UEMS child and adolescent psychiatry psychotherapy training guidelines

The Section and Board of Child and Adolescent Psychiatry (CAP) of the European Union of Medical Specialists (UEMS) has a working group that has produced psychotherapy guidelines in response to the substantial need for psychological treatments for the psychiatric disorders and disturbances of children and adolescents and the consequent need for specialist training. These guidelines outline different levels of training and competence. They are now available on the UEMS website (http://www.escap-net.org/web/images/stories/document/guidelines_on_psychotherapy_training.pdf) and comments are invited.

In brief, the working group recommended that all psychotherapy training should consist of: familiarity with theoretical models; personal skills and knowledge of techniques; and awareness of the effect of one's own life experiences. The duration of training should be 3–4 years and consist of a minimum of 400 hours in any model and competence must be demonstrated.

- *Familiarity with theoretical models*. Psychoanalytic/psychodynamic psychotherapy requires knowledge of theories of both child and family development and of techniques. Cognitive–behavioural psychotherapy requires knowledge of learning theory, focused on human behavioural, cognitive, emotional and social development and functioning as well as of the brain–behaviour relationship and the dynamics of social networks. Family psychotherapy requires proficient knowledge of family development and functioning in normal and disordered families, and how specific family features affect the development of children.
- *Personal skills and knowledge of techniques*. All modes of therapy require the capacity to develop a therapeutic relationship with the child and significant others. Psychoanalytic/psychodynamic psychotherapy requires the ability to recognise that meaningful communication involves emotional contact and participation (empathy), and the ability to differentiate the limits and objectives in case management, environmental interventions, counselling, support and psychotherapy. An optional recommendation is skilled training in infant or child observation. Cognitive–behavioural psychotherapy requires the therapist to be able to reflect on the aspects just described and to apply various techniques and protocols for specific psychiatric disorders. In family psychotherapy the therapist must be able to attend fully to the verbal and non-verbal contributions of each family member.
- Part of psychotherapy training involves heightening awareness of the fact that the therapist's own emotional reactions and life history experiences are an essential and inevitable part of the psychotherapy process.

The national status and criteria for psychotherapy differ across European countries, and as a consequence the training resources and curricula will vary. The trainers responsible for CAP psychotherapy training must be trained therapists themselves.

J. Tsiantis, Professor of Child Psychiatry, University of Athens, and President of the UEMS Section of Child and Adolescent Psychiatry; J. Piha, Professor of Child Psychiatry, University of Turku; D. Deboutte, Professor of Child Psychiatry, University of Antwerp

UEMS response to the EU green paper

The UEMS/CAP Section and Board, while fully supporting the intentions of the Green Paper from the European Commission, *Promoting the Mental Health of the Population: Towards a Strategy on Mental health for the European Union*, have produced a response that raises concerns that the topic of mental health for children and adolescents is not sufficiently addressed. The view is that these important initiatives should be framed according to a life-cycle approach, with a specific focus on children, adolescents and their social context. The full text of the response can be found at http://www.escap-net.org and correspondence can be conducted with J. Tsiantis, President of the CAP section, via email (itsianti@med.uoa.gr).

Early intervention in psychiatry

Reflecting a new and important trend in psychiatry, Blackwell has announced a new international journal for 2007, *Early Intervention in Psychiatry*. There is a call for papers at http://mc.manuscriptcentral.com/eip. The Editor-in-Chief is Professor Patrick McGorry.

Correspondence

Psychiatric care in south-west Stockholm: the SHO perspective

Sir: Academic overseas visits are usually the undertaking of senior psychiatrists. Recent articles have tended to focus on service provision (Kennedy, 2005) or to have reported on the struggles of mental health services in low- and middle-income countries (Feinstein, 2002).

In May 2005, a group of six senior house officers on the St George's Hospital Scheme in London visited the Karolinska Psychiatric Institute in Huddinge, Stockholm. The inspiration came after a group of Swedish doctors visited our trust at the invitation of Dr Najmeddine Al-Falahe, a Stockholm-trained local consultant. Our self-funded visit was planned to coincide with a bank holiday. Whereas Friday and Monday were academically oriented, we used the weekend to discover Stockholm by day and night.

On arrival, the educational coordinator, Dr Maria Starssjo, our excellent host for our stay, escorted us to the faculty's breakfast meeting. We were allocated residents to shadow on various in-patient units and community facilities. The wards,

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run by dedicated doctors with no community commitments, were in pristine condition. They consisted of individual rooms and a communal area that featured a large aquarium, reading lounge, small library and table tennis table. The doctors wore white coats over casual clothes and the atmosphere was generally relaxed. Despite a policy of separating patients who were severely psychotic from those who were less disturbed, in-patient units faced familiar pressures of bed shortages and social problems delaying discharge. While general, forensic and child and adolescent psychiatry had equivalents in Sweden, the management of organic illnesses such as dementias was left to medical teams. Separate drugs and alcohol services were based in central Stockholm. As might be expected, we found similarities with the biopsychosocial and multidisciplinary approach adopted in the UK, but were impressed with the quality of administrative and logistical support. Trainees had access to individual computers, modern on-call facilities and trendy quarters. A tour of the laboratories revealed common monitoring of psychotropic blood levels and the availability of metabolic profiling.

Recruitment into psychiatry had traditionally been difficult. The number had peaked from the late 1990s and stood at 1400 in 2002 (Silfverhielm & Stefansson, 2006). After 5 years of medical school and 18 months as house officers, doctors enrol on a 5-year training programme that leads to recognition as specialists. Many trainees we met had recently joined following a successful recruitment campaign based on financial and academic incentives. These included encouragement and funding to train in a range of psychotherapy modalities, a flexible on-call system and research opportunities. In contrast to their British counterparts, residents became actively involved in research early on and were given appropriate time and resources.

We found our visit extremely informative, enjoyable and productive. It highlighted some of the positive aspects of our own clinical practice and provided valuable lessons for the future. We strongly recommend that international visits be incorporated into training at an early stage. They broaden horizons and encourage reflection. They also further links between institutions and professionals that can only benefit service users and the National Health Service.

Joseph El-Khoury and Claire Dillon

Senior House Officers, St George's Training Scheme, London, UK, email joelkhoury@yahoo.com

Feinstein, A. (2002) Psychiatry in post-apartheid Namibia: a troubled legacy. *Psychiatric Bulletin*, **26**, 310–312.

Kennedy, P. (2005) Lessons from and for Japan on service delivery. *Psychiatric Bulletin*, **29**, 309–311.

Silfverhielm, H. & Stefansson, C. G. (2006) Country profile. Sweden. *International Psychiatry*, **3**(1), 9–12.

Tremors within the health system

Sir: I read with great interest M. M. Khan's paper 'Earthquake 2005: challenges for Pakistani psychiatry', in the July 2006 issue of *International Psychiatry* (vol. 3, no. 3, pp. 21–23). It was heartbreaking to read of the state of mental health in Pakistan, but hope still remains as long as there are people putting in effort to rectify this. I agree that the Pakistan Psychiatric Society should play a more prominent role than it has up to now.

At the same time, one should not underestimate the difficulties and obstacles in improving standards of mental health in a country where almost a third of the population live below the poverty line. We are also observing an increase in the incidence and prevalence of mental illness in that region, owing to growing insecurity, terrorism, economic problems, political uncertainty, unemployment and disruption of the social fabric. A feudal mind-set exists not only in the rural areas of the country but also in institutions of learning, where established psychiatrists do not promote or help junior doctors, for fear of either increased competition or of being replaced by the younger generation, but this puts patient care at stake. Not enough effort is being directed towards psychiatric research either, and there is no dedicated psychiatry journal in the country. According to Gadit (2006), the *Journal of Clinical Psychiatry*, which was once published regularly from Lahore, has ceased to exist and the first issue of the journal of Pakistan Psychiatric Society, called *JPPS*, was published in the year 2003 but was blocked politically and not reproduced again.

Prejudice and nepotism are the major factors contributing to decline. The system, which is already fragile, is further destabilised when locally trained psychiatrists in Pakistan are recruited internationally as consultants, leaving behind an increasing doctor:patient ratio.

In principle, I also agree with Dr Khan that one-off programmes should be discouraged and solutions which help in the longer run should take priority. After graduating in Karachi, I was involved in a community mental health initiative with our head of department in 2001–02, at Manora, an island near Karachi in the Arabian Sea with a population of 25 000. The Manora Health Project was launched in 2000 and was working under the aegis of Department of Psychiatry, Hamdard University Hospital, with the objective of improving the general health of the population, but with a special emphasis on improvement of their mental health status. It was a centre which provided consultations with health professionals and medication free of charge. It also worked at training local mental health social workers. Referral to its parent private teaching hospital provided patients with further treatments at a discount. This greatly helped in identifying and managing numerous mental illnesses in that community which were either misunderstood or ignored owing to a lack of knowledge, stigma or financial incapability.

Last but not least, I think it is high time that in Pakistan there was a separate postgraduate college for each medical specialty.

Yasir Abbasi

SHO in Forensic Psychiatry, Rampton Hospital, Nottingham Healthcare NHS Trust, Porchester Road, Nottingham NG3 6AA, UK, email yasir.abbasi@nottshc.nhs.uk

Gadit, A. A. (2006) Mental health in Pakistan: where do we stand? *Journal of the Pakistan Medical Association*, **56**, 198–199.

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