Statements of the European Federation of Psychiatric Trainees (EFPT) 2014-2015

PREFACE

The European Federation of Psychiatric Trainees (EFPT) is an **independent** federation, and **represents** the consensus of psychiatric trainee's organizations in more than 30 European countries, **supporting** thousands of psychiatric trainees in all branches of psychiatry across Europe.

The EFPT is officially **recognized** by the European Board of Psychiatry and the European Board of Child and Adolescent Psychiatry. Since its inception in 1992, the EFPT has played a major role in **improving** psychiatric training throughout Europe, regardless of the country.

The EFPT Statements are implemented as the official **EFPT policy** to work with, after being voted by the General Assembly. These, derive from the gathering of the National Trainees Associations' country reports and the information provided through EFPT Working groups.

The **EFPT Statements 2014-2015** result from the collection of the agreement over the years on matters considered important and of concern, seeking to shape the future of psychiatry.

These shall be **communicated** to the relevant organizations to influence policies concerning training in Psychiatry, aiming to improve the mental health care provided.

Mariana Pinto da Costa
EFPT President 2014-2015,
On behalf of the EFPT Board

ACKNOWLEDGEMENTS

We wish to thank all the EFPT members who contributed to the development of the EFPT statements from the past 20 years (from Cork 1994 to London 2014).
The EFPT Statements demonstrate trainees strengthen and determination to shape the future of psychiatry.

CONTENT

1. ORGANISATIONS

NATIONAL TRAINEES ORGANISATIONS

EFPT believes that organized trainee interest is key to promoting high quality psychiatric training in each country, therefore it is essential that both adult and CAP psychiatric trainees are represented by national trainee organizations in each country.

(Copenhagen 1995, Gothenburg 2008, Prague 2011)

2. TRAINING IN PSYCHIATRY

GENERAL MEDICINE AND NEUROLOGY IN PSYCHIATRIC TRAINING

Psychiatry is an integral part of medicine. Psychiatric training bodies must be responsible for ensuring psychiatric trainees acquire and maintain adequate knowledge and skills to manage all medical conditions and refer patients to medical specialists when appropriate. This can be achieved by organising rotations of six months to one year in general medicine, internal medicine and/or neurology.

(Cork 1994, Gothenburg 2008, Cambridge 2009, Zurich 2013)

EXPERIENCE IN RESEARCH

Psychiatric trainees should be trained in basic knowledge of research methodologies. They should have basic training in critically appraising research evidence. Trainees involved in research should be encouraged to communicate the results of their work. Trainees should also be encouraged to develop scientific attitudes towards their professional activities and an ability to effectively implement new research evidence into their clinical practice.

We recognize that research is a vital element for the scientific development of psychiatry. Therefore we recommend that adequate time, resources and research supervision (by a PhD level supervisor) are made available to all trainees to train in and carry out research. Access to basic research facilities such as a medical library, internet, office facilities and communication with other related professionals (e.g. statisticians) are also recommended to enhance the quality of the training experience. Experience in research can also be a part of exchange programme.

(Cork 1994; Athens 1997; Naples 2001, Istanbul 2005, Gothenburg 2008, Zurich 2013)

BRAIN DRAIN

Brain Drain represents the large-scale migration of a group of skilful and knowledgeable individuals. This phenomenon greatly affects the population of psychiatric trainees across Europe, who relocate to countries with better work opportunities. This migration affects the health services and care, in both donor and host countries.

The EFPT acknowledges the social, cultural, economic and political aspects regarding this workforce migration among psychiatric trainees. We look forward to enhance both the support for those remaining in their countries, as well for those who migrate.

(London 2014)

Training in Child and adolescent Psychiatry

Within this period, we recommend that the trainees should gain experience with 0-18 year old children with mental health problems within varying settings of care with access to relevant sub-specialty training that is provided by the training program.
We recommend that there are clear training guidelines for CAP in each country and that implementation of these guidelines is monitored.
Trainees should have access to CAP specific psychotherapy training opportunities, provided within their training program.
CAP trainees should be routinely supervised by CAP specialists at a level appropriate to the trainees' level of training.

(Lisbon 1996, Sinaia 2002, Istanbul 2005, Gothenburg 2008, Cambridge 2009, Dubrovnik 2010, Prague 2011, Zurich 2013)

CAP Forensic Psychiatry

There is a lack of formal training in Forensic CAP in Europe.
Forensic Training in CAP is highly desirable for becoming a competent CAP Specialist.
Structured Forensic CAP Training should be a regular part of the CAP Training Curriculum.

(London 2014)

Psychotherapy training

A working knowledge of psychotherapy is an integral part of being a psychiatrist and this must be reflected in training in psychiatry. All trainees must gain the knowledge, skills and attitudes to be competent in psychotherapy. Competence should be gained in at least one recognised form of psychotherapy (of the trainee's choice) and basic knowledge should be gained in the other forms of psychotherapy to allow the trainee to evaluate suitability for referral to specialist psychotherapist.

Training in psychotherapy must include supervision by qualified therapists. A personal psychotherapeutic experience is seen as a valuable component of training. It is crucial that trainees have access to relevant psychotherapy experience to cater to the needs of the appropriate patient group that the trainee is dealing with or is expected to deal with in the future.

Relevant training authorities should ensure that time, resources and funding are available to all trainees to meet the above mentioned psychotherapy training needs.

(Lisbon 1996, Tampere 1999, Napoli 2001, Sinaia 2002, Paris 2003, Istanbul 2005, Gothenburg 2008, Cambridge 2009, Zurich 2013)

TRAINING IN COMMUNITY BASED PSYCHIATRY

There should be a training period of at least 6 months in community-based psychiatry, in the training of all psychiatrists, during which:
- The trainee is able to see patients outside the hospital, for example in community-based clinical settings, on home visits and by visiting other institutions caring for mentally ill. The aim is to learn to know and understand the social environment of the patient.
- The trainee is trained in co-operating with other health professionals and other agencies involved in the treatment of psychiatric patients. The aim is the ability to work in and lead a multidisciplinary team caring for the patient, and interact effectively with other agencies involved in the care of the patient.

The aims mentioned above are achieved by structured education, and by personal supervision concentrating on these issues. A minimum amount of personal supervision should be one hour per week.

(Sinaia 2002, Zurich 2013)

OLD AGE PSYCHIATRY

Demographic trends suggest a substantial increase in the elderly population across Europe. To fulfil the increasing mental health needs of the elderly population all adult psychiatry trainees should have the knowledge, skills and attitudes needed to manage the mental health needs of older people.

For trainees who have a special interest in old age psychiatry, the training structure in their country should allow and encourage them to acquire the specific competencies in this field. Senior psychiatrists who are experts in older people's mental health should supervise this training experience.

(Paris 2003, Gothenburg 2008, Zurich 2013)

CONSULTATION & LIAISON PSYCHIATRY (CLP)

There is a growing awareness of the increasing psychiatric and psychological needs of patients with physical health problems. Even though the last few decades have seen significant development in diagnostic and treatment modalities in CLP, there seems to be lack of proportionate increase in CLP training opportunities.

It is important to recognise the need for CLP training, not just as a subspeciality but also as a core competency in psychiatric training across all ages. Each training programme should include opportunities to train in CLP as subspeciality and develop those liaison skills that are essential for the practice of any aspect of psychiatry.

(Istanbul 2005, Gothenburg 2008, Zurich 2013)

LEGAL, ETHICAL AND HUMAN RIGHTS ISSUES

It is mandatory for all trainees in psychiatry to have a theoretical and practical education and experience in the principles and practice of their own country's mental health legislation. Trainees should as well be trained to recognise ethical dilemmas, discuss them with colleagues and act in a manner that promotes human rights. These aspects should continuously be a part of the training in all fields of psychiatry.

(Cambridge 2004, Istanbul 2005, Cambridge 2009, Zurich 2013)

RELATIONSHIP WITH PHARMACEUTICAL INDUSTRY

EFPT recognizes the obligation for all psychiatrists, including trainees to maintain transparent relationships with commercial organizations (including pharmaceutical industry) based on ethical principles.

EFPT acknowledges the need for more robust information regarding current practices and attitudes, especially the impact of these on training in psychiatry.

(Dubrovnik 2010, Zurich 2013)

EXCHANGE OF CULTURAL DIVERSITY

We believe that the exchange of cultural diversity in Europe is important for trainees and for good clinical practice in psychiatry.

(Sorrento 2012, Zurich 2013)

3. ORGANISATION OF TRAINING

FLEXIBLE (PART-TIME) TRAINING

Flexible or less than full time training should be available in each psychiatry training scheme across Europe. Standards and qualities of this training should be equivalent to full-time training.

(Cork 1994, Gothenburg 2008, Zurich 2013)

EXCHANGE OF TRAINEES BETWEEN DIFFERENT COUNTRIES

We acknowledge the impact of growing mobility of citizens across Europe on the medical profession. The EFPT foresees an increase in the challenges to psychiatric trainees in particular.

The EFPT should promote an intercultural professional exchange and cooperation among psychiatric trainees across Europe, with a focus on individual experience.
With the EFPT exchange programme, we aim to provide trainees with the opportunities to:
-Promote awareness of intercultural aspects of Psychiatry
-Engage in clinical, and/or research, and/or teaching activities
-To become acquainted with different mental health systems
-To gain experience of different illness manifestations and treatment options
-To experience a different training programme

(Copenhagen 1995, Napoli 2001, Sinaia 2002, Paris 2003, Prague 2011, Zurich 2013)

INDEPENDENT APPEAL PROCEDURE FOR THE TRAINEE

There should be an effective and independent appeal procedure for the trainee who wishes to express complaints or appeal decisions about training matters.

(Sinaia 2002)

REMOVAL OF A TRAINEE FROM TRAINING

Unsuitability of a trainee to work with a medical speciality needs to be distinguished from unfitness to be a medical doctor. A trainee must not be expelled for political or personal reasons that are unrelated to his/her professional competence. Trainees should be treated like qualified doctors in the process of being assessed regarding their fitness to practice. Emphasis should lie on supporting a trainee whose suitability is questioned. The final decision of removing a trainee should rest with a national professional organization. Participation of trainee representatives in the decision-making process is desirable.

(Ghent 1998, Istanbul 2005, Zurich 2013)

MENTAL HEALTH PROMOTION

Mental health promotion and mental illness prevention are integral parts of public health. Psychiatric trainees should receive information on the ongoing initiatives to promote mental health and mental illness prevention and be provided with the opportunity to participate in them.Similar efforts should be incorporated to promote destigmatisation of mental illness in Europe.

(Tampere 1999, Cambridge 2004, Gothenburg 2008, Zurich 2013)

WORKING CONDITIONS

We acknowledge that working conditions strongly affect training as well as patient care. We are aware of the variability of working conditions in different countries.

(Cambridge 2009)

4. QUALITY OF TRAINING

QUALITY OF SUPERVISION

Supervision in psychiatry training includes educational supervision, clinical supervision, psychotherapy supervision and, if required, research supervision. This statement deals with educational and clinical supervision. We recommend that these kinds of supervisions are led by one or more adequately qualified and fully-trained senior psychiatrists.
An important component of good quality assurance of training should be ensuring continuity of training and adequate supervision of the trainees. A central independent professional body should evaluate all programmes and posts. This evaluation, which must include trainees, should ensure, that regular and high quality supervision takes place in each training placement.
(Copenhagen 1995, Napoli 2001, Sinaia 2002, Istanbul 2005, Gothenburg 2008, Zurich 2013)

EDUCATIONAL AND CLINICAL SUPERVISION

Educational supervision must be trainee-focused rather than patient-focused. It should be individual and personal and should involve tutorship, reciprocal evaluation in dialogue, professional skills training, teaching, career guidance, management, and critical appraisal of scientific literature. The trainee should, in consultation with his/her supervisor, determine the contents of the educational supervision appropriate to his/her stage of training. Subjects covered during supervision sessions and agreed future plans should be documented. Educational supervision should result in an open, flexible and confidential dialogue.

One hour of educational supervision per week should be the irreducible minimum throughout the whole of psychiatry training. This should, in effect, make educational supervision an integral, compulsory part of training that takes place during working hours and at no extra cost. The educational supervisor involved can be external or internal to the training centre. For reasons of continuity, educational supervision is provided by the same supervisor for reasonable length of time. Ideally, the trainee should be able to choose his/her supervisor. Educational supervision should be distinguished from trainee assessment.

Clinical supervision should be systematic and involve sharing responsibility for individual patient care, day to day clinical guidance and training in matters as interview skills, phenomenology, diagnosis, treatment and clinical management. Every trainee should have constant access to clinical supervision when on duty, including when the trainee is on call. We recommend that the supervisor as well should organize systematic patient discussions and bedside teaching. Both regularly observing a supervisor's psychiatric interview and being observed while interviewing a patient, followed by discussion, are essential in clinical supervision. Clinical supervision on an individual basis can be complemented with interdisciplinary team discussion or ward rounds. Joint evaluation of new patients by trainee and supervisor should be rule in the beginning of training and readily available as training progresses.

We acknowledge that the implementation of clinical and educational supervision is heterogeneous across Europe and remains unsatisfactory in some training centres and settings.

(Copenhagen 1995, Napoli 2001, Sinaia 2002, Istanbul 2005, Cambridge 2009, Dubrovnik 2010,Zurich 2013)

5. QUALITY ASSURANCE IN TRAINING

QUALITY ASSURANCE IN TRAINING CENTRES

An important part of quality assurance is visitation (auditing) of training centres. These regular visitations should be made by independent teams to training centres at least every three years or more frequently if this is needed. The team should include a psychiatric trainee. Auditing of training centres should include significant clinical and academic aspects as well as working conditions. The statutory body for quality assurance should have the power to enforce recommended improvements to quality of training. In extreme cases, where these improvements cannot/are not implemented after the indicated period of time, consideration should be given to review whether the training centre still meets accreditation criteria. A written report must be available to all parties, including trainees.

(Athens 1997, Gothenburg 2008, Zurich 2013)

LOGBOOKS

The essence of the logbook should be to improve training within each country across Europe. The trainees should have the ownership of the logbook. The logbook should act as a guide for the trainee in both self-assessing the quality of training and competencies obtained, as well as providing indications for areas of improvement. The key requirements of psychiatric training according to European standards need to be clearly stated. Trainee involvement should be integral to the development of any logbook and the monitor of its use.

(Athens 1997, Ghent 1998, Cambridge 2004, Istanbul 2005, Zurich 2013)

COMPETENCY BASED TRAINING

The EFPT supports the recommendations of UEMS on competency based training (CBT) in postgraduate training in psychiatry. Implementation at national level should be appropriately paced, well resourced and not overly bureaucratic. Differences in healthcare infrastructure and cultural perspectives have to be considered. Trainers and trainees should collaborate at all stages of planning, implementation and continuous evaluation, both at national and European levels. Focus has to be on improved quality of training and thus, patient care.

(Riga 2006, Gothenburg 2008, Cambridge 2009, Zurich 2013)

6. TRAINEES

PHYSICIAN HEALTH

Psychiatrists are very good at taking care of patients with mental health problems, but sometimes psychiatrists can be patients themselves.

The EFPT recognises the importance of supporting doctors who become unwell, and believes that appropriate services should be made available to ensure doctors do seek help, and do not feel stigmatised or punished in doing so.

(Sorrento 2012)

PROMOTING RECRUITMENT AND A POSITIVE IMAGE OF PSYCHIATRY

Recruitment of medical students and junior doctors into psychiatry is an important issue in many European countries. This issue is closely linked to the image of the psychiatric profession. As psychiatric trainees, we come into direct contact with medical students. EFPT therefore believes that psychiatric trainees should be involved in actions that can improve the image of the psychiatric profession and wants to provide a platform for the exchange of ideas and successful initiatives.

(Zurich 2013)