Atlas

PSYCHIATRIC EDUCATION AND TRAINING ACROSS THE WORLD

2005

World Health Organization

World Psychiatric Association
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For further details on this project or to submit updated information, please contact:

Dr S. Saxena
Department of Mental Health and Substance Abuse
World Health Organization
Avenue Appia 20, CH-1211, Geneva 27, Switzerland
Fax: +41 22 791 4160, email: mhatlas@who.int
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Contributions from all individuals who responded to the questionnaire and provided written comments on specific topics have been valuable in the production of this volume. Their names are provided in the appendices.

The contribution of each of these team members and partners, along with the input of many other unnamed people, has been vital to the success of this project.

The publication of this volume has been assisted by Ms Tushita Bosonet (graphic design) and Mr Christophe Grangier (map).
Psychiatrists play an important role in the delivery of mental health services. However, global information about the quality of training of psychiatrists is largely unavailable. Do countries train adequate numbers of psychiatrists for their mental health needs? How satisfactory is the training in view of the changing roles of a psychiatrist? Does the training take into account enormously different environments in which psychiatrists work across the world? These and other similar questions need urgent answers. _Atlas: Psychiatric Education and Training across the World_ is an initial attempt in this direction.

This member of the Atlas family is a joint publication of the World Health Organization (WHO) and the World Psychiatric Association (WPA) and is a testimony to the active collaboration between these two organizations. The Atlas also clearly responds to the mandates and visions of the two organizations.

The overall strategic direction of the World Health Organization, Department of Mental Health and Substance Abuse, is to reduce the burden associated with mental, neurological and substance use disorders and to promote mental health worldwide. WHO recognizes that close attention to training of appropriate human resources is crucial to achieving these objectives. Mental Health Atlas-2005 has clearly demonstrated the severe shortfall of mental health professionals, including psychiatrists especially in low and middle income countries. Atlas Psychiatric Training provides further information to assist in planning by countries to reduce this shortfall.

The World Psychiatric Association is an international association of psychiatric societies. Its objectives include to “increase knowledge and skills necessary for work in the field of mental health and in the care for the mentally ill” and “to promote the development of the highest quality standards in psychiatric teaching as well as observance of such standards”. The WPA Secretary for Education and the Education Coordination Center strive to fulfil these objectives. Atlas Psychiatric Training provides critical information for national psychiatric societies to take their work forward in this important area.

At the global level, the Atlas provides an overview of the situation and also documents the existing regional variations. At the country level, it provides some useful information along with references to sources within countries that can provide more information.

We hope that this Atlas is successful in drawing the attention of health and medical education departments of countries to the enormous need for developing plans to establish or reform psychiatric training in their countries. WHO, as well as Member Societies of the World Psychiatric Association are ready to assist them in this important task.

_Benedetto Saraceno_
Director, Department of Mental Health and Substance Abuse
World Health Organization

_Ahmed Okasha_
President
World Psychiatric Association
Preface

We are pleased to present Atlas: Psychiatric Education and Training Across the World.

Project Atlas of the World Health Organization has the primary objective of collecting, compiling and disseminating information on mental health resources on a worldwide scale. Psychiatrists are essential and important human resources to provide mental health care as well as to assist development of policy and services for mental health within the country. The present Atlas provides information on psychiatric education and training from across the world. Like other publications in the Atlas series, the information has been collected using a questionnaire sent to key informants within countries. Since the project has been undertaken jointly by the World Health Organization (WHO) and the World Psychiatric Association (WPA) through its Education Coordination Center, the extensive network of these two organizations were available to support the project. Key informants were largely the office bearers of WPA Components (WPA Member Societies and Members of the WPA Educational Liaison Network), but additional information was collected from WHO Collaborating Centres and Regional Offices.

Shekhar Saxena
Coordinator, Mental Health: Evidence and Research
World Health Organization

The results of Atlas Psychiatric Training reveal a general deficiency and a marked variability in training across the world. Many medium sized countries have either no training facilities or the facilities cater to a very small number of trainees every year. The content of training and the quality also vary considerably. Standards either do not exist or cannot be followed strictly due to a variety of constraints. Inadequate attention is given to making the trainees develop knowledge and skills in activities that they are likely to undertake in actual practice during their professional career. Teaching methods, evaluation, licensing and continuing education all showed considerable scope for improvement within many responding countries.

Though the present Atlas was not able to achieve a high coverage of countries, the findings nevertheless provide a good indication of the areas needing the greatest and the most urgent attention. We hope that the Atlas will facilitate action to make psychiatric education and training more widely available and respond to the critical needs of mental health systems within countries.

Roger Montenegro
Secretary for Education
World Psychiatric Association
Introduction

Countries are under increasing pressure to expand and reform their mental health services and systems. This was anticipated in the World Health Report 2001 (World Health Organization 2001a). Recent research findings have further confirmed the high prevalence of mental disorders (WHO World Mental Health Survey Consortium 2004) and the large burden associated with them (The World Health Report 2004). The World Mental Health Survey, in the analyses of data from 15 countries found that the 12 month prevalence of mental disorders varied between 4.3% in Shanghai, China to 26.4% in the United States of America. Milder disorders were more prevalent than severer ones. The prevalence of moderate and severe disorders was 0.5-9.4% and 0.4-7.7%, respectively, compared to 1.8-9.7% for mild disorders. World Health Organization (2004) also estimates that the burden of neuropsychiatric conditions in Disability Adjusted Life Years is 13% of the total burden of all health conditions and this is likely to increase.

Expansion and reform of mental health services and systems require human and financial resources. Information on mental health resources of the world was almost absent prior to the publication of the findings of the WHO Project Atlas (World Health Organization 2001 b, c). Recent data show that the median distribution of psychiatrists per 100 000 population in the world is 1.2 (SD 6.07) with a variance of 0.04/100 000 population in Africa to 9.8/100 000 population in Europe (World Health Organization 2005). Resources are especially scarce in low and middle income countries (Saxena and Maulik 2003). Researchers have also identified a huge gap in the need for psychiatric care (Kohn et al 2004). The median treatment gap, as evident from the review of 37 studies across regions of the world, was estimated to be 32.2% for schizophrenia and other non-affective psychotic disorders, 56.3% for major depression, 50.2% for bipolar disorder, 78.1% for alcohol abuse and dependence, etc. The WHO World Mental Health Survey Consortium (2004) found that treatment was received by 0.8% to 15.3% of those affected with a mental disorder, the proportion of treatment was higher for severe cases (14.6% – 64.5%) compared to mild cases (0.5% – 35.2%). Overall, the chances of getting treated for any type of disorder was more in developed countries than in less developed countries.

The role of psychiatrists in reducing the burden of mental disorders is quite apparent. Psychiatrists have to play multiple roles if this treatment gap is to be corrected – as clinicians and mental health experts within multidisciplinary teams, as teachers imparting knowledge and skills to students and other staff, as researchers to increase the repertoire of knowledge on mental health, as public health specialists in developing the infrastructure for mental health services and as advocates to increase awareness and needs around mental health issues. These multiple roles require comprehensive initial as well as continuing training of psychiatrists.

Psychiatric training has undergone major development over the past decades and scientific developments in the field of molecular biology, neurobiology, genetics, cognitive neurosciences, neuroimaging, psycho-pharmacology, psychiatric epidemiology and many other related fields have contributed to the increasing growth of psychiatry as a medical discipline (Rubin and Zorumski. 2003). However, very little is known about the availability and quality of psychiatric training imparted to medical students in different countries. As with information on mental health resources, basic information on psychiatric training is especially deficient from low and middle income countries.

The World Health Organization (WHO) along with the World Psychiatric Association (WPA) embarked on an initiative to gather basic information on psychiatric training programmes in all countries of the world, with the aim of generating a knowledge base and using the information to develop or improve psychiatric training facilities in countries. The Atlas: Psychiatric Education and Training Across the World reflects that effort. The project was launched in 2004 after consultations between WPA and WHO. This publication presents the first set of data collected in this project. It is envisaged that this data will require strengthening and updating periodically.

References


Method

This study was undertaken jointly by the World Health Organization (WHO) and the World Psychiatric Association (WPA). At WPA, the work was carried under the direction of the Secretary for Education. At WHO, the work was coordinated by the team of Mental Health: Evidence and Research under the Department of Mental Health and Substance Abuse. The format was that of a cross-sectional assessment in the form of a questionnaire based survey.

Initially, WPA and WHO, identified the need for such a project and defined the areas for assessment. Mental health professionals within WHO, carried out an initial search to identify the different themes that required probing through the questionnaire. Once the themes were identified the next stage involved developing the questionnaire which was done at WHO by a team of mental health professionals. Though no psychometric assessments were done, the questions were framed so that they reflected the different areas of need for assessment. The questionnaire was then sent to the WPA for further modification. After implementing the modifications, WPA Education Coordination Centre (WPA ECC) sent the questionnaires to the National Member Societies. It was sent to 143 National Societies from 121 countries. To reinforce the importance of this project, all WPA Components were informed of the actions to be taken through the WPA Electronic Bulletin and the WPA website. The WPA Zone Representatives and members of the Educational Liaisons Network were specially asked for collaboration regarding those countries in which there were no WPA Member Societies.

The Member Societies were requested to complete the questionnaire and return it to the WPA ECC along with any other supportive documents. Reminders were sent several times. Eventually completed questionnaires were received from 73 countries and one WHO territory. Another attempt was made to contact countries that had not responded through WPA Member Societies as well as WHO contacts within the Regions and countries. Information was gathered about presence or absence of psychiatric training in their country.

An electronic database was generated and the data were entered at the ECC and later analysed by the ECC and WHO. Both quantitative and qualitative data were incorporated. While the quantitative data were analyzed by WHO Regions, World Bank country level income groups and population in countries, the qualitative data were collated in a logical manner and used to highlight certain issues. The population figures were based on the values of the World Health Report 2005 and the income group of the countries was based on the figures obtained from the World Bank website – http://www.worldbank.org/data/countryclass/classgroups.htm (as accessed on 16th February 2005). The income groups according to Gross National Income per capita are – low income (≤$825), lower middle income ($826 – $3255), higher middle income ($3256 – $10 065) and high income (>$10 065). Statistical analysis involved simple frequency distribution and measures of central tendency. Experts within Member Societies were also requested to provide additional information on selected themes which were used to enrich the qualitative data.

The major limitation of the study was the low response rates from the countries. Information on presence or absence of training is available from 179 countries and information on aspects of psychiatric training is available from only 74 countries and WHO Territories. The reasons for this could be many – absence of a training programme; inability to provide aggregated information when the country is large with a lot of diversity in the quality of individual programmes; absence of any functioning psychiatric organization in the country; absence of any known key person with the ability to respond to the questionnaire. Even when they did respond the completion rate was poor. In view of these limitations, the analyses presented could not be generalized to reflect WHO Regional differences. Even differences shown under World Bank income criteria should be judged keeping the above limitations in perspective. The other limitation was that some of the questions required qualitative grading and so were liable to certain degrees of inaccuracy. Some of the other limitations pertaining to specific sections are dealt with under the respective sections.

The final analysis are presented in this volume under themes and supported by tables and graphical representation as charts and maps.
Summary of Results

This project attempted to gather basic information about psychiatric training programmes in the world through the use of a questionnaire. The questionnaire was sent out to 121 countries and responses were received from 73 countries and one WHO territory. This represented only 38% of the 192 countries of the world. Hence, WHO and WPA used other sources to gather more information about the presence or absence of a psychiatric training programme. Eventually, it was found that 122 (68.2%) countries had a psychiatric training programme. This varied from 47.4% countries in Africa Region to 94.1% countries in European Region. When analyzed according to World Bank income group psychiatric training facilities were present in 54.5% of low income countries compared to 77.1% of high income countries. Information on aspects of psychiatric training was however available from 74 countries and WHO Territories.

About half of the countries reported having an accredited diploma or a Master’s degree in psychiatry. Super-specialization in specific areas of psychiatry or a doctoral programme in psychiatry was reported by fewer countries. While 16 countries reported that they had facilities to train more than 45 students in a diploma course, 10 countries reported having facilities to train the same number of students in a Master’s degree. While more than 10 teachers for psychiatry were reported by 32 countries, less than 15 countries had more than 10 teachers in the area of clinical psychology, psychiatric social work and psychiatric nursing. Each country sets specific criterion for training programmes depending on the regulations laid down by its institutions or bodies. Forty-five countries (60.8%) reported the criterion of minimum number of teaching beds with an average of 136 beds. The average outpatient attendance was a criterion in 33 (44.6%) countries. Presence of rehabilitation facilities and support of anaesthetists was a pre-requisite in less than 40% of countries. Presence of open wards, residential facilities, facilities for day-care were reported by 77-87% of countries. Only a third of the low income countries reported that they had open wards in most centres in their respective countries.

The training methods also varied across countries. A written curriculum was present in 63 countries. While a rotation in medicine and neurology was a prerequisite in most centres across a third of the countries, training in psychotherapy, national mental health activities and promoting independence in trainees were encouraged in most centres in only 19-27% of countries. Training in psychotherapy, training in multidisciplinary teams and participation in national mental health activities was reported by two-third of low income countries compared to almost four-fifth of high income countries. Knowledge about – psychopathology and mental disorders and diagnostic and therapeutic skills – were imparted in most centres in more than 60% of countries. However, teaching and managerial skills were taught by fewer centres in some countries only. About half of the countries preferred using case vignettes, case conferences and seminars as the most commonly used teaching techniques. Self-directed learning was a less prevalent technique and was most commonly used in one fourth of countries.

Evaluation of training was done either by oral or written methods during some point of time during the training. Ongoing or end of training evaluation of knowledge by oral methods was the more preferred modes of evaluation in 39 and 46 countries, respectively. Teaching and research skills were evaluated during some point of training in about 55% and 70% of countries, respectively. The commonest assessment methods for examinations as recommended by national bodies were clinical examination (73.0%) followed by essay type answers (66.2%), patient interviews (66.2%), multiple choice questions (63.5%) and dissertation (55.4%). Thirty-three countries used a combination of internal and external examiners to evaluate the trainees.

Information about super-specialization courses was reported by fewer countries. Child psychiatry courses were the most commonly reported super-specialization in psychiatry followed by addiction psychiatry and forensic psychiatry. About half of the countries reported having no bilateral arrangement with another country for postgraduate training. Migration of trained psychiatrists to high income countries was an issue for many low income countries.

While 40 countries reported that they had permanent licensing facilities, 19 countries reported licensing facilities for limited duration only. Different bodies were identified by the countries as having a role in psychiatric training and accreditation of the qualification. The most common were the different Ministries of the Government, Medical/Psychiatric Councils, National Psychiatric institutions and the Psychiatric Societies. Besides being involved in setting guidelines for training and accreditation, these institutions or bodies were also involved in setting a curriculum, maintaining the quality of infrastructure, conducting examinations and arranging seminars for continued medical education.

The results of Atlas: Psychiatric Education and Training Across the World suggest that attention is needed on the quantitative and qualitative aspects of psychiatric training, especially within low and middle income countries. International technical assistance and guidelines in combination with strong professional leadership within the countries are necessary to improve the situation.
Presence of psychiatric training programmes

Salient Findings

Information about the presence of psychiatric training programmes in a country was obtained from all possible sources. Out of the 192 Member States of WHO, psychiatric training was present in 122 countries (63.5%), absent in 57 countries (29.7%) and information was unavailable about 12 countries (See appendix 1 for the list of countries). Countries with a training programme accounted for a total population of 6039.8 million which is 96% of the world’s population. Psychiatric training programmes among the different WHO Regions varied between 47.4% in Africa Region to 94.1% in European Region. Similarly, it was present in 54.5% of low income countries, 68.5% of lower middle income countries, 59.5% of higher middle income countries and 77.1% of high income countries. Seventy-three countries (38% of WHO countries) and one WHO territory (China, Hong Kong, SAR) had responded to the assessment. Completed questionnaires were received from 4/46 countries in Africa, 17/35 in Americas, 6/11 in South East Asia, 31/51 in Europe, 7/22 in Eastern Mediterranean and 9/28 (including Hong Kong, SAR) in Western Pacific. When analysed according to income group of countries, responses were received from 16/66 low income countries, 23/54 lower middle income countries, 17/37 higher middle income countries and 18/36 high income countries and territories (including Hong Kong, SAR).

1.1 Psychiatric education and training across the world

The designations employed and the presentation of material on the above maps do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dashed lines represent approximate border lines for which there may not yet be full agreement.

Pschiatric Training Atlas © WHO 2005
**Limitations**

Presence of a training facility neither provides sufficient information regarding the quality of training provided nor the uniformity of training across the country.

**Implications**

Expansion of psychiatric training is needed in all but the smallest low income countries. Psychiatric training is best carried out within the country so that the training can be most appropriate for the needs of the mental health system within the country. Regional collaboration on training would be beneficial to all countries especially those with inadequate resources and training facilities. This would also benefit the smallest low income countries (e.g., some of the island countries in the Western Pacific Region that have a small population and limited resources) which would find it extremely difficult to develop their own training facilities.
Training programmes and infrastructure

Salient Findings

Thirty-one countries reported having at least one accredited postgraduate diploma course and 35 countries reported the presence of at least one accredited Master’s programme. Twenty-three countries reported having at least one accredited super-specialization course in areas like child psychiatry, addiction psychiatric, geriatric psychiatry, and 22 countries had at least one doctoral course. While super-specialization was not reported by any of the Eastern Mediterranean countries, more than half of the countries from Europe had super-specialization within the country. Only two out of the seven countries reporting from Eastern Mediterranean Region and three out of the nine countries reporting from the Western Pacific Region had a Master’s course.

The minimum duration of training varied to a great degree among countries. While 22 countries out of 74 reported 3-4 years training for diplomas, 28 countries reported the same time frame for the Master’s programme. Super-specialization required 1-2 years in 18 out of the 35 countries reporting on it. PhD training was generally completed in 3-4 years in 22 countries that reported its presence.

Diplomas were the most common postgraduation training offered to students, with 16 countries reporting more than 45 students each per year. Master’s programmes were also offered in large numbers, with 10 countries reporting that they trained more than 45 students each per year. Fourteen countries reported having at least 15 students in their Master’s programme. Super-specialization training was provided to 1-15 students per year in 17 countries and PhD was offered to 1-15 students per year in 21 countries. Facilities to train more than 15 students in super-specialities and doctorate degrees were reported by nine and four countries, respectively.

<table>
<thead>
<tr>
<th>Criteria for recognition of postgraduate training programmes in psychiatry</th>
<th>Yes</th>
<th>No</th>
<th>No information</th>
<th>Average outpatient attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of teaching beds</td>
<td>13.5%</td>
<td>25.7%</td>
<td>61.0%</td>
<td></td>
</tr>
<tr>
<td>Facilities for rehabilitation</td>
<td>27%</td>
<td>39.2%</td>
<td>33.8%</td>
<td></td>
</tr>
<tr>
<td>Facilities for dangerous patients</td>
<td>13.5%</td>
<td>55.4%</td>
<td>31.1%</td>
<td></td>
</tr>
<tr>
<td>Support of anesthesiology</td>
<td>29.7%</td>
<td>39.2%</td>
<td>31.1%</td>
<td></td>
</tr>
<tr>
<td>Psychological testing</td>
<td>23%</td>
<td>23%</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td>Neurophysiological testing</td>
<td>21.6%</td>
<td>68.9%</td>
<td>9.5%</td>
<td></td>
</tr>
<tr>
<td>Library facilities</td>
<td>27%</td>
<td>56.8%</td>
<td>16.2%</td>
<td></td>
</tr>
<tr>
<td>Facility for biostatistics</td>
<td>25.7%</td>
<td>41.9%</td>
<td>32.4%</td>
<td></td>
</tr>
</tbody>
</table>
The number of recognized postgraduate teachers varied according to the discipline. While more than 10 teachers for psychiatry were reported by 32 countries; clinical psychologists, psychiatric social work and psychiatric nursing teachers were fewer in numbers. Out of the countries responding, more than 10 teachers in clinical psychology, psychiatric social work and psychiatric nursing were reported by 15, nine and eight countries, respectively.

The minimum criteria for training could be broadly divided into two groups – those related to psychiatry directly like number of teaching beds, facilities for rehabilitation and psychological testing; and general infrastructure like biochemical testing, radiology, support of anaesthetists, library facilities, biostatistics, access to ethics committee. Forty-five countries (60.8%) reported the criterion of minimum number of teaching beds with an average of 136 beds. The average outpatient attendance was a criterion in 33 (44.6%) countries. Presence of facilities for rehabilitation and anaesthetists support was a prerequisite in less than 40% of countries. Presence of psychological, biochemical, radiological and neurophysiological testing was a prerequisite in 43-50% of countries.

Specified training facilities like the presence of open wards, residential facilities and facilities for day-care were reported by 77-87% of countries. Audio-visual aids, computing facilities and access to electronic databases and subscription to five or more psychiatric journals were reported to be present in 77-85% of countries. Rehabilitation facilities and facilities for forensic patients though present in many countries, was available in a few centres in most of the countries. While quantifying the number of centres within a country having the above facilities, low income countries reported that only a third of them had open wards in most centres. The remaining facilities were present in most centres in less than 10% of countries. This contrasts with the report from higher middle income and high income countries, which reported having all the training facilities in most centres in 40-65% of countries. But even for them, rehabilitation and forensic psychiatry facilities were present in fewer centres.
The quality of psychiatric training varies to a large extent across countries. Even within countries there are areas of training which are particularly weak. Turkey has good training opportunities in biological psychiatry, psychopharmacology and psychiatric nosology. On the other hand, training opportunities in psychotherapy, community psychiatry, forensic psychiatry and cultural and administrative issues are relatively less. Bolivia has modules on epistemology, statistics, community care, epidemiology and methodology of scientific research as a part of their psychiatric training. Psychiatric training in Syria started seven years ago. The trainees are based in two mental asylums and the curriculum is under-developed. There are no facilities for psychotherapy, social work and quality research. The quality of training is poorly monitored and there are no licensing laws. In contrast, postgraduate psychiatric training in Australia and New Zealand is essentially an apprenticeship model, with great emphasis placed on a particular set of clinical rotations and careful clinical supervision. The college maintains an accreditation process and oversight of all of those clinical placements and the documented supervision. In addition, there are formal, more academic programmes which vary a lot from place to place, but usually occupy one or two half days per academic year, for three to five years. Those courses cover the standard knowledge base relevant to clinical psychiatry e.g. relevant pre-clinical disciplines, biological psychiatry, psychological and social sciences, psychotherapy, ethics. Psychiatric training in Sweden is for a period of five years and the curriculum is established by the Swedish National Board of Health with cooperation from professionals in the Swedish Medical Association and the Swedish Board of Psychiatry. The curriculum is set to be revised in 2006.

The M.Med Psychiatry course in Tanzania consists of six semesters and includes basic sciences courses and theoretical and skill modules specific to the discipline of psychiatry and mental health. Basic science courses include physiology and clinical pharmacology, biochemistry, microbiology/immunology, epidemiology and biostatistics. Apart from clinical psychiatry, medical, sociological, anthropological and psychological disciplines are part of the course. A structured supervised dissertation is an essential part of the curriculum.

In Tunisia, the curriculum lasts four years during which residents are encouraged to spend a six-month training period in child psychiatry and in neurology. Many residents are offered a one-year training period abroad, mainly in France to increase their knowledge in an area not available in Tunisia e.g. cognitive behavioural therapy or neuroimaging. Psychiatric training in China lasts for three years. A doctoral programme on the other hand extends for 5-6 years. There is no specific programme devoted solely to psychiatry in Kuwait. However, the Kuwait Institute for Medical Specialization (KIMS) runs a specialist programme, for which the native Kuwaiti doctors involved do rotation in the psychiatric hospital.

Limitations

Though WPA has defined criteria for diploma, Master’s and super-specialization programmes, it is possible that many countries have different definitions. Thus there is a variance in the data, both in number of programmes and time frame. For example, the United Kingdom and Australia/New Zealand have different nomenclatures for postgraduate training to the one specified in the question.

The time frame could also vary depending on how the respondents had calculated the beginning of the course, e.g. the training period for Master’s degree within the super-specialization period, may or may not have been included.

Implications

Despite the availability of the WPA curriculum for training of psychiatrists, there is a large amount of variance in both the nomenclature and period of training. This leads to a huge disparity in the quality of training across countries and even within countries. Though, it is desired that each country should cater to its own needs and the training programme should incorporate those needs, there should be some common standard which all training programmes should adhere to.

The basic training requirements should be standardized and a broad guideline should be followed. Forensic psychiatry and rehabilitation facilities were fewer in all countries across the world. It is surprising to find that less than 40% of countries have rehabilitation facilities and anaesthetist support as a pre-requisite, given that psychiatric conditions are chronic in nature and require long-term management and rehabilitation. Anaesthetist support is generally considered essential for administering electroconvulsive therapies. Low income countries need to increase their training resources in definite even though small steps to reach the standards generally prevalent in higher income countries.
### 2.3 Proportion of centres for postgraduate psychiatric training in the country with specified training facilities or aids across income group of countries

<table>
<thead>
<tr>
<th>Facilities for training</th>
<th>Low</th>
<th></th>
<th>Lower middle</th>
<th></th>
<th>Higher middle</th>
<th></th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=16</td>
<td>%</td>
<td>N=23</td>
<td>%</td>
<td>N=17</td>
<td>%</td>
<td>N=18</td>
</tr>
<tr>
<td><strong>Open wards</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>few</td>
<td>5</td>
<td>31.3</td>
<td>9</td>
<td>39.1</td>
<td>2</td>
<td>11.8</td>
<td>0</td>
</tr>
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Training curricula and teaching methods

Salient Findings

The structure of training for a diploma as well as a Master’s degree varied across countries. A written curriculum was present in 63 countries. Rotation in medicine, neurology and multidisciplinary team work was a prerequisite in most centres across one third of the countries. Training in psychotherapy, national mental health activities and promoting independence in trainees were encouraged in most centres in 19-27% of countries. One third of the countries had scope for continued medical education and kept records of dissertation in most of their centres. Out of those responding to the questionnaire, about 70-80% of countries across the Americas and the European Region, had facilities for medical and neurology rotation, psychotherapy training and participation in national mental health activities. Training in psychotherapy, training in multidisciplinary teams and participation in national mental health activities was reported by two thirds of low income countries compared to almost four fifths of high income countries.

Among the training skills imparted to trainees – knowledge about psychopathology, diagnostic interview and clinical skills, knowledge of mental disorders and diagnostic and therapeutic skills – were present in most centres in more than 60% of countries. About a third of the countries reported that most centres provided training in psychotherapy, genetics and basic neuroscience, psychology, research methodology including biostatistics and ethics and public health psychiatry. Teaching and managerial skills were taught by a few centres in one third of countries.

While case vignettes, case conferences and seminars were the most commonly used teaching techniques in 50-60% of countries, discussion on ethics and self-directed learning was commonly used in about one fourth of the countries.
### 3.2 Proportion of centres for postgraduate psychiatric training in the country with specified training arrangements across different income group of countries

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The approach to psychiatric training has been different across countries. The United States of America has recently focused on biological psychiatry with some centres having a greater focus on psychotherapy. There is scope for imparting different forms of psychotherapy to those interested. In Slovakia, psychotherapy is an integral part of specialization within psychiatry and includes cognitive-behavioural therapy and psychodynamic therapy covering 120 hours of training. This includes both theoretical courses and compulsory supervised sessions. Psychotherapy is part of the programme of postgraduate training in psychiatry in Spain, since it was developed in the 1970s. Interested students can pursue psychotherapy training for a full one year of their four-year training period. However, not all countries are able to provide uniform training in psychotherapy. For example, Turkey has seen a recent improvement in psychotherapy training following the development of a written curriculum and formation of a training board, but even then, training facilities in psychotherapy are available in only a few centres.

Neurology and neuroimaging are important components of psychiatric training as many psychiatric disorders have overlapping neurological problems. Many neurological disorders also present with psychiatric symptoms. In Pakistan, psychiatrists are trained in neurology and neuroimaging. The training includes basic introduction to neuroimaging with respect to major psychiatric disorders such as schizophrenia, depression and obsessive compulsive disorder. There is an emphasis on neurological examination. In the United States of America, all residents in psychiatry must complete a minimum of two months of training in neurology. The emphasis is often on both the common neurological disorders likely to be seen in psychiatry practice, and issues at the intersection of the two disciplines, such as presentations of neurological disorders with mental status changes, and of psychiatric disorders with neurological symptoms.

Psychiatric training on law and ethics is conducted in only a few specialized centres of forensic medicine or forensic psychiatry. In some countries e.g. India and Turkey, often the only exposure to forensic psychiatry in most centres is through a reference to the laws related to mental health in national meetings and the laws pertaining to forensic psychiatry.

Public health aspects of mental health are often neglected and even in a high income country e.g. the United States of America, there are limited lectures on economics, quality of services and public health issues.

Training psychiatrists on issues related to cultural sensitivity are part of the training in some countries e.g. Switzerland and Denmark. In the latter, there are both introductory courses and a few lectures focusing on the cultural issues relevant to psychopathology and treatment. Uganda trains its psychiatrists in different culture bound syndromes and provides some idea about the treatment methods followed by traditional healers.
Limitations

No method could be developed under Atlas to reliably determine the quality of psychiatric teaching and training. Since a number of countries have responded that they have a large number (‘many’ / ‘most’) as well as ‘few’ centres with different types of training methods, it is difficult to form a specific idea about variation of psychiatric training within countries. However, the Atlas data show that there is a lot of heterogeneity in the quality of training across countries and also within a country.

Implications

The quality of training across different countries varies widely. Even within countries there are differences across centres.

The variance is not only due to the method of teaching but also due to the content taught. Public health psychiatry, training in teaching and managerial skills are offered by fewer centres. The implications of this may be that there are fewer psychiatrists in teaching and managerial posts.

Research experience is often in the form of a dissertation and no formal research training is imparted.

Students are not encouraged to develop their own skills in most centres as few centres offer self-directed training. Joint conferences with allied discipline and research conferences are few and the training is heavily weighted towards clinical psychiatry and somatic therapies.
Evaluation of Training

Salient Findings

Evaluation is an important component of education and training. Countries reported that knowledge, skills, attitude and clinical acumen were evaluated by written and oral examinations as part of ongoing and end of training evaluation. Ongoing or end of training evaluation of knowledge by oral methods was the more preferred modes of evaluation in 39 and 46 countries, respectively. Managerial, teaching and research skills were evaluated during some point of training in about 40%, 55% and 70% of countries, respectively. Research was the only skill that was evaluated more through written format. This was most likely due to the fact that the assessment was often based on a dissertation submitted by the trainee.

There are some similarities in evaluation across countries. For example, in Slovakia, the 12 weeks of final educational activities are followed by a specialization examination. Each candidate has to submit a thesis on a selected topic before the specialization examination. In India, the evaluation depends on a mixture of a written and oral examination that tests theoretical and practical skills of the psychiatry trainees. Examinees are also assessed on clinical skills. Each Master's, super-specialization and doctoral programme trainee needs to submit a thesis/dissertation as part of the evaluation. However, diploma programme trainees need not submit a dissertation.

The commonest assessment methods for examinations as recommended by national bodies were clinical examination (73.0%), essays (66.2%), patient interviews (66.2%), multiple choice questions (63.5%) and dissertation (55.4%).

While 33 (44.6%) countries used a combination of internal and external examiners to evaluate the trainees, 25 (33.8%) countries used only internal examiners. An independent or accrediting body to evaluate the trainees was used by 20.3% and 21.6% of countries, respectively.

### 4.1 Content area, phase of training and format of evaluation

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Ongoing evaluation</th>
<th>End of training evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=74</td>
<td></td>
</tr>
<tr>
<td>Knowledge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>oral</td>
<td>39</td>
<td>46</td>
</tr>
<tr>
<td>written</td>
<td>31</td>
<td>40</td>
</tr>
<tr>
<td>Skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>oral</td>
<td>38</td>
<td>40</td>
</tr>
<tr>
<td>written</td>
<td>27</td>
<td>30</td>
</tr>
<tr>
<td>Attitudes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>oral</td>
<td>35</td>
<td>37</td>
</tr>
<tr>
<td>written</td>
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<tr>
<td>Clinical</td>
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<td>43</td>
</tr>
<tr>
<td>written</td>
<td>29</td>
<td>34</td>
</tr>
<tr>
<td>Teaching</td>
<td></td>
<td></td>
</tr>
<tr>
<td>oral</td>
<td>24</td>
<td>22</td>
</tr>
<tr>
<td>written</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td>Research</td>
<td></td>
<td></td>
</tr>
<tr>
<td>oral</td>
<td>24</td>
<td>22</td>
</tr>
<tr>
<td>written</td>
<td>26</td>
<td>30</td>
</tr>
<tr>
<td>Managerial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>oral</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>written</td>
<td>11</td>
<td>13</td>
</tr>
</tbody>
</table>
Limitations

The available information is inadequate to form a clear idea about the exact modalities and qualities of evaluation for psychiatric training and education. Moreover, there are likely to be large differences across centres within countries that have not been investigated.

Implications

The assessment method should be harmonized within the country and some standards and benchmarks developed following minimum international criteria.

4.3 Authorized body to conduct the end of training examination across WHO Regions

<table>
<thead>
<tr>
<th>Authorized bodies</th>
<th>World n (N=74)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training programme internal examiners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>25</td>
<td>33.8</td>
</tr>
<tr>
<td>no</td>
<td>24</td>
<td>32.4</td>
</tr>
<tr>
<td>unrated</td>
<td>25</td>
<td>33.8</td>
</tr>
<tr>
<td>Training programme internal &amp; external examiners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>33</td>
<td>44.6</td>
</tr>
<tr>
<td>no</td>
<td>18</td>
<td>24.3</td>
</tr>
<tr>
<td>unrated</td>
<td>23</td>
<td>31.1</td>
</tr>
<tr>
<td>Independent board</td>
<td></td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>15</td>
<td>20.3</td>
</tr>
<tr>
<td>no</td>
<td>28</td>
<td>37.8</td>
</tr>
<tr>
<td>unrated</td>
<td>31</td>
<td>41.9</td>
</tr>
<tr>
<td>The accrediting body</td>
<td></td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>16</td>
<td>21.6</td>
</tr>
<tr>
<td>no</td>
<td>25</td>
<td>33.8</td>
</tr>
<tr>
<td>unrated</td>
<td>33</td>
<td>44.6</td>
</tr>
</tbody>
</table>

4.2 Criteria for recognition of postgraduate training programmes in psychiatry

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Yes</th>
<th>No information</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essays</td>
<td>27%</td>
<td>6.8%</td>
<td>66.2%</td>
</tr>
<tr>
<td>Clinical examination</td>
<td>6.7%</td>
<td>20.3%</td>
<td>73%</td>
</tr>
<tr>
<td>Objective structured clinical exam</td>
<td>24.3%</td>
<td>29.7%</td>
<td>46%</td>
</tr>
<tr>
<td>Multiple choice questions</td>
<td>31.1%</td>
<td>9.5%</td>
<td>59.4%</td>
</tr>
<tr>
<td>Chat stimulated recall</td>
<td>17.6%</td>
<td>16.2%</td>
<td>66.2%</td>
</tr>
<tr>
<td>Dissertation/project material</td>
<td>23%</td>
<td>155.4%</td>
<td>21.6%</td>
</tr>
<tr>
<td>Log book/training check list</td>
<td>24.3%</td>
<td>43.3%</td>
<td>32.4%</td>
</tr>
</tbody>
</table>
Super-specialization and bilateral arrangement

Definition

Super-specialization – degree programmes are those that are approved by national authorities (e.g. from the Department of Medical/Psychiatric Education or Medical/Psychiatric Council) for advanced studies beyond the degree in general psychiatry.

Salient Findings

Information on speciality psychiatric training was reported by fewer countries. Twenty-nine countries reported that they had at least one child psychiatric training programme in the country. Fourteen countries reported having a drug de-addiction training programme and 15 countries reported having a forensic psychiatric training programme. Training in other psychiatric super-specializations were reported by even fewer countries.

About half of the countries had no bilateral arrangement with other countries for postgraduate training. Those having some agreement (28/74) had it usually in the form of sending students to a more developed country. Only 11 countries reported having facilities to both send and receive students from countries with which it had such arrangements.

Thirty five countries reported that less than 500 psychiatrists were still residing within the country and 11 countries reported that more than 30 of their psychiatrists had trained abroad.

While in some countries super-specialization is more common, in others there are no or only a few opportunities. Super-specialization in psychiatry, in Argentina, is available in different areas – child psychiatry, consultation-liaison psychiatry, drug de-addiction, forensic psychiatry, geriatric psychiatry and neuropsychiatry. More than 500 psychiatrists have been trained since the first programmes started, more than 15 years ago. Teachers have been trained in Europe and USA. In addition, there are several Master’s programmes in fields such as neuropsychosendocrinology, neuropsychopharmacology and stress trauma and disaster interventions. In India, super-specialization in child psychiatry is available only in one centre and limited seats are offered. The course involves training in different aspects of child psychiatry over a two year period and the evaluation is in the form of an examination. There are no other courses available for super-specialization in India, though discussion is underway to start a course in addiction psychiatry in another institute.

Migration of psychiatrists to high income countries from low and lower-middle income countries is an increasing common phenomenon. Nearly 10% of the 200 psychiatrists from Tunisia have settled abroad in France and in Canada. Uganda has also faced similar problems. India has reportedly lost more than 200 locally trained psychiatrists to high income countries during the last three years. This has led to worsening situations with respect to mental health resources and service delivery in the these countries.

PsycHiatric Training Atlas © WHO 2005
Limitations

The definition of super-specialization varies across countries as does the training requirements and time periods. It is not possible to ascertain the exact number or the quality of the training programmes through the present exercise.

Information on bilateral training arrangement does not specify the licensing methods applicable to foreign trainees. It also does not specify the quality of training provided or the regional differences.

No information was collected regarding the proportion of psychiatrists residing in the country out of the total pool of psychiatrists trained within the country.

Implications

Advanced training in psychiatric disciplines is still in its infancy and a lot needs to be done. Since advanced training in psychiatry is followed differently across countries there is a need to develop a common framework of understanding across countries to define the concept. The period of training needs to be standardized.

Bilateral arrangement between countries is possible only when training facilities are recognized between countries. Given the wide variance in training programmes it is not surprising that bilateral arrangement exists between a few countries only.

Migration of psychiatrists from resource poor developing countries to more developed countries is gaining immense proportions to the detriment of the poorer countries. The median number of psychiatrists per 100 000 population in the world is estimated at 1.2 (SD 6.07) (World Health Organization 2005) with the median number within low income countries being as low as 0.05/100 000 population. Continued migration of trained psychiatrists will further affect mental health services as well as psychiatric training in these countries.
Definitions

Departments of Medical/Psychiatric Education of national governments are bodies at the level of the national government that are responsible for setting guidelines on psychiatric education. These may be a part of the Directorate of Education or of Health.

National Medical/Psychiatric Councils are bodies that are responsible for providing criteria for accreditation of psychiatric training programmes and ensuring standards of psychiatric education.

Other organizations/institutions providing guidelines about psychiatric training are non-governmental organizations which have traditionally held or have been delegated the task of providing guidelines for or ensuring standards of psychiatric education in the country.

Accrediting bodies ensure that training programmes meet minimal laid down criteria for initial and continued recognition. It may be the National Medical/Psychiatric Council or another body.

Salient Findings

While 40 countries had permanent licensing, 19 countries said that they had licensing for limited duration only. Continued medical education was cited as a requirement for maintaining a license in 12 out of the 16 countries responding to that question.

The main roles of the national institutions in psychiatric training have been developing courses for training, developing mental health services and licensing and accreditation. Setting the curriculum and procedure for examination and conducting courses for continued medical education are also some of the other functions. While countries with limited resources often have one major psychiatric institute coordinating the training programme in the whole country (e.g. Cambodia), those with more resources have a number of institutes and governmental bodies coordinating the training programme (e.g. Argentina). The Ministry of Health or Ministry of Education are the two commonest governmental offices responsible for overall training, but often the actual function is carried out by the Medical Councils or specific institutions (e.g. The Royal College of Psychiatrists in the United Kingdom).

The Medical/Psychiatric Councils are mainly involved in developing the curricula for psychiatric training and conducting examinations according to predetermined criteria (e.g. Israel, Tunisia). Some are also involved in accreditation (e.g. Mexico, Thailand). These councils are also responsible for maintaining the quality of training programmes across the country and standardizing the minimum infrastructure required to train a resident. The national psychiatric societies perform supportive role in the training programme. They often provide expert opinion on guidelines set by the Medical/Psychiatric Councils and Ministries (e.g. Poland and the Russian Federation). They also organize courses and seminars and facilitate continued medical education (e.g. France and Georgia). The psychiatric societies also help to build a network of psychiatrists who work collectively to improve the standards of training within countries and across other countries, too.

Some of the roles of the institutes or bodies associated with psychiatric training programme in some countries are worth noting. Since 2001, psychiatric training in Slovenia is organized according to the Charter of Training, produced by U.E.M.S., Board of Psychiatry. The quality of training is also assessed. In India, the Medical Council of India is responsible for postgraduate medical training. The Indian Psychiatric Society supports psychiatric training by conducting various workshops, seminars on continued medical education and provides expert opinion to the government when required. The main national body for coordination of postgraduate training in Slovakia is the Slovak Medical University and its main functions are to provide training courses and organize examinations for evaluation. The Education and Curriculum Commission on Psychiatry in Turkey, set minimum standards and requirements for psychiatric education last year. Accordingly a programme for postgraduate education in psychiatry was formed based on the WPA Core Curriculum. The Ministry of Health of Turkey started to develop a standard training curriculum in medical specialties and the Psychiatric Association of Turkey recently formed the Turkish Board of Psychiatry which would have the function of monitoring the training institutions.
**Limitation**

Apparently there are a number of overlapping functions of different bodies with respect to psychiatric training. However, it is not clear to what extent the functions overlap and how do these bodies coordinate their activities.

**Implications**

Though licensing and accreditation are governed by national laws, there is a need to have clear international guidelines and minimal standards for accreditation to practice as a psychiatrist.

For some countries it may be worthwhile to streamline the function of several bodies involved with psychiatric education and training to avoid duplication.
Psychiatric education and training across a high income and a low income country

Psychiatric training aims to serve the countries’ mental health services needs, which vary widely across the world. A comparison of training programmes in two countries – Switzerland (high income country) and Uganda (low income country) follows. It is apparent that there are some basic differences in the mode of training, especially in the area of duration and standardization of the quality of training. Switzerland is an example of high level of resources for its small population, whereas, Uganda typifies a low income country with minimal resources for a large population. Despite the differences in training, there are some basic similarities in the principles of training pursued by these two countries. The complete description of the case studies is given in the appendix 3.

<table>
<thead>
<tr>
<th></th>
<th>Switzerland</th>
<th>Uganda</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current resources</td>
<td>2229 psychiatrists for 7.2 million population</td>
<td>18 psychiatrists for 25.8 million population</td>
</tr>
<tr>
<td>Psychiatric training</td>
<td>6 years residency, standardized curricula, stringent accreditation policies</td>
<td>3 years residency</td>
</tr>
<tr>
<td>Biological psychiatry</td>
<td>Standardized and fixed period of training in different aspects of biological psychiatry</td>
<td>1st year of postgraduate training imparts skills in biological psychiatry This is hampered by lack of modern laboratories</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>3 years training in analytical or cognitive behavioural therapy</td>
<td>Mainly theoretical knowledge with some practical training in cognitive behavioural therapy over one semester</td>
</tr>
<tr>
<td>Psychology and social science</td>
<td>Basic theoretical knowledge about psychology, sociology and anthropology is provided Interpretation of psychological assessments are taught</td>
<td>Basic theoretical background in social sciences is taught Interpretation and application of psychological tests in diagnosis is also provided</td>
</tr>
<tr>
<td>Neurology and neuroimaging</td>
<td>Provision of a one year rotation in somatic therapy and neurology could be an option during that period Adequate exposure to different neuroimaging and neurophysiological tests are provided</td>
<td>Neurological skills are taught during the training Exposure to modern neuroimaging and neurophysiological tests is limited by the lack of resources across all centres in the country</td>
</tr>
<tr>
<td>Rational prescription</td>
<td>Evidence-based practice is encouraged and taught</td>
<td>Molecular pharmacology and psychopharmacology is taught during the course rational prescription practices are imparted</td>
</tr>
<tr>
<td>Research</td>
<td>Epidemiological and statistical training is provided as a course requirement Individual skills and research interests can be gained through an optional one-year posting in a research centre</td>
<td>Basic research skills in statistics and epidemiology are taught as part of the compulsory dissertation submitted by all students as part of their course requirement</td>
</tr>
<tr>
<td>Public health and health economics</td>
<td>Public health principles and health economics as applied to mental health are taught</td>
<td>Basic principles in public health and macro-economics as applied to financing of mental health systems are provided</td>
</tr>
<tr>
<td>Law and ethics</td>
<td>Provision for stipulated period of training in laws and principles of ethics as applied to the country</td>
<td>Mental health legislation and its relevance to practice are taught as part of forensic psychiatry principles</td>
</tr>
<tr>
<td>Cultural sensitivity</td>
<td>Aspects of transcultural psychiatry and social psychology are emphasized during training to improve the communication skills and psychiatric understanding of multi-ethnic clients</td>
<td>Knowledge about culture bound syndromes and traditional healing practices are imparted during the training period</td>
</tr>
<tr>
<td>Others</td>
<td>Migration of psychiatrists is not a major issue</td>
<td>Uganda is severely affected my migration of its limited number of psychiatrists to high income countries</td>
</tr>
</tbody>
</table>
## Psychiatric education and training across the world

### WHO African Region
- Algeria
- Angola
- Benin
- Botswana
- Burkina Faso
- Burundi
- Cameroon
- Cape Verde
- Central African Republic
- Chad
- Comoros
- Congo
- Côte d’Ivoire
- Democratic Republic of the Congo
- Equatorial Guinea
- Eritrea
- Ethiopia
- Gabon
- Gambia
- Ghana
- Guinea
- Guinea-Bissau
- Kenya
- Lesotho
- Liberia
- Madagascar
- Malawi
- Mali
- Mauritania
- Mauritius
- Mozambique
- Namibia
- Niger
- Nigeria
- Rwanda
- Sao Tome and Principe
- Senegal
- Seychelles
- Sierra Leone
- South Africa
- Swaziland
- Togo
- Uganda
- United Republic of Tanzania
- Zambia
- Zimbabwe

### WHO Region of the Americas
- Antigua and Barbuda
- Argentina
- Bahamas
- Barbados
- Belize
- Bolivia
- Brazil
- Canada
- Chile
- Colombia
- Costa Rica
- Cuba
- Dominica
- Dominican Republic
- Ecuador
- El Salvador
- Grenada
- Guatemala
- Guyana
- Haiti
- Honduras
- Jamaica
- Mexico
- Nicaragua
- Panama
- Paraguay
- Peru
- Saint Kitts and Nevis
- Saint Lucia
- Saint Vincent and the Grenadines
- Suriname
- Trinidad and Tobago
- United States of America
- Uruguay
- Venezuela

### WHO South-east Asia Region
- Bangladesh
- Bhutan
- Democratic People’s Republic of Korea
- India
- Indonesia
- Maldives
- Myanmar
- Nepal
- Sri Lanka
- Thailand
- Timor-Leste

### Notes
- Yes
- No
- No information
WHO European Region
- Albania
- Andorra
- Armenia
- Austria
- Azerbaijan
- Belarus
- Belgium
- Bosnia and Herzegovina
- Bulgaria
- Croatia
- Cyprus
- Czech Republic
- Denmark
- Estonia
- Finland
- France
- Georgia
- Germany
- Greece
- Hungary
- Iceland
- Ireland
- Israel
- Italy
- Kazakhstan
- Kyrgyzstan
- Latvia
- Lithuania
- Luxembourg
- Malta
- Monaco
- Netherlands
- Norway
- Poland
- Portugal
- Republic of Moldova
- Romania
- Russian Federation
- San Marino
- Serbia and Montenegro
- Slovakia
- Slovenia
- Spain
- Sweden
- Switzerland
- Tajikistan
- The former Yugoslav Republic of Macedonia
- Turkey
- Turkmenistan
- Ukraine
- United Kingdom
- Uzbekistan

WHO Eastern Mediterranean Region
- Afghanistan
- Bahrain
- Djibouti
- Egypt
- Iran (Islamic Republic of)
- Iraq
- Jordan
- Kuwait
- Lebanon
- Libyan Arab Jamahiriya
- Morocco
- Oman
- Pakistan
- Qatar
- Saudi Arabia
- Somalia
- Sudan
- Syrian Arab Republic
- Tunisia
- United Arab Emirates
- Yemen

WHO Western Pacific Region
- Australia
- Brunei Darussalam
- Cambodia
- China
- Cook Islands
- Fiji
- Japan
- Kiribati
- Lao People’s Democratic Republic
- Malaysia
- Marshall Islands
- Micronesia (Federated States of)
- Mongolia
- Nauru
- New Zealand
- Niue
- Palau
- Papua New Guinea
- Philippines
- Republic of Korea
- Samoa
- Singapore
- Solomon Islands
- Tonga
- Tuvalu
- Vanuatu
- Viet Nam

Yes
No
No information
**WPA's activities in psychiatric education and training**

**World Psychiatric Association Institutional Program on the Core Training Curriculum for Psychiatry**

The World Psychiatric Association (WPA) developed the plan to provide a core training curriculum for psychiatry at the postgraduate level following the production of the "Core Curriculum in Psychiatry for Medical Students", which was done together with the World Federation for Medical Education.

A clear premise for this programme was not to impose a psychiatric curriculum originating in developed countries on other regions of the world. On the contrary, the underlying idea was to share educational expertise and experiences from psychiatric trainers from all over the world, so as to maintain the sensitivity and recognition of the very many realities co-existing in different parts of the world.

The World Psychiatric Association has produced and implemented many educational programmes for the benefit of those seeking continuing medical education.

The WPA has worked together with the World Federation for Medical Education and the World Health Organization to close the gap between psychiatry and the rest of medicine, promote a better understanding of mental illness and care for the mentally ill and strive to introduce improvements to medical education.

The WPA has developed a variety of educational programmes in conjunction with WHO (ICD 10 Training Kit, International Guidelines for Diagnostic Assessment), with the WFME (Core Curriculum in Psychiatry for Medical Students), through its Scientific Sections (Mental Health in Mental Retardation, Autism and Related Disorders, International Guidelines for Diagnostic Assessment, Sexual Health), etc. These can be found at http://www.wpanet.org/education/edu4a.html and downloaded for immediate use.

Besides these, there is a Declaration on Ethical Standards for Psychiatric Practice (Madrid Declaration) which is an ethical guideline for the practice of psychiatry, and some position and consensus statements and are available online at: http://www.wpanet.org/about/ethic1.html and http://www.wpanet.org/institutional/consensus.html

Other publications are: World Psychiatry (the official Journal of the WPA), Science and Care and a number of publications on different aspects of psychiatry like depressive disorders, schizophrenia, dementia, etc. series on mental health care, psychiatric education, psychobiological research, epidemiology of psychiatric disorders, child and adolescent psychiatry and geriatric psychiatry in different countries; and "Anthologies in Psychiatry" focusing on French, Spanish, and Italian classical texts.

Scientific meetings and educational activities are also held for the continuing medical education of psychiatrists.

The reviewed Core Curriculum in Psychiatry for Medical Students, was produced together with the World Federation for Medical Education and the World Health Organization. It was aimed at equipping all future doctors with the skills necessary to identify and treat mental illness and disability. It deals with both the teaching of psychiatry and the clinical policy involved in the practice of medicine. The educational objectives of this Core Curriculum focus on attitudes, knowledge and skills to be acquired by students. In the proposed teaching process, the student is given an active role. The programme also deals with methods of teaching and learning and methods of assessment.

The main educational aim was to build the core elements of a training curriculum in psychiatry, so as to create competent psychiatrists all over the world, who will ensure the highest quality of psychiatric services. Ethical principles and patients’ rights were also very important in this context. The result is a programme that focuses on knowledge, skills, attitudes, type of clinical rotations, and evaluation components. Details of the programme are available online at:

http://www.wpanet.org/institutional/programs2.html.

The core curriculum has been introduced in many medical schools around the world. The aim has been to broaden the scope of psychiatric training across the world while maintaining a standard quality with special reference to local needs and cultural issues.
Case study: A comparison in psychiatric training

Switzerland

Psychiatry as a recognized medical specialty has a long history going back to the early years of the 19th century. The first psychiatric asylum, in Lausanne, was founded in 1810, followed by other institutions, and about 100 years later appeared the first out-patient institutions.

The first committee of “alienists” inside the Société helvétique des sciences naturelles was established in 1850, to become the Association of Swiss Alienists in 1864. Earlier, psychiatry started being taught in medical school (Wilhelm Griesinger, Zurich). The separation of neurology from psychiatry took place before World War I, different opinions regarding psychoanalysis being a factor in the split. The first training curriculum was issued by the Swiss Society of Psychiatry in 1922. The year 1927, saw the first board examination for psychiatry as a specialty and the issuing of diplomas. Further milestones were the separation of child psychiatry as a separate specialty in 1954 and the introduction of the double title psychiatry-psychotherapy in 1961. The Swiss Society of Psychiatry and Psychotherapy (SSPP) have approximately 1400 members. Both the private and the state sector are well-equipped with in-patient, out-patient and community care facilities. There has been a continuous reduction in recent years in the number of beds in hospitals in favour of community based settings. At present, Switzerland has 2229 psychiatry specialists for a population of 7.4 million. More than 1800 are in private practice.

Psychiatric training

In Switzerland, responsibility for the education of medical specialists lies with the Swiss Medical Association (Foederaatio Medicorum Helvetiorum FMH), on behalf of the Federal Department of Home Affairs. The FMH approves the programmes for postgraduate education and develops the curriculum for it, whereas the diplomas are issued by the Federal Department. Devising the psychiatric training curriculum and its periodic reviews, organizing and administering the specialty board exams as well as visitations are the responsibility of the Board on Psychiatric Training and Education of the SSPP.

At present, there are two ongoing efforts for recognition of the first two psychiatric subspecialties, old age psychiatry and forensic psychiatry, as well as the implementation of the recommendations of the European Union of Medical Specialists (UEMS) regarding the current review of the post-graduate curriculum.

The current postgraduate programme for specialists in psychiatry and psychotherapy was adopted in 2001. It stipulates a six-year residency time, of which one year is to be spent in a somatic specialty and five years in psychiatry. Both in-patient and out-patient settings need to be part of the residency experience, and a rotation between different institutions is required. The institutions of a region are organized in a regional organization of postgraduate education and offer a common set of theoretical and practical courses. A multiple-choice-exam is administered at the end the residency: 40% of the exam questions are from the general foundations of psychiatry (descriptive psychopathology, diagnostics, clinical and epidemiological questions), and 20% allotted to each of biological and pharmacological, psychological and psychodynamical, as well as social and systemic aspects of psychiatric diseases. Moreover, the candidates must present in a colloquium a written paper regarding one or more clinical cases and answer the questions raised therein. Traditionally, Swiss curricula have strived for a well-balanced content of biological and psycho-social scholarship.

The affiliated societies of the SSPP, such as Societies for Consultation-Liaison Psychiatry, Old Age Psychiatry, Forensic Psychiatry, have played an important role in the psychiatric education by offering various postgraduate courses.

Biological psychiatry

Biological psychiatry has an important place in the education of a psychiatry specialist. First and foremost is an education on psychopharmacology, consisting of compulsory graduate courses (60 hours) as well as a host of elective postgraduate options. Both the neurobiological causes and the biological method of treatment are taught for a variety of psychiatric disorders. Besides psychopharmacology, the education embraces genetics, laboratory medicine, EEG, neuroimaging, light therapy, electroconvulsive therapy, etc.

Psychotherapy

Traditionally, psychotherapy occupies a central place in the curriculum. The current residency programme stipulates a three year training in one of three recognized models (psychoanalytic, cognitive-behavioral or systemic). The psychotherapeutic requirements consist of attending psychotherapeutic courses, of 125 hours of supervised training, and of self-awareness in psychotherapy.
**Psychology and social science**

Aspects relevant to psychiatry of these two areas are given due attention. Trainees are exposed to important elements of test psychology and neuropsychology, of psychosomatic and psychosocial medicine, of social psychology and social psychiatry, of rehabilitation and system theory.

**Neurology and neuroimaging**

Clinical activity in neurology is not required, but a one year neurological residency can serve as part of the one year somatic residency requirement. Neuroradiology and nuclear medicine have been introduced in psychiatric residency programmes.

**Rational prescription**

The current residency programme orients itself by the principles of evidence-based medicine and of rational prescription both in pharmacology and psychotherapy.

**Research**

The curriculum includes the teaching of the fundamentals of the theory of science and of methods of research including statistical methods and empirical methods of investigation. Moreover, the trainee’s interest for research is stimulated by allowing a maximum one-year long stay in a university or non-university research institute to be counted as a residency year.

**Public health and health economics**

The current training curriculum requires that trainees be taught the foundations of the health and in particular of the mental health system, the organization and the financial aspects of psychiatric services. The acquisition of knowledge regarding quality management of psychiatric services is contained in the residency curriculum.

**Law and ethics**

The legal foundations for psychiatric services in Switzerland are part of the curriculum. Trainees are also required to acquire knowledge of forensically relevant legal texts (penal and civil code, insurance law, asylum rights, patients’ rights). The development of an ethical position and familiarity with the ethical aspects and problems of psychiatric practice are also part of the curriculum.

**Cultural sensitivity**

As a country with a high percentage of immigrants, Switzerland has a significant experience with aspects and problems arising when different cultures and social groups live side by side. The various aspects of transcultural psychiatry and socio-psychology (social strata, minorities, migration problems) are emphasized during the psychiatric residency, aiming at an improved communication and at adapting treatment accordingly.

**References**


Union Européenne des Médecins Spécialistes: Charter on Training of Medical Specialists in the EU. Requirements for the Speciality of Psychiatry. UEMS, Berlin, 2003

http://www.uemspsychoiatry.org/board/reports/Chapter6-11.10.03.pdf
Psychiatric training in Uganda is part of training in all medical, nursing and clinical officers’ schools. Psychiatric training in Uganda has existed since the early 1960’s. Over the years it has improved both in quality and intensity and in the total time allocated to it both at undergraduate and at postgraduate levels. There is a continuous effort to improve health services including mental health, by insuring improvements in basic medical and specialist training. This effort in the case of Uganda has yielded dividends as many health workers have become aware of issues related to mental health and its importance. Uganda has only 18 psychiatrists for a population of 24 million people.

**Psychiatric training**

It is offered either as a speciality or as a core course for postgraduate in internal medicine and paediatrics. Because of the improved teaching environment and serious and interactive way of teaching, many undergraduate students now find psychiatry a popular discipline.

The duration of courses range from an orientation of two weeks for rotating nursing students to an eight-week hands-on training course for undergraduate medical students. In addition, the undergraduates are given some general lectures in psychiatry, psychology and other related fields between the first and fourth years. Postgraduates in internal medicine and paediatrics have a 15 week semester on mental health aspects related to their disciplines. Postgraduate psychiatry trainees have three years training and submit a research project before they pass out as specialists in psychiatry.

**Biological psychiatry**

This is covered in two course units namely – psychiatry and organic psychiatry, where the organic basis of psychiatric disorders is explored. Prior to this, in the first postgraduate year a foundation for biological psychiatry is laid in separate course units of neuroanatomy, neurophysiology, neuropathology, neurobiochemistry and genetics. The neurochemical basis of psychiatric disorder is covered theoretically. At undergraduate and other levels (e.g. Nursing and Clinical Officers) the organic basis of psychiatric illness is explored in a couple of lectures.

**Psychotherapy**

A semester is dedicated to limited psychotherapy training at postgraduate level. Much of this is theoretical with supervised practical training in cognitive behavioural therapy. Undergraduates are introduced to the theories behind the types of different schools of psychotherapy but are not given training in each of them due to the lack of trained professionals.

**Psychology and social science**

This is taught under two course units namely clinical psychology and medical sociology and anthropology. The former teaches the student the psychological assessment, evaluation and management in psychiatric practice. In the latter course unit the concepts of sociology, anthropology and social work are taught to enhance understanding of the impact of social and cultural factors in health, disease and health seeking behaviour.

**Neurology and neuroimaging**

Clinical skills required for the management of neurological disorders relevant to psychiatry are taught in a whole semester. The theoretical and practical basis of neuroscience and imaging is taught with emphasis on their application to clinical evaluation and management of neurological and endocrine disorders. Exposure to various specialised neuroimaging procedures employed in the diagnosis of psychiatric and neurological disorders is expected in the training. This, however is often limited by lack of facilities e.g. for MRI, SPECT, PET.

**Rational prescription**

Receptor physiology and psychopharmacology are taught as a basis for rational prescription. Clinical psychopharmacology is then taught with emphasis on classification, application and rational use of psychotropic drugs as well as the adverse effects of these drugs.

**Research**

This is part of the resident training in psychiatry. A foundation for research training is laid by courses in epidemiology, biostatistics and research methods. Every trainee in psychiatry is expected to carry out a research and present a dissertation as a requirement for the award of a specialist degree. Much of the research however is epidemiological and clinical. There is little by way of biological psychiatry research due to lack of appropriately equipped modern laboratories.
Public health and health economics

These are tackled in the course units on administrative psychiatry and health systems management. The national decentralised structure and basis for service delivery is taught with respect to psychiatry. Policy issues relevant to psychiatry as well as levels of care are covered here. The relationship between psychiatry, the individual and the national economy is also taught. Students are introduced to basic macro-economic theory and its application to the health sector. Principles of management are introduced, including financial and human resource management with emphasis in community financing social insurance, user fees, privatisation, equity and efficiency improvement.

Law and ethics

This is covered under the course unit of forensic psychiatry, ethics and patient rights. The course emphasises the relationship between psychiatry and the law, the role of a psychiatrist in a court of law, the Mental Health Act, the penal code as well as issues of incapacity, management of estates and consent. Ethics in psychiatry and the rights of patients are also covered.

Cultural sensitivity

A course on transcultural psychiatry is offered. This emphasises the influence of culture on mental illness. Cultural differences are discussed in terms of symptom expression, health seeking behaviour, explanatory models of illness, culture bound syndromes and the role of traditional healing systems.

Mental health training/understanding in other medical models

In a newly developed course unit called transcultural and social psychiatry, there is coverage of the role of the traditional healing systems. This is important as 80% of patients who come to psychiatry attend the traditional healer first. Research in this area by students is encouraged. The role of complimentary and alternative medicine in mental illness and health is discussed under this unit. These include homeopathy, naturopathy, massage, acupuncture, and reflexology. These are only introduced briefly as there are no lecturers in these areas at the university.

Migration of newly trained psychiatrists

There is an acute shortage of psychiatrists in most low income countries and Uganda is no exception. Almost all are absorbed into the largely unfilled posts within the Ministry of Health and the University establishments. Uganda has experienced little migration of newly trained psychiatrist lately possibly because of a favourable and stable political and economic environment.

Psychiatric training at undergraduate level

This begins with a foundation course called “Behavioural Sciences” in the first year of medical school. It comprises the basic principles of psychology and sociology. In the second year psychopathology is introduced. Clinical psychiatry is covered in the 3rd to 5th years, beginning with the theoretical teaching of the various psychiatric syndromes. In the fourth and fifth years the hands on clinical psychiatric training is done for eight weeks, along with related subjects such as psychopharmacology. Students are expected to assess and manage patients under close supervision. With the new problem based learning curriculum (PBL) psychiatry features in the 3rd to 4th years as an integrated subject. Training lays emphasis on the biological model of the mental illness with very little emphasis on the psychological or social models. The course tends to teach more about the major psychiatric syndromes and their drug management. Training is primarily hospital based until recently when a programme called Community Based Education System (COBES) was introduced to encourage students to learn within real communities. During the five week long COBES, students are supervised on how to identify and manage the common mental health problems in primary health care. Psychiatry is largely well received by undergraduate students who often find it very interesting and many would wish to take it on as a speciality at postgraduate level if opportunities existed.
# Atlas respondents/key contacts and training institutes/bodies

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<th>Country</th>
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| Argentina   | Graciela Lucatelli, Luis Elleman, Miguel-Angel Materazzi, Hugo Alfredo de la Vega, Gastón Noriega, Alejandro Ferreira, Silvia Tártalo | Dirección de Registro, Fiscalización y Sanidad de Fronteras, Área de Registro unico de Profesionales, Argentina  
National Academy of Medicine, Argentina  
Argentine Medical Association  
Argentine Association of Psychiatry  
Association of Argentinean Psychologists  
Universidad de Buenos Aires, Argentina  
Comisión Nacional de Evaluación y Acreditación Universitaria, Ministerio de Educación, Ciencia y Tecnología, Argentina |
| Armenia     | Andrey M Khachaturyan                                                                          | National Institute of Health, Armenia  
Educational Methodological Council of the National Institute of Health, Armenia |
| Australia   | Paul Loughran                                                                                  | The Royal Australian and New Zealand College of Psychiatrists, Melbourne, Victoria, Australia |
| Austria     | Gerhard Lenz                                                                                    | Ministry of Health Legislation, Bundesministerium fur Soziale Sicherheit und Generationen, Wien, Austria  
Austrian Association for Psychiatry and Psychotherapy, Osterr Gesellschaft fur Psychiatrie U.Psychotherapie Baumgartnerhome, Wien, Austria  
National Medical Council, Vienna, Austria |
| Azerbaijan  | Fuad Ismayilov, Araz Manuchery-Lalei                                                            | Ministry of Health, Azerbaijan  
Azerbaijan Psychiatric Association  
Azerbaijan State Institute for Physicians’ Postgraduate Training  
Azerbaijan Medical University  
Commission for Certification of the Ministry of Health, Azerbaijan  
Supreme Attestation Commission under the President of Azerbaijan Republic |
| Bahrain     | Adel Al-Offi                                                                                    | Psychiatric Hospital, Bahrain  
Arabian Gulf University, Bahrain  
Ministry of Health, Bahrain |
| Barbados    | Gajapathy Asokan                                                                               | University of the West Indies, Barbados |
| Belarus     | Dzianis Paduchyny, Roman Eversegheev                                                          | Belarusian Academy of Post-graduate Education |
| Belgium     | Evrard Jean-Luc                                                                                | Ministre de la Sante Publique et des Affaires Sociales, Bruxelles, Belgium  
Royal Society of Mental Medicine of Belgium and BCNBP  
Institut National Pour La Maladie et l’Invalidite, Departement de L’affectation Medicale, Bruxelles, Belgium |
| Bhutan      | Chencho Dorji                                                                                  |                                                                                      |
| Bolivia     | GA Arroyo, NN Tapia                                                                            | Mental Health Department, La Paz, Bolivia  
Sociedad Crucena de Psiquiatria |
| Brazil      | Miguel Roberto Jorge                                                                           | National Committee of Medical Residency, Ministry of Education, Brasilia-DF, Brazil  
Brazilian Medical Association  
Brazilian Association of Psychiatry |
| Bulgaria    | Vladimir Velinov                                                                               | Ministry of Health and the Ministry of Education and Science, Bulgaria  
Bulgarian Psychiatric Association  
Association of Private Psychiatrists, Bulgaria  
Bulgarian Society of Biological Psychiatry |
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| Cambodia     | Ka Sunbaunat                                  | Department of Psychiatry, University of Health Sciences, Phnom Penh, Cambodia  
Mental Health Sub-Committee at the Ministry of Health, Cambodia |
| Chile        | Enrique Jadresic  
Alejandra Armijo  
Pablo Arancibia  
Fernando Ivanovic-Zuvic | Association of Medical Faculties (Universities), Chile  
Departamento de Psiquiatria Facultad de Medicina, Santiago, Chile |
| China, Hong Kong SAR | Desmond Nguyen | Medical Council, Hong Kong  
Education Committee, Hong Kong College of Psychiatrists  
Central Academic Course Organizers, Hong Kong |
| Costa Rica   | Rigoberto Castro Rojas                       | CENDEISSS, Caja Costarricense Seguro Social San Jose, Costa Rica  
Centro de enseñanza y docencia en salud y seguridad, Costa Rica |
| Croatia      | Bjubomir Hotujac                             | Clinic for Psychiatry, Clinical Hospital Split, Split, Croatia  
Committee for Psychiatry, Ministry of Health, Republic of Croatia |
| Cuba         | Alberto Galvizu Borrel  
Celestino Vasallo Mantilla | Postgrado del Instituto Superior de Ciencias Médicas de la Habana Cuba  
(Universidad de Ciencias Médicas de la Habana), Cuba  
Diección de Formación Académica, Habana, Cuba |
| Czech Republic | Cyril Höschl  
Ivan Tuma                                     | Department of Postgraduate Education in Psychiatry, Prague, Czech Republic  
Psychiatric Society of the Czech Medical Asssociation of J.E. Purkyne |
| Ecuador      | Enrique Aguilar Zambrano                     | Postgraduate Institute Medical Faculty, Central University of Ecuador  
Consejo Nacional de Universidades y Escuelas Politécnicas, Ecuador  
National University Guayaquil, National University of Cuenca, Catholic University of Guayaquil |
| Egypt        | Ahmed Okasha  
Tarek Okasha                                   | Egyptian Board of Psychiatry  
Supreme Council of Egyptian Universities  
Ministry of Health, Egypt  
The High Egyptian Committee of Medical Specialities |
| Ethiopia     | Mesfin Araya                                 | Department of Psychiatry, Addis Ababa University, Addis Ababa, Ethiopia  
Amanuel Psychiatric Hospital, Addis Ababa, Ethiopia |
| Finland      | Raimo KR Salokangas                          | Medical Faculties of the Universities of Helsinki, Turku, Tampere, Kuopio and Oulu  
The Finnish Psychiatric Association, Helsinki, Finland |
| France       | Botbol Michel  
Kipman Simon-Daniel                           | Ministry of National Education, France  
French Federation of Psychiatry |
| Georgia      | George Naneishvili  
Eka Chkonia                                    | Ministry of Labour, Health and Social Affairs, Tbilisi, Georgia  
The Council of Continuing Medical Education and Postgraduated Study of Georgia  
Asatiani Research Psychiatric Institute,Tbilisi, Georgia  
Department of Psychiatry of State Medical University, Georgia  
Department of Psychiatry of Medical Academy, Georgia  
Society of Georgian Psychiatrists  
Mental Health Association, Georgia  
Ministry of Health of Georgia |
| Greece       | Basil Alevizos  
Maria Margartl                                | Central Council of Health, Greece  
Hellenic Psychiatric Association, Greece |
| Guatemala    | Edwin Raul Higueros Lopez  
Victor Antonio Lopez Soto                      | Hospital Nacional de Salud Mental, Guatemala |
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| Hungary                   | Ferenc Töry, Attila Németh                         | Council of Postgraduate Trainings and Qualification in Health, Ministry of Health, Hungary  
Department of Psychiatry No 1, National Institute of Psychiatry and Neurology, Hungary  
Landspitali – University Hospital, Reykjavík, Iceland  
The National Medical/Psychiatric Council, Iceland |
| Iceland                   | Engilbert Sigurdsson                               | The Medical Council of India, New Delhi, India  
The Indian Psychiatric Society  
National Board of Examination, New Delhi, India |
| India                     | Mohan K Isaac                                      | Scientific Council of Psychiatry, Iraqi Commission of Medical Specialisation, Baghdad, Iraq  
Iraqi Society of Psychiatrists, Baghdad, Iraq |
| Indonesia                 | Albert Maramis, Sasanto Wibisono                   | Indonesian Medical Council                                                                                                                                                                                                                         |
| Iraq                      | Numan S Ali                                        | Scientific Council of Psychiatry, Iraqi Commission of Medical Specialisation, Baghdad, Iraq  
Iraqi Society of Psychiatrists, Baghdad, Iraq |
| Israel                    | Fischel Tsvi                                       | Israel Medical Association                                                                                                                                                                                                                         |
| Italy                     | Giuseppe Ferrari, Maurizio Bellini, Paolo Scudellari, Ilaria Tarricone | MIUR (University and Research Department of National Government), Italy  
National University Council, Italy  
National Medical Training Observatory, Italy  
National Accreditation Observatory, Italy  
National Council, Italy |
| Japan                     | Toshio Yamauchi, Shin-Ichi Niwa                    |                                                                                                                                                                                                                                                     |
| Kazakhstan                | Saltanat Numagambetova                             | Department of Psychiatry & Narcology of Health Care Ministry, Kazakhstan  
National Medical Council, Almaty, Kazakhstan  
Kazakh Association of Psychiatrists & Narcologists |
| Lao People's Democratic Republic | Chantharavady Choulamany                  |                                                                                                                                                                                                                                                     |
| Latvia                    | Biruta Kupca                                       | Latvian Association of Physicians  
Latvian Psychiatric Association  
Department of Psychiatry, Riga Stradins University, Latvia  
Medical Academy of Latvia, Department of Psychiatry, Latvia |
| Malawi                    | Joshua Tugumisirize                                |                                                                                                                                                                                                                                                     |
| Malaysia                  | Ahmad Hatim Sulaiman                              | School of Medical Sciences, Universiti Sains Malaysia, Malaysia  
Malaysian Medical Council, Ministry of Health, Jalan Cenderasari, Kuala Lumpur, Malaysia  
Lembaga Akreditasi Negara, Malaysia |
| Malta                     | Joseph R Saliba                                   | Department of Psychiatry, Health Division & University of Malta  
The Specialist Accreditation Committee of the Malta Medical Council  
Maltese Association of Specialists in Psychiatry |
| Mexico                    | Enrique Camarena Robles, Armando Vázquez López-Guerra, Alejandro Diaz Martinez | National Department of Medical Education, Mexico  
National Council of Psychiatry, Mexico  
Departamento de Psicología Médica, Psiquiatría y Salud Mental, Facultad de Medicina, UNAM, México City, Mexico  
Instituto Mexicano de Psiquiatría “Dr Ramón de la Fuente”, México City, Mexico |
<p>| Morocco                   | Driss Moussaoui                                   | High Education Ministry, Morocco                                                                                                                                                                                                                   |</p>
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| Nepal                        | Shishir Kumar Regmi, Pramod Mohan Shyangwa     | Nepal Medical Council, Maharajgunj, Kathmandu, Nepal  
Psychiatrists’ Association of Nepal, Nepal  
Hospital Psiquiátrico Nacional, Managua, Nicaragua  
Universidad Nacional Autonoma de Nicaragua  
Jefe Nacional de la Catedra de Psiquiatría, Nicaragua  
Ministerio de Salud, Nicaragua  
Pakistan Medical and Dental Council  
College of Physicians & Surgeons Pakistan, Karachi, Pakistan  
Pakistan Psychiatric Society  
Specialisation Board in Psychiatry, Medical Association, Norway  
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<th>Country</th>
<th>Atlas respondents/key contacts</th>
<th>Key institutes/bodies associated with psychiatric training</th>
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<tr>
<td>Spain</td>
<td>Jose Francisco Montilla García, Manuel Gómez Beneyto</td>
<td>Servicio de Psiquiatría, Hospital 12 de Octubre, Madrid, Spain, Comision Nacional de la Especialidad de Psiquiatría, Spain</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>N Mendis, S Sujeevan</td>
<td>Postgraduate Institute of Medicine, University of Colombo, Colombo, Sri Lanka</td>
</tr>
<tr>
<td>Syrian Arab Republic</td>
<td>Adib Essali</td>
<td>Council of Medical Specialities, Ministry of Health, Syrian Arab Republic</td>
</tr>
<tr>
<td>Thailand</td>
<td>Vira Khuangsinrikul</td>
<td>Secretariat Office of The Royal College of Psychiatrists of Thailand, Department of Psychiatry, Faculty of Medicine, Siriraj Hospital, Bangkok, Thailand. Secretariat Office of the Medical Council, Ministry of Public Health, Thailand</td>
</tr>
<tr>
<td>The former Yugoslavia Republic of Macedonia</td>
<td>Antoni Novotni</td>
<td>Ministry for Health of Republic of Macedonia, Skopje, Macedonia, Clinic of Psychiatry, Clinical Center Skopje, Macedonia</td>
</tr>
<tr>
<td>Tunisia</td>
<td>Saida Douki, Zouhair Hachmi, Rym Ghachem</td>
<td>Hôpital Razi, Tunisia, National College of Psychiatry, Tunisia, Societe Tunisienne de Psychiatrie Hospitalo – Universitaire, Tunisia</td>
</tr>
<tr>
<td>Turkey</td>
<td>Rasit Tükel, Peykan G Gökalp</td>
<td>Council of the Minister of Health, Medical Specialization Committee, Ankara, Turkey, GATA Faculty of Medicine, Department of Psychiatry Etilik, Ankara, Turkey, Psychiatric Association of Turkey, The Education and Curriculum Commission on Psychiatry Branch in Medicine, Ankara, Turkey</td>
</tr>
<tr>
<td>Uganda</td>
<td>Samuel Mailing</td>
<td>Department of Psychiatry, Kampala, Uganda, Makerere University Senate, Faculty of Medicine, Kampala, Uganda</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>Gareth Holsgrove</td>
<td>Royal College of Psychiatrists, London, United Kingdom</td>
</tr>
<tr>
<td>United States of America</td>
<td>Deborah J Hales, Nancy Delanoche</td>
<td>Council on Graduate Medical Education, Division of Medicine and Dentistry, Bureau of Health Professions, Health Resources &amp; Services Administration, U.S. Dept.of Health &amp; Human Services, Maryland, United States of America, Accreditation Council for Graduate Medical Education, Chicago, Illinois, United States of America</td>
</tr>
<tr>
<td>Uruguay</td>
<td>Angel M Ginés, Laura Viola, Angel Valmaggia</td>
<td>Clínica Psiquiátrica, Escuela de Graduados, Hospital de Clínicas, Uruguay, Graduate School of the School of Medicine (National University), Uruguay</td>
</tr>
<tr>
<td>Uzbekistan</td>
<td>Tashmatov Bakhodir, Khodjaeva Nargiza</td>
<td>Ministry of Health of Uzbekistan, Tashkent, Uzbekistan, Department of Education, Uzbekistan, Commission of Accreditation of Psychiatrists in the Ministry of Health, Uzbekistan, Tashkent Postgraduate Medical Training Institute, Uzbekistan, Tashkent State Medical Institute, Uzbekistan</td>
</tr>
<tr>
<td>Venezuela</td>
<td>Guillermo Ginnari Antich</td>
<td>Universidad Central de Venezuela, Universidad del Zulia, Universidad de los Andes, Universidad Centro Occidental Lisandro Álvarado, Universidad de Oriente</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>Sekai Martha Nhiwatiwa, FB Chikara</td>
<td>Dept. of Psychiatry, College of Health Sciences, Harare, Zimbabwe, Zimbabwe Medical and Dental Health Professions Council</td>
</tr>
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## Contributors of Additional Information

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<tr>
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<td>Argentina</td>
<td>MA Materazzi</td>
<td>Netherlands</td>
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<td>Australia</td>
<td>H Herrman</td>
<td>New Zealand</td>
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<td>Bangladesh</td>
<td>AHM Firoz</td>
<td>Pakistan</td>
<td>HR Chaudhry</td>
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<td>L Vavrusova</td>
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<td>China</td>
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<td>C Cimilli</td>
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<td>India</td>
<td>JK Trivedi</td>
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<td>RA Kallivayalil</td>
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<tr>
<td>Kuwait</td>
<td>J Ohaeri</td>
<td>United Republic of Tanzania</td>
<td>S Kaaya</td>
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<td>Lebanon</td>
<td>J Madi-Skaﬀ</td>
<td>United States of America</td>
<td>DR Wilson</td>
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Psychiatrists play an important role in the delivery of mental health services. However, global information about the quality of training of psychiatrists is largely unavailable. Do countries train adequate numbers of psychiatrists for their mental health needs? How satisfactory is the training in view of the changing roles of a psychiatrist? Does the training take into account enormously different environments in which psychiatrists work across the world? These and other similar questions need urgent answers. *Atlas: Psychiatric Education and Training across the World* is an initial attempt in this direction.

The results of Atlas Psychiatric Training reveal a general deficiency and a marked variability in training across the world. Teaching methods, evaluation, licensing and continuing education all showed considerable scope for improvement within many responding countries.

This member of the Atlas family is a joint publication of the World Health Organization (WHO) and the World Psychiatric Association (WPA). It is hoped that this Atlas is successful in drawing the attention of health and medical education departments within countries to the enormous need for developing plans to establish or reform psychiatric training in their countries.