

# Psychiatric sub-specialization in Africa - introduction to a series

Psychiatrists have long had practices that focus on particular areas within the field, and sub-specialty journals have published research from these areas for some time. Nevertheless, the formal literature on psychiatric sub-specialization is remarkably sparse. A recent edition of *World Psychiatry* on the future of psychiatry, for example, had only a few words on sub-specialization.<sup>1</sup> Nevertheless, a number of articles from high income countries have focused attention on the value of developing sub-specialties or even sub-sub-specialties, including forensic psychiatry<sup>2,3</sup>, geriatric psychiatry<sup>4-7</sup>, addiction psychiatry<sup>8-11</sup>, and liaison psychiatry.<sup>12-16</sup>

There is limited literature from low and middle income countries on sub-specialization. This is hardly surprising, perhaps, given the frequent lack of human resources that characterizes such settings, and the need to focus therefore on training of general psychiatrist where possible, and on the value of task-shifting to less well trained health care workers if this can be done.<sup>17</sup> Nevertheless, there has been some recent attention to this issue in South Africa<sup>18</sup>, and several new sub-specialties will shortly be officially promulgated.

It is relevant to consider the pros and cons of psychiatric sub-specialization in Africa. Even where consensus is that there is a need for particular sub-specialties, it may be that the process of sub-specialization may need to be adjusted in order to accommodate local needs. For example, in a country with relatively few psychiatrists, and a lack of resources to produce sub-specialists, it may be possible to offer psychiatry trainees the option of spending a portion of their training in a particular area, so that they can be recognized as having specific skills in that sub-discipline.

A number of advantages of sub-specialization are apparent. As with other areas of medicine, psychiatry has grown rapidly in recent decades, and no one person can master all areas. As in medicine generally, it is beneficial for patients to be seen by someone who has expertise in their particular problem, provided that services do not become overly compartmentalized.<sup>19</sup> Sub-specialization may be accompanied by advanced training for practitioners, and can encourage improved research in particular areas.

At the same time, there are clear problems with sub-specialization, perhaps particularly in low and middle income countries. In such places, it may be argued that there are simply insufficient resources for sub-specialists, and a primary care approach is needed. A counter-argument is that a primary care approach does not obviate the need for area experts, who can provide tertiary consultations as well as training of primary care

practitioners. In a stepped-care approach with potential for maximizing resources and delivering evidence-based care, specialists and sub-specialists are needed in addition to a well supported primary care system.

A cost-benefit analysis of various scenarios may be needed to help optimize the number of sub-specialists needed and in which areas. One might hypothesize that in areas where there is particular burden of disease in low and middle income countries, funding of sub-specialists would be particularly cost-effective. With changes in knowledge, and shifts in burden of disease, there may be a need to create new sub-specialties and/or to shift resources between existing sub-specialties.

Indeed, the formal development of sub-specialties (no doubt like the earlier recognition of specialties) is also a political process, often driven by questions about whether there are resources for particular hospitals or Universities, and whether there will be recognition for particular individuals or disciplines, and the like. Nevertheless, in Africa, many sub-specialties have long existed in practice, with a range of sub-discipline services provided for patients, and with associated training and research programs. For example, Red Cross Children's Hospital and the University of Cape Town have long provided sub-specialty training in child & adolescent psychiatry.

It is important to give due recognition both to the accomplishments of such sub-specialty services, and to the enormous challenges faced in moving forwards in the 21st century. With this in mind, we plan to invite African leaders in particular sub-specialties to provide a window on their fields – describing the history, the progress made, and the future that awaits them. We plan to cover the best-established fields (e.g. child and adolescent psychiatry), but also some of the newer ones (e.g. neuropsychiatry), and this way to encourage further discussion of the relevant issues on the continent.

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## African Neuroscience Educational Grant

**This year sees the final awarding of the sanofi-aventis "African Neuroscience Educational Grant", following 5 years of the award.**

The article selected for the award (equivalent of R50 000) by the editorial board is:

Ndetei et al "Perceived economic and behavioural effects of the mentally ill on their relatives in Kenya: a case study of the Matahari Hospital". Published in the November 2009 edition of the Journal.

On behalf of the editorial board, heartfelt congratulations to the authors.

Further, many thanks to sanofi aventis for their support over the duration of the award.

**Christopher P. Szabo**

Editor-in-Chief



## Erratum

**The second author for the scientific letter "Consequences of untreated severe psychiatric disorders in northern Nigeria" which appeared in the May 2010 edition of the Journal should have read "FT Nuhu".**