



UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES EUROPEAN UNION OF MEDICAL SPECIALISTS

Association internationale sans but lucratif

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Training Requirements for the Specialty of Child and Adolescent Psychiatry

European Standards of Postgraduate Medical Specialist Training

Preamble

The UEMS is a non-governmental organisation representing national associations of medical specialists at the European Level. With a current membership of 34 national associations and operating through 39 Specialist Sections and European Boards, the UEMS is committed to promote the free movement of medical specialists across Europe while ensuring the highest level of training which will pave the way to the improvement of quality of care for the benefit of all European citizens. The UEMS areas of expertise notably encompass Continuing Medical Education, Post Graduate Training and Quality Assurance.

It is the UEMS' conviction that the quality of medical care and expertise is directly linked to the quality of training provided to the medical professionals. Therefore the UEMS committed itself to contribute to the improvement of medical training at the European level through the development of European Standards in the different medical disciplines. No matter where doctors are trained, they should have at least the same core competencies.

In 1994, the UEMS adopted its Charter on Post Graduate Training aiming at providing the recommendations at the European level for good medical training. Made up of six chapters, this Charter set the basis for the European approach in the field of Post Graduate Training. With five chapters being common to all specialties, this Charter provided a sixth chapter, known as "Chapter 6", that each Specialist Section was to complete according to the specific needs of their discipline.

More than a decade after the introduction of this Charter, the UEMS Specialist Sections and European Boards have continued working on developing these European Standards in Medical training that reflects modern medical practice and current scientific findings. In doing so, the UEMS Specialist Sections and European Boards did not aimed to supersede the National Authorities' competence in defining the content of postgraduate training in their own State but rather to complement these and ensure that high quality training is provided across Europe.

At the European level, the legal mechanism ensuring the free movement of doctors through the recognition of their qualifications was established back in the 1970s by the European Union. Sectorial

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Directives were adopted and one Directive addressed specifically the issue of medical Training at the European level. However, in 2005, the European Commission proposed to the European Parliament and Council to have a unique legal framework for the recognition of the Professional Qualifications to facilitate and improve the mobility of all workers throughout Europe. This Directive 2005/36/EC established the mechanism of automatic mutual recognition of qualifications for medical doctors according to training requirements within all Member States; this is based on the length of training in the Specialty and the title of qualification.

Given the long-standing experience of UEMS Specialist Sections and European Boards on the one hand and the European legal framework enabling Medical Specialists and Trainees to move from one country to another on the other hand, the UEMS is uniquely in position to provide specialty-based recommendations. The UEMS values professional competence as “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served”¹. While professional activity is regulated by national law in EU Member States, it is the UEMS understanding that it has to comply with International treaties and UN declarations on Human Rights as well as the WMA International Code of Medical Ethics.

I. Training Requirements for Trainees

1) Content of training

a. Theoretical knowledge

Has advanced knowledge of normal **child development** from infancy and milestones. Knows how the child’s development can be distorted by abnormal biological, psychosocial and environmental influences, risk and protective factors.

Thorough knowledge of child and adolescent **safeguarding** and a comprehensive knowledge of the **legal framework** of the practice of child and adolescent psychiatry including relevant international conventions such as UN Convention on the Rights of the Child (1989) and the European Union Agenda for the Rights of the Child (2007).

Masters knowledge and skills to evaluate and handle **acute** child and adolescent psychiatric conditions.

Advanced knowledge of assessment, using a biopsychosocial approach, investigation and the use of international diagnostic systems (ICD and DSM), medical treatment and follow up, course and prognosis of **child and adolescent disorders including:**

¹ *Defining and Assessing Professional Competence, Dr Ronald M. Epstein and Dr Edward M. Houndert, Journal of American Medical Association, January 9, 2002, Vol 287 No 2*

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This document refers to the International Classification of Diseases (WHO) throughout – currently ICD-10².

All appropriate axis 1 diagnoses including adult disorders with an onset in childhood or adolescence such as mood disorders, psychotic disorders, anxiety disorders, organic disorders and psychosomatic disorders (F00-F59) but also including advanced knowledge of disorders of childhood including:

Disorders of Psychological Development (F80-F89)

Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F90-F98).

Trainees will be expected to be able to use the multi-axial classification system in ICD-10 for Child and Adolescent Psychiatry. The trainee will have:-

Advanced knowledge of **pharmacological treatment** of child and adolescent psychiatric conditions
Sound knowledge of psychological and **a range of psychotherapeutic treatment** methods
An understanding of **paediatrics**, particularly paediatric neurology and rehabilitation
Knowledge and understanding of advances in **medical technology** that are relevant to child and adolescent psychiatry

An understanding of **adult** psychiatric conditions, particularly in young adults and parents

An understanding of **drug and alcohol misuse** and its comorbidity with child and adolescent psychiatric conditions

An understanding of **environmental influences** on child and adolescent psychiatric conditions from conception to adulthood to include: pregnancy, family, child maltreatment, housing, neighbourhood, media (e.g. computer use, social media networking, gambling), school climate and other environmental stressors.

An understanding of **forensic psychiatry** including its organisation and duties, both criminal and civil frameworks of justice.

The trainee will master evaluation and **prioritisation of** children's and young people's psychiatric care needs in the light of biological/genetics, psychological and social factors that lead to an increased risk of mental illness.

They will develop the knowledge and understanding that informs **managerial and leadership** skills including an understanding of the organisation, management, and regulatory systems of health care

² ICD – 11 is expected during the life of this document and this document will be updated after its publication

Competence in medical science and in quality improvement

They will be capable of and use a medically scientific outlook and approach. The trainee will have an understanding of, and competence in assessing the developing evidence-base in child and adolescent psychiatry to improve the quality of assessment and treatment.

They will have an understanding of the factors that aid mental health among children and adolescents as well as methods for promoting health and preventing illness.

b. Practical skills

Key skills to possess in Child and Adolescent Psychiatry

The doctor will:-

- (1) Establish and maintain **therapeutic relationships** with children and adolescents of all ages and families.
- (2) **Develop high level interviewing skills** both diagnostically and therapeutically working with children, young people and families including the use of (semi)-structured diagnostic tools
- (3) Have good **written communication** skills
- (4) Demonstrate **liaison skills** – across the multi-disciplinary team, working between agencies and transferring patients to adult care.
- (5) Show knowledge and skills to work in both **outpatient and in an intensive intervention** service such as an inpatient child and adolescent service
- (6) Have **transcultural skills** – understanding and skilfully taking account in their work of issues of culture and diversity as they affect individual children, adolescents and families in the particular society in which they live.
- (7) Have the skill to do a **neurological examination**, to do appropriate tests and the skill to work with colleagues from other disciplines who are more expert in this field
- (8) Training must include training in **psychotherapy for individuals, groups or families according to behavioural/cognitive, psychoanalytic/dynamic, systemic methods or other appropriate psychological therapies**. The training should include theoretical

seminars, supervised treatment techniques and individual or group self-awareness. It should be guided by the current UEMS-CAP Psychotherapy Guidelines (most recent version 2009)

Training must include, alongside the normal clinical work:

- clinical supervision which is an integral part of all practical training, and
- clinical co-operation with relevant institutions and professionals (e.g. Liaison work)

- (9) Work with patients/families through **psychoeducation** and informing other doctors and co-workers as well as students
- (10) Have **leadership competence** : Capable of mentoring other doctors / co-workers / students. Will develop capability to lead collaboratively, maintain a dialogue with co-workers/students and have an understanding of one's individual role in the organisation.
- (11) Develop **teaching skills**: They will be able to organise teaching sessions in a variety of formats. The doctor will understand the different styles of learning and can design teaching to meet these differing needs. They will use written and verbal feedback to improve their own teaching.
- (12) **Appraisal**: The doctor can complete a structured assessment of another's performance and deliver constructive feedback

Number of procedures: An ongoing caseload of 25-35 cases is normally appropriate during training with an annual number of assessments of about 75 cases as a guideline. In inpatient settings, the caseload will be lower. Trainees should aim to see at least 10 cases of each common disorder and 5 cases of each of the less common disorders during their training.

Length of training: Normally training in child and adolescent psychiatry will take a minimum of three years of work with children and young people. If training is proposed to take less time, then this must be robustly and evidentially justified in terms of the role of the consultant independent practitioner.

Regular supervision: Trainees are expected to be offered and to use regular weekly individual supervision of their work and of their training needs.

c. Professionalism

Child and Adolescent Psychiatrists will show the highest professional and ethical standards taking particular account of the vulnerable patient group with which they work. They will provide:

1. Good clinical care

2. Will build relationships of trust with patients, carers and their own colleagues and will respond positively to feedback. They must demonstrate a commitment to the principles of diversity, consent and confidentiality balancing this with the need to protect children from neglect and abuse.
3. They will maintain good medical practice through life-long learning.
4. They will teach and train others with effective communication skills. They will contribute to supervision and must be open and honest in appraisals, written references etc.
5. They will work well with colleagues and demonstrate good listening skills and an ability to contain anxiety. They will know the limits of their own skills, when to refer to others and when to consult senior colleagues.
6. They will demonstrate honesty, trustworthiness and probity and act to maintain public trust. They will act quickly if they believe that their own or a colleagues performance or health may put patients at risk. They will carry out their duties in a timely, conscientious manner.

II. Organisation of training

a) Selection for training as a child and adolescent psychiatrist

There should be a transparent competitive process for selection which should include practice assessment of their skills and aptitude to become a child and adolescent psychiatrist.

b) Assessment and evaluation

i) Assessment:

There should be clear opportunities for formative assessments as well as those that will contribute to evaluating the trainee's developing skills (summative assessments).

As part of the training in psychiatry the trainee will pass both a written knowledge based examination and an oral examination. This assessment should include a clinical skills examination.

Continuing assessment of clinical skills is vital through the training. Interviewing skills should be assessed through episodes of observed practice when the trainee's clinical work is watched by a senior colleague. Short episodes as well as longer ones are encouraged. There should also be opportunities to observe and assess the trainee's ability to chair clinical discussion meetings with colleagues, medical and non-medical.

There should be opportunities to hear cases presented to senior colleagues and discussion of the formulation and treatment plans developed for the patient by the trainee.

Trainees should have their teaching skills assessed by their peers and by senior colleagues.

Trainees should obtain annual feedback from peers, colleagues and patients using the national system that has been created for assessing doctors in that country.

ii) Evaluation:

Trainees should have their progress through training evaluated on an annual basis against transparent criteria of progress. The final evaluation leading to recognition on a national specialist register or equivalent must be against transparent criteria.

c) Schedule of training

The minimum duration of training in child and adolescent psychiatry itself will be three years. Normally, the majority of this training will be carried out in outpatient and community settings. Additional time will normally be spent in adult psychiatry and/or paediatrics and/or neurology. It is expected that trainees demonstrate their knowledge of psychiatry / child and adolescent psychiatry through examination. The timing of such examination (entry to child and adolescent psychiatry or exit examination) will be decided nationally. At least six months inpatient experience is a necessary component of training in child and adolescent psychiatry.

III. Training Requirements for Trainers

1. Process for recognition as trainer

a. Requested qualification and experience

Trainers will be expected to have achieved the nationally recognised qualification to allow them to practice as a specialist child and adolescent psychiatrist.

b. Core competencies

Trainers will be specialist child and adolescent psychiatrists. In addition, they will have had training in the principles of adult learning, supervision, appraisal and feedback. They will demonstrate through their own continuing professional development an interest in education of trainees. They will treat their trainees with respect and honesty, recognising the power differential between themselves and their trainees and being very careful not to abuse this relationship in any way.

2. Quality management for trainers

The training institution will work with the organising department and with regional or national systems to ensure that the quality of training provided by recognised trainers is of a high standard. The use of confidential interviews with trainees, surveys etc will contribute to triangulated feedback of trainer performance.

IV. Training Requirements for Training Institutions

1. *Process for recognition as training centre*

- a. Organising Department: (OD) – The training should be organised by a postgraduate training organisation with knowledge and skill to provide or arrange provision of all the aspects of child and adolescent psychiatry contained in this curriculum framework.
- b. The OD should appoint a training director (TD) who must be a child and adolescent psychiatrist and who should take responsibility and who should be given the resources to organise and arrange delivery of the CAP training locally. This may well require the appointment of a deputy or the arrangement of a training committee in larger schemes. It may involve some training placements at a distance. When this is necessary, careful consideration must be given to the training benefit and the impact on the family life of the trainee.
- c. Each trainee should have a senior educator (an educational supervisor) who must be a child and adolescent psychiatrist, providing educational supervision through the period of their training. Trainees will have occasion to ask for a change in educational supervisor either temporarily or for the remainder of their training. Normally such a request would be allowed though repeated requests. One situation where this may arise is if the trainee is to undertake a clinical placement with their educational supervisor. Trainees should normally expect to meet with their educational supervisor at least 3 times each year. These meetings are to monitor the training placement contract between the trainee and the clinical supervisor. This training contract should relate to the particular trainee's training requirements. They will vary by the stage of training, a trainee's previous experience and their particular interests. There will be further meetings to monitor progress midway through placement and to prepare for a formal annual review of a trainee's progress, whether this is locally organised, regionally or nationally organised.
- d. The curriculum provided should have national approval and periodic audit of its local implementation by the ODs in that country (not less than every 5 years). Such national oversight may be provided by a government designated organisation. In the absence of such an arrangement, the national body responsible for standards and excellence in CAP should take this responsibility.

2. *Requirements of clinical activities*

Teacher/Trainee Ratio

The ratio between the number of qualified CAP specialists in the teaching staff and the number of trainees should provide for close personal monitoring of the trainee during his/her training and provide adequate exposure of the trainee to the training.

Training Opportunities

The OD must provide or arrange provision of a variety of patient experiences in the community and in hospital to provide good learning experience to encompass the age range and the intellectual range of patients who will be seen by the trained child and adolescent psychiatrist in that country. Typically this will include all appropriate children and young people up to and including the age of 17 (ie up to 18th birthday). In some countries this age range is expanded to young adulthood.

It may be necessary to provide some experience some distance from the training centre. This is allowed with certain caveats:

- (a) The experience must be part of the required or optional training experiences that cannot otherwise be fulfilled locally in the training timeframe or
- (b) An experience that the trainee particularly wants to gain for specialist aspects of their training and that the TD agrees that it is appropriate to arrange at a distance from the OD.
- (c) That the impact of training at a distance from the OD for a period has been given for the family life of the trainee.

Requirements for equipment and accommodation

- Own desk in a quiet room for office work
- Lockable filing cabinet
- Computer with internet access
- Library
- Bench books in clinical settings (ie a range of essential texts for the profession)
- Equipment to carry out basic medical physical examination
- Interview rooms that are appropriate for individual, family and group work.

2. Quality management within training institutions

Manpower planning: There should be national arrangements to monitor manpower needs for specialist child and adolescent psychiatrists taking into account national and European agreed norms for number of specialist child and adolescent psychiatrists. The norms should also take into account the nature of the local population, any index of deprivation, undergraduate and postgraduate teaching responsibilities, research responsibilities and managerial and leadership responsibilities.

Regular report: There must be a system in each training scheme for monitoring the quality of the training. This will include anonymously collected data from trainees and from trainers; it should also include data collected from patients about the quality of service offered. Various aspects of the training should be locally monitored including the quality of the academic programme, the quality of placements, the quality and regularity of supervision, the regularity of observed practice episodes, the access for trainees to external courses and conferences relevant to their training, access to equipment and a clinical working environment that is child and family friendly including a range of

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age appropriate toys and play materials; this clinical environment should allow interviews to be held confidentially – ie not being overheard from neighbouring rooms.

External auditing: There must be a national system for auditing the quality of training provided by the ODs within each country. This system should gain information through multiple sources including feedback from trainees and trainers. A system that involves periodic inspection of training schemes by peers has learning advantages. Were it possible to develop comparisons of quality of training between European countries this would have advantages.

Transparency of training programmes: There should be a clear description of each training programme with information available to possible applicants about capacity of the programme, placements, the academic programme and research opportunities. It should also describe any known limitations of the scheme. The method of application and criteria for selection should also be publically available to candidates.

Progress through training and the reasons that decisions about progress are made should be against transparently available criteria. If a trainee's progress is delayed, this should not normally happen without the trainee already being aware that there are concerns. The only foreseen exceptions to the trainee having notice of a possible delay to training progress would usually be when the trainee's health prevents progress or if issues of probity have arisen. There should be processes in place to support trainees and schemes in the event that a trainee is encountering difficulty in meeting training requirements.

The criteria for completion of training must be publically available. The reasons for allowing qualification and the trainee's evidence that they have achieved the required standard should be audited regularly.