ACTIVITIES OF THE UEMS SECTION & BOARD OF PSYCHIATRY

Authors:
Dr Anne Lindhardt (Denmark)
President, UEMS Section of Psychiatry
Dr Joseph Saliba (Malta)
Secretary, UEMS Section of Psychiatry

In line with UEMS policy and direction, the UEMS Section of Psychiatry was established in 1962. It was, however, without much activity until revitalised following a meeting of the European Societies in 1990 called by the Royal College of Psychiatrists in England and chaired by Dame Fiona Caldicott. At the following meeting in Brussels, Dr Paul Lievens (Belgium) was elected President.

The UEMS Board of Psychiatry was established in 1992 as a working group of the Section with particular focus on training matters. To ensure the most effective way of working it was decided from the outset that the Section and Board would be composed by the same members with separate, albeit inter-related agendae. The Section is chaired by Dr Anne Lindhardt (Denmark) and the Board by Professor Manuel Gomez-Beneyto (Spain).

Over the years, the Section and Board have focused on the main task of providing standards for training in psychiatry in accordance with contemporary knowledge, current developments and ethical issues. Alongside this, work has concentrated on gaining knowledge, clarifying the state of the art in the European countries and focusing on a number of issues relevant to the conceptualisation of psychiatry as practised in member countries. In this task, it has been crucial throughout, to recognise cultural and structural differences in order to achieve common and achievable goals for training.

The Section and Board see their role as a quality assurance organisation, setting standards by stimulating the process of development in member countries. It is thus left to the professional bodies of the individual countries to use the standards and

recommendations internally, so as to achieve the goals with their respective members and government authorities. The Board has not opted to act as a European examining board for the speciality.

The Section and Board meet twice a year in April and October and, apart from its full members, have a large number of associate member countries, these being: Croatia; Czech Republic; Estonia; Hungary; Latvia; Lithuania; Malta; Poland; Slovakia; Slovenia and most recently, Turkey. Furthermore, a number of other bodies hold observer status. These are the Association of European Psychiatrists (AEP), European Federation for all Psychiatric Trainees (EFPT), Permanent Working Group (PWG) and the World Health Organisation, through its Mental Health Regional Advisor. There are also active links with the World Psychiatric Association and the American Psychiatric Association.

The Section and Board have focused extensively, but not exclusively, on a number of important UEMS Charters (figure 1) especially those on Training, CME, Visitation of Training Centres and Quality Assurance. For this purpose, the Section and Board have set up a number of working groups and activities, some to customise the aforementioned UEMS Charters for use in psychiatry, others to focus on fields of activity, more exclusively relevant to psychiatry (figure 2). The latter have included Biological Psychiatry, Psychotherapy, Old Age Psychiatry, Mental Health Legislation, Profile of the Psychiatrist and most recently, Mental Health Service Profile. The latter two are still at an early stage of activity. Some of the working groups and their activities will be described.

Training of Medical Specialists in the EU - Requirements for the Speciality of Psychiatry

The Section and Board have focused especially on **Chapter 6 of the Charter on Training of Medical Specialists in the EC**, which deals with the requirements for the particular Specialty[1]. This Charter, with its various appendices, was finalised by the Section and Board of Psychiatry in Strasbourg (April 2000) and is now available on the UEMS website.

The minimum **duration of training** in Psychiatry has been set at five years with stipulated **common trunk** content to include in-patient, outpatient, liaison, consultation and emergency psychiatry. **Psychotherapy training** is also part of the common trunk. Whereas, general adult psychiatry, old age psychiatry and psychiatric aspects of substance misuse should form a mandatory part of the common trunk, it is highly recommended that developmental psychiatry and forensic psychiatry are also included. So far, however, the Board has not recognised subspecialties in psychiatry, as there are big differences in recognition of subspecialties between the different member countries.

Apart from ongoing clinical supervision, there should be at least forty hours of weekly **individual supervision** related to all aspects of working as a psychiatric trainee. In addition, specific psychotherapy supervision should be provided. Training programmes should be **individualised** to the needs of the trainee in line with National rules and EU recommendations. Because communication has an additional importance in the field of Psychiatry, it is particularly important to uphold the UEMS Training Charter recommendation that trainees have sufficient **linguistic ability** to communicate with patients, study international literature and communicate with foreign colleagues.

The **logbook** (figure 3) should be the trainee's personal file to help the trainee obtain maximum benefit from training. As such it should include a description of activities reflecting **compulsory training requirements** and providing for verification and monitoring of the training process and

should also provide for identification of **specific 'educational objectives'** to reflect the approved training direction that the trainee is pursuing beyond minimum requirements.

A separate appendix sets out the logbook structure including compulsory elements of training and other clinical and academic training activities such as external courses, research and international exchange. Other **appendices** of the Training Charter deal with theoretical aspects, psychotherapy, community psychiatry, and biological psychiatry.

Although the number of trainees should not exceed the number of approved training posts, however in psychiatry so far, it has not been considered necessary to stipulate a **numerus clausus**.

With regard to **formal recognition of training institutions and teachers**, distinction should be made between **large complete institutions** where full-time training can take place and **smaller specialised institutions**, which can only contribute to part of the training. The time interval for external visitation to maintain **Quality Assurance,** has been set at a minimum of every five years and there should be independent consultation of trainees.

The Section and Board of Psychiatry have described training in psychiatry in Europe in the 1997 supplement of the European Archives of Psychiatry & Clinical Neuroscience[2].

Visitation of Training Centres

Another field in which the Section and Board have been active has been Visitation of Training Centres in accordance with provisions of the UEMS Charter on Visitation of Training Centres (Figure 4)[3]. Experience in the visitation process is being acquired by encouraging training centres in countries hosting Section and Board meetings to submit themselves to inspection visits in accordance with the Charter and led by Professor Willem Schudel (Netherlands) who already has extensive similar type experience in his own country. Member countries are thus starting to acquire experience, both in the process of preparing for and carrying out such visits in anticipation of formal implementation of the Charter. So far, Budapest, Hungary and Krakow, Poland have submitted to such visits. So as to encourage training centres to commence this process, consideration is being given to the possibility of granting provisional recognition status to Centres where good training initiatives fall short of the full requirements.

Quality Assurance

Another of the working groups led by Dr Karl-Otto Svärd (Sweden) has dealt with application of the Charter on Quality Assurance to Psychiatry[4]. Following a questionnaire survey of member countries, recommendations have already been drawn up identifying targets to be achieved by the year 2000 (figure 5). The working group is currently establishing standards in specialised psychiatric care in the four phases of referral, assessment, treatment/stabilisation and rehabilitation.

Mental Health Legislation

A further area of activity has been that of mental health legislation. Dr Helle Aggernaes (Denmark), who leads this working group, had originally carried out a questionnaire survey in 1993 of the 16 member countries regarding legislation for compulsory admission and other compulsory acts in psychiatry. This had led to an internal report, which highlighted wide variations both in legislation and also in the way that it is applied[5]. Subsequently the working group has focused on trying to identify harmonising principles for mental health legislation. This report is being updated on the basis of a repeat survey of the enlarged Section/Board membership. Most recently, this work coincided with that of the Council of Europe's Working Party on Psychiatry and Human Rights, the

latter leading up to a white paper/consultation document on the protection of the human rights and dignity of people suffering from mental disorder[6]. The UEMS Section has commented on this "White Paper" endorsing its importance and stressing that priority should be given to decreasing risk of involuntary admission and treatment by advising the governments to give more emphasis to improved access to adequate and high quality community based and outpatient psychiatric services.

Profile of the Psychiatrist

The problem of defining the role and sphere of activity of the medical specialist is by no means peculiar to psychiatry. There are several other medical specialities where a blurring of boundaries has developed between that which is the exclusive professional activity of the medical specialist and that which can be legitimately done by related non-medical professionals. This has obvious implications for protecting specialist medical acts from non-medical encroachment, but more importantly, for ensuring that patients are treated by the right type of professionals in possession of the appropriate skills. This working group, which is being led by Dr Charles Smith (Ireland), is at an early stage of activity. This topic is already being addressed in individual member countries. In the Netherlands, the Dutch Psychiatric Association has prepared a Psychiatrist's Profile[7]. In the UK, the Medical Royal Colleges and Specialist Associations have been establishing standards in each medical speciality, which are likely to contribute to the appraisal and re-validation of medical practitioners. The Royal College of Psychiatrists has recently published its own recommendations in 'Good Psychiatric Practice 2000'[8]. It is likely that these documents will act as a basis for the discussion of this working group.

Mental Health Service Profile

The last working group to be mentioned will be developing a Mental Health Service Profile. Its aim would be to try to harmonise recommendations regarding good models of service, defining irreducible minimum standards of acceptable care. The task is not an easy one given the great diversity that exists, both in models of service delivery and adequacy of service provision. However, it is a field of investigation, which is already receiving considerable attention. de Jong has devised a tool, the international Classification of Mental Health Care (ICMHC), for describing services providing mental health care[9]. Thornicroft and Tansella have also described mental health outcome measures including the 'Matrix Model'[10,11]. In the UK, Thornicroft has described a National Service Framework for Mental Health[12,13]. Finally, a recent supplement of The British Journal of Psychiatry edited by Thornicroft et al is devoted to reliable outcome measures for mental health service research, based on a comparative cross-sectional study of care of people with severe mental illness (schizophrenia) in five European countries: the EPSILON Study (an EU BIOMED-2 funded research project)[14]. Thus, a significant amount of work has already been done which can guide the working group in formulating its project.

Conclusion

Psychiatry is a medical field, which is greatly expanding in recent years. Bordering on humanistic and sociological disciplines, it provides great challenges to clinicians and researchers. New and promising knowledge on neurobiology alongside a renewed interest in psychopathology have strengthened the search for evidence-based treatment methods, in the fields of psychotherapy, psychopharmacology and social psychiatry. Most encouraging is the attempt to integrate knowledge from the aforementioned areas of research, acknowledging the close inter-relatedness between human psychology, biology, social circumstances and how, changes in one area influences the others. Psychiatry deals, on the one hand, with persons who have a very good prognosis if given the right treatment at the right time, as for example with anxiety disorders and depressive disorders. However, psychiatry also deals with persons who have very severe and lasting disorders

such as schizophrenia. New integrative and preventive methods are being investigated for early detection and intervention. For chronic patients, community based assertive outreach treatment and social support are enhancing the patient's social role function and thus quality of life. In psychiatry, the necessary starting point for any treatment is the establishment of a treatment alliance, thus the importance of the interaction and interrelation between doctor and patient. Therefore, the subjective experience must be acknowledged to be as crucial as the "objective" medical findings. Ethical questions and human rights issues are part of the psychiatrist's everyday work. Finally, compulsory admission and treatment pose ongoing ethical dilemmas to the psychiatrist and should be perceived accordingly.

To be a psychiatrist is thus both challenging and fulfilling. There is a need to recruit young doctors with both the interest and the personal abilities to make careers in the field of psychiatry.

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Figure 1

Activities of the UEMS Specialist Sections and Boards

- **Charter for Medical Specialists in the EU**
- **Charter on Training of Medical Specialists in the EU**
- **Charter for CME of Medical Specialists**
- **Charter on Visitation of Training Centres**
- **Charter on Quality Assurance of Medical Specialists in the EU**

Figure 2

Activities of the UEMS Section and Board of Psychiatry

- **Charter of Training**
- **Log Books**
- **Visitation of Training Centres**
- **CME**
- **Biological Psychiatry**
- **Psychotherapy**
- **Old Age Psychiatry**
- **Quality Assurance**
- **Mental Health Legislation**
- **Profile of the Psychiatrist**
- **Mental Health Service Profile**

Figure 3

The Log Book & Contents

- **Training package**
- **Description of training activities**
- **Specific educational objectives**
- **Compulsory elements**
- **All other clinical training**
- **External courses & workshops**
- **Research practice**
- **Posters oral presentations & publications**
- **International exchange**
- **Other training experiences**

Figure 4

UEMS Charter on Visitation of Training Centres

- **Statutory & voluntary visitation**
- **Visiting committee**
- **Organisation of the visits**

- **Actual visit – criteria and assessment**
- **Visitation Report**
- **International Visitation**

Figure 5

<u>Recommendations on Quality Assurance</u>

- **National Psychiatric Associations (NPAs) should establish working groups on QA with the purpose of:**
    - **Formulating QA policies according to national standards**
    - **Stimulating the development of QA activities in professional psychiatric bodies and in clinical psychiatric practice at local level**
- **NPAs should establish areas of QA priority both national and local**
- **NPAs should start formulating clinical guidelines on diagnosis and/or problems from within the above areas of priority**
- **Working groups at local/clinical level should be established in the public sector to identify local areas for QA projects**
- **Systems of documentation recording activity and outcome should be in place in the public sector**
- **The above recommendations should also apply to private practice**