An international medical education perspective on training in child and adolescent psychiatry

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I write this commentary from Australia in the Asia-Pacific region. The work of the World Psychiatric Association (WPA) Consortium of Academic Child and Adolescent Psychiatrists (CAP) in undertaking such international comparison is immense. Collaboration allows us to learn from each other and find better ways of doing things. International comparison also supports CAP advocacy allowing benchmarking against comparable countries. An effective approach in Australia where CAP numbers are less than comparable European countries (RANZCP, 2019).

In this study the CAP profession almost universally reports a large ‘treatment gap’ between available CAP resources and community need, even in wealthy countries. Not surprisingly it shows wealthier countries have more CAP resources than less wealthy countries; not just number of CAP but also access to a CAP training program, national training guidelines, a broader range of training rotations and guidance from a National Child and Adolescent Mental Health Policy. But the connection between a countries wealth and CAP resources is far from universal. Collaborative approaches examining this variation will help us understand the enablers and barriers to greater CAP resources in all countries.

The study asks CAP about the perceived need for more CAP and CAMH professionals. Almost universally such a need is reported. Understandably it focuses on CAP. However, CAP do not work in isolation and what care they provide is determined by the system of care in which they work and how tasks are allocated between the various professions; both within specialist CAMH services (if available) and between primary and specialist care. The relative cost of training and employing various professionals is relevant with CAP being expensive to train and employ. A future challenge is looking at a broader multidisciplinary comparison of the CAMH workforce and the system of care they work in.

Modern CAMH place CAP in a role of clinical leadership, delivering direct and indirect consultation to other professionals, and oversight of care delivery by others. Defining the professional capabilities of the modern CAP guides what CAP training should include in curriculum and workplace training experiences provided.

The study asks about professional structures supporting CAP including the presence of a National Society, CAP Journal and availability of University CAP Academic Departments. It explores if CAP is a recognized specialty or subspecialty and the interface with general psychiatry. Such structures support the CAP profession, however distilling which and how such professional structures enable the profession requires further exploration. International collaboration is required to better understand what works best. The study demonstrates general psychiatrists deliver a lot of CAP care even in the presence of a CAP workforce. Clearly their training in CAP is important. In Australia debate exists on the balance between ensuring general psychiatrist training involves CAP experience verse emphasizing a sub specialized CAP workforce.

The study examines the frequency of overseas training placements. These are available for a minority of countries across the three regions and usually occurs in high income countries (HIC). Australia provides such CAP training placements, in particular for Sri Lankan and Malaysian trainees. A larger question is how do CAP in wealthy countries best support our colleagues in less wealthy countries? The authors recognize the benefits of such HIC training placements but also the risk of encouraging migration of the professional. Other issues arise including suitability of clinical training experiences in HIC settings to the clinical work undertaken by the graduate CAP at home. Also, the recognition of the trainee’s requirement for sufficient medical licensing to practice as a doctor not just observe or attend teaching activities. Additionally, how to support trainee’s cultural adjustment when living and training in a HIC. Despite the challenges the overseas training experience in Australia has provided benefit for Sri Lankan, Malaysian and Australian CAP. An alternative is overseas placements in neighboring low- and middle-income countries (LMIC) and examples can be found in PNG and Nigeria. These may provide a more culturally and clinically aligned training then achieved in HIC.
The authors rightly emphasize the benefit of “in country” training support in LMIC. Partnering with LMIC universities or training organizations may represent one approach.

Migration provides Australia and New Zealand (ANZ) with a multicultural CAP workforce. Overseas medically trained CAP frequently remain professionally engaged with their country of origin and potentially provide a skilled, culturally aligned workforce wishing to support CAMH there. We have sought to support these CAP effectively engage with CAMH in their countries of origin. A group of Australian overseas born CAP have come together to provide mutual support and assistance to develop and deliver projects in Sri Lanka (Rathnayaka et al., 2016) and India (www.pathwaysfoundationkovai.org). There is great potential in this multicultural workforce to support CAP internationally.

Broader ‘in country’ approaches to CAP regional engagement in the Asia-Pacific region are occurring. The Royal Australian and New Zealand College of Psychiatrists (RANZCP), Faculty of Child and Adolescent Psychiatry (FCAP) has developed an approach in partnership with Pacific Island nations using ANZ CAP volunteers supporting training and workforce development (Kowalenko et al., 2020; Robertson, Hagali, et al., 2019; Robertson, Paul, et al., 2019). Such endeavors occur elsewhere also. Interest exists in ANZ CAP in volunteerism representing a significant volunteer workforce to support CAMH regional development. How to best organize and deploy such a volunteer workforce is currently being explored through a Pilot Volunteer Program. “In country” training has its risks for recipients, volunteers, and organizations that auspice such endeavors especially in the context of resource inequity, structural racism and the continuing impact of colonialism and cultural dispossession of indigenous people to name a few. We need to be thoughtful in the relationships we develop with international CAP colleagues ensuring respect and allowing mutual influence and learning from each other; while recognizing the enormous disparity of resources.

Since 2020 the COVID pandemic has brought changes severely limiting international travel. Training placements in Australia for overseas trainees are more limited and ANZ CAP traveling to provide “in country” projects have ceased. However, the pandemic has placed telehealth (videoconferencing) in the mainstream. The potential of telehealth for international engagement is immense although its full benefits and limitations are yet to be distilled. In 2020, a partnership involving Fiji National University (FNU), St Vincent’s Mental Health and FCAP, pivoted to deliver a 12-week CAMH lunch time professional development course via telehealth (OPHELIA Training: Online Pacific Health Exchange; Chang et al. 2022). The biannual FCAP Pasifika Study Group (PSG) (Robertson, Hagali, et al., 2019) occurred online in September 2021 for the first time. However, telehealth relies on adequate infrastructure and has potential to increase disparities even further. Whatever, telehealth is going to change what we do going forward.

In finishing let me describe something of CAP in the Pacific region. It was not part of WPA–CAP study but could be in the future. CAP in the Pacific region has similarities to the three regions in the study but also significant differences. Papua New Guinea (PNG) with 9 million people has one CAP and about 10 general psychiatrists. Specialist general psychiatry training is available through PNG University including for neighboring countries such as Solomon Islands (SI) and Timor-Leste. SI has two general psychiatrists. In the English-speaking Western Pacific Island nations of Fiji, Vanuatu, Samoa, Tonga, Niue, Kiribati, and others there is a single CAP based in Fiji along with a range of general psychiatrists and mental health doctors with some training in CAMH. There is hope FNU will provide psychiatric training soon. On the other hand, modern Australia and NZ, both born of British colonialism with important indigenous cultural heritage, are wealthy countries with well-developed health systems including CAMH services. CAP training follows a tradition similar to the UK and North America. There are countries in the Pacific less familiar to ANZ CAP including the French-speaking island territories of New Caledonia and Tahiti who are well resourced for CAP and relate to France; the Philippines and Hawaii are also in the Pacific. We can see the Western Pacific Island nations, PNG and SI are under resourced for CAP or CAMH and rely heavily on primary care. The Pacific presents unique differences with the Pacific Island nations being small landmasses with small populations (2 million) in vast expanses of ocean. PNG and SI have very rugged terrain with limited road infrastructure. Travel is expensive and challenging. Telehealth is developing and has huge potential, but significant infrastructure challenges exist. The Pacific is also one of the most natural disaster-prone regions of the world with tropical storms and tsunamis and at the forefront of the climate disaster. Expanded international CAP collaboration will benefit Pacific children and adolescents and their families.

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