



World Child & Adolescent Psychiatry

ISSUE 20, September 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



Editor and Section's Chair: Prof. Norbert Skokauskas (Norway)

Deputy Editors: Prof. A. Guerrero (USA) & Dr. T. Hirota (Japan-USA)



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Chair's Column

Dear Colleagues,

Welcome to the September issue of "World Child and Adolescent Psychiatry," an official journal of the World Psychiatric Association Child and Adolescent Psychiatry Section (WPA CAP).

The WPA 20th World Congress of Psychiatry took place online from 10 to 13th of March 2021. I wish to thank all members who attended the section's assembly during the World Congress and who elected the WPA Child and Adolescent Psychiatry (WPA CAP) section officers: Dr. Vlatka Boričević Maršanić (Croatia) - secretary, Prof. Anthony Guerrero (USA) - co-chair, Prof. Norbert Skokauskas (Norway) - chair.

The WPA CAP section has several goals for the next term:

1. Dr. Afzal Javed is the new WPA President. Child and adolescent mental health is a priority in the WPA Action Plan 2020-2023. The WPA CAP leads the WPA Presidential working group on child and adolescent mental health. The group will focus on research, education and advocacy.

2. Coronavirus disease 2019 (COVID-19) is a disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). During the COVID-19 pandemic, extraordinary measures are being taken to protect the general population. The general population control measures (i.e., the closure of businesses and educational institutions, travel restrictions, and social distancing) are stressful for families, especially children. When social distancing and quarantine constitute everyday life experiences, the well-known and critical protective factors for resilience and mental health (i.e., social and community support) are substantially disrupted. WPA CAP will support member associations by sharing relevant information and providing advice and consultations about Covid-19 and child and adolescent mental health.

3. Worldwide, there are more than 2.2 billion children. For the nearly 2 billion of these children who live in developing countries, mental health and developmental disorders remain one of the leading causes of the global burden of disease and years lived with disability. The WPA CAP section will work with all countries and will continue to place a special focus on developing countries on all continents.

4. The "mal-distribution" of child and adolescent psychiatrists occurs on multiple levels: between countries, between rural and urban communities, and between private and public sectors of care. The WPA CAP section will continue to pay special attention to trainees and early career child and adolescent psychiatrists, for whom the section aims to coordinate brief research and management training courses.

5. The WPA CAP section's scientific and professional communications will be organized mainly online, including WPA CAP section's webinars.



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6. *World Child and Adolescent Psychiatry* is an official journal of the WPA CAP section. It aims to be an independent, peer reviewed, and diverse journal publishing papers from all continents.

7. WPA CAP will closely collaborate with other international associations in the area of child and adolescent mental health, including but not limited to the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP) and the World Association for Infant Mental Health (WAIMH).

8. WPA CAP will endorse digital mental health initiatives, which aim to increase access and improve the quality of child and adolescent mental health services.

9. The WPA CAP section will facilitate and coordinate WPA CAP sessions at the WPA and other international and national mental health conferences and meetings.

10. And last but not least, the WPA CAP section remains open for new initiatives coming from our members or colleagues who wish to become members of the section.

And finally, the majority of our section's materials, including all past "World Child and Adolescent Psychiatry" issues can be found at <https://www.wpanet.org/child-adolescent-psychiatry>

Happy Readings!

Prof. Norbert Skokauskas (Norway)
Editor, "World Child and Adolescent Psychiatry"
Chair, World Psychiatric Association,
Child and Adolescent Psychiatry Section





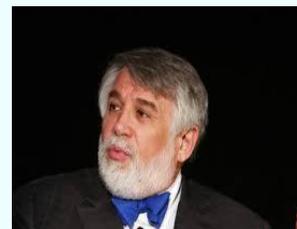
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The New Normal?

Prof. Bennett L. Leventhal, (USA)



As a human being, one has been endowed with just enough intelligence to be able to see clearly how utterly inadequate that intelligence is when confronted with what exists.

Albert Einstein, "An Intimate Look at the Night Sky"

The so-called "COVID era," beginning sometime in late 2019 or early 2020, brought about remarkable disruptions in our lives that are still difficult to comprehend. These "COVID era" changes have continued, perhaps for longer than necessary, while the virus is causing uncountable death, damage, and destruction. While many have been affected, no greater impact has been that which has been visited upon children, youth, and their families. While we hope that the "COVID era" slowly fades away, there are mounting challenges as we try returning to our "normal" pre-COVID lives. What was the previous normal and is return to that "normal" even possible? Instead, must we prepare for a "new normal?"

COVID has been labelled "the first pandemic in 100 years." It is said that it was preceded in scale only by the so-called "Spanish flu" of the early 20th century. While that experience should have been sufficient to prepare us for future pandemics, the world appears to have been "surprised" by the rapid and lethal spread of COVID. One might readily argue that, rather than surprise, over that past 100 years, we have become indifferent to pandemics, as there have been so many more than we thought. These pandemics have come in various forms, and not all of them have been apparent in the Western or "developed" parts of the world.

Plagues that are the result of infectious disease have been the traditional image of a "pandemic." The "Black," or "bubonic," plague is perhaps the best-known pandemic; pandemics have been around for a very long time. Devastating bubonic and pneumonic plagues appear to have started in the 6th century CE with the Plague of Justinian, peaking with the 14th Century Black Plague in Europe. However, it did not end there. In fact, there have been major outbreaks of "the plague," largely in Asia and Africa, well into the mid-20th Century. With so much persistence and prevalence to pandemics, it is a surprise that so many were surprised about COVID.

Yersinia pestis is not the only plague we have faced, even in the past century. Some remember Ebola, SARS, MERS, Eastern Equine Encephalitis, AIDS, and many other widespread and dangerous infections. However, few seem to remember Polio, Diphtheria, Measles, and Pertussis? Each one is terrible and can be fatal, especially for children. Tragically, even though there is an existing, very safe, and very effective vaccine, in 2018 (the latest year with available data), 140,000 people died of measles, mostly children under the age of 5 years. Indeed, all plagues impact children disproportionately. Unnecessary pain and death appear to be a part of the pandemic tradition.

Pandemics are not only caused by viruses or bacteria. Over the course of history, the world has experienced horrific plagues of war, genocide, sexual assault, poverty, malnutrition, and gun violence, just to mention a few. Each plague



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is of pandemic proportions, and each is damaging lives around the world, especially the lives and futures of children and youth.

Based on the data, there is no reason why we should be surprised and unprepared for an onslaught of pandemics. Yet, for some reason, these occurrences lead to either “shock and awe” for the period of a “news cycle” that provides images of violence, injury, pain, suffering, and death, each and every day. Are we seeing pandemics so often and so graphically that they cease to cause discomfort, sadness, or even empathic pain in the observer? This numbing does not apply to all observers, especially those who are experiencing one of the many pandemics. Day after day, there are millions languishing in refugee camps, facing abject poverty, hiding from marauders and rapists, or never having enough food, clean water, and sanitation. For children and youth, there may also be a pandemic of lack of schools and stable communities to foster healthy development. While many of these events should be self-evident, they are not, because many of us have at least a modicum of distance, in both space and time, from the world's actual pandemics.

We should all be troubled by these many pandemics, past and present. However, many of us are not. The lack of information and personal connection to these events ensures repeated “surprises” when these common events recur, especially if they directly affect us. In this context, it is not a surprise that the COVID pandemic was a “surprise.” It then only follows that there is little reason to be surprised by individual, community, and government pandemic responses, which have been a mix of shocking and inspiring.

While there are many arguments for why the COVID pandemic has been somewhat unique in its impact on our lives, it appears that complacency and selfishness play a major role. Complacency, an uncritical satisfaction with oneself, appears to be pervasive in that so many are so sure that they “know” what is going on with COVID and the vaccines when, in fact, they do not. Indeed, the complacency is fostering ignorance and encouraging the mass distribution of misinformation. This is occurring in the face of the creation of vaccines that truly represent a “miracle” of modern medical science. Selfishness comes into play in two ways. First, there is the massive refusal of individuals and leaders to assume personal responsibility to act in a way that would minimize virus transmission – specifically wearing masks, maintaining social distancing and, above all, getting vaccinated. The arguments that “I do not believe that I am at risk” (whether true or not), completely miss the obligation we have to not only protect ourselves but also our family, friends, and neighbors. This selfish disregard for others is occurring in numbers that are staggering. The second element of selfishness has been the willingness of political leaders and others to place their own desire for power and position above the responsibility for the general welfare of their communities. Complacency and selfishness are a toxic combination that has led to massive morbidity and mortality for millions.

Despite the many surprises and disappointments, we have a clear responsibility to address the most immediate concerns about the COVID-19 pandemic as well as prepare for the “new normal” that will hopefully follow. Even though some will be surprised, many elements of the “new normal” may not be that new. This preparation starts with recognizing that, as with many pandemics, COVID is not going away so readily. The pervasive presence of



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COVID will be an intrinsic part of our “new normal.” This means that we must prepare for ongoing “inconveniences” and fundamentally change our value systems and how we live our daily lives.

The “new normal” will include the inconveniences of limitations in the practical and social elements of daily life. Whether we like it or not, these will likely be with us for some time to come. Wearing masks and social distancing will be the most evident of these inconveniences, and they will impact the most mundane aspects of our daily lives by adding complexity to shopping, seeking services, dining out, participating in various activities, and attending large audience events. They will also have an impact on events like family and neighbor gatherings. And, of course, they will have a tremendous and persistent impact on going to work and to school.

While some of these inconveniences appear to be mostly annoying, they have serious implications for children, especially under age 12 years, as they are not yet protected from COVID by vaccines. For those who can return to school, these inconveniences will create distance in peer-to-peer and student-to-teacher relationships and will adversely affect the essential social learning of group projects, group extracurricular activities, and, most importantly, play. Unless we can creatively develop new educational techniques, they will have a long-lasting, adverse impact on child development. And, in those communities where mask mandates and vaccines are unwelcome, children will be at great risk of contracting serious, if not fatal, infections.

In the “new normal,” fear will be a persistent part of our daily lives, especially for children. Traditionally, it has been the role of adults to offer safety, which allowed children to grow and explore the world. Now, many adults cannot, or will not, offer that assurance. We cannot count on our neighbors to be vaccinated and safe. We cannot count on our political leaders to promote the general welfare.

This lack of security is happening in countries on each continent. In turn, this lack of security leads to fear; this fear is actively promulgated by many in positions of authority for the purpose of securing their own well-being, at the expense of others. In this process, truth has become illusive, and respect for science and other authority has eroded. This erosion represents a fundamental change in values. Instead of living by the credo that “the only thing we have to fear is fear itself,” we now see finger-pointing and handwaving that displaces personal responsibility and promotes anger and hostility. These emotions, too, all seem to be a part of the “new normal.”

So, what can we do to counter make a different “new normal?”

1. Recognize and understand the challenges caused by being complacent.
 - a. Actively engage in learning the facts/truth. This learning requires identifying real, knowledgeable authorities and doing our own reading.
 - b. Do not rely on the news media, political leadership, Google or Wikipedia as sources of knowledge. As physicians, we know how to be diligent consumers of the scientific literature. This diligence must be an ever more important part of our “new normal.”



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2. Use knowledge to offer the reassurance that children and families need – they need a lot of it! Constant transmission of knowledge and reassurance about how to use that knowledge will be even more important in the “new normal.”
 - a. Help children and families understand why they need to be vaccinated, and help get them vaccinated.
 - b. Help children and families understand why they need masks and social distancing, and help them use masks and social distancing.
 - c. Help children and families find successful adaptations to these inconveniences so they can still live and enjoy happy, interesting and successful lives - yes, even with the inconveniences, you can meet other people, play, and creatively explore the world around you.
3. Do not succumb to the abandonment of the principles of personal and community responsibility.
 - a. Lead by example by being more responsible than ever.
 - b. Make yourself an example of accepting responsibility for yourself and others.
 - c. Speak up and speak out on issues of health, safety, responsibility, and the essentials to support successful child development.
 - d. Eschew selfishness.
4. Speak directly to children and their families.
 - a. They are desperate for credible messengers who can help them face the overwhelming confusion in the world around them.
 - b. Listen to what children are saying, so you can address their wants and needs directly.
 - c. Give children the facts, at a developmentally appropriate level.
 - d. Be specific about what we can, and will, do to keep them safe.
 - e. Be specific about what the child can do to keep safe.
 - f. Children feel reassured when they feel heard and then get responses that make sense and instructions that are developmentally appropriate for them to follow.
 - g. Teach parents how to support and reassure their children, while protecting them from fear, complacency and selfishness.
5. Create specific structures that help children and families adapt to the stresses of the “new normal.”
6. Help prevent fear from being the dominant force in the “new normal” and, most particularly, in the lives of children.

These are not new principles or ideas any more than the “new normal” is “new.” But, they are things that we know will foster healthy development for children and their families.

We have the knowledge, now we must put it to good use.

“Nothing in life is to be feared, it is only to be understood. Now is the time to understand more, so that we may fear less.”

Marie Curie

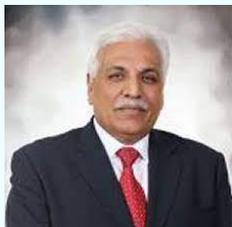


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Child & Adolescent Mental Health: A Priority Area For WPA's Future Work



Dr. Afzal Javed, President, World Psychiatric Association

COVID-19 pandemic has brought a significant change in our lives. In addition to an increasing sense of fear and anxiety, mental health consequences of Covid 19 are contributing to several problems around the globe. This phenomenon has also led to short term as well as long term psychosocial and mental health implications for children and adolescents. It is true that the quality and magnitude of impact on this population is determined by many vulnerability & predisposing factors but the fears of social isolation due to infection or fear of infection could influence the mental health of adolescents during this period. The COVID-19 pandemic could also result in increased psychiatric disorders.

Additionally, adolescents with psychiatric disorders are at risk of a break or change in their care and management. The COVID-19 pandemic and lockdown may have a negative impact on the mental health of adolescents, and we are getting more data on the long-term impact of this crisis. Adolescents' individual, familial, and social vulnerability, as well as the coping abilities, are factors related to adolescent mental health in times of crisis. Adolescents are often vulnerable and require careful consideration by caregivers and healthcare system adaptations to allow for mental health support despite the lockdown. Research on adolescent psychiatric disorders in times of pandemics is necessary, as such a global situation could be prolonged or repeated. Similarly, supporting children of healthcare workers during the COVID-19 pandemic may come up as a global challenge and lead to further breaks in health and social care delivery models.

While spread of COVID-19 around the world is increasing risk of developing mental disorder, relapse of existing mental disorder and poor mental wellbeing, this unprecedented has upended family life and parents around the world are struggling with facing new challenges on daily basis. The recent literature suggests many adverse psychological outcomes of quarantine, loneliness & social isolation on children, these factors may add greater consequences for parents and the families. Demands for caring children in stressful conditions, economic uncertainty, working remotely with childcare responsibilities and keeping children busy and managing demands of home-based schooling with no clarity on how long the situation will last are adding further difficulties in day-to-day functioning. Furthermore, looking after children with special needs add further discomfort for parental stress.



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It is therefore important to highlight the needs of children & adolescents with defined mental health conditions & for those who are living in highly vulnerable situations. Mental health promotion and preventive interventions set new directions for the future work of the Section. These programs, of course, require a joint & collaborative approach with an additional focus on health or social care settings, schools or the community, and varied strategies to reach adolescents, particularly the most vulnerable by using media technology.

I am pleased that WPA Section on Children & Adolescent Psychiatry continues with their efforts for highlighting such issues in clinical, academic and research domains. The membership of this section with able leadership of Prof Norbert Skokauskas has kept Child, Adolescent & Youth Mental Health as a priority area for WPA's action plan. WPA firmly believes that child & adolescent mental health and capacity building in several areas will continue in WPA's future programmes. WPA's recently established working group to look at child & adolescent mental health needs is actively formulating plans and projects that we will share with WPA membership very soon & implement required strategies in different settings and countries. I personally rely on WPA's section expertise for their continuous dedication and support and look forward receiving their recommendations during the current triennium.



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The Working Group on Child and Adolescent Psychiatry for the WPA 2020-2023 Action Plan

Prof. Bennett Leventhal (USA), Prof. Peter Szatmari (Canada), Prof. Muhammad Waqar Azeem (Qatar), Dr Gordana Milavic (UK), Dr. Andrea Raballo (Italy), Dr. Christian Kieling (Brazil), Dr. Hinemoa Elder (New Zealand), Dr. Harold Koplewicz (USA), Prof. Norbert Skokauskas (Norway)

The WPA Working Group on Child and Adolescent Psychiatry was convened by the President to carry out work related to the President's 2020-2023 Action Plan. Prof. Bennett Leventhal and Prof. Norbert Skokauskas were invited to chair the group. Since child and adolescent mental health is a key feature of the WPA 2020-2023 Action Plan, the activities of the WPA Working Group on Child and Adolescent Psychiatry are of particular importance.

The Working Group started its work in December 2020 and will continue with its activities until the end of the triennium after which the Group's existence may be continued should this be considered helpful to WPA's overall program of activities.

The Working Group is primarily focusing on global advocacy, capacity building and research in child and adolescent mental health:

- **The Advocacy Committee** is examining activities to increase the conversation about children's mental health around the world while reducing stigma and encouraging the increase in awareness and resources. In its effort, we are partnering with the Child Mind Institute (CMI) in New York City, USA a leader in innovative child advocacy programs. CMI is a non-profit, non-governmental organization dedicated to transforming the lives of children and families struggling with mental health and learning disorders. It has consistently run campaigns in the public media that have engaged celebrities in sending messages to the broader community. While mostly focused in the US, the CMI programs are readily transferable to other communities and settings. This year, in response to the COVID-19 pandemic, CMI is sending a message of hope in its "Getting Better Together" program in which celebrities are recording messages about their own struggles with mental health problems and how they are working to get better.





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With the support of CMI, we are proposing to develop a similar program in New Zealand. Led by Dr. Hinemoa Elder, we will use some of the CMI materials and build new content to be consistent with language and culture for children and families in the Maori community.

Hinemoa Elder MNZM is a New Zealand youth forensic psychiatrist and former television presenter. She is a professor in indigenous research at Te Whare Wānanga o Awanuiārangi, a fellow of the Royal Australian and New Zealand College of Psychiatrists, and sits on the Māori Advisory Committee of the Centre for Brain Research - Rangahau Roro Aotearoa.

Dr. Hinemoa Elder

This will be a small-scale project completed as a proof of concept. Once completed and assessed, we will develop proposals to deliver similar programs in other countries and cultures around the world. This is the first step in a broader advocacy campaign designed to make children's mental health an important part of global and local healthcare planning and policy. It is anticipated that this effort will also reduce stigma and yielding increases in the availability of resources for child and youth mental health.

- **The Training and Capacity Building Committee** has considered various options and factors: specialist vs capacity building; length of training; ease of implementation; finding trainers; local resources; accreditation; and, funding. After exploring various options, it was decided to focus on adult psychiatry colleagues who will benefit from a Child and Adolescent Psychiatry training Course. A needs analysis was explored and curriculum recommendations for child and youth mental health training directed at family doctors and paediatricians will be carried out. Prof. Peter Szatmari is exploring opportunities with colleagues from University of Toronto, Canada (UFT) to examine the possibility of accreditation by UFT for the training course.
- **Research Committee** has met several times to identify projects that can be completed in a relatively short time-frame, utilizing modest resources. The committee has identified several potential projects. It decided to begin by writing a paper on the training of clinician-scientists in child and youth mental health. This is because it is an essential component of reducing the burden of suffering of mental disorders. The committee is concerned that the dearth of proper training programs for developing clinical-researchers and the lack of funding for early career track clinician-scientists, globally. The committee has completed a literature search on clinical-research training programs, written a first draft of the commentary and has developed a tentative set of recommendations for the WPA to consider in its efforts to support clinician-scientists in child and adolescent psychiatry.



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International developments toward building a rationale mental health system for children and youth



Prof. Peter Szatmari (Canada)

The current mental health system for children and youth is not rationale

A 'rationale' mental health system for children and youth (CY) is one that is sufficiently resourced to achieve optimal (even 'reasonable') mental health outcomes for the population at large. This should include not only providing clinical services for those with mental disorders but also providing prevention programs for those at high risk of developing a disorder and a mental health promotion program delivered to the population as a whole.¹

In a rationale mental health system, targeted, prevention and health promotion programs are evidence based, incorporate patient values and are derived from clinical practice guidelines developed free of bias.² Moreover, the implementation of these programs will reach those who are targeted and will be delivered with fidelity to the principles of the intervention.³ Finally and ideally, the interventions have the capacity to be scaled up from the local to the population level.⁴ Following these indicators, it is all too clear that we do not have a rational mental health system for CY in either high or low and middle-income countries (LMIC). In spite of the welcome explosion of new evidence based treatments in children and youth, there is a serious evidence to practice gap.⁵ Around the globe, the mental health system appears to fail in many ways to meet the needs of the population. The quality of clinical practice guidelines in our field generally fail to meet international standards of trustworthiness and usefulness.⁶ In many jurisdictions (see as an example ⁷) evidence based interventions are not consistently implemented in the community. If they are implemented, there are problems with fidelity to the original intervention. Wait-lists are much too long and even when youth are enrolled in evidence based treatments, engagement of children, youth and families in the intervention is poor. For example, a recent clinical trial of psychosocial interventions for adolescent depression required 12 sessions, yet the average number of sessions attended by youth was less than half that⁸. The mental health system simply does not work for CY and their families.



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Part of the problem, no doubt, is a resource issue. The amount of resources apportioned to mental health in children and youth is much less than expected relative to the expenditure for adult mental health conditions and much less than for pediatric physical disorders.⁹ The need is great once we realize how common mental disorders are in children and youth are at a single point in time¹⁰ let alone how high the cumulative prevalence is by emerging adulthood¹¹. I will argue in this commentary that a key step in making the mental health system for CY more 'rationale' is to adopt a 'value-based' health care framework; that is a focus on outcome per unit cost¹². I would then like to briefly describe two recent innovations (measurement based care and stepped care) that maybe key to improving the value of our CY mental health system. These innovations have been piloted in several jurisdictions recently but are not well known in CY mental health in either high or LMIC. Once rigorous clinical trials evaluating these innovations are completed, both may be of significant benefit to those planning a more rational mental health system for CY.

Employing a value based health care system framework

Porter and colleagues in several influential publications^{12, 13} advocate for a value based health-care lens rather than a focus only on resources expended and 'process' outcomes. Process outcomes refer to benchmarks such how many people accessed the service, how many beds were occupied, what was the length of stay, how many health care workers participated in an episode of care? Sometimes patient ratings of satisfaction are obtained to contextualize the process outcomes accumulated. Traditionally, to determine if a service was 'worthwhile,' a comparison of process and satisfaction outcomes to expenditure is made and a judgement rendered as to whether or not the outcomes justified the expenditure.

Porter and colleagues argue persuasively that we should not be measuring process or satisfaction outcomes alone but rather should include individual health outcomes¹². The key question is; 'what is the relative change in a health outcome achieved and was that worth the expenditure?' Or put another way; what is the outcome per unit cost? A value-based health care system compares health outcomes to costs expended to achieve those outcomes. It may be that some outcomes are 'worth' a greater expenditure in the short term as they might save resources later on or might be worthwhile in and of themselves. Without a clear understanding of health outcomes it is impossible to build a value-based health care system.

Unfortunately, the routine measurement of health outcomes is rarely implemented in CY mental health settings. Measurement-based care (MBC) is a recent innovation to come out of collaborative care models in adult mental health¹⁴ and involves the routine and systematic collection of valid and reliable outcome data to guide decision making over the course of a treatment episode. MBC has been shown to improve outcomes in adult mental health settings¹⁴ but there are no controlled clinical trials in CY mental health as yet. There are several systematic reviews of interventions that allow for feedback between a CY and a clinician and these show promising results^{15, 16}. However, even better outcomes may be observed if the selection of outcome domains and measures was systematically accomplished.

MBC depends on the development of Core Outcome Sets



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A key question for a value based mental health care system is what outcome domains should be addressed and what outcome measurement instruments (OMI) should be used as part of a MBC framework? An outcome domain refers to the behavioural target of treatment (depressive symptoms, social functioning, family conflict etc.). An OMI refers to the measurement instrument used to assess change in that domain. OMIs vary depending on whether they cover the appropriate content (content validity) and are sensitive to change. Just because an OMI has good reliability and construct validity, does not mean that it is sensitive to change. The COSMIN website (<https://www.cosmin.nl/>) is a valuable source of information about outcome instruments in general. The Child Outcomes Research Consortium (<https://www.corc.uk.net/>) from the UK is another very useful resource specifically focused on child and youth mental health outcomes.

Many fields in physical health care have developed standard sets or core outcome sets to measure outcomes in clinical trials, cohort studies and measurement based care. The International Consortium of Health Outcome Measurement (<https://www.ichom.org/>) has been a leading advocate of these efforts and has recently focused on mental health, in particular child and youth mental health. A standard set for the measurement of outcome in anxiety and depressive disorders has recently been published¹⁷. Harmonization of outcome measurement across jurisdictions and across domains allows for bench marking, international comparisons, and more precise evidence syntheses. ICHOM went through a rigorous process of seeking stakeholder (including youth with lived experience) and expert opinion in selecting domains and OMIs to be used in outcome monitoring for anxiety and depression in children and youth. In addition, suggestions were provided for what baseline information should be collected that can contextualize outcome assessments and for the timing of outcome assessments during an episode of care. It is hoped that this standard set will be widely implemented globally.

Harmonization and standardization of outcome measurement would be a significant step forward in the implementation of a value-based health care system. Harmonization allows for collaboration and comparison across jurisdictions and benchmarking within jurisdictions using the 'best-available' OMIs derived from expert consensus and youth input. Only by using a common metric can we ensure a comprehensive understanding of the outcomes that are part of the value-based health care equation and as a result, continually modify a mental health delivery service to achieve better outcomes.

Stepped Care Models

The other part of the equation is a consideration of cost and how to make the most efficient use of current resources. Stepped care models are receiving increased notice as a useful way of triaging resources to the degree of need associated with a mental health presentation¹⁸. It is a framework for a rational mental health system, not a specific type of intervention.

The traditional mental health clinic for children and youth is hospital based and often starts with a lengthy assessment carried out by a highly trained specialist in psychology or psychiatry. Depending on the diagnostic assessment a treatment is offered (say twelve sessions) of some psychosocial intervention (like CBT for



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depression) with the option of medication. In other words, almost every CY is offered a resource intensive assessment and a standard intervention at the very start of their clinical journey. After the first episode of treatment, many clients are kept on the books with access to only intermittent care as the transition to primary care or community based mental health services is either delayed or faces many barriers. In this model, the highest expenditure of resources occurs at the outset and dwindles as time goes on.

In stepped care models, the allocation of differing intensities of resources is reversed. At presentation to a mental health service, a brief assessment of need is carried out with a clear specification of goals¹⁹. A full biopsychosocial formulation and diagnostic assessment is not completed. With a greater appreciation of the degree of comorbidity among children and youth with mental disorders and of the efficacy of trans-diagnostic interventions²⁰, many children/youth will only require the lowest level of resource allocation. This might include a single session to support problem solving, a course of psychoeducation, or an internet-based CBT program. With the aid of MBC assessments, the clinician and the CY and family can evaluate treatment progress and in a shared decision making interaction²¹ choose to access more resource intensive interventions such as group or individual CBT, a more lengthy diagnostic assessment to refine treatment choices, or the addition of a medication. Youth who present with serious at-risk behaviours (self-harm, eating disorders etc.) of psychosis can be 'fast-tracked' to more intensive assessments and interventions as needed

The model can work in many different settings and organizations. In our Integrated Youth Service Hub (a community based one stop shop for mental health services for adolescents), after an initial assessment all youth receive one to two sessions of problem solving therapy to address immediate needs²². Adolescents who do not respond to this level of treatment or whose goals are not met are then offered a more resource intensive array of services including dialectical behavior therapy, peer support, family support, or linkage with primary care. Those who do not respond to this level of care are seen by a nurse practitioner and psychiatrist to review the diagnosis and formulation, address the need for medication, and offer other treatment options such as hospitalization, or a day program. We have successfully implemented a similar MBC/stepped care model for the treatment of depression in a hospital outpatient service²³, a primary care setting and in a community mental health agency. While the outcome domains and OMIs remain the same, the interventions differ depending on the context (for free access to a number of clinical tools to support MBC and stepped care please see <https://www.camh.ca/en/science-and-research/institutes-and-centres/cundill-centre-for-child-and-youth-depression>).

Conclusion

A rationale mental health system for children and youth is one that focuses on value; that is, it maximizes individual health outcomes at a cost that is assessed as worthwhile. Outcomes are optimized by the implementation of evidence based diagnostic tools and treatment interventions, by monitoring outcomes and by engaging in shared decision making with youth. Relying on 'satisfaction' ratings and process outcomes instead of employing standard sets of outcomes and at the same time ignoring the cost of implementing evidence based interventions will never convince decision makers that a particular program will have an



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impact that is worth the expenditure. Stepped care models provide a framework in which evidence based treatments, MBC and shared decision-making can be embedded to support a true value based mental health care system.

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Global Child Mental Health Webinar Series



Dr Ayesha Mian (Pakistan), Dr. Daniel Shuen Sheng Fung (Singapore), Prof. Norbert Skokauskas (Norway), Prof Myron Belfer (USA)

Worldwide 1 in 5 adolescent experience a mental health problem in any given year (1). Fifty percent of mental health problems begin by age 14 and seventy five percent by age 24 (2).

We are now seeing a further global increase in the burden of child and youth mental health due to the current pandemic which has caused a disruption in families, schools, jobs, spaces of congregation, physical activity, and other routine activities. Various societies and organizations working with children and adolescents are coming together to speak to what is now being called a “shadow pandemic”.

The COVID 19 pandemic has highlighted the urgent need and opportunity to respond to this mental health crisis through a globally focused strategic lens and vision. We propose that American Academy of Child and Adolescent Psychiatry (AACAP), (International Association for Child and Adolescent Psychiatry and Allied Professions') IACAPAP and the World Psychiatric Association, Child and Adolescent Psychiatry Section (WPA CAP), as the three largest organizations working for the promotion of child and adolescent mental health, come together to propose a holistic, systems focused and globally applicable strategic plan to respond to this need.

Any strategic plan focused on mental health must include stakeholders from all areas that affect children's emotional growth. We would like to bring together thought leaders from the fields of education, pediatrics, law, urban planning, economics, environmental advocacy, legal and grassroots advocacy and organizations dealing with children and youth in a community context to hear and document their perspectives on global child mental health. This would be done through a series of webinars featured live on social media/virtual platform, hosted in collaboration with the AACAP, WPA CAP and IACAPAP. The webinars will host collaborators, informants and patrons with the goal of establishing an ongoing dialogue to shift traditional paradigms and develop a strategic vision for global child and adolescent mental health priorities for today's world and the future. The information and resulting vision will be incorporated in a detailed report for broad dissemination to civil society, international agencies, and governments.

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Missing in Action: Epidemiologic Data for Child Substance Use Disorder



Dr. Gerald Busch (USA)

From establishing curricula for child and adolescent psychiatric training to determining the prevention and treatment needs of a community, region, or country, or even global disease burden, epidemiologic data serve as the foundation for clinical and policy decisions regarding the allocation of healthcare resources and establishment of effective delivery platforms. In this regard, although variable, most countries do not collect, publish, or monitor prevalence or incidence data pertaining to Substance Use Disorder (SUD) in children less than age 12. The following brief global spot check of selected state monitoring policies provides a window to view the degree to which child substance abuse for age less than 12 is identified, monitored, or recognized.

Beginning with the United States, survey data regarding substance abuse is collected nationally for ages 12 and older. The US Center for Disease Control conducts monitors “youth” mental health and substance abuse with the Youth Risk Behavior Surveillance Survey (YRBSS). This is a survey of high school grades 9-12 (ages 14-18). The US National Survey on Drug Use and Health records substance abuse and mental health data for the US population age 12 and above.

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the European Union's decentralized agency for providing an overview of European drug problems. In this instance, substance abuse prevalence data is collected and provided for ages 15 and older. Similarly, the European School Survey Project on Alcohol and Other Drugs (ESPAD) is a cross-sectional study of substance use and other forms of risk behavior for aged 15-16 years students conducted every 4 years and includes 35 countries.

The Australian Secondary Students' Alcohol and Drug Survey (ASSAD) is the largest adolescent substance abuse national survey in Australia, providing estimates of the current prevalence of tobacco use, alcohol use, and the use of other substances among students in Australia aged 12 to 17. In Japan, the Nationwide Junior High School Student Survey on Drug Abuse and Their Background Lifestyle surveys ages 12 to 15. National surveys of substance abuse in Mexico begin at age 12, as do those in Chile. The Malaysian Anti-Drugs Agency in the Ministry of Home Affairs monitors drug use data beginning at age 13. Uganda conducts school surveys age 12 and screens for substance abuse of regionally prevalent substances of abuse, such as alcohol, tobacco, khat, kuber, and aviation fuel.

The member nations of the Organization for Economic Cooperation and Development all begin their national surveys at age 12. Some of the non-OECD countries show a tendency to monitor drug use from as early as age 10. For example, a survey of Palestinian youth age 15-16 provided self-reports of initiation of tobacco as early as age less than 10. The Russian Federation monitors and gathers information on narcotic disorders for its population. The youngest age range subjected to monitoring of the number of psychoactive substance abusers is age 10-14. According to the WHO, 15 to 20% of children under age 12 are addicted to Catha Edulis (Khat) in Yemen.



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Although the Ukraine currently relies on EMCDDA data for population substance abuse monitoring, previous studies revealed that 13% of drug dependent population were in the 11 – 14 age range. Clinical interviews of a community trial cohort involving project SeeTheChild - Mental Child Health in Uganda unexpectedly detected alcohol abuse/dependence in 7.4% of the study group, ages 5 – 8.

Although US substance abuse disorder surveillance excludes less than age 12, US Treatment Episode Datasets (TEDS) from the Substance Abuse and Mental Health Administration confirm that surveys of substance use disorder patients in treatment revealed that over 10% of patients in treatment had initiated drug or alcohol use at age 11 or younger. Of this cohort, 39% had a co-occurring mental health disorder.

The decision to conduct national substance abuse surveys with the minimum at age 12 is arbitrary, perhaps based upon a statistical assumption that younger than 12 will yield diminishing incidence data. Unfortunately, the selection of a minimum age of 12 also produces bias and the appearance of substance use disorder not being a problem for children aged 11 or less. This unintended consequence leads to a type of institutional and nosological neglect in a highly vulnerable population. The appearance that substance use disorder is simply not a disorder of children becomes a tacit assumption.

The authoritative text on youth substance abuse disorders covers age 12 – 17, but not less than age 12. The deficit of epidemiologic evidence of this disorder in the child population has resulted in a lack of effort to craft developmentally-informed survey questions, assessments, or treatment. Furthermore, SUD treatment principles in adolescents are re-defined from the adult population by the neurocognitive and socioecological developmental level. This same principle would require application to the child subpopulation. It remains unknown what the potential impact of substance use disorder treatment at this age might have on the subsequent course. The study of substance use disorder in children remains wide open for development.

Child and adolescent psychiatrists can enhance the recognition of substance use disorder in children by publishing case reports and advocating for national surveys in their home countries to include children younger than age 12. Finally, organizations such as the World Bank that are involved in funding health initiatives in lower middle income countries can be made aware of this missing piece of the epidemiologic puzzle.



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“It’s complicated”: Evolving concepts of developmental psychopathology



Dr Gordana Milavić (UK)

Looking back on the events of the last several months one particular lecture stands out.

Organised by the Royal Society of Medicine in London, U as part of its Mind Matters series the webinar entitled ‘Its complicated’: Evolving concepts of developmental psychopathology’ was delivered in the spring of 2021 by Bennett Leventhal, Professor of Child and Adolescent Psychiatry, Professor of Psychiatry and Behavioral Sciences, Medical Director, Center of ASD and NDD’s, University of California San Francisco. Professor Andrea Danese, Department of Child & Adolescent Psychiatry and the Social, Genetic, and Developmental Psychiatry (SGDP) Centre at the Institute of Psychiatry, Psychology & Neuroscience joined the lecture as Discussant. Professor Danese’s perspective and contribution stems from his work as lead of the Stress & Development Laboratory, his highly-cited publications on the measurement of childhood trauma, risk factors for trauma exposure, biological mechanisms through which trauma affects later health, mechanisms of resilience, modelling of individualised risk prediction for trauma-related psychopathology, and the epidemiology of child trauma and trauma-related psychopathology.

The webinar was chaired by Dr Gordana Milavić, Consultant Child Psychiatrist at the Maudsley Hospital, Chair of the Association of Child and Adolescent Mental Health (ACAMH) and President Elect of the Psychiatry Council of the Royal Society of Medicine.

This lecture gave participants insight into the evolving roles of biology and environmental factors in relation to developmental psychopathology. Professor Leventhal presented facts and concepts in brain development and their impact on the understanding of neurodevelopment and neurodevelopmental disorders. The concept of a “neurodevelopmental disorder” was examined with the consideration that most psychiatric disorders in children and adults are indeed neurodevelopmental disorders. Professor Leventhal convincingly set out the arguments for the case. It was emphasized during the lecture and in the ensuing discussion how taking a neurodevelopmental approach to psychopathology can alter clinical practice. A lively participant discussion brought together questions about environmental influences and more specifically, the influence of maltreatment on the developing brain and biology.

Concern For Mental Health, a UK Registered Charity linked with WPA CAP teaching activities in India and Pakistan had made a donation in support of this webinar. The agenda, content, and organisation of this webinar had not been influenced by the donation in any way.



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From crisis to rebirth: today's challenges for child and adolescent psychiatry in France



Dr. Jonathan Lachal (France)

France was one of the first pioneers to explore child and adolescent psychiatry (CAP) in partnership with the world. In 1937, George Heuyer, a French child psychiatrist, with Léo Kanner and Moritz Tramer, organized the first International Congress of Child Psychiatry in Paris (1). The creation of the CMP (territorial organization of community-based outpatient and inpatient care services for the entire population) in the 1970s of the so-called CMP led to the golden age for CAP at the end of the 20th century. During these times, treatment was provided to anyone seeking it, with no differentiation between psychiatric and mental health problems. Child and adolescent psychiatrists (CAPS) with their teams were considered “omnipotent practitioners”, dealing with any health problem. We can name this period the myth of the omnipotent child and adolescent psychiatrist.

However, the last two decades have seen the onset of a crisis, with a sharp drop in the supply of psychiatrists while the demand for care has continuously grown and diversified. Within a 10-year time span, the total number of CA psychiatrists was more than halved, declining from 1235 in 2007 to 593 in 2017. Even more concerning is that 80% of them are older than 60 years. The same trends are true for CAP faculty who teach in Universities. The lack of teachers for CAP is so egregious that President Macron has promised “to give a new prospect to child psychiatry” – e.g., financial and institutional support to academic CAP.

Simultaneously, CAP is the victim of its own success. The acknowledgment of CAP's effectiveness by parents and society has been accompanied by a diversification of its applications and practices. On the one hand, CA psychiatrists are called upon today for more and more mental health and social difficulties, such as family relationships, school problems, and other issues that benefit most from social services or school-based services, before seeking the expertise of CAPs. On the other hand, the ever more scientific nature of CAP, its rapidly growing evidence base and increased reliance on technology, requires more specific and more specialized care.

With fewer people to do more work, we are forced to watch the deconstruction of the myth of the omnipotent CA psychiatrist. However, crisis inevitably leads to rebirth, destruction to reconstruction.

Fortunately, a new generation of CA psychiatrists are training, ready to stand up and work towards the future of French CAP. They will face three main challenges:



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- First, they must move from a psychopathological framework to a more phenotypical model. Their principal work will transition from understanding the psychological functioning of the patient to making diagnoses and coordinating treatment. A key aspect of this transformation will be their management of the inheritance of psychoanalysis. Psychoanalysis is invaluable and foundational, adding complexity when integrating with a phenotypical approach. The risk here is losing the richness provided by the psychoanalytic approach in understanding the patient's global functioning. This change will require CAPs to work more closely with psychologists, whose participation in care in France has thus far been insufficient. A pilot trial where psychological care for adolescents was covered by the national health insurance fund began in 2017, with some benefit and should be pursued. CA psychiatrists will also need to promote the extensive training of nurses and social workers to provide primary mental health care. A new program for training in advanced care nursing is launching this academic year in France, and support for research and teaching in nursing is growing.
- This trend will obviously be accompanied by a move from the generalist CAP care offered today by the CMP (where any request leads to a medical consultation) to a new model of care, currently being developed in expert centers and resource centers. CAP. This certainly should not impair the care available, but we must carefully evaluate a more efficient and effective distribution of the provision of mental health care and psychiatric care. A key factor will involve cooperation with and support of social work, which has historically been separated from health care in France, with little collaboration between the two systems. Interest is also growing in improving support and continuity for youths treated too often as “hot potatoes,” sent from one institution to another, with no one really responsible for their intertwined social and psychological problems (2,3).
- Finally, the new generation will need to turn the corner definitively from paternalistic approaches to care. This change, of course, has long been underway. Young patients and their parents are more aware of the youth's medical condition and of all of their rights and responsibilities as decision-makers, alongside the medical team. But efforts to communicate about diagnosis will reinforce this trend and the development of partnerships with both patient and parents - just beginning in French CAP. Furthermore, CAP's involvement in study protocols is a necessary development for research that is more in line with international standards (4).

CAP is a young discipline. After a powerful childhood, its French section has experienced a kind of “adolescent crisis” in recent years. Its empowerment will necessarily entail more cooperation and interaction with other disciplines as it becomes a fully mature discipline.

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The Youth and Mental Health Study (YAMHS) – a Norwegian longitudinal prospective cohort investigation



Dr. Jannike Kaasbøll, Prof. Norbert Skokauskas, Prof. Anne Mari Sund (Norway)

Introduction

Mental health problems in adolescence may continue into adulthood and have enduring consequences [1-3]. The Youth and Mental Health Study (YAMHS), a Norwegian representative prospective cohort study, was designed over 20 years ago to study risk and resilience factors for the development of depressive symptoms and disorders in adolescence. Before the YAMHS, there had been no community based Norwegian longitudinal studies of adolescents' mental health in both a population-based cohort and a clinical subgroup combined. However, there are some longitudinal community-based cohort studies that substantially increased the knowledge of the longitudinal trajectories of adolescent mental health or, more specifically, depressive symptoms and disorders [4-8]. In recent decades, a range of longitudinal cohort studies on the transition into adulthood were conducted [9-15]. Longitudinal cohort studies may provide useful insight for recognizing depression as well as testing and improving preventive measures at the community level. The aim of the current short report is to provide a description of the Youth and Mental Health Study (YAMHS), including presentation of the main findings and future perspectives.

Methods

In two counties (Sør- and Nord-Trøndelag) in central Norway, 9292 adolescents attended 8th and 9th grades in 1998. The majority (98.5%) of the adolescents attended a public school. A representative sample of this population (2813 students, from 22 schools) was selected with a probability according to the school size (proportional allocation). The exclusion criteria for the schools were: small schools ($n = 534$), i.e., those without at least one class for each grade level. Twenty-one pupils (0.7%) were not eligible for the following reasons: having been absent from school on the day of the assessment (i.e., were admitted to a hospital or were temporarily located abroad), having been in an institution, having not been proficient in Norwegian, or having recently arrived in Norway. A total of 2792 adolescents were eligible for the study. Adolescents and their parents received an invitation letter to participate in the study; 88.3% of the adolescents consented. Hence, the baseline sample population consisted of 2464 adolescents attending the 8th and 9th grades in private and public schools in Central Norway during autumn 1998 (51% females).



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The mean age of the participants was 13.7 years (range 12.5-15.7, SD 0.6). Data were gathered through questionnaires completed during two school hours.

The first follow-up was conducted after one year, in 1999 (T2) (n = 2432, response rate of 87.1%, mean age 14.9 years). Additionally, a subgroup of participants was assessed at T2 (n = 345) with clinical interviews, and this subgroup was reassessed in 2005 (T3) (n = 265, 70.1%, 20 years). In 2012, the last follow-up (of participants assessed at T1 and T2) was conducted (T4) (n = 1266, 51.9%, 27.2 years) (Table 1). For further details see Kaasbøll et.al. [27].

At all four study waves, identical reliable and valid measures were used with supplementary questions related to life phase. Parental information was gathered at T2 from a subsample created at T2, ensuring inclusion of high scoring individuals on a depression rating scale. Information about mental and somatic health, in addition to life-style factors, suicidal ideation and attempts and resilience was collected. Factors in the immediate and more distant environment like chronic and acute life stress, including bullying, relationships to parents, partners and friends, parental health, school/job factors, SES, and ethnicity were also included. The main instruments in the study are:

- The Kiddie-SADS- PL interview (Schedule for affective disorders and schizophrenia for school aged children – present and life-time version) [16].
- The Mood and Feelings Questionnaire (MFQ) [17]: 34 items assessing depressive symptoms covering DSM-IV criteria of major depressive disorders.
- The ASEBA system [18]: CBCL (parents T2), YSR (Youth Self- report) and ASR (adult-self-report) covering anxiety, depressive symptoms and conduct problems.
- Somatic health: Medical illnesses, BMI, pain, use of medicine, substance use, use of health care services, sleep pattern, levels of physical activity.
- Vulnerability and Resilience factors: The Coping Inventory for Stressful Situations (CISS) [20], Self-Perception Scale for Adolescents [21], Metacognitive questionnaire MCQ-30 [22], DAS (dysfunctional Attitude Scale) [23], The Connor-Davidson Resilience Scale (CD-RISC) [24], McMaster Family Assessment Device [25], The Inventory of Parent and Peer Attachment (IPPA)[26]. In addition, The Coping with Depression Questionnaire and The Early Adolescent Stress Questionnaire (EASQ) [19] were made for the study, modified for life phase.



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Table 1. Sample sizes, year of the data collection, response rate, age and sex of the adolescents

Data waves	T1	T2	T2 subgroup	T3 (subgroup)	T4
Year	1998	1999	1999/2000	2005	2012
Mean age (years) ^a	13.7	14.9	15.0	20.0	27.2
Range, age (years)	12.5-15.7	13.7-17.0	13.7-17.0	18.9-21.4	26.0-28.2
N adolescents	2464	2432	345	265 ^d	1266
% adolescents	88.3% ^b	87.1% ^b	94.1% ^c	76.8%	51.9% ^e
% girls	50.8%	50.4%	72.5%	76.9%	56.7%

^a Standard deviation=0.6 for all waves. ^b Response rate % at T1 and T2 is calculated based on adolescents invited at T1 (n=2792 adolescents). ^c For the subsample (T2), the response rate is calculated based on a subset (n= 364) at T2 that was invited for a clinical interview using the Kiddie-SADS- PL based on scores on the Mood and Feelings Questionnaire. ^d Includes interviews and self-reports. ^e The response rates for adolescents (T4) are calculated based on adolescents participating at T1 and T2 (n=2532, of which 72 students consented at T2 who had not participated at T1). Note: T1 = Time 1, T2 = Time 2 etc.

Results

The main findings of YAMHS are:

- The prevalence of depressive disorders at age 15 years was 9 %, mostly minor disorders [28], with a more severe course for girls from early to late adolescence [29].
- Comorbidity with any other disorders at the age of 15 years was 60 % (unpublished data)
- Use of mental health services was low among depressed adolescents [28].
- Gender, ethnicity, attachment to parents, stressful events and school stress [30] were associated with [19] and preceded depressive symptoms early in adolescence [31].
- Both being bullied and being aggressive towards others were linked with depressive symptom levels [32], both short-term and long-term [33].



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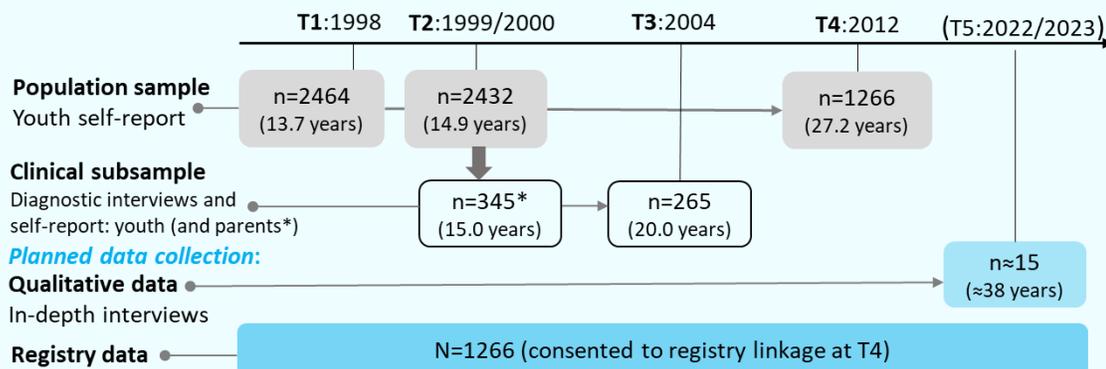
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- Parental divorce, own alcohol and substance use, specific depressive symptoms and violent life events predicted suicide attempts in late adolescence [34].
- Physical activity and teacher support protected against stressful events in the development of depressive symptoms [35].
- Gender differences were found regarding prevalence of symptoms and disorders, but seldom related to risk factors [28].
- Among the individuals who were clinically depressed at 15 years of age, 50% had received mental health care in their life-time, but rarely from the specialised services and the affective symptoms were seldom reason for contact [28].

To date, 30 peer-reviewed papers, five doctoral theses [36-40] and numerous masters' theses that include the YAMHS data have been completed. In addition, one doctoral thesis compared the population YAMHS data with data from a clinical study population [41].

Discussion

The strengths of the YAMHS includes the relatively large school-based representative study population with a high response rate and the long follow-up period of 12 years from early adolescence to adulthood. Another strength applies to the subgroup study, with the oversampling of adolescents who reported high levels of depressive symptoms and were assessed for depressive disorders. A weakness of the study is the relatively large time intervals between assessment points after early adolescence. Intervening factors could have changed trajectories and affected individuals' mental health in unexpected ways that were not accounted for in this study. Moreover, all results in the study were determined based on adolescent and young adult self-reports, except for the interview data from the subgroup including parents at T2. Thus, a multi-informant perspective and more objective data would have strengthened the validity of the findings. Nevertheless, with the subgroups including adolescents with a depressive disorder and controls followed from adolescence, the YAMHS are in a unique position to study the trajectories of depressive disorders in young people, which are not always detected by health services.





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Figure 1. Research procedure/samples and planned data collection.

Future perspectives of the YAMHS involve further analysis of existing data as well as conducting a qualitative follow-up study of a subgroup of participants. In addition, a linkage of the existing data to different national registers that are of high quality (e.g., the Norwegian Patient Register) is planned (figure 1). Linkage to national registers makes it possible to perform generational studies with a large number of participants. Researchers who are interested in forthcoming collaborations using the YAMHS database should contact the research group at jannike.kaasboll@ntnu.no. Rather than an open access resource, the study is designed to be a limited access resource in which external researchers affiliated with a qualified research institution can access the data given having available resources to facilitate and administer collaboration.

References available on request



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Migration and suicide risk: what can we learn from risk patterns in Guyana?



Dr. Ellen-ge Denton (USA),

Dr. Ana Ortin-Peralta (USA)

Background: Suicidal behavior among youth born and living in Guyana

According to the World Health Organization (WHO) suicide is the second leading cause of death among adolescents and young adults. Seventy-seven (77%) of global suicides occurred in low- and middle-income countries (LMIC) in 2019 (WHO, 2021). Guyana, a LMIC in South America with less than a million inhabitants, has one of the highest rates of suicide worldwide, at 44.2/100,000 deaths in 2014 (WHO, 2014). Guyanese ancestry is comprised of a population with very diverse ethnic identities (e.g. East Indian, Chinese, Amerindian, Black, etc.), and English as the national language.

In Guyana, an average of 200 deaths by suicide were recorded each year between 2010 and 2013 (Ministry of Public Health-MoPH, 2015). More than 50% of reported suicide attempts (SAs) were among youth and adults who identify as East Indian, followed by those self-identified as Black, who accounted for 25.9% of the SAs (MoPH, 2015). Between 2014 and 2017, Dr. Denton collected descriptive data from 77 youths (ages 6-21) enrolled in the Guyanese Child Welfare Program (Denton et al., 2017; Denton, 2021). In this sample, 39% (N = 30) of the youths reported a previous SA, of which 9.1% (N = 7) self-identified as East Indian and 18.2% (N = 14) as Black. Twenty-six percent (N = 20) of the total sample endorsed recent suicide ideation (SI). These data contribute to the scarce published figures on suicidal behavior in Guyana. Given the observed high suicide risk and breadth of demographic characteristics in Guyana, an exploration of how suicide risk varies within Guyanese individuals and their immigration status can provide valuable information on the sociocultural and environmental protections against suicide risk.

Methodology and Results: Suicidal behavior among Guyanese individuals who migrated to the US

According to the World Bank, 2.1% of the total Guyanese population immigrated to the United States (US) in 2015; a 17.2% increase from 2010 (World Bank, 2021). A large body of literature indicates that individuals born in the US are more likely to report a higher prevalence of SI or SAs than US immigrants from the same racial/ethnic group (Duldulao et al., 2009; Peña et al., 2008). Evidence also indicates that the longer immigrants resided in the US, the higher the risk for suicidal behavior (Duldulao et al., 2009; Breslau et al., 2009). For example, Williams and colleagues (2007) found that third-generation Caribbean Blacks had worse mental health outcomes than first-generation Caribbean Blacks (Williams et al., 2007). These findings support the healthy migrant hypothesis, which posits that individuals who are inclined to migrate may be part of a healthier and more psychologically hardy subset



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that protects them from developing health problems (Salas-Wright, 2018; Rubalcava et al., 2008). Furthermore, other studies suggest that the age of immigration matters. Individuals who immigrate to the US as children develop worse outcomes over time than those who immigrate as adolescents or adults (Barr, 2016).

We used de-identified data from the National Survey of American Life (NSAL)-Caribbean Supplement to explore if these hypotheses applied to Guyanese migrant and non-migrant populations. For this supplemental sample, 1,623 Black individuals with Caribbean origin, including Guyana, were recruited from US geographic areas with relatively high density of Caribbean descents (> 10% of the population) (Jackson et al., 2004; Jackson et al., 2021). The Guyanese NSAL subsample was comprised of 94 Black adults (66% female, age range 18-82 years old, mean = 39.95; SD = 17.82), who indicated that they or at least one of their parents or grandparents were from Guyana (details of study design in Joe et al., 2006). For the present report, this sample was divided in two groups. The Guyanese heritage group (N = 16) included individuals born in the US who had either a parent or grandparent from Guyana. The Guyanese immigrants group (N = 78) included individuals born in Guyana and living in the US at the time of the assessment (N = 68) and individuals of Guyanese descent who were born elsewhere and immigrated to the US (N = 10). Immigrant status was dichotomized based on when they arrived in the US: in childhood (12 years old or younger) or in adolescence/adulthood (13 years old or older) (Breslau et al., 2009).

In this sample, 8.5% of the individuals (N = 8) reported lifetime SI and 3.2% (N = 3) reported a lifetime SA. Pairwise comparisons show that Guyanese immigrants and heritage individuals reported similar percentages of SI (9% vs. 6.3%; $X^2 = 0.13$; Fishers exact p-value = 1.0) and SA (2.6% vs. 6.3%; $X^2 = 0.58$; Fishers exact p-value = .43). Among the Guyanese immigrants born in Guyana (N = 68), only those who arrived in the US as children endorsed lifetime SI (N = 5, 7.3%) or a lifetime SA (N = 2, 2.9%). Those who arrived in the US at the age of 13 or older did not report any SI or SA.

Discussion and Conclusions

There is little information about the prevalence of SI and SAs, the strongest predictors of suicide death, in the Guyanese population. Our descriptive data on the prevalence of suicidal behavior among child welfare youth contribute to addressing this problem. Also, these data contextualize suicide risk exposures across the lifespan. In this sample, a different race/ethnic profile from the Ministry of Public Health report emerges among the suicide attempters, with Black youth reporting more SAs than East Indian youth. Given that suicide risk factors vary across settings, we examined suicide risk between migrant and non-migrant Guyanese individuals as another layer to environmental influence on suicide risk.

Our preliminary findings partially support the healthy migrant hypothesis (Salas-Wright, 2018). We did not find statistically significant differences in SI and SAs between the heritage and the immigrant groups. However, Guyanese-born individuals who immigrated to the US as children, and presumably have been in the US longer at the time of the assessment, reported lifetime SI and SA. Yet, this was not the case for Guyanese individuals who migrated at the age of 13 or older. In a similar vein, Williams and colleagues (2007) found that Black-Caribbean immigrants who arrived in the US at the age of 18 or older had less risk of developing psychiatric disorders (including mood, anxiety, and substance use) than US-born Caribbean individuals. This protection was not observed among those individuals who migrated as children or adolescents (Williams et al., 2007). In contrast, Lacey and colleagues (2019)



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found that first-generation Guyanese immigrants who resided in Canada for longer had several less health conditions than those who resided in Canada for less than 10 years (Lacey et al., 2019). Lacey's and our findings highlight the importance of considering the interplay between the age of arrival and the countries of origin reception when examining the environmental influences on suicide risk. Different factors that may be driving this variation in suicide risk include individual-level experiences, such as acculturation level, reason for migration, legal status, ethnic identity and lifestyle, discrimination experiences, and difficulties establishing a supportive network. Country-level factors to consider include access to care and public health policies, collective efficacy, and neighborhood resource availability. When possible, these factors should be examined within racial/ethnic categories. For instance, differences in access to quality care between individuals who migrate to Canada or the US may explain the diverting trajectories in health among Guyanese immigrants.

The examination of environmental experiences on suicide risk among Guyanese individuals adds to a growing body of literature that considers distinct community perspectives. Suicide studies that capture contextual and influential factors of lifetime suicide risk can contribute to the design of comprehensive and culturally sensitive approaches for prevention and intervention.



References available on the request



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The Zagreb Child and Youth Protection Center: A multidisciplinary approach to traumatized children



Professor Gordana Buljan Flander,

Ana Marija Španić and Ella Selak Bagarić (Croatia)

In Croatia, for the past 30 years, non-governmental organizations (NGO) as well as the media and local governmental agencies have had concerns that there are gaps in the system to address child abuse. When cases were disclosed, areas identified as needed improvement included an insufficient number of professionals trained in working with abused children, inefficient interagency collaboration and a lack of understanding of the role of professionals involved in the process.

An NGO, the Zagreb Child and Youth Protection Center (the Zagreb Center) was founded in 2002. Professor Gordana Buljan Flander, the Center's Director, was among the first professionals in Croatia who recognized the importance of the issue of child abuse and neglect. In 1997, Professor Flander founded the Brave Phone, an NGO helpline for abused and neglected children. In 2002, Professor Flander also initiated the foundation of the Zagreb Child Protection Center. Professor Flander's work is widely recognized in Croatia and worldwide including being awarded the Life Achievement Award for promoting children's rights.

The Zagreb Center provides assessment and treatment for abused and neglected children, sexually abused children from all parts of Croatia, as well as neighboring countries, with 1200 to 1600 new patients per year and about 800 patients in continued treatment. The Zagreb Center remains the only institution of its kind in this area to provide five diverse but interconnected activities: 1) assessment and treatment; 2) research and scientific work; 3) education of students, staff and other professionals; 4) publishing and 5) forensic activities. Additionally, the Zagreb Center has expanded to provide services to children and adolescents with other mental health conditions and has pivoted to its current role as a permanent part of the health care sector to avoid a loss of sustainability and accessibility and ensure access to treatment.

The Zagreb Center includes three basic principles: a multidisciplinary approach, interagency collaboration and a child-friendly environment to ensure the best interest of the traumatized child.



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The multidisciplinary team consists of psychiatrists, clinical psychologists, social workers, social pedagogues, a neuro paediatrician, a speech therapist and a jurist, supported by nurses, is tailored according to the individual needs of each child. After conducting a multidisciplinary assessment of the child, which may include gathering data about the suspected abuse and/or neglect in a forensic interview, a multidisciplinary report is made. The multidisciplinary team exchanges the gathered information and cooperates in developing an assessment and a treatment plan according to the individual needs of the child.

The Zagreb Center strives for best practices in the approach to forensic interviewing of children. All professionals at the Zagreb Center receive continuous training in forensic interviewing skills; forensic interviewing is done by a court order in the assessment phase of the case; professionals appear before the court during the proceedings as expert witnesses. In addition, judges are encouraged to interview children on the Center's premises, with the Center's interviewer and the child in one room, while the judge and other involved parties are connected through a video link in another room and can pose questions with the help of the mental health expert interviewing the child. In that way the recording of the interview can be used as evidence in a court procedure, avoiding multiple interviews and shortening the court process.

A child-friendly approach is achieved through the use of evidence-based protocols, creating a child-friendly setting, pre-interview planning and taking into consideration the child's age, developmental level and emotional state necessary for the differentiation of the child's developmental characteristics from the lack of credibility that can otherwise be inaccurately assumed to avoid re-victimization and re-traumatization due to repeated interviews with more than one interviewer at a different location.

The child and all non-abusive caretakers are provided short-term and long-term support at the Zagreb Center, which includes access to information, crisis support interventions and treatment, including diverse evidence-based and trauma-informed interventions. In order to avoid contamination of the child's testimony, psychotherapeutic support begins after the forensic interview, and is done in a forensically sensitive manner if the court process is prolonged. Individual treatment is provided by mental health experts trained in numerous psychotherapy approaches and intensive group treatment is available in the day hospital, led by a psychiatrist with the help of a clinical psychologist. After treatment has ended, children and their families may receive continuous follow-up. The team continuously cooperates and exchanges information with other relevant institutions within the child protection system, such as social welfare centers, the police, the judicial system, schools, kindergartens, children's residential care facilities, paediatricians/general physicians etc.

The funding sources for the operation of the Zagreb Center itself include the Croatian Health Insurance Fund (2/3 of the budget), the City of Zagreb (1/3 of the budget); and by obligatory health insurance that covers all children in Croatia to cover the cost of the child protection work done by Zagreb Center professionals which includes education and training of professionals within the Center as well as within the child protection system, and for research and scientific work that the Center is conducting.



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Another important aspect of the support provided by the local government, the City of Zagreb, includes providing free of charge financing for activities such as raising public awareness through publishing brochures and leaflets for parents, children and professionals working with children; the distribution of 17 publications in 500 000 copies free of charge, as well as online (<https://www.poliklinika-djeca.hr/category/english/publications/>) through brochures, leaflets, guidelines and other printed material, with the aim of preventing abusive/neglectful behaviors and inappropriate reactions to the disclosure of abuse, and supporting the course of the treatment as a method of psychoeducation.

The Zagreb Center includes an emphasis on scientific research-based findings to provide a starting point for the development of prevention and intervention programs for children and their families, as well as public campaigns and collaboration with the media and stakeholders to raise awareness. In addition, the Zagreb Center engages in collaboration with governmental and non-governmental organizations in creating research-based prevention, intervention programs, and the education of the staff in line with the current needs of the victims and witnesses of violence (more information on <https://www.poliklinika-djeca.hr/category/english/research/>, “Behind this door lives Mia”, and how to stay active in supporting professionals and public despite the limitations of the COVID-19 pandemic.

The Zagreb Center includes continuous education for staff, trainings for partner professionals in the child protection system, and for trainees.

The Zagreb Center also emphasizes the need to provide supervisory support to all staff members involved in direct work with children due to the high risk of vicarious traumatization and burnout inherent in this type of work.

In line with the UN Convention on the Rights of the Child, the Zagreb Center includes three active boards respecting the right of the child to be heard: the Children Board (children aged 7-11 years), the Youth Board (12-18 years) and the Parent Board, all formed in 2017 as advisory boards aimed to give valuable insight and improve the work of the Center to advocate for the mental health needs of children and youth.

In summary, the Zagreb Center continues to do this important work to provide the critical expertise. The Zagreb Center has been recognized as an example of exemplary practice in Europe and worldwide and has received the Multidisciplinary Team Award 2008 –from the International Society for the Prevention of Child Abuse and Neglect (ISPCAN), an award reserved for multidisciplinary teams that make a significant difference in the treatment and prevention of abuse and neglect of children in their community.



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Zagreb Center professionals continue to provide expert leadership to many relevant EU projects, such as PROMISE project and as a part of the PROMISE Barnahus Network (more information on <https://www.barnahus.eu/en/about-us/>) to support the recovery of traumatized children.



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The 5th Research and Leadership Skills Course for Early Career Mental Health Specialists and Students



Prof. Irina Pinchuk (Ukraine)

For the first time in the history of Ukrainian psychiatry, the WPA 2021 Regional Congress “PSYCHOPATHOLOGY IN PERIODS OF TRANSITIONS” was held on July 7-9, 2021 in Kyiv, Ukraine, in hybrid format (with both virtual and face to face access). The WPA 2021 Regional Congress served the educational mission of by providing high-quality training courses, covering all aspects of psychiatry. Within the framework of the Congress program, a pre-congress workshop “The 5th Research and Leadership Skills Course for Early Career Mental Health Specialists and Students” was held.

Thanks to the UNA Partnership these courses have been held in Ukraine for past 5 years consecutively. The first one of these courses was organized in December, 2017, in Kiev, Ukraine. The second course was held in September, 2018, to be followed by the third in April, 2019 and the fourth in November, 2020. In 2021, we ran our fifth Research and Leadership Skills Course for Early Career Mental Health Specialists and Students and we are pleased that Research and Leadership Skills Courses for Early Career Mental Health Specialists and Students have now become a tradition in Ukraine. While selecting participants for these Courses, priority has been given to young psychiatrists, psychologists and other mental health professionals who were planning a PhD in the future. In total, ninety-five participants from Ukraine, Georgia, Armenia, Sweden, Norway, Japan, Kazakhstan and Kyrgyzstan have attended the courses so far. These courses aim to provide high-quality intensive training in the relevant research elements such as developing a research project, launching a research project in a clinical environment and research methods, including the key principles of statistics, writing scientific papers and presenting research findings.

The 5th Research and Leadership Skills Course for Early Career Mental Health Specialists and Students started with the opening remarks from Professor Norbert Skokauskas (WPA, Child and Adolescent Psychiatry Section Chair), the greetings of Professor Irina Pinchuk (Director, The Institute of Psychiatry of the Taras Shevchenko National University of Kiev) and Dr. Semyon Gluzman (President, Ukrainian Psychiatric Association). which was followed by Professor Bennett Leventhal (USA). Young professionals from seven countries benefited from the course in 2021.



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ESCAP/UEMS-CAP/EFPT Training Day: An Unprecedented Initiative for European CAP Trainees



Dr Asilay Seker (UK), President, European Federation of Psychiatric Trainees

Background

Europe has been one of the most severely impacted continents by the Covid-19 pandemic. Hygiene measures and travel restrictions limited even the most locally organized training activities for almost every medical specialty, including child and adolescent psychiatry (CAP). This was a drawback in many ways, however, it pushed trainers and trainees to move teachings online, which resulted in increased accessibility for many. Digitalizing such activities also enabled them to somewhat global participation – ‘anyone with the link can join’. The content of any training event naturally limited its audience, however, remote access was a clear advantage. Online platforms also allowed trainers in distant places to come together to share their knowledge and experience.

With the above points in mind, three prominent psychiatric associations of Europe, ESCAP, UEMS-CAP, and the EFPT, decided to collaboratively prepare an unprecedented online programme of training for CAP trainees.

The aims were to

- Bring the diverse and complementary visions of the 3 organizations; ESCAP with its strong roots in research, UEMS-CAP for its regulatory function in training, and the EFPT to include the perspective of trainees who were the target audience,
- Offer CAP trainees valid and substantial training from renowned experts,
- Increase the visibility of these 3 organizations to have more trainee engagement.

Preparations and Training Day:

Three organizations decided to offer a 1-day online training content for CAP trainees, named ‘ESCAP/UEMS-CAP/EFPT Training Day’, immediately prior to the 1st ESCAP Expert Day. ESCAP provided the online platform and technical support for this event. After reasonable discussion, it was agreed that the Training Day should be exclusive and free of charge for CAP trainees.

The event was prepared between October 2020 – June 2021 through regular meetings with representatives from the 3 organizations. There were 3 parallel columns for each organization with 3 sessions each, and a final case discussion panel by all 3 organizations at the end. Sessions did not have one common theme; each session was aimed to have varied formats with different content from research to clinical, continuous learning to advocacy. Associations were



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responsible for organizing their respective columns of events, reflecting the diverse features of each organization. All the speakers accepted to hold the session without any financial incentives.

3 columns were as follows;

1) ESCAP

- Treatment of patients with Anorexia Nervosa by Johannes Hebebrand (workshop)
- Genetic testing in child and adolescent psychiatry by Franziska Degenhardt (workshop)
- Clinical high risk for psychosis model in children and adolescents by Marco Armando (clinical lecture)

2) UEMS-CAP

- How to join the political table for child mental health by Sue Bailey and Marc Hermans (workshop)
- Active lifelong learning in CAP by Thorsten Schumann, Marit Hafting, and Ioanna Giannopoulou (workshop)
- Administrative load – a millstone for CAP trainees? by Peter Deschamps and Gyri Hege Vorren (workshop)

3) EFPT

- Integrating research into clinical CAMHS training by Petrus De Vries and Eugene Davids (workshop)
- Medically unexplained symptoms in CAMHS by Elena Garralda (interactive webinar)
- Organizing digital consultations in CAMHS by Alka Ahuja (interactive webinar)

Trainees registered for the event through ESCAP's website and registrations were capped off at 200 as some of the sessions were designed for a limited number of participants to promote interactions among the participants. As the registrations were online, we received interest from overseas CAP trainees and accepted them to the event. Only the final plenary Case Discussion was open for every registrant to discuss a pre-submitted case by a participant with representatives from Europe- European Society for Child and Adolescent Psychiatry (ESCAP), European Union of Medical Specialists (UEMS)-CAP and the EFPT (European Federation of Psychiatric Trainees) . This case was pertaining to the challenges of the Covid-19 pandemic for trainees in their clinical case management.

Participants reached the individual sessions from a common platform. We didn't arrange a separate registration pathway for each session, but the limited-participation sessions were delivered on a first come first served basis to mimic the 'real life' congresses where one would look for another available session if one room was too full. Zoom was used for every session as its features such as polls or BreakOut rooms came in handy for enhanced interaction. During the final Case Discussion session, we used 2 cases from 2 CAP trainees from different countries. The first case was about an early onset psychosis and the other Anorexia Nervosa, two disorders which increased during the pandemic with the latter having a more dramatic rise. Cases were presented briefly, and discussion was started by the 3 representative discussants from the 3 organizers, to reflect different backgrounds of each association and offer different perspectives. Participating trainees also joined the discussions and asked questions.



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Feedback:

Two main feedback routes were organized for this event. First, is a more conventional questionnaire with both quantitative and qualitative questions. This was sent to all the participants to fill out after the Training Day. The second feedback method pursued is more novel with a focus group of participants involved in a series of qualitative feedback. Results from both routes are planned to be published to inspire and guide similar endeavours.

What's next?:

This Training Day was planned as a pilot project to explore the options to offer accessible yet substantial training content for CAP trainees during times of restrictions and how it can be done in collaboration with 3 pioneering CAP associations in Europe. As the event = served as the opportunity to understand what the trainees look for in online learning and how they use what they acquire through the online learning, the organizing associations will take these into account and plan for future events accordingly.



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IACAPAP 2022 World Congress in Dubai: Child and Adolescent Mental Health: Shaping the Future



Dr. Ammar Albanna, Congress Chair (UAE),

Dr. Hesham Hamoda, Chair of the Scientific Committee (USA)

The prevalence and burden of mental disorders is significant and increasing globally. The majority of adult mental disorders start before the age of 25, and a significant proportion start prior to the age of 18. We are living through difficult and unpredictable times, as the COVID-19 pandemic continues to impact the world. Vulnerable populations, including children, are specifically impacted by the stressors related to the current pandemic, including but not limited to interrupted education, adjusting to online education, lockdowns, safety procedures, financial uncertainties and the illness and death of loved ones. We have learnt from recent epidemics that the mental health impact may continue to increase months, if not years, following the end of the acute infectious phase. Responding to the mental health needs, especially among children and youth, poses a significant challenge to health systems globally. Furthermore, COVID-19 is striking healthcare systems that are unequally setup, from well-developed systems to countries with very few mental health professionals. This may very well impact the responsiveness of the healthcare system. There is a desperate need for a revolution in child mental health services, in order to address the gap.

The recent years have witnessed significant technological and social innovations that have positively impacted different medical sectors, including mental health. Advancements have been emerging in different mental health areas include uncovering neurobiological underpinnings of childhood mental disorders through cutting edge technology and incorporating artificial intelligence, to the development of innovative treatments of childhood mental health conditions. Digital innovations have been increasingly used as a tool from the early detection of mental disorders to addressing the gap in mental health services. This was particularly evident during the present pandemic, as tele-mental health services have been adopted in response to the lockdowns, and many people were able to receive mental health services. The International Association for Child and Adolescent Psychiatrists and Allied Professions (IACAPAP) is an umbrella organization of child mental health associations and professionals from across the world, aiming to improve child mental health through policy, practice, and research. IACAPAP has been running successful world congresses since 1937, to bring the attention to important child and adolescent mental health topics, and interest



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to specific geographic areas. The 25th World Congress of IACAPAP will take place in Dubai (December 5-9, 2022), for the first time ever to be held in the region.

Under the theme of “Child and Adolescent Mental Health: Shaping the Future”, the congress will examine the role of emerging technologies on revolutionizing child mental health. Harnessing modern technology will indeed change every aspect of mental health practice and offer exceptional opportunities for patients, families, and the community at large. Psychiatric diagnosis will become more specific and more personalized with advancements in brain imaging, genomics, and personalized medicine, Tele-psychiatry will expand access to mental health services in ways we have not witnessed before. Mobile technologies will provide opportunities for psychotherapeutic interventions and for monitoring symptoms and outcomes in real time. Big data will enable us to pool resources and examine research questions in ways that were never available before. The opportunities seem boundless! The conference will also discuss regionally relevant topics like refugee health and the role culture plays in mental health.

Dubai is a vibrant and futuristic city, and world hub, that demonstrated consorted cross sectorial efforts to combat COVID19, while balancing its economy. Furthermore, Dubai is ready and excited to host the world Expo, under the theme of “connecting minds and creating the future”. This world event connects very well with the Dubai IACAPAP 2022 theme of “Child and Adolescent Mental Health: Shaping the Future”. The conference will take place during the Dubai Expo Event and will bring in exceptional world experts and keynote speakers and serve as a global hub for researchers, clinicians, and child mental health professionals to engage in learning, and networking in order to create a better future. Dubai is the perfect city to host IACAPAP congress during these circumstances and to discuss these themes. There is no better place. There is no better time. The IACAPAP 2022 congress will be hosted by Al Jalila Children's Specialty Hospital, the UAE's only children specialty hospital, and the Emirates Society for Child and Adolescent Mental Health. Join us in this exceptional event, during these exceptional times. Join us to collaboratively shaping the mental health future for our children. Be part of this event and join us, in-person, in Dubai! For more information and to register your interest visit: www.iacapap2022.com



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IACAM (Indian Association for Child and Adolescent Mental Health) Academy



Prof. Savita Malhotra, Dr. Nitin Gupta, Prof. Henal Shah (India)

The Indian Association for Child and Adolescent Mental Health (IACAM) celebrated the establishment of its new initiative, IACAM Academy, as well as the commencement of its first course in CAP for general psychiatrists in India on 7th August 2021. Professor Daniel Fung, President of IACAPAP was the Chief Guest; Professor Norbert Skokauskas, Chair WPA CAP Section and Dr Gautam Saha, President of the Indian Psychiatric Society were the honored Guests. August 7, 2021, is a key milestone in the history of development of CAP in India. IACAM (Indian Association for Child and Adolescent Mental Health) has been in existence since 1990, and during the last 3 decades has now over 700 active members, conducts its national conferences every two years and national mid-term CME in alternate years, and has its own journal (J-IACAM). IACAM is an active member society of the IACAPAP since 1992 and has been host to two international congresses- the 15th IACAPAP Congress in 2002 (which was cancelled at the last minute due to the prevailing unstable political situation in the region, though the Congress went ahead nevertheless as a non IACAPAP event), and the 7th ASCAPAP Congress in 2013. Currently IACAM is led by Dr Kishore Wishwanath Gujar (President), Dr Devashish Konar (Vice President cum President Elect), Dr Chhitij Shrivastava (Secretary-General), Dr Savita Malhotra (Life President) amongst others.

IACAM Academy

IACAM Academy, a brainchild of the Life-President, Savita Malhotra, is the new initiative undertaken by IACAM with the purpose of increasing the manpower resource and bolstering the mental health services and care of children in the country. India has 574 million population below 18 years of age, and trained child psychiatrists are about 1 per 5 million. There are nearly 250 colleges offering a postgraduate degree, MD Psychiatry, to approximately 1000 students, but not all centres have the capacity to provide dedicated training in child and adolescent psychiatry (CAP). Specialization in CAP is in its nascent stage with very few centres offering a DM (super specialization) and a post doc fellowship. Currently most CAP cases come to general psychiatrists who must do the needful. Therefore, it was thought essential to train and empower general psychiatrists in basic clinical care of child cases that reach their doorstep. Widespread acceptance and expansion of digital technology in education and healthcare during the ongoing Covid-19 pandemic opened the opportunity for this initiative. It is in this context that six months ago, IACAM approved the idea of establishing IACAM Academy to undertake the task of running courses in CAP for various professional groups.



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The IACAM Academy Core Committee members comprising of 10 members worked tirelessly to lay the groundwork and develop the needed infra structure in a short span of 3 months. They comprised of: Dr Savita Malhotra (Academy Director); Drs Kishor Gujar, Devashish Konar, Chhitij Shrivastava, Shekhar Seshadri, Henal Shah, Pratap Sharan (Academy Consultants); Nitin Gupta (Academy Coordinator); and Drs Darpan Kaur and Nidhi Chauhan (Academy Assistant Coordinators). A one-year certificate course to be conducted online involving multiple formats of teaching and evaluation was initiated. Senior, experienced academicians have been roped in as the teaching faculty as we are committed to providing quality education. Quality Assurance parameters have been identified and a program evaluation is planned to help in improvement and maintenance of quality of the course. The course curriculum has been designed in a way to cover primarily clinical aspects of Child and Adolescent Psychiatry and minimum basic essential theory to help conceptualize and formulate management plans. There will be four modules, one basic and essential, and three others covering groups of related conditions. The entire course will be completed in 25 teaching sessions, of two hours each, on biweekly basis, over a period of one year. For delivering this course curriculum, the faculty will use a variety of formats including didactic teaching, seminars, case presentations, case vignettes, videos, case-based discussions etc. The entire course will be online.

Participants will be assessed using written assignments at regular intervals during the course. The assignments will assess application of skills which are learnt during the synchronous classes as well as interactive participation. There will be ongoing assessment at the completion of each module. To earn an e- certificate, it would be mandatory to have an attendance above 80%, complete e-Assignments as well as pass all tests. At the end of the course each participant will be provided with a "Certificate of Course Completion".

The Future

We hope we can make a difference to the lives of children in need of mental health care and propagate principles and skills related to CAP amongst all those who feel responsible and concerned about Child Mental Health. We see it as start of a journey aiming to expand its scope in the future to include mental health professionals other than psychiatrists, and also include participants from neighboring SAARC and other countries where training facilities in CAP are negligible/absent.





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The Hague International Model United Nations (THIMUN) Mental Health Festival: A collaboration of THIMUN and the Division of Child and Adolescent Psychiatry, Sidra Medicine, Doha, Qatar

Dr. Muhammad Ather, Dr. Ahsan Nazeer, Dr. Finza Latif, Dr. Fatima Al Mehdi (Qatar)

The Hague International Model United Nations (THIMUN) Qatar is a student leadership organization established in 2011. THIMUN regularly organizes conferences, seminars, and workshops to develop student leadership through Model United Nations. Because of the COVID-19 pandemic, THIMUN and the Child and Adolescent Psychiatry Division of Sidra Medicine worked together in developing preventative strategies to protect young people from the mental health adversities of the pandemic. As a result, THIMUN Qatar's 2021 student executive team, in collaboration with Child and Adolescent Mental Health Services (CAMHS), Sidra Medicine, created the first-ever Mental Health Festival to provide comprehensive psychoeducation of the youth of Qatar, covering the most prevalent mental health issues. At the festival, three lectures on different topics were delivered by the CAMHS faculty of Sidra Medicine. THIMUN Qatar's 2021 student executive team selected these topics following a need assessment survey. Dr. Ahsan Nazeer talked about symptoms, assessment, and management of depression and stressed the importance of accessing mental health services early. He also clarified the common misconceptions associated with depression. Dr. Muhammed Ather talked about substance misuse in young people highlighting its prevalence, the risk factors, associated comorbidities, and available services in Qatar. He also spoke about the stigma, legal framework, confidentiality and encouraged young people to seek help when needed. Dr. Finza Latif delivered a comprehensive talk on anxiety disorder, its types, symptoms, and treatments. She stressed that anxiety is not a weakness, and psychological therapies that are effective and readily available should be accessed. She reiterated the importance of early diagnosis and treatment to prevent impairment. Youth leader Jumana Al Anizi also gave an insightful talk on her own journey through mental health challenges. Finally, all the students demonstrated their interest in learning about mental health, and many of them had the opportunity to ask questions in the Q&A session. After the Q&A session, all the students joined their preassigned, student-led groups to discuss the presentations and ways to get more resources for mental health support in Qatar.



From L to R: Dr. Muhammad Ather, Dr. Finza Latif, Dr. Ahsan Nazeer, Prof. Muhammad Waqar Azeem

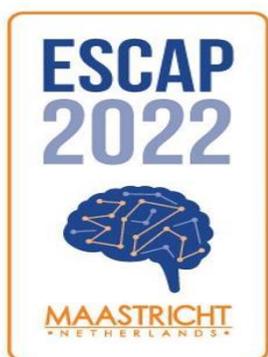


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Future meetings

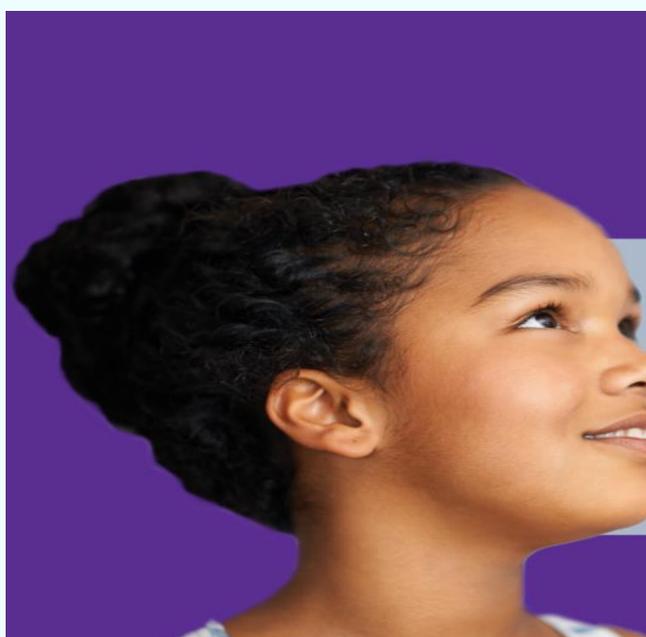


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