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while exercising caution in the use of Western classifications. The numbers of refugees using the service should be recorded to help argue for extra resource allocation. Arrangements for interpreters should be monitored closely because we have found that they are often unsatisfactory. Professional interpreters are best (Phelan & Parkman, 1995) but they could be supplemented with volunteers if properly organised. Written information should be available in various languages. The psychiatric services should forge links with NGOs and RCGs, who want to play a greater role. This could be of mutual benefit with interpreting, befriending and cross-cultural understanding.

On a larger scale there could be more cooperation between health authorities in different parts of London. This has been recommended in various reports but there is little sign of it happening. This illustrates the difficulty in, and perhaps the resistance to, helping this vulnerable group.

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References

BRADY, K., PEARLSTEIN, T., ASNIS, G., *et al* (2000) Efficacy and safety of sertraline treatment of post traumatic stress disorder: a randomized controlled trial. *JAMA*, **283**(14), 1837–1844.

BRUNTLAND, G. (2000) Mental health of refugees, internally displaced persons and other populations affected by conflict. *Acta Psychiatrica Scandinavica*, **102**, 3.

BUNCE, C. (1997) Psychiatrists plan network to help asylum seekers. *BMJ*, **314**, 535.

CYR, M. & FARRAR, M. (2000) Treatment for post-traumatic stress disorder. *Annals of Pharmacotherapy*, **34**(3), 366–376.

DE JONG, J., SCHOLTE, W., KOETER, M., *et al* (2000) The prevalence of mental health problems in Rwandan and Burundese refugee camps. *Acta Psychiatrica Scandinavica*, **102**, 171–177.

DEPARTMENT OF HEALTH (1999) *National Service Framework for Mental Health*. London: Department of Health.

EASTMOND, M. (1998) Nationalist discourses and the construction of difference: Bosnian Muslim refugees in Sweden. *Journal of Refugee Studies*, **11**, 161–181.

FOA, E. (2000) Psychosocial treatment of post-traumatic stress disorder. *Journal of Clinical Psychiatry*, **61** (suppl. 5), 43–48.

JONES, D. & GILL, P. (1998) Refugees and primary care: tackling the inequalities. *BMJ*, **317**, 1445–1446.

PHELAN, M. & PARKMAN, S. (1995) Work with an interpreter. *BMJ*, **311**, 555–557.

THE REFUGEE COUNCIL (2000) *The Immigration and Asylum Act 1999*. Briefing Paper. London: The Refugee Council.

SILOVE, D. (1999) The psychosocial effects of torture, mass human rights violations, and refugee trauma. *Journal of Nervous and Mental Disease*, **187**(4), 200–207.

SUMMERFIELD, D. (2001) Asylum-seekers, refugees and mental health services in the UK. *Psychiatric Bulletin*, **25**, 161–163.

WATTERS, C. (2001) Emerging paradigms in the mental health care of refugees. *Social Science and Medicine*, **52**, 1709–1718.

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JOSEPH SALIBA AND CORNELIUS KATONA

European Union of Medical Specialists – activities of the Section and Board of Psychiatry

The European Union of Medical Specialists (UEMS) was set up on 20 July 1958, 16 months after the Treaty of Rome was signed. In 1962, the UEMS Section of Psychiatry was established. It was, however, relatively inactive until it was revitalised following a meeting of the European Societies in 1990 called by the Royal College of Psychiatrists and chaired by Dr (now Dame) Fiona Caldicott. The UEMS Board of Psychiatry was established in 1992 as a working group of the Section with a particular focus on training matters. The Section is currently chaired by Dr Anne Lindhardt (Denmark) and the Board is chaired by Professor Manuel Gomez-Beneyto (Spain). Both Section and Board meet twice a year.

Over the years, the Section and Board have focused on standards for training in accordance with contemporary knowledge and current developments in Europe. It has always been and remains crucial to balance the desire for harmonisation with the recognition of cultural and structural differences. The Section and Board see their role as a quality assurance organisation, setting standards by stimulating the process of development in member countries. It is for the national professional bodies to use these standards and recommendations internally to achieve the goals in their own countries. The Board has not seen it as either helpful or necessary to act as a European examining board for the speciality.

Apart from the full European Union members, there are also a large number of associate member countries. The Association of European Psychiatrists (AEP), the European Federation for all Psychiatric Trainees (EFPT), the Permanent Working Group (PWG) and the Mental Health Regional Office of the World Health Organization also attend, with observer status.

The Section and Board have set up a number of working groups to focus on important UEMS Charters (Box 1) and on fields of activity more exclusively relevant to psychiatry (Box 2). The last three activities in Box 2 are still at an early stage.

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Box 1. Activities of the UEMS Specialist Sections and Boards

- Charter for Medical Specialists in the European Union
- Charter on Training of Medical Specialists in the European Union
- Charter for Continuing Medical Education of Medical Specialists
- Charter on Visitation of Training Centres
- Charter on Quality Assurance of Medical Specialists in the European Union

Box 2. Activities of the UEMS Section and Board of Psychiatry

- Charter of Training
- Logbooks
- Visitation of training centres
- Continuing medical education
- Biological psychiatry
- Psychotherapy
- Old age psychiatry
- Quality assurance
- Mental health legislation
- Profile of the psychiatrist
- Mental health service profile
- Role of the tutor in supervision

Box 3. The logbook and contents

- Training package
- Description of training activities
- Specific educational objectives
- Compulsory elements
- All other clinical training
- External courses and workshops
- Research practice
- Posters, oral presentations and publications
- International exchange
- Other training experiences

Box 4. The UEMS Charter on Visitation of Training Centres

- Statutory and voluntary visitation
- Visiting committee
- Organisation of the visits
- Actual visit – criteria and assessment
- Visitation report
- International visitation

Working groups and activities

The Section and Board have focused particularly on Chapter 6 of the UEMS Charter on Training of Medical Specialists in the European Community, which deals with the requirements for the particular speciality (UEMS, 2000*a*, available on the UEMS website: http:/ www.uems.be/psychiat.htm). The minimum duration of training in psychiatry has been set at 5 years, with a stipulated common trunk content that includes in-patient, out-patient, liaison, consultation, emergency psychiatry and psychotherapy. General adult psychiatry, old age psychiatry and psychiatric aspects of substance misuse should form a mandatory part of the common trunk and it is highly recommended also that developmental psychiatry and forensic psychiatry be included. Apart from ongoing clinical supervision, there should be at least 40 hours of weekly individual supervision related to all aspects of working as a psychiatric trainee and additional psychotherapy supervision. Training programmes should be individualised to the needs of the trainee in line with national rules and European Union recommendations. It is stipulated that trainees should have sufficient linguistic ability to communicate with patients, study international literature and communicate with foreign colleagues.

The logbook (Box 3) should be the trainee's personal file to help the trainee obtain maximum benefit from training. As such, it should include a description of activities reflecting compulsory training requirements and providing for verification and monitoring of the training process. It should also provide for identification of specific 'educational objectives' to reflect the approved training direction that the trainee is pursuing beyond minimum requirements. Although the number of trainees should not exceed the number of approved training posts, in psychiatry it has not been considered necessary to stipulate a maximum number.

With regard to formal recognition of training institutions and teachers, distinction should be made between large institutions where full-time training can take place and smaller specialised institutions that can contribute only to part of the training. The time interval for external visitation by national organisations in order to maintain quality assurance has been set at 5 years. There should be independent consultation of trainees. Training in psychiatry in Europe is described in the 1997 supplement of the *European Archives of Psychiatry and Clinical Neuroscience* (Hohagen & Lindhardt, 1997).

Another field in which the Section and Board have been active is the UEMS Charter on Visitation of Training Centres (UEMS, 2000*b*), as shown in Box 4. So far, Budapest in Hungary and Kraków in Poland have submitted to such visits. Consideration is being given to the possibility of granting provisional recognition status to centres where good training initiatives fall short of the full requirements.

A working group has dealt with application of the Charter on Quality Assurance to Psychiatry (UEMS, 2000*c*). Following a questionnaire survey of member countries, recommendations have been drawn up identifying targets to be achieved by the year 2000 (Box 5). The working group currently is establishing standards in specialised psychiatric care in the four phases of referral, assessment, treatment/stabilisation and rehabilitation.

A further area of activity has been that of Mental Health Legislation. A questionnaire survey was carried out in 1993 of the 16 member countries with regard to legislation for compulsory admission and other compulsory acts in psychiatry. An internal report highlighted

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Box 5. Recommendations on quality assurance

- National Psychiatric Associations (NPAs) should establish working groups on quality assurance with the purpose of:
  - formulating quality assurance policies according to national standards
  - stimulating the development of quality assurance activities in professional psychiatric bodies and in clinical psychiatric practice at local level
- The NPAs should establish areas of quality assurance priority, both national and local
- The NPAs should start formulating clinical guidelines on diagnosis and/or problems from within the above areas of priority
- Working groups at local/clinical level should be established in the public sector to identify local areas for quality assurance projects
- Systems of documentation recording activity and outcome should be in place in the public sector
- The above recommendations should apply also to private practice

wide variations, both in legislation and in the way it is applied. The working group also focused on identifying harmonising principles for mental health legislation. Recently, this work coincided with that of the Council of Europe's Working Party on Psychiatry and Human Rights, the latter leading to a White Paper/consultation document on the protection of the human rights and dignity of people suffering from mental disorder (Council of Europe Steering Committee on Bioethics, 2000). The UEMS Section, commenting on this 'White Paper', stressed that priority should be given to decreasing the risk of involuntary admission and treatment by advising governments to give more emphasis to improved access to adequate and high-quality community-based and out-patient psychiatric services.

The working group on the 'Profile of the Psychiatrist' is at an early stage of activity. The problem of defining the role and sphere of activity of the medical specialist is by no means unique to psychiatry and is necessary to determine the legitimate professional activity of the medical specialist. This is not only to protect specialist medical acts from non-medical encroachment but, more importantly, to ensure that patients are treated by the right type of professional with the appropriate skills. This topic is being addressed already in member countries. The Royal College of Psychiatrists has recently published its own recommendations (Royal College of Psychiatrists, 2000). Similarly, in The Netherlands, the Dutch Psychiatric Association has prepared its own 'Psychiatrist's Profile' (Dutch Psychiatric Association, 1996). It is likely that these documents will act as a basis for the discussion of this working group.

The working group developing the Mental Health Service Profile aims to harmonise recommendations regarding good models of service and defining irreducible minimum standards of acceptable care. Considerable work has been done already in this field. De Jong has devised a tool, the International Classification of Mental Health Care (ICMHC), for describing services providing mental health care (de Jong, 1996). Thornicroft and Tansella also have described mental health outcome measures, including the 'Matrix Model' (Thornicroft & Tansella, 1996, 1998). Thornicroft also has described a National Service Framework for Mental Health (Department of Health 1999; Thornicroft, 2000). Finally, the Epsilon Study (Thornicroft *et al*, 2000) has explored reliable outcome measures for mental health service research based on a comparative cross-sectional study in five European countries. However, the initial targets of this working group will be less ambitious, focusing mainly on a preliminary qualitative and quantitative database of existing services and provisions.

The most recent working group to be set up will deal with the role of the tutor in supervision. This role is central to the whole process of training and is a major factor determining the outcome of the training process, and yet there are insufficient European guidelines regarding the essential ingredients of this supervisory role. This working group is chaired by Professor Katona. A draft paper was considered at the October 2001 meeting in Prague.

This brief article has summarised the function and activities of the UEMS Section and Board of Psychiatry and its links with related organisations. Given the scope that exists within this organisation to harmonise standards of training and quality service delivery, it might be said that the UEMS has not been sufficiently active in disseminating its charters and other information through national organisations. On the other hand, it is only the national organisations themselves that can decide the extent to which such information is relevant, useful and applicable in their own countries.

Finally, there are several European 'players' in the field with potentially overlapping roles and it is important for these to have a complementary role with each other to maximise output. In this regard, a recent joint meeting between the representatives of European psychiatric organisations in five World Psychiatric Association zones and the UEMS Section and Board of Psychiatry was held in London to coincide with the College's Annual Meeting. This joint meeting was very well attended and has provided a potentially useful step in the right direction. It is hoped that there will be useful follow-up meetings.

References

COUNCIL OF EUROPE STEERING COMMITTEE ON BIOETHICS (2000) *White Paper on the Protection of the Human Rights and Dignity of People Suffering from Mental Disorder* (restricted document). Strasbourg: Council of Europe.

DE JONG, A. (1996) *ICHMC – International Classification of Mental Health Care: a Tool for Describing Services Providing Mental Health Care.* Groningen, The Netherlands: WHO Collaborating Centre for Research and Training in Mental Health, Department of Social Psychiatry, University of Groningen.

DEPARTMENT OF HEALTH (1999) *National Service Framework for Mental Health. Modern Standards and Service Models.* London: HMSO (available from http://www.doh.gov.uk/nsf/mentalhealth.htm).

DUTCH PSYCHIATRIC ASSOCIATION (1996) *Psychiatrist's Profile,* Task Force Psychiatrist's Profile. Utrecht, The Netherlands: Dutch Psychiatric Association.

https://doi.org/10.1192/pb.26.6.224 Published online by Cambridge University Press

HOHAGEN, F. & LINDHARDT, A. (1997) Training in psychiatry in Europe. *European Archives of Psychiatry and Clinical Neuroscience*, **247**(suppl. 1), no. 6.

ROYAL COLLEGE OF PSYCHIATRISTS (2000) *Good Psychiatric Practice 2000*, Council Report CR83. London: Royal College of Psychiatrists.

THORNICROFT, G. (2000) National Service Framework for Mental Health. *Psychiatric Bulletin*, **24**, 203–206.

— & TANSELLA, M. (1996) *Mental Health Outcome Measures*. Heidelberg: Springer Verlag.

— & — (1998) A conceptual framework for mental health services: the Matrix Model. *Psychological Medicine*, **28**, 503–508.

—, BECKER, T., KNAPP, M., *et al* (eds) (2000) Reliable outcome measures for mental health service research in five European countries: the EPSILON Study. *British Journal of Psychiatry*, **177** (suppl. 39), S1–S54.

UEMS (2000*a*) UEMS Charter on Training of Medical Specialists in the European Community. *Compendium of Medical Specialists*, **1**(1), 24–27.

— (2000*b*) UEMS Charter on Visitation of Training Centres. *Compendium of Medical Specialists*, **1**(1), 36–43.

— (2000*c*) UEMS Charter on Quality Assurance in Medical Specialist Practice in the European Union. *Compendium of Medical Specialists*, **1**(1), 44–45.

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Military psychiatry

A unique national resource

The aim of the defence medical services (DMS) is to maintain the health of those individuals who volunteer for service in HM Armed Forces, in order that they may efficiently discharge their duties.

Military psychiatry is therefore an occupational service in which the military psychiatrist has responsibilities to both the individual and the organisation, rather like forensic psychiatrists and prison doctors. Military culture is distinct from civilian culture and offers a unique social environment in which to practise psychiatry.

There is no civilian equivalent to military psychiatry; the closest would be liaison psychiatry. There is, however, an interesting mix of adolescent, forensic, psychotherapy (individual and group), rehabilitation psychiatry (physical, including injury, and psychological injury), public health, occupational medicine and transcultural work. Serious mental illness, other than index episodes of psychosis is rare. Personality differences, post-combat (traumatic) mental health issues; somatisation; abnormal illness behaviours; sequellae of childhood abuse; reactions to extreme stress; the effect of hostage taking; teaching (para- and non-medical personnel); providing psychological advice and psychological 'threat' assessments for commanding officers; working with welfare and religious organisations; undertaking psychological autopsy; aviation and underwater psychiatry; and so forth are all part of a uniformed psychiatrist's remit.

DMS psychiatry is tri-service and serves 210 000 service personnel (and when abroad, their dependants). The service is community-based in departments of community psychiatry (DCP) with an in-patient assessment and treatment facility in North Yorkshire at the Duchess of Kent's Psychiatric Hospital. Each DCP manages around 4000 new referrals and 20 000 out-patients per year. The in-patient unit receives approximately 450 new patients each year and acts as a triage and receiving centre for psychiatric aero-medical evacuations. The DMS employs a large number of civilian psychologists, nurses and psychiatrists.

There are 16 DCPs in the UK (Fig. 1), Germany, Gibraltar and Cyprus. Each serves a catchment population of approximately 15 000 servicemen and consists of consultant psychiatrist(s) and community psychiatric nurses with psychology and social work support.

Origins of military psychiatry

Military psychiatry can look to 1904/1905 as its birth date. It was the Russians who first enunciated the basic principle of military psychiatry relating to the social context of an individual's distress. They found that when soldiers were removed from the social role and evacuated from combat their psychological symptoms became fixed and they suffered the long-term mental illness, the so-called evacuation syndrome. They also found that the symptoms of many of those soldiers who were kept close to the front, with their colleagues and units, improved, indeed some could even return to duty.

World War One revealed that every man has his breaking point. World War Two showed the importance of the group dynamic before, during and after combat in protecting and supporting combatants. The Vietnam War reminded us of the long-term psychological sequelae of combat. The Yom Kippur served as a reminder that acute psychological breakdown could occur rapidly. The Gulf War reminded us of post-conflict war syndromes seen first in Scottish and Swiss mercenaries in the 18th century.

Psychiatric casualties are now as much a part of military medical planning as infectious diseases and gunshot wounds. Their initial management is primarily the responsibility of command. Their subsequent management the responsibility of medical officers and psychiatrists, a task with its unique moral and ethical dilemmas.

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