UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES
EUROPEAN UNION OF MEDICAL SPECIALISTS

The UEMS Section of Child and Adolescent Psychiatry

EUROPEAN TRAINING REQUIREMENTS

FOR

CHILD AND ADOLESCENT PSYCHIATRY

UEMS Council April 2025

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Preamble

What is UEMS?

The UEMS (Union Européenne des Médecins Spécialistes, or European Union of Medical Specialists) is a non-governmental organisation representing national associations of medical specialists at the European level. The UEMS is committed to promote the free movement of medical specialists across Europe while ensuring the professional consensus on the framework for the highest possible level of their training. This will pave the way to the improvement of quality of care for the benefit of all European citizens and beyond.

The Aim of European Training Requirements

Since the most recent version of the EU Directive on the recognition of Professional Qualifications was introduced in 2013, the UEMS Specialist Sections and other UEMS Bodies have worked to develop documents in a common Template Structure on European Training Requirement(s) (ETRs).

The aim of ETRs is to provide the recommendations at the European level for high quality training in each specialty, as the quality of medical care and expertise are directly linked to the quality of training, achieved competencies and their continuous update and development provided to the medical professionals. No matter where doctors are trained, they should have the same core competencies when employed in Europe.

Each ETRs shall reflect modern medical practice and current scientific findings in each of the specialty fields. But the aim of the ETRs is to provide for each specialty the basic training requirements as well as optional elements and they should regularly be updated by UEMS Specialist Sections and European Boards to reflect scientific and medical progress. It is at the same time an aim of the UEMS ETRs to raise standards of training to make sure that European patients continuously find high quality standards of safe specialist care.

The three-part structure of all ETRs reflects the UEMS approach to have a coherent pragmatic document for each individual specialty, not only for medical specialists but also for decision-makers at the national and European level interested in knowing more about medical specialist training. To foster harmonization of the ETR by adopting more specific guidelines, the CanMEDS competency framework (formerly the Canadian Medical Education Directions for Specialists) is recommended which defines the entire set of roles of the professionals, which defines the entire set of roles of the physician. UEMS use an abbreviated version of the competencies within those roles.

Distinction between Knowledge and Competency

Competency-based education is not oriented towards the period of clinical rotations, but towards trainee, and trainee's progress in the acquisition of competencies. A clear distinction within an ETR between competencies and knowledge helps define both how that training should be delivered and how it should be assessed. The appropriate use of different methods of assessment of knowledge and acquired skills, emphasising the workplace-based assessment, is an essential component of quality postgraduate training, focused on high standards of specialist medical practice. To improve the methods of assessment it is also recommended to use the so-called Entrustable Professional Activities (EPAs) in all specialties' ETRs. To recognise common and harmonised standards on the quality assurance in specialist training and specialist practice at a European level some UEMS Specialist Sections and Boards also have European examinations (supported and appraised by the UEMS CESMA - Council of European Specialist Medical Assessments).

Overlapping of learning outcomes and competencies between specialties

Each of the UEMS ETRs defines a syllabus or knowledge base and describes learning outcomes defined for given competencies. Some of these curricula encompass a whole specialty, other focus on areas within or across specialties and define content of the training requirements for specific areas of expertise. By recognizing the potential overlapping, it creates the opportunity for those writing ETRs to draft overlapping or common goals for learning outcomes. Similar measurement does not necessarily equate to the same targets. Rather, across different specialties the final goal may differ, i.e. there may be clearly defined individual goals for trainees with different expectations. But it is important, when an ETR is developed, that each specialty section acknowledges what is core competencies in the specialty and what is core in other specialties. When there is a need to describe overlapping competencies, it must be done in close collaboration with the specialties that have focus on the overlapping competencies.

UEMS ETRs and national curricula

Professional activity is regulated by national laws in EU Member States and the amount and scope of specialties differs within each country. However, the UEMS strongly encourages the National Medical Competent Authorities (NMCAs) to adopt requirements as it is the most efficient way of implementation of good standards in postgraduate training. UEMS respect and support the vital role of the NMCAs in setting high standards of training and care as well as the differences of the specialties in their respective Countries and checking through robust quality control mechanisms the qualifications of medical specialists moving across Europe.

The UEMS ETRs are developed by and for professionals and this adds unique value to them. UEMS aim is to indicate the knowledge and competencies that should be achieved by trainees in EU/EEA countries and also competencies and organisation of the training centres. The training environment and results described in UEMS ETRs may be achieved in adapted ways, depending on local traditions, organisation of healthcare system and of medical specialist training. Adaptation of UEMS ETRs to local conditions assures the highest quality of specialist training and each state may include additional requirements, depending on local needs. This also means, that the requirement is meant to be recommendation and not mandatory in respect of the different national needs and structure of the healthcare.

Importance of collaboration with other representative European medical bodies

The UEMS always wishes to work with all Colleagues, NMAs, professional and scientific organisations across Europe. In the process of ETRs development, the UEMS recognises the importance of meaningful collaboration with the other European medical representative bodies, the European Junior Doctors (EJD representing doctors in training), the European Union of General Practitioners (UEMO – Union Européenne des Médecins Omnipraticiens), the Standing Committee of European Doctors (CPME - Comité Permanent des Médecins Européens), the Federation of European Salaried Doctors (FEMS) and the European Association of Senior Hospital Doctors (AEMH - Association Européenne des Médecins des Hôpitaux). In addition, UEMS especially stress the need when developing ETR to do it as close as possible with the many European Specialist Societies in order to facilitate a common understanding of the training requirement for medical specialist training at the highest level.

Introduction

Across Europe, training of medical specialists is mostly set at a national, sometimes regional level while the scientific body of evidence and clinical guidelines are mostly developed in networks cooperating internationally. For those concerned with training child and adolescent psychiatrists across the EU and beyond, the current European Training Requirements (ETRs) document for child and adolescent psychiatry (CAP), can serve as an inspiration and provide guidance. The ETRs have been developed and updated by a large group of international CAP trainers from across Europe and with wider consultation from other medical specialties. In their essence the ETRs try to capture similarities between training practices across the EU to help increase efficiency, to inspire and to share best practices from regional and national training organizations. The UEMS-CAP section respects cultural and context differences across Europe and realises that the application and use of the framework should take these into account. Different contexts are likely to make it hard to (yet) achieve all of the requirements and sometimes there may even be good reasons not to try and meet some of them. Nonetheless, the CAP ETRs summarise the essentials of CAP training. It provides a range and standard that we think and hope families across Europe are entitled to expect.

What to expect from the ETRs

So, what to expect from the ETRs and how to use this document best? The Child and Adolescent Psychiatry European Training Requirements first cover the *'how to train CAP'* and describe three aspects: The standards trainees are expected to attain and maintain throughout the course of their training; the standards required of trainers; and the contributions expected from training organisations/ institutions to contribute to high quality of CAP training programmes. The remaining chapters are organised in appendices and together cover the actual '*content of training in CAP and resulting competencies'* – the knowledge, skills, and attitudes that we expect trainees to acquire before they can register as a child and adolescent psychiatrist. In previous versions of the ETRs, these chapters were also called the Curriculum Framework.

New in the current revision, is that the competencies have been organised and ordered based on the structure of the CanMEDs including general and specific clinical skills, but also the many other roles that have become crucial for medical specialists to practice within larger networks of health care.

Assessment and the ETRs

Also, for the first time, an attempt is made to suggest how the various competencies could be assessed. Assessment is one of the essential drivers for learning as formative assessment and feedback helps trainees to evaluate where they stand. Summative assessment strategies play their role in accountability towards society and help trainers to assess both the individual trainee, the group of trainees and the effect of the various elements of training on specific competencies.

One tool that is specifically helpful for assessment are Entrusted Professional Activities (EPAs). EPAs are building blocks of essential *activities* that trainees are likely to perform in their role as *professionals* and medical specialists. They help to track progress regarding these activities from novice to a stage where the trainee can be fully *entrusted* to perform the activity without supervision. Nevertheless, in the current ETRs version, EPAs have not yet been integrated. The development of EPAs requires a rigorous process that combines educational evidence with consensus of opinion of clinician-educator experts and other important stakeholders. A handful of European countries recently started drafting EPAs for CAP and the UEMS-CAP section aims to stimulate this development in other regions and to bring together expertise over the next years, working towards another future version of ETRs in CAP.

What the ETRs do not cover

What the ETRs do not cover is the broader development of medical specialists and their ongoing training and education that follows the postgraduate education phase of specialist training. However, we would like to provide the reader with three notions and invite them to bear these in mind when reading the document.

The first notion is the importance of life-long learning for professionals adapting to the ever-changing landscape of science, societal demands and service-provision. For postgraduate training, this implies that a balance should be found during training between acquiring a large set of specific skills and the acquirement of generative competencies upon which can be built further throughout the career.

The second notion is that it is important for trainers to collaboratively work with trainees in open dialogue and discussion to create individualised training plans that take into account the trainee's educational and training needs, as well as factors such as the trainee's wellbeing. Such a conversation and consideration is all the more important for CAP, as mindful timing of the many aspects of one's own educational pathway without becoming overwhelmed, may be one of the essential elements to help maintain a good personal balance, resilience and wellbeing.

The final notion is a general attitude of humility of one's own knowledge and skills and the learning, inquiring attitude that comes with that. The complexity of the matter of (ab)normal brain development and child and adolescent psychiatric complaints is high. The young people and their families with mental health problems that we work with are often vulnerable and may need help to express their own perspectives and wishes. Additionally, children, young people and their families can present with mental disorders alongside complex needs and vulnerabilities linked with social and other factors beyond the scope of CAP services. It is crucial for CAP trainees to understand the limitations of what they can offer in such circumstances and be able to work in collaboration with patients and families on principles of co-production. It is essential for child and adolescent psychiatrists that they know the boundaries of their own field and respect the importance of co-creation.

The revision processes

The first stage of the revision process of these ETRs started with the revision of the 2014 version of the curriculum framework at the UEMS-CAP annual section meeting in Ljubljana in October 2019. The section established a working group that conducted an iterative process involving editing and commenting on an online platform. Several rounds were conducted presenting consecutive drafts to members of the working group and a broader group of UEMS-CAP delegates. The revised curriculum framework draft was presented to a variety of stakeholders in the member countries (national CAP associations, junior CAP doctors´ organizations and patient-carer groups in the fields of child and adolescent mental health). Respondents were asked to provide feedback via an online consultation platform from November 2020 to June 2021. The feedback was analyzed and presented at a virtual roundtable meeting in September 2021. Changes were incorporated into the final version that was adopted at the UEMS-CAP Virtual Annual Meeting October 2nd 2021.

The second stage of the revision of the ETRs started in 2022. In multiple rounds during and between UEMS-CAP delegates meetings, the previous version of the UEMS-CAP ETRs was adjusted and put into the new structure adhering to UEMS recommendations and standards. In 2023 the latest version of the ETRs of the section of psychiatry was published. To assure the best possible alignment between CAP and general psychiatry, wherever that was possible, items and formulations were integrated into the UEMS-CAP ETRs.

A reading guide

We hope that these ETRs may serve as a roadmap for constructing national and regional training programmes for those concerned with postgraduate CAP training and help to further develop and implement high-quality training of CAP trainees in Europe. For trainees, it may provide guidance and map out training goals. It helps them to get an overview of where to go and at what stage they are in their training process. On an individual as well as a group level it helps to identify which learning goals have already been achieved. This allows a shift in focus for their education, providing time for new goals. It can allow for fast tracking some trainees and build in extra depth or new areas of learning (e.g. research, teaching, leadership, advocacy, psychotherapy). If a trainee is struggling, it can alert them and their trainer to offer remedial support or rarely, to halt their training. For training programme directors, trainers and for all those concerned with training, the framework can help to provide focus and ensure all relevant parts of training are included in the programme.

As a final note, we like to point out that the order of the chapters and the numerical assignments within the chapters does not imply importance / hierarchy but are random or at best derived from an attempt at logical sequences in clinical work or organization of knowledge, skills and professional behaviors.

Training Requirements for Trainees – Content of Training

1.1.1 The training process includes practical clinical work and relevant theory, covering biological psychological and social assessment and treatment modalities in a developmental perspective.

1.1.2 The training process ensures development of all aspects of the knowledge, skills, attitudes and personal attributes in the roles as medical expert, communicator, collaborator, leader, health advocate, scholar and professional as described in the European Framework for Competencies in Child and Adolescent Psychiatry (see Appendix 1).

1.1.3 Training includes practical experience in different areas of psychiatric practice including exposure to psychiatric conditions throughout the life span, community psychiatry, consultation-liaison and psychotherapy.

1.1.4 Trainees acquire and maintain adequate knowledge and skills to recognise relevant medical conditions and refer to other medical specialists and allied professions when appropriate - as Child and Adolescent Psychiatry is an integral part of medicine.

1.1.5 Trainees acquire organizational skills in their work context. Trainees engage in clinical audit / quality improvement initiatives.

1.1.6 Trainees acquire basic knowledge of scientific methodology, skills in critical interpretation of study results and critical appraisal of literature and experience with current methods such as evidence-based medicine.

1.1.7 Trainees have an active role in teaching, including the teaching of medical students, other members of the healthcare team, other healthcare professionals and the general public.

1.1.8 Trainees receive formal teaching about local medico-legal issues, as well as ethical issues. Training fosters general aspects of medical professionalism to enable the doctor to act in the best interests of patient and the public.

1.1.9 The training process ensures an increasing degree of independent responsibility as skills, knowledge and experience grow, and this is defined explicitly for each stage of training.

1.1.10 Trainees act as adult learners and take responsibility to fully engage in the learning process. Each trainee has a training log-book, training portfolio or similar document that is kept throughout their specialty training, in which they record their learning experiences.

1.1.10 Trainees are involved in the formulation of objectives, design and further refinement of the training programme through regular feedback.

Organisation of Training

a. Assessment and evaluation

2.1.1 The training includes a process of assessment; the competent authorities define and state the method used for the assessment of trainees, including the criteria for passing examinations or other types of summative assessment. Assessment systems include formative in-training methods.

Decisions on progress through training are made according to transparent and publicly available criteria. The reasons for granting qualification and the trainee's evidence that they have achieved the required standard are audited regularly.

2.1.2 The learning of trainees is guided by processes of supervision and regular appraisal and constructive feedback from trainers, supervisors and teachers. This includes a minimum of one hour a week of personal supervision for each trainee, delivered by their trainer, and a formal evaluation of the trainee's progress by the trainer and trainee twice a year. Training institutions provide a system of appraisal – at entry into each part of the programme, at midpoint and at the end. A structured goal setting for each training period according to the curriculum and its evaluation is recommended.

Continuing assessment of clinical skills is vital through the training. Clinical experience is assessed through a review of the patients seen by a trainee and for whom the trainee has had a personal responsibility as regards their care. Evidence of such engagement is kept in a logbook, e-portfolio or equivalent. Interviewing skills are 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 are opportunities to observe and assess the trainee's ability to chair clinical discussion meetings with colleagues, medical and non-medical. There are opportunities to hear cases presented to senior colleagues and discussion of the formulation and treatment plans developed for the patient by the trainee. Trainees have their teaching skills assessed by their peers and by senior colleagues.

Trainees meet with their Training Programme Director on a regular basis. The Training Programme Director and (a team of) trainers meet and review the trainee´s progress at least once a year. Such discussions take the format of an appraisal with the trainee, providing information about how he/she is progressing, accompanied by documented evidence (portfolio) of clinical engagement and achievement of learning and training outcomes. The purpose of the appraisal is to enable a constructive discussion about how the learning needs of the trainee should be met. Subsequent appraisals revisit earlier appraisals to determine progress in achieving these needs. The appraisals are not part of any summative assessment process but are designed entirely to support the trainees.

2.1.3 The Training Programme Director ensures that each trainee's progress is formally reviewed on an annual basis against transparent criteria of progress. Trainees obtain annual feedback from peers, colleagues and patients using the national system that has been created for assessing doctors in that country.

The Training Programme Director ensures that the individual trainees' documentation (training portfolios) are up to date, advises trainees and ensures that they attend appropriate and approved courses, provides opportunity for research, audit and other educationally valid activities such as attending courses and scientific meetings, provides valid documentation as to the satisfactory completion of training and provides guidance/coaching and access to Continuous Medical Education for trainers in their role.

2.1.4 Trainees in difficulty are identified proactively through competency assessment. There is a remediation processes in place to support trainees, and schemes in the event that a trainee is encountering difficulty in meeting training requirements. These procedures include external resources in medical education and guidance. Training institutions provide guidance in alternative carrier paths for trainees, if pursuing further postgraduate training in child and adolescent psychiatry is not feasible. The institution / network and, if necessary, the relevant regional / national authority, will intervene if disagreements between the Training Programme Director and the trainee cannot be resolved.

There is a procedure, consistent with the legal requirements of the nation concerned, to remove an unsuitable trainee from training. Participation of trainee organisations in developing this procedure is desirable. There is an effective and independent appeal procedure for the trainee.

b. Schedule of training (including access to specialty training)

2.2.1 Candidates for specialty training in child and adolescent psychiatry have completed the Degree in Medicine at one of the universities of the EU or associated countries or an EU recognised equivalent.

2.2.2 The criteria and process for selecting trainees has been agreed upon and made public by competent authorities and the medical professional organisations. For those who wish to apply, clear information about each training programme's placements, academic programme, research opportunities, and any known limitations is available. There is a transparent, fair, multifaceted and competitive process for selection, open to all eligible persons.

2.2.3 The selection process includes an assessment of trainee candidates' skills and aptitude to become a child and adolescent psychiatrist. It ensures that trainees have sufficient linguistic and communication skills to interact with patients, their families, and other health professionals. They must be able to work in the social and cultural context of the country in which he/she is based, have adequate language, computer and internet skills to access and study the international medical literature and be able to communicate with colleagues from other cultural settings to enhance trans-cultural learning.

2.2.4 The overall composition, structure and duration of training and professional development is described and determines how the training programme will meet its stated outcomes, which are sufficient to enable independent practice in child and adolescent psychiatry.

2.2.5 The minimum duration of training is five years. The minimum duration of training in child and adolescent psychiatry itself is three years. Most of this training is carried out in outpatient and community settings. At least six months of inpatient experience is a necessary component of training in child and adolescent psychiatry. Additional time is normally spent in adult psychiatry and/or paediatrics and/or neurology.

2.2.6 The training can take place in different institutions, either inside or outside the EU, as long as the training is recognised by a competent authority.

2.2.7 Training can be conducted in part-time (ie less than full-time) positions. National authorities provide guidance facilitating part-time training, including prolongation of training with the equivalent of time needed to acquire all competencies.

Training Requirements for Trainers

Process for recognition as trainer

a. Required (requested) qualifications and experience

3.1.1 The Training Programme Director has been practicing as a child and adolescent psychiatrist for at least five years after specialist accreditation as a child and adolescent psychiatrist and has five years of experience in education (teaching, training, supervision, etc).

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

3.1.3 Supervisors are specialised clinicians with a medical or multidisciplinary background and take responsibility for supervising an element of a trainee's work – this may be psychotherapy or another element of clinical work, or the trainee's research, teaching or leadership activities.

3.1.4 Teachers are usually clinicians with a medical or multidisciplinary background who are engaged in the transfer of theoretical knowledge or practical skills in simulation training contexts.

3.1.5 Trainers, supervisors and teachers are officially recognised in their training institution. Therefore, there are transparent procedures for the appointment of trainers, supervisors and teachers. These specify the expertise required and the responsibilities and duties of each post.

b. Core competencies

3.2.1 Trainers understand the structure and purpose of and their role in the relevant training programme.

3.2.2 Trainers, supervisors and teachers are able to give constructive feedback on performance.

3.2.3 Trainers, supervisors and teachers who are involved in the assessment of trainees, both in the workplace and in formal examinations, are trained in the use of the assessment method and are clear as to what is acceptable performance.

3.2.4 Trainers have training in adult learning theories, and demonstrate competencies in setting learning objectives, monitoring trainees' progress and in understanding the process to be followed in dealing with a trainee whose progress gives cause for concern.

3.2.5 Trainers are trained in how to use logbooks, training portfolios or equivalent documents to support the learning of trainees. Where a specific e-portfolio is used, trainers are trained in its use.

3.2.6 Psychotherapy supervisors have a recognised training in psychotherapy, are trained in supervision methodologies and are supported in their role by the Director of the Psychotherapy Training Programme.

Quality Management for Trainers

3.3.1. Trainers, supervisors and teachers receive regular feedback on their performance of these roles and demonstrate reflection on this feedback. This feedback includes commentary from trainees and from other members of the training group.

Training Requirements for Training Institutions

Process for recognition as a training centre

4.1.1 The training locations are selected and recognised by the competent authorities, which maintain a set of published standards for the approval of training institutions and a transparent process for withdrawing approval from institutions that fail to meet the standard.

4.1.2 The training institutions clearly state the responsibilities for the professional leadership for the child and adolescent psychiatry training programme.

4.1.3. Training institutions have policies in place to safeguard all children, adolescents and vulnerable adults. These policies include provisions, where appropriate, for implementing reasonable adjustments to accommodate vulnerable patients. Training institutions act along explicit policies regarding diversity and inclusivity.

4.1.4 Training institutions have general guidelines concerning patient care and patient information (patient's informed consent), referrals, medical records, documentation, on-call and back-up schedules, days off, staffs´ and trainees' working schedules, attendance to conferences and to educational activities. These guidelines are co-constructed with trainees and other staff, and are available to all users.

4.1.5 Training and the training programme are an integral part of the Training institution´s general medical audit and quality assurance systems. The Training Programme Director oversees the overall learning environment of the Training Institution where all members of staff contribute to the continuous improvement of their colleagues´ competencies.

4.1.6 Training institutions work 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. contribute to triangulated feedback of trainer performance.

4.1.7 It is not a requirement that a Training institution is also an academic center for child and adolescent psychiatry, but it is necessary for a Training institution to have academic links and to contribute to research.

4.1.8 A national register of approved hospital Training institutions is available.

Requirement on clinical activities (workplace-based learning)

4.2.1 Training institutions have sufficient clinical/practical facilities to support the delivery of training, enough patients and an appropriate variety of psychopathological cases to meet training objectives. The training exposes the trainee to a broad range of experience in child and adolescent psychiatry and, when relevant, includes both inpatient and outpatient care and on-duty activity.

4.2.2 The apprenticeship nature of professional development is respected to ensure that the integration between training activities and service provision (workplace-based learning) is assured. Clinical training is complementary to, and not subordinated to, service demands.

4.2.3 Trainees receive training in a full range of child and adolescent psychiatric services, including community settings that are relevant to mental health services, outpatient clinics and emergency services, acute in-patient units and on-duty activity targeting children from birth and young people up to and including the age of 17. In some countries this age range is expanded to young adulthood.

4.2.4 Trainees receive training in more specialised mental health services focusing on specific problems such as eating disorders, addiction problems, early intervention services, assertive community treatments, as well as alternatives to both acute hospital beds (crisis and home treatment teams). Trainees receive training in consultation-liaison services in hospitals and consultation/collaboration with primary health care services and other related agencies. Trainees receive training in work with patient organizations and experts by experience.

4.2.5 Experience of a different training and mental health system (e.g. exchange programme) as an observer or participator is promoted as a means to gain further skills. If an individual trainee wants to broaden the educational experience at a different Training Institution, the Training Programme Director will

formulate a written agreement of collaboration, receive regular progress reports and feedback from the trainee and engage in dialogue with trainers at this institution to assure the following:

(a) The experience is part of the required or optional training experiences that cannot otherwise be provided locally in the training timeframe, or an experience that the trainee particularly wants to gain for specific aspects of their training.
(b) The experience/training at a different Training Institution complies with applicable standards described in these ETRs.
(c) Consideration is given to the impact on the trainee´s family / private life when training at a distance from the main Training Institution for a period of time.

4.2.6 Trainees have opportunities to develop skills at multidisciplinary practice and in multidisciplinary teamwork.

4.2.7 Programmes include theoretical and practical exposure to psychotherapy, including supervised practice. Training in psychotherapy is conducted in working time and is funded as part of the training programme. The quantity of such training is defined and consists of at least 120 hours of theoretical teaching and 100 hours of supervision, of which at least 50 hours are individual. The definition includes the number of cases to be included. At the minimum, the training is sufficient to ensure that trainees can demonstrate acquisition of the relevant competencies in the European Framework for Competencies in Child and Adolescent Psychiatry (Appendix 1). The experience is gained with a broad range of diagnoses and with individuals, groups and families. It includes assessment and evaluation of outcome, as well as research methodology as applied to psychotherapy. As part of this, a personal psychotherapeutic experience is highly recommended, but not mandatory. Where this experience is not available, there is some provision of a learning experience in which trainees have the opportunity to explore the impact of their thinking and feeling as part of the interpersonal contact with patients, and to use this therapeutically.

4.2.8 Acceptable standards of performance are explicitly specified and conveyed to both trainees, trainers and supervisors.

4.2.9 Trainees have access to competent clinical supervision at an appropriate level to the trainee, from a named person at all times when the trainee is providing clinical services. This includes supervision in psychotherapy. Trainees receive one hour of scheduled educational supervision per week provided by their trainers.

Requirement on equipment, accommodation, facilities, etc.

4.3.1 There is sufficient teaching personnel (trainers, supervisors and teachers) to enable the safe and effective delivery of all aspects of training. Manpower planning should be monitored regularly and adjusted based on quality management processes.

4.3.2 The time required for providing training, supervision and teaching is included as responsibilities in the work schedules of trainers, and their relationship to work schedules of trainees is described. The number of trainees determines the amount of time allocated for their support, the minimum time allocated to a trainer for support of a trainee is one hour per week.

4.3.3 Trainees have space and opportunities for practical and theoretical study and library facilities to access relevant scientific literature as well as equipment for training of practical techniques. Trainees have

access to an own desk in a quiet room for office work, a lockable filing cabinet, a computer with internet access and access to a scientific library and bench books in clinical settings (ie a range of essential texts for the profession). Trainees have access to Interview rooms that are appropriate for individual, family and group work and access to consultation facilities equipped to carry out basic medical physical examination. The clinical working environment is child and family friendly, including a range of age-appropriate toys and play materials; this clinical environment allows interviews to be held confidentially – ie not being overheard from neighbouring rooms. The provision of access to digital mental health care facilities, simulation or virtual reality scenario training or other specific learning and supervision strategies in the field of digital psychiatry is strongly recommended.

4.3.4 The Training institution facilitates trainees´ active participation in research activities and theoretical courses as outlined in the national curriculum – covering time for preparation, travel/accommodation and time for follow-up on learning. When theoretical courses are provided by external partners, the Training Institution offers active contribution and assures the scientific and didactic quality, appropriate depth fitting the pre-existing knowledge and developmental phase of the trainees and specialist standards, stimulation of active learning of trainees and wherever possible link with workplace-based learning. It is recommended that Training institutions facilitate trainees´ participation of national, European and international meetings, courses and congresses financially and timewise.

4.3.5 The Training institution provides support and resources for trainees in helping to ensure that their logbook, learning portfolio or equivalent is kept up to date. This includes access to appropriate IT resources if an e-portfolio is used.

4.3.6 Trainees work in a safe environment, there are systems in place to ensure their safety and they have training in personal safety.

4.3.7 When trainees are expected to stay in hospital accommodation, it is safe and comfortable.

4.3.8 Training institutions have administrative staff of sufficient numbers and expertise to support the implementation of the programme.

4.3.9 Trainees have access to educational advice that includes appropriate guidance on professional, training and career development matters.

4.3.9 Appropriate services are made available to ensure that trainees seek help if they become unwell. They are supported and not stigmatised or punished in doing so.

Quality Management within Training Institutions

4.4.1 There is evidence that training is adequately resourced, including evidence that trainers, supervisors and teachers have access to resources to ensure that they are up to date in educational matters.

4.4.2 There is a clear line of responsibility and authority for the budgeting of training resources.

4.4.3 The number of trainees in a Training Institution is proportionate to the clinical/practical training opportunities, supervisory capacity and other resources available.

4.4.4 There is regular internal review of the quality of training provided. The internal review is informed by a wide range of data, including systematic feedback from trainees, survey results, results of summative

assessments of trainees, feedback from trainers and Training institutions as well as evidence of impact of training on patient care. The voice of patients and carers is included in the process. This includes monitoring of the provision of scheduled educational supervision and psychotherapy teaching and supervision. The educational work of trainers and Training Programme Directors is appraised annually within the Training Institution. The results of the review are reported to all stakeholders, both internal and external. There is evidence that the findings from the quality review are acted upon.

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

4.4.6 Trainees participate in local quality management processes on training.

4.4.7 There is a national system for external audit of the quality of training provided by the Training institutions within each country. This system follows explicit guidelines and gains information through multiple sources including feedback from trainees and trainers. Regular progress reports from external auditing initiatives generate input to the Training Institutions´ quality improvement strategies.

Roles in Postgraduate CAP Training

Training Programme Director

Senior member of the faculty who is responsible for organising the training programme in a Training Institution, allocating training posts and taking a strategic and long term view of the training needs of the trainees for whom they are responsible.

Director of the Psychotherapy Training Programme
Child and adolescent psychiatrist who allocates and coordinates the psychotherapy training for trainees. In some programmes this may be a senior psychotherapy supervisor; the Training Programme Director may fulfil the role.

Supervisor
Supervisors are specialised clinicians in child and adolescent mental health services with a medical or multidisciplinary background and take responsibility for supervising an element of a trainee's work. This may be psychotherapy or another element of clinical work, or the trainee's research, teaching or leadership activities.

Teacher
Teachers, usually clinicians with a background in medicine or allied professions who are engaged in the transfer of theoretical knowledge or practical skills in simulation training contexts.

Trainer
Trainers have achieved the nationally recognised qualification to allow them to practice as a specialist child and adolescent psychiatrist. A trainer oversees a trainee's development within a placement. This person is providing the trainee with one hour per week of educational supervision.

APPENDIX A: The European Framework for Competencies in Child and Adolescent Psychiatry (EFC-CAP)

PURPOSE

The main aim of the European Framework for Competencies in Child and Adolescent Psychiatry (EFC-CAP) is to provide a list of learning outcomes that national associations and other regulators of psychiatry training in Europe may refer to when constructing curricula for postgraduate training as well as systems for continuing professional development.

STRUCTURE

The learning outcomes in the European Framework for Competencies in Child and Adolescent Psychiatry (EFC-CAP) are arranged under the seven physician roles or meta-competencies, derived from the CanMEDS 2005 physician competency framework (Frank et al, 2005 & 2015) in a template from the European Training Requirements for Psychiatry (UEMS-Psychiatry 2023). The content is adapted from the UEMS-CAP Curriculum Framework (Deschamps & Schumann, 2022).
The seven physician roles consist of Psychiatric Expert/Clinical Decision-Maker, Communicator, Collaborator, Leader, Health Advocate, Scholar and Professional. Each physician role is divided into key competencies, which are underpinned by supporting competencies. The UEMS-CAP working group has attempted to formulate the supporting competencies in an operational way that will facilitate the delivery of learning and assessment. In doing so, the group was aware of the need to strike a balance between the need to provide meaningful guidance and the risk of being over-prescriptive.
The Framework includes a grid of suggested methods that may be used to assess the acquisition of each supporting competency. The rationale for the selection of assessment methods is described in more detail in Appendix B.

WE	Written Examinations
OE	Oral Examinations
CE	Clinical Examinations
ASCE	Assessment of Simulated Clinical Encounter
DOP	Directly Observed Practice
MSAP	Multi-source Assessment of Performance
DBD	Document-based Discussion

Assessment should be followed by feedback to stimulate self-reflection. Formative assessment strategies such as reflective essays or discussion of learning logs with a trainer or peers can supplement the aforementioned assessment strategies in identifying learning gaps and promoting self-regulated learning. Assessment strategies to monitor learning progression can be part of a programmatic assessment strategy and provide the basis for decisions on learning goal achievement or eligibility for certification procedures.

1 Child and Adolescent Psychiatric Expert / Clinical Decision-Maker

Definition
Child and adolescent psychiatrists deal with the prevention, assessment and treatment of mental, behavioural and neurodevelopmental disorders in children and adolescents, sometimes extending into

young adulthood. To manage this, child and adolescent psychiatrists possess a defined body of medical, developmental and psychopathological knowledge and a defined set of procedural skills that are used to collect and interpret data, make appropriate clinical decisions in collaboration with patients and their parents / guardians / carers and carry out diagnostic and therapeutic procedures using a combination of biological, psychological, and sociological methods, providing high quality, safe and patient-centred care.

Description

Medical experts perform diagnostic and therapeutic activities involving the management of situations where medical prioritization and decisions are required. The distinctive features of (mental) healthcare services are that they are often complex and unpredictable. In some cases, priority setting and decision-making take place based on inadequate information and uncertainty about evidence and best practice. Medical experts' work requires the mastery of creative solutions based on health-scientific knowledge, skills, and abilities and ability to handle uncertainty. The role of the medical expert is central to the function of child and adolescent psychiatrists and draws on the competencies included in the roles of communicator, collaborator, health advocate, manager, scholar and professional. Appendix C gives an overview of the clinical conditions and settings covered by the practice of child and adolescent psychiatrists.

Competencies

The child and adolescent psychiatrist is able to:

1.1 Demonstrate diagnostic skills within defined scope of practice to investigate, describe and define psychopathological and other clinical findings.

The child and adolescent psychiatrist is able to:

	Knowledge	**Competence**	**Performance**
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
1.1.1 Conceptualise both mental health and mental, behavioural and neurodevelopmental disorders using different models (with biological, developmental, psychological, behavioural, sociological and systemic approaches)	WE OE		DOP DBD
1.1.2 Understand and integrate into the assessment process factors contributing to predisposition, precipitation and perpetuation of mental, behavioural and neurodevelopmental disorders as well as protective factors for individual children, adolescents and families within their unique social contexts. This will include but not be limited to (epi-)genetics, the influence of family life and transgenerational influences (interactions between mental health of children and parents), the effects of loss, trauma, abuse, neglect and/or economic hardship, consequences of natural and man-made disasters,	WE	ASCE	DOP DBD

forced migration, human rights violations such as torture, war, incarceration and politically, ethnically and racially based persecution and issues related to gender incongruence, sexual orientation and diversity, the impact of patients´ digital lives including their presence and experiences in social media and as virtual personae on their real-life perceptions of self and others. Protective factors will include personal resilience, supportive relationships and social inclusion.			
1.1.3 Assess the development of children and adolescents in the domains of language and motor skills, cognition, social competencies including play, emotion and behavioural regulation, moral judgement, feeding / eating, sleep-wake cycles, adaptation to growth and changes in body functions, sexuality and issues of identity formation, and identify trajectories of atypical development		ASCE	DOP DBD
1.1.4 Understand and consider during the assessment process the full range of psychopathology in a developmental perspective and international diagnostic systems in accordance with updated / evidence-based clinical guidelines	WE	ASCE	DOP DBD
1.1.5 Obtain a comprehensive psychiatric history appropriate to the patient's developmental level, including information from other sources		CE	DOP DBD
1.1.6 Perform and document a psychiatric assessment with attention to cultural diversity including the ways that cultural and ethnic factors influence a person's response to and expression of distress and psychiatric symptoms and the influence of cultural factors and migration on common mental, behavioural and neurodevelopmental disorders		CE	DOP DBD
1.1.7 Carry out and document a mental state examination		ASCE	DOP DBD
1.1.8 Observe and interpret interactions between infants, children and adolescents and their parents / caregivers		ASCE	DOP DBD
1.1.9 Assess patient's capacity for decision making		ASCE	DOP DBD
1.1.10 Assess patient's functional status		ASCE	DOP DBD
1.1.11 Identify and secure the (interdisciplinary) assessment and management of medical conditions that are incidental, consequential, contributory or of differential diagnostic significance to mental, behavioural and neurodevelopmental disorders and their treatment	WE	ASCE	DOP DBD
1.1.12 Perform and document a relevant physical and neurological examination (in concordance with		ASCE	DOP DBD

learning objective nr 3 in Appendix D), order and interpret appropriate tests to assess body functions			
1.1.13 Understand, select, apply and interpret the results of the main psychometric assessments and psychological tests relevant to mental, behavioural and neurodevelopmental disorders	WE	ASCE	DBD
1.1.14 Apply knowledge of the indications for and interpret reports of the main genetic, metabolic, neurophysiological and neuroimaging examinations relevant to mental, behavioural and neurodevelopmental disorders	WE	ASCE	
1.1.15 Elicit and recognise signs and symptoms in relation to children and adolescents´ development, and apply them to a multiaxial differential diagnosis		ASCE	DOP DBD
1.1.16 Identify and appraise the factors affecting the course and prognosis of mental, behavioural and neurodevelopmental disorders	WE	CE	DBD
1.1.17 Take into account the interaction between the disorder and personal life and assess / respond to the patient´s lifestyle / behavior (including regarding nutrition, physical activity, sleep & rest) in a non-judgemental way (in concordance with learning objective nr 2 in Appendix D)		ASCE	DOP DBD MSAP
1.1.18 Detect mental illness and other challenges affecting parenting capacities in parents / carers		ASCE	DOP DBD
1.1.19 Draw up a diagnostic formulation including risk assessment of agitated, aggressive and suicidal behavior in emergency situations		CE ASCE	DOP DBD
1.1.20 Review and revise a diagnosis over time			DBD MSAP

1.2 Demonstrate therapeutic skills for effective and ethical management of the spectrum of diagnosed patient care problems.

The therapeutic skills include especially: Biological treatment, psychotherapy, pedagogical, psychosocial, family-oriented and community psychiatric interventions. The ability to integrate treatment modalities to optimise treatment, to establish and promote growth-oriented goals of care and to formulate an optimal patient-centred management plan is based upon a comprehensive biopsychosocial formulation of relevant aetiological factors.

1.2.0 General Competencies

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments

			DBD DOP MSAP
1.2.0.1 Establish, maintain & repair a therapeutic alliance			MSAP DOP
1.2.0.2 Determine which available biological, psychotherapeutic and social psychiatric interventions are appropriate to the patient's treatment expectations, circumstances and culture	WE OE	CE	DBD
1.2.0.3 Draw up, document and implement an integrated and individualised biological, psychotherapeutic and social treatment plan for mental, behavioural and neurodevelopmental disorders (see Appendix B), including child safeguarding and risk management in consultation with patient, carers and allied professionals and in accordance with updated / evidence-based clinical guidelines		CE	DBD MSAP
1.2.0.4 Provide psycho-education for patients taking into account mental state and developmental aspects, as well as for carers / families and networks		ASCE	MSAP DOP
1.2.0.5 Use voluntary and involuntary admission and treatment measures appropriately in compliance with legal standards and ethical principles	WE	CE	MSAP DBD
1.2.0.6 Recognise, prevent, and address adverse effects associated with therapeutic interventions	WE OE		DBD
1.2.0.7 Perform and monitor basic medical interventions for the physical health problems encountered in the treatment of mental, behavioural and neurodevelopmental disorders			DBD DOP
1.2.0.8 Perform basic resuscitation in toddlers, children, adolescents and adults		ASCE	
1.2.0.9 Optimise concordance with the treatment plan, with the expectation that treatment will be provided with the patient's / the parents´ / the guardian´s consent, except on rare occasions			DBD MSAP
1.2.0.10 Review, revise and document changes to a treatment plan over time			DBD MSAP
1.2.0.11 Systematically evaluate outcomes, know when to modify or terminate treatment and facilitate appropriate follow-up	WE	ASCE	DBD MSAP
1.2.0.12 Recognise and manage potential risk to self and others in a clinical encounter, especially in emergency situations		ASCE	DBD MSAP
1.2.0.13 Facilitate young people´s transition to other services including adult mental health highlighting early detection and management of at-risk mental health states and preparing adolescents for autonomy in accessing care (in concordance with learning objective nr 4 in Appendix D)		ASCE	DOP MSAP

1.2.1 Psychopharmacological treatment as well as other biological-technological treatment modalities

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
1.2.1.1 Understand the theories that underpin biological treatments of mental, behavioural and neurodevelopmental disorders including pharmacokinetics, pharmacodynamics, pharmacogenetics and interactions of psychoactive substances as well as other biological-technological treatment modalities	WE OE		
1.2.1.2 Use safely and effectively biological treatment methods in child and adolescent psychiatry on the basis of values and the best evidence available in consultation with patients (where possible), parents and carers	WE	ASCE	DBD DOP
1.2.1.3 Take into account the psychological aspects of using biological treatments, such as medicalisation, labelling, placebo effects and the meaning that prescribed medication carries for the patient			DOP MSAP

1.2.2 Psychotherapies

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
1.2.2.1 Understand the theories that underpin models of individual, group and family psychotherapies according to behavioral/cognitive, psychoanalytic/dynamic, systemic/narrative or other appropriate evidence-based psychotherapy methods available for the treatment of mental, behavioural and neurodevelopmental disorders	OE WE		
1.2.2.2 Practice psychotherapy safely and effectively on the basis of values and the best evidence available			DBD DOP

1.2.3 Pedagogical, psychosocial, family-oriented and community psychiatry interventions

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
1.2.3.1 Understand the theories that underpin the models of pedagogical, psychosocial, family-oriented and social psychiatric interventions available for treatment of mental, behavioural and neurodevelopmental disorders	OE WE		
1.2.3.2 Use safely and effectively pedagogical, psychosocial, family-oriented and social psychiatric interventions on the basis of the best evidence available and in collaboration with other agencies			DOP DBD
1.2.3.3 Provide advice on, signpost and take into account the impact of challenges to parents´ and caregivers´ parenting capacities on their child and opportunities for change		ASCE	DOP MSAP
1.2.3.4 Engage in productive cooperation with local social and cultural networks, voluntary organizations and self-help groups			MSAP

1.2.4 Demonstrate skills in utilizing the social context as a tool for child and adolescent psychiatric rehabilitation and recovery

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
1.2.4.1 Understand the theories that underpin different models of child and adolescent psychiatric rehabilitation, including recovery, in facilitating return to a life that is meaningful to the individual	WE OE		
1.2.4.2 Use child and adolescent psychiatric rehabilitation methods safely and effectively on the basis of values and the best evidence available			DBD MSAP

1.3 Apply child and adolescent psychiatric expertise in situations other than in direct patient care

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments

			DBD DOP MSAP
1.3.1 Apply the medico-legal knowledge and skills required to give appropriate child and adolescent psychiatric advice to courts of law and other settings		ASCE	DBD
1.3.2 Apply the knowledge and skills to contribute to the development of health services	OE		MSAP

1.4 Recognise personal limits of expertise

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
1.4.1 Reflect on own limitations of expertise by using self-assessment, intervision and/or feedback			DBD
1.4.2 Consult and liaise with other professionals, and promptly refer when needed, for optimal patient care			MSAP DBD

1.5 Consult effectively

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
1.5.1 Offer consultation and liaison services to medical and non-medical professionals in hospitals, out-patient clinics and other secondary health care settings, primary health care, schools / day care institutions and youth welfare / social services			DOP MSAP
1.5.2 Offer professional advice on a specific clinical situation		ASCE	DOP
1.5.3 Offer appropriate verbal or written advice to a professional on a patient examined for second or specialist opinion		ASCE	DOP DBD

2 Communicator

Definition
As communicators, child and adolescent psychiatrists form therapeutic relationships with patients and their families / carers. It is vital to ensure and facilitate effective gathering and sharing of essential information

regarding a patient's mental condition and general health condition. In addition, the child and adolescent psychiatrist must develop communication skills in relation to multidisciplinary colleagues inside and outside one´s organisation.

Description

Child and adolescent psychiatrists enable patient-centred therapeutic communication by exploring the patient's symptoms, and by active listening to the patient's experience of illness and all the circumstances that have led to mental health difficulties via conversations with patients and parents / carers / families. One of the basic skills of the child and adolescent psychiatrist as a communicator is the de-escalation of situations complicated by worry, agitation, conflict and aggression. Communication in clinical settings means exploring the patient's and the parents` / carers` / family´s perspective, including fears / ideas about the illness, feelings about the impact of the illness, and expectations towards the health care professionals. The child and adolescent psychiatrist as a communicator integrates knowledge and shares decision-making by finding common ground with the patient and parents / carers in developing a plan and health goals in a manner that reflects the patient's needs, values, and preferences. This plan should, when possible, be made according to evidence and guidelines. In the revised CanMeds version, the communicator role includes both oral and written communication as well as visual media to optimise clinical decision-making, patient information, confidentiality and privacy. As communicators, child and adolescent psychiatrists convey medical problems and solutions through respectful rapport involving patients, their parents / carers / families, colleagues and other collaboration partners. The child and adolescent psychiatrist must also be able to communicate constructively with patient/consumer organizations, policy makers and media as well as legal, educational and social authorities.

Competencies

The child and adolescent psychiatrist is able to:

2.1 Establish therapeutic relationships with patients in an age-, development- and context-sensitive manner as well as with families / carers, using a person-centreed approach and foster an environment characterised by understanding, trust, empathy and confidentiality

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
2.1.1 Be aware of factors influencing the patients' and families´ reactions to the physician and others, including the effect of previous trauma, and one's own reactions when dealing with patients / families			DBD MSAP
2.1.2 Communicate effectively, professionally and empathically, both verbally and non-verbally appropriate to the patient's developmental level where necessary across linguistic and cultural boundaries, using appropriate translation services and technological support, ie telepsychiatry		ASCE	DOP MSAP

2.1.3 Establish, maintain and conclude appropriate therapeutic relationships with patients, families and carers taking into account different cultural backgrounds / diversity and respecting appropriate boundaries at all times, especially with vulnerable and marginalised people			DBD MSAP
2.1.4 Facilitate a structured clinical encounter (in concordance with learning objective nr 1 in Appendix D)		ASCE	DOP

2.2 Elicit and synthesise relevant information from the patient, their families, and their communities about patients' problems

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
2.2.1 Obtain comprehensive and relevant information systematically and understand the meaning of this information in the context of the patient's / the family´s culture, diversity and expectations		ASCE CE	DBD DOP
2.2.2 Perform a detailed developmental history with particular reference to the impact of adverse life events		ASCE CE	DBD DOP

2.3 Listen effectively

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
2.3.1 Demonstrate the ability to understand all aspects of communication, including verbal and non-verbal, and lead the interview effectively in an open and nonjudgemental way		ASCE CE	DBD DOP
2.3.2 Demonstrate the ability to use de-escalation techniques to help prevent violent and aggressive behaviours in the workplace		ASCE CE	DBD DOP

2.4 Discuss appropriate information with the patient, their families and other healthcare providers to facilitate optimal healthcare for patients

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
2.4.1 Recognise and respect the right of patients and parents / guardians to be optimally informed about the diagnostic formulation and treatment options		ASCE	DOP MSAP
2.4.2 Communicate with the patient, family and carers using a wide range of information resources including written material and online sources		ASCE	DOP MSAP
2.4.3 Foster a shared understanding of issues, problems and plans with patients, families, primary health care and other professionals through discussion, questions and interaction in the encounter		ASCE	DOP MSAP
2.4.4 Effectively handle challenging communication issues such as obtaining informed consent, delivering bad news, addressing emotional reactions and other factors that may lead to misunderstanding or conflict		ASCE	DOP

2.5 Use available means to handle the challenges to effective communication posed by differences in language, culture and other factors

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
2.5.1 Use available means to handle language, cultural and other communication barriers when appropriate and demonstrate empathy while doing so			DOP DBD

2.6 Document and share, including providing written reports and electronic information when appropriate to do so, about the medical encounter to optimise clinical decision- making, patient safety, confidentiality, and privacy

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
2.6.1 Document and present reports of clinical encounters and care plans appropriately in a clear and understandable manner			DOP DBD

2.7 Demonstrate effective communication skills in non-clinical settings

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
2.7.1 When opportunities arise, effectively present appropriate information on mental health issues to the public or media		ASCE	MSAP DOP

3 Collaborator

Definition
Child and adolescent psychiatrists do not work in isolation: As all medical specialist, a child and adolescent psychiatrist works as a partner within a system designed to provide optimal, safe, and high quality care for patients. For most child and adolescent psychiatrists this will also involve working within a multidisciplinary team and therefore it is essential that a child and adolescent psychiatrist is able to effectively work in such settings.

Description

The child and adolescent psychiatrist as a collaborator proactively engages in partnership with others who are involved in the care of their patient, including the patients' family, physicians and other professionals in health care, social services and educational settings. Collaboration involves the effective negotiation, and solution of interpersonal conflicts.
Successful collaboration requires relationships based on trust, respect, and shared decision-making among a variety of professionals involved in the healthcare, social and educational system. Professional culture and practice style play an important role in developing effective collaborative care for patients. The collaboration process requires an understanding of the roles of others, pursuing common goals and outcomes, being transparent as to limitations of own perceptions, competencies and capabilities and managing differences. Child and adolescent psychiatrists need to collaborate with patients, their families and other professionals to develop a personalised plan of care to promote health and wellbeing that incorporates integrative approaches.

Competencies

The child and adolescent psychiatrist is able to:

3.1 Establish and maintain positive relationships with patients, colleagues, other medical and non-medical specialists in order to support a collaborative culture

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance

	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
3.1.1 Clearly define own role and responsibilities to other professionals		ASCE	DOP MSAP
3.1.2 Recognise and respect the diversity of roles, responsibilities and competences of other professionals			MSAP DOP
3.1.3 Maintain professional relationships with health care providers for the provision of quality care			MSAP DBD DOP
3.1.4 Effectively work with other health professionals to prevent, negotiate and resolve conflict			MSAP DBD DOP
3.1.5 Be able to work with local social and cultural networks, voluntary organisations and self-help groups			DBD DOP

3.2 Negotiate overlapping and shared responsibilities with other medical specialists and other colleagues in episodic and ongoing care, including the liaison work and transfer of patient care to another health care professional or setting and the provision of safe handover during a patient transition

The child and adolescent psychiatrist is able to:

	Knowledge	**Competence**	**Performance**
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
3.2.1 Serve as an effective consultant to other medical specialists, mental health professionals and community agencies			DOP MSAP
3.2.2 Obtain, interpret and evaluate consultations from other professionals		ASCE	DBD MSAP
3.2.3 Effectively participate in handovers of patient care between professionals		ASCE	DOP MSAP
3.2.4 Effectively participate in the transitioning of patient care between services, including when patients transition to adult mental health services			DBD DOP MSAP

3.3 Engage in respectful shared decision-making process with patients / parents / carers and other professionals in health care, education, social care, youth justice services, police and voluntary sector

The child and adolescent psychiatrist is able to:

	Knowledge	**Competence**	**Performance**
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments

			DBD DOP MSAP
3.3.1 Work jointly with patients, parents and carers in the formulation and revision of care plans and be receptive to their preferences and views			MSAP DOP DBD
3.3.2 Ensure a smooth and effective care pathway by prioritizing, timing and integrating activities and demonstrating effective shared decision-making with other professionals, especially in emergency situations			DBD DOP MSAP

4 Leader

Definition

A child and adolescent psychiatrist as a leader is someone who engages in shared decision-making and takes responsibility for the operation and ongoing evolution of the health care system. Child and adolescent psychiatrists are also able to handle different aspects of their practice and make every day systematic decisions involving resources, co-workers, tasks, policies and their personal life in the settings of individual patient care, practice organizations and in the broader context of the healthcare system.

Description

It is expected from child and adolescent psychiatrists to function as individual health care providers, as members of teams, and as participants and leaders in the relevant health care system.
Leadership is based on several values, among which are: Providing understandable, personalised care for the patient in continuity and confidentiality; adapting care to meet the needs of the population, maintaining one's own physical and mental health, submitting one's daily practice to peer review, engaging in continuous improvement of one's practices in response to new requirements and technological options, and recognizing that research and instruction are part of child and adolescent psychiatrists' professional obligations.
As healthcare is increasingly focused on multidisciplinary teams and working in partnership with consumers and other physicians, leaders should be able to lead effectively within the diversity that characterises an effective system.

Competencies

The child and adolescent psychiatrist is able to:

4.1 Demonstrate personal qualities based on values and self-awareness in order to deliver high standards of care and professionalism

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP

4.1.1 Recognise and articulate their own values and principles, understanding how these may differ from those of other individuals and groups			MSAP DBD
4.1.2 Identify one´s own emotions and prejudices and understand how these can affect one´s own judgement and behaviour			MSAP DBD
4.1.3 Recognise team dynamics and engage in multidisciplinary teamwork			MSAP DOP
4.1.4 Obtain, analyse and act on feedback from a variety of sources			MSAP DOP
4.1.5 Recognise the biases of other, consider its origins and maintain an open mind with a willingness to stimulate reflection and modify one´s own and the team´s approach and as far as possible ensure that these do not adversely affect the delivery of healthcare			MSAP DOP

4.2 Encourage improvement and innovation of health care services and medical education

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
4.2.1 Plan relevant elements of health care and educational delivery and implement change where appropriate	WE		MSAP DOP
4.2.2 Design and implement quality improvement projects or interventions that improve clinical effectiveness, patient safety and patient experience gathering information and advice at a structural/organizational level from experts by experience and using up to date improvement methodologies	WE		MSAP DOP
4.2.3 Participate in clinical audit to continually improve the quality of services			MSAP DOP

4.3 Utilise time and resources effectively to balance patient care, learning needs, outside activities and personal life

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments

			DBD DOP MSAP
4.3.1 Manage one's own time to balance patient care, learning needs, other activities and personal life			MSAP DOP
4.3.2 Balance personal and professional priorities to ensure personal health and sustainable practice and prevent burn-out			DOP MSAP
4.3.3 Manage and allocate the available resources to ensure optimal professional circumstances for self, patients and the wider team			MSAP DOP

4.4 Allocate finite healthcare and health education resources effectively

The child and adolescent psychiatrist is able to:

	Knowledge	**Competence**	**Performance**
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
4.4.1 Understand essential principles of resource and finance management	OE WE		
4.4.2 Understand organisational features of national, regional and local (mental) health care structure	OE WE		
4.4.3 Recognise the importance of equitable allocation of healthcare resources, balancing effectiveness, efficiency and access with optimal patient care	OE WE		DOP
4.4.4 Base resource allocation and clinical guidelines on best evidence and practice	OE WE	ASCE	DBD
4.4.5 Prioritise patient case loads on the basis of severity, impairment and urgency			DOP MSAP DBD
4.4.6 Appropriately delegate tasks and responsibility			DOP MSAP

4.5 Demonstrate effective administrative and managerial skills

The child and adolescent psychiatrist is able to:

	Knowledge	**Competence**	**Performance**
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
4.5.1 Understand the fundamentals of medical informatics and digital information technology concepts / use and critically reflect on the implications for daily practice	WE		DOP MSAP

4.5.2 Use patient-related databases at a basic level			DBD MSAP
4.5.3 Recognise and manage potentials and risks of digital technology to promote patient treatment efficacy, safety and welfare	WE OE		DOP
4.5.4 Ensure implementation of evidence based guidelines in clinical practice			MSAP DOP DBD
4.5.5 Understand and apply the principles of risk management and clinical governance	WE		DOP DBD
4.5.6 Work with systems for handling complaints from patients, carers and staff in a way that supports effective governance of clinical services		ASCE	DBD DOP
4.5.7 Understand current mental health and other relevant legislation including international conventions as well as national legislation on refugees, asylum seekers and awareness of related human rights issues	WE OE		DBD
4.5.8 Encourage and facilitate the professional development of peers and other related professionals			MSAP
4.5.9 Question and challenge the performance of other team members when standards appear to be compromised and be responsive to comments by other team members about one's own performance			DOP MSAP
4.5.10 Acquire and maintain leadership skills to effectively lead the mental health team´s efforts, contribute to the organisation´s goals and adapt the leadership style to changing healthcare contexts			MSAP DOP DBD

5 Health Advocate

Definition

A child and adolescent psychiatrist as a health advocate represents the needs of psychiatric patients and their families in terms of preventive measures of mental, behavioural and neurodevelopmental disorders as well as improving the general health and well-being of people who are diagnosed with mental, behavioural and neurodevelopmental disorders. A child and adolescent psychiatrist should advocate with integrity, showing the challenges to mental health represented by social, environmental, and biological factors. Child and adolescent psychiatrists should contribute to efforts to improve the health and well-being of their patients and families, the prevention of mental, behavioural and neurodevelopmental disorders and promote the anti-stigmatisation of child and adolescent psychiatry in society.

Description

Child and adolescent psychiatrists should see advocacy as an essential and fundamental component of mental health promotion that occurs at the level of the individual patient, the practice population, and the broader community. By definition advocacy involves promoting public discussion, making the community aware of important issues and guiding the decision-makers towards constructive solutions.
One of the main goals for a child and adolescent psychiatrist in order to be a good health advocate is to help change society's perceptions of people who suffer from mental, behavioural and neurodevelopmental

disorders. A key skill of a child and adolescent psychiatrist is the ability and the need to be empathic and engage patients and their families in both the short and long term.
Child and adolescent psychiatrists advocate the right of their patients to be treated equally, receiving health care and having access to family and educational support, social integration processes and benefits. Advocacy often requires engaging other health care professionals, community agencies, administrators and policy-makers. A child and adolescent psychiatrist may need to influence policy changes through presenting the challenges faced by people who use mental health services.

Competencies

The child and adolescent psychiatrist is able to:

5.1 Identify and address the determinants of mental health that affect the patient and the community

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
5.1.1 Recognise and address the determinants of mental health of populations and how public policy including legislation impacts on mental health	WE OE		
5.1.2 Recognise and address the impact of mental disorder on families and carers, and take remedial measures	WE		DBD DOP
5.1.3 Collaborate with other community sectors / agencies to promote mental health and prevent mental disorder at all levels focusing particularly on family, school, day care institutions and workplace			MSAP
5.1.4 Identify and address barriers and inequity in access to care, particularly for vulnerable or marginalised populations			MSAP
5.1.5 Provide relevant psycho-education whenever required especially to vulnerable and marginalised people for example, recently arrived refugees and asylum seekers			DOP

5.2 Be aware of the factors that affect the physical health and well-being of people who have mental illnesses and be able to intervene appropriately

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP

5.2.1 Promote good physical health and well-being in patients regarding nutrition, physical activity, sleep & rest, particularly in those with severe mental, behavioural and neurodevelopmental disorder based on best evidence			DBD

5.3 Recognise and respond to those issues, settings, circumstances or situations in which advocacy in collaboration with and on behalf of patients, professions, or society are appropriate to ensure the best interests of patients

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
5.3.1 Respect and promote the human rights of people with mental disorders and collaborate with user and carer associations and advocacy groups			MSAP
5.3.2 Empower children and adolescents with mental, behavioural and neurodevelopmental disorders and their parents / carers			MSAP
5.3.3 Recognise and address prejudice, stigma and discrimination associated with mental disorder and its treatment			MSAP DOP
5.3.4 Use strategies to enhance patient's harm reduction, self-management and autonomy		ASCE	DBD
5.3.5 Actively oppose the use of (child and adolescent) psychiatry for social and/or political repression	WE		
5.3.6 Recognise the possibility of conflict inherent in their role as a health advocate for a patient or community with that of manager or gatekeeper	OE		DBD MSAP

6 Scholar

Definition

The child and adolescent psychiatrist as a Scholar commits to lifelong learning, continuously improves one´s own skills and uses up-to-date evidence from research to achieve excellence in clinical practice as well as in teaching, training and coaching patients, families, colleagues, doctors in training, medical students, and others.

Description

The Scholar is a learned or erudite person, especially one who has profound knowledge of a subject and who studies in great detail. A child and adolescent psychiatrist as a Scholar engages in a life-long pursuit of mastery of their professional expertise. A child and adolescent psychiatrist should recognise the specialty as a scientific endeavour which develops, changes and gets more and more enriched by evidence-based

information. A child and adolescent psychiatrist should recognise the need to continually learn and inspire the education of colleagues, as well as patients, families, doctors in training, medical students, and others, including, when appropriate, the general public.
The active role of the Scholar ensures that a child and adolescent psychiatrist arrives at clinical decisions informed by evidence while taking patients´ and families´ values and preferences into account. Using the abilities of a Scholar, a child and adolescent psychiatrist shows excellence in professional work and provides high quality mental health care. The Scholar also invests time, effort and personal capabilities in promoting the growth and development of colleagues, doctors in training and medical students which may involve the use of supervision and mentoring.

Competencies

The child and adolescent psychiatrist is able to:

6.1 Develop, implement, and document a personal and continuing education strategy

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
6.1.1 Recognise and apply the principles for maintaining competence as a life-long learner	WE OE		DBD MSAP
6.1.2 Recognise and reflect on learning issues in practice through methods such as self-audit and engage in Continuous Professional Development (CPD)			DBD DOP
6.1.3 Access and interpret the relevant evidence and integrate this new learning into practice			DBD
6.1.4 Evaluate the impact of any change in practice, according to explicit standards of care, seeking bench marks			DBD
6.1.5 Document the learning process (e.g. logbook)			DBD

6.2 Use the best source and relevant evidence based medicine for clinical decision making in daily work

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
6.2.1 Understand the principles of critical appraisal and apply them in clinical contexts	WE		DOP

6.2.2 Integrate critical appraisal conclusions into clinical care			DBD

6.3 Be familiar with general scientific principles and methods, contribute to research and to the development of new knowledge

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
6.3.1 Recognise and apply the principles, methodology and ethics of research and scholarly inquiry	WE OE		
6.3.2 Formulate a research question and conduct a systematic search for evidence	WE OE		DOP
6.3.3 Select and apply appropriate methods to address the question	WE OE		DBD DOP
6.3.4 Analyse, interpret and report the results	WE OE		DBD DOP
6.3.5 Appropriately disseminate and utilise the findings of a study			DBD DOP MSAP

6.4 Contribute where appropriate as an effective teacher, to the learning and development of others including medical students, doctors in training and other health professionals

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
6.4.1 Understand and apply the principles of learning and the ethics underpinning medical education including mentoring	WE OE		MSAP
6.4.2 Work with others to identify respective learning needs			MSAP
6.4.3 Select and apply teaching strategies and interventions based on best evidence			MSAP DOP
6.4.4 Demonstrate that one's own clinical behaviour can be a model for the learning of others			MSAP DOP
6.4.5 Teach, present and reflect on feedback			MSAP DOP
6.4.6 Recognise and apply the principles of assessment and demonstrate the difference between formative and summative assessment	WE		DOP
6.4.7 Recognise and apply the principles of appraisal	WE		DOP MSAP

6.4.8 Give feedback in a timely and constructive manner showing respect and confidentiality			DOP MSAP

7 Professional

Definition

A child and adolescent psychiatrist is expected to work together with patients, families and other relevant stakeholders in order to achieve best outcomes for the patient. This is done by reference to ethical frameworks, maintaining high standards, showing integrity and respect to all, by demonstrating a commitment to continuous professional development and by being aware of one's limitations.

Description

The child and adolescent psychiatrist as a Professional is dedicated to the health and care of others. The role of the Professional incorporates contemporary society's expectations of physicians, which include clinical competence, a commitment to ongoing professional development, promotion of the public good, adherence to ethical standards and values.
The fundamental principles of professionalism are primacy of patient welfare, patient autonomy, social justice with commitment on the part of physicians to professional competence, honesty with patients, confidentiality, improving quality of and access to care, just distribution of finite resources, scientific knowledge and professional responsibilities including values such as integrity, altruism, humility, respect for diversity, and transparency with respect to potential conflicts of interest.
Professionalism is the basis of the implicit contract between society and the medical profession, granting the privilege of physician-led regulation with the understanding that physicians are accountable to those served, to society, to their profession, and to themselves.

Competencies

The child and adolescent psychiatrist is able to:

7.1 Deliver the highest quality of care with honesty, integrity and compassion

The child and adolescent psychiatrist is able to:

	Knowledge	Competence	Performance
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
7.1.1 Understand the history of psychiatry and its impact upon contemporary (child and adolescent) psychiatry	WE OE		
7.1.2 Maintain and promote child and adolescent safety			MSAP DBD
7.1.3 Show cultural sensitivity in their practice		ASCE	MSAP DOP DBD
7.1.4 Maintain highest standards of clinical competence and professional behaviour based on values and			MSAP DOP DBD

evidence in pursuit of the best interests of the child or adolescent			
7.1.5 Ensure the provision of treatment to all children and adolescents in need, irrespective of their social, cultural, racial, gender and economic background			MSAP DBD
7.1.6 Care for patients with integrity in a sensitive, empathic and compassionate manner		ASCE	MSAP DOP
7.1.7 Conduct oneself (also in the digital world) in a way that commands respect and confidence of patients, parents and carers and show respect for patients and their parents and carers			MSAP DOP
7.1.8 Observe professional boundaries with patients, parents and carers			MSAP DOP
7.1.9 Understand all aspects of professional relationships including the power differential between psychiatrists and patients / parents / carers and do not misuse this power differential			MSAP DOP
7.1.10 Understand and address the issues involved when the doctor-patient relationship ends		ASCE	DOP

7.2 Exhibit appropriate personal and interpersonal professional behaviours

The child and adolescent psychiatrist is able to:

	Knowledge	**Competence**	**Performance**
	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
7.2.1 Observe professional boundaries with colleagues and others involved in patient care			MSAP DOP
7.2.2 Recognise professional needs of other colleagues and respond appropriately			MSAP DOP
7.2.3 If asked, write constructive and objective references for trainees and colleagues			DBD
7.2.4 Respond to communication with health professionals in a sensitive and timely manner			MSAP DOP

7.3 Practice medicine in an ethically responsible manner that respects medical, legal and professional obligations of belonging to a self-regulating body

The child and adolescent psychiatrist is able to:

	Knowledge	**Competence**	**Performance**

	Knowledge tests WE OE	Clinical examinations ASCE CE	In-training assessments DBD DOP MSAP
7.3.1 Observe professional, regulatory and legal obligations at all levels	WE	ASCE	MSAP DBD
7.3.2 Maintain high quality records of clinical encounters and plans			DBD
7.3.3 Observe ethical codes of practice and manage conflicts of interest		ASCE	DOP MSAP
7.3.4 Maintain transparent relationships with commercial organisations (including pharmaceutical industry) based on ethical principles			MSAP
7.3.5 Recognise the principles and limits of patient confidentiality as defined by professional practice standards and the law, specifically addressing the role of parents / guardians	WE OE	ASCE	DBD
7.3.6 Identify and address appropriately unprofessional conduct of other health care professionals			MSAP
7.3.7 Review own professional conduct, acknowledge, remediate and draw learning from medical errors, should they occur and demonstrate an awareness of the impact of their own world view on professional conduct			DBD MSAP
7.3.8 Understand the components of informed consent from patients / parents / guardians, including capacity	WE	ASCE	DBD DOP
7.3.9 Recognise the extent of one's own limitations and seek advice and support			MSAP DBD

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APPENDIX B: Assessment Strategies

Adapted * from: European Training Requirements for Psychiatry. UEMS-Psychiatry 2023. https://www.uems.eu/__data/assets/pdf_file/0008/166976/UEMS-2023.39-European-Training-Requirements-for-the-Specialty-of-Psychiatry.pdf

Introduction

This appendix accompanies the assessment grid of the European Framework for Competencies in Child and Adolescent Psychiatry (EFC-CAP). The assessment grid shows suggested methods of assessing the competencies. The purpose of this appendix is to explain what the different methods are and to give examples of how different tools based upon these methods may be used in practice.
It is now widely recognised that assessment drives learning therefore an assessment system must be considered as being an integral part of any curriculum that is to be developed from the competency framework. This applies as much to professional training as to continuing professional development. Assessment strategies to monitor learning progression can be part of a programmatic assessment strategy and provide the basis for decisions on learning goal achievement or eligibility for certification procedures. There are three principles that should guide the construction of assessment systems:

- Assessment systems should be transparent, so that learners and teachers know what is being assessed and how it will be assessed.
- Each competency should be assessed, not just those that are easy to assess
- Competency assessment must be triangulated, that is each competency must be assessed in more than one way on more than one occasion.

A further consideration is the utility of the assessment system. Van der Vleuten (1996) pointed out that in mathematical terms the utility of an assessment system might be considered as the product of its reliability, validity, feasibility and educational impact (that is the effect that assessment has upon learning). It follows that if the value any of these qualities approaches zero, no matter how positive the remaining values are, the utility of the assessment system will also approach zero.
Miller (1990) described a conceptual model of the different domains of medical skill and how they may be assessed. Miller's model emphasises the importance of the assessment of performance (that is, what the doctor actually does in their day-to-day practice), rather than surrogates, which are actually assessments of knowledge or competence.
In the assessment grid in Appendix A, we have sought to identify at least two methods of assessment for each competency. For ease of viewing, we have arranged the assessment methods into one of the three domains in Miller's model, knowledge ('what the doctor knows'), competency ('what the doctor can do') and performance ('what the doctor does').
In the following sections of this appendix, we will describe each method of assessment and what is known about the reliability, utility, feasibility and educational impact of tools that are based on the methods, so that national associations and other regulators of psychiatric training may make informed choices regarding assessment methods. We will give more attention to the tests of the 'does' level, as they are likely to be less familiar to readers.

KNOWLEDGE ASSESSMENTS (TESTS)

Written examinations (WE)

There are two main types of written assessment: multiple-choice papers, in which the candidate selects the correct response from a number of alternatives and essay papers or short answer papers, in which the candidate has to construct text.
Multiple-choice questions: Papers based on multiple-choice questions (MCQ) offer a high degree of reliability per hour of testing time (Schurwirth and van der Vleuten, 2003) and if constructed well, they can test more than factual recall. There are now several question types available in addition to the traditional 'true/false' format. They clearly offer a reliable, valid form of assessment as long as due care is given to the construction and evaluation of questions. The facility to mark MCQ's electronically contributes to their high feasibility.
Essays and Short Answer Papers: Essay papers have been used to examine the ability of candidates to express themselves in writing and to use other intellectual skills (Schurwirth and van der Vleuten, 2003). Indeed, there is a great degree of face validity to this form of assessment in a highly language dependant discipline such as psychiatry. The use of this form of assessment is limited by the time taken to answer essays and hence essays have only limited feasibility. Short answer papers appear to assess similar domains of knowledge as MCQ papers, and since they depend on human markers, they can be less reliable and are also less feasible.

Oral examinations (OE)

Oral examinations may be defined as "examiner/examinee encounters where topics unrelated to specific patients are discussed" (Wass et al, 2003). This form of assessment is intended to assess clinical reasoning and decision-making skills and professional values. Swanson et al (1995) estimated that approximately eight hours of examiner time (either as paired examiners or individual examiner) is needed to produce an acceptable degree of reliability. A similar study of UK general practice candidates indicated that a well structured oral examination covering between 20 and 25 topics over three to three and a half hours of testing could produce acceptable reliability (Wass et al, 2003). The validity of this form of assessment must be carefully monitored, however, as Roberts et al (2000) found evidence the oral examination has a particular potential for bias against candidates from minority ethnic groups.

COMPETENCY ASSESSMENTS

Clinical examinations (CE)

The long case examination is one of the most venerable forms of assessment in medical education (Jolly and Grant et al, 1997). In the long case, candidates are given up to an hour to assess a non-standardised patient. They are assessed on the subsequent presentation they deliver to the examiner(s) and sometimes also on a brief observed interview with the patient. The examination may take up to an hour and a half. There are serious concerns about the reliability of the long case examination (Jolly and Grant, 1997) and these concerns arise because the assessment is based upon an encounter with one patient and unstructured questioning by examiners (Fitch et al, 2008). Norcini (2002) has reported reliability estimates for a single long case of 0.24. Having more assessments performed by more assessors and observing the whole encounter between candidate and patient increase the reliability of the long case. Six such long case assessments are needed to bring a reliability coefficient of 0.8. Unfortunately, however, the large amount of assessment time needed and the lack of willing and suitable patients severely limits the feasibility of the long case examination. Calls to restore the long case in psychiatry periodically emerge but have been rebuted (Burn and Brittlebank, 2013).

Assessment of simulated clinical encounter (ASCE)

The ASCE examination seeks to assess clinical competency by rotating each candidate around a number of standardised situations. Typically, each 'station' (encounter) in the examination will consist of a clinical scenario enacted by a role player and the candidate is given a task. The examiner observes the candidate performing the task and marks the performance against a given set of criteria, which is why this form of assessment is widely referred to as the Observed Structured Clinical Examination (OSCE). Newble and Swanson (1998) found that acceptable levels of reliability are attained after about 16 OSCE stations with one examiner at each station. This equates to about three hours of test time per candidate. The OSCE examination in UK postgraduate psychiatry has been shown to produce similar reliability estimates (Lunn, personal communication).
Recruiting and training examiners and role players, as well as finding suitable examination venues, are the factors that most restrict the feasibility of this assessment tool.

PERFORMANCE ASSESSMENTS

This form of assessment is often referred to as workplace-based assessment (WPBA) to emphasise that it is based upon a doctor's real-time day-to-day work and to distinguish it from standardised tests that may be conducted at a national level or will involve visiting an examination centre away from the place of work. Fitch et al (2008) identified three methodologies to WPBA:
• The observation and assessment of a doctor's performance conducting their work - direct observation of practice
• The collation of standardised data from several assessors – multi source feedback
• Retrospective assessment of performance through conversations based upon written material, such as log books or clinical records – document-based discussion
The results of a small pilot study (Brittlebank et al, 2011) and of a larger field study (Brittlebank et al, 2013) of WPBA in UK psychiatry demonstrated that the assessments are feasible to deliver and that with a relatively modest deployment of resources, they may offer acceptable levels of reliability and validity.

Directly observed practice (DOP)

The DOP method entails an assessor watching a doctor conducting a task, which may involve interacting with a patient, performing a practical procedure or performing a non-clinical task, such as teaching or giving expert testimony. A large number of different DOP tools have been evaluated.
The mini-Clinical Evaluation Exercise (mini-CEX) involves an assessor observing a doctor performing a task, such as history-taking or gaining informed consent, which involves communicating with a patient. It takes around 20 minutes, followed by 5-10 minutes for feedback. The mini-CEX has a large evidence base, with a generalisability coefficient (reliability score) of 0.77 for 8 assessments (Kogan et al, 2003) and reasonable construct validity (Holmboe et al, 2003).
The Clinical Evaluation Exercise (CEX) involves an assessor observing the doctor conducting an entire clinical encounter with a patient, in this way it is a WPBA equivalent of the long case assessment and it has strong face validity in psychiatry (Brittlebank, 2007). A CEX takes over an hour to perform. Its reliability is quite low; Norcini (2002) reported that two CEX assessments conducted in internal medicine produced a combined reliability coefficient of 0.39.
The Direct Observation of Procedural Skills (DOPS) was developed as a tool to assess a trainee's performance of practical procedures, such as venepuncture or intubation (Wilkinson et al, 2003). Early psychometric data on the DOPS suggests that the reliability and validity of this instrument compares favourably with the data for the mini-CEX (Wilkinson et al, 2008).
The feasibility of DOP-based assessments in psychiatry is determined by the length of time involved in the process, the acceptability to patients of having an observer present in the consultation and (especially in the case of mini-CEX and DOPS) how easily psychiatric practice may be broken down into smaller portions.

It is also influenced by the training needed to complete assessments; Holmboe et al (2004) has demonstrated that assessors need to be trained in order for them to be able to conduct fair assessments. A number of other DOP type instruments have also been evaluated in psychiatry and been shown to be useful these include tools to assess performance in teaching (Assessment of Teaching), presentation skills (Journal Club Presentation and Case Presentation) and performance of non-clinical skills (Direct Observation of non-Clinical Skills).

Multi-source assessment of performance (MSAP)

MSAP entails the assessment of a doctor's performance from several viewpoints, using a standardised measure that is then collated and fed back to the doctor. The feedback may be from colleagues, both peers and coworkers from different professions and/or levels in the organisational hierarchy, and from patients. MSAP may also involve an element of self-assessment.
MSAP has been widely used in professions outside healthcare for many years, where it is more commonly referred to as multi-source feedback or 3600 appraisal (Fletcher, 2004). According to Malik et al (2008) the use of MSAP in medicine has three main attractions:
• Assessments from multiple sources may be perceived as being fairer than assessment from a single source
• MSAP may facilitate assessment of areas of performance (such as the humanistic and interpersonal aspects of medicine) that are not easily assessed using other methods
• To address wider social issues about the accountability of the medical profession.
The feasibility of MSAP is influenced by the availability of competent raters and their access to components of the doctor's practice; raters can only assess that which they can observe and are competent to assess. There will be aspects of practice that peers have not observed and areas that coworkers and patients may not be qualified to comment upon. Feasibility also depends upon the time taken to complete MSAP tools and the ability of the person who collates the data to give helpful feedback to the doctor. Wilkinson et al (2008) have demonstrated that it takes an average of six minutes to complete a typical MSAP form used in medical practice.
The published data on the peer and coworker MSAP tools that have been used in medical training suggest that responses from as few as four (Archer et al, 2006) to 12 assessors (Wilkinson et al, 2008) can produce reliable data. Furthermore, one form, the Sheffield Peer Review Assessment Tool (SPRAT) has been shown to have good feasibility and construct validity data (Archer et al, 2005). A high level of reliability was also demonstrated for nine responses on an MSAP tool (the Team Assessment of Behaviour) that was developed to be mainly a screening tool to identify trainees in difficulties (Whitehouse et al, 2007). Although a number of tools have been developed to enable patients to give feedback on the performance of their doctor, none has been developed to be used on doctors in training and only two, the Physician Achievement Review (PAR) and SHEFFPAT, have been subjected to reasonably rigorous reliability and feasibility studies (Chisholm and Askham, 2006). These studies indicated that around 25 patient responses were needed to provide reliable data on doctors' performance (Crossley et al, 2005, Violato et al, 2003).

Document-based discussion (DBD)

In this method, a doctor's documented performance in clinical work is assessed through a discussion led by an assessor. There are two main methods in this, discussions based on logbooks or based on patient case records. Although logbooks have been in use in medical training for some time, there is little information in the literature concerning their use as part of a structured assessment. There are several descriptions and evaluations of the use of case records as the focus of assessed discussions – 'Chart Stimulated Recall' (CSR) in the United States. A review of these studies (Fitch et al, 2008) showed that CSR displayed good reliability and validity in assessing medical undergraduates and physicians.

In the CSR, a doctor presents a number of case records to an assessor, who chooses one record to be the focus of the discussion. The assessor questions the doctor on their performance and handling of the case, based on information the doctor has recorded. The discussion allows the doctor to explain their decision making and can allow exploration of the doctor's clinical reasoning, including the medical, ethical and legal aspects.
The process takes between 20 and 30 minutes to complete and assessors need little training in this method, other than guidance regarding the format of the assessment. It is therefore potentially a highly feasible form of assessment.

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* The European Training Requirements for Psychiatry encompasses suggestions for Entrustable Professional Activities (EPAs). The UEMS section of child and adolescent psychiatry wishes to stimulate the development of valid and reliable instruments for workplace-based assessments and supports further scientific inquiry into relevant strategies but finds it premature to establish the concept of EPAs for our specialty at this point.

APPENDIX C: Clinical Conditions and Settings

The child and adolescent psychiatrist is able to practice as a competent independent doctor with regard to conditions and settings in the high-level category in the table below.

The child and adolescent psychiatrist is able to conduct a primary assessment and to decide to manage on a basic level or refer to an expert setting concerning the conditions and settings in the minimum basic category in the table below - but might require supplementary learning to achieve competent independent practice in these areas (depending on working context and interests).

The level of competency required typically depends on:

a) The frequency with which the child and adolescent psychiatrist will be required to manage particular disorders in their practice / whilst on call and their complexity

b) The need to make urgent decisions when there is no opportunity/ time to reflect/ consult with others

Clinical disorders are listed according to ICD11 (corresponding diagnostic categories in DSM5 apply) keeping in mind the fluidity of nosology and nomenclature. The listing of clinical settings refers to areas where the child and adolescent psychiatrist will apply competencies and does NOT necessarily imply the necessity of workplace based learning / clinical rotations in postgraduate training.

National bodies can upgrade their curriculum demands according to their own context.

Level	Clinical disorders	Clinical settings
High level	1. Neurodevelopmental disorders 2. Schizophrenia or other primary psychotic disorders 3. Mood disorders 4. Anxiety or fear-related disorders 5. Obsessive-compulsive and related disorders 6. Disorders specifically associated with stress 7. Feeding or eating disorders 8. Elimination disorders 9. Disorders due to substance use or addictive behaviors 10. Disruptive behavior or dissocial disorders 11. Personality disorders and related traits 12. Tic disorders	Out-patient services In-patient services Pediatric liaison Acute and emergency services
Minimum basic level	1. Sleep-wake disorders 2. Catatonia 3. Dissociative disorders 4. Disorders of bodily distress or bodily experience 5. Impulse control disorders	Mental health of infants and under 5's Acute outreach services

	6. Paraphilic disorders 7. Factitious disorders 8. Neurocognitive disorders 9. Mental or behavioral disorders associated with pregnancy, childbirth or the puerperium 10. Gender incongruence	Adolescent forensic psychiatry

APPENDIX D:

Training objectives for UEMS specialists pertaining to the care of adolescents and young adults

Version September 2022

Context

Worldwide, the specific health needs of adolescents and young adults (AYAs) defined as individuals aged 10 to 24 are increasingly recognized. This phase of exploration and of shaping of one's identity drives both opportunities and risks, such as improved self-confidence, health enhancing behaviours, or poor therapeutic adherence, lack of long-term vision, which potentially interfere with treatment. Both specialists and primary care practitioners (e.g. in-practice paediatricians, family physicians, school doctors) can play a pivotal role in tailoring their approach to the specific needs of AYAs. This training package has been developed by members of the UEMS Multidisciplinary Joint Committee in Adolescent Medicine and Health (Chair, Prof. P.-A. Michaud, Lausanne, Switzerland), an initiative launched by the European Academy of Pediatrics. The content has been carefully discussed and reviewed by the MJC members, as well as an international group of experts working in the field and belonging to the Euteach training program (www.euteach.com).

The present document lists a set of practical, clinically oriented, holistic objectives that should allow all European specialists and primary care providers (paediatricians and family doctors) to respond better to the special health care needs of AYAs. They are competency-based and integrate knowledge, attitude and skills. In this respect, they are inspired by the CanMEDS model, as well as the "EPA" (Entrustable Professional Activities) approach. They can be freely adapted to the specific health care approaches and topics of various UEMS specialties (including paediatricians) and family doctors. Additionally, they should be applied taking into account the variety of cultural and legal frames of European countries. In the near future, it is foreseen to develop an accompanying tutorial (content, slides and videos) to assist trainers in implementing and developing teaching sessions.

1. The health care provider initiates and conducts the consultation with an AYA patient in a developmentally appropriate way (considering the patient's puberty stage, age as well as cognitive & affective level)

- ✓ Offers a setting that respects privacy and guarantees a trustful, empathetic and respectful relationship with the patient,
- ✓ Explains confidentiality and makes sure to get time alone with the patient for an appropriate part of the consultation. Agrees with the AYA what to disclose or not to disclose to the parent/guardians by the end of the consultation
- ✓ Uses developmentally appropriate communication skills: adapts language and wording to the age/cognition, verifies that the patient understands the information
- ✓ Clarifies the reason for the consultation and its goal and process. Gives the parents/guardians time to voice their worries
- ✓ Is attentive to cues for undisclosed problems ("hidden agenda").
- ✓ Assesses the adolescent's capacity in autonomous decision making (competence)
- ✓ Involves the parents/guardians in the evaluation, treatment and further measures, balancing the importance of the patient's privacy and increasing autonomy on one hand, and the communication within the family on the other hand
- ✓ Pays attention to the needs of AYAs minority groups, low socio-economic groups, homeless, refugees, LHBTI. Collaborates with trained interpreter when meeting AYA & family of foreign origin/cultural context.

2. The health care provider assesses and responds to the patient's lifestyle/behaviour in a non-judgmental way, paying extra attention to areas prone to be problematic in the age group and the AYA's resources *(The HEADSSS acronym provides useful guidance in this regards)*

- ✓ Assesses the patient's cognitive and affective development and daily functioning
- ✓ Identifies AYA's personal and environmental resources/protective factors, including the presence of trusted adult(s)
- ✓ Discusses daily leisure, diet, sports and social activities
- ✓ Assesses school/academic performance, screens for learning difficulties and other conditions (developmental/neurocognitive) leading to poor academic outcomes
- ✓ Screens for overt and covert symptoms of depression and/or anxiety in exploring mood, behaviour and expectations. Identifies self-harm, suicidal ideation and former or planned suicide attempts, as well as any victimization or violence
- ✓ Explores the value of substance use from the patient's viewpoint, the patient's use/misuse of drugs, the associated risk factors, the perceived range of consequences and the preparedness for change
- ✓ Discusses screen/internet/social media misuse and its health consequences

- ✓ Respectfully explores sexuality and reproductive life, including questions of gender identity and sexual orientation. Responds appropriately to common situations
- ✓ Assesses safe/unsafe sexual behaviour and risk for sexually transmitted infection and treats or refers for treatment; identifies need for contraception and responds empathetically to a suspected or verified pregnancy (pregnancy test, referral)
- ✓ Opens up for disclosure of subjection to violence and involvement in criminal activity.

3. The health care provider performs a physical examination taking into account the patient's growth and development

- ✓ Explains the process of any physical examination and the reasons for it
- ✓ Adapts the examination to the AYA's complaints/symptoms, physical/sports activity, social and professional background
- ✓ Follows a sequence that respects patient comfort and intimacy
- ✓ Evaluates and comments the patient's pubertal stage (e.g., Tanner stage)
- ✓ Assesses systems that change particularly during puberty (skeletal, sight, skin etc.)
- ✓ Investigates body shape's representations and self-image within the cultural and social context

4. The health care provider provides appropriate care to an AYA living with a chronic condition and facilitates transition and adaptation to adult health care settings

- ✓ Assesses the impact of chronic condition on patient's daily functioning
- ✓ Fosters an inter-professional approach and collaborates with the appropriate resources and people to assist the patient in coping with the chronic condition and life
- ✓ Promotes optimal adolescent development: minimizes the impact of the chronic condition on education and social life together with interdisciplinary team members
- ✓ Promotes self-confidence and capacity in managing health and illness
- ✓ Beyond the care of the chronic condition itself, addresses the basic health care needs of the patient; (HEADSSS, immunization, complaints regarding general health)
- ✓ Participates in the transition process from paediatric to adult health care settings: preferred age for transfer, adolescent's expectations, available support during transition (e.g. clinical nurse, social worker and psychologist) and joint consultation with both paediatric and adult health care provider. Actively involves the AYA in all decisions regarding transition.

Training tool

Teachers and mentors who want to set-up training sessions (bedside, small groups. Lectures) can access to a series of concrete training tools which have been specifically developed by EuTEACH faculties http://www.euteach.com to cover the UEMS training objectives. They can be particularly useful to professionals who are not familiar with the field of adolescent medicine and health. They are *freely accessible* at: https://moodle.unil.ch/course/view.php?id=24722. Once on the website, click on "invite" and use the password: euteach2022

In addition, the Euteach website offers a set of educational illustrations as how to organize and deliver effective and interactive training:

https://www.unil.ch/euteach/home/menuinst/how-to-teach/interactive-teaching-methods.html