Psychiatry training in 42 European countries: a comparative analysis

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Abstract

Psychiatry qualifications are automatically recognized among European Union (EU) countries despite differences in national training programs. A widening gap between the number of psychiatrists, their competencies and the growing burden of mental illnesses in Europe has renewed calls for international standardization of training. Comprehensive information about training programs is missing, which limits thorough comparisons and undermines development of an actionable strategy to improve and harmonize psychiatry training. This study describes and compares the existing postgraduate psychiatry programs in 42 countries in the European region. Representatives of national psychiatry associations completed a semi-structured, 58-item questionnaire. Training structure and working conditions of each country were compared with population needs calculated by the World Health Organization to determine the European mean and contrasted among pre-2004 and post-2004 EU members and countries with unrecognized qualifications. Differences were tested with nonparametric (Wilcoxon) and parametric (Anova) tests. Median training duration was 60 months, significantly shorter in countries with unrecognized qualifications (48 months, $\chi^2$16.5, $p<0.001$). In 80% of the countries, placement in a non-psychiatric specialty such as neurology or internal medicine was mandatory. Only 17 countries (40%) stipulated a one-month rotation in substance abuse and 11 (26%) in old-age psychiatry. The overall deficit of training versus population need was 22% for substance abuse and 15% for old-age psychiatry. Salaries were significantly higher in pre-2004 EU members ($\chi^2$22.9, $p<0.001$) with the highest in Switzerland (€5,000). Significant variations in curricula, training structure and salaries exist in Europe. Harmonization of training standards could offer significant benefits for improving mental healthcare.

Keywords: European psychiatry, professional qualifications, psychiatry training, medical education, mental health, psychiatry curricula.

1. Introduction

Mental health disorders comprise a considerable proportion of the global disease burden (EC; James et al., 2018). In Europe alone, mental healthcare expenses exceed €800 billion yearly (Gustavsson et al., 2011) and the mismatch between population needs and available resources continues to grow (Patel et al., 2013; Saxena et al., 2007). International migration of psychiatrists facilitated by the European Union's (EU) free movement laws (EC, 2005, 2011a, 2013) can help mitigate local shortages (EC, 2013, 2019; Pinto da Costa et al., 2017). However, national shortages are exacerbated by skilled professionals leaving their countries of origin after completion of training, resulting in unbalanced distribution of mental healthcare resources across Europe (Pinto da Costa et al., 2017). One of the major factors identified for driving psychiatrists' emigration is a lack of high-quality educational opportunities in their home countries (Barrett et al., 2020; EC, 2005, 2011a, 2013; Pinto da Costa et al., 2017), which raises questions about regional differences in training standards.

Previous studies of postgraduate psychiatry programs have reported considerable competencies gaps in European countries with some trainees, for instance, not having access to training in psychotherapy, psychiatry of intellectual disabilities, neuromodulation or community psychiatry (Baessler et al., 2015; Casanova Dias et al., 2020; Gargot et al., 2017; Karabekiroglu et al., 2006; Kuzman et al., 2012; Lotz-Rambaldi et al., 2008; Mayer et al., 2014; Muijen, 2010; Naber and Hohagen, 2008; Pinto da Costa et al., 2019; Simmons et al., 2012). Recent studies on child and adolescent psychiatry (CAP) and transitional care from child to adult psychiatry also highlight variations in the assessment of trainees and their access to clinical and educational supervision and medical education (Barrett et al., 2020; Hendrickx et al., 2020; Russet et al., 2019; Tuomainen et al., 2018). A lack of supervision and training in essential and evidence-based components of psychiatric care also negatively impacts patients' quality of care in those countries (Baessler et al., 2015; Gargot et al., 2017; Karabekiroglu et al., 2006; Kuzman et al., 2012; Lotz-Rambaldi et al., 2008; Mayer et al., 2014; Muijen, 2010; Naber and Hohagen, 2008; Pinto da Costa et al., 2019; Simmons et al., 2012). Since working conditions and quality of training are linked to workforce migration and retention (Pinto da Costa et al., 2017), suboptimal training and shortage of psychiatrists can lead to suboptimal patient care.

Regulatory guidelines for psychiatry training were first published in 2003 in the 'Charter on Training of Medical Specialists in the EU: Training Requirements for the Specialty of Psychiatry' (UEMS, 2000, 2009, 2017; WHO, 2018). After an evaluation of the EU professional qualifications directive in 2011, the European Commission (EC) concluded

that the minimum training requirements were to be updated to better reflect current practices (EC, 2013). The latest revision of the guidelines was published in 2017 (UEMS, 2017) by the Union Européenne des Médecins Spécialistes (UEMS) with input from the European Federation of Psychiatric Trainees (EFPT), an umbrella organization for psychiatry trainee associations. However, these guidelines are non-binding and training standards are usually set by local governing bodies or medical associations (Dias et al., 2016). Every country decides its own requirements and modifies its training curricula according to its specific needs and objectives (Kuzman et al., 2012; Mayer et al., 2014; Nawka et al., 2010; Ross and Rohrbaugh, 2014).

Even though voluntary standardized European examinations are in place for more than 15 medical specialties (Brittlebank et al., 2016; Pandey et al., 2008), curricula for psychiatry training within the EU and the wider European region continue to fall short of best practice examples and minimal competency requirements identified by international organizations as well as European population's mental health needs (Gaebel et al., 2017; UEMS, 2015). Comprehensive information about the details of training programs in Europe is currently missing, which has limited thorough comparisons and undermined the development of an actionable strategy to improve and harmonize psychiatry training throughout Europe.

Aims and objectives

High mobility of medical professionals in Europe and heterogeneous living, working and training conditions mean meeting the mental health needs across all European countries by providing an adequately trained workforce of psychiatrists is a challenge. Our aim was to comprehensively map differences and similarities in psychiatry programs across Europe by means of a survey of national training structure and working conditions. We hypothesized that the training conditions would significantly differ between three groups of countries i.e. countries that comprised the EU before 2004; countries which joined the EU after 2004; and countries whose training credentials are not automatically recognized in the EU. We also aimed to determine national training requirements versus the population needs calculated by the World Health Organization (WHO). Based on our findings, we propose a checklist to monitor future changes to psychiatric training for facilitating the quantification of future harmonization efforts.

2. Experimental procedures

Study design

This cross-sectional study was conducted between 2014 and 2016 via an online questionnaire sent to the national representative of the European Federation of Psychiatric Trainees (EFPT) in the following 42 countries:

- EU member countries (28): Austria, Belgium, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and the United Kingdom (UK).
- Non-EU countries (14): Albania, Azerbaijan, Belarus, Bosnia-Herzegovina, Georgia, Israel, Macedonia, Montenegro, Norway, Russia, Serbia, Switzerland, Turkey and Ukraine.

Survey responses were compared with information from literature sources related to mental healthcare, population, national income and institutionalization of psychiatric care to determine population needs and deficits. Answers were descriptively analyzed to calculate the percentage agreement among the variables for determining variance among countries. For further comparison of heterogeneity, variables were compared between pre-2004 and post-2004 EU members and countries with unrecognized psychiatry qualifications. When a training association was not in place, people in comparable positions or former country representatives e.g. Early Career Psychiatrists representative for the WPA, completed the questionnaire. In countries with an established national committee representing trainees, this would usually be a prominent member of that committee. In countries where no such committee existed, a trainee with access to a comparable level of information was contacted.

Questionnaire

A questionnaire comprising 58 closed- and open-ended questions was used to collect data. This questionnaire was developed iteratively over several years by trainee representatives, who identified important factors for postgraduate psychiatric training from fieldwork and attendance at annual EFPT meetings. Development was also based on feedback from previous surveys (Kuzman et al., 2012; Nawka et al., 2010; Oakley and Malik, 2010). The questions concerned the organization, content and working conditions of the national training program in the respondents' country such as the number of trainees in the country, average salaries and working hours, minimum duration of training program and proportion of

rotations spent in subspecialties or separate specialties, standardization of curricula and perceived shortcomings.

The questionnaire was sent by email to the participants. In one case, the questionnaire was completed via a telephone interview.

Participants

We approached national representatives of 42 national psychiatry trainee associations who registered for the EFPT Forum 2014, London. EFPT fora are annual meetings of trainee representatives that provide an opportunity for national representatives to meet and discuss pertinent issues, with the primary objective of enhancing standards of psychiatric education and training across Europe. EFPT membership is open to any national association in a country within the European region, as defined by the World Health Organization (WHO). National trainee associations aim to (1) represent and connect psychiatry trainees in each country; and (2) represent them internationally to improve psychiatry training in each country and within Europe as a whole.

National representatives, have assumed leadership positions within their respective associations and are capable of providing accurate and comprehensive responses, either through their own knowledge base or their access to reliable local data sources. In countries where no such association existed, an individual with access to a comparable level of information was contacted to complete the questionnaire.

Data validation

To ensure accuracy, responses obtained from questionnaires were compared with a number of external sources, including published scientific literature, national curricula and training guidelines, and contacting national training organizations (CPI, 2012). Data were also cross-checked with EFPT board members and psychiatrists with personal experience of training in other European countries. For Bosnia-Herzegovina, data were combined and recalculated because there were two national programs in two similar-sized regions of the country.

For clarity, specializations related to but independent from psychiatry, such as neurology or internal medicine, are referred to as ‘separate’ specialties in this paper. The term ‘subspecialty’ was used to refer to rotations within psychiatry such as ‘addiction psychiatry’ and ‘old-age psychiatry’. For undefined rotations, we have used ‘not specified’. Questionnaire responses using synonyms were identified and categorized under the primary heading for ease

of data analysis. For instance, rotations for substance misuse, substance dependence or substance use were clustered under addiction psychiatry.

Comparative analysis

In order to determine gaps between population needs and available resources, additional variables such as country population (WB, 2016), national gross domestic product (WB, 2016), hospital beds per 100,000 citizens (WHO, 2013), number of psychiatrists (WHO, 2014), automatic recognition of the specialization (EC, 2005) and disability-adjusted life years (DALYs) (WHO, 2018) were calculated. From annual DALYs lost (WHO, 2016, 2018), the largest morbidity burden in Europe was identified for unipolar depression (ICD-10 F32-F39), substance use disorders (ICD-10 F10) and dementia (ICD-10 F0x, G20). Together with anxiety disorders (ICD-10 F4x), these four disorders were among the top three psychological problems in 95% of the surveyed countries (WHO, 2016, 2018) and therefore chosen for our comparative analysis.

Population needs deficit was calculated from the DALYs lost for each condition per country in percentage compared with the duration of the training rotation in the specific specialty/subspecialty. For example, time spent in addiction psychiatry and old age psychiatry rotations was compared with the DALYs for substance use disorders and dementia, respectively. The deficit could be calculated by subtracting the proportion of DALYs from the proportion of training in the specific subject. The European mean was calculated by combining the population deficits for all countries. The heterogeneity of psychiatry training programs was compared for all variables, including the content and length of training, number of trainees, salary, working hours, mandatory rotations, etc. among countries. The variance was calculated with percentage agreement. Percentage agreement between variables of up to 76-100% was classified as ‘minimally heterogeneous’; between 60% and 75% as ‘moderately heterogeneous’; and 50-59% agreement as ‘very heterogeneous’.

For an aggregated regional comparison, the countries were divided into three groups: a) pre-2004 EU members; b) post-2004 EU members; and c) countries whose psychiatry qualifications are not recognized by the EU or ‘countries with unrecognized qualifications’ (Table 1). Switzerland and Norway were not included in the groupings since their psychiatric qualifications are automatically recognized within the EU although they are not members.

Table 1: The division of surveyed countries for regional comparison.

Statistical analysis

Characteristics of psychiatry training in European countries were examined by descriptive statistics. All data are presented as median (IQR) unless stated otherwise. Normality of distribution was assessed by examination of quantile-quantile plots (not shown). Differences across the three country groups (pre-2004 EU members, post-2004 EU members and countries with unrecognized qualifications) were performed with nonparametric (Wilcoxon test) and parametric (ANOVA) tests depending on whether the relevant data was normally distributed. Comparisons were performed with pre-2004 EU member countries as the reference group using Dunn method for joint ranking. Switzerland and Norway were again excluded from this analysis. Associations between continuous variables were examined using Spearman correlation analysis. $P < 0.05$ for intergroup comparisons and 0.01 for correlations were considered statistically significant.

Statistical data were analyzed with JMP Pro (v14.3).

3. Results

Training and working conditions

Median psychiatry training program duration was 60 months, ranging between 12 months in Ukraine and 84 months in Ireland. The UK had the highest (n=2,900) number of trainees. Trainees worked between 35 hours per week (in Belarus, Bosnia-Herzegovina, Bulgaria and Ukraine) and 65 hours per week (in Malta).

Net income ranged between €0 in Georgia and €5,000 in Switzerland. In Switzerland, trainees earned 35 times more than their counterparts in Ukraine who also worked eight hours more per week. In North Macedonia, trainees opting for training in the private sector had to pay about €8,000 themselves over five years to receive training.

Table 2 provides a summary of the major characteristics of psychiatry training conditions in all surveyed countries.

Table 2: An overview of psychiatry training programs in 42 surveyed countries.

Training was nationally standardized (i.e. a single national curriculum) in 34 of the 42 countries. There was no training program in Luxembourg and trainees followed the curricula of neighboring countries. Psychiatrists received the title of ‘psychiatrist and psychotherapist’

in Austria, Germany, Liechtenstein and Switzerland (German-language speaking countries) that recognized CAP as a separate discipline. In the UK, where six psychiatry specialties exist, the formal term was 'general psychiatry' for adult psychiatry. In Belgium, the title specified 'psychiatrist for adults' and separately for CAP as 'psychiatrist for children and adolescents'.

Training structure

A summary of the average proportion of time spent in rotations specified for psychiatry training programs in Europe is provided in Figure 1. Two examples are discussed below:

In the UK, psychiatry training provided an example of the 'common trunk' or 'core training' approach. The six-year training was preceded by a two-year foundation program divided into four-month placements in a variety of specialties. The training was split into two three-year components: core and higher training. Trainees first completed the core training which required at least 12 months in general adult psychiatry; a placement in developmental psychiatry (in CAP or intellectual disability psychiatry); a minimum number of nights on call; assessing a minimum number of patients in emergency settings; and the completion of basic psychotherapy training. To progress to the 'higher' training program, trainees completed the membership examinations of the Royal College of Psychiatrists, two written papers and an Objective Structured Clinical Examination (OSCE) test to assess clinical skills. Entry to the higher training level depended on a competitive system in one of the six areas of specialization: general adult, CAP, old age, forensics, intellectual disability or psychotherapy. Dual accreditation was also possible e.g. old age and general adult psychiatry (accordingly longer training period).

In Germany, the five-year psychiatry program was distinctly separate from CAP training or training in psychosomatics, which were both offered as separate specializations. There was one compulsory rotation (one year in neurology) with options of one year in CAP or psychosomatics, or six months in internal medicine, general practice, neurosurgery or neuropathology.

Figure 1: The mean organization of psychiatry training programs for specialties and subspecialties mandatory in the curricula in all countries.

Differences in training programs

CAP was a separate specialization from adult psychiatry in 32 countries. The other 10 countries (Azerbaijan, Belarus, France, Georgia, Latvia, Malta, Netherlands, Russia, Slovenia and Spain) recognized CAP as a sub-specialty of psychiatry. One-fifth of the psychiatry placements consisted of rotations in allied/independent specialties, which were mainly in neurology, internal medicine and radiology.

In 80% of the countries, experience of up to 18 months in a separate specialty was mandatory. Up to 84% of psychiatry training (44 months) was in adult psychiatry. Rotations in 'adult psychiatry' were categorized by subspecialties such as 'old age psychiatry', 'psychosis', and 'in/out-patient services', 'acute', 'prolonged' or 'rehabilitation' psychiatric care or type of hospital (e.g. university hospital). Five countries included psychosomatics placements during a training program. Two countries required rotations in a university hospital (six months in France, three in Hungary); one country (Greece) required six months in the psychiatry ward of a general hospital; and one country (Switzerland) required spending time in a hospital separate from the training institution. In 29 countries, it was compulsory or optional to train in neurology to qualify as a psychiatrist. For 12 countries, rotations reported infrequently were clustered under the category of 'various'.

In many countries, the structure of the curriculum did not reflect the prevalence of any specific psychiatric disorder. For instance, for alcohol use disorders DALYs, Hungary had the second highest percentage (39%) in Europe but its rotation in substance misuse comprised only 5% of the training. Conversely, Estonia with the third-highest percentage for alcohol (35%) plus 11% for substance misuse dedicated 21% of the curriculum towards addiction.

The heterogeneity of psychiatry programs is detailed in Table 3.

Table 3: Heterogeneity of influential factors on training conditions in the surveyed countries.

Regional comparison

Differences in psychiatry training were examined across three different European geographic and political regions (pre-2004 EU members, post-2004 EU members and countries with unrecognized qualifications). The three regions differed significantly in terms of the duration of training (Wilcoxon test χ^2 16.5, $p<0.001$) and average trainees' net salary (χ^2 22.9, $p<0.001$). Trainees in pre-2004 EU member countries earned a significantly higher monthly net salary compared to other European countries (pre-2004 EU members *vs* post-

2004 EU members p=0.002 and *vs* countries with unrecognized qualifications p<0.001; Figure 2). However, the regions did not differ in terms of trainees' reported weekly working hours and the ratio of trainees' net income compared to the average net income in a country.

Psychiatry training was significantly longer in pre-2004 EU countries compared to countries with unrecognized qualifications (p<0.001; Figure 2) but not from the post-2004 EU members (p=0.123, Figure 2). The number of trainees was also significantly higher in pre-2004 EU member countries (318.2 trainees per 100,000 inhabitants (IQR (median with interquartile range) 222.2; 568)) compared with countries with unrecognized qualifications (IQR 66.7/100,000 inhabitants (IQR 24; 125), p=0.001) and post-2004 EU countries (200/100,000 inhabitants (IQR 115; 328.8).

The duration of psychiatry training correlated significantly with trainees' salary (Spearman's ρ=0.703, p<0.001) and the number of trainees per 100,000 inhabitants (ρ=0.615, p<.001). Trainees' salary also correlated with countries' GDP (ρ=0.527, p<0.001) and number of psychiatrists (ρ=0.563, p<0.001) as well as trainees (ρ =0.684, p<0.001) per 100,000 inhabitants. Finally, the number of trainees per 100,000 inhabitants correlated with a country's GDP (ρ =0.407, p=0.008) and the number of psychiatrists per 100,000 inhabitants (ρ=0.488, p=0.001), but not with country population, nor the number of hospital beds per 100,000 inhabitants. Trainees' reported weekly working hours did not correlate with any of the studied variables.

Figure 2: Heterogeneity of major training characteristics among different blocs of European countries.

4. Discussion

The growing gap between mental health care needs and number of psychiatrists and rising migration of skilled professionals has renewed debates about international standardization of psychiatry programs in European countries. This study is the first to describe the working conditions and quality of psychiatry training in 42 countries of the wider European region in an effort to quantify these differences of educational qualifications. Our results show that psychiatry training curricula vary considerably between countries and the emphasis remains on completing a minimum amount of time in training, rather than the acquisition of defined competencies. We also confirmed our hypothesis that significant differences in training conditions exist between countries clustered into geopolitical groups of

pre-2004 EU members, post-2004 EU members and countries from the wider European region whose credentials are not recognized in the EU.

Differences in salaries, working hours and training conditions combined with freedom of movement and automatic recognition of qualifications are understood as precursors of 'training tourism' or workforce migration usually towards pre-2004 EU countries (Pinto da Costa et al., 2017). Previous studies have shown that a lot of patients in the EU (ranging between 33% in Austria and 82% in Malta) are comfortable with the idea of treatment by a physician trained anywhere in the EU (EC, 2011b). On the one hand, this suggests a widespread belief that medical training is standardized across the EU, and on the other hand, completely sidelines psychiatry's distinctiveness as 'speaking medicine' (Galasiński, 2018) since European countries do not share a common language. Language proficiency has been correlated with underutilization of psychiatric services (Ai Ohtani et al., 2015). While native populations might be skeptical about foreign psychiatrists on assumptions that they may not be fully understood, there is also an important lack of psychiatrists fluent in foreign languages that becomes a barrier for migrant populations (Ai Ohtani et al., 2015; Jenkins et al., 2010). Thus, one can anticipate a balance in how migration of psychiatrists with standardized training might close healthcare gaps and increase health equity.

Working conditions

The average salary for psychiatry trainees in pre-2004 EU member countries was four times higher than in countries whose credentials are not recognized and almost 2.5 times more than in countries that joined the EU after 2004. Income is recognized as a major reason for migration within European countries with Switzerland, Sweden and the UK considered attractive destinations for psychiatrists (Giurgiuca et al., 2018; Kilic et al., 2019; Pinto da Costa et al., 2017). This financial factor is significantly relevant for trainees in lower income countries (<€500) but less important for psychiatry trainees in high-income countries (>€2,500), where personal reasons are the most influential drivers of migration (Pinto da Costa et al., 2017). This high migration tendency could improve the opportunities for professionals but exacerbates the mental health treatment gap in donor countries.

The minimum official duration of training programs was on average 23 months shorter in countries without automatic recognition of qualifications when compared with the pre-2004 EU countries. While the EU stipulates a minimum four-year psychiatry program, the UEMS guidelines recommend a minimum of a five years (UEMS, 2009; WHO, 2018). Even though the national authorities only determine the minimum duration of training, the timeframes for completing the program vary from individual to individual (for example if they have career

breaks for parenting or other reasons). Only Azerbaijan, Belarus, Georgia, Russia and Ukraine had stipulated less than four years for national psychiatry programs. Qualifications obtained in these countries are not mutually recognized within EU countries since they do not meet the minimum conditions.

Countries which joined the EU before 2004 have the highest number of psychiatrists and trainees, highest salaries and their training programs are more often tailored according to local population needs. For instance, in these countries the mean was one psychiatrist for 6,993 people (318.2 trainees per 100,000 inhabitants) compared with one psychiatrist for 10,989 people in the newer EU countries (200 trainees per 100,000 inhabitants). In countries with unrecognized qualifications this difference increased further to one psychiatrist for 14,925 people (66.7 trainees per 100,000 inhabitants) (WHO, 2014). We expect these differences can be attributed to some extent to the relative differences in average GDPs between the three groups. Countries with higher GDPs are likely to have more money to invest in healthcare systems and, therefore, afford more psychiatrists.

Training structure and differences

Psychiatry curricula have historically been duration-oriented. In the majority of the training programs surveyed, the rotations were defined only by the length of rotation and not by skills-based outcomes despite recent calls for competency-based education (WHO, 2018). Newer curricula increasingly employ a variety of modern educational methods such as simulation techniques, e-learning or blended learning. (Al-Elq, 2010; Casanova Dias et al., 2017; Crawford et al., 2016; EFPT, 2016; Gargot et al., 2020; Jani et al., 2017; Reynolds et al., 2011; Sørensen et al., 2017; Ten Cate, 2017). More evidence is needed to know the advantages, efficacy and economical sustainability of these approaches and their learning outcomes in order to standardize psychiatry training and its harmonization in Europe.

Rotations should be available in different branches of mental health services to improve the quality and breadth of training. Europe has the highest proportion in the world of total ill health and premature deaths due to alcohol, and the highest level of alcohol and tobacco consumption in the world (WHO, 2015) but psychiatry training in substance misuse was found to be lacking. Our results corroborate a recent study looking specifically at trainees attitudes, knowledge and training in addiction psychiatry (Orsolini et al., 2020). Similarly, rotations in old-age psychiatry were found to be 15% below the required level. Given the forecast for European ageing patterns, it would be prudent to ensure that psychiatrists are trained adequately in old age psychiatry, including an understanding of comorbidities and

treatment interactions. A lack of training was also evident in community-based psychiatry, echoing previous findings (EFPT, 2013). This could have negative consequences in terms of stigmatization of patients, prioritization of more acute psychiatric presentations and a lack of interest in prevention, psychotherapy and recovery techniques.

Towards standardization

The 'minimum conditions' for European recognition of psychiatry training were agreed among EU countries about 35 years ago (EC, 2011a). A standardized European competency-based curriculum with innovative training methods needs to be developed with specific timeframes for competencies. Training curricula should be redesigned, to account for the gap between written curricula and practical implementation to meet the needs of the population. Simply adding certain requirements might not bring additional benefits. In the process of harmonization of European curricula it would be wise to take the differences in mental health needs into consideration. Thus, it would be advisable to reserve a proportion of a baseline curriculum, which could be customized according to the particular needs of each country.

Future studies will need to assess the relative efficacy of different structures of training (e.g. with CAP as a different specialty or as a sub-specialization) and teaching methods (e.g. e-learning), level of salary and satisfaction with the job, the advantages and pitfalls to have more specialized services in psychiatry. We recommend continuing the evaluation of training across Europe at regular intervals and propose a checklist of variables derived from a descriptive analysis of our data verification process and results. This is intended as a research tool for curriculum planners, trainee associations, trainers, trainees, etc. to compare, quantify and ensure the uniformity of standards of psychiatry programs in Europe (Table 4).

Table 4: The Training-24 checklist: recommended checklist on training in psychiatry.

Limitations

The survey was based on responses from the EFPT delegates. Directly contacting the trainees in every country could improve representativeness and generalizability of data. Some questions were subjective and survey responses could be different from the official figures. Others included a broad range of possible answers, making representativeness more difficult. For example, the questionnaire asked for the average salary including on-call reimbursements and after-tax deductions, which in the UK varies between £31,301 and £47,175 with additional on-call supplement of 20%-40%. This corresponds to a take-home salary of

between £2,789 and £3,155 per month (€3,600 in 2014), which is lower than that reported in the survey and used for analysis. In Portugal for instance, trainees receive two extra monthly salaries per year, meaning the real income is higher than reported.

Data were collected during 2014-2016 and even though developments on the international front have been minimal, the local situation might have changed in many countries. For example in France, the training was recently divided into three stages with different pedagogical objectives (DGOS, 2017).

Conclusions

Significant variations in postgraduate psychiatry training conditions, structure and content exist among European countries. Although the current European psychiatry training recommendations cannot be enforced at a national level, countries that have been part of the EU longer evidently perform better in terms of training quality and conditions. A European certification for psychiatrists can not only help to create a quality standard for psychiatrists working in the region, but could also serve as a benchmark for national training programs against a clear set of internationally recognized competencies, resulting in further improvements and harmonization of psychiatric training and patient care in Europe.

Our study shows that current psychiatry training programs are failing certain patient populations. Future research on the relationship between training programs and population needs is required to determine which deficits are currently most urgent to address and understand why they occur.

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