

decision-making and psychiatric advance directives – all of which allow individuals to exercise greater choice and control over their own care – show benefits over usual care^{3,4}. These benefits are found in rates of adherence and self-management as well as in medical and mental health outcomes, yielding improved cost-effectiveness, service satisfaction, and quality of life, as well as reduced inpatient and emergency room use⁵⁻⁷ and possibly involuntary care⁸. These benefits appear to be even greater when interventions are more comprehensive, intensive, and integrated into routine care^{3,9}.

The international recovery movement has in many ways always been rooted in a human rights mission, yet that mission has most often identified formal service systems as the primary target for change. In doing so, we have failed to realize the full potential of recovery-oriented systems transformation. The recently released guidelines of the World Health Organization reaffirm this commitment to human rights. In order to honor that commitment the field must now grapple with the many structural and social factors that often place people on the margins of society and limit their opportunities for community belonging. Person-centred care planning represents one tool that the field can use

to address these challenges in supporting the whole person on his/her chosen pathway to recovery and community inclusion.

Larry Davidson, Janis Tondora

Program for Recovery and Community Health, Department of Psychiatry, Yale School of Medicine, Yale University, New Haven, CT, USA

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Youth psychiatry: time for a new sub-specialty within psychiatry

In 1973, M. Rutter was appointed as the first professor of child psychiatry in the UK. He is considered the “father” of modern child psychiatry due, in large part, to his seminal epidemiological studies of psychiatric disorders in children and adolescents in the Isle of Wight and London, carried out between 1964 and 1975. On the other side of the Atlantic, L. Kanner was the first physician to practice as a child psychiatrist, but children’s mental health remained within a psychoanalytic child guidance clinic model. The American Academy of Child Psychiatry (AACP) was not founded until 1953, and child psychiatry was not officially recognized as a specialty until 1959¹. In 1972, D. Cotter was the first US-trained child psychiatrist to be appointed to a consultant post in Ireland².

Gradually, it was recognized that the term “child” was not adequate for the range of ages. In 1983, the title of the AACP was changed to the American Academy of Child and Adolescent Psychiatry. The age range for child and adolescent psychiatry varied internationally, but common practice in most countries was to offer a service up until a young person’s 18th birthday. Young people persisting with or presenting after that age with mental health problems had to transition to, or present to the adult mental health services.

The pioneering work by P. McGorry and colleagues over several decades presents a compelling case that it is time for another paradigm shift in psychiatry similar to the emergence of the specialty of child psychiatry. In this issue of the journal, McGorry et al³ argue that epidemiological and clinical evidence, as well as advances in developmental neuroscience, no longer support schismatic service delivery between child and adolescent and adult mental health services.

Youth is a time when the incidence of mental disorders peaks, but in which access to coherent and user-friendly secondary care services is largely absent. The transition from the family-centric child and adolescent services to adult service models is too stark, and many young people cannot engage and fall through the cracks⁴. The cut-off age between different service models could be considered structural age-based discrimination. The Transitions of Care from Child and Adolescent Mental Health Services to Adult Mental Health Services (TRACK) study demonstrates that less than 4% of youth transitioning from child to adult services experience good continuity of care⁵.

The youth mental health services described by McGorry et al³, which attempt to address this gap, are based largely within primary care, with limited access to psychiatry. In Australia, a large proportion of young people seen by these primary care services require a higher level of specialist care than can be provided there, and fall between the criteria for primary and adult secondary care. They have been called “the missing middle”³.

There is a well-recognized relationship between continuity of care and mortality of patients with mental disorder, and this young adult age group has relatively high rates of suicide in most countries. Epidemiological studies show that mental disorders account for the greatest burden of disease in young people, yet our service delivery and training structures do not take account of this.

This period between mid-adolescence and the early twenties also coincides with many significant life changes, such as moving out of the family home, transition to third level education, starting a new career, and beginning (and ending) new romantic re-

relationships. Furthermore, the COVID-19 pandemic has sparked growing concerns about the well-being of young people, as normative developmental milestones and protective factors have been affected⁶. The field of “student mental health” or “student psychiatry” is also emerging as a new area of interest. College life can uncover or worsen pre-existing mental health problems⁷.

Youth mental health needs a specific philosophy of care in order for young people to effectively transition to independent established adulthood whilst experiencing serious mental health problems. Primary care mental health services, most often delivered by our allied health professional colleagues, have adapted much more rapidly to provide developmentally appropriate models of care for young people. The result is that a new field in mental health is developing, which targets an age group with a high incidence of serious mental disorders and suicide, largely without psychiatry input^{7,8}.

Psychiatry as a whole endorses a lifespan approach to mental illness. Due to high rates of comorbidity across different mental disorders, psychiatrists need training to meet the needs of those presenting with mental health problems based on an understanding of their developmental stage, culture and environmental circumstances. However, the impressive body of evidence presented by McGorry et al³ firmly points to the need for a new sub-specialty of youth psychiatry which would be a lifespan focused sub-specialty embedded within and between child and adolescent and adult services. Such a sub-specialty would span the period between the late teens and late twenties.

There are known skillset gaps within both child and adolescent and adult psychiatry when dealing with the mental health issues of young adults, such as treatment of persistent attention-deficit/hyperactivity disorder, management of autistic spectrum disorders and other neurodevelopmental disorders, management of polysubstance use and emergent personality disorder, crisis care for suicidal behaviours, and assessment and treatment of new-onset psychoses.

Neither child and adolescent psychiatry nor adult psychiatry covers the full range of skillsets needed by a youth psychiatrist. New curricula and training are required. Formal curriculum de-

velopment and training programs are being pioneered in Australia⁹. The College of Psychiatrists of Ireland has recently developed and approved a Faculty of Youth and Student Psychiatry (www.irishpsychiatry.ie). This is, to our knowledge, the first such faculty attached to a postgraduate psychiatry training body worldwide.

A new sub-specialty of youth psychiatry would particularly focus on emerging and pre-existing mental illness in the context of transitions and stresses in a young person’s life, with a philosophy of care that aims to establish a young person’s success and independence. Youth psychiatry should include relevant stakeholders in governance and service development, particularly young people, in order to maintain service attractiveness, quality, value and investment. Youth psychiatry services should have close links with education and training organizations as part of a whole community approach to good mental health.

In psychiatry, our service provision is not matching recent advances in developmental neuroscience or the changing place, role, challenges and expectations of young people in society. The structure of psychiatry training is stuck in a model from the last millennium. We are lagging behind the evidence and the practice of allied health professionals. Psychiatry needs to improve its offering to young people. It is time for a new approach to training and a new sub-specialty.

Mary Cannon¹, Emmet Power¹, David Cotter¹, Michele Hill²

¹Department of Psychiatry, Royal College of Surgeons in Ireland (RCSI) University of Medicine and Health Sciences, Dublin, Ireland; ²Student Health Department, University College Cork, Cork, Ireland

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