Transition as a topic in psychiatry training throughout Europe: trainees' perspectives

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Abstract The majority of adolescents with mental health problems do not experience continuity of care when they reach the transition boundary of their child and adolescent mental health service. One of the obstacles for a smooth transition to adult mental health services concerns the lack of training for health care professionals involved in the transition process. This study aims to seek psychiatric trainees' opinions regarding training on transition and the knowledge and skills required for managing transition. A survey was distributed to trainees residing in European countries. Trainees from 36

countries completed the questionnaire of which 63% reported that they came into contact with youth and young adults (16-26 years) during their clinical practice. Twenty seven percent of trainees stated they have good to very good knowledge about the transition process. Theoretical training about transition was reported in only 17% of the countries, and practical training in 28% of the countries. Ninety four percent of trainees indicated further training about transition is necessary. The content of subsequent transition-related training can be guided by the findings of the MILESTONE project.

Keywords transition, psychiatry, training, Europe, trainee

Introduction

When young people receiving care or treatment for their mental health needs are about to reach the end of secondary school, they face, besides a developmental transition from adolescence to adulthood, a potential transition from child and adolescent mental health services (CAMHS) to adult mental health services (AMHS); the latter will be referred to as 'transition' in the rest of this paper. As mental health problems during adolescence are common [1] and can continue into, and during, adulthood [2], it is crucial to ensure appropriate continuity of care. However, very few young people referred by CAMHS to AMHS experience this [3]. A UK study identified that less than 5% received optimal transitional care, which was defined as adequate transition planning, good information transfer across from child to adult provider, joint working between care providers, and continuity of care following transition [4].

At the service level, several bottlenecks have been identified that hamper optimal transition and continuity of care. These include differences in the structure, organizational culture and remit of child and adult services [5-7], transparency of the care programmes, care accessibility (cost price, location), and lack of training for health care professionals [8]. All professionals involved in the transition process need adequate training on how to work with young people with mental health disorders in general, and transition in particular, since such knowledge and skills are crucial for managing transition effectively [9-10]. Besides theoretical training, it has been recommended that all psychiatrists and clinical psychologists undergo relevant work experience in child, adolescent, and adult mental health to enhance the knowledge of the others' specific skills and expertise that will benefit the transition process [9].

The structure and content of psychiatry training has been a topic of concern for decades, with a shift from aiming for a common psychiatric training programme throughout Europe to aiming for similar

quality of training programmes [11-12]. To ensure the quality of the different training programmes, the European Union of Medical Specialists (UEMS) published The European Framework for Competencies in Psychiatry [13]. This framework states the competencies psychiatric trainees should have acquired by the end of their training [14]. However, very little is known about the competencies today's psychiatric trainees acquire to help manage the transition process. In comparison with other medical specialties, psychiatry seems to be falling behind. For example, pediatric residents' training in adolescent medicine has already been investigated, and competencies required in adolescent medicine, and transition in particular, have been developed [15-16].

Addressing the need for training requirements regarding the transition from CAMHS to AMHS is one of the aims of the MILESTONE project [17-18], a European Union-funded project on mental health transitions. This survey, which is part of MILESTONE, aims to seek psychiatric trainees' opinions regarding training on transition and the knowledge and skills required for managing transition. More specifically, we wanted to answer three questions: a) Is the topic of transition addressed in current training? b) What are the topics that a training about transition should include? and c) Which learning methods are best for acquiring knowledge and skills about transition?

Method

A collaboration was set up with the European Federation of Psychiatric Trainees (EFPT) for conducting a survey among its members. The EFPT is an independent umbrella organization which brings together representatives of national psychiatric trainee associations across Europe with the aim of enhancing and harmonising training standards. (Figure 1) (http://efpt.eu/) [19].

Figure 1. EFPT member states (http://efpt.eu/nta/)

Survey sample

In the first phase, the survey sample was a convenience sample of all EFPT members from more than 30 countries attending the EFPT forum in Antwerp, Belgium, in July 2016. This annual forum is attended by members from as many countries as possible whereby all member states are encouraged to send a delegate from both child and adolescent psychiatry as well as adult psychiatry. After the forum, the EFPT contacted missing countries and posted a link to the online survey on their website. In a second phase, in order to obtain a completed questionnaire from the countries who were still missing, we contacted trainees via the national trainee association, via a staff member of a university, or via a MILESTONE research assistant in one of the MILESTONE countries [18].

Survey instrument

A specific questionnaire (Appendix 1) was developed to gain insight into current psychiatry training in the EFPT member states. The questionnaire was composed of four sections, with a total of 39 multiple-choice items, and was written in English which is the EFPT's official language. The first section covered information about respondents' socio-demographics the and content of their current psychiatry training. The second section addressed trainees' experience with transition in clinical practice, and whether transition as a topic was included in their training. The third section asked which of the listed topics should be included in training on transition and in what ways knowledge about the topics is best acquired. The transition-related training topics were gained from the MILESTONE transition model [17-18], the NICE guidelines on transition [10] and the Adocare report [9], and covered the recommended competencies of clinicians dealing with transition. The fourth section assessed the trainees' opinion of the 'Managed Transition' approach, which is currently being tested in the MILESTONE study [17-18], and whether they think it is practicable in their country. This last part, however, is not included in this paper as it is beyond the scope of mapping the current training and transition related training needs.

Data collection and analysis

A paper version of the survey instrument was handed to all EFPT members during the EFPT forum. The members of the countries who did not complete the questionnaire at the forum were sent an email with a link to the online version. We used the software Limesurvey 2.0 (Limesurvey: an open source survey application. http://www.limesurvey.org/) to develop the online survey.

Respondents were asked to provide their personal perspective of the institution they were part of; as the content of curricula between training institutions within a country can differ, which makes it not feasible to provide one general answer to some questions.

All data were analyzed using SPSS (IBM Corp. Released 2017. IBM SPSS Statistics for Windows,

Version 25.0. Armonk, NY: IBM Corp) to produce descriptive statistics. Data from the paper version were entered manually into Microsoft Excel 2016 (Microsoft® Microsoft Office 2016) and crosschecked for errors before exporting to SPSS. Data obtained via Limesurvey were exported directly to SPSS.

Categorical items analysed at country-level (e.g. theoretical transition training is present in the curriculum of the country: yes/no/unknown), but answered by more than one trainee of the same country, were merged. If there was discrepancy in the responses but at least one of the trainees answered 'yes', this item was counted as such in order to cover for inter-curriculum variability within a country's training institutions.

Results

Data were collected between July 2, 2016 and November 30, 2017. All 40 member-countries of the EFPT were contacted. 78 trainees from 36 countries (90% of all countries) completed the questionnaire: Albania (n=1), Austria (n=4), Azerbaijan (n=2), Belarus (n=2), Belgium (n=5), Bulgaria (n=1), Croatia (n=1), Czech Republic (n=1), Denmark (n=3), Estonia (n=1), Finland (n=5), France (n=1), Germany (n=1), Greece (n=1), Hungary (n=2), Ireland (n=1), Italy (n=2), Kosovo (n=2), Latvia (n=3), Lithuania (n=1), Republic of Macedonia (n=1), Moldova (n=1), the Netherlands (n=5), Norway (n=3), Poland (n=1), Portugal (n=7), Romania (n=1), Russia (n=1), Serbia (n=1), Slovakia (n=1), Slovenia (n=6), Spain (n=4), Sweden (n=2), Turkey (n=1), UK (n=2) and Ukraine (n=1). We were unable to obtain data from Bosnia and Herzegovina, Israel, Malta and Switzerland.

Personal data and current training

81% of the participating psychiatric trainees were females, 26% were training to become a general psychiatrist (i.e psychiatrists trained to manage people of all ages), 32% an adult psychiatrist, and 40% a child and adolescent psychiatrist (Table 1). The majority of trainees (46%) were in their third or fourth year of postgraduate training in psychiatry.

Regarding clinical practice acquired during their training, 73% of trainees gained work experience with children and adolescents, especially in services for 0-14 years of age (Table 2). For child and adolescent psychiatric trainees, the mean number of months of work experience in services for minors vs. adults is about the same (mean months 0-18y: 18.6; mean months 18-65: 15), whereas adult and general psychiatric trainees work the majority of the time in adult services (adult trainees: mean months 0-18y: 5; mean months 18-65: 41.9; general trainees: mean months 0-18y: 3.5; mean months 18-65y: 23) (Table 2). 49 of 78 trainees (63%) have come into contact with youth and young adults (16-26 year) during their clinical practice (Table 1).

Table 1. *Sociodemographic data of psychiatric trainees (YP = Young people)*

	n	%
Gender		
Female	63	81
Male	15	19
Psychiatrist title		
General	20	26
Adult	25	32
Child and adolescent	31	40
Other (e.g. still undecided)	2	2
Current year of training		
1-2	25	32
3-4	36	46
5-6	17	22
Work experience with YP 16-26 years of age		
Yes	49	63
No	29	37
Number of months of work experience with YP aged 16-26 (N=49) (n missing data = 7)		
1-6	20	41
7-12	13	27
13-24	2	4
+25	7	14

Table 2. *Clinical practice according to the age of service user and type of trainee*

	0-14 years old			14-18 years old			18-65 years old			+65 years old			no age boundary		
	n	%	mean months	n	%	mean months	n	%	mean months	n	%	mean months	n	%	mean months
Child and adolescent															
Yes	27	88%	21.5	27	88%	15.7	22	71%	15	6	19%	3	5	16%	10
No	2	6%		2	6%		9	29%		25	81%		25	81%	
Missing	2	6%		2	6%		0	0%		0	0%		1	3%	
Adult															
Yes	14	56%	5.3	13	52%	4.7	20	80%	41.9	17	68%	6.3	8	32%	38.8

No	11	44%		12	48%		5	20%		8	32%		17	68%	
Missing	0	0%		0	0%		0	0%		0	0%		0	0%	
General															
Yes	15	75%	3.7	15	75%	3.3	16	80%	23	15	75%	3.3	9	45%	17.4
No	5	25%		5	15%		3	15%		4	20%		10	50%	
Missing	0	0%		0	0%		1	5%		1	5%		1	5%	

Transition in practice and during the current training program

Seventy-seven percent of psychiatrist trainees indicated having "much" to "very much" interest in the topic of transition (Figure 2). This is in contrast to their current knowledge on transition management, with only 27% stating they have good to very good knowledge about this subject.

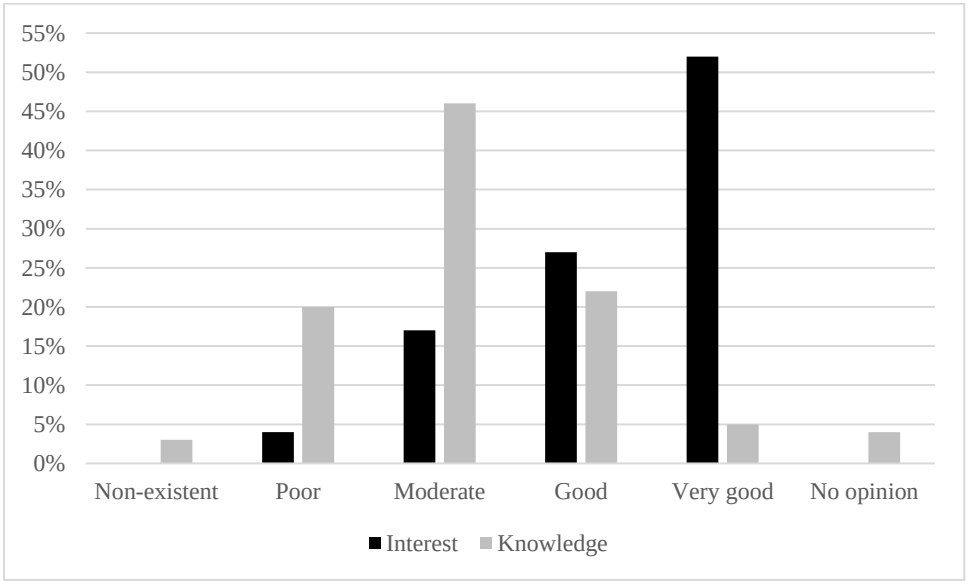

Figure 2. Trainees' interest in and knowledge about transition

Training in adolescent psychiatry and transition

Adolescent psychiatry/psychopathology is part of the curriculum in 50% of the participating countries (Table 3). Fifty percent of the responding trainees (N=30) from these countries had at least 10 hours of lectures about this topic (Table 4). In 8 (22%) countries (Bulgaria, Czech Republic, Lithuania, Republic of Macedonia, Poland, Serbia, Slovakia and Ukraine) responding trainees said they did not have any lectures about adolescent psychiatry, and the responding trainees of 10 (28%) countries (Albania, Belarus, Estonia, Finland, Ireland, Italy, Latvia, Moldova, Romania and Turkey) were not completely sure if they had any lectures on the topic.

Theoretical training about transition is present in only 6 (17%) countries (Austria, Azerbaijan, Belgium, Finland, Kosovo and the UK) (Table 3), with 50% of lectures taking 1-5 hours (Table 4). Practical transition training is more common. Trainees of 10 (28%) countries (Austria, Azerbaijan,

Belarus, Estonia, Finland, Greece, Kosovo, the Netherlands, Romania, and the UK) indicated they have experienced practical training (Table 3 and Table 4). This knowledge is mostly gathered by discussing a specific case (55%) and during their clinical practice (45%) (Table 5). It seems, however, that these figures depend on the specific training program. Whereas child and adolescent psychiatric trainees have most lectures about adolescent psychiatry/psychopathology compared to adult and general psychiatric trainees (61% vs. 16% and 35%), a higher proportion of adult psychiatric trainees than child and adolescent and general psychiatric trainees indicated they have theoretical training on transition (12% vs. 6% and 5%). Practical training is almost equal between child and adolescent psychiatric trainees and adult psychiatric trainees (16% and 20%). Overall general psychiatric trainees have the least transition-related training (5%) (Table 3).

Table 3. Adolescent psychiatry/psychopathology and transition-related training in current curricula by country and according to trainees in different specialties.

		Adolescent psychiatry/ psychopathology		Transition theoretical training		Transition practical training	
		n	%	n	%	n	%
By country N=36							
	Yes	18	50%	6	17%	10	28%
	No	8	22%	28	78%	22	61%
	Unknown	10	28%	2	5%	4	11%
Child and adolescent trainees							
N=31	Yes	19	61%	2	6%	5	16%
	No	5	16%	29	94%	25	81%
	Unknown	7	23%	0	0%	1	3%
Adult							
N=25	Yes	4	16%	3	12%	5	20%
	No	5	20%	20	80%	17	68%
	Unknown	16	64%	2	8%	3	12%
General							
N=20	Yes	7	35%	1	5%	1	5%
	No	7	35%	19	95%	18	90%
	Unknown	6	30%	0	0%	1	5%

Table 4. Time spent on lectures about adolescent psychiatry/psychopathology and theoretical training on transition

	Adolescent psychiatry/ psychopathology (N=30)		Transition theoretical training (N=6)	
	N	%	n	%
1-5 h	6	20%	3	50%
5-10 h	2	7%	1	17%
10-20 h	3	10%	0	0%
>20 h	12	40%	2	33%
Missing	7	23%	0	0%

Table 5. Methods of practical transition-related training (N=11)

Training method	n	%
Lecture	4	36%
During internship	5	45%
Supervision	3	27%
Cross training	1	9%
Discussing a specific case	6	55%
Self-study	4	36%

Ninety four percent (n=72) of the trainees agreed that further training regarding transition is necessary. The most important topics that should be included are: how to deal with the developmental tasks of the young person, and knowledge about specific transitional barriers and how to overcome them. Eighty two percent and 81% of trainees, respectively, rated these topics as fairly or very important. This is followed by the subjects how to support parent/carers of the young person (79%), knowledge about different services for young people (78%), and how to plan transition and how to discuss it with stakeholders (78%) (Figure 3). Seventy seven percent of the trainees indicated that the most effective methods to acquire this knowledge and skills is through cross-training in which CAMHS and AMHS clinicians receive training together on transition-related studies, supervision sessions (67%), and by

discussing a specific case with clinicians from both CAMHS and AMHS (66%) (Figure 4).

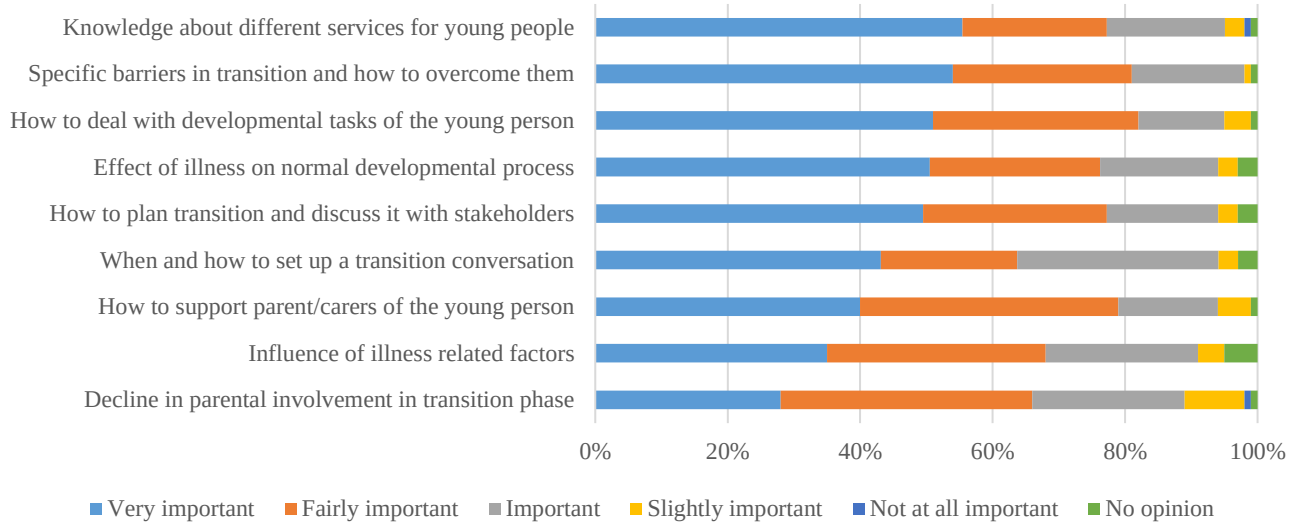

Figure 3. Topics to be included in transition-related training (n=78)

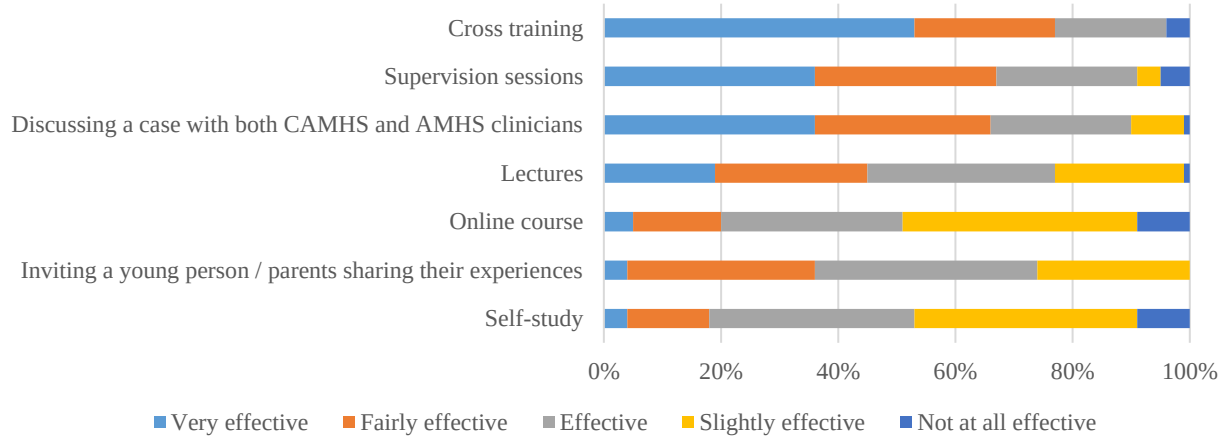

Figure 4. Training methods (n=78)

Discussion

The survey shows that although 63% of the sampled psychiatric trainees came into contact with young people (16-26 years) during their clinical practice, theoretical training about transition is reported by the trainees in only 17% and practical training on transition in only 28% of the 36 European countries included in the study. It is therefore possible that the majority of practicing psychiatrists have not received specific training on transition and may not have sufficient knowledge regarding transition. Moreover, 94% of trainees indicated that further training regarding transition is necessary.

These results should be further analyzed in light of the finding that less than 5% of youth and young adults attending CAMHS experience optimal transition during the transition from CAMHS to AMHS

and that nearly a quarter of those who are referred to AMHS are discharged before the first appointment [3-4]. However, there is no guarantee that improved knowledge of transition will lead to higher numbers of young people experiencing optimal transition; we are not aware of published findings in this topic area. Nonetheless, it is assumed that increased knowledge may lead to change in practice by altering the clinicians' attitudes. As for transition it is known that the differences in viewpoints between CAMHS and AMHS clinicians is one of the impeding bottlenecks [6]. Although guidelines regarding transition have been developed (e.g. NICE [10]), it is important to question how these can be properly implemented if clinicians are not trained in this topic area. The guidelines can only achieve their intended purpose if clinicians receive appropriate training linked with the required knowledge and skills.

The UEMS requirements for the speciality of psychiatry states that a common trunk of fundamental knowledge and skills should be present in every national curriculum, including general adult psychiatry and developmental psychiatry (child and adolescent psychiatry, learning difficulties and mental handicap) [20-21]. This common trunk, or modified version which includes adult psychiatry and child and adolescent psychiatry, seems to be successfully implemented in almost 100% of European countries [22]. However, this is not in line with our survey, as for only 50% of the countries trainees indicated they certainly received lectures on adolescent psychiatry/ psychopathology (Table 3). A possible explanation is that the common trunk focuses on children so that the trainees felt they have not acquired sufficient knowledge about adolescents.

Besides theoretical training, it is recommended that all psychiatrists should have relevant work experience in child, adolescent, and adult psychiatry to enhance the knowledge of each other's discipline which will benefit the transition process [9]. In practice, this does not seem to be the case as not all adult or general psychiatric trainees have clinical practice with minors, and not all child and adolescent psychiatric trainees have clinical practice with adults (Table 2). This is supported by the research of Lotz-Rambaldi et al [23] which showed that practical training in child and adolescent psychiatry was mandatory in only 59% of the investigated European countries.

Aiming for well-trained health professionals in the field of transition starts with the development of a specific training module. The topics included in the MILESTONE transition model [17-18] and those recommended by the NICE guidelines [10] and the Adocare project [9] were all rated 'fairly important' or 'important' by the trainees (Figure 3) and should be included in the module.
Up to now, there is no consensus on the transition-related decision-making process and the mental health trajectory of the young person depends on the clinical judgment of the individual practitioner. This judgment is not always based on a structured overview of transition-relevant factors that influence the severity of the problems and the need for further help. Moreover, the individual

judgment of the practitioner seems to be subject to diverse biases [24]. To address this need, one of the outcomes of the MILESTONE project is the development and validation of an assessment instrument, the Transition Readiness and Appropriateness Measure (TRAM), to guide the clinician during the transition process [17]. The TRAM summary score report provides information on symptoms and risk factors experienced by the young person but also highlights disruption experienced by them and barriers to successful transition. Instructions on how to use and interpret the TRAM and to make most of the TRAM report could be included in the training.

Moreover, the MILESTONE study will also provide data about different trajectories of young people who have reached the transition boundary of their CAMHS in the eight participating countries, experiences related to the transitions process and 'managed transition', barriers to transition, and how these link with the wellbeing of the young people [17-18]. Including findings from the MILESTONE study in the module will be very important as knowledge about transition experiences in European countries and good practice regarding transition is very limited at the moment.

Mapping the current situation regarding psychiatry training is only one step in the course of action associated with improving transitional mental health. The challenge now is to put these findings into practice. This can be done by implementing the transition topic in the psychiatric training programs throughout Europe/worldwide. One possible way to do this is to take an example of the CanMEDS roles and to translate these to specific transition related competencies [14]. Relevant findings from the MILESTONE study could guide the content of these competencies. The fact that the UEMS is aware of the importance of the transition process – it is already mentioned in the training logbook for child and adolescent psychiatrists [25] – is a positive development which will certainly facilitate the implementation process. Furthermore, the UEMS has recently set up a transition working group, joined by both the child and adolescent section and the adult section. However, it must be noted that member countries are not obliged to comply with the UEMS guidelines.

Although the focus of this paper has been on the training of clinicians, more specifically psychiatrists, transition can only be optimal if the three levels of policy, organization and individual work closely together. As one of the trainees commented "*training is needed, but training is insufficient if the institutions aren't prepared for adequate transition*".

Strengths and limitations

An important strength of this study is that we obtained data from 36 European countries regarding training and transition. However, caution is advised in interpreting these results as the representativeness of the sample of trainees completed the questionnaire is unknown. The results

regarding training provision may be biased due to memory errors linked to the retrospective nature of the questionnaire. Memory mistakes can also be an explanation for the interuniversity variability within one country when more than one trainee completed the survey. However, intra-country variability can also be linked to curricula differences between national training institutions. Furthermore, some of the trainees were in an earlier stage in their training, and may not have yet received training on this topic. The reader should bear in mind that the findings are linked to this specific sample and no statements are made about the generalizability of the data. Secondly, we did not provide the trainees with a glossary of terms. We can therefore not guarantee that all respondents understood all terminology as we intended.

Multiple completed surveys from one country can be explained by a couple of reasons. EFPT member states are encouraged to send national delegates of both the child and adolescent and the adult section to the annual forum. Members of both sections were also contacted to complete the online questionnaire. Moreover the link to the survey on the website of the EFPT did not made it possible to control for the number of completed questionnaires per country.

Besides, it is beyond the scope of this survey to compare the answers of the trainees to the official curriculum of any training institution. As this study is limited to the viewpoint and experiences of the trainees only, we did not cross check their answers with official (inter-)national organisations or associations, e.g. UEMS.

Lastly, psychiatric training takes several years and curricula are dynamic. It is possible that these results do not reflect the current content of the training as the curricula may have been revised.

Conclusion

The review undertaken of psychiatric trainees' experiences of training indicates that the knowledge and skills to be able to manage the transition process from child and adolescent to adult mental health services are often absent. However, psychiatric trainees are interested in obtaining knowledge and skills regarding transition. The current lack of knowledge could contribute to the suboptimal transition process and to young people falling through the care gap between services.

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Compliance with ethical standards

Conflict of interest: The authors declare that they have no conflict of interest.

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