



World Child & Adolescent Psychiatry

ISSUE 21, December 2021

Improving child and adolescent mental health by connecting global wisdom with everyday practice and advocacy

World Psychiatric Association,
Child and Adolescent Psychiatry Section's
Official Journal



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Chair's Column:

Dear Colleagues,

Welcome to the final 2021 issue of "World Child and Adolescent Psychiatry," the official journal of the World Psychiatric Association, Child and Adolescent Psychiatry Section.

2021 was another very busy and productive year for the WPA Child and Adolescent Psychiatry section. Unfortunately, 2021 brought also some sad news. Professor Michal Rutter, the most influential psychiatric scientist of his generation, died in 2021. Sir Michael Rutter was often described as the father of modern child and adolescent psychiatry. He was the first professor of child and adolescent psychiatry in the United Kingdom, and his work provided the first evidence that autism had a genetic basis. Prof. Bennett Leventhal has dedicated his editorial to his hero, teacher, mentor and friend: Prof. Michael Rutter.

2021 was marked with the COVID-19 pandemic, but what awaits us in the near and far future? Prof. Norman Sartorius, former director of the World Health Organization's (WHO) Division of Mental Health, and former president of the World Psychiatric Association and of the European Psychiatric Association, shares his wisdom in the paper, "Psychiatry After the COVID Pandemic."

This issue also features the 10th anniversary of the ground-breaking book, "Where There Is No Child Psychiatrist." This book, written by Professor Valsamma Eapen and colleagues, was and still is a key textbook and a powerful resource for allied professionals.

And this is not the only 10th anniversary. The International Child Mental Health Study Group is also celebrating its 10th anniversary. If you would like to know how to succeed with child psychiatry research without any major funding, please read the paper by Dr. Dejan Stevanović

In this issue, you will also find contributions from our younger colleagues. Dr. Mandar Jadhav is a child and adolescent psychiatrist and a Congressional fellow in Washington, D.C. USA. He provides an inside look into a legal machine that drives a great deal of mental health service delivery in the United States.



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We continue the tradition of providing reports on child and adolescent psychiatry in various countries and regions, and in this issue, Grenada, Hong Kong, Egypt and New Zealand are featured.

Finally, I would like to thank our editorial team and reviewers for their time and work in 2021.

Have a Happy Festive Season and a Prosperous and Healthy 2022!

Happy Readings!

Prof. Norbert Skokauskas (Norway) Editor,

“World Child and Adolescent Psychiatry”

Chair, World Psychiatric Association, Child and Adolescent Psychiatry Section



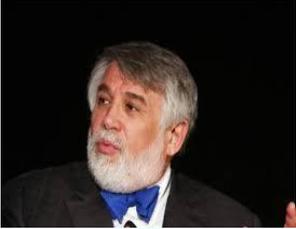


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In Memoriam: Professor Sir Michael Llewelyn Rutter



Prof. Bennett Leventhal (USA)

"Our death is not an end if we can live on in our children and the younger generation. For they are us; our bodies are only wilted leaves on the tree of life."

Albert Einstein

Professor Sir Michael Rutter died peacefully at home on 23 October 2021, surrounded by family, for whom he was a loving and loved husband, father, and grandfather. We join in their grief.

To us, Professor Rutter was a father of a different sort. He was the visionary father who created modern child and adolescent psychiatry by bringing it into the community of evidence-based medicine and science. He was also the father of the broader field of developmental psychopathology. For me, as for many others, Sir Michael played a fatherly role in my career, first as a hero who later became my teacher, then my mentor, and, ultimately, Mike, my friend.

Mike was born in August, 1933, in Brummana, Lebanon, a town in the hills above Beirut, where his father, Llewellyn Rutter, a general practitioner, worked in the American Friends Hospital. He was the eldest child in a Quaker family. His mother, Winnifred, had worked for Cadbury's before marriage. In 1937, with war looming in Europe, the family returned by ship to England, where his father practiced medicine in Wolverhampton, a suburb of Birmingham. Three-year-old Rutter, as a fluent Arabic and English speaker, amazed those on the ship. (In later years, he claimed no recollection of Arabic).



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In 1940, when Mike was 7 years old, he and his sister, Priscilla, were sent to live with Quaker families in New Jersey, due to fears that Hitler would invade England. Mike later reported a very positive experience in America, because, in his view, his foster parents kept his family very much present in his life so that he could transition between the two families effortlessly. He was able to contrast this arrangement with his sister's experience, which was considerably less comfortable. Mike maintained a close relationship with his foster parents throughout his life. He reported returning to England somewhat Americanized, at least to the extent that, upon his return at the end of the war, his grandmother, perhaps in jest, wondered, "Have they sent the right boy home?" In any case, Mike was able to make a smooth transition from Moorestown Friends Academy in New Jersey to Wolverhampton Grammar School, without difficulty. He subsequently attended boarding school at the Bootham School, a Friends school in York.

Rutter came from a family of physicians, so it was not a surprise that he followed in his father's medical footsteps when he entered medical school at the University of Birmingham in 1950. However, his interest in psychiatry may have begun at Bootham, when his physics teacher recommended that he read Freud. This assignment led to an early fascination with dreams and his own practice, during adolescence, of awakening and then writing down his dreams. However, Mike reported that the critical step in moving toward psychiatry was a medical school rotation with Professor Wilhelm Mayer Gross, who had escaped Nazi Germany and joined the clinical faculty at the University of Birmingham. Gross, a graduate of Heidelberg University, was a powerful influence on British psychiatry, and by Rutter's account, a powerful teacher. Years later, Mike recounted an exercise in which Gross sent students to interview patients on a ward for one hour and then come back and report what they observed. Mike said he returned to Gross and was somewhat ashamed to report that he "failed" the assignment and had little to report. Gross then kindly walked Rutter through his experience and demonstrated all the remarkable things he had seen. This exercise led to both relief and a newfound interest in psychiatry.

The next step in Mike's career, after serving as a house officer in Birmingham, was a move to the Maudsley in London, where, according to Mike, Sir Aubrey Lewis had gathered a group of brilliant colleagues to build a center for modern British psychiatry research. Lewis knew his trainees well and, perhaps, in Mike's case, very well. Lewis advised Mike to become an academic child psychiatrist. At the time, Mike later recounted, he knew



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little about child psychiatry and had little interest in research. Nonetheless, he followed Lewis' advice, and he said, years later, "it seems like a good fit."

Mike never had formal training in child psychiatry. Indeed, Aubrey Lewis advised against it and said that the training programs were not good enough. So, he helped Rutter get training through another route, beginning with incredible mentorship during a sojourn (1961-1962) at the Albert Einstein College of Medicine in New York, where he was met and befriended by Professor Herbert Birch, a physician scientist with a doctorate in psychology. During this time in New York, he also met many others, including Stella Chess and Alexander Thomas, who became mentors and supported his career development.

Another nodal point in Mike's life was when he met his wife of 60 years, Marjorie Heys, a nursing student in the hospital in Birmingham. They met in his last year in Birmingham. Marjorie is a remarkable person in her own right. She not only was a critical force in so many aspects of Mike's life, but also maintained a remarkable career in her own right, as a nurse. Marjorie told wonderful stories of her times with Mike. As a young married couple at the Maudsley, they lived in cramped quarters. Their first sojourn was in the US, immediately after psychiatry training. With little funds, Mike took a fellowship at Einstein in New York, and they had to make do with young children and limited resources. But, for Marjorie, it was part of the adventure. In addition to their children, Sheila, Christine, and Stephen; Marjorie and Mike shared a wonderful marriage. They also shared a love for hiking at their holiday home in the English Lake Country and elsewhere, especially Yosemite in the US. Their home, for many years, in Dulwich, was full of life, laughter, and work, some shared and some independent. They wrote one book together, *Developing Minds: Challenge and Continuity Across the Lifespan* (1993). Marjorie was a very successful nurse practitioner in her own right. Like Mike, Marjorie was a pioneer in her work with families struggling with infertility; she was one of the earliest to work with and counsel families going through infertility treatment and in vitro fertilization. Amongst her many accomplishments, Marjorie also did groundbreaking work helping gay and lesbian families who wanted to have children. Marjorie survives Mike and, with support from family and friends, still lives in their wonderful home facing the park in Dulwich. At a recent visit, we sat in the wonderful sunroom and looked at photos, while Marjorie told stories about Mike, their family, and their shared, remarkable journey together, with both a twinkle and a tear in her bright eyes.



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His prodigious career is reflected in more than 550 scientific papers and 52 books and exemplified by groundbreaking epidemiologic studies of developmental psychopathology on the Isle of Wight and in Inner London. He also led explorations, with twin studies, of autism genetics and developed hypotheses later confirmed by molecular genetics. He also played a pivotal role in the Romanian adoption studies, validating his earlier work on attachment and developmental disruptions in early childhood. This incredible productivity is but a small portion of his extraordinary corpus of work that encompasses virtually the entirety of human development and developmental psychopathology.

Mike's approach to science was deliberate and forceful. He was an admirer of Peter Medawar and, in some ways, modeled his own work in that fashion. In 1971, he said, "Of course, it would be quite futile to collect facts without a purpose. As Medawar has described so well, science consists of both discovery and proof, hypothesis and then careful testing to discriminate between alternative hypotheses." His rigor in this regard was unrelenting. In 2020, Professor Jim Stevenson, a distinguished psychologist and Rutter collaborator, completed an encyclopedic summary of Mike's publications to date. This "digest" is not only a review of the work of a great clinician-scientist but also of the progress in the field of child and adolescent psychiatry of the past half-century. (Refer to the Association for Child and Adolescent Mental Health (ACAMH) to download this paper: <https://www.acamh.org/blog/a-digest-of-the-published-work-of-michel-rutter-1958-2020-2/>) The breadth of topics is staggering: Adolescence, Attention-deficit Hyperactivity Disorder (ADHD), Antisocial Behavior, Assessment (of various sorts), Autism (20% of his work, including the Autism Diagnostic Interview, or ADI, and the Autism Diagnostic Observation Schedule, or ADOS), Childhood Disorders, Adult Disorders, Classification, Depression, Epidemiology, Genetics, Head Injury/Brain Dysfunction, Institutional Care, Language Development, Maternal Deprivation, Parental Mental Illness, Physical Health Conditions, Reading, Research Methods and Design, Resilience, Risk and Adverse Experiences, Schools, Temperament, Treatment, as well as other publication topics that defy classification.

Mike was one of the world's first Professors of Child and Adolescent Psychiatry (1973), and the first in England. Mike set up the first, and only, independent Department of Child and Adolescent Psychiatry at the Institute of Psychiatry. In 1983, he became the founding Director of the first Medical Research Council (MRC) Research



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Unit in Child and Adolescent Psychiatry. He also became the founding Director of the Social, Genetic, and Developmental Psychiatry Centre (1998). These units both reflected Sir Michael's own work and served as the very models for interdisciplinary and collaborative research, focusing on how biology ('nature') and the environment ('nurture') interact to affect psychiatric disorders, neurodevelopment, and individual differences across development. Here, as elsewhere, Mike collected a myriad of outstanding students and distinguished colleagues who were made better by his teaching, mentoring, interest, and personal support.

Professor Rutter was the deserved recipient of numerous awards, including multiple honorary degrees, Fellowship in the Royal Society, US National Academy of Medicine membership, and Knighthood (1992). Mike was also honored when the Maudsley renamed its child and adolescent psychiatry clinic, The Michael Rutter Centre.

Most were in awe of Mike's intense scientific prescience, the focus on his work and his competitive nature (in science and in tennis). He had a prodigious knowledge of psychiatry and medicine. For some, he was a feared critic. But, for those who shared his discipline and enthusiasm for pursuing knowledge, he was accessible, kind, and supportive. A skilled clinician, Mike always had children at the very center of his work. He was a talented clinician who was committed to personally interviewing children on the Isle of Wight, in London, in Romania, and wherever else he conducted research. He respected children and was proud and grateful in acknowledging all he learned from them. Here, again, Mike is a worthy model for all clinicians and scientists.

While Mike's leaf has wilted and fallen, the tree of life stands taller and stronger for his work, as well as his presence in our lives and in the lives of the children and families we serve.



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Sir Michael Rutter (1933–2021)



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Psychiatry after the COVID pandemic



Prof. Norman Sartorius (Switzerland)

The source of the confused, inefficient and slow reaction to COVID that characterized governments of most countries of the world is probably rooted in the 1970's when it seemed that humans have overcome the threat of disease. Those were the years when it was made clear that many of the killers of the past – such as measles or smallpox - can be controlled by vaccination and most of the other dreaded diseases such as typhus, syphilis, various types of pneumonia, scarlatina and others could be successfully treated by antibiotics. (Mackenzie, D.,2020) Malaria was eradicated in southern European countries and the extensive and intensive antimalaria programs reduced its deadly effects in low-income countries as well. Tuberculosis was halted and receded with improved living conditions and medications. In high income countries departments of infectious diseases were reduced in size and importance. Public health authorities became convinced that the communicable diseases in low-income countries will be controlled as more money becomes available by industrial development or international aid. The reduction of noncommunicable diseases was still seen as a problem but no longer a problem primarily resolvable by health services - it was behavior diet, exercise, control of pollution, stress, smoking and other lifestyle factors which were to be righted and it was hoped that the population will follow so that these diseases will not be a major problem.

And then, as the end of the 20th century came closer it became clear that the reliance of the populations changing their behavior was optimistic and that noncommunicable diseases will continue to grow in importance.



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International non-governmental organizations became very active and in 2012 even the United Nations acknowledged that noncommunicable diseases are a major and growing problem. Mental and neurological disorders were left out of these considerations and it took another decade to see their control included among the United Nations sustainable development goals. Governments were urged to take resolute measures

In addition to these worries - recognized as important and requiring action - governments were also confronted with the resurgence of communicable disease problems. The first of these was AIDS but a number of others followed, often caused by agents transmitted from. Some of them were deadly, others less dangerous some spreading fast, others a bit slower. Swine flu, Lyme disease, SARS, MERS, Ebola and Zika are examples of disorders which were fought with variable success.

As if this was not enough, it was gradually becoming clear that a number of communicable diseases are caused by agents which are resistant to treatments (which could be obtained if the country had money to buy them.) Non-communicable diseases increased in numbers and severity. Diseases such as dementia grew in importance in line with the changes of the demographic structure of the population.

Meanwhile much of the formal apparatus controlling diseases – such as the ministries of health and international organizations created to deal with diseases which know no borders, lost much of their vigor and power. When AIDS hit the world, the World Health Organization could not cope with all that needed to be done and a new organization dealing with classical WHO subjects – control of malaria, tuberculosis and now AIDS had to be created. Responsibility for international vaccination programs moved to yet another creature, the global vaccination agency, GAVI. And at the country level, the weakness of WHO was mirrored by the weakness of ministries of health which were no longer among the most important parts of the government – they had significantly reduced budgets; as a result, the salaries of staff were not attractive to the best of national experts, and national health care schemes did not function as well as they were supposed to function. The skills and knowledge necessary to implement public health measures – such as the control of communicable diseases – was not longer available. The authority of the ministries was reduced and transferred to the provincial level or simply ignored. The COVID pandemic is partly due to the weakness of the health systems and lack of authority of health



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care leaders; it is also partly the result of the lifestyle of the modern world with unlimited travel, cessation of health education for the general public and urbanization amassing millions of people into towns, thus exposing them to physical proximity. It is probable that a similar virus would not have spread to a pandemic in yesterday's world. Some of the anti-COVID measures were introduced because that they were helpful in dealing with epidemics many years before; they unexpected results or no effect because the world had changed since these measures were first used. Thus, confinement which did not require major changes of living when implemented in rural areas with a lot of space to roam, had very different consequences when applied in the towns of the 21st century. Confinement of large families in small apartments in towns contributed to a significant increase of intrafamilial violence. Alcohol, in modern times, was easy to get, and used much more, partly to pass the time and partly to cheer up and forget the worries about losing jobs and other consequences of the pandemic. Vaccination, previously a normal part of health care, was previously seen as a privilege and a service by the health care system but, now, no longer remembered as such and therefore partly feared. People experienced anxiety and depression, partly to the level of a psychiatric disorder.

People who had mental disorders carry the burden of stigma, as could be expected, particularly in this tough time, were the last to be vaccinated and many of them received poor care when sick. This led to higher COVID mortality rates than the rates of those who did not have mental disorders. The departments of psychiatry were requested to free the beds so as to use them to people with COVID. Personnel looking after people with mental disorders were asked to leave their jobs and their patients in order to participate in the treatment of people sick with COVID19s. These multiple actions put individuals with mental disorders at ever increasing risk. The infodemic accompanying the COVID pandemic is unprecedented – in size and intensity. Carried by modern social media and strengthened by the total absence of censorship in matters concerning health and the pandemic as well as by the universal use of the English language. It adds problems which were not experienced in previous epidemics. In addition to misinformation about the disease (which makes many measures against the disease inefficient or impossible) the infodemics has strengthened pre-existing prejudice against refugees, migrants, those of a different religion or a difference of color of skin. These prejudices as well as ideas about the disease will continue to linger in the population long after the pandemic is over.



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Psychiatry and the protection of mental health have been more prominent during the COVID pandemic than in previous epidemics. This is partly due to the increases in the prevalence of anxiety and depressive disorders, as well as alcohol and drug abuse during the pandemic. It is also partly due to the widely shared worries about the troubled future and its impact on mental health. The experience gained during the COVID pandemic will enrich psychiatry's capacity to offer help in future pandemics and other massive emergency situations. In addition to changes resulting from the effects of the pandemic, there are other changes which are a logical consequence of the changes in medical comorbidity and the development of medical knowledge, in general. Some of the foreseeable changes will be made more rapid because of COVID and its social and medical consequences. Thus, for example, psychiatrists will have to develop ways of dealing with the comorbidity of mental and physical disorders. The prevalence of comorbidity is likely to increase partly because of the increased prevalence of noncommunicable diseases, and partly due to the prolongation of life expectancy offering more years lived with a noncommunicable disease. Collaborative care, where it was possible to bring it into existence, is a way to solve the problem of comorbidity. The problem, however, is that well-functioning collaborative care is still a rarity, often surviving only because it is under the responsibility of exceptional people; these are difficult to find.

Offering a credible response to the problems of care for people with comorbidity of mental and physical disorders will require a reform of the education of medical students and physicians, particularly for those who will choose general practice as their specialty. Psychiatrists will also have to return to their medical roots so as to be able to deal with mental as well as physical illnesses, establishing, wherever possible, collaborations with other medical disciplines. Other tasks before psychiatry of tomorrow will not be easy either. Psychiatrists will have to resist the tendency of super-specialization, such as narrowing their interest and expertise on subjects such as a particular disease (e. g. bipolar disorders) or a particular intervention (e.g. a method of treatment). Resisting super-specialization is not easy; the knowledge which psychiatry as a discipline has amassed is ever more difficult to master and limiting one's work to a particular part of psychiatry is a natural tendency. The fact that superspecialists can also charge higher fees may also play a role in becoming a superspecialist. Psychiatry will also have to update its knowledge about the origin and development of mental disorders – a task that will require much closer connection with other branches of medicine and of sciences than is currently the case.



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And then, there are new developments in the practice of medicine which will also be of relevance for psychiatry. The first and probably foremost is the digitalization in general and the use of telemedicine in. Finding the right dose of reliance on communication tools will have to be done while remaining aware of the fact that the fabulously developed technology of communication should always remain a servant of medicine rather than its master.

Being with others of the psychiatric professions and exchanging views and experience with them has always been a source of learning and an occasion to make and keep friends. Current technology is being offered as a considerably cheaper and vastly more efficient way of communication. Zoom, and other forms of making webinars and virtual events seem to offer cheaper and more efficient ways of togetherness. However, it is to be hoped that it will be remembered that they serve to transmit information but do not provide a basis for empathy, friendship, and other ingredients of making friends and keeping a profession together. The increasing number and seriousness of mental health problems will also drive psychiatry into the position of serving as a leader and advisor to public health authorities, educational authorities, and governmental agencies dealing with the implementation of laws. To be able to play these roles, psychiatrists will have to increase the armamentarium of their communication skills, skills of convincing and of building alliances. Having acquired these skills, preferably during their undergraduate and postgraduate education, psychiatrists will have to use them in order to make public health authorities undertake action that will result in the primary prevention of mental disorders and in necessary changes of the many services that must work together to help people with mental illness.

Thus, psychiatry after the COVID epidemic, will in many ways remain the same and the pandemic will be an event which all will remember like they remember a war or other period of danger and uncertainty. It will be wonderful if psychiatry critically examines its experience of working in the pandemic and learn from it – both how to practice in pandemics and how to do it well in the time between pandemics.

References available on the request.



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Where there is No Child Psychiatrist:

A reflection on child mental health capacity building from Australia



Prof. Valsamma Eapen (Australia)

Dr Paul Robertson (Australia)

As we approach 10 years since the publication of *Where There Is No Child Psychiatrist* (1), we reflect upon how far we have come with global child and adolescent mental health (CAMH). Specifically, here we look at developments over the last 10 years from Australia and New Zealand (ANZ) and the Asia-Pacific region within which they sit.

While individual ANZ Child and Adolescent Psychiatrists (CAPs) had previous or existing engagements with colleagues in the Pacific and Asia, a concerted and organized approach to regional engagement in CAMH by the CAP profession commenced in 2013 with the establishment of the first Pasifika Study Group (PSG). Professor Olayinka Omigbodun, Nigerian CAP and then-president of the IACAPAP, was an invited international speaker to the Royal Australian and New Zealand College of Psychiatrists (RANZCP) Faculty Child and Adolescent Psychiatrists (FCAP) 2013 Annual Conference in Melbourne. With her guidance and practical support, and based on her experience and model of IACAPAP study groups in Africa, we conceived and delivered the inaugural PSG. The FCAP partnered with a local NGO Mental Health for the Young and their Families in Victoria (MHYFVic) to bring together a small group of Pacific Island nation doctors practicing in mental health in their



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countries for a 2-day program in Melbourne at the Mindful center for training and research in developmental health. The PSG provided a networking, leadership development and educational function. Following the 2-day program, participants attended the annual FCAP conference and presented a symposium on the PSG outcomes and hopes for the future. Professionals from Fiji, Papua New Guinea (PNG), Vanuatu, and the Cook Islands, along with ANZ CAPs, participated.

Following the success of the first PSG meeting in 2013, it was decided to hold a regular biannual event (2) in the Pacific region. These events were facilitated by important organizational partnerships of the FCAP with the Pasifika Medical Association (PMA), the principal Pacific health organization, and the Pacific Community (SPC), a Pacific intergovernmental developmental agency. These partnerships allowed the PSG to run in parallel with, and then as part of, the PMA conference held in the Pacific biannually. This partnership saw the second PSG occur alongside the PMA conference in Port Vila, Vanuatu (along with the FCAP annual conference) in 2015; Noumea, New Caledonia in 2017 and Niue in 2019, with increasing integration. The COVID pandemic saw a telehealth (Zoom) PSG in September 2021. Over time, the PSG has evolved to include more Pacific Island countries and broader multidisciplinary representation while holding a focus on education, professional networking, and leadership. The PSG supported the development of a local Pacific professional organization, the Oceania Society of Mental Health Professionals (OSMHP) (3), now an important ongoing partner and voice for Pacific mental health professionals. While the PSG remains focused on the mental health needs of children and youth, to accommodate the generalist nature of Pacific mental health services, the program has broadened to provide a developmental and family-centered approach to mental health across the lifespan. The support provided to Pacific nations has resulted in further development of local mental health leaders and greater service capability. However, it is recognized that the influence is mutual, and we in ANZ have learned much from our Pacific colleagues, for example, in the use of extended family and community to support our children and young people.

The PSG has provided an umbrella for the development of further projects with various partners across the Pacific. The Vanuatu Psychiatry Mentorship Program is one example (4). The success of this ongoing mentoring program is now expanding with the development of mentoring programs for mental health doctors in Samoa, Kiribati, Solomon Islands, PNG and Fiji, all in various stages of development. In partnership with IACAPAP,



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their training package iCAMHS has been trialed in Fiji and PNG (5). Another project, in partnership with the Fijian Health Department, led to the CAMH in Primary Care Fiji in 2018 and 2019, where the focus was on primary care and its link to specialist services (6). Mental health support following natural disasters has also been provided under the PSG umbrella in Samoa and Fiji.

The suspension of international travel and face-to-face meetings with the COVID pandemic in 2020 saw disruption of PSG programs and forced us to innovate with telehealth delivery. The Ophelia Project was piloted in 2020 using a Zoom videoconference-based delivery of a 10-week lunchtime Professional Development program in CAMH in conjunction with St Vincent's Mental Health (Victoria) and Fiji National University (FNU). The pilot saw 43 health worker participants from seven Pacific countries attend. The success of the pilot Ophelia project led to the delivery of an expanded Ophelia Project in 2021.

From small, informal beginnings in 2013, the FCAP, through the PSG, has developed organizational structures to oversee the various projects that are now managed by a standing subcommittee, the Child and Adolescent Psychiatry International Relations (CAPIR) subcommittee, and supported by a part-time paid project officer (7). A Pilot Volunteer Program is underway to examine how best to harness and organize the potential volunteer resource within the CAP profession. CAPIR recognizes the importance of organizational partnerships. Partnerships already mentioned with the PMA, SPC, OSMHP, St Vincent's Mental Health and FNU have been essential in delivering projects and ensuring sustainability and ownership locally. Other partnerships have supported funding through ANZ international aid funding structures and philanthropic organizations.

In Asia, other capacity building activities have been undertaken with the support of FCAP in countries such as Vietnam, Indonesia and Cambodia. One such example is an 'Introductory Child and Adolescent Mental Health Training Program' provided in Cambodia to a key group of professionals from primary care, adult psychiatry, paediatrics, and nursing in late 2019 and in early 2020. This program, a partnership between FCAP and St Vincent's Mental Health Melbourne, was deemed a great success, and, currently, a follow up project is being developed to provide a series of Continuing Professional Education sessions to build child and adolescent mental health capacity in Cambodia.



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Recognizing that it is important to train child and adolescent psychiatry specialists, and given that many countries do not have the infrastructure to establish a CAP specialist training program, we have partnered with the Adult Psychiatry Board in countries where general psychiatry training is available to support nascent CAP training. One example is in Iraq, where the program offers the opportunity for those with an interest in child psychiatry to undertake an additional 'CAP' specialty training after completion of general psychiatry training. In this model, local clinical placements are supported via video conference-based clinical supervision by an international faculty of child and adolescent psychiatrists. On completion of this structured training program, examinations (Objective Structured Clinical Examination, or OSCE, and clinical VIVA, or oral exam) are conducted (through co-examination by an international CAP faculty paired with a local adult psychiatrist) and organised through the local Psychiatry Board Certification authority of Iraq. The first batch has successfully completed the CAP specialist training with certification provided by the Iraqi Board of Psychiatry. The plan is to extend this model to other countries, in partnership with their local General Psychiatry Certification Board. While this program commenced pre-Covid, it pivoted to telehealth with lectures, supervision and examinations through videoconferencing.

A number of other Australian initiatives in supporting regional global mental health have also occurred in the last decade, both influencing and influenced by the FCAP work. A group, 'Creating Futures,' (8) has delivered conferences in Australia, PNG and Fiji along with Leadership in Mental Health courses with a broader mental health agenda than CAMH alone (9). Through the Mindful centre for training and research in developmental health, part of the Department of Psychiatry at The University of Melbourne, a group of international-born, Australian CAPs have provided mutual ideas, encouragement and practical support to assist CAMH in their countries of birth, particularly Sri Lanka and India. An example is the use of IACAPAP iCAMH training in Sri Lanka with adult psychiatrists to increase their capability in CAMH in the absence of sufficient Sri Lankan CAPs. Another is the development of local NGO training for grassroots CAMH clinicians in India. It is important to recognise that the ANZ CAP profession includes many migrants who hold ongoing cultural and professional links with their country of birth along with a desire to support and give back to their country of birth.

In summary, much has happened for ANZ and its regional neighbors in the Pacific and Asia since the publication



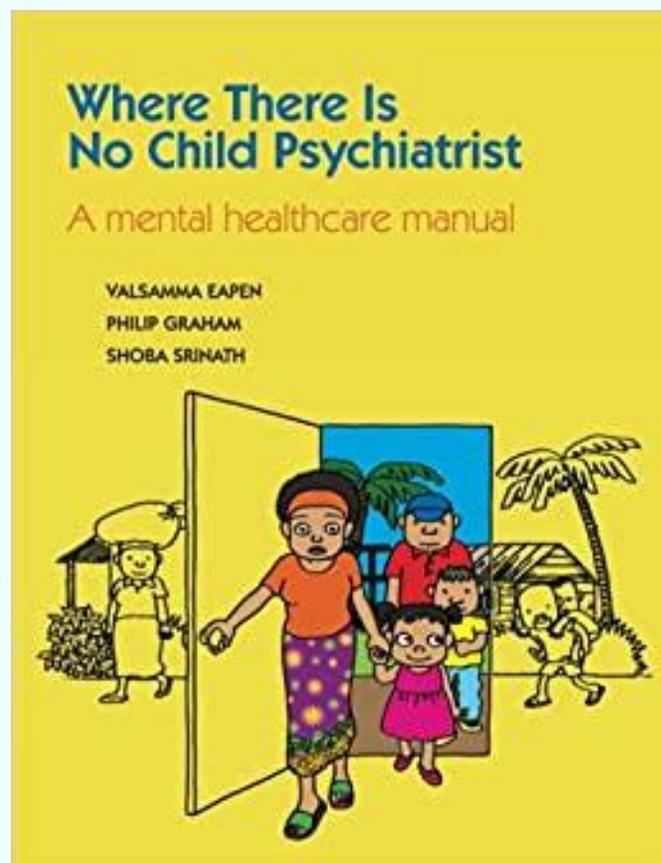
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of Where There Is No Child Psychiatrist. There continues to be exciting developments, not the least of which are innovations around telehealth brought by the COVID pandemic. Much more could be achieved. Where There Is No Child Psychiatrist was instrumental in providing an accessible, powerful tool both as a manual in print and also as an e-book with appropriate available case histories for discussion. It is hard to imagine how we might have started back in 2013 without this resource.

References available on the request.





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Unusual Models for Psychiatrists to Engage with Government



Dr. Mandar Jadhav (USA)

Psychiatry is unique among health professions in how deeply our work intersects with the education system, social norms, local and national laws and regulations, and the justice system. In every country with a version of a public mental health system, there is also interplay with healthcare financing and administration. Often a decision made in a school superintendent's office, a chamber of parliament, a courthouse, or a government administrator's office has wide-ranging implications for psychiatrists and the people we serve. These decisions can be influenced by parents, teachers, voters, lawyers, economists, and a variety of corporate interests such as hospitals, pharmaceuticals, insurers etc. Psychiatrists have maintained some presence in these conversations over the years through writing on the issues, public speaking, research publications, and meeting with decision-makers directly and via our professional organizations' government affairs liaisons. Some have chosen to work for or volunteer in positions within the education, legal and justice system. Overall, however, this type of engagement still involves a relative minority of our colleagues. When it comes to trainees, there is a great deal of enthusiasm for advocating for systems-level changes, but this energy is not consistently matched with providing them the right opportunities. Within this context, I consider myself extremely lucky to have gotten a look inside the legal machine that drives a great deal of mental health service delivery in the United States. Through a competitive selection and placement process, I was granted one of two year-long positions as a Congressional fellow in Washington, D.C. this year. This fellowship program is supported by the American Psychiatric Association Foundation. The program was established in honor of Dr. Jeanne Spurlock, M.D., who was a ground-breaking



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advocated for child and minority mental health priorities, and a former deputy medical director of the APA. The goal of the program is to help psychiatry residents or early career psychiatrists expand their knowledge of federal legislative processes pertaining to healthcare and to support the offices in which they are placed in their psychiatry-related endeavors. In my case, I am placed with the office of a Senator who has been a leader in advancing mental health care in the US, whilst my counterpart is placed with a House member who does the same. The emphasis on specific issues and political perspectives varies between the two offices, but the mission is the same- improve mental health service delivery for all Americans.

For my part, I have been included in my office's efforts involving improving maternal health, caring for people with autism, nursing home residents' safety, health data privacy and interoperability, studying social media impacts on mental health, access to telehealth services, streamlining professional licensure, insurance coverage parity, and healthcare financing. In addition to assisting with these endeavors, I have had the privilege of learning about many other social, economic, and political issues from a stellar team of expert staff that serves in this office. They have welcomed my input when my professional training and experience has proven useful. Just a few months into this experience, I am already more enthused about the possibilities for transforming mental health services using democratic processes. I have heard similar positive reflections on his experience from my colleague on the House side. These are of course not the only avenues for psychiatrists to engage with government. Just this year an early career child and adolescent psychiatrist was selected as one of a select group of White House fellows. He is gaining experience within the administrative branch while lending them his expertise. Moving forward, we should fully expect and advocate for more such transformative opportunities for trainees and psychiatrists to avail of to make a lasting difference for our profession and those we serve. For countries that have not embraced this degree of government engagement for our profession, I hope these models provide a good example of how to get started.

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International Child Mental Health –

Study Group (ICMH-SG): The first 10 years



Dr. Dejan Stevanovic (Serbia),

Prof. Panos Vostanis (UK),

Dr. Olayinka Atilola (Nigeria) and ICMH-SG

During a meeting in Istanbul (Turkey) in November 2011 led by Panos Vostanis (the UK at that time), Olayinka Atilola (Nigeria), Yatan Pal Singh Balhara (India), Mohamad Avicenna (Indonesia), and Dejan Stevanovic (Serbia) established the International Child Mental Health – Study Group (ICMH-SG; <https://www.icmhsg.org/>). The ICMH-SG was conceived as a network of researchers who might ensure the inclusion of children, adolescents, and their families, as participants, as well as clinicians and researchers working in undeveloped and developing world regions to organize, conduct, and support cross-cultural research in child and adolescent mental health (CAMH). Over the next ten years, the ICMH-SG has made significant contributions to cross-cultural CAMH research; new ideas for future project development pave the road to improve global CAMH practice and research.



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The organization

The ICMH-SG follows a natural bottom-up strategy in its structure free of affiliation with a formal registered organization and, as such, it does not belong to any entity, society, or individual. Instead, the ICMH-SG relies on each individual's self-control, motivation, and responsibility in any activity (the bottom) and creates collective self-organization towards a goal (the up). Although not strictly pre-defined or regulated, the ICMH-SG has been devoted to needs-identification, ethical, responsible, and sustainable cross-cultural CAMH research based on the inclusiveness, rigor, openness, and transparency of our people, our activities, and our data.

Inclusiveness – The ICMH-SG's activities have included clinicians and researchers from different professional and educational backgrounds, levels of expertise, interests, and ideas; and from different parts of the world, especially from undeveloped and developing regions. Such inclusiveness has been built upon respect and trust and the vision to develop together to advance cross-cultural CAMH research.

Openness – The ICMH-SG has been open for new clinicians and researchers to join, new initiatives to start, and new networks to build. There have been adaptations in response to recent findings, new ideas, population needs, and research priorities, including open data sharing as data is intended to serve the global community.

Rigor – The ICMH-SG has conducted projects and research studies with the highest scientific standards possible, respected ethical aspects and human rights, and adhered to reliable and valid research methods; thus, producing trustful and impactful findings to advance cross-cultural CAMH research. The ICMH-SG has introduced and promoted CAMH research to new institutions, clinical and research groups worldwide.

Transparency – The ICMH-SG has operated to be easy for others to observe and replicate our activities; the data from any project have been transparently used and published; all communications and reports have been transparent, too.

The people

Over the past ten years, nearly 300 individuals from 21 countries have contributed to articles or reports generated on behalf of the ICMH-SG, data collection, interpretations, analyses, and/or logistics for its projects. The ICMH-



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SG has included early career and senior clinicians and researchers, from a range of professional disciplines, with different interests and expertise in CAMH.

The Projects

The ICMH-SG has organized three international projects over the past ten years. The first project, "Quality of life (QOL) and substance use among adolescents in undeveloped and developing countries", initiated in 2011, aimed to assess the aspects of and relationships among general psychopathology, QOL, and substance use in general adolescent populations across undeveloped and developing countries by surveying 2,400 adolescents from seven countries. The second project, "Recent trauma and life stress events as related to major psychological problems among adolescents", initiated in 2013, aimed to assess aspects of and relationships between life stressors and traumatic events with emotional problems in adolescents via a survey of 4,000 adolescents from 11 countries. The third survey project, "Problematic internet use (PIU) and internet gaming among college and university students worldwide", initiated in 2018, aimed to assess the patterns of internet use of 3,400 college and university students across more than 15 different European and Asian countries; focusing on problematic internet use (PIU) and internet gaming disorder (IGD).

Uniqueness of the ICMH-SG

The ICMH-SG has also encouraged and helped some colleagues to publish articles for the first time in international journals and some PhD students to acquire skills and fulfill requirements on their way to the degree and demonstrated that it is possible to conduct collaborative multisite CAMH research without having physical contacts among collaborators: most of us have never met each other in person (Franic, Atilol, & Stevanovic, 2014). In addition, the ICMH-SG has been able to conduct collaborative multisite CAMH research and produce knowledge without external funds, relying on collaborators' in-kind contributions and access to local resources (Franic, Atilol, & Stevanovic, 2014).



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Productive Scholarly Outputs

From the data collected in these projects, 16 scientific papers were published in peer-reviewed journals, and these were cited 316 times at the time of writing this article. In addition, the datasets advanced cross-cultural CAMH research in several ways, most relevantly in three.

First, we studied relationships between specific psychological constructs and psychopathologies in adolescence across different cultures to comprehensively understand the constructs and generate new hypotheses. For example, one of our studies showed that external locus of control partially mediated the association between cumulative trauma exposure and post-traumatic stress symptoms among adolescents (Atilola et al., 2021). The findings directly relate to practice, implementation of interventions, and service delivery in resource-constrained settings.

Second, we evaluated the cross-cultural measurement properties of some frequently used scales for adolescent psychopathologies. For example, one of our studies showed that the Revised Child Anxiety and Depression Scale (RCADS) has satisfactory cross-cultural validity and suitability for cross-cultural comparisons in adolescent anxiety and depressive symptoms (Stevanovic et al., 2017) a finding that can inform planning of new studies, especially among early career researchers, and incorporation of measures in routine service monitoring.

Third, we demonstrated relevant epidemiological data for some psychopathologies for specific regions for the first time. For example, one of our studies reported for the first time the rates of symptoms of post-traumatic stress disorder (PTSD) present in adolescents exposed to trauma in Serbia, Bulgaria, and Romania, namely 6 – 8% (Stupar et al., 2021). The dissemination of these findings introduced relatively new constructs to local practice and influenced the early recognition of emerging mental health problems.

Future Directions

The ICMH-SG aspires to future improvement in CAMH practice and excellent cross-cultural CAMH research based on multisite projects that include different world regions, functional knowledge acquired beyond traditional educational systems, with enhanced and extended collaborations across professional disciplines. The ICMH-SG plans three strategic tracks for its activities over the next years.



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First: deliver directly impactful research. Following good research practice and its primary mission goal, the ICMH-SG will continue to organize, conduct, and participate in studies related to evolving CAMH priorities, either organized by its members or by partners. It has become evident for us working on the previous ICMH-SG projects that cross-cultural CAMH research should next move beyond epidemiological research and offer studies with directly applicable findings in low- and middle-income countries (LMIC). One focus should be studying common psychopathologies from multiple perspectives, following transdiagnostic and neurodiverse paradigms, and with various types of information integrated in clinical and at-risk populations of children and adolescents. Another focus should be studying cross-culturally interventions in CAMH, such as whether and to which extent are applicable in low-resource settings. These could include early interventions for neurodevelopmental disorders, crisis interventions for traumatized youth, or neuro-psychopharmacological treatment for early-onset severe psychiatric disorders. Other priorities could be replicating impactful studies by high-developed western research groups while adapting to different socio-cultural contexts.

Second: facilitate knowledge exchange. Besides being more active in delivering articles for journals, books, newsletters, blogs, and other means of communication, the ICMH-SG plans to launch an international, peer-review journal. The journal will be a hub for articles reporting cross-cultural CAMH studies and whose authors are mainly from undeveloped and developing world regions. The objective is to produce an integrative (i.e., combining various types of information related to CAMH) and interactive journal (i.e., providing support at multiple levels for inexperienced authors and researchers). In addition, education online training and consultations on conducting cross-cultural CAMH research will be established with our members and online webinars related to cross-cultural CAMH to disseminate knowledge and skills to a broader audience. We are now living in an era in which bringing in trainees and others without access to traditional structures is not only easy to manage but it is also functional and impactful.

Third: extend collaborations. The ICMH-SG has been developing fast, with more and more collaborators added since 2011. Over the next ten years, the ICMH-SG plans to grow by including more collaborators in its activities and collaborating with other national and international CAMH and allied organizations further. The collaborations would involve exchanging communications with interested partner individuals and organizations,



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sharing experiences and knowledge, sharing logistics, establishing future connections, and developing links with community and service user groups. Integrating various types of information for improved cross-cultural CAMH is only possible through mutual collaborations between different parties, in which global networks, such as the ICMH-SG, play an increasingly important role.

Looking back at our kick-off meeting in 2011, our goal was to make impactful changes through cross-cultural CAMH research rather than to create an influential network. Our vision is to advance cross-cultural CAMH research over the next ten years to secure inclusiveness, accessibility, and sustainability for the benefit of vulnerable children, youth, and families across the world. Based on the experience of the first phase of the ICMH-SG and the evidence-based presented above, we passionately believe that this expanding and evolving network can significantly contribute to global cross-cultural policy, research, practice, and service provision. In the aftermath of the unprecedented COVID 19 pandemics, CAMH needs and services will face new challenges in the face of decreasing resources and a need for their different allocations of services and research resources. This 'new' reality will also bring opportunities through digital technologies, learning, and requirements for CAMH to adapt to and address population needs as a global network that can respond to priorities by producing, sharing, and disseminating knowledge across large regions.

The ICMH-SG illustrates how a grassroots approach to research and practice can complement established international policy and professional bodies in their strategic goals. We thus extend an invitation to interested colleagues and organizations to contribute with new ideas for future collaborations.

References available on the request.



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The current scenario of child and adolescent psychiatric training and service in Hong-Kong



Dr Phyllis Chan (Hong Kong)

Brief introduction of the Hong Kong College of Psychiatrists

The Hong Kong College of Psychiatrists was formerly called the Hong Kong Psychiatric Association, which was founded in 1967. At the start, the membership of the association was no more than 30. In April 1968, it became a member society of the World Psychiatric Association.

Since the establishment of the Hong Kong Academy of Medicine by Statute in 1993, the Hong Kong College of Psychiatrists became one of the 15 constituent Academy Colleges. The College has been playing a key role in post-graduate psychiatric training thereafter, holding Fellowship examinations and conferring our Fellows.

Introduction of the specialist training system Junior and senior trainee training and examination

The College's specialist training system consists of the six years of general and higher professional education, every trainee must have a minimum of eighteen months' experience in General Adult Psychiatry, including six months duration of experience of management of patients governed under Part III Cap 136, Mental Health Ordinance, Hong Kong. Also, a minimum of fulltime training of six months



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duration or its equivalent in three of the other subspecialties apart from General Adult Psychiatry is required. Last, senior trainee are required to have a minimum of eighteen months duration of attachment in a subspecialty. It is also necessary for trainees to go through some training in psychological methods of treatment.

Psychiatry specialist trainee may sit for the Part I Fellowship examination after completion of minimum one year's full-time continuous post-registration experience in the psychiatric training scheme and trainee must have passed the Part I examination or hold an equivalent qualification approved by the College to proceed to the Intermediate Examination. The Part II (Intermediate) Examination should be taken normally after three years with a continuous full-time experience in post-registration training approved by the College. To sit for the Part III (Exit) examination, trainee should have received more than or equal to three years of full-time continuous General Professional Training, passed intermediate (Part II) examination, and completed more than or equal to twenty-nine months of higher professional training.

The position of Child and adolescent psychiatry in Junior Senior training- Core competence

Upon completion of training in the subspecialty in Child and Adolescent Psychiatry, Psychiatrists shall be able to demonstrate core competencies as set out in the College's guidelines. These competencies include patient care, medical knowledge, Interpersonal and Communications Skills, Learning and Improvement and Professionalism.

Specialty forming being voted down, post fellowship training only have certificate course for example on ADHD

A ballot on the resolution of proposed subspecialties establishment in Psychiatry was conducted at the 25th AGM held on 12 December 2014. The proposal was not adopted however, with the majority voted against the resolution.

In 2017, the Working Group of Post-Fellowship Training Course has conducted a survey on needs of developing a subspecialty training course. However, the Working Group received low response rate as



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around 20% reflected that College members were not interested in pursuing a post-fellowship training course. The Working Group only re-activated in 2019 and organised a post-fellowship training course-Certificate course on ADHD due to long waiting time of new case booking for child and adolescent psychiatry. Since Hospital Authority would alliance paediatricians with child and adolescent psychiatry on providing clinical treatment for mild cases of ADHD to relieve the long waiting time of child and adolescent psychiatry in public sector, the Working Group collaborated with the College's Professional Skills Enhancement Committee to organize training course for both psychiatrists and paediatricians on ADHD. The course was conducted in two modules with duration of 16 hours in each module. Module 1 focused on Mild and Moderate ADHD and the targeted audiences were Paediatricians working in HA and Psychiatrists who had no prior training in child and adolescent psychiatry and Fellow psychiatrists who were interested in child and adolescent psychiatry. Module 2 focused on Moderate and Severe ADHD and the targeted audiences were fellow psychiatrists who were interested in child and adolescent psychiatry. Upon completion of the course, participants were expected to acquire the skills in conducting a comprehensive assessment, formulation, working out an individual profiling and delivering for ADHD patients and able to work collaboratively with different allied health professionals implementing a comprehensive, effective and feasible management with ADHD. 41 fellow psychiatrists and 19 Paediatricians from Hong Kong and Macau attended the course. Over 94% of the participants agreed that the course helped improve their skills and knowledge in handling ADHD cases.

The clinical division of Child and adolescent psychiatry

The Clinical Divisions were formed in 2009 to provide a platform for exchange among fellows with interests in specific areas of psychiatric practice, to develop standards for core competencies and skills in psychiatry, and to explore the pathways for subspecialty development under the College of Psychiatrists with an aim for further improvement of the quality of psychiatric services.

The Clinical Division of Child and Adolescent Psychiatry had set out the core competencies and skills for Child and Adolescent Psychiatry in 2011 to standardize training among different clusters, and to define



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the process and requirements of the 6 months for Junior trainee. These included competencies expected for all psychiatrists in general, together with specific competencies unique to the subspecialty.

The Child and Adolescent Psychiatry clinical division also began in 2011 bimonthly discussion forum. This targets senior trainee in Child and Adolescent teams; set between topics, knowledge-based case conferences, or exchange of clinical experiences. Trainee or organizers set topics with frameworks set against the Core competencies. However the division became quite dominant afterwards.

The Number of trainees and fellows working in this specialty in Hong Kong

There are currently 35 fellow psychiatrists working in the Child and Adolescent Psychiatry subspecialty in the public sector and 17 trainee under training of this subspecialty as of January 2021.

Training collaboration with hospital authority

The College works closely with Hospital Authority in developing curriculum for specialty training. The Central Academic Course (CAC) has been in place for more than 20 years, in order to fulfill the training requirements of Royal College of Psychiatrists as approved training centers for the MRCPsych (UK) examinations outside the UK (the only officially recognized specialist examination before 1997).

After 1997, the officially recognized specialist examination has been replaced by the Hong Kong College of Psychiatrists Fellowship Examinations. Since 1997, CAC has been functioning as an academic course for all junior and senior trainees to provide didactic knowledge-based training on a wide range of academic topics of psychiatry. With increasing emphasis on a balanced development of knowledge, skills and attitudes in the nurturance of a competent specialist, the College reviews the course from time to time to broaden the scope of CAC to include additional training on appropriate skills and attitudes as a psychiatrist, while retaining certain knowledge-based academic courses. The term 'Central' implies centrally coordinated academic courses under the governance of Education Committee of the Hong Kong College of Psychiatrists, collaborated with the Tutor Committee under Hospital Authority.



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Training / Community collaboration

The Student Mental Health Support Scheme was launched in 2017 by the Food and Health Bureau (FHB) to step up mental health support services to students and their families in need which was steered by FHB in collaboration with Hospital Authority, Education Bureau and Social Welfare Department. Under the scheme, College provides training targeted at healthcare, educational and social welfare professionals and supporting staff, including psychiatric nurses of HA, school coordinators, relevant teachers, educational psychologists, school social workers, etc. of primary and secondary schools, as well as social workers from relevant social service units, with an aim to enhance their understanding and skills on the management of students with mental health needs through multidisciplinary collaboration at a school-based platform. It is held at the Hong Kong Academy of Medicine and our fellow psychiatrists would provide a 2-5 days training course consists of lectures, case sharing and scenario discussion in various topics related to common mental health problems of children and adolescents. As of May 2021, 37 batches of training course have been provided, 770 designated professional staff and 444 school personnel have enrolled for the course. A questionnaire has been designed to collect the views, mentality and attitude towards mental health from participants of the designated professional staff training before commencement and after completion of the training course. A comparison for pre- and post-training was conducted. The result shows improvements of participants' attitude towards mental health related issues after the training programme, and agreed further that mental health education should be included in the basic curriculum of schools. Positive responses were received from participants on practical skills sharing and case discussion by trainers. Many participants expressed eagerness to learn more practical skills on handling of students with different mental health needs, which would help them to deal with students with mental health issues in their work place.

The College partners with Department of Psychiatry, Queen Mary Hospital (Child and Adolescent Psychiatry Team), Tung Wah Group of Hospitals, St. James Settlement and the Boys' & Girls' Clubs Association of Hong Kong, introduced the "Parent Education in Mental Health" project in Jan 2020 with 2 years funding fully supported by 2 donors, extended to another 5 schools by a new donor in November



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2021. The project aims in providing both preventive parent education and on-demand counselling to primary schools' parents and equip parents with the knowledge and skills based on the developmental needs of Primary School students so that they can nurture their children in a supportive home environment. The project consists of a six year curriculum, to be implemented by the three NGOs and piloted in 6 primary schools. The project consists of four components, the first component is a theory-based and practical skills training with Practicum for social workers and teachers from NGOs and Schools so that they could implement the project. Second component is Parent Education which comprises 3 levels of training: Level 1 is basic training in forms of talks and workshops for all parent covering topics such as Parents' Stress Management, Parenting Skills Training, Internet Use, Happy Kids and Executive function. Level 2 is advanced Training for parents in need in forms of small group workshops covering more advanced topics such as Homework Support through executive function and Sexuality and Love Education. Level 3 is One-on-One case management for parents in need which is an Individualized Parenting Programme with care plan and formulation and intensive coaching on parenting skills. The third component of the project is the Parent Mentoring and Support Scheme which pairs up parents of higher grades students with those of lower grades for mentorship, experience sharing and networking. And the last component is project evaluation using the Parenting Stress Scale, Happy Kids Questionnaires, Child Behavioral Checklist, Strength and Difficulties Questionnaires, etc. As of Aug 2021, over 1900 parents have participated in the project and over 1700 parents took part in the evaluation survey. The survey results shows that majority of the participants suggested the parent education program is useful and effective and there is a trend of improvement in Parental self-efficacy, Parenting styles, Children's behavior, Parents permissive parenting style and Children hyperactivity problem. However, Parental stress showed slight increment during the academic year, it may due to long-lasting pandemic situation which parents had to face children at home for longer period. The project will continue to provide talks and workshops with topics adjusted to fulfill parents' expectations and new elements would be added to increase interactions with parents following the feedbacks collected from parents last year.



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The college also launched training program for “The Pilot Scheme on New Service Protocol for Child and Adolescent with Attention Deficit / Hyperactivity Disorder and Comorbidity (“ADHD+”)” in March 2021, commissioned by the Food and Health Bureau (FHB) of the HKSAR. The training targeted for members of the 5 “Core Teams” of multi-disciplinary allied health professionals which include Clinical Psychologist, Advanced Practice Nurse, Occupational Therapist I and Assistant Social Work Officer of 5 NGOs covering the whole territory of Hong Kong. It aims to equip Core team members with the skills to conduct assessments and triage of ADHD+ clients, formulation and implementation of intervention and manualized treatment packages, social welfare support services as well as referral of cases to suitable HA and SWD service units for diagnosis, treatment or supporting services as appropriate. There are currently 25 participants in the scheme, they have all completed a 5-day theoretical training and 5-day practicum covering topics such as assessment tools for early detection and intervention for mild to moderate low risk ADHD symptoms; medical, educational and social support for children/adolescents with ADHD in community setting. There will be ongoing bimonthly technical support from the college throughout the 2 year program.

Way forward

The college will carry on the arduous task of setting up subspecialties including child and adolescent psychiatry in future. In the meantime, we may organise quotable or unquotable training courses at post fellowship level for our fellows in different subspecialties.

Our continuous effort of training partner professional staff in different mental health projects in child and adolescent psychiatry help setting up evidenced base standard for non-pharmacological intervention for them to work at community or school level, to help ease the workload of child and adolescent psychiatric service at tertiary level.

Besides we understand that the manpower implications for psychiatrists in Hong Kong especially child and adolescent psychiatrists as this subspecialty have the longest waiting time for non-urgent cases among



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all specialties in psychiatry. It could be up to 2 to 3 years which understandably pose a drastic impact on the developing child and adolescent and the family.

Last but not the least, we will carry on our goal of implementing parent education in mental health, not only at primary school level but extending to secondary school and kindergarten level as well as devising and formulating the possibility of setting up mental health curriculum for secondary school students in Hong Kong.

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Reflections of a Māori child and adolescent psychiatrist in the time of COVID



Dr Hinemoa Elder (New Zealand)

“Ko te maumahara kore ki ngā whakapapa o ōu mātua tūpuna, e rite ana ki te pūkaki awa kāore ōna hikuawa, ki te rākau rānei kāore ōna pakiaka”

“To forget one’s ancestors is to be a brook without a source, a tree without its roots”

Te Aupōuri, Ngāti Kurī, Te Rarawa, Ngāpuhi nui tonu.

I grew up with pictures of our Grandmother’s mum, Heeni Murray, in our home for as long as I can remember. She had eight children, the last one Gus, was only 6 months old when she died. That was March 1919. From what we know, she died from H1N1 Influenza A, in what was known as The Great Flu pandemic. 500 million people are reported to have become infected around the world and 50 million are conservatively estimated to have died. 100 odd years ago.

Since COVID came into our lives I have been looking at her photo differently. And our Nanni, Heeni has been looking back. She seems to have something different to say in her expression now. Something relevant to our



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current pandemic. I had not thought of her in this way before. As her descendant, a doctor, a child and adolescent psychiatrist, her life, and her death gives me a new sense of history and purpose in these difficult times.

We are all health and wellbeing professionals. We work daily to care for others, with respect, we do what we say, we are there no matter what, and we are committed to learning and growing in order to be better in our roles, to deepen our understanding and our connection, to better serve. Whakawhanaunga, connectivity, manaaki, support and care, whakamana, empowerment, ako, learning and teaching. These are our values.

The impact of the COVID's Delta variant continues to evolve here in Aotearoa, as everywhere. We have been through lockdowns and now mandated vaccination is a reality for many. This is a complex issue for our communities.

As Māori our lived experience is to be deeply questioning about any government imposed mandate. We have all grown up with experiences of racism and we know how racism impacts on our tangata whaiora, our patients, in both personal and systemic ways. And as specialists we see, we feel, and we are impacted by the inherent racism in the systems we work in. The age based COVID vaccine roll out here in Aotearoa NZ is one well-recognized recent example. Our Māori population is much younger than the dominant culture and we have very pre-existing high rates of all illnesses. We still die 8 years earlier than non-Māori. Our access to COVID vaccination was delayed by government policy. Now our rates of COVID are higher. We are 17% of the population, there are more than 800,000 of us. At the time of writing we have the lowest vaccination rates of any ethnicity, with 662/1000 of us fully vaccinated. We are 44% of all COVID cases, the highest of any ethnic group.

So we bring our history and current COVID experiences to where we are now.

Everyone is having to make decisions under novel and prolonged stress. The last 20 months or so has been a roller coaster ride. We are tired, patience is harder to find, we are struggling to maintain any sense of routine. Our raised baseline levels of anxiety means we are more sensitive. There is a lack of ability to plan for the future, we fear for our safety, our whānau, our health, our lives.

Since March last year we have seen the world outside of Aotearoa steadily and then accelerating into chaos, millions of deaths, sickness, and the growing impact of the COVID virus on the basics of daily life. Here in



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Aotearoa we have been through phases of over and underestimating the virus. We have been in denial at times. We have been avoidant. We have had to re-set our own risk assessment analyses a few times. And the virus itself has changed, which is in its nature, something not everyone has had a chance to deeply consider and digest. Now we recognize this a serious and at times life threatening multi-organ disease with a significant long term impact for some, with considerable neurological and psychiatric consequences.

And we know that not everyone believes this. Social media platforms and their algorithm settings have played a part. The delay in vaccine roll outs has also played a crucial role in providing space and time for misinformation to spread. We have seen the pairing of unlikely bed fellows here. White supremacists, church groups and some indigenous rights supporters have marched together on parliament. These groups have driven around cities to deliberately block traffic. The vitriol towards those who make positive statements about the protective role of vaccination on social media has been vicious and unrelenting.

And as child, adolescent and family mental health and addiction specialists we have been busier than ever.

Last year during lock down I worked in our regional child and adolescent and mothers and babies inpatient unit. Having to don PPE to work with our most mentally unwell young people was tough. We could see this made our patients more fearful. Rules about visitors changed several times over those first few weeks. In the end, patients were allowed one visitor and they had to live on the unit until patients were ready to go home. It was a difficult adjustment for everyone. Especially the whānau.

This year I have been working in zoom clinics for the local District Health Board CAMHS in our largest city, which at the time of writing remains in lock down. We had managed to address the long waiting list from last year just before the current lockdown. Tamariki mokopuna, rangatahi, children and teenagers and their whānau have been struggling. Suicidal thinking is now much more commonly part of the way people are feeling. I see the desperation and suffering every day. As I am sure do you.

And COVID has reminded us about our global connections. Family members, sick and dying in different parts of the world. Experiences of loss and grief at separation and isolation a new norm.



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For our Māori communities cultural practices have been curtailed. Not being able to have tangihanga, cultural funeral practices. Not being able to hongī, traditional greetings where we share the same breath by pressing noses. These are central aspects of who we are. We have had to find ways to adapt.

As we live with this changing face of COVID we are learning it is much more than an infectious disease pandemic it is a mental health and addictions pandemic too. Around the world this is being called a syndemic, because it synthesizes all the health inequalities and exposes them. The death gradient for COVID is the same as the socio-economic-cultural inequity gradient of mortality and morbidity that we already know too well. COVID kills the most vulnerable. And in Aotearoa NZ that means Māori.

We learnt in our earliest days at medical school that humans have been in a war with microorganisms that goes back millenia. A constant tussle since time immemorial.

As med students we learnt that any time we thought we were winning, we were kidding ourselves. I never believed I would see such an example of this in our lifetimes. And yet here we are.

There was a the time when simple handwashing was regarded as controversial. We now have a new appreciation of the importance of handwashing. And now we wear masks.

Looking at photographs from the Great Flu pandemic of 1918 and 1919 we see masks being worn. But only by those who had the money to access them. Here in Aotearoa we know that local councils were in charge of health measures at that time. Many left Māori communities to die, they used Police to restrict access to hospitals. The conservative figure often mentioned is that we died at 8 times the rate of no-Māori. Estimates suggest around 2,500 of our ancestors died in that way.

Communicating, normalizing and supporting health workers, communities and my own patients in their decision making has become a part of my role. Mental health professionals around the world are being brought forward to help with conversations about the psychology of pandemics.

Being part of our Ministry of Education and Health's media campaigns my approach has been to emphasize listening carefully and compassionately, avoiding the temptation to refute others perspectives. Encouraging



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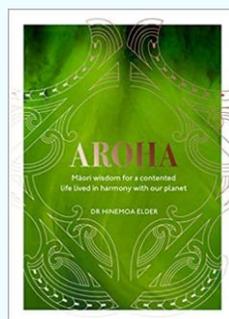
statements about what is meaningful: our whānau surviving. Our tamariki, our children living through this, coping with the changes in their lives. Decoding the scientific jargon, presenting data in meaningful ways. Particularly relevant to us is discussion about the emerging evidence that people with mental illness and addictions are at greater risk of contracting COVID.

And like any health promotion activity the science is necessary but not sufficient. We have excellent evidence that people do not make health seeking decisions based on logic alone, and sometimes not based on any logic at all.

My sense of responsibility comes from our whakapapa, genealogy. As a representative of our tūpuna, our ancestors, I look at the photo of our Nanni. I am proud to be her descendant, a doctor, working to help our people, especially our young ones and their whānau with the complex psychiatric aspects of COVID, like the pandemic that took her life.

He whakakapi māku, I conclude as I have started, with the whakatauākī in the title. A proverbial saying, from one of our beloved teachers, Te Wharehuia Milroy. We must remember our forebears, what they lived and died through. Their stories are at the heart of how we learn from their experiences. Their ghosts are here to haunt us and to help us, in order to survive in this pandemic and the next.

Dr Elder is the author of “Aroha. Māori wisdom for a contented life, lived in harmony with our planet”. Penguin Random House, 2020. An Oprah Winfrey Book Club list title in 2021.





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Child and adolescent mental health in Grenada

Dr. Kynan Brown (USA), Dr. Abishek Bala (USA)

Grenada is a small, independent Caribbean nation, consisting of the islands of Grenada, Carriacou, and Petite Martinique, located in the West Indies. The main island is divided into six parishes, while Carriacou and Petite Martinique function as dependencies. Governed by parliamentary multi-party democracy, Grenada is considered a developing country of upper medium income and relatively high human development. The economy is heavily dependent on tourism and agriculture, with persistently high rates of unemployment. According to UNESCO, 3.6 % of the country's GDP in 2018 went into education, with the island reporting a 98.6% literacy rate in 2014 for ages greater than 15. The total population of Grenada estimated by UNESCO for 2019 ranges at 112,000. The last "Population and Housing census" report by the Grenadian government in 2011 indicates a population of 106,667, with approximately 32% of the population being less than 19 years of age (Central Statistical Office, 2020). Grenada is now preparing for an updated census in 2021 (Straker, 2021). Most of the population is of African ancestry, which has a strong influence on the island culture, along with cultural remnants of former French and British colonial rule.

Health Services

In recent years, Grenada began the transition to a National Health Insurance (NHI) scheme, under which citizens are covered for most health services (Government of Grenada, 2021). However, as of 2018, government spending accounted for only 40% of per capita health spending, while out-of-pocket spending still accounted for over 55% (Institute for Health Metrics and Evaluation, 2019). With the exception of one small private hospital and a handful of private practices, nearly all medical services are government-run. At the community level, primary care services are provided through 37 government-operated medical stations and health centers, spread across seven Health Districts that roughly correspond with the parishes. The greatest concentration of medical services is found in the capital, St. George's, which is also home to the island's largest hospital, Grenada General Hospital. Two additional smaller hospitals serve less densely populated areas (Government of Grenada, 2021). Grenada is home to St. George's University School of Medicine, one of the most reputable medical schools of the Caribbean region.



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A small minority of enrolled medical students are Grenadian nationals, and fewer still go on to train in psychiatry (St. George's University, 2020). However, with no local residency or fellowship programs, most graduates continue their post-graduate training in the United States or the United Kingdom. Once that training is complete, and lacking financial incentives to return home, many Grenadian physicians continue medical practice abroad. Indeed, Grenada consistently ranks among the top 20 countries globally for brain drain (The Fund for Peace, 2021). As a result, Grenada's physician workforce has for many years been supplemented with support from Cuban medical brigades, providing numerous specialist physicians, including psychiatrists (Vasconcelos et al., 2020). Mental health services are overseen nationally by the Mental Health Division of the Ministry of Health. As a result of NHI, most patients with mental disorders are not charged any expenses – this coverage includes those with major mental disorders such as depression, bipolar disorder, and psychosis, as well as rehabilitation for substance addiction (WHO, 2017). In addition to a psychiatric unit in the general hospital, Grenada has one dedicated adult inpatient psychiatric facility, Mt. Gay Psychiatric Hospital, and one addiction rehabilitation center, both located in the capital. Outpatient services, including education, therapy, and home visits, are provided primarily by Community Mental Health Workers and Psychiatric Social Workers. They are joined by a psychiatrist, psychiatric nurse, and pharmacist for weekly or monthly community clinics in each parish (Government of Grenada, 2021).

Child & Adolescent Mental Health Services

As of 2017, the Ministry of Health did not report having any plan or strategy for child and adolescent mental health (WHO, 2017). The health system also does not offer a psychology service, and there are few resources for identifying and referring early-childhood mental disorders in the school or community setting (Vasconcelos et al., 2020). However, the government does provide a comprehensive school-based program for mental health promotion (WHO, 2017). Grenada has limited inpatient options for child and adolescent psychiatry (WHO, 2017). When young patients are a danger to themselves or the lives of others, they are admitted to the Pediatrics unit of Grenada General Hospital, which is not adequately equipped to provide optimal care for mental illness. As a result, many young patients who would benefit from psychiatric hospitalization have few options (Vasconcelos et al., 2020). Likewise, there has historically been few Child and Adolescent Psychiatrists (CAP) or other



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professionals specially trained in child and adolescent mental health. From 2015 to 2019, Cuba's medical brigade temporarily provided Grenada with its first CAP. That resulted in the island's first Child Psychiatry Clinic, which operated out of the general hospital one day per week. In addition to the CAP, the clinic team consisted of two general practitioners, a social worker, a nurse, and a nursing assistant (Vasconcelos et al., 2020).

Trends in Child and Adolescent Mental Health

Much of the existing literature on child and adolescent mental health in Grenada centers on substance abuse and child abuse, both reflections of Grenadian culture. Although drug use is the leading cause of psychiatric admission in adults, Grenadian society has significant tolerance for alcohol and drug use, with minimal appreciation of the involved risks (Vasconcelos et al., 2020). Grenada ranks 15th in the world for adolescent alcohol use, roughly 30% higher than the global average (Global Change Data Lab, 2010). For many children and adolescents, verbal and corporal punishment are accepted parts of family life – rates are exceptionally high throughout the Caribbean region, including Grenada (Orlando, 2020). Several authors have identified strong associations between these cultural determinants, psychological distress, and alcohol use in Grenadian adolescents (Balogun et al., 2014; Francis, 2017). Likewise, child abuse has been associated with numerous behavioral consequences in Grenadian youth, including depression, post-traumatic stress, and psychopathy (Boduszek et al., 2019; Debowska et al., 2018; James et al., 2016). Child sexual abuse is also a significant problem, exacerbated by a culture of silence (Jeremiah et al., 2017). For many Grenadian adults, poor biopsychological outcomes are traced to adverse childhood experiences and trauma in early life (Mueller et al., 2019). Among patients seen at the Child Psychiatry Clinic, family dysfunction, including neglect and mistreatment, was identified as one of the most commonly associated risk factors for mental illness, while poverty and unemployment were also significant (Vasconcelos et al., 2020). In most cases seen in the Child Psychiatry Clinic, there was a family history of mental illness. The most commonly seen disorders were conduct disorders, psychotic disorders, and substance-related disorders, while anxiety disorders and trauma-related disorders were also significant (Vasconcelos et al., 2020). Though limited, the available data suggests a significant overall health burden from child and adolescent mental illness in Grenada. For example, self-harm ranks second for both cause of death and overall burden of disease among girls aged 10-14 (UNICEF, 2019). Anxiety disorders rank third for burden of disease in girls aged 10-14, and



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fourth in those aged 15-19. In girls and boys aged 15-19, depressive disorders rank second and fifth, respectively, for burden of disease. Childhood behavioral disorders rank third for burden of disease in boys aged 10-19. Looking at younger children, most of the burden of disease from mental or nervous system disorders specifically, in those aged 1-4, is attributed to epilepsy and autism, while in those aged 5-9 conduct disorders and anxiety disorders gain prominence (PAHO, 2020). Mental illness generally carries a strong stigma in Grenadian society. Most of the population has poor knowledge or understanding of mental illness. As a result, it is likely that many child and adolescent psychiatric and neurodevelopmental conditions go untreated, either because symptoms go unrecognized or unreported. For these same reasons, treatment may at times be delayed by years, potentially resulting in avoidable complications. The preventable long-term consequences can be most important for younger children. Notably, only 1% of the clinic's patients were pre-school age, and only 10% were school-age children, which raises concerns for significant underdiagnosis of neurodevelopmental disorders, learning disabilities, and other age-specific conditions. While community-level medical stations and health centers, described earlier, are the foundation of primary care throughout Grenada, such centers referred only 6% of cases seen by the Child Psychiatry Clinic, suggesting that there is much room for education on mental illness, both for primary care providers and for the communities they serve (Vasconcelos et al., 2020).

Consequences of COVID-19

Prior to the pandemic, the burden of mental health illness remained a concern, with 1 in 7 surveyed adolescents, or roughly 166 million adolescents estimated to have a mental health illness. It is highlighted as one of the leading causes of death and disability for those aged 10-19 worldwide (Santomauro et al., 2021). Although the majority of the available data does not adequately represent the burden in low- and middle-income countries, it does shine light on the significance of this issue. With risk factors including COVID-19's acute and long term effects on physical health, exacerbation of underlying mental health conditions due to inadequate access to treatment, grief secondary to familial bereavement, illness anxiety, loneliness from social isolation through school closures, cancellation of sporting events, lack of recreational activities, financial hardships from parental unemployment, possible exposure to domestic violence and other household trauma due to the lockdown with concurrent limitations in protective services, etc, the warning of a global mental health crisis raised by several experts does



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not seem far-fetched. As of December 2021, a total of 5908 COVID cases and 200 deaths secondary to COVID have been recorded in Grenada (WHO, 2021). Prior to the pandemic, Depression was ranked in the top 10 causes of daily age adjusted death and disability by the Global Burden of Disease Study in this country (Vos et al., 2020). The impact on adverse childhood experiences further exacerbating the risk factors for negative mental health outcomes in the population should also be accounted for. Given such immediate impacts of COVID-19 and its psychosocial sequelae, public health interventions targeting pediatric mental health are highly essential in Grenada.

Need for Further Evaluation and Development

Data collection in pediatric mental health is needed especially in the current pandemic world. Studying the prevalence of mental illness in this age group, while taking into account the island's systemic protective factors will be key when formulating culturally cognizant interventions. Continued monitoring and evaluation of trends, utilization of resources, and its impact on the population should also be integrated into the process. Programs like UNICEF's Measurement of Mental Health Among Adolescents at the Population Level, that are working towards data acquisition, while accounting for limited resources and need for standardized tools are promising. Past collaboration with regional leaders like the Organization of Eastern Caribbean States (OECS), to direct resources into primary research and community stakeholder involvement in the context of climate related disasters like the recent Hurricane Irma demonstrates some scope for development of such projects in Grenada during and post-pandemic. In addition, mental health awareness and promotional activities within member nations of the Community (CARICOM) and the Caribbean Public Health Agency (CARPHA) will likely further assist in developing grassroots initiatives over time. Perhaps such projects will encourage policy making and resource allocation to address gaps in data, shortage of community workers in mental health and feasibility of collaborative care models for pediatric mental health in primary care settings.

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Child and Adolescent Psychiatry Training and Services in Egypt:

An Updated Overview



Dr. Dina Aly El Gabry (Egypt),

Prof. Nermin Mahmoud Shaker (Egypt),

Prof. Maha Sayed (Egypt)

Youth mental health still lacks recognition as a significant public health burden and, hence, has received differing degrees of prioritization throughout the Middle East (El-Gilany, 2010). Moreover, despite this lack of prioritization towards child and adolescents' mental health in the region, there is an indisputable demand for these specialised services with the continuous growth of the region's child and adolescent population (Assaad & Roudi-Fahimi, 2007). There are still significant barriers to accessing mental health services, which might be related to stigmatisation of mental health issues, the lack of awareness among professionals, and ultimately, the lack of research needed to back regional approaches to education and workforce expansion (El-Gilany, 2010).

Hence, the World Psychiatric Association in Child and Adolescent Psychiatry (WPA CAP) established the Consortium on Academic Child and Adolescent Psychiatry in the Middle East (CACAP ME). The Consortium uses the term CAP 'specialty' (and not subspecialty) in adherence to international recognition of CAP as a key component to global public health that is uniquely equipped to tackle the current child and adolescent mental health challenges (Skokauskas, 2019).



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Egyptian Resources for Child and Adolescent Mental Health:

Forty percent of the Egyptian population are under the age of 18 years (CAMPS, 2017) and 15–20% of them need mental health services; unfortunately, only 5% of these individuals receive mental health services. Child and adolescent mental health services are provided by the public health sector (40%) and the public sector (60%), which comprise paediatricians (50%), general psychiatrists (20%), non-professionals (20%), child and adolescent psychiatrists (7%) and primary care physicians (3%). Meanwhile, educational services are provided by National governmental schools (70%), private sector schools (20%) and public sector schools (5%) (WHO, Child and Adolescent Report, 2017).

Pathway to Child and Adolescent Mental Health Services among Patients in Urban Settings in Egypt: In about 67% of mental health cases, the first contact is either with a paediatrician or a psychiatrist while 5% of cases seek traditional healers. Most patients are referred to the clinic by relatives (30%) followed by paediatricians (21%), school teachers (12%), and traditional healers (5%) (Hussein et al., 2012).

Child and Adolescent Mental Health Training in Egypt:

Child and Adolescent Psychiatry has been recognised as a separate entity, owing to the early work of two eminent Egyptian professors from Ain Shams University, Ahmed Okasha and Zeinab Bishry, at a time when having a sub-specialty in the region was considered a form of an academic luxury. Professor Bishry established the first child and adolescent psychiatry outpatient clinic in 1982 at the Institute of Psychiatry Ain Shams University hospitals. The clinic was run twice weekly at first, and after six months it became four days a week; the clinic now runs six days/week. A rehabilitation unit was later added for art therapy and behaviour modification (Shaker, 2019).

Egypt not only has the highest number of academic CAP departments but is also one of only five countries in the Middle East that reports having a national CAP society where almost 30% of psychiatrists receive six months specialised training in Child and Adolescent Psychiatry. In addition, 10% of paediatricians also receive specialised training in child and adolescent psychiatry (Shaker, 2019). A national curriculum for general psychiatry and general psychiatry training is required prior to CAP, and inpatient and outpatient CAP rotation



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together with a general paediatric rotation is available. Exit exams are available in CAP training as the fellowship of Child and Adolescent Psychiatry, Egyptian Board of Psychiatry. Newly approved Master's degree in 2021 from the Higher Egyptian Counsel of Medical Education.

Unfortunately, however, there is still no national curriculum for Child and Adolescent Psychiatry or specialised CAP scientific national journal or national mental health policy.

Training during the Covid-19 Pandemic:

Ain Shams University has provided an online Master class with a specialised Child and Adolescent Psychiatry module, together with a Child and Adolescent teleclinic that opened in June 2020 and now has 1,329 bookings with 525 successful consultations, yielding a 39.5% success rate.

Challenges and Unmet Needs:

The gap to integrate the child and adolescent psychiatry service first requires solid data with respect to the prevalence of mental health problems among children and adolescents. Unfortunately, proper epidemiological data have not been collected for child and adolescent mental health disorders, especially suicide rates (Shaker, 2019).

Egypt is the most populous country in the Middle East and is still in need of an increased workforce in child and adolescent psychiatry. Meanwhile, economic restrictions affect our ability to document and evaluate the exciting resources and outcomes and prohibit overseas electives in child and adolescent mental health or become affiliated to international recommendations and standards, hence affecting the uniformity of our practice.

References available on the request.



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Making regular, internationally collaborative case-based learning possible: The Brazil ABENEPI / IACAPAP / WPA / ECHO Project hub in Child and Adolescent Psychiatry

Dr. Flávio Dias Silva (Brasil), Dr. Ricardo Nogueira Krause (Brasil), and Dr. Ana Carolina Romero (USA)

Can we imagine the possibility of regular meetings with colleagues from around the world to discuss cases and formulate solutions to everyday clinical problems? Teleconferences became possible a couple of decades ago, and internet and related hardware and software technology have accelerated the user-friendliness of video teleconferenced meetings. However, linguistic barriers, funding limitations, and even professional engagement challenges have made worldwide tele-education difficult to sustain. With continuously increasing burden and complexity of mental health problems – as has been seen with many children and adolescents who lost a parent to COVID-19 – collaborative care, especially in primary care settings, is not just an option but a necessity. Collaborative care models, proven to be effective in more than eighty clinical trials, can be as simple as case-based learning discussions between specialists and primary care doctors. That is the model used in the ECHO (Extension for Community Healthcare Outcomes) Project from the University of New Mexico, USA (<https://hsc.unm.edu/echo/>). With impressive results, ECHO Project is a model of tele-mentoring based on 90-to-120-minute case discussions that help distant sites to solve complex clinical problems. The Brazilian Association of Child Neurology and Psychiatry and Allied Professionals (ABENEPI) is starting an ECHO Project hub designed to promote regular case-based sessions in partnership with the World Psychiatric Association (WPA) and the International Association of Child and Adolescent Psychiatry and Allied Professionals (IACAPAP). We propose that this project could inspire other countries to adopt a similar approach.

The ECHO Project was created in 2003 by Dr. Sanjeev Arora, a gastroenterologist, in response to the need to teach health professionals how to treat hepatitis C in rural areas and prisons of New Mexico. At that time, a consultation with the specialist had more than 8 months of waiting time, and the treatment could last for months. Many patients were unable to travel for treatment and died from a treatable disease. Dr. Arora then started sharing



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knowledge for free through teleconferences with other professionals. This strategy proved to be effective for successful management of many cases. ECHO sessions are structured as follows: participants present real (anonymized) cases to the specialists and to each other for discussion and recommendations. Participants learn from one another, as knowledge is tested and refined through a local lens. This continuous loop of learning, mentoring and peer support is what makes ECHO unique, with a long-lasting impact far beyond that of a single webinar, e-learning course, or telemedicine encounter. The project collects data and displays it in a free online [Data Marketplace](#) to monitor outcomes and increase impact.

Since its beginning, ECHO has had a huge expansion and has been used to improve health outcomes in countless areas, including diabetes, bone health, rheumatology, mental health, and perinatal health. According to its founder, "the benefits of knowledge are a social good that should be available to everyone. Together, we empower local communities to use the ECHO model as a tool to share expert knowledge wherever they live. Experts and participants learn from each other as knowledge is refined and tested through local experience." The projects are funded by partner organizations and foundations. Many universities use the ECHO model as a community of practice for residents and students and as continuing education or university outreach. More than 25 organizations around the world are superhubs that train local partners. There are currently programs in more than 51 countries (including 13 countries in Latin America and the Caribbean), with 640 hubs and more than 4,000 programs.



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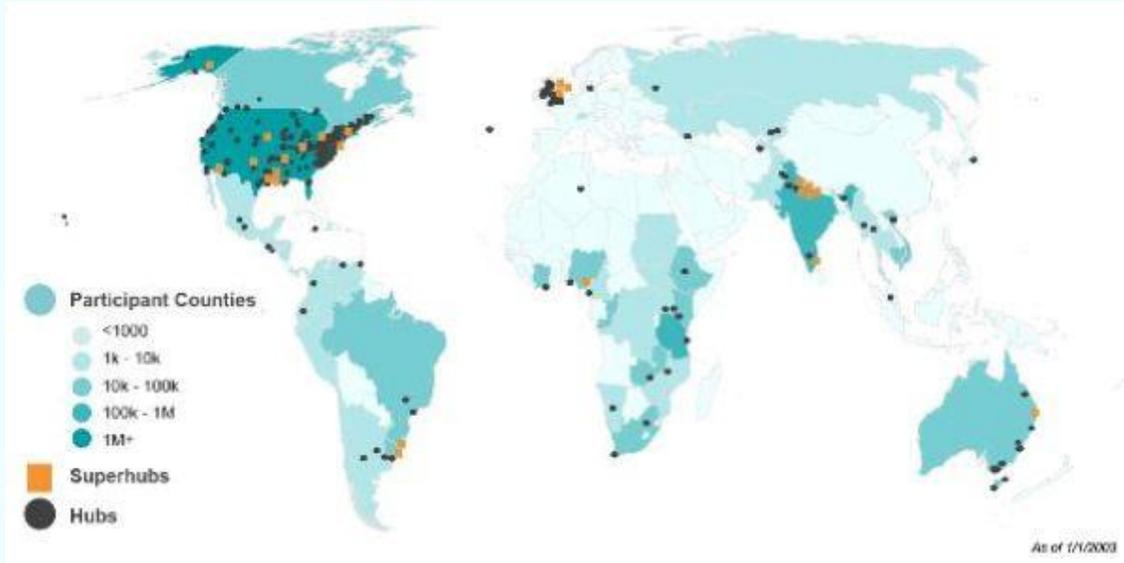


Figure1: ECHO hubs and superhubs. Source: ECHO Institute™,

In the ECHO network, experts and teleconference session participants support each other through ongoing collaboration, problem solving and professional growth. See a [short video](#) about how teleconferences work. Participation is always free. ECHO Governments and public health systems in India and some countries in Africa and elsewhere have adopted the ECHO model to address critical public health challenges. The majority of ECHO hub sessions are conducted in English or Spanish, and a lot of them are dedicated to mental health (see the hub of [Ontario Mental Health CAMH and University of Toronto](#), Canada; one of several Autism hubs like the hub of [University of Missouri, USA](#); and the hub of [University of Vermont Project ECHO Children's Mental Health, USA](#)).

As mentioned earlier, ABENEPI directors have been recently trained by colleagues from Uruguay Republic University to start an ECHO Project hub in Brazil - the first one in child and adolescent psychiatry. The hub will consist of regular monthly meetings involving case-based learning, where a Brazilian child and adolescent mental health professional will bring a case, and international colleagues from IACAPAP and WPA will act as consultant specialists. ABENEPI will support simultaneous translation to Portuguese and intends to invite participants from other Portuguese-language countries (Portugal, Mozambique, Guinea-Bissau, Angola, Cape Verde, East Timor,



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São Tomé and Príncipe, and Equatorial Guinea) to attend sessions. Furthermore, sessions will be opened to primary care professionals too. We hope this experience can be of extreme value. We ask our international colleagues that would like to join this global initiative to please contact us. It will be lovely to enhance our friendship, share our common passion for our field, and collaborate internationally in this effort.

Below are selected publications in the field of child/adolescent and general mental health. We also provide the link to the [entire collection of publications](#) about the impact of ECHO Project.

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16th International Research Training Seminar in Child and Adolescent Psychiatry: Attendee perspective

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The Fondazione Child Foundation has been organising the International Research Training Seminar in Child and Adolescent Psychiatry for trainees in psychiatry and early career psychiatrists since 2005. This year's seminar, the 16th edition, was held in September 2021 over five days in Rome and was the first international meeting for the research seminar during the COVID-19 pandemic. The seminar comprised of a series of presentations, symposiums and small group sessions addressing aspects of research in child and adolescent psychiatry, including designing a research project and presentations from an international panel of faculty regarding their research. Twenty-seven international participants attended the seminar either in person or online. For some, it was a possibility to approach the research domain as a beginner, while for others, it was an opportunity to gain new insights and review each step of the research process in detail. In this article, we aim to share our experiences of attending the seminar and have provided quotes from the authors, as the attendees, to highlight these experiences.

During the seminar, we had the unique opportunity to meet and build a network with colleagues from around the world and mentors whose research we were familiar with from their extensive publication in journals. The faculty was incredibly professional and approachable. Periods such as meals that may at other events be labelled as breaks were instead used to facilitate interaction between faculty members and trainees. We had a fantastic experience in this community, where exchanges were open, friendly, and supportive, with high professionalism and a non-judgmental attitude. Attendees felt respected, valued, and heard. The topics that came up through conversation varied widely due to the cultural and geographical diversity of the group. This melting pot experience has led to



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a broader and more empathetic understanding of each other's research concerns, interests and priorities and the reasons behind this.

Attendees found the diversity of the group a particularly valuable aspect of the seminar in understanding the status of child and adolescent mental health services in different countries, with one attendee saying, "I travelled the world in five days, with the price of just one ticket to Rome!" (Rwanda Gaffaz, Libya). Through discussion, participants realised that although their training programmes, working conditions, available resources, and treatment options differed, their goal to improve children and adolescents' mental health was similar across cultures. As one attendee said, "we all had the same dream: make a difference for a beautiful world!" (Şafak Eray, Turkey). As part of making a difference and advocating for the mental health of children and adolescents at an international level, we attended a reception at the Italian Embassy to the Holy See. This was a great privilege and enhanced the connection between research and the real world and how engaging in research benefits the child and adolescent population.

A unique aspect of the seminar was its hybrid nature due to the COVID-19 pandemic. The conference organisers used information and communication technology (ICT) to facilitate virtual attendance for the attendees and faculty members who could not travel to Rome due to travel restrictions. Online attendees were thankful for the opportunity to attend, although they did experience some challenges due to the virtual nature of ICT connections. The virtual attendees felt they would have been more satisfied if they could have had the opportunity to meet the other attendees and mentors in person and got to experience the added benefits of international conferences, such as exploring the local area and experiencing the culture. However, it was felt that there were also advantages to attending virtually, including avoiding travel expenses, not worrying about contracting COVID-19 and attending the seminar in the comforts of their homes. Although in-person attendance may be preferable, virtual attendance has been a helpful resource to enable those unable to travel to still be included in the conference. As highlighted by one of the attendees, "in times of crisis, lies unexpected opportunities and room to learn. Whether the learning process occurred physically or virtually, the full presence of the heart, mind and soul will eventually determine



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how much one would gain and how much one would contribute and share the experiences" (Nurul Nadia Ismail, Malaysia). Another attendee highlighted that "the faculty's dedication, passion, and kindness were palpable through the screen and continued to deepen my interest in child and adolescent psychiatry research despite virtual attendance having more barriers to discussions compared to in-person attendance. I believe this training seminar will inspire other attendees worldwide regardless of being held virtually or in-person in the future" (Lalita Thitiseranee, Thailand).

Participants who attended in person expressed feeling grateful to interact with one another, and at the same time, felt apprehensive to varying degrees about being in physical proximity to one another. The organisers managed this, and overall, the quality of the seminar was not threatened by it. The seminar's planning and considerable precautions yielded a successfully held seminar. Some attendees found it tough being back in a physical learning environment, and we will need time to adjust to being physically close to other people again. Nevertheless, well organised international meetings, like this one, show that scientific events can and must happen in the future. Child and adolescent psychiatry is a specialty based on human relationships, and promoting face-to-face training is really important regarding the possibility of trainees bonding and supporting each other in future research.

A significant component of the seminar was the attendees developing their own research project that could add to the literature improving the mental health of children and adolescents. We were divided into small group discussions during the seminar, with five to seven participants attending the small group either in person or virtually with two to three faculty members. Attendees felt that these small group sessions were a highlight of the conference. These small group sessions created a fully immersive experience that promoted learning and allowed for the exchange of knowledge and expertise among the faculty members and peers. During the sessions, everyone could discuss their proposed research project. Participants felt out of their comfort zone at first, but after facing the initial anxiety, the mentors' advice and constructive critique were seen by participants as positive experiences and enabled us to reflect and adjust our proposed study's aims, objectives, and design accordingly. We learnt the importance of collaborative work, especially as junior researchers, and learning from each other. As highlighted



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by one of the attendees, "the melting pot experience afforded by the research training seminar is a reminder that regardless of our origins, be it Asia, Africa, America, Europe, the work that we do in our little corners in psychiatry matter and can contribute cumulatively to changing the world, one person at a time" (Gbonjubola Abiri, Nigeria).

During the small group sessions, we also had the opportunity to practice delivering a presentation regarding our proposed research projects, which we delivered to the broader group on the last day of the seminar. Most participants found presenting our projects to peers and faculty was a fantastic opportunity and it was interesting to hear about the planned research projects worldwide regarding child and adolescent psychiatry. As highlighted by one of the attendees, "I found the experience of the presentation session to be invaluable. It provided me with the opportunity to share my work with international peers, learn about their projects, and to gain expert feedback from the mentors" (Iolanda Tiedt, Ireland). Furthermore, the mentoring sessions during the seminar maximised the benefit of learning from the mentors and may have fostered longer-term relationships, which participants felt could be a positive experience for young researchers finding their initial steps in the world of child and adolescent psychiatry research.

The satisfaction with the seminar was high, with attendees finding the intensely jammed packed week of lectures interesting and educational. During the seminar, the attendees felt inspired by the faculty and the "years of knowledge and experience delivered to us, packed in hours of presentations" (Vishal Gupta, India). The seminar confirmed some of the attendee's aspirations to continue with research or pursue an academic career in psychiatry. Meeting colleagues through this event opened an opportunity to work longer term with similarly minded people interested in research. The benefits of this experience are already visible in the actualisation of the strong bond that unites us and the production of this article. Collaborations, both formal and informal, have and will continue to grow after this seminar. For some, it may provide an opportunity to work abroad or collaborate on research projects. For others, it may be an opportunity to build lifelong relationships.



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To improve similar events in the future, we would like to share the suggestions gathered from the participants of the 16th edition of the research training seminar who wrote this article. A key point is offering a mixture of theoretical and practical sessions. Mentoring sessions in this event have received such positive feedback, and ensuring mentors and mentees stay connected post-seminar would add to the career impact such events can have. Finally, we recommend writing an article to recap the experience after each research seminar. This final experience together has been another important educational experience for those involved. It has also enabled participants to develop connections further and "simultaneously learn and get to know colleagues from all over the world" (Rozela Tarazhi, Albania).

We would like to conclude this article by highly recommending the Fondazione Child Foundation International Research Training Seminar in Child and Adolescent Psychiatry and encourage all early career and trainee child and adolescent psychiatrists interested in research to seek opportunities to engage in research regardless of their level of experience. Research may require hard work, and it is normal to feel overwhelmed even before beginning. We learned from this seminar's mentors that the perfect start does not exist. It is always possible to refine and improve your research project. This should not discourage emerging researchers. Mistakes can be the best way to improve oneself. International seminars, like this one, are crucial for developing the research skills of young researchers and help to foster social connections and making worldwide acquaintances, which expands the potential professional network that will engage in research to improve the mental health of children and adolescents worldwide.

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