WPA Recommendations:

Principles and Priorities for a Framework

for Training Psychiatrists

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1. Introduction

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In 1996 the World Psychiatric Association (WPA) and the World Federation for Medical Education (WFME) drafted the basic principles that should be taught to medical students in order to identify and treat mental illnesses. The Core Curriculum was adapted to the needs of a "New Medicine" in which healing or treatment were not enough anymore, prevention and promotion of mental health started to acquire more and more importance. This project highlighted the importance of psychiatry in the curriculum of medical students for two main reasons: The need to treat human beings as a whole, the second because the skills learned in psychiatry are important for other physicians (such as the ability to establish a good relationship with the patient, assess mental status), moreover taking into account that almost 15 to 20% of patients who are seen by other specialists do suffer from a mental disorder, and this figure can even be increased to up to 40% by those who directly attend mental health services.

More than 20 years have passed since that project. During that time, the WPA has continued to work to improve the education and training of psychiatrists. Fifteen years ago the result of a work coordinated by Prof. Juan J. López-Ibor and Prof. Ahmed Okasha and directed by Prof. Pedro Ruíz, the Institutional Program on the Core Training Curriculum for Psychiatry was approved and has served as guide in many countries (WPA, 2002). In recent years though certain sectors started to believe that psychiatry is in crisis as a medical specialty. This is probably due to several reasons. Research in the broad and extensive field of neurosciences (including genetics and pharmacology) is not reflecting the expected results for clinical applications. Probably psychopathology is not receiving the necessary attention. But in our actual world new situations are emerging that affect people's mental health (migration, natural disasters, military conflicts, catastrophes, ...). It is therefore essential to lay the foundations of the knowledge, skills and attitudes for those physicians who decide to specialize in psychiatry.

In 2014, Dr. Edgard Belfort, Secretary of Education of the World Psychiatric Association, proposed to the WPA Executive Committee and its President to create a Task Force to study and lay down the principles and priorities for a framework for training psychiatrists. The work has been developed by the WPA Operational Committee which met several times in Madrid (Spain), Cape Town (South Africa), Cuenca (Ecuador) and Vilnius (Lithuania) with the logistic help of the Juan José López-Ibor Foundation.

WPA Member Societies and WPA Sections were asked to fill in a questionnaire related to the duration and characteristics of the training of psychiatrists. An interim report on the outcome of this questionnaire is included at the end of this document.

The goal of this educational project is not to propose one single training program suitable for all countries, but to present core elements of a syllabus leading to a framework regarding knowledge, skills and attitudes for training psychiatrists. Based on the elements of such a framework, trainers can build a training curriculum according to their own local national needs and priorities.

We are aware that continuing professional development is also needed. Later in a career as a recognised psychiatrist, specific domains of competency can be addressed following specific training programs. But a psychiatrist as a medical specialist needs to further incorporate relevant results obtained from research in fields so different as genetics, psychopharmacology, ethics, anthropology, psychopathology ..., in order to provide the best possible treatment for patients, support for their families and promotion of mental health.

We hope that these Principles and Priorities for a Framework for Training Psychiatrists can be useful to WPA Member Societies and their countries and to improve mental health and recovery of mentally ill patients.

2.Members of the Task Force

Chair of the task force	Dinesh Bhugra	United Kingdom
Chair of the task force	Belfort Edgard	Venezuela
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They also want to recognize those officers and bodies who responded to the questions of the Task Force.

This work would have been far more difficult to organize if the Task Force’s meetings wouldn’t have been supported to the extent it has been offered by the Fundación Juan José López-Ibor in Madrid. The members remember gratefully how they could enjoy several times the generous hospitality offered by the foundation.

3.WPA Educational Perspective

3.1. WPA Position Statement on High Quality Training (WPA 2017)

World Psychiatric Association (WPA) for the benefit of our patients places the highest importance on the quality of training for psychiatrists at all levels. This includes undergraduate, post-graduate and continuing medical education (CME).

In this Position Statement, we note that there exist huge variations not only in levels of training but also in duration as well as quality and supervision of training especially at undergraduate and postgraduate at post-graduate level.

In order to ensure that our patients get the best treatment they need and deserve no matter where in the world they reside, WPA make the following recommendations. We urge all our member associations and societies to disseminate these to regulatory bodies, all trainees and training facilities.

1. Our patients should receive and expect the highest levels of professional standards of psychiatric care, regardless of the training grade of the doctor treating them. Trainees (residents) must be aware of the high level of responsibility and trust placed on them by patients, their careers and families and others.

2. WPA recommends that those responsible for organising and delivering training are accessible, fair and trained in up-to-date methods of assessment and therapeutic interventions. As professionals, it is critical that trainees are truly engaged in the process of training. They should be able to raise concerns without fear and be encouraged to share ideas for improving the quality of their training. The training should be seen as a two-way process, and the trainers and trainees should have regular confidential supervision sessions.

3. Trainees at all stages should be encouraged to demonstrate professionalism at all levels including ethical and culturally appropriate practice.

4. Trainees should be encouraged to participate actively in training so that they are fully prepared to be high quality independent practitioners at the end of their training.

5. WPA recommends that local health care systems and regulations are taken into account while designing and delivering training. Cultural values and settings should be recognised. Core training should be high standards matching international levels and higher training should focus on country needs. Training should follow international standards with due cultural variations.

6. Training takes place in the context of service delivery, so it is imperative that a regulated amount of time for training only be set aside. This would include attending ward rounds, grand rounds, journal clubs, academic lectures and activities and suitable conferences. Only organisations which provide a safe environment for training with sufficient time and resources should be encouraged to provide training.

7. Trainees need regular assessment of progression through training, using a judicious mix of competency based assessment and knowledge based assessment. WPA recommends that the assessment processes are well-regulated, evidence based and delivered by highly trained trainers. Assessment *for* and *of* training are both relevant but the former is more relevant to improve standards of training.

8. WPA urges policy makers in each country to create enough training posts to ensure that sufficient numbers of placements are available to meet the comprehensive mental health needs of its population.

3.2. The Task Force's approach in creating this WPA document

The WPA International Congress, Taipei (16-22 November 2015) was the first event in which the newly composed Operational Committee on Education established the Task Force to produce a WPA document on principles and priorities of a framework for training psychiatrists.

Several earlier public documents were taken into consideration. Some were published and unpublished ones, some published by the WPA, some by other psychiatric organisations.
The main conclusion unfortunately was that they all seemed to have had a limited impact on influencing the member associations' design of training curriculum for their trainee psychiatrists. One possible reason might be that these documents might not meet the constraints of member associations. Besides, these documents presented one single training model which might not fit the training constraints of all member associations. Furthermore, they were probably too much out of reach to be implemented in Low and some middle income countries.

The members of the Task Force therefore decided to adopt a different approach and follow two major pathways. The first task would be to review the existing documents and identify what seemed interesting enough to keep. But beyond that, they decided to also question the actual training modalities and perceived training needs in the WPA member associations' countries by sending out a questionnaire in order to look for better ways to understand their experienced needs, more specifically in Low and middle Income Countries (LMICs).

On several meetings [1] the structure and content of the final document was fine-tuned. Members took notice of a lack of coherence in the terms used in many of these documents. The use of one single term in one single language, English, didn't guarantee for one single concept and could create confusion if translated into other languages. Hence the authors decided to write down a glossary of terms.

It was also noted that the influence on training by societal, economic and cultural factors on a national and even regional level was so high in different parts of the world, that it would be erroneous to conceive one single worldwide shared curriculum.

Because of this view on the complexity created by this multidimensionality of interacting factors, it became clear that filtering out essential elements in a training programme could lead to the concept of a minimal curriculum of knowledge, skills and attitudes to be acquired by each psychiatrist of the world. However, from the very beginning it was also clear that by no means this would be sufficient for a training programme in Middle Income and high income countries with more resources invested in mental health than the Low Income Countries.

Since no work stands for ever and evolutions may run faster than one wished for, the members of the Task Force decided to have this concept of a WPA proposed minimal curriculum peer reviewed through a Delphi procedure. This would lead to a stepwise prioritisation process with regards to the elements of the proposed curriculum.

Furthermore, in a time where internet communication is widely accessible, the Task Force members propose to develop an internet based WPA Training Forum where trainers can exchange experiences; ask for advice and support related to training aspects in their own country.

This should lead to a better integration of knowledge available within WPA member associations and Sections, to intensified collaboration between member associations and the Sections and to better training curricula for trainees. With a defined core curriculum for all psychiatrists, WPA might play a future role in the accreditation of established training programmes in member associations so that a minimum standard and quality of training in different parts of the world can be ensured.

This document is a proposal to WPA member associations to adopt a framework of core competencies proposed by the Task Force based upon earlier documents published by WPA and others, the results obtained from the worldwide survey on the training needs and provisions by member associations, the consensus by world experts in the prioritisation of

[1] These meetings took place in Taipei 18-22/11/2015, Manila 4-6/02/2016, Madrid 21-22/06/2016, Cape Town 18-22/11/2016, Cuenca 8-11/02/2017, Madrid 20-21/03/2017 and Vilnius 4/05/2017

training content in the core curriculum of training of psychiatrists, and the follow-up comments obtained in the proposed WPA Training Forum.

This WPA document wants to offer guidance to the national member associations for developing their own training curriculum, but also bearing in mind about their needs for adaption of the curriculum according to their own unique needs and background.

4. A Framework for Training

4.1. Glossary of terms[2]

The *national/regional framework* within a particular country/region describes and contains

a *syllabus* with the elements of theoretical knowledge

a list of *skills* a trainee should acquire

a list of *attitudes* a trainee should dispose of

the *necessary competencies for trainers*

a list of *basic rotations, modules of general psychiatric training within a particular clinical setting* each trainee should have participated in

a list of *subspecialty rotations* a trainee might have to choose from after finishing the basic training

the *tools for evaluation* of trainees as well as trainers

A *training institution* is recognised by the competent authority within a particular country/region

A *training program*

is the set of training elements offered by an established training institution

it can be *complete* if this program allows a trainee for being recognised as a psychiatrist after successfully finishing it

it can be *partial* if it constitutes only a recognised part of the training

A *trainee* is a medical doctor being accepted to start a training program in order to become a recognised specialist in psychiatry

A *curriculum*

A curriculum is "*a statement of the intended aims and objectives, content, experiences, outcomes and processes of an educational programme, including:*

a description of the training structure (entry requirements, length and organisation of the programme, including its flexibilities, and assessment system)

a description of expected methods of learning, teaching, feedback and supervision

The curriculum should cover both generic professional and specialty-specific areas.

The syllabus content of the curriculum should be stated in terms of what knowledge, skills, attitudes and expertise the learner will achieve (Grant et al. 2005).

Trainees have to build their *own curriculum* in concordance with the required framework in order to be eligible for recognition as a rightfully trained specialist in psychiatry.

A *syllabus* is simply a list of the main topics of a course of study, only a part of the curriculum

[2] This glossary of terms was agreed upon by the members of the taskforce for operational reasons

A trainee can only be a *recognized specialist in psychiatry* after graduation from their training institution

Credentials are documents that are proof of the acquired competencies and delivered by the competent authority in their country/region

A *license to practice* can be obtained from the competent authority within a country/region and allows a recognised specialist in psychiatry to practice in a particular country/region

Fulfilling criteria concerning *continuous medical education* might influence the duration of validity of this licence to practice

4.2. Filling the gaps of the framework: a list of existing items, a questionnaire and a Delphi approach

Presenting the WPA member associations with a framework will only result in a successful outcome when it offers an answer to the needs of patients and psychiatrists in the particular context of their living circumstances for the first, their working conditions for the latter and the opportunities their health care system is able to deliver for both.

The Task Force decided to send a questionnaire to all WPA member associations. A first version in English produced only partial data, though it yielded a limited response. Therefore, the Task Force developed a Spanish version which was also dispatched to all WPA member associations. Based upon the outcome of this questionnaire the list of items below (point 4.3.) was adjusted and fine-tuned.

4.3. The syllabus for training in psychiatry

The syllabus below is obviously an extensive, and perhaps an overinclusive list but it's based upon existing syllabuses.

Basic sciences

- Communication skills
- Normal Mental development
- Psychology
- Sociology
- Human embryology
- Neuroscience
- Psychopharmacology
- Statistics
- Research Methodology
- Evidence Based Medicine
- Philosophy

Ethics
Deontology

Pathogenic aspects

Genetic risk factors
Environmental risk factors
Gene-environment interaction and epigenetics
Stigmatisation
Serious somatic diseases and psychiatric disorders
Disasters and conflictual situations
Migration

Psychopathology

Semiology
Nosology
Classification of disorders
Child and Adolescent psychopathology
Adult psychopathology
Old age psychopathology
Psychiatric Assessment and Reporting
Epidemiology

Therapeutic approaches

Psycho-education
Psychopharmacotherapy
Psychotherapy
Somatic treatments
Recovery paradigm based interventions
Rehabilitation
Internet based interventions

Mental Health Promotion and Prevention

Promotion of resilience and healthy life style
Reinforcement of healthy mental patterns
Primary prevention
Secondary prevention
Tertiary prevention

Particularities in Psychiatry

Consultation liaison psychiatry
Emergency psychiatry

Legal issues related to psychiatry
History of psychiatry
Forensic psychiatry
Social psychiatry
Transcultural psychiatry
Gender aspects in psychiatry
Intellectual Disability and Mental Health
Religion and spirituality in psychiatry

4.4. Professional roles

(based on CanMEDS 2005; further adapted now from CanMEDS 2015)

1. **Psychiatric Expert/Clinical Decision Maker** is able to:

1.1 conceptualise, understand and apply the diagnostic skills to investigate, elicit, describe and define psychopathological and other clinical findings.

1.2 apply therapeutic skills to effectively and ethically manage the spectrum of patient care problems diagnosed.

1.3 apply psychiatric expertise in situations other than in direct patient care

1.4 recognise personal limits of expertise

1.5 consult effectively

2. **Communicator** is able to:

2.1 establish a therapeutic relationship with patients

2.2 elicit and synthesise relevant information from the patient, their careers and other relevant sources

2.3 discuss appropriate information with the patient, their careers and health professionals that facilitate optimal care. This implies the ability to inform and counsel a patient in a sensitive and respectful manner while fostering understanding the patient's active participation in decisions about their care.

3. **Collaborator** is able to:

3.1 effectively consult with other physicians and healthcare professionals

3.2 contribute effectively to other interdisciplinary team activities

3.3 participate actively in shared decision making with patients and carers

3.4 collaborate effectively with patient and carer organisations

4. **Manager** is able to:

4.1 allocate limited healthcare resources

4.2 manage personal resources

4.3 work in a healthcare organisation

4.4 use information technology to optimise patient care, continued self-learning and other activities

5. **Health Advocate** is able to:

5.1 identify the determinants of mental disorder as well as the factors that may contribute to positive mental health so as to be able to prevent disorder and promote mental health

5.2 identify and address issues and circumstances when advocacy on behalf of patients, professions, or society is necessary

6. **Scholar** is able to:

6.1 develop, implement and document a personal continuing education strategy

6.2 apply the principles of critical appraisal to sources of medical information

6.3 facilitate learning in patients, students, trainees and health professionals

6.4 facilitate the learning of colleagues, trainees and students through the appropriate use of assessment, appraisal and feedback

6.5 contribute to research and to the development of new knowledge

7. **Professional** is able to

7.1 deliver the highest quality of professional care

7.2 relate to co-workers in a professional manner

7.3 practise medicine in an ethically responsible manner that respects medical, legal and professional obligations

8. **Leader** is able to:

8.1 engage in shared decision-making for the operation and ongoing evolution of the general and the mental health care system

8.2 demonstrate collaborative leadership and engagement within the general and the mental health care system

8.3 contribute to the development and delivery of continuously improving general and mental health care and engage with others in working towards this goal

8.4 to integrate their personal lives with their clinical, administrative, scholarly and teaching responsibilities

8.5 to function as individual care providers, as members of teams, and as participants and leaders in the general and mental health care system locally, regionally, nationally, and globally

5. MINIMUM CORE CURRICULUM

The members of the Task Force consider writing one single curriculum valid for all countries and regions of the whole world probably an impossible and a rather unreasonable task. A minimum core curriculum serving as a compass for low and middle income countries nevertheless can be considered feasible and eventually supported by the WPA.

This does also mean that this curriculum is far from sufficient for training psychiatrists in the better off countries in the middle income range, even more so for those in the high income countries.

Year 1:

The overall objective: to nurture a budding doctor to become a safe and caring psychiatrist and effective care team member

Pre-requisite: a medical degree, a commitment to patient care, and natural curiosity and interest in human psyche and the interaction of mind, body, and the external world

Objective 1 – Medical knowledge and clinical skills

Knowledge	Skills	Attitudes shown through behaviour
1. Risk assessment - the risk factors associated with suicide, physical and sexual violence - the mitigating factors associated with the above violence - the above factors should include personal, clinical, epidemiological, lifestyles, and environmental ones	- to be able to identify the key signs and symptoms of psychiatric disorders - to be able to establish good rapport and hence build a therapeutic alliance with the patient, their caregivers, and significant others - to be able to give a clear explanation to the patient and their caregivers about the predisposing, triggering, and maintaining factors of the disorder, with due attention to the impact of family, religion, sexual orientation, race, politics, and culture on the illness - to appreciate the different explanatory models of illness held by the patient and	- to be attentive, curious, and open about the personal story of the patient as an individual - to appreciate how the illness has evolved in relation to the past experiences and its uniqueness - to instil reasonable hope about recovery from the illness - to pay respect to the patient and their caregivers in terms of differences in the explanatory models of illness - to be mindful of personal prejudices being applied to the patient with possible impact on the accuracy of the assessment - to explore issues of concern in a sensitive

	their caregivers and be prepared to come up with a mutually acceptable case formulation - to identify personal strengths of the patient and how these strengths have led to alleviation of the patient's suffering - to accurately elicit signs and symptoms commonly associated with suicide, physical and sexual violence - to consider the clinical features of the illness, associated factors that predispose to risky behaviour, characteristics of the victims and their relationship with the patient, and the particular circumstances surrounding a risky incident in the context of previous histories, collated from the widest possible range of sources to develop a formulation - to work collaboratively with the patient to develop a coherent shared formulation of risks and to identify early signs of deterioration of mental state and behavior plus potential triggers and situational factors which may lead to risky behaviors recurring and to consider potential protective factors and strengths that may	way that can increase patients' understanding, possible insight and motivation - to maintain an open but serious attitude in making a balanced assessment of personal and situational factors in contributing to the violence incidents and to future recurrence of violence

	reduce the likelihood of risky behavior occurring in the future - to develop a clear action plan with clear responsibilities identified for various parties with equal attention to both the victim and the perpetrator	
2. Management of patient - pharmacological management of common mental disorders (mood and anxiety disorders) - pharmacological management of severe mental illness (schizophrenia, bipolar and other psychotic disorders) - basic counselling approaches and protocol-driven brief psychological interventions -knowledge about the social resources available in the locality	 - to prescribe optimal dose of medication for the patient at the appropriate point in time for the appropriate duration of time - to be able to identify and manage side effects related to prescribed medication - to be able to take into consideration potential interactions with other prescribed or illicit drugs taken by the patient - to be able to identify and detect signs of non-adherence to treatment - to be able to identify early signs of relapse and to establish a relapse prevention plan with the patient and their relatives - to be able to take into consideration the impact of comorbid physical illness on the treatment of illness - to be able to apply protocol-driven brief psychological interventions for common mental disorders	 - to foster a realistic treatment goal to patient and caregivers according to their abilities and needs - to select the most appropriate medication for the patient based on its cost-effectiveness - to prescribe without undue influence by drug industry - to be able to take into consideration the psychological impact of medications/psychological treatment on patient’s self-esteem and dynamics with their significant others - to draft a care plan consistent with patient’s strengths and level of function - to sustain optimism and instil hope for recovery for the patient and their caregivers

	- to be able to refer the patient to appropriate social agencies for social intervention if available	

Objective 2: Effective communication and collaboration

Knowledge	Skills	Attitudes shown through behaviour
1. Teamwork - appreciate the roles and responsibilities of different parties in a clinical team, including patient, caregivers, non-government organizations, patient organizations, probation or welfare officers in playing a role in the care plan for the patient	- to work with stakeholders including patient, caregivers, other treatment teams, correctional or probation services	-an open attitude in devising a collaborative care plan for the best benefit of the patient - to suspend prejudices or biases with respect to particular stakeholders involved in the care of the patient
2. Education - patient education on self-management of his or her illness - education of other related disciplines in basic knowledge of mental illness and its management - self-education for periodic assessment of competencies	- to inform and educate the patient, their caregivers, and the related social partners about the illness - to equip with training skills to educate related disciplines in an effective manner	- to be open and investigative about the differences in views on the management of the illness so as to arrive at an effective care plan acceptable to the patient and their caregivers - to be flexible and engaging in training professionals with different educational, theoretical, religious or work backgrounds

		- to have a positive learning attitude - to be ready to seek supervision and support when in doubt - to be responsive to constructive remarks from trainers and supervisors
3. Written communication - knowledge about preparation of medical report for clinical and legal purposes - etiquette in letter, email and internet communication	- to be able to write in a concise and precise style - to equip with good case report writing skills - to be able to write with due attention to the issues of confidentiality, information and security.	- to provide written accounts to the best of the knowledge and understanding of the patient - to be mindful of personal conflicts of interests - to write with honesty and integrity - to write in a professional and respectful manner

Year 2:

Overall objective: to build up confidence and competence of a promising psychiatrist to provide quality care to adult patients with multiple needs

Pre-requisite: successful acquisition of the above core competencies in the first year, continuing practice of these competencies in the second year, and successful pass in the first year assessment

Objective 1 – Medical knowledge and clinical skills

Knowledge	Skills	Attitudes shown through behaviour
1. Patient assessment - diagnosis of patients with mental disorders with psychiatric comorbidity (axis-1 and/or axis-2) - diagnosis of patients with co-occurring mental and neuropsychiatric disorders - understanding of the interplay of physical, psychological and social factors in the development and clinical manifestation of signs and symptoms in the patient	- to be able to identify the relative contribution of the different disorders to the patient's clinical presentation - to be able to appreciate the impact of these multiple needs in securing good rapport and building therapeutic alliance with the patient, their caregivers, and significant others - To be able to give a clear explanation and case formulation to the patient and their caregivers with due emphasis on the mutual influence of co-occurring disorders - to identify and prioritize the manifold needs of the patient and their caregivers so as to come up with a feasible and	- to maintain a professional stance even in face of negative interactions with the patient and/or their caregivers - to remain clear minded even in face of multiple problems presented by the patient - to manage and utilize counter-transference feelings towards the patient for betterment of patient care

	acceptable treatment plan - to identify personal strengths even when faced with multiple deficits and life challenges	
2. Risk assessment -assessment of the presence of multiple risk factors (including physical and personality factors) associated with different types of violence -assessment of the mitigating factors that might only be apparent after repeated careful assessments	- to dispose of management skills to participate in a multi-disciplinary team for thorough assessment of risks from multiple perspectives - to develop a clear action plan with clear responsibilities identified for various parties with particular attention to the complex group dynamics resulting from patient care	- to develop the courage to listen and accept patient's vivid accounts with details on violence to self and others
3. Management of patient -pharmacological management of patients with multiple needs (during pregnancy and lactation, comorbid drug abuse, comorbid anxiety and alcohol abuse) -supportive psychotherapy - to participate in a multi-disciplinary	- to be able to prescribe the most cost-effective medication for the patient given the lack of strong clinical evidence and guidelines for these disorders - to be able to provide a comprehensive treatment plan that takes into consideration different contributing and	- to be able to take into consideration the psychological impact of medications/psychological treatment on patient's self-esteem and dynamics with their significant others and the treatment teams - to demonstrate empathic understanding

care team for delivery of integrated care treatment	protective factors and multiple needs in consultation with the patient and their caregivers - to be able to deliver supportive psychotherapy to foster patient trust and growth	of the needs of the patient presenting with disabling and complex mental health problems - to sustain optimism and instill hope for recovery for the patient and their caregivers, as well as the team members even when faced with of multiple needs

Objective 2: Quality improvement

Knowledge	Skills	Attitudes shown through behaviour
4. Audits - the principle of clinical audits and its significance in the clinical context	 - to be able to apply audit principles in service-wide context, undertake a small audit, and to implement results in a completed audit cycle	 - to appreciate the importance of adopting a quality and safety perspective in improving current service provisions
5. Appraisal and utilization of clinical evidence - Basic understanding of research methodologies - Basic understanding of the appraisal of level of evidence in recommended guidelines	 - to be able to appraise literature and to apply it in clinical practice - to be able to make a balanced judgment of care when level of evidence is low	 - to appreciate the importance of lifelong pursuit of knowledge and skills as being relevant to provision of quality care to patients

Year 3:

Overall objective: to deliver a confident and competent psychiatrist who can lead a multi-disciplinary team and/or work independently to provide safe and quality care to the patient, as well as an advocate for the patient'

Pre-requisites: successful acquisition of the above core competencies in the first and second years, continuing practice of these competencies in the past two years, and successful pass in the past annual assessments

Objective 1 – Medical knowledge and clinical skills

Knowledge	Skills	Attitudes shown through behaviour
1. Patient assessment - diagnosis of patients with complex clinical presentations, e.g. eating disorders, severe personality disorders, treatment-resistant bipolar or psychotic disorders, forensic conundrums etc.	- to be able to identify and prioritize the needs to maximize treatment outcome - to be able to engage the support from the caregivers in patient care	- to be able to self-reflect and learn from repeated encounters of failures of treatment strategies in face of complex needs
2. Risk assessment - systematic risk assessments in preparation for medical reports for forensic or social purposes - integration of information of assessments from different disciplines to provide a comprehensive risk assessment as a	- to equip with leadership skills to lead a multi-disciplinary team for thorough assessment of risks from multiple perspectives - to develop a clear action plan with clear responsibilities identified for various parties with particular attention to the complex	- to assume a leader role model for the clinical team - to tolerate diversity of opinions, be mindful of personal weaknesses as areas of self-improvement - to be compassionate to oneself, team colleagues, patients, caregivers and other

leader of a multidisciplinary team	group dynamics resulting from patient care - to provide detailed and comprehensive assessments and prepare medical reports that suit forensic or social purposes	relevant stakeholders even in face of severe challenges and repeated treatment failures.
3. Management of patient - pharmacological management of patients with complex needs (treatment resistant schizophrenia and bipolar disorders, comorbid multiple drug abuse, severe personality disorders) - good knowledge in at least one form of evidence-based psychotherapy - to lead a multi-disciplinary care team for delivery of integrated care treatment	 - to be able to prescribe the most cost-effective medication for the patient given the lack of strong clinical evidence and guidelines for these disorder - to be able to provide a comprehensive treatment plan that takes into consideration different contributing and protective factors and complex needs in consultation with the patient and their caregivers - to be able to deliver effective, medium to long term psychotherapy for the patient	 - to demonstrate empathic understanding and compassion of the needs of the patient presenting with disabling and complex mental health problems - to sustain optimism and instill hope for recovery for the patient and their caregivers, as well as the team members even in face of complex needs - to cultivate a self-reflective attitude to review personal strengths and weaknesses, to develop personal resilience, and to seek supervision and help as necessary

Objective 2: effective communication and collaboration

Knowledge	Skills	Attitudes shown through behaviour
4. Teamwork - to designate and allocate the roles and responsibilities of different parties in a clinical team, including patient, caregivers, non-government organizations, patient organizations, probation or welfare officers in deciding on the care plan for the patient	- to communicate, negotiate, and liaise with other stakeholders including patient, caregivers, other treatment teams, correctional or probation services - to understand and manage the dynamics of different institutions (like police or children home) so as to ensure positive working relationships	- an open and assertive attitude in devising a collaborative care plan for the benefit of the patient - to suspend prejudices or biases with respect to particular stakeholders involved in the care of the patient
5. Education - training and supervision of other related disciplines in the delivery of interventions to the patient - public education to promote mental health and early intervention of mental illness - knowledge on public mental health - teaching of medical students and junior trainees - continuing medical education for oneself	- to possess training and supervision skills - to possess presentation skills - to ensure effective delivery of important messages to general public - to be familiar with the training guidelines and curricula for medical students and psychiatric trainees - to equip with self-management skills to regularly update knowledge through self-reading, attending workshops or conferences, or enhance skills through	- to be flexible, responsive and engaging in training and supervision - to develop an interest and attitude about life-long learning for the sake of patient care and personal improvement - to cultivate a passion of nurturing the next generation of mental health professionals

	direct supervision	

Objective 3: a clinical leader and a patient advocate

Knowledge	Skills	Attitudes shown through behaviour
6. Leadership - to acquire updated knowledge on leadership and management skills - to acquire project and people management skills	 - to implement the learnt skills in the management of wards, clinics and your care team staff	 - be honest, responsible, innovative, and supportive - be decisive and directive in face of management crises
7. Patient's advocate - appreciate the importance of social justice, health equity and discrimination of mental illness - basic knowledge on political, economic and social theory - basic knowledge on stigma management	 - being equipped with negotiation skills with political leaders for the advancement of psychiatric care and public mental health - being equipped with skills to reduce self-stigma among patients, and external stigma by the general public	 - to be enthusiastic, passionate about one's cause, creative and resilient against setbacks - to have a sense of social responsibility to stand for the rights of people with mental health problems

Objective 4: a scholar, researcher and mentor

Knowledge	Skills	Attitudes shown through behaviour
8. Research - knowledge in research design and project management - knowledge in statistics and writing of scientific papers	- to conduct and manage research projects - to translate the research into daily clinical practice - to disseminate the research to other relevant stakeholders - to cultivate a research environment in the care setting	- have a scientific mind - view service research as important as experimental research
9. Mentoring - Familiarize with mentoring theories	- to equip with skills to mentor the junior psychiatrists - to negotiate with hospital management for provision of mentoring opportunities	- to be enthusiastic, passionate about nurturing good future psychiatrists

Additional years:

Overall objective: to develop a psychiatrist with expertise in the management of patients with specific needs

Pre-requisites: successful acquisition of the above core competencies in the previous three years, continuing practice of these competencies in the past three years, and successful pass in the past annual assessments and the final exit examination as a general adult psychiatrist (see Section 6 on the evaluation of the training). The objectives of Year 3 apply to Year 4 and following but the focus will be on specific population (e.g. children and adolescents, elderly, psychotherapy etc.)

5.1 Recommended content of training for the attainment of the above core competencies in different years of training

	Knowledge	Skills	Attitude
Year 1	- normal mental development - psychopathology - semiology and nosology - environmental risk factors - psychopharmacology - psychotherapy (basic) - neuroscience (basic) - somatic treatments - evidence based medicine - classification of disorders - mental health laws - spirituality & religion in psychiatry - elected topics related to a trainee's needs or preferences	- communication skills Psychiatric assessment and reporting	- learning professional roles - respecting ethical standards
Year 2	- chronic disease and psychiatric disorders - genetic risk factors - gene-environment interactions - psychotherapy (advanced) - consultation liaison psychiatry - substance misuse - intellectual disability and mental illness	- self-reflective and mindfulness skills	- developing professional roles
Year 3	- research methodology - statistics - stigmatisation and discrimination - epidemiology - neuroscience (expanded) - internet based interventions - recovery interventions - prevention strategies - mental health economics	- leadership development - teaching and training skills - presentation skills	- perfecting professional roles
Years 3+X	- old age psychopathology - child and adolescent psychopathology - forensic psychiatry		

6.The Evaluation Aspects of a Training

6.1. Preliminary remarks

The evaluation of training should be considered as a dynamic process. Since the transversal assessment does not seem to be the most appropriate way to have a thorough evaluation of the psychiatrists in training, a continuous process over the years of training is advisable. Consistently with this dynamic perspective, the role of the “evaluator/referent” becomes more relevant to decrease the risk of bias, training the trainers should be encouraged, as well as including more than one single evaluator in charge of this task.

WPA is well aware of the difficulties that, especially in LMIC, trainers and evaluators can face when trying to implement the assessment methods. Aiming to support these colleagues, the Task Force members suggest to develop a WPA Forum on Training where every professional can discuss his/her doubts about the process of evaluation.

Evaluation of the competencies of a trainee should also be taken into account: cultural, social, economic aspects, in other words the complete context and the setting in which the clinical activity is taking place (hospital, community, primary care etc.). Hence competencies should be defined according to the complete sociocultural and economic context where they must be implemented. Beyond this “macro” framework, a more detailed “micro” view on the clinical setting trainees are working in should be taken into consideration e.g. a general hospital, a monothematic psychiatric ward, a social and community psychiatry unit, etc.

The evaluation of the patient-physician relation has to include subjective aspects more difficult, but at the same time essential to assess. Whatever the method used it remains to be characterized subjectively.

As long as subjectivity is involved in this assessment, it is important to find a way to reduce possible biases and increase evaluation reliability, without giving up these subjective dimensions in the patient and the professional.

Evaluation in psychiatry should remain consistent with the idea that beside the transmission of knowledge it is necessary to foster relational and emotional capacities of trainees. The Task Force sees it as a condition to cultivate the emotional and affective capacity of the trainees. Innovative methodologies of evaluation are strongly recommended.

The content of the following two paragraphs has been extensively copied from part of the document *European Framework for Competencies in Psychiatry* published by the UEMS Section of Psychiatry (UEMS Section of Psychiatry, 2009).

6.2. General considerations

It is now widely recognized that assessment drives learning. Therefore, each trainee should be assessed on their acquired knowledge, skills and attitudes.

The Evaluation Component of this document suggests methods of assessing different competencies. It explains what the different methods are and gives examples of how trainers can use in practice different tools based upon these methods. An assessment system must thus be considered as being an integral part of any curriculum developed from the competency framework.

There are three principles that should guide the construction of assessment systems:

- Assessment systems should be transparent. Learners and teachers should 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.

As Van der Vleuten (1996) pointed out, in mathematical terms the utility of an assessment system might be considered as the product of its reliability, validity and feasibility. It should result in an educational impact, the effect that assessment has upon further learning. It follows that if the mathematical value of any these three qualities approach zero the utility of the assessment system will also approach zero, no matter how positive the remaining values might be.

Miller (1990) described a conceptual model of the different domains of medical skills and how they may be assessed. This model emphasizes the importance of the assessment of performance i.e. what doctors actually do in their day-to-day practice, rather than surrogates, which are actually assessments of knowledge or competence.

In the assessment grid below, the reader will find at least two methods of assessment for each competency. For ease of viewing, the assessment methods are arranged 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 paragraphs one can find each method of assessment and what is known about the reliability, utility, feasibility and hence educational impact of tools based on the

methods. This allows national associations and other regulators of psychiatric training to make informed choices regarding assessment methods.

6.3. Assessment methods

6.3.1. 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.

6.3.2. 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.

Assessment of simulated clinical encounter (ASCE)

The ASCE examination seeks to assess clinical competency by rotating each candidate around a number of standardized 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.

6.3.3. PERFORMANCE ASSESSMENTS

Workplace-based assessment (WPBA)

This form of assessment is based upon a doctor's real-time day-to-day work and to distinguish it from standardized 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 standardized 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*

To date, very little work has been done evaluating the utility of WPBA in psychiatry; an early field trial in the UK indicated that a programme of assessment based on the three main methodologies outlined above was feasible and acceptable to doctors and their assessors and had some positive educational impact (Brittlebank, 2007). All of the reliability and validity data of the methods has come from areas of medical practice outside psychiatry.

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 to be able to conduct fair assessments.

A series of other DOP type instruments are undergoing evaluation; 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 standardized measure that is then collated and fed back to the doctor. The feedback may be from colleagues, both peers and co-workers from different professions and/or levels in the organisational hierarchy, and from patients. MSF 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 co-workers 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 co-worker 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 series 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 series 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.

7. Synthesis and Recommendations

This WPA document suggests basic areas of competence to be acquired for a future psychiatrist. It aims to offer a framework to support WPA member associations in setting up their own local curricula for training medical doctors on their way to being a fully trained psychiatrist.

Therefore, the Task Force Members have chosen to take a different approach based on the following guiding principles.

- *to take into account the needs of WPA member associations*

For this purpose, a questionnaire was sent around. After a rather limited response it was translated in Spanish and Arab. The outcome of this questionnaire should orient the implementation of these recommendations.

- *a theoretical approach might remain useful*

The wide use of English as a shared language might create the impression of uniformity, but the actual content of the same terms used is sometimes far from being similar. The authors thought it to be necessary to start with a *glossary of terms*.

Convinced about the fact that it is not wise to suggest one single general curriculum to the whole wide world, we listed a series of elements that could make up *a syllabus*.

According to the national needs, these elements can be used to put together a *framework for training* based upon a series of competencies defined according to the CANmed 2015 competencies.

But a *training programme* should in the first place respect local/regional/national requirements. This is left to the national regional agencies competent to decide on its content when setting up a particular curriculum for a trainee.

- *a minimum core curriculum – as a* minimum minimorum *– still can be written down.*

This can then become the basis for further expansion into a more elaborated training programme. In no way should this curriculum be considered sufficient for the betterment of training in countries among the middle income group and the high income group.
The members of the Task Force are quite evidently not all-knowing. To obtain a prioritisation of the components within this curriculum, a Delphi procedure has been set up. Indeed, national or local influences and traditions must be paid respect.

- *the implementation of syllabus elements into local curricula is our goal*

A different *WPA task force* should offer assistance by initiating, facilitating and coordinating processes to improve local training quality

These initiatives should at their best be *in response to needs* expressed by WPA member associations in the less off countries.
WPA Sections should develop initiatives relying on their specific competencies to answer to these expressed needs supported by volunteers out of the better off countries.
Zonal representatives can play a major role to support implementation process, being the link between member associations and task force and hence improve the impact of WPA recommendations.
An *internet based Forum* should allow to interactively feedback about ongoing changes, about successes and pitfalls, to share with the WPA community experiences.

- *the members of the Task Force take into consideration other important aspects.*

Perhaps too little attention has been given to the particular situation of psychiatric patients and care delivery. In many countries of the world psychiatric disorders don't deserve the parity of esteem as should be. Ethical standards are too poorly respected with regards to psychiatric patients and ways leading to stigmatisation are many a time inherent to legal regulations. Aspects related to violence, be it societal, intra-familiar or individually towards patients remain underestimated too many times.

- *leadership issues play a major role in the professional position of a psychiatrist*

Perhaps more than in other specialties leadership should be shown in different contexts. Consider the position of trainer, team leader, supervisor, mentor, manager requesting more specific training, important aspects but beyond the scope of this document.

- *this document is not the end but just the beginning of a series*

Let's be humble. The authors accept that this work is a never-ending story. Therefore, they conceive an internet based platform allowing to further fine-tuning elements in it as essential. It would be most successful if it would be the start of an ongoing interactive process worldwide, leading to increased collaboration among the WPA Sections offering support to those of our colleagues who are working in less well-off countries, if it would lead to better trained psychiatrists worldwide and hence to better psychiatric care for our patients.

We strongly suggest the WPA to work towards a regular update, e.g. every two years, to be published on line, subject to progressive insight as outcome of the processes on the internet Forum.

Perhaps these aspirations are too ambitious, but out of vision and hope a better future for patients and professionals alike might emerge.

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