Sub-specialties in psychiatry: Towards parity in mental health training and services

Neuropsychiatric disorders account for 5 of the 10 most disabling medical disorders worldwide,[1] and for a particularly large component of the burden of disease in South Africa.[2] Unfortunately, as elsewhere, training and services in psychiatry have lagged behind those of other major disciplines, and much additional work is needed to achieve parity. We focus in particular on the status of psychiatric sub-specialties in South Africa, considering the pros and cons of their recognition in a developing country.

South Africa has long recognised the existence of various specialties and sub-specialties in medicine. Internal medicine and surgery were among the first recognised specialties, but we also have a long history of formal recognition for a broad range of sub-specialties. Paediatrics and obstetrics and gynaecology have also had a range of their sub-specialties recognised. Psychiatry was a relative latecomer to the specialties, and until recently offered a certificate in only one sub-specialty – child and adolescent psychiatry.

The reasons for the past neglect of psychiatry in undergraduate and postgraduate training are debatable. Possible contributors include conceptual and methodological weaknesses in psychiatry and stigmatisation of mental illness. But in the past several decades psychiatry has become increasingly scientific in its approach, and the efficacy and cost-efficiency of its treatments have become increasingly valued, given recognition of the burden of mental illness.[3,4]

Consistent with the re-medicalisation of psychiatry, and the advances in its diagnoses and treatment, psychiatry has become recognised as one of the 'big five' undergraduate and postgraduate clinical disciplines throughout the world. Where the need for parity of psychiatry with other medical disciplines is recognised by policy-makers, clinicians, and consumer advocates, on the basis of the burden of psychiatric disorders and the rights of those with these conditions to accessible treatment, then resources for psychiatric services and research are more likely to match those provided to other medical or surgical disciplines.

In such settings, a range of psychiatric sub-specialties have been formally recognised (e.g. child and adolescent psychiatry, old age psychiatry, forensic psychiatry, addiction psychiatry, consultation-liaison psychiatry, neuropsychiatry, public or community psychiatry). Some sub-specialties may be open to various disciplines including psychiatry (e.g. intellectual disability, pain medicine, sleep medicine). While parity for psychiatry is more often achieved in high-income countries, several of these sub-specialties are now recognised in various low- and middle-income countries.

There are important advantages of formally recognising the psychiatric sub-specialties. At a scientific level, this acknowledges significant growth in particular areas, requiring mastery of particular concepts and methods. At a clinical level, it allows patients to receive high-quality sub-specialty assessment and intervention where appropriate. At a health policy level, it ensures that policy-makers provide appropriate funding for particular services within psychiatry, potentially attracts a broader range of clinicians to the public sector, and contributes to the human rights goal of ensuring the parity of psychiatry with other medical disciplines. Similar considerations also apply to psychology.

An important potential criticism of psychiatric sub-specialisation is that it is not consistent with a primary care philosophy. Psychiatry is a discipline that is particularly important at primary care level, where a significant number of consultations are for emotional problems. In low- and middle-income countries where there are very few psychiatrists, these therefore need to be generalists, or generalists with special interests. A focus on narrow tertiary sub-specialty psychiatry fails to address the needs of the many requiring primary care and secondary generalist services. Nevertheless, it is important to emphasise that the primary care philosophy does not do away with the need for secondary and tertiary care; on the contrary, such services allow for seamless referral and consultation across levels. Indeed, psychiatric sub-specialty services are often optimally based at more primary levels of care; they are often suited to revolve around consultative input to colleagues, rather than being focused on tertiary hospital procedures.

Costs involved in providing sub-specialties are a further potential criticism. The debate about the extent to which a low- or middle-income country can afford sub-specialised services may be particularly relevant where sub-specialised services are highly expensive. However psychiatric sub-specialty services do not typically require costly equipment, they are often optimally based at primary care sites, and their interventions are highly cost-efficient. For more expensive sub-specialised services there are strong ethical arguments for retaining some expertise to ensure high-level training and to help deserving patients.[5]

Within psychiatry there has been debate about the distinction between secondary and tertiary services. Medical and surgical sub-specialties have come into being in part via new equipment and procedures. In contrast, psychiatric sub-specialties are by and large defined in terms of expertise. The addiction psychiatrist is defined by the need for some patients to receive expert assessment and treatment in this area of practice with particular pharmacotherapies and psychotherapies. Specialised psychopharmacology and psychotherapy services can also be considered as sub-specialty areas within psychiatry. Sub-

specialists working in these areas may be crucial in setting up relevant primary and secondary level screening and other services, and at the same time being available for the tertiary work that will flow from increased referrals by these levels of care.

Given the historical neglect of sub-specialty psychiatric training in South Africa, several practical issues arise. Lack of sub-specialty recognition means that there is no budget for sub-specialty posts, which makes it difficult to develop these disciplines, maintains the status quo, and slows down the necessary adaptation to needs. This situation requires creative solutions such as recognising as sub-specialists those who have practised in particular sub-specialties for many years, and whose academic credentials in these areas are clearly apparent from publications or other measures by 'grandfathering' and 'grandmothering'.

In summary, recognition of the psychiatric sub-specialties is important to achieve parity for mental health in medical training, service provision and research. This is consistent with the primary care philosophy and may bolster evidence-based treatments at primary care level (e.g. recognition of addiction psychiatry might lead to better services across levels in this field). We salute those who have put forward sub-specialty training programmes at various universities, and the decision of the College of Psychiatry to assist in obtaining formal recognition of these programmes. We urge policy-makers to provide parity for psychiatry by funding posts in psychiatric sub-specialties, in the interests of equitable health care across all disciplines. There is no health without mental health.[6]

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