Brazilian Journal of Psychiatry
bjp
Revista Brasileira de Psiquiatria
Brazilian Psychiatric Association
Fully open access
No APCs

BJP PRE-PROOF
(article published as accepted)

Editorial

Eight hundred and twenty-seven: the invisible crisis of child and adolescent psychiatry in Brazil

Danilo Bastos Bispo Ferreira

http://doi.org/10.47626/1516-4446-2026-4995

Submitted: 26-Apr-2026

Accepted: 04-Aug-2026

BJP PRE-PROOF

This is a preliminary, unedited version of a manuscript that has been accepted for publication in the Brazilian Journal of Psychiatry. As a service to our readers, we are providing this early version of the manuscript. The manuscript will still undergo copyediting, typesetting, and review of the resulting proof before it is published in final form. The final version may present slight differences in relation to the present version.

Eight hundred and twenty-seven: the invisible crisis of child and adolescent psychiatry in Brazil

Danilo Bastos Bispo Ferreira[1,2]

[1]Department of Psychiatry, Universidade Federal de Alagoas, *campus* Arapiraca (UFAL), Arapiraca, AL, Brazil.
[2]Child and adolescent psychiatrist, Hospital Universitário Professor Alberto Antunes (HUPAA-UFAL), Maceió, AL, Brazil.

Correspondence: Danilo Bastos Bispo Ferreira, Universidade Federal de Alagoas, *campus* Arapiraca, Arapiraca, AL, Brazil. E-mail: danilo.bispo@arapiraca.ufal.br

BJP PRE-PROOF

Brazil currently has **827** board-certified child and adolescent psychiatrists (CAPs), a number that defines the scale of a workforce crisis affecting approximately 54.5 million children and adolescents aged 0–19 years[1,2]. Based on these figures, this translates to approximately 1.52 CAPs per 100,000 children and adolescents, far below the WHO-observed median of 3.4 per 100,000 in the European Region according to the WHO Mental Health Atlas 2020[3]. More recent data from the WHO Mental Health Atlas 2024 confirm that this scarcity is a global phenomenon rather than a uniquely Brazilian one. Worldwide, the median availability of specialized mental health workers dedicated to children and adolescents is only 1.5 per 100,000 total population, and the report describes the level of dedicated human resources for this age group as very low or even barely detectable in low- and middle-income settings. Even where specialists are comparatively more available, child and adolescent provision remains a fraction of adult provision, with at least ten adult mental health workers for every child and adolescent mental health worker in upper-middle- and high-income countries[4]. In the state of Alagoas, for instance, seven CAPs serve a population of approximately 969,694 children and adolescents, yielding a ratio of 0.72 per 100,000, with six of these professionals concentrated in the state capital, leaving a single specialist to cover the entire interior of the state[1,2]. The city of Arapiraca, the second largest in Alagoas with over 230,000 inhabitants[2], currently has a single board-certified CAP specialist serving its population and

surrounding region. At Hospital Universitário Professor Alberto Antunes (HUPAA-UFAL) in Maceió, the first R4 CAP residency program in the state is currently under institutional development, with an expected annual training capacity of one specialist upon implementation. This process itself illustrates the structural barriers facing CAP training expansion in underserved regions, where even the institutional will to train specialists encounters significant logistical and regulatory hurdles. By comparison, when a Brazilian task force first sounded the alarm in 2008, the ratio stood at one CAP for every 621,504 children and adolescents[5]. The improvement over the past 17 years, while real, remains profoundly insufficient.

The magnitude of the unmet need is well established. Polanczyk et al.'s landmark meta-analysis found a global prevalence of mental disorders in children and adolescents of 13.4%[6]. More recently, Kieling et al.'s analysis of the 2019 Global Burden of Disease study estimated that more than one in ten children and adolescents aged 5 to 24 years live with a diagnosable mental disorder, accounting for over one-fifth of all disease-related disability in this age group[7]. Applied to Brazil's current pediatric population, these figures translate to an estimated 6.3 million individuals in need of specialized mental health care. Yet epidemiological surveillance in Brazil remains geographically uneven: most population-based studies have been conducted in São Paulo and Rio Grande do Sul, leaving the North and Northeast, precisely the regions with the fewest specialists, systematically underrepresented in the evidence base, a pattern empirically documented in a recent nationwide systematic review of child and adolescent mental health research in Brazil[8]. The gap between prevalence and access is not incidental. It is structural.

The workforce deficit has deep roots. The 2008 task force analysis published in this journal demonstrated that the annual rate of new CAP certifications was approximately 18 per year, a pace that, at the time, would require 117 years to reach WHO-recommended levels[5]. As of 2024, 62 residents were enrolled in CAP training programs nationwide[1], representing a more than three-fold increase from the 18 annual certifications reported in 2008. While this growth reflects real progress, the structural bottleneck in postgraduate training has not been addressed proportionately. The R4 residency in child and adolescent psychiatry remains a one-year program that requires prior completion of a three-year psychiatry residency. This subspecialization model, in which CAP training follows the completion of a general psychiatry residency, is shared by several high-income countries, including

BJP PRE-PROOF

the United States, Canada, the United Kingdom, and Australia, although the duration of the additional CAP-specific training varies and is comparatively short in Brazil[9]. An alternative model exists in which trainees enter a dedicated, direct CAP residency without first completing general psychiatry; in Greece, for instance, child and adolescent psychiatry is an independent specialty whose residency spans five years, in alignment with the training requirements of the European Union of Medical Specialists[10,11]. The relative advantages and disadvantages of these models, including their differing duration and structure, warrant further discussion in Brazil, particularly in light of the workforce shortage described here. According to data from the National Medical Residency Commission (CNRM) and the Ministry of Education (MEC), training programs in this subspecialty remain scarce and geographically concentrated in the Southeast, reproducing the very inequality they could help correct, as illustrated in Table 1[1,12].

The regional dimension of this crisis deserves particular emphasis. Brazil's overall psychiatrist-to-population ratio stands at 6.69 per 100,000 inhabitants, already below the OECD average of approximately 14 per 100,000[1]. For CAPs specifically, the disparity is far more pronounced. The concentration of specialists in capital cities and major academic centers means that interior municipalities across the North and Northeast are, in practice, virtually without coverage.

This geographic concentration has consequences that extend beyond access. Children and adolescents in underserved regions are disproportionately affected by poverty, social vulnerability, and exposure to trauma; precisely the risk factors most strongly associated with mental disorders[13]. Moreover, 50–75% of adult mental disorders have their onset before the age of 18[14], meaning that diagnostic delays and treatment gaps in childhood translate directly into greater chronicity, morbidity, and economic cost in adulthood. Underinvestment in CAP is therefore not only a childhood health problem; it is an intergenerational public health failure.

Although general psychiatrists represent a substantially larger workforce, with 13,581 professionals registered in Brazil as of 2025[1], their formal training in child and adolescent mental health remains structurally limited under the current national curriculum. According to Resolution CNRM 18/2021, which governs psychiatric residency competencies in Brazil, CAP-specific training is introduced only in the second year of a three-year program, with mastery-level competencies expected only by the third year[15]. The absence of defined minimum practicum hours in child

BJP PRE-PROOF

and adolescent settings means that CAP exposure during general psychiatry residency is inherently dependent on local program structure and available training infrastructure, leading to significant variability in subspecialty preparation across the country. While general psychiatrists undoubtedly contribute to mental health care delivery for children and adolescents, particularly in settings where no CAP specialist is available, this structural variability suggests that their involvement cannot be relied upon as a systematic solution to the workforce gap described in this commentary.

The Psychosocial Care Centers for Children and Adolescents (CAPSi) are specialized community-based mental health services within Brazil's Unified Health System, designed to provide multidisciplinary care for children and adolescents with severe and persistent mental disorders, as well as those with needs arising from the use of crack, alcohol, and other drugs. Established under Ministerial Ordinance 3,088/2011, which instituted the Psychosocial Care Network (RAPS), CAPSi services are indicated for municipalities or regions with populations above 150,000 inhabitants[16]. Despite this regulatory framework, implementation remains critically uneven. The state of Alagoas operates a single CAPSi, located in the state capital, Maceió[17]. Arapiraca meets the regulatory threshold but lacks a CAPSi entirely. This gap illustrates how normative frameworks, even when well-designed, fail to translate into equitable service coverage in the absence of a sufficient specialist workforce to staff them.

The expansion of *lato sensu* postgraduate courses in child and adolescent psychiatry, offered by private medical education institutions across the country, has been presented as a partial solution to the training gap[1]. While such courses may improve general clinical competence among pediatricians and general psychiatrists, they do not confer board certification and should not be conflated with formal residency training. Telemedicine has similarly expanded access in some settings, though its limitations for complex psychiatric assessment in children are well recognized[18]. These are stopgap measures. The structural problem requires a structural response.

Three interconnected interventions deserve priority. First, the expansion of R4 CAP residency vacancies, particularly in federally funded university hospitals in the North, Northeast, and Center-West regions, must become an explicit target within Brazil's national medical residency policy. CNRM and MEC already have regulatory instruments; what is missing is the political will to direct resources toward this

BJP PRE-PROOF

subspecialty. Second, mechanisms for regional retention of newly certified specialists are urgently needed, including differentiated remuneration in public services, protected research and teaching time in university settings, and structured mentorship networks linking isolated practitioners with national academic centers. Third, mental health literacy and collaborative care competencies must be integrated more robustly into the curricula of medical schools, pediatric residencies, and general psychiatry programs, ensuring that, in the absence of a CAP, other clinicians are equipped to initiate care and provide appropriate referral.

The number 827 should not remain invisible. It represents a diagnostic of neglect of a specialty that trains its professionals in small cohorts, certifies them in concentrated regions, and then expects them to serve the mental health of 54.5 million children and adolescents. The Brazilian Psychiatric Association, CNRM, and the Ministry of Health have the collective authority to change this trajectory. The scientific evidence is sufficient to act. What is required now is the institutional recognition that child and adolescent psychiatry in Brazil is not a niche specialty, it is an underfunded pillar of the national health system, and the cost of inaction is borne by the patients least able to advocate for themselves.

Table 1. Child and Adolescent Psychiatry (R4) training programs identified in the ENARE 2025 national residency selection process, by region.

Region	State/City	Institution	Vacancies (2025)
Northeast	BA / Salvador	Hospital Juliano Moreira	2
Northeast	CE / Fortaleza	UFC / HUWC	2
Northeast	CE / Fortaleza	SES-CE / H. Frota Pinto	2
Northeast	CE / Fortaleza	ESP-CE / RAS Fortaleza	1
Southeast	MG / Montes Claros	Unimontes / HUCF	2
Southeast	MG / Belo Horizonte	SMS-BH / H. Odilon Behrens	3
Southeast	MG / Belo Horizonte	UFMG / HC-UFMG	2
Southeast	RJ / Rio de Janeiro	SMS-RJ	2
Southeast	RJ / Niterói	UFF / HUAP	2
Southeast	RJ / Rio de Janeiro	UFRJ	2
South	PR / Curitiba	UFPR / CHC-UFPR	4
North	—	No programs identified	0
Central-West	—	No programs identified	0

BJP PRE-PROOF

Total		**11 programs**	**24**

Source: EBSERH; Fundação Getúlio Vargas. ENARE 2025. Available at: https://enare2025-ebserh.conhecimento.fgv.br. Note: ENARE does not encompass all Brazilian CAP training programs. Additional programs operating through independent institutional or state selection processes were identified in Paraná, Rio Grande do Sul, Santa Catarina, São Paulo, and Pernambuco, suggesting that the figures above represent a conservative estimate of total training capacity.

Disclosure

The author reports no conflicts of interest.

Author contributions

DBBF: Conceptualization, Writing – original draft, Writing – review & editing.

Edited by: Arthur Caye.

References

1 Scheffer M, coord. Demografia Médica no Brasil 2025. Brasília: Ministério da Saúde; 2025. 446 p. ISBN: 978-65-5993-755-4. Available from: https://bvsms.saude.gov.br/bvs/publicacoes/demografia_medica_brasil_2025.pdf

2 Instituto Brasileiro de Geografia e Estatística (IBGE). Censo Demográfico 2022. Rio de Janeiro: IBGE; 2023. Available from: https://censo2022.ibge.gov.br

3 World Health Organization. Mental Health Atlas 2020. Geneva: WHO; 2021. Available from: https://www.who.int/publications/i/item/9789240036703

4 World Health Organization. Mental Health Atlas 2024. Geneva: WHO; 2025. ISBN: 978-92-4-011448-7. Available from: https://iris.who.int/handle/10665/345946

5 Moraes C, Abujadi C, Ciasca SM, Ribeiro MVM. Força-tarefa brasileira de psiquiatras da infância e adolescência. Braz J Psychiatry. 2008;30(3):294-5. doi:10.1590/S1516-44462008000300021

6 Polanczyk GV, Salum GA, Sugaya LS, Caye A, Rohde LA. Annual research review: a meta-analysis of the worldwide prevalence of mental disorders in children and adolescents. J Child Psychol Psychiatry. 2015;56(3):345-65. doi:10.1111/jcpp.12381

7 Kieling C, Buchweitz C, Caye A, Silvani J, Ameis SH, Brunoni AR, et al. Worldwide Prevalence and Disability From Mental Disorders Across Childhood and

BJP PRE-PROOF

Adolescence: Evidence From the Global Burden of Disease Study. JAMA Psychiatry. 2024;81(4):347-356. doi:10.1001/jamapsychiatry.2023.5051
8 Marchionatti LE, Campello AC, Veronesi JA, et al. The science of child and adolescent mental health in Brazil: a nationwide systematic review and compendium of evidence-based resources. BMJ Glob Health. 2026;11:e018542. doi:10.1136/bmjgh-2024-018542
9 Gnanavel S, Sharma P, Sebela A, Gomez Alemany T, Chang JP-C, et al. Child and adolescent psychiatry training curriculum: a global trainee’s perspective. BJPsych Int. 2020;17(3):69-71. doi:10.1192/bji.2020.8
10 Marchionatti LE, Schafer JL, Karagiorga VE, et al. The mental health care system for children and adolescents in Greece: a review and structure assessment. Front Health Serv. 2024;4:1470053. doi:10.3389/frhs.2024.1470053
11 European Union of Medical Specialists. Training Requirements for the Specialty of Child and Adolescent Psychiatry. Brussels: UEMS; 2014. Available from: http://www.uemscap.eu
12 EBSERH; Fundação Getúlio Vargas. Exame Nacional de Residência (ENARE) 2025: Psiquiatria da Infância e Adolescência [Internet]. Brasília: EBSERH; 2025 [cited 2026 May 21]. Available from: https://enare2025-ebserh.conhecimento.fgv.br
13 Kieling C, Baker-Henningham H, Belfer M, Conti G, Ertem I, Omigbodun O, et al. Child and adolescent mental health worldwide: evidence for action. Lancet. 2011;378(9801):1515-25. doi:10.1016/S0140-6736(11)60827-1
14 Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry. 2005;62(6):593-602. doi:10.1001/archpsyc.62.6.593
15 Ministério da Educação (BR). Resolução CNRM nº 18, de 6 de julho de 2021. Aprova a matriz de competências dos programas de Residência Médica em Psiquiatria no Brasil. Diário Oficial da União. 2021;126(Seção 1):456. Available from: https://www.in.gov.br/en/web/dou/-/resolucao-cnrm-n-18-de-6-de-julho-de-2021
16 Ministério da Saúde (BR). Portaria nº 3.088, de 23 de dezembro de 2011. Institui a Rede de Atenção Psicossocial. Diário Oficial da União. 2011. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt3088_23_12_2011_rep.html

BJP PRE-PROOF

17 Secretaria de Estado da Saúde de Alagoas (SESAU-AL). Mapa da Saúde: Centros de Atenção Psicossocial [Internet]. Maceió: SESAU-AL; 2025 [cited 2026 May 21]. Available from: https://cidadao.saude.al.gov.br/servicos/caps
18 Santosh P, Polanczyk GV, Sonuga-Barke E, et al. Remote assessment of ADHD in children and adolescents: recommendations from the European ADHD Guidelines Group following the clinical experience during the COVID-19 pandemic. Eur Child Adolesc Psychiatry. 2023. doi:10.1007/s00787-023-02148-1

BJP PRE-PROOF