possible. To what extent can psychiatric training by rotation or exchange be developed beyond the current limited movement of a small number of trainees for some of their training?

PSYCHIATRIC EDUCATION IN EUROPE. INTRODUCTION

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The teachings of Hippocrates and the "holistic" approach of the ancient Greek physicians and philosophers have been infiltrated through the Centuries in the French and German "schools" which were dominant in the 19th Century. A productive osmosis between these two schools was later extended to include the factual and experimental "Anglosaxon" approach.

Yet, European Psychiatry, is by no means homogeneous and the differences in psychiatric tradition in the various European countries are reflected in psychiatric education and practice.

Following the establishment of the European Community (Treaty of Rome, 1958) mutual recognition of basic and specialist medical qualifications has occurred (Directive 93/16/EEC/1993). This called for "harmonization" of psychiatric training among the European Union countries (and also the EFTA countries). For this purpose the European Board of Psychiatry was established in October 1992 as a working Committee of the Psychiatry Section of the UEMS. The purpose of this symposium is to present some of the surveys carried out by the Board and some of its basic recommendations.

PRESENT STATE OF POSTGRADUATE PSYCHIATRIC EDUCATION IN EU COUNTRIES

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Aim: To obtain a description of National Guidelines on Psychiatric Training in the countries of the European Union.

Method: Delegates of the "Union Européenne des Médecins Spécialistes" UEMS Section of Psychiatry representing 18 European countries were asked to fill in questionnaire on Psychiatric Training, according to the information contained in the National Training Guidelines of their country.

Results: Fifteen valid questionnaires were analysed. Results will be described under three headings: administrative and training requirements for entering psychiatric training, the content of the National Training Programmes and quality assurance.

Conclusion: Results are discussed in relation to the difficulties of harmonizing psychiatric training in EU. The main obstacles are the differences in the process of selection of trainees, the requirements to enter psychiatric training, the duration of training. The con-tents of the programmes are not sufficiently specified in some countries and this makes difficult any comparisons.

TRAINING IN PSYCHIATRY IN EUROPE — RECOMMENDATIONS OF THE EUROPEAN BOARD OF PSYCHIATRY

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At present, the concept of psychiatry and psychiatric training in Europe is changing. Due to highly different standards of specialty training in psychiatry in the respective European countries, there is a great need to harmonize psychiatric training requirements in Europe. This should contribute to the goal of achieving comparable and high standards of psychiatric training and patient care in all of Europe. The European Board of Psychiatry has formulated requirements for the specialty of psychiatry. These include rules about recognition of teachers and training institutions, quality assurance, as well as selection procedures for and access to the training itself. Training duration should be five years. Theoretical training should include a structured training over four years, on average for four hours per week. All relevant aspects concerning diagnosis and therapy of psychiatric disorders should be taught. Psychotherapy training should be compulsory with one theoretical course per week (120 hours in total). Psychotherapeutic theory should include at least psychodynamic and cognitive-behavioral approaches. Personal therapeutic experience is highly recommended but not mandatory. A minimum of 100 hours of psychotherapy supervision should offer the trainee experience in different therapeutic approaches. Practical training must include alongside the normal clinical work, daily clinical supervision of minimum one hour per week (at least 40 hours/year).

The different activities of the trainee should be recorded in a logbook. Rotation in training should be compulsory including training in in-patient and out-patient settings.

The main objective of these requirements is to offer a multidimensional approach to diagnosis and therapy of psychiatric disorders based on biological psychiatry, psychotherapy and social psychiatry.

S90. Biomed II project: outcome of depression in Europe

Chairmen: G Wilkinson, O Dalgard

THE OUTCOME OF DEPRESSION IN EUROPE: THE EFFECT OF PERSON CENTRED PREVENTION IN URBAN AND RURAL SETTINGS

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This study has two objectives: to provide reliable and valid data on the prevalence, risk factors and outcome of depressive illness in rural and urban settings within the European community based on an epidemiological sampling frame; and to assess the impact of a person-centred preventive approach on the outcome of depression and on service utilisation and costs.

Six centres across the EU with expertise in mental health epidemiology and interventions are participating in this study. Suitable urban and rural areas have been identified in each centre. The sampling frame is adults aged 18–64, identified via primary care data bases or electoral registers. A two stage screening procedure has been adopted. Potential cases of depressive illness and depressive adjustment disorder are identified using the Beck Depression Inventory. Then detailed interviews are undertaken by mental health trained researchers. They use PSE10/SCAN to assign caseness against DSMIV and ICD10 criteria; they also assess co-morbidity, disability, genetic/familial susceptibility, psychosocial stressors, personality traits and cognitive factors; and assess provision, expectations and utilisation of local health care services. A randomised controlled trial of person-centred prevention is then undertaken for respondents identified as cases of depression/depressive adjustment disorder. This has three arms. 1: Individual intervention: a community mental health facilitator (MHF) provides individual training in cognitive problem solving approaches. 2: Group intervention: as above, but group rather than individual training in problem solving approaches. 3: A control group with no intervention from the research project. Subjects will be followed-up at

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