

## Editorial

### Developing Child and Adolescent Psychiatry Workforce for Low- and Middle-Income Countries

**Pratap Sharan, MD, PhD**

**Address for Correspondence:** Professor Pratap Sharan, Department of Psychiatry, All India Institute of Medical Sciences, New Delhi – 110029, Email: [pratapsharan@gmail.com](mailto:pratapsharan@gmail.com)

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Estimates indicate that 10%-20% of children and adolescents develop psychiatric disorders; and approximately 5%-12% suffer from functionally impairing conditions.<sup>1,2</sup> However, for most young people, mental health and substance abuse problems are either unrecognized or inadequately treated. Even in high-income countries, only about 20% of emotionally disturbed children and adolescents receive some kind of mental health care and only a small fraction of them receive evaluation and treatment by child and adolescent psychiatrists.<sup>3</sup>

In low- and middle-income LAMI countries, attention on child and adolescent mental health workforce has been lacking. There is a dearth of sub/super-specialists in child and adolescent mental health. Children and adolescents needing mental health care are mostly attended by general physicians (e.g. those with Bachelor of Medicine and Bachelor of Surgery degree), family physicians, pediatricians, and mental health professionals; who usually lack specific training in child and adolescent psychiatry. Moreover, there is a severe shortage of even the general mental health practitioners in most LAMI countries, e.g. in India, the number of psychiatrists is at 0.2, psychiatric nurses at 0.05, psychologists at 0.03, and psychiatric social workers at 0.03 (per 100 000 population).<sup>4</sup>

Some experts have suggested that sub/super-specialty training in child and adolescent psychiatry should be initiated in developing countries, basing their argument on the need to ensure appropriate standards of care for children and adolescents. Others favour sharing the burdens of care with allied health professionals. Perhaps the two approaches need to be combined to make a real difference in the health of the nations' youth.

#### **Has the time come for the sub/super-specialty training in child and adolescent psychiatry in LAMI countries?**

Sub/super-specialization in psychiatry has been viewed critically by some who have expressed concerns about fragmenting the field, weakening the generalist, increasing the cost of care, and undermining core graduate education.<sup>5</sup> Some experts from LAMI countries are apprehensive that sub/super-specialization will spread thin the already meager human resources available for mental health.

Others have convincingly argued that sub/super-specialization is desirable and strengthens the field. It is stated that accredited sub/super-specialty training programs increase focus, scholarship, and research in selective areas.<sup>5</sup> In many high-income countries, child and adolescent psychiatry has developed its identity, its scientific base, and its workforce gradually over the latter part of the twentieth century. The discipline has made a number of impressive strides in promoting basic and clinical research, teaching evidence based medicine, developing new therapeutic methods, and creating educational models.<sup>6,7</sup>

In some LAMI countries a significant proportion of available mental health manpower focuses on mental health issues of children and adolescents, usually on a part-time basis. Based on data relating to the membership and conference attendance of the Indian Association for Child and Adolescent Mental Health (IACAM), it is estimated that about 500 physicians (psychiatrists/pediatricians) in India devote much time to child and adolescent mental health practice and that the number of such physicians has continually increased over the last two decades. Interest in the sub/super-specialty is also indicated by the existence of the above mentioned national society and its dedicated journal, as well as proposals for super-specialty academic degrees in a few institutions and the accrediting body (Medical Council of India).

Dedicated child and adolescent psychiatrists could easily fit into the tiered human resource model for mental health care of Srinivasa Murthy, wherein he proposed that non specialists can be trained in circumscribed functions (e.g. lay volunteers: crisis intervention; school teachers: integrating mental health into their ongoing work) and can operate adequately provided safeguards regarding their functioning are implemented (e.g. scope of training and limits of care are spelt out, support in the form of consultation and referral are provided).<sup>8</sup> Primary care physicians and other primary caregivers could be trained to manage mild to moderate mental disorders; general psychiatrists, moderate to severe mental disorders; and child and adolescent psychiatrists complex or extreme mental disorders.

However, even with the emergence of the discipline, the number of sub/super-specialists will always be low relative to the needs of child and adolescent patients. Hence, in LAMI countries, the primary aim of discipline would be provision of leadership in service and policy development, advocacy, education of practitioners, detailing standards of care, and advancing research agenda. Child and adolescent psychiatrists could also build a strong network of support for their primary care colleagues in meeting the bulk of children and adolescents mental health care needs across a broad range of settings.

### **Approaches to training in child and adolescent psychiatry as a sub/super-specialty**

A number of approaches for the training of sub/super-specialists in child and adolescent psychiatry have been described. Traditionally sub/super-specialty training in child and adolescent psychiatry in high-income countries occurs after general psychiatry training and usually lasts 2 years. Alternatively, some residencies offer programs combining adult and child and adolescent psychiatry, usually lasting upwards of 5 years.

Another approach to increase the numbers trained in child and adolescent psychiatry is through the pediatrics portal. Pediatricians interested in providing more comprehensive biopsychosocial care of children and families are provided child and adolescent psychiatry (and some general psychiatry) training over a 2-year period. A novel approach to attract medical undergraduates whose interests encompass both the medical and psychological disorders of childhood combines training in paediatrics (24 months), general psychiatry (18 months) and child and adolescent psychiatry (18 months) in the 'the triple board program' through a carefully designed curriculum lasting 5 years. It is hoped that these groups of child and adolescent psychiatrists who were trained and socialized as pediatricians can bridge the gap between the pediatric (and medical) and the child and adolescent psychiatric communities.<sup>9,10</sup>

### **Fast-tracking ‘special interest’ training in child and adolescent psychiatry in LAMI countries**

The above mentioned approaches to sub/super-specialty training would lead to a specialization that is equivalent to a DM (Doctor of Medicine) degree in India. A suggestion for developing countries would be to provide intensive child and adolescent psychiatry training of 1-year duration within general psychiatry and pediatrics courses designed to provide MD (Doctor of Medicine) degrees, with certification documenting child and adolescent psychiatry as a ‘special interest’ area. In effect, creating a group of psychiatrists and pediatricians, who can practice general psychiatry/pediatrics and yet focus on child and adolescent mental health. The benefit of this “fast tracking” into child and adolescent psychiatry would be the expenditure of less total time (and other resources) for training, and earlier entry into the workforce. Such programmes could also be offered in a larger number of educational institutions than would be feasible for sub/super-specialty (DM level) programmes as they would be less demanding in terms of curricular requirements (e.g. creation and adoption of a fresh curriculum) and teaching expertise. Further, this approach would not require the creation of novel cadre (positions) in the public sector that would be necessary for the employment of sub/super-specialists. The experience from triple board programmes suggest that such a fast-track programme is unlikely to compromise training in general psychiatry or paediatrics. However, initiating such an integrated pathway is not without challenges. It would require detailed accounting of training requirements, and close coordination between specialties with clear delimitation of roles.<sup>11</sup>

### **Training of generalists in child and adolescent mental health issues**

Despite the need for child and adolescent mental health services, the growth of dedicated child and adolescent psychiatry workforce in LAMI will be slow. Hence, efforts will have to be made to increase child and adolescent psychiatry core competency of all psychiatrists, pediatricians and medical undergraduates.<sup>12,13</sup> Important features that can differentiate the new training requirements for these physicians from previously practiced educational models would include early introduction of and specification of a minimum dedicated period of training in child and adolescent psychiatry. In addition other tiers of mental health manpower available in LAMI countries can be trained in circumscribed functions related to child and adolescent mental health as suggested by Srinivasa Murthy.<sup>8</sup>

Medical/psychiatric educators should take the development of the workforce for child and adolescent psychiatry as a mission to provide crucial mental health care and health care advocacy for the country’s youngest and most vulnerable citizens.

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Professor Pratap Sharan, Department of Psychiatry, All India Institute of Medical Sciences, New Delhi – 110029.