UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES

SECTION FOR PSYCHIATRY

APPROVED Minutes of the 28th meeting of the UEMS[1] Section of Psychiatry held in Zagreb, Croatia, on 8th October 2004

1. Present

Dr Julian Beezhold – **United Kingdom** - EFPT[2]
Prof Dinesh Bhugra – **United Kingdom** – Royal College of Psychiatrists
Dr Pedro Cabral Varandas – **Portugal** – Portuguese Medical Association
Prof Can Cimilli – **Turkey** – Psychiatric Association of Turkey
Dr Defne Eraslan – **Turkey** – EFPT
Dr Tsvi Fischel – **Israel** – Israeli Psychiatric Association
Prof Pier Maria Furlan – **Italy** - Italian Psychiatric Association
Dr Dan Georgescu – **Switzerland** – Swiss Society of Psychiatry and Psychotherapy
Prof Manuel Gómez-Beneyto – **Spain** – Spanish Association of Neuropsychiatry; **President, European Board of Psychiatry**
Dr Torben L Hansen – **Denmark** - Danish Psychiatric Association
Prof Edvard Hauff – **Norway** - Norwegian Medical Association
Prof Paul Hodiamont – **Netherlands** – Dutch Psychiatric Association
Dr Slaðana Ivezięæ – **Croatia** - Croatian Medical Association, Society for Clinical Psychiatry
Prof Matti Joukamaa – **Finland** - Finnish Psychiatric Association
Dr Astrid Kubli Bauer – **Switzerland** – Swiss Society of Psychiatry and Psychotherapy
Prof Gerhard Lenz – **Austria** – Austrian Association for Psychiatry & Psychotherapy
Dr Anne Lindhardt – **Denmark** – Danish Psychiatric Association; **President, Section for Psychiatry**
Dr Brigitte Mauthner – **Austria** – Austrian Medical Chamber
Prof Michael Musalek – **Austria** – AEP[3]
Dr James O'Boyle – **Ireland** – Irish Psychiatric Training Committee
Dr Eva Palová – **Slovakia** – Slovak Psychiatric Association
Prof Andreas Parashos – **Greece** – Hellenic Psychiatric Association
Dr Kari Pylkkänen – **Finland** – Finnish Psychiatric Association; **Vice-President, Section for Psychiatry**
Dr James Strachan – **United Kingdom** – Royal College of Psychiatrists; **Vice-President, Section for Psychiatry**
Dr Roelof ten Doesschate – **The Netherlands** – Dutch Psychiatric Association; **Treasurer, Section and Board of Psychiatry**
Dr Roland Urban – **Germany** – Professional Association of German Psychiatrists
Dr Ivan Tuma – **Czech Republic** - Psychiatric Association of the Czech Medical Society
Assoc. Prof Slavko Ziherl – **Slovenia** - Psychiatric Association of Slovenia, Medical Chamber of Slovenia; **Vice-President, European Board of Psychiatry**
Mrs Joanna Carroll – **United Kingdom** – Royal College Psychiatrists (in attendance)

2. Apologies

Prof Jacek Bomba – **Poland** - Polish Psychiatric Association
Dr Brendan Cassidy – **Ireland** – Irish Medical Organisation
Dr Anne Kleinberg – **Estonia** - Estonian Psychiatric Association
Prof Michal Hrdlicka – **Czech Republic** - Psychiatric Association of Czech Medical Society
Prof Fritz Hohagen – **Germany** - German Association of Psychiatry, Psychotherapy & Nervous Diseases; **Vice-President, Section for Psychiatry**
Prof Blanka Kores Plesničar – **Slovenia** - Psychiatric Association of Slovenia, Medical Chamber of Slovenia
Dr Andres Lehtmets - **Estonia** - Estonian Psychiatric Association

[1] EUROPEAN UNION OF MEDICAL SPECIALISTS
[2] EUROPEAN FEDERATION OF PSYCHIATRIC TRAINEES
[3] ASSOCIATION OF EUROPEAN PSYCHIATRISTS

Assoc. Prof Nils Lindefors – **Sweden** – Swedish Psychiatric Association
Dr Matt Muijen – **Denmark** – World Health Organisation
Prof Stein Opjordsmoen – **Norway** - Norwegian Psychiatric Association
Prof Yiannis Papakostas – **Greece** – Hellenic Psychiatric Association
Dr Brian Parsons – **Ireland** – PWG[4]
Dr Miquel Roca Benasar – **Spain** - Spanish Society of Psychiatry
Dr Joseph Saliba – **Malta** - Maltese Association of Specialists in Psychiatry; **Secretary, Section and Board of Psychiatry**
Dr Harald Sontag – **France** – French Psychiatric Association
Prof László Tringer – **Hungary** - Hungarian Psychiatric Association

Dr Lindhardt welcomed the delegates to Zagreb and thanked Dr Iveziæ for organising the meeting.

Dr Lindhardt extended a special welcome to new members of the Section and Board: **Dr Tsvi Fischel**, appointed in August 2004, a new delegate from Israeli Psychiatric Association joining the Section and Board as observer; **Prof Gerhard Lentz**, appointed in June 2004, from the Austrian Association for Psychiatry & Psychotherapy, replacing Prof König, and **Dr Brigitte Mauthner**, a new delegate from the Austrian Medical Chamber, appointed in June 2004. Dr Lindhardt also welcomed absent delegates who were newly appointed by their associations but could not attend: **Prof Yiannis Papakostas** from Greece, appointed in October 2004 to replace Prof Rabavilas; **Dr Anne Kleinberg** and **Dr Andres Lehtmets** from Estonia appointed in May 2004 to replace Prof Janes; **Dr Matt Muijen** from the WHO[5], replacing Dr Rutz. The President informed the meeting that Dr Brian Parsons, PWG representative from Ireland, had resigned due to the lack of funding.

3. To receive and approve the minutes of the last meeting

The minutes were approved as the correct record of the proceedings. It was agreed that a list of abbreviations should be attached to the minutes.

4. Matters arising from the minutes not covered by the agenda

France

Dr ten Doesschate reported that one of the French psychiatric associations, the SPF[6], had recently paid their subscription to the Section and Board of Psychiatry. The SNPP [7]had not as yet paid their subscription. This meant that France still owed half of its dues to the Section and Board which might have implications for its membership.

Rules of Procedure for Officers' Elections

The working group on RoP for Officers' Elections had not yet been established as the MC had not finished their work on revising the existing RoP to bring them up to date. It was hoped this would happen at the MC meeting the following week and the results would be reported at the Section's next meeting in April 2005.

Visit feedback questionnaire

It had been suggested that visits to local schemes should be concluded with a report to the host associations. This would create a formal record of such visits which national associations might find useful. A WG[8] would be set up to develop this initiative. This would need to take into account the potentially sensitive nature of any such feedback and to recognise the position of the Section as a guest in the host country. Never the less, it was felt that as a group of senior psychiatrists the Section and Board had a range of expertise to potentially provide constructive feedback. Prof Furlan, Prof Gómez-Beneyto and Dr ten Doesschate expressed interest in joining the WG.

Psychotherapy Report

The psychotherapy report approved by the Section at the previous meeting was submitted to the MC for ratification. Dr Pylkkänen reported that it was on the list to be published as a position paper of the MC after their further meeting.

[4] PERMANENT WORKING GROUP FOR JUNIOR DOCTORS
5 WORLD HEALTH ORGANISATION
[6] SYNDICAT DES PSYCHIATRES FRANÇAIS
[7] SYNDICAT NATIONAL DES PSYCHIATRES PRIVÉS
[8] WORKING GROUP

Website links

The President reminded the delegates to urge their associations to establish links between their websites and the Section's website. A reminder to that effect would be circulated shortly after the current meeting.

ACTION: JC to send a reminder re links.

5. Rules of Procedure for Officers' Elections – voting rights for EFPT and PWG

The President explained that the PWG was an independent organisation closely linked to the UEMS. Its membership was made up of national organisations of junior doctors in each member country, thus resembling the structure of the UEMS. It had a right to vote in the Management Council as explained by Dr Maillet at the meeting in Edinburgh. Delegates supported the suggestion that both trainee organisations should have the same voting rights as each other. It was therefore agreed that from that point onward the EFPT would have a right to vote in Section and Board matters.

As the RoP for Officers' elections were not yet available the elections of the Board's Officers the following day would be conducted according to the existing rules of procedures. Prior to the meeting, notice of procedures and elections had been circulated to all delegates together with the agenda papers. The Treasurer clarified that only countries that had paid their subscription in full, i.e. not only for all the previous years but also for the current year, had a right to vote. In a point of clarification, it was noted that each national association received an invoice and was required to pay within two months. Invoices were sent out in January with a reminder two months later. This allowed delegates to ensure the subscriptions were paid by the spring meeting. This arrangement was agreed as reasonable.

On enquiry from Prof Musalek, the Treasurer explained that the AEP was required to pay their subscription as their membership included individual psychiatrists and had an observer status at the Section and Board whereas the EFPT's subscription was covered by the Section because they were a trainee organisation with a full member status and the membership structure resembling that of the Section and Board. The WHO and WPA were observers which meant they were not required to pay a subscription and did not have a right to vote.

6. Financial matters

a) Account 2003 Report

The Treasurer submitted the annual account for 2003 for information. He reported that the general reserve of the Section and Board was at the moment almost as high as the annual expenditure. There was, therefore, no need to raise subscriptions. The account for 2003 was approved.

b) Budget 2005

The Treasurer submitted the Section and Board budget for 2005 for discussion. He informed the delegates that the current sharing out key was used to draft the budget. The sharing out key was currently being discussed by the MC and it was likely to change. It would most likely affect the new member countries as their subscriptions would be raised to the same proportional level as the other members. It was unclear, however, when the new key might be available. The budget for 2005 was approved. Italy and Slovenia, whose accounts were marked as unpaid for 2004, asked to have their accounts clarified as the delegates were certain that their associations had paid the subscriptions. It was also pointed out that the new member countries should now be listed as full members rather than associate members. The Committee thanked the Treasurer for his excellent work.

7. Brief feedback from delegates on professional, training or service matters

Austria: Psychotherapy training was currently being revised. It would now include 200 compulsory hours of theory and 120 hours of supervision, with each trainee having to take on 6 cases. 240 hours of self experience, 50 hours of individual and 40 hours of group psychotherapy were also required. The funding for the psychotherapy training would also change and would be reimbursed by insurance companies to replace the current arrangement whereby trainees were expected to fund it themselves. The Legal framework for these plans was being prepared. The duration of postgraduate training would be 5 years including six months in neurology and six months in general medicine. The postgraduate written exam had also been changed to structured oral exam during which each candidate would have to discuss 8 cases.

Croatia: UEMS recommendations for training were being submitted to the ministry of health and were still under discussions. Community psychiatry was also actively being developed.

Czech Republic: New legislation to govern postgraduate training was being introduced, and a training programme in psychiatry was being revised. The framework for psychotherapy training was similar to the Austrian model without a specific number of hours, however rotation between departments would be compulsory. The new model had not yet been formally recognised by the ministry but would be soon.

Denmark: Recruitment was still a big problem and was likely to continue as such for the next 5 to 6 years. The recent training reform had encountered implementation problems but training institutions were working on it. The main changes to training included extended syllabus, competence-based evaluation of training replacing the final exam. The reform of the administrative units in Denmark was being planned to enlarge the smallest community units to allow them to cater for at least 30.000 population. The borderline between the delivery of social services to psychiatric patients and treatment psychiatry had not yet been clarified. The government had initiated work to define a common set of values for psychiatry including the social services for psychiatric patients. The values defined included a) mutual respect; b) developing professional skills, research and monitoring of professionals; and c) continuity of care and shared responsibility. These values would be implemented on three levels, i.e. individual healthcare workers level (between patient and professional, and between professionals), secondly, organisational level, and thirdly, political level. This model would be endorsed by the parliament but its implementation had not yet begun.

Finland: The country experienced shortages of psychiatrists and difficulties in recruitment of young psychiatrists. From March 2005 a new law on access to treatment would be in force. It would regulate maximum waiting times for treatment. In summary, it would mean that the public healthcare sector had a duty to examine the patient within 3 weeks from the time of referral and the treatment must start within 6 months from the time of assessment. There would be common medical criteria the patient would have to meet in order to obtain treatment. Where those criteria were met but the public sector could not provide the treatment the service would have to be bought from the private sector. This model would not be easy to implement in psychiatry as the private sector had no community psychiatry concentrating primarily on psychotherapy.

Germany: The ministry of health was planning to reduce the number of hospital beds but failed to provide resources for community psychiatry claiming the responsibility for community psychiatry funding lay with insurance companies which, however, were struggling financially.

Greece: Rural areas in the country, e.g. the islands, were experiencing problems with developing psychiatry. The ministry of health was being lobbied to increase funding for professional services to implement at least the main services.

Ireland: The implementation of the EWTD[9] was proving difficult due to insufficient manpower. Its impact on training would be substantial as training would be regarded as part of the trainees' working week. A compromise would have to be reached. The new mental health act would cover both hospital and community treatment and the emphasis would be on treatment in the community. The organisation of health care provision was set to change when a new body – a healthcare executive - took over responsibility for policy making, implementation, etc. The new disability law to be introduced shortly would give equal access to services for all disabled people including those with mental health problems.

Israel: The training programme in psychiatry lasted 4 and half years. During their residency trainees were expected to sit stage one exam which consisted of a written multiple choice paper. A new curriculum was being implemented describing the expected outcomes at the end of training in terms of competencies. Psychotherapy was an important part of psychiatric training but was not compulsory. Trainees were expected to treat two long term patients and two short term ones and discuss them in their final exam.

In terms of service provision, psychiatry was not covered by the national health insurance. The ministry of health subsidised the services but patients had to cover their own medical insurance. A reform of mental health services was underway, cutting the number of beds to give more resources to community treatment. The legal aspect of compulsory admission would also be changed, which would reduce the psychiatrist's involvement in the process. A district psychiatrist was able to give an order for a week's detention and a

[9] EUROPEAN WORKING TIME DIRECTIVE

further week after that. If further detention was required after the two weeks it was decided by a tribunal in which psychiatrists only had an advisory role and had no direct involvement in the final decision.

Italy: Compulsory admission was for one week initially, which could be extended for further periods of seven days however the psychiatrist had to justify the reasons for continuing the detention. A new law was being introduced to allow psychiatric patients to be involved in the process of compulsory detention. Patients under compulsory detention retained their legal rights. Clinical psychology was now being taught in medical schools. However, there was a discrepancy in funding for postgraduate training, i.e. training in medical specialities was covered by the state whereas psychologists had to pay their own fees. There was currently a debate in the parliament with a strong lobby in favour of allowing psychologists to prescribe. At present, Italy did not seem to have any problems with recruitment. A psychiatric rehabilitation technician was a new allied profession in Italy.

Netherlands: According to a body responsible for the planning of the number of specialists in the Netherlands there would be too many psychiatrists in the future and recommended the number of residential training places should be reduced.

Norway: The country was struggling to make the services more cost effective. The government had pledged to invest in mental health but the impact of that decision had not as yet been apparent. The next year's budget announced recently allocated more funds for urban psychiatry to improve acute treatment as well as the treatment of the long term ill. By law every patient should have a long term plan involving the patient's family, psychiatrists and any allied professionals such as psychologists and nurses. The changes in training revolved around attempts to secure more academic input in the training schemes, including a proposal for a new dual academic/clinical programme to obtain a PhD and become a specialist psychiatrist.

Portugal: A new law had been introduced to reform postgraduate training. Portugal had one of the longest training systems in Europe. To qualify as a psychiatrist, one spent 6 years in a medical school, 2 years in an internship and 5 years in specialist psychiatric training. The current reform stipulated that after graduating from a medical school doctors would be able to choose their speciality immediately and spend one year in common trunk medicine, surgery, or community medicine. Psychiatry would probably be part of the general medicine training. This would count as one year in psychiatry consequently reducing formal psychiatric training to 4 years.

Slovakia: The country was undergoing rapid changes with new laws being introduced every 3 months. All healthcare would be based in the private sector, however the government would retain 51 percent of ownership. The psychiatric training in Slovakia lasted 5 years (6 in neuropsychiatry) and could be taken up either in child and adolescent psychiatry or general psychiatry. Psychotherapy was included in the general psychiatry, however trainees had to pay for their psychotherapy training. There was one examining body in Slovakia.

Slovenia: After 8 years of drafting, the new mental health law was finally going to the parliament. The main change under the new law would be the introduction of community psychiatry. Compulsory detention and treatment was similar to the Dutch model.

Spain: There had been plans to extend the length of psychiatric training to 5 years but the government decided it should remain at the current level of 4 years. The government was now working on preparing an administrative frame for psychotherapy to regulate the training and provision.

Switzerland: The routine revision of the curriculum was underway in which the UEMS training recommendations would be taken into account, e.g. a logbook, the revision of training scheme assessments and visitation forms. Psychotherapy training in Switzerland was of a very high standard which often caused problems with doctors from other countries who might not always have the same level of expertise as Swiss psychotherapists. The new curriculum would stipulate 6 years training to become a general psychiatrist and an additional 2 years to cover training in the proposed two subspecialities: old age psychiatry and forensic psychiatry. Some Cantonal hospitals had undertaken a comparative study of compulsory treatment in general adult and in old age psychiatry to produce common benchmarks for all. The government ban on opening new private practice centres introduced in 2002 will probably be extended for another 3 years.

Turkey: The Turkish Psychiatric Association was founded in 1995, largely thanks to the UEMS. Its membership included most of the country's psychiatrists (95 percent). It had 1300 members in total, 300

of which were trainees and 600 members were specialists in private practice. The Association organised three congresses a year, published a bulletin with 3 issues a year. The Association had recently established a Board of psychiatrists whose main role would be to set up criteria for psychiatric training. Trainers who met the criteria would be board certified. Subspecialities recognised in Turkey included old age, liaison and forensic psychiatry. The Association was currently working on a curriculum which was widely consulted with training institutions and trainees themselves. The level of satisfaction with the new curriculum among the trainees seemed to be acceptable.

UK: The proposal for a new England and Wales mental health act was published in September this year. The College had grave concerns about the proposed legislation in terms of civil liberties, ethics, practicality and effectiveness. The main anxiety was that the new act could further distance the practice of psychiatry from the rest of medicine and might result in people with mental health problems having less rights than those with physical illnesses. The Scottish mental health act 2003 concentrated on the benefits to the patient with lesser focus on public safety than was the case with the English act.

The organisation of training was also due to change with the establishment of a new regulatory body (PMETB[10]) with the responsibility for the standards and quality assurance of all postgraduate education, training and assessment in medicine and dentistry. The government had published a Policy Statement on modernising medical careers setting out principles for a major reform of postgraduate medical education. It underlined the importance of care based on effective, interdisciplinary teamwork and of flexible training pathways tailored to meet service and personal development needs. After graduating from undergraduate study, doctors would undertake an integrated, two-year Foundation Programme focused on generic competencies and the management of acute illness. This would act as a bridge between undergraduate and specialist medical education. A Foundation Year 2 programme in Psychiatry was currently being piloted. A research project was to be set up to determine reasons why some universities had more success in stimulating recruitment into psychiatry than others.

8. UEMS Matters

a) UEMS Management Council – Role and Function

For the benefit of the new delegates, Dr Pylkkänen briefly outlined the structure of the UEMS and the MC and his own role there. The membership of the MC consisted of representatives from non-governmental national medical professional organisations. The organisations were represented on the Management Council by up to two delegates who must be specialist doctors. Dr Pylkkänen was appointed by the Finnish Medical Association as their delegate to the MC and not in his role as a psychiatrist. When his term of office in the MC ended there would not necessarily be a psychiatrist in the MC.

The last meeting of the MC was held in March 2004 where the main topic for discussion was examinations issued by some European Boards. It was emphasised that these exams had no legal standing in Europe and EU Member States were not obliged to recognise them. Their status was purely prestigious and the MC's policy did not grant any official recognition to such examinations. This contrasted with the position of national degrees and diplomas.

The MC continued to lobby the European Parliament through national employment, health and education ministries, and the MEPs on the subject of the professional recognition of qualifications and the impending changes to the directive. The MC's position was that all 52 currently recognised specialities should retain their status. In May 2004 the Council of Ministers agreed that medical specialities recognised in two fifths of Member States would be also recognised at a European level. This was an improvement on the previous proposal which stipulated that only specialities recognised in all Member States would be formally recognised by the EU. The final decision would be taken by the EU Parliament probably in October and the UEMS MC would continue to lobby for the old system of recognition whereby any speciality would be recognised if it was established in two or more Member States. A previous suggestion that professionals could practise their profession in any EU country for 16 weeks without a formal registration with a relevant body in the host country had been abandoned in professions with health and safety implications which included medical doctors.

[10] POSTGRADUATE MEDICAL EDUCATION AND TRAINING BOARD

The MC continued its work on the CME[11], CPD[12] and quality assurance. Concerns raised by some delegations highlighted the differences in healthcare systems operating in different EU states. Any position paper adopted by the MC should aim to reinforce and support the position of a medical specialist.

Dr Pylkkänen briefly outlined the history of the Sections and Boards' representation in the MC the main aim of which was to promote the closer collaboration between the Sections and the MC. All the Sections were divided into three groups each being represented by one Section for two years. At the moment, the Section and Board of Psychiatry was being represented by Child and Adolescent Psychiatry Section. All three Section representatives universally agreed that the representational system did not work very well as the internal communication between Sections in each group was very poor. It was also suggested that the term of office for each group representative should be extended to 4 years to allow time to familiarise themselves with the structures and workings of the UEMS and other European institutions.

It was reported that France's overdue subscriptions for 2002, 2003 and 2004 amounted to €90,000 of which only €10,000 had been paid recently. The French delegation had been asked to present a written timescale for the payment of their dues in time for the MC's meeting in Lisbon.

The new EU Member States would have their subscriptions raised in a progressive system over the next 3 years to reach the level of other members. The sharing out key would remain the same until reliable data regarding the components of the key could be obtained from the national medical organisations.

In conclusion, Dr Pylkkänen reported that the Section's psychotherapy report was very well received and adopted as the MC position paper. The Section and Board should now endeavour to have most of its reports approved as UEMS policy papers which would give them a much grater political influence. The matter would be put on the agenda for the next meeting.

Action: Section and Board reports to be adopted as MC policy papers – item for the Spring agenda.

b) UEMS Child and Adolescent Psychiatry Section

Dr Sontag was not present to offer his report.

c) Report from the latest meeting of the MC with Sections and Boards

Prof Gómez-Beneyto, attended the annual meeting of the Sections and Boards with the Management Council held on 15 May 2004 in Brussels. Each section provided a report for the meeting distributed for information. This meeting confirmed the concerns expressed during the MC meeting in March about the effectiveness of the Sections and Boards representational attendance at MC meetings. The recurring complaint was the lack of communication between the Sections and their representative in the MC. It was suggested that agendas should be distributed at least one month in advance to facilitate discussions in the Sections.

The MC was planning to circulate a questionnaire regarding the evaluation of psychiatric candidates and another one on common values of the regulated professions in Europe. It was hoped that national authorities would express interest in obtaining such data and provide some funding towards the project. Prof Gómez-Beneyto believed that although the Section and Board had to cover the travel and accommodation expenses to attend those meetings, and even though they were not always very productive, it was never the less essential for the Section and Board of Psychiatry to attend them. It offered an opportunity to re-affirm the Section and Board's identity as an independent body representing the profession with no political interests, unlike the CPME[13] - a body composed of medical associations mostly discussing political issues.

9. Collaboration with psychiatric organisations in Europe

a) Leaders in European Psychiatry

A joint letter from the leaders in psychiatry was tabled at the meeting informing the delegates of the 5th meeting of Leaders of European Psychiatry to be held in Florence, Italy, on 10th November 2004. The letter was accompanied by the consensus statement on psychiatric services and training approved at the previous meeting of the leaders in Geneva in April 2004. The statement made several points regarding implications

[11] CONTINUING MEDICAL EDUCATION
[12] CONTINUING PROFESSIONAL DEVELOPMENT
[13] STANDING PERMANENT COMMITTEE OF EUROPEAN DOCTORS

that evolving community psychiatry would have on psychiatric training. They included, among others, the need for training in multidisciplinary practice, in community and primary care settings, in working with the patient's families and in core psychotherapeutic skills. Prof Gómez-Beneyto urged the delegates to encourage their associations to send a representative to the meeting in Florence to support collaboration among those organisations.

b) AEP

Prof Musalek reported that the AEP was currently undergoing substantial changes within its organisation as well as in collaboration with other bodies. Its biennial congress would be replaced by an annual conference which in the future would have scientific sessions, educational symposia and courses (10-15). National associations were being encouraged to invite the AEP to organise courses at their meetings. The AEP would cover the organisational costs whilst accommodation would be provided by the host association. Prof Henning Sass from Germany would replace Prof Mario Maj as the next President of the AEP in January 2005.

c) WHO

The last WHO regional meeting was held in Copenhagen in October. A recent paper on non-communicable diseases and psychiatry was not mentioned but it was agreed by popular demanded that mental health should be included.

The WHO would hold a ministerial conference in Helsinki from January 12th to 15th. A declaration and an action plan on Mental Health for Europe would be endorsed at that conference. This would determine the policy on mental health for the next decade. Europe in a WHO context comprised 52 countries and reached as far South as the Caucasus and as far East as the Ural Mountains. It was vital that psychiatry leaders should attend the conference. However, invitations were issued to ministries of health in each member country.

d) CME Task Force

Dr Lindhardt and Prof Gómez-Beneyto reported jointly on the developments regarding the CME/CPD accreditation in Europe. They reminded the delegates that the EACCME[14] was established by the MC in 1999 with the purpose of ensuring access to quality CME events and securing European exchange of CME credits. It did not accredit CME events directly but acted as a clearing house, i.e. it did not supersede national accreditation systems. The CME Task Force, comprising representatives from all the major psychiatric organisations in Europe, was created independently and after some initial frictions between the two bodies co-operation had now been established. It was agreed that the EACCME would consult the Task Force on CME events in psychiatry. Mutual responsibility for CME with other organisations such as AEP and WPA provided the uniformity at an international level. The delegates strongly supported this collaboration. It was important to maintain and develop it to prevent the proliferation of profit making groups in the field of CME. It was pointed out, however, that national authorities which had the ultimate responsibility for CME accreditation, might not accept credits granted by a European body such as the EACCME. The EACCME had to date negotiated agreements with four national authorities which had accepted the EACCME responsibility for CME at a European level.

The system was supported by the delegates.

10. Website update

Mrs Carroll informed the delegates the new website was up and running. It had been agreed at the meeting in Limassol that the names and email addresses of all delegates should be available on line. A permission form would be re-circulated to those delegates who had not yet returned it. Mrs Carroll also asked the delegates to ask their organisations to install a link from their websites to the Section website. To date none had been installed. It was agreed that the minutes of Section and Board meetings should be available on the website once they were approved by the delegates.

ACTION:

1. **Delegates to arrange for links to be established from their association's website to Section site**
2. **Publish approved minutes**

[14] THE EUROPEAN ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION

11. Any other business

International Psychiatry bulletin, produced by the Board of International Affairs of the Royal College of Psychiatrists had published an article by Dr Lindhardt, Prof Gómez-Beneyto and Dr Saliba about the work of the Section and Board.

Prof Gómez-Beneyto received a letter from the MC which referred to the European Commission's planned directive "to ensure that service providers can exercise as easily throughout Europe as they do within each member state". This would no doubt facilitate the growth and expansion of medical insurance companies in Europe. It could potentially be a welcome development, however the interests of insurance companies did not always match those of the medical profession, psychiatry in particular as was clearly demonstrated by the current situation in the USA. Prof Gómez-Beneyto suggested that the Section should discuss the relationship between the medical profession and insurance companies and the way this might affect psychiatric practice. A position paper on this key issue might be useful.

The President thanked Dr Iveziæ for inviting the Section and Board to Croatia and for an excellent organisation of the meeting.

12. Dates of next meetings

14-16 April 2005 – Turin, Italy
6-8 October 2005 – Košice, Slovakia
April 2006 – Vienna, Austria

13. Reports from the Working Groups

(a) Mental Health Services

In the absence of Dr Saliba the working group did not meet.

(b) Profile of a Psychiatrist

Following some intensive discussion, the working group was now confident that the final draft would be ready in time for the next meeting. It would be circulated to all delegates for comments and the amended version submitted for further discussion at the plenary discussion in Turin next April. This working group had selected Dr Strachan as Vice-Chair.

(c) Recruitment and Retention

Prof Bhugra reminded the delegates that the working group had circulated a brief questionnaire aimed at eliciting basic data regarding problems with recruitment and retention reported in most countries. The working group received replies from 14 countries. All respondents seemed to indicate similar problems. Out of 14 replies received 9 countries reported problems with recruiting. The working group urged those who had not yet replied to submit their responses as soon as possible.

(d) Stigma

In the absence of Prof Hohagen the working group did not meet.

(e) Private practice

Preliminary results of an ad hoc survey conducted after the meeting in Edinburgh showed that some 15 to 20 thousands doctors across Europe were working in private practice, 50 per cent of them full time. The working group would like to concentrate on, and produce, recommendations for issues that needed clarification, such as accreditation and training, child and adolescent psychiatry, stigma brought upon by the restrictions in the funding and insurance systems, patient rights. It was hoped that the first draft of the report would be ready for the next meeting.

(f) Visit Feedback Questionnaire

Prof Gómez-Beneyto was appointed chair of this new working group whose objective was to develop the way in which the host country could obtain structured feedback on the visit to their services. Although the visit day was found very useful by the delegates, it was felt that the host institution did not seem to benefit

from the opinion of experts inspecting their services. It was felt important to find a way in which the delegates' impressions on the visit day could be conveyed to the host in a helpful and constructive manner. The sentiment was shared by many delegates who had hosted the UEMS visits in the past. There seemed to be a common perception that a visit report was often a very useful tool in negotiations with local politicians. This process would be informal and designed to provide as much useful information and/or advice as reasonably possible in the setting of such visits.

The working group was proposing to develop a set of standards acceptable in all European countries against which services could be assessed. These would be initially based on the WHO standards set up by a group of experts to help former communist countries to develop their community based mental care services. The working group was hoping to be able to develop the standards by email and test them in Turin as a pilot case.

Some delegates were rather concerned about the use of standards as an assessment tool. Standards normally came from within a certain set of circumstances relevant to a particular country and as such would not apply across Europe. It was suggested that it might be more appropriate to develop a basic profile for services that would specify minimum requirements acceptable to all countries. The system of feedback would be voluntary and provided on express request of the host.