


# A certificate in youth psychiatry: meeting the training needs of psychiatrists

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## Abstract

**Objective:** This paper provides the rationale for the development of sub-specialty training in youth psychiatry.

**Method:** Training needs for youth psychiatry are discussed and the opportunities provided by sub-specialisation in youth psychiatry are presented.

**Results:** The majority of mental disorders have their onset prior to 25 years. There has been substantial recent growth in services to meet the clinical needs of young people. The development of these services has exposed gaps in current training for psychiatrists, which varies considerably between child and adolescent, and adult psychiatry. Competencies acquired by psychiatrists in youth mental health are non-standardised, which may hinder optimal care.

**Conclusions:** Sub-specialty training in youth psychiatry is needed to meet workforce demands. The development of a certificate in youth psychiatry, by the RANZCP Section for Youth Mental Health, is underway. This will complement existing training and provide trainees and psychiatrists the opportunity to develop specialist skills in the provision of mental health care for young people negotiating the transition between adolescence and adulthood.

**Keywords:** education, psychiatrists, youth mental health, adolescents

“The test of a first-rate intelligence is the ability to hold two opposed ideas in mind at the same time and still retain the ability to function.”

F. Scott Fitzgerald, *The Crack Up*, 1936

care.<sup>1,2</sup> These services aim to meet the clinical needs of young people and reduce the burden of persistent disability, which accrues following the onset of mental health problems, 75% of which have their onset manifest by the age of 25.<sup>3</sup>

Since their initial introduction in Australia, youth mental health (YMH) and early intervention (EI) services have been implemented worldwide, improving young people’s access to, and engagement with mental health

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YMH services support young people with a wide range of existing and emerging mental health problems, while EI services are oriented to treatment of young people who meet the 'ultra-high risk' criteria of psychosis or who have developed a psychotic disorder. EI models are being developed for other diagnostic groups, including bipolar disorder<sup>4</sup> and eating disorders.<sup>5</sup>

YMH services worldwide, including headspace in Australia, address the extended transition from childhood to adulthood, when most adult-type mental and substance use disorders emerge, by accepting people between the ages of 12 and 25. Through intentional co-design of youth-friendly environments, YMH and EI services aim to minimise barriers to care for young people with mental health problems.<sup>6,7</sup>

YMH services reduce disruption of care as people transition from child and adolescent, to adult services,<sup>8</sup> at the peak time of onset of mental health problems.<sup>9</sup> Key research has starkly illustrated the failures of the child and adolescent/adult split, with a boundary at 18 which few successfully navigate.<sup>10</sup>

YMH services may be situated within primary, secondary or tertiary care, ranging from community-based services to specialist inpatient centres. Psychiatrists are most likely to be involved at the secondary and tertiary levels but can also play a key role in enhanced primary care services. Vertical, seamless service integration from primary through to tertiary care is desirable and is being implemented in some settings.

There is a sound, and rapidly developing evidence base across YMH, from interventions and models of care to neurobiology. With international expansion of YMH and EI services, it is essential to ensure the supply of a suitably trained psychiatry workforce that understands the expanding evidence base and is equipped with the requisite skills.

### Current training for psychiatrists in youth psychiatry

Psychiatric treatment in YMH and EI services may be provided by adult psychiatry-trained psychiatrists who necessarily work with some people younger than covered in the bulk of their specific training, or by child and adolescent psychiatrists working with people older than their specific training covers. The changing complexities that accompany age, in, for example, legal status, family, educational and vocational needs, and neurobiology of young people, have exposed training gaps at the interface of two established fields of psychiatry – child and adolescent, and general adult psychiatry, both of which, in a number of countries, have their own curricula, training schemes and governance structures. Transitional care between child and adolescent services and adult services is a notable gap in the content of existing training programmes.<sup>11</sup>

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Fellowship includes a mandatory child and adolescent placement, requiring experience with younger children as well as adolescents. Otherwise, the majority of training experiences for the awarding of a fellowship in psychiatry are in general and sub-speciality adult psychiatry. Child and adolescent psychiatry training is focussed on people ranging from infancy to the age of 18. Neither programme has a specific focus on the provision of mental health care to young people in the transition between adolescence and adult life.

Child and adolescent services and adult psychiatric services have very different origins, cultures, training and approaches to treatment.<sup>12</sup> These differences may contribute to the barriers that have been identified around the transition of young people between services.<sup>13,14</sup> A lack of confidence in the treatment of transition-age young people has been highlighted as a significant concern by service users.<sup>15</sup> Service development, and implementation, in YMH have exposed additional training and education needs for the psychiatry workforce, to improve the standard of care provided.

### Training in youth psychiatry

Currently, acquisition of knowledge and skills by trainees in youth psychiatry is largely ad-hoc and opportunistic. An opportunity exists to enhance the skills of the psychiatric workforce, and address the discontinuity in training, which is an artefact of the traditional boundary at 18, between adult and child and adolescent psychiatry.

There are substantial differences in treatment approaches to young people, and those provided to both adults and younger children. Young people tend not to engage well with traditional 'clinic-based' services,<sup>16</sup> resulting in a significant 'gap'. Best practice in YMH addresses this through flexibility in care regarding location of treatment, family involvement, according to clinical indications and the young person's expressed wishes, employment of peer workers to support engagement, and integration of services with youth employment services and educational institutions. This model is different from service delivery in both child and adolescent and adult sectors.

Importantly, there are differences in psychopharmacology for adolescents and young adults, compared to younger and older populations. Young people show differential responses to a number of pharmacological agents, including serotonin reuptake inhibitors and dopamine antagonists/partial agonists,<sup>17</sup> with different pharmacodynamics/pharmacokinetics and side effect profiles.<sup>18</sup> A focus on psychopharmacological treatment of young people is essential for working in YMH, to ensure best practice and optimise response while reducing iatrogenic harm.

### **Box 1. Suggested areas for development of training and core competencies for youth mental health psychiatry trainees**

Developmental tasks of transition to adulthood; emerging adulthood as a new concept to augment traditional notions of adolescence

Clinical staging, early intervention, risk states and transdiagnostic models of care

Nosology, epidemiology, diagnostic instability, neurodevelopmental and neurocognitive models of disorders

Disorders with an onset in childhood that can persist, present, worsen or attract new comorbidity in young people (e.g. attention deficit, autism spectrum and disruptive behavioural disorders)

Adverse childhood experiences, trauma and attachment as key concepts in youth and emerging adulthood

Family-inclusive practice and family therapy across the spectrum of emerging adulthood

Ethics relating to youth such as competency/capacity and disclosure of information to families and external services

Diversity in youth – gender, sexual attraction, cultural and linguistic

Home-based interventions and outreach, initial engagement of youth and families

Youth forensic mental health and offending behaviours

Substance use: preventive and treatment strategies including new and emerging psychoactive substances

Child protection of adolescents relating to both intra-familial and extra-familial maltreatment and exploitation

Evidence-based interventions – cognitive-behavioural therapies, including for psychosis and risk states, digital, family and systemic therapies, other psychological therapies, psychopharmacology, vocational interventions

Metabolic risk, dietary factors, management of side effects, physical health screening, and interventions

Psychopharmacology in young people and drug naïve people

Interviewing, engagement and core psychotherapeutic skills with young people

Sexual health, perinatal care for young parents, supporting healthy intimate relationships

Vocational and educational trajectories and recovery; individual placement and support models

Professional bodies have recognised YMH and EI services, and are developing governance structures. The RANZCP has developed a section on YMH, with a remit to:

- Promote the objectives of the College relating to youth mental health
- Advise on training in YMH
- Advance and disseminate research in YMH
- Contribute to, and promote, the highest standards of clinical practice in YMH.

There are, currently, some opportunities for trainees to gain experience in YMH, but availability is variable and not coordinated. Rotations in adolescent psychiatry, eating disorders, EI services, headspace, forensic adolescent psychiatry and neuro-developmental disorders exist. Postgraduate certificates, diplomas and master's programmes in YMH are also available.

## **Conclusions**

Aspects of both general adult and child and adolescent psychiatry training are necessary, but not sufficient, to offer the breadth of knowledge and experience to equip psychiatrists to provide optimal care to young people

with mental illness. Whilst training for YMH psychiatrists will incorporate and integrate aspects of both child and adolescent psychiatry and adult psychiatry, additional skills are required, which are more specific to young people. Some of the content under consideration by the RANZCP Section for Youth Mental Health, and developed by those involved in the Section's planning, with trainee involvement, for a training programme is listed in **Box 1**.

We recommend that professional bodies internationally give consideration to reviewing training for psychiatrists, to enable the development of curricula that provide the skills, knowledge and competencies required for psychiatrists working in YMH services.

A training programme for a Certificate in Youth Psychiatry by the RANZCP Section for Youth Mental Health is being developed, and will provide psychiatrists and trainees the opportunity to prepare for careers in YMH and EI services. The Certificate would benefit both adult, and child and adolescent psychiatrists who wish to enhance their skills in working with young people, and may serve as a useful model internationally.

We believe that this model is consistent with the International Declaration on Youth Mental Health, and advances its objectives, which advocate improved training in recognition and intervention and the development of comprehensive and dedicated YMH services. Australia leads the world in many aspects of youth mental health care, and opportunity now exists for the

## bi-national RANZCP to lead in education and training in youth psychiatry.

### Disclosure

The author(s) declared the following potential conflicts of interest with respect to the research, authorship, and/or publication of this article: IM, MK and JGS are members of the bi-national committee of the RANZCP Section for Youth Mental Health. PM is president, International Association of Youth Mental Health; founding board member, headspace, the National Youth Mental Health Foundation; former board member, Headstrong/Jigsaw, Ireland's National Youth Mental Health Foundation; treasurer, IEPA: Early Intervention in Mental Health; initial convener of Special Interest Group/Section for Youth Mental Health, RANZCP. DP is the current chair of the RANZCP Section for Youth Mental Health.

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