4 to 5 years.

#### Greece

Prof Parashos reported that a 5-year period of psychiatric training was a legal requirement in his country introduced last year.

#### EFPT

President, Dr Mihai (Romania), supported meaningful and fair assessment throughout the period of training with reliable quality assurance in place. The EFPT recognised that total uniformity throughout Europe would be extremely difficult to achieve and not necessarily desirable. The trainees' viewpoint was that proper support by assessment throughout training was more valuable than a final examination. It was agreed that a working group on trainee assessment would be set up. Prof Katona agreed to chair it once the current working group on supervision finished its work.

#### France

Dr Sontag asked delegates to consider how to exert pressure on politicians who, as a routine, seemed to accept recommendations from professional experts but seldom acted on them.

#### Slovenia

Prof Zihlerl, in reply to Dr Sontag's point, said that involvement of a politician who was genuinely interested often helped to achieve the results which would otherwise be lost through bureaucracy, an approach which he adopted during the UEMS meeting organised in Ljubljana, where the Minister for Health was invited to meet the members of the Section and Board. As a result some of the UEMS guidelines had since been implemented.

### **20. Feedback from Delegates: October 2002, Palma de Mallorca**

#### Austria

Prof König informed the meeting that the sub-speciality of child and adolescent psychiatry had recently obtained the status of speciality in its own right. This development was in line with the Austrian Medical Chamber's policy against the development of sub-specialities.

#### Belgium

Dr Martin reported on a recent development in Belgium whereby psychiatrists were asked to submit reports on their workload which were to be used to decide how many trainees should be allocated to each psychiatrist. Belgian Professional Union of Neurologists and Psychiatrists opposed this exercise but was ignored by the government.

#### Germany

Prof Hohagen reported that the German Society for Psychiatry, Psychotherapy and Neuromedicine was reviewing the training requirements and there were plans to introduce a forensic psychiatry sub-

speciality. It would be very helpful, therefore, if the UEMS discussion on sub-specialities was taken up at the earliest opportunity.

#### Norway

Dr Hagemo reported that her national association had recently made a recommendation to extend compulsory psychotherapy training to three years with the final year devoted to psychodynamic or cognitive behaviour approach. Furthermore, the Norwegian Psychiatric Association had recently sent a letter to Norwegian Medical Association the urging them to oppose any plans for introducing sub-speciality or re-certification.

#### France

Dr Sontag said that the Ministry of Health asked universities in France to make psychotherapy a mandatory part of psychiatric training.

#### Italy

Prof Furlan reported that all university curricula were being reviewed in Italy and a new three-year course had been introduced for a technician in rehabilitation in psychiatry and neurology run by Medical Faculties. Furthermore, clinical psychology had been recognised as a medical speciality in addition to clinical psychology as a psychology speciality which created a two-tier speciality depending on the route through which it had been obtained.

#### Croatia

Dr Iveziæ informed the meeting that a survey of psychiatric training was being carried out to determine the extent of implementation of the Board's recommendations for training.

#### Ireland

Dr O'Boyle said the Irish Psychiatric Training Committee (IPTC) had been demanding that employers allowed tutors two teaching sessions in addition to their organisational and supervision duties. This had not yet been successful except in one case. The IPTC were also trying to obtain the approval of psychotherapy as a speciality by the Irish Medical Council, but without success.

#### UK

Dr Strachan reported that the Royal College of Psychiatrists was currently heavily involved in a dispute with the government over the reform of the Mental Health Act. The new proposal was to use the legislation as a preventative measure for psychiatrists to detain mental patients with severe personality disorders indefinitely in secure psychiatric units even before they committed an offence. The main point of contention in this debate was that psychiatrists were against being used as a social control tool.

It was vital to take note of such instances as there was evidence throughout Europe of governments trying to use psychiatry as a means of social control by demanding that psychiatrists report instances of child abuse by their patients, possession of weapons, and other illegal or antisocial activities. In Austria and Ireland the profession had successfully opposed such attempts but the political dimension in relation to psychiatry should not be ignored by the Section and Board.

## **21. Collaboration with other organisations**

#### AEP

Both Presidents of the Section and Board were invited to attend a joint meeting organised by the AEP, WHO and WPA in Stockholm on 3<sup>rd</sup> May to discuss closer collaboration between psychiatric associations and government agencies in Europe. One of the issues to be discussed was the proposal to set up a developmental and research network in Europe. Dr Pylkkänen would also be attending the meeting as the WPA Zonal representative for Northern Europe.

#### WHO

The Section and Board would like to improve communication with WHO in the light of their recent initiatives on mental health. Unfortunately, the Section did not seem to be formally informed of

developments. Prof Tringer, who is the official national counterpart for Hungary, agreed to keep the Section informed of WHO initiatives which was a welcome addition to the Section and Board.

Prof Katona was a member of the WPA steering group working on the postgraduate curriculum in psychiatry, which would be a flexible framework easily adaptable to national circumstances. The outline of the curriculum would be published at the WPA congress in Yokohama which would then be followed by a more detailed publication. The WPA was also considering the possibility of accreditation of national curricula if support and funding could be found. At the moment it was still in early planning stages.

### EFPT

The issue of exchange visits for trainees has been raised this year. A survey conducted by Prof König a few years ago showed that any exchange programme in Europe would first have to resolve financial, linguistic, political and administrative problems before any form of successful exchange could be considered. It was agreed that Prof König's report would be circulated to all delegates for information. This item should also be discussed in connection with the website which could act as an excellent medium for finding and sharing information about training opportunities abroad.

## **22. Reports from Trainees**

### a) Report from the EFPT

At the April 2002 meeting in Thessaloniki, Dr Mihai (Romania), President of the EFPT reported that the next EFPT meeting would be held in Romania on 6-9 June 2002 and Dr Mihai thanked the Royal College of Psychiatrists in the UK for providing funds to help organise the meeting.

A document listing all the statements issued by the EFPT was tabled at the meeting. Over the last ten years the EFPT made official statements on general medicine and neurology in psychiatric training (1994), part-time training (1994), national trainees organisations (1995), quality of training (1996, 2001), training in child psychiatry (1996), psychotherapy training (1996, 1999, 2001), requirements for teachers (1996), log books (1997), exchange of trainees (1995, 2001), and many others. As the document included reports on many subjects previously taken up by the Board it was agreed that it would be placed on the agenda for the autumn 2002 meeting of the Board. It would be very useful to assess the degree of consensus between the EFPT and UEMS statements.

At the following meeting, Dr Mihai presented a comprehensive report on all statements produced by the EFPT to date. The EFPT had issued 17 policy statements, including quality of training, training in child and adolescent psychiatry, psychotherapy training, exchange of trainees between different countries, part-time training, mental health promotion and many others. The last EFPT congress took place in Sinai, Romania, in June, where discussions concentrated around a recent survey carried out by the EFPT which was designed to compare European approaches to psychiatric training. Its objective was to compare selection criteria, length and structure of training, psychotherapy as a part of training, evaluation of knowledge and the final exam.

Selection criteria differed significantly and included entry exams at national or local level (Romania, Spain, France), university selection (Belgium) and waiting lists (Greece). Some countries (Denmark, Finland) did not have any selection procedures at all. The average length of psychiatric training in Europe was five years with Hungary, Italy, Portugal, Slovenia and Spain offering four years and Austria, Belgium, Finland, France, Switzerland and the UK, six years. Psychotherapy was compulsory in Denmark, France, Finland and Germany, whereas in the UK, where it was free of charge, it was widely included in training programmes.

The structure of training varied substantially between countries with 13 out of 19 countries including neurology, and 7 out of 19, child psychiatry, as an integral part of psychiatric training. The survey also showed that psychotherapy was mandatory only in Denmark, Finland, Germany and The Netherlands, with Denmark offering 60 hours of psychotherapy and Germany 520 hours. The main obstacles to including psychotherapy as part of formal training were high costs, location (usually outside the main training centre), lack of skilled supervisors and lack of recognition.

Based on the survey, the EFPT produced the following recommendations for psychotherapy:

- Psychotherapy should be seen as an indispensable part of being a psychiatrist.
- Basic training in psychotherapy must include supervision by qualified therapists of clinical practice as well as theoretical training in a broad range of psychotherapy.
- Trainees should acquire basic psychotherapy knowledge during psychiatric training in at least two main forms of psychotherapy (psychodynamic, cognitive behaviour, systemic psychotherapy).
- Psychotherapy training should be financed by the training institution and it should take place during working hours.

Summarising the results of the survey, Dr Mihai said it was important to remember that the study reflected the trainees' views and it was significant that they differed from those of trainers. The discrepancy could partly be explained by the variations between training programmes and individual training centres. However, it must be noted that the trainees' views seemed to reflect reality rather more closely than the idealistic picture presented by trainers.

The Sinai meeting produced statements on supervision and evaluation, training in community based psychiatry, psychotherapy, exchange of trainees and training in child and adolescent psychiatry.

Following elections, the new President of the EFPT was Dr Dominique Mathis (France), President Elect, Dr Julian Beezhold from (UK), Secretary General, Dr Corrado De Rosa (Italy) and Treasurer, Dr Martin Finger (Germany).

The delegates agreed in their comments on Dr Mihai's report that it was of utmost importance to convince powers that be that psychotherapy must form part of psychiatric training and trainees should not be expected to fund it themselves.

Prof Gómez-Beneyto said that to avoid the discrepancy between the opinions of trainees and trainers the Board must be very careful in formulating questionnaires to ensure that questions were as precise as possible. Questionnaires should include a glossary and be translated to avoid misinterpretation of questions.

#### b) Report from the PWG

At the April 2002 meeting in Thessaloniki, Dr Cassidy (Republic of Ireland) reported that the PWG celebrated its 25<sup>th</sup> anniversary in 2001 and currently had 23 members. Their recent meetings took place in Stockholm in Spring 2001 and in Paris in Autumn 2001.

The main concern of the PWG at present is the European working time directive which introduces a 48-hour week for all employees except junior doctors who will have their working week gradually reduced over the next few years to reach 48 hours. By August 2004 junior doctors' working week should not exceed 58 hours. It is estimated that the process can take as long as 10 to 15 years. The effects of this directive on individual countries will vary greatly due to significant differences in working hours between countries. The implementation of this directive will also be greatly affected by the recent decision of the European Court of Justice in a case of a Spanish doctor, ruling that the whole of the time doctors spent on call on the hospital premises should be counted as working time even if the doctor was not called.

At its meeting in Paris, the PWG approved the results of a survey of working time in member states. The report was published and is now available from the PWG. Its findings show that the main difficulties in implementing the directive are likely to occur in the UK, Ireland, France and Germany. In Ireland, for instance, the recent survey showed the average working week of a junior doctor was 77 hours. The PWG is studying the new working patterns in The Netherlands, Norway and Denmark where junior doctors' working week has already been reduced to 37 hours. The PWG is also trying to assess the impact of the directive on continuation of training, patient care, etc.

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The PWG prepared a statement in collaboration with the Comité Permanent on postgraduate medical training opposing re-accreditation while supporting CME and CPD.

The PWG is very supportive of its position on each of the European Boards. There will be a working party to address the issue of representation.

A recent survey of refugee doctors in Europe published by PWG shows substantial differences in the way refugee doctors are treated in each country.

The PWG is normally funded by the national organisation whose member is president of the PWG at the time. The presidency now moved from Portugal to Finland. The PWG is looking into the possibility of arranging independent funding and a lot of progress has been made to date.

The PWG is concerned with the new EU directive reducing the number of specialities recognised throughout Europe to seventeen as it is likely to restrict free movement of specialists within Europe. The PWG is also keen to collaborate with other European organisations in an attempt to resolve the concerns caused by the abolition of specialist Advisory Committees which were replaced by one new accreditation committee comprising representatives from all professions. It is hoped that an effective collaboration between organisations could lead to successful lobbying at the central level within the EU.

### **23. Next meetings**

1 – 3 May 2003	<b>Limassol, Cyprus</b>
9 – 11 October 2003	<b>Berlin, Germany</b>
1 – 3 April 2004	<b>Edinburgh, Scotland</b>

**JOSEPH R. SALIBA**  
**SECRETARY**