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ORIGINAL CONTRIBUTION

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Can we – and should we – have a Europsychiatry for Children and Adolescents?

The work of the UEMS Section and Board for Child and Adolescent Psychiatry/Psychotherapy[1]

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[1] This article is an update and extension of Hill P, Rothenberger A (2004) International Psychiatry 6:19–21

Abstract The Union of European Medical Specialists (UEMS) paves the way for harmonisation of training and free movement of medical doctors within the European Union. For more than 10 years, Child and Adolescent Psychiatry has been a distinct specialty at this European level – separate from Adult Psychiatry and Pediatrics.

The article gives detailed information on the background of the section/board of Child and Adolescent Psychiatry/Psychotherapy (CAPP), training issues including the Training Log Book and the recent situation as well as future perspectives of Continuous Professional Development (CPD) in CAPP, all of which influence the corner stones of CAPP and its delineation from other medical and non-medical organisations.

Child and Adolescent Psychiatry as the application of trained specialist medical practice to mental illnesses and psychological disorders in children and young people up to the age of about 18 years reflects more and more the growing research advances of the last years within the field with more progress to come. On the other hand, shortcomings of patient provision in Europe still have to be resolved and CAPP may help to do so.

Key words UEMS – Child and Adolescent Psychiatry – children – CME – CPD – training

Introduction

Since 1994, Child and Adolescent Psychiatry has been a distinct specialty, separate from Pediatrics and Adult Psychiatry, within the Union of European Medical Specialists (UEMS). It has a slightly curious title, of which more later. It has proved a successful arena for promoting training, and this in turn has led to a developing European view of what exactly child and adolescent psychiatry might be, and how it could properly be practised. This paper tries to reflect this.

One can take various views as to what the UEMS is for. At first sight, it is an advisory body aiming to influence the Council of Ministers and the European Parliament. Because it draws its members from nominations made by national medical associations, one view is that it is effectively a trade union, promoting the interests of its professional members. Yet, it also draws its delegates from national scientific or academic societies, which indicates that it is rather more than this. It can point, in its policies, to an evidence base for practice and includes both the trainers and the trained. This is a potent source of information and advice on training, and it has been the development of policies on training that has been the main success of the UEMS.

It can also be argued that another function of the UEMS is that it is a network of doctors with shared interests yet different traditions, providing opportunities for fertile discussion of problems in common and of competing solutions to these. This occurs both within and outside of formal meetings. Within meetings, the

UEMS tradition of attempting to obtain consensus first rather than an early resort to voting means that there is considerable open discussion.

Why a separate section and board?

Within the UEMS, child and adolescent psychiatrists used to be part of Psychiatry. Yet, it became apparent that, as is the case in all children's medical specialties, it was adult-orientated physicians who tended to occupy the positions of power. It was sometimes difficult for the child-orientated specialists to be understood or heard. They were in a minority, often used a different knowledge base, had different work patterns and in some countries had separate training from their colleagues in practice with adults.

A small number of child and adolescent psychiatrists made the point that the structure of the UEMS allowed a separate section and board for child and adolescent psychiatry because most European countries recognised child and adolescent psychiatry as a distinct specialty. Accordingly, child and adolescent psychiatry established itself independently within the UEMS in 1994.

One of the first resolutions to be adopted was that the Section (professional interests) and the Board (academic and training) would have the same membership, yet different Presidents. This has worked well and has been a protective measure against unhelpful splits.

Why the odd name (Child and Adolescent Psychiatry/Psychotherapy)?

The formal title of the child and adolescent monospecialty within the UEMS is Child and Adolescent Psychiatry/Psychotherapy (CAPP). The last part of this does not refer to non-medical psychotherapy, nor to psychotherapy with adults. It was chosen because of the difficulty child and adolescent psychiatrists in some countries (particularly Germany) were experiencing in obtaining appropriate reimbursement for psychotherapy with children. It was necessary to make a statement that psychological methods of treatment are particularly important in the psychiatric treatment of the young and that they need a degree of medical supervision to prevent inappropriate use by some non-medical practitioners.

Whether to retain the Psychotherapy tag is a topic of current debate within CAPP. It has admittedly caused a little confusion. Also, it is not the only area in which it is necessary to make the point that child and adolescent psychiatry incorporates a number of concepts and treatment approaches. For instance, neuropsychiatry is a prominent part of the specialty, especially in Austria and Italy, something which requires emphasis for training purposes.

For years, well before the existence of the UEMS, there has been discussion in most countries as to whether child and adolescent psychiatry should be primarily associated with paediatrics or adult psychiatry. This issue came to something of a head when medical specialties had to be sorted into groups within the UEMS so that there could be representation at the Management Council. Taking the views of child and adolescent psychiatrists within the section revealed different opinions. Roughly speaking, it seemed that those specialists who spent most of their time with pre-adolescent children tended to favour links with Paediatrics, and those who treated mainly adolescents saw benefit in close ties with Psychiatry.

As it happens, CAPP sends a representative to meetings of each of the above Sections and exchanges minutes with both. For the last years, CAPP has been one of the leads for representation at the Management Council for a group of medical specialties including Psychiatry. Hence, CAPP may reach high awareness for psychiatric issues and play an important role at the UEMS if the section/board is further active in the different bodies of the UEMS.

Training

In common with other Boards within the UEMS, child and adolescent psychiatry has been particularly interested in the harmonisation of specialist training. The first task of the Board, once established, was to draw up recommendations. The point of the exercise was to establish standards, drawing on best practice and giving priority to evidence of effectiveness, independent of any national traditions.

This important task has several consequences. Firstly, if specialist training can indeed be harmonised, then there can be free mobility of both specialists and trainees within the EU without prejudicing the mental health of children and adolescents. Secondly, establishing a European consensus as to what training should comprise leads to defining a certain sort of specialist. For example, the Training Log Book for CAPP published by the Board and updated in 2000 (Rothenberger 2001; a printed version can be obtained for free from the corresponding author), is explicit that the trained specialist will have 'a bio-psycho-social developmental model in mind' (p. 5). Such a specialist will do more than investigate, diagnose and treat child and adolescent psychiatric conditions, but include, for instance, preventive activities and advice on issues related to child-rearing. Trainees will 'acquire knowledge of and insight into the leadership role of the physician'.

In virtually all European countries, experience in psychiatry with adults of working age is a necessary component of training in child and adolescent psychia-

try. Similarly, experience of paediatrics is welcomed or required by many countries. Leaving the traditions of any particular country aside and working out an adequate yet realistic training that would incorporate such experiences led the Board to recommend specific experiences and a 12-month minimum time limit for training in adult psychiatry. Similar placement in paediatrics or neurology is recommended, but optional. Nevertheless, trainees are required to have knowledge of and practical experience in a number of paediatric clinical problems and situations.

The Log Book has been the most important document produced by the Board and has already proved important in helping new EU member countries to develop their own specialist training in CAPP.

Standards set in the Log Book are high and may well exceed those set by the relevant national authority on training. Nevertheless, they are aspirational. Although it may be the case that a country's training standards fall a little short of the Log Book's standards, there may be individual centres or schemes in that country that do meet them. Such a scheme can apply for Board approval and if a visit confirms that standards are met, the scheme can state that it has UEMS CAPP approval. This requires a visit by Board members including a trainee and an unresolved problem is how such visits may be funded. A few have been carried out and the estimated cost is about Euro 1500.

Continuing professional development (CPD)

The UEMS generally is currently concerned with CPD, and CAPP is no exception. It includes a CPD slot at its meetings, but the uneven state of development of CPD across Europe has hampered progress towards harmonisation and the setting of standards. The European organisation established by the UEMS to provide accreditation for CPD events is EACCME and, from time to time, it asks the Board for advice. The principle adopted by the Board is whether the issues addressed in any CPD event have a positive scientific evidence base and approval hinges upon that. A particular problem for CAPP is that CPD includes contributions from non-medical organisations, for example, those concerned with family therapy, and a supranational clearing house for CPD approval needs to be able to accommodate this.

One aspect of CPD that has attracted considerable interest is long-distance learning. Unexpectedly, this may lead to a closer association with the United States as there are American commercial programmes for CPD (e. g. in paediatrics) which would like to expand into Europe.

The nature of child and adolescent psychiatry

The point that setting standards and content for specialist training will also influence the type of specialist has already been made. Frequent topics at the UEMS CAPP meetings centre around what child and adolescent psychiatry actually is. Over the last few years, services have been required to provide a remarkable range of activities. At one extreme, provision of a place for illegal immigrant children to stay, at another the need for a precise delineation from paediatric neurology. In order to try and provide an agreed definition of what child and adolescent psychiatrists should do or be required to do, a short statement has been sent out to all EU countries and affiliates. This centres around the specifically medical contribution to child and adolescent mental health and makes the point that the psychiatry applied to young people is different in many important ways from that applied to adults. Which is, of course, where we came in.

Annex

Child and Adolescent Psychiatry/Psychotherapy (CAPP) – Compendium of UEMS

Child and Adolescent Psychiatry is the application of trained specialist medical practice to mental illnesses and psychological disorders in children and young people up to the age of about 18 years.

The title of the Section and Board includes the word *'psychotherapy'* because much treatment in child and adolescent psychiatry is psychological and can generally be regarded as psychotherapeutic. 'Psychotherapy' here refers to expert psychological management of children and adolescents by child and adolescent psychiatrists; something that is occasionally mistaken by employing or reimbursing authorities as being equivalent to non-specialist counselling.

There are important differences between child and adult psychiatric practice. Compared with adult practice, child and adolescent psychiatry:

- covers a different range and time frame of disorders (as in the International Classification of Diseases)
- has referral pathways to services that emphasise family and school
- uses more psychological than physical treatments
- uses less in-patient care
- emphasises a multi-disciplinary approach
- has a different legal framework
- relies on an approach that refers to the child's developmental status and an emphasis on family functioning as well as traditional disease/disorder diagnoses.

The specialist medical contribution: child and adolescent psychiatry

Child and adolescent psychiatrists are physicians who have pursued an extensive postgraduate training specifically in the psychiatry of childhood and adolescence. They will also have training in adult psychiatry, though the extent of this varies from country to country. In addition, they will usually, though not universally, have had training in paediatrics, and in some countries a substantial training in paediatric neurology. Specialist training is long, thorough and to a high standard. This is reflected in the *Child and Adolescent Training Logbook* prepared by the UEMS CAPP section.

Although a number of professions, medical and non-medical, contribute to children's mental health care and treatment, child and adolescent psychiatrists have a central contribution. Because of their medical training and qualifications, child and adolescent psychiatrists have:

- specialist medical knowledge of physical factors relevant to mental disorder in children
- the ability to examine their patients medically
- the power to prescribe medication or dietary treatments
- an ethical basis for clinical practice shared with the rest of the medical profession
- expert knowledge of classification systems and the power to make diagnoses.

In many countries, child and adolescent psychiatrists will also have legal powers and responsibilities, particularly relating to child protection, compulsory admission to hospital, and young offenders with mental health problems.

Not all the work carried out by child and adolescent psychiatrists is directly with children and their families. Some is consultative, providing advice and information to other agencies. There is considerable demand for teaching and training for all levels of medical training and for non-medical disciplines. Clinical research into children's mental health problems and disorders is carried out and studied. There is a separate scientific base and specialist publications for child and adolescent psychiatry, compared with adult psychiatry and paediatrics, though there is, of course, some overlap.

Children are not simply small adults. Their life circumstances, developmental status and different pattern of illnesses are often qualitatively different from adults. This also applies to treatments, so that some (such as electro-convulsive therapy) are rarely used in childhood and, conversely, others (such as family therapy) are widely used with children but rarely used with adults. It is becoming increasingly considered important to provide specialist health care for children, separate from adult clinical services.

Adequate clinical practice in child and adolescent mental health requires professionals specifically trained in children's and adolescent's mental health. It cannot be done safely or effectively by those whose training has been only in adult practice.

This applies both to professions and services. In medicine, this requires recognition of child and adolescent psychiatry as a medical specialty separately from adult psychiatry; something already evident in the UEMS where the two specialties are separate. In nearly all EU countries this also applies to the provision of mental health services, so that clinics and hospital in-patient units for children are separated from those for adults.

Many, in some countries most, young children with mild to moderate mental health problems are dealt with by paediatricians. This is to be welcomed. The role of the child and adolescent psychiatrist is a specialist one and it can be expected that he or she will see the most complex or severe cases.

The CAPP specialist section has a close working relationship with the sections of Psychiatry and Paediatrics, exchanging minutes and collaborating on such issues as medicines for children. CAPP sends observers to participate in the meetings of the two other sections.

Current issues

Continuing delineation of child and adolescent psychiatry from general adult psychiatry and paediatrics is the main concern of the CAPP section. There are still a few European countries in which child and adolescent psychiatry and general adult psychiatry are not yet separate specialties or services. For the reasons given above, the section thinks this is not a satisfactory standard for Europe's children and teenagers.

There is also a parallel issue concerning the definition of the specific medical contribution of child and adolescent psychiatry, distinct from non-medical specialties such as psychology, non-medical psychotherapy or social work. This is sometimes an issue with funding bodies.

CME/CPD and child and adolescent psychiatry

The CAPP section has devoted considerable thought to the issue of CME/CPD. There are a few major issues:

- the range of useful educational opportunities extends into areas such as child development, family theory or psychological therapies in which the major promoting bodies are non-medical and may not consider seeking medical approval for CME/CPD recognition
- the low level of pharmaceutical industry involvement with children's mental health. There are far fewer sponsored conferences for child and adolescent psychiatrists. Within this context, the pharmaceutical industry and the producers of medical devices have an important task in passing on the latest findings. Collaboration between manufacturers of drugs and medical devices and the profession must be further developed so that knowledge about the latest medical findings reaches the doctors quickly, efficiently and in a scientifically correct manner
- involvement of the industry should go hand in hand with careful policies for disclosure of conflict on interests and for unrestricted educational grants. The UEMS believes that the governing principle is that the methods for financial accountability – both for individual doctors and for CME/CPD providers – must command widespread confidence and be based on openness and transparency. Funding from third parties, such as the pharmaceutical industry, must comply with these criteria and should only be permitted in accordance with national and international guidelines (Rothenberger et al. 2004)
- the small size of the specialty means that child and adolescent psychiatrists are spread thinly. Local cover for absence at a CME/CPD meeting may be impossible, and participants will have to take more time away from practice to travel further to meetings organised specifically for them.

Innovations

The repeated and continuing revisions of the major classification systems reflect research advances in understanding causation and natural history of psychiatric disorders in the young. Genetics and neuroscience have been increasingly important in this endeavour. The use of operational definitions has led to greater international co-operation in scientific studies of psychopathology and treatment.

Since the last issue of the Compendium, the major innovations have been in treatment. Cognitive behavioural (psycho)therapy uses a systematic, problem-centred approach employing an applied science model, and yields measurable results which provide a promising evidence base for efficacy. Although newly trained child and adolescent psychiatrists are generally conversant with the techniques, CME/CPD training opportunities for more senior specialists are relatively few.

Psychopharmacology, hardly in evidence in the psychiatry of the young 10 years ago, is now vigorous and increasingly employed. It is still the case that most research in this area is American which is a mild limitation in view of cultural and classification differences and there is a need for a specifically European approach. Much of the dissemination of relevant knowledge is funded by the pharmaceutical industry.

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