



World Child & Adolescent **Psychiatry**

ISSUE 18, September 2020

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

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



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Chair's Column:

Dear Colleagues,

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

Coronavirus disease 2019 (COVID-19), a disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), has impacted many areas of our lives. In this issue, we have very interesting insights on this topic from leading child and adolescent psychiatrists: WPA CAP Immediate Past Chair Prof. Bennett Leventhal (USA) and International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP) Immediate Past President and WPA CAP Co-Chair Prof. Bruno Falissard (France).

In this issue, we also have an overview of the international child and adolescent psychiatry movement, by Prof. Helmut E. Remschmidt (Germany), who has been both a WPA CAP Chair and also IACAPAP President. As we plan our journal very carefully and well in advance, it is important to state that Prof Helmut E. Remschmidt's article was prepared before the COVID-19 pandemic crisis. This article helps us to remind ourselves that many positive things in our clinical and academic lives happened before the pandemic, and we need to have a broad vision for our field for the future to come.

As always, our contributors are not only well known and leading child and adolescent psychiatrists. In this issue, I am pleased to introduce a new member of our section: early career child and adolescent psychiatrist Dr. Camille Noël. She, together with Professor V. Delvenne, writes about child and adolescent psychiatry in her native Belgium.

And last, but not least, we are delighted to publish WPA President-Elect Dr. Afzal Javed's vision for his triennium (WORLD PSYCHIATRIC ASSOCIATION 2020-23 ACTION PLAN), which clearly states that Child, Adolescent & Youth Mental Health is A Priority Area. It is very important that Dr. Afzal Javed follows a good tradition of his predecessors by recognizing the importance of child and adolescent mental health and putting it on the official WPA agenda.

And finally, as WPA has moved to a new website, 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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COVID TIME

Professor Bennett Leventhal (USA)



"So all a man could win in the conflict between plague and life was knowledge and memories."

Albert Camus, *La Peste* (*The Plague*), 1947

In the time of COVID, we have seen incredible, unimagined events and conflicts that have damaged children, taxed their parents and killed their grandparents. It has been a time of fear and confusion for all. And, as Camus suggests, it has surely left us with *new knowledge* and *remarkable memories* of "COVID Time."

What is "COVID Time?" Actually, it represents two, very distinct concepts of "time." The first refers to the period, or epoch, during which the COVID-19 pandemic ravaged the world. It is the time when modern healthcare systems were challenged to their breaking points, all over the world. This has led to pain, suffering, disability and death for hundreds of thousands, perhaps millions, with the attendant disruption and closure of businesses and schools. COVID Time is a period of both political triumph and abysmal failure. COVID Time has seen faith in the scientific method and evidence-based medical practice attacked and falter. If this is not sad enough, COVID Time is an era in which the world is choosing to eschew globalism; in its own way, each country is protecting itself, with limited regard for its relationship to its inextricable links with neighbors and allies, both near and far. These neighbors often include LMIC (low-middle income countries) where victims include large numbers of the poor and people of color, once again indicating the persistence of systemic racism, inequality and lack of inclusion by citizens of the developed countries. In short, COVID Time is an era in which a tiny virus has intimidated vast populations and brought economic powerhouses and the nuclear powers to their knees. It is a time of fear and panic with an intense focus on the present with little perspective on the future and for the children who represent our future.

What about the other type of COVID Time? The other COVID Time is a new way of marking time. It is a bit like a time zone as well as another measure of the passage of time. It is like a time zone because we are all experiencing COVID but not in the same way or at exactly the same time. This version of Covid Time is measured by many different units: days sheltering in place, days in quarantine, time until a vaccine, days until businesses reopen, and days until schools re-open. Other metrics include benchmarks such as: when a certain number of dead are counted, when a specific number of individuals were infected, when hospitals were filled, when businesses closed, when "hot spots" or "surges" are identified and many more. Sometimes, COVID Time moves very quickly and, at other times, it is painfully slow. However, at no time is COVID Time a "good time."

For many children and adolescents, COVID Time will be the "memory" suggested by Camus promised. But, exactly what will be the metric of what they remember, and will they gain the knowledge that Camus? The good news is that, during COVID Time, our youth will expand their knowledge about biology, medicine and healthcare.



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They will learn about RNA, RNA viruses, immunology, herd immunity, vaccines and public health. They can also learn that social distancing can be good and safe and, for those in the developed countries, schools can “Zoom on,” even if the students cannot be in class with their friends and teachers. With good support from parents, communities, governments, and others, our youth will learn how to be strong, flexible and resilient in the face of an enormous, potentially lethal challenge.

Despite our best efforts, what children and adolescents learn in COVID Time may be less optimal. They will learn that COVID Time is an epoch of fear about a small piece of RNA that randomly attacks vulnerable people and makes them very ill or dead. This fear will be amplified by the new knowledge that many political, business, community, and other leaders have acted irresponsibly and/or out of their own self-interest. They have argued the science and ignored the basic principles of public health. This failure has taught children and adolescents to be cynical, at best, because those sworn to protect them can no longer be depended upon for protection. Indeed, in many cases they could not keep themselves safe. They ask their parents tough questions about their health and safety and parents do not know where to turn for answers.

Despite the overwhelming nature of COVID Time, we must take the offensive and seize the opportunity to change the seemingly inevitable course. In the face of his plague, Camus saw hope in the pursuit of knowledge and memory. We have the capacity to help change the focus of memories facing our youth by helping children, adolescents and their families recognize and talk about the many *superheroes* in this battle against COVID. These include first responders, healthcare workers, scientists, grocery store clerks and other essential workers who have stayed on the job in spite of the personal risk. Their teachers have adapted to continue to support learning in the best possible ways available. And, finally, parents and other family members have done all they can to keep their children and adolescents safe, while also providing food and shelter, often against heavy odds. For our youth to have memories of these heroes will give them a brighter sense of the future, as well. We must play our role in fostering this image of what happened in COVID Time.

And, as clinicians and scientists, we can surely rise to the challenge of creating knowledge out of this tragedy. There is much to learn in this awful natural experiment. We have a duty to learn about the nature of the virus and its direct impact on health and brain function. But, we can go well beyond that. There is a great opportunity to learn much more about risk and resilience. By methodologically sound study and observation, we can determine those factors that put children and families at greater, and lesser, risk to the direct and indirect consequences of COVID. Amongst these consequences is an appreciation of those who were truly resilient and able to weather the storm with little or no disruption in their development. If we understand risk and resilience, we can design preventive interventions and treatments for the impact of COVID on developing youth. This knowledge about risk and resilience, prevention and treatment will be enduring. If we carefully analyze and record it, we can use it to assist children, adolescents and their families as they face the next natural or man-made disaster which sadly but inevitably will come our way. Even more importantly, since COVID has affected all of us living on this planet, perhaps we can come to understand the universal elements of resilience and treatment so that the most discriminated and deprived amongst will share equally in what we have learned.



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There is no doubt that there are mighty challenges in COVID Time. We must be committed to do more than surviving the era but to mark the time as one in which we renewed our commitment to develop and use solid evidence to guide us as we stand alongside children and families fighting COVID and its consequences. Let's mark this time not with death and despair but a new hope for a better in the future understanding of risk and resilience in support of healthy child development even in the face of disaster.

By using the memories of our past along with present and future knowledge, we will prevail "win in the conflict between plague and life." It requires that we work together with persistence and determination. We are in this together. For those who completed studies in COVID Time, share your knowledge quickly. For those who have started the studies in COVID Time, let us know how we can all help. For those who are working to care for children and families, use the knowledge to provide the best prevention and treatment that Child and Adolescent Psychiatry has to offer.

In *La Peste*, Camus also opined, "What we learn in times of pestilence: that there are more things to admire in men than to despise." Let us commit ourselves be among the men and women to be admired for what we did, for what we do and for what we will do, as we prepare for the COVID Time known as "Post-COVID."



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Reflections on the Role of Child and Adolescent Psychiatry/ Child and Adolescent Mental Health

Prof. Helmut E. Remschmidt (Germany)



1. Historical remarks

Attitudes towards children underwent a significant change during the 18th century in the context of tremendous social and technical revolutions. But it was only in the 20th century when children were looked upon as independent beings with their own needs, rights, and also duties. There are several theoretical concepts with impact on the development of child and adolescent psychiatry. In the 20th century, developmental theory, psychoanalysis, learning theories, and neuropsychological approaches became dominant.

In the 20th and 21st centuries, child psychiatry in Europe and also in other parts of the world has evolved from four traditions: The neuropsychiatric tradition going back to its roots in 19th century neurology and psychiatry, from which child psychiatry has evolved in several places, the tradition of therapeutic education (remedial pedagogics), which developed mainly in pediatric settings in Austria, Germany, and Switzerland and can be considered as a precursor of the departments of psychosomatics in pediatric hospitals, the psychodynamic-psychoanalytic tradition, which goes back to the beginning of psychoanalysis, and (4) the empirical-epidemiological tradition. This approach was established in the 1960's and 1970's and influenced to a great extent by empirical researchers from the UK and the USA.

However, it has to be stated that all these influences did not lead to child psychiatry becoming a mixture of heterogeneous disciplines, but instead an independent specialty that integrates all these influences in order to give psychiatrically ill and disturbed children and their families the best possible support. The "cradle" of child psychiatry was in Europe, as E. Harms (1960) expressed in relation to the textbook Hermann Emminghaus entitled "Psychic disturbances in childhood" (Psychische Störungen des Kindesalters), which appeared in 1887, and as Leo Kanner (1963) repeated with reference to Moritz Tramer (1882-1963). In the same year, the first juvenile court was established in Chicago, and some historians therefore date this year as the beginning of child psychiatry in the United States (Schowalter, 2003).

Until 1971, the International Association for Child Psychiatry (IACP) was the only worldwide organization devoted to the diagnosis and treatment of children with psychopathological disorders. The history of this organization (now IACAPAP) was described in detail by Remschmidt, Belfer and Rydelius in the IACAPAP Bulletin No. 50 (2018). In the following years, several other organizations with similar goals have emerged:

- WPA Section of Child and Adolescent Psychiatry. The Section was established at the Maudsley Hospital in 1971 and initiated by Wilfried Warren, William Sergeant, and Dennis Leigh. It was the first Section of WPA, and a structure was established, which was subsequently used as a model for other Sections of the WPA. It was proposed that a key function of the Section would be: "Exchange of information, in all languages,



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concerning child and adolescent psychiatric conditions.” Serge Lebovici, who was, at that time, the president of IACAPAP, facilitated its establishment and the affiliation with IACAPAP. At its first meeting, Lukas Kamp (Netherlands) was elected chairman and Christopher Warren (UK), secretary. The Section was formally accepted by the General Assembly of the World Psychiatric Association at the 5th World Congress of Psychiatry in Mexico in 1971. The constitution defined the following main functions of the Section: (1) The collection and dissemination of information concerning activities of special interest to child and adolescent psychiatry, (2) establishment of working relationships with national and international organizations in the same field with a view to achieve greater coordination, organization of scientific meetings on an international scale, and (4) organization of symposia at world congresses of the World Psychiatric Association. The Section has had meetings and symposia at all psychiatric world congresses.

Lukas Kamp and Christopher Warren continued as chairman and secretary until their retirement in 1980 and 1975. John F. McDermott, Jr. (Hawai'i, USA) was the next chairman; after his retirement in 1989, Helmut Remschmidt (Germany) was elected chairman and held this position until 1999. At that time, the Section committee comprised 17 child psychiatrists from countries all over the world. John Corbett was elected secretary and was also the editor of a newsletter that came out twice or three times a year. Helmut Remschmidt, as chairman, was followed by Dimitris Anagnostopoulos, and, after him, by Bennett Leventhal. Currently, the chairman is Norbert Skokauskas (Trondheim, Norway), the two co-chairs are Bruno Falissard (past president of IACAPAP, Paris, France) and Anthony Guerrero (Honolulu, USA), and the Secretary is Vlatka Boričević Maršanić (Zagreb, Croatia). The Section publishes a journal entitled “World Child and Adolescent Psychiatry.”

- The International Society for Adolescent Psychiatry (ISAP) was founded in 1985 and renamed later as the International Society of Adolescent Psychiatry and Psychology (ISAPP). The aim of this organization is: “to improve knowledge and scientific research on adolescent psychiatry and psychology, create and develop links between psychiatrists, psychologists, and allied professions involved in the field of adolescent psychiatry and psychopathology” (ISAPP homepage). ISAPP has members in 20 countries and publishes an open yearbook regularly.
- The World Association for Infant Mental Health (WAIMH) was founded in 1992 as World Association for Infant Psychiatry and Allied Disciplines. The name was changed to the current one some years later.

2. Achievements and future perspectives

2.1 General achievements

The major achievements during the last decades in child and adolescent mental health can be summarized as follows:



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(1) The number of child and adolescent mental health workers is increasing all over the world, and the above-mentioned organizations played a facilitating role in this process;

(2) There is growing awareness with regard to child and adolescent mental health.

The contact between international and regional organizations, such as European Society for Child and Adolescent Psychiatry (ESCAP), the Asian Society for Child and Adolescent Psychiatry and Allied Professions, the Eastern Mediterranean Association for Child and Adolescent Psychiatry and Allied Professions, the Latin American Association for Child and Adolescent Psychiatry and Allied Professions, and the Australian Infant, Child, Adolescent and Family Mental Health Association has been important but can be improved;

(3) Special professional groups have been established, such as the South-East European Network, including Albania, Bosnia-Herzegovina, Bulgaria, Croatia, Kosovo, Macedonia, Montenegro, Slovenia, and Romania;

(4) An ADHD research network and an eating disorders network have been established, including IACAPAP members and members of other professional organizations;

(5) Advocating groups, like parents' associations, have been established, among them Autism Europe, Autism Network International, Families Empowered and Supporting Treatment;

(6) There are also new journals, such as the journal, World Child and Adolescent Psychiatry of the WPA – CAP section (since 2012), and it can also be looked upon as progress that the Journal of Child and Adolescent Mental Health (since 2003) has become an official organ of the IACAPAP;

(7) Several international educational activities have been established, including the training seminars of the WPA-CAP section. IACAPAP activities include study groups; fellowship programs such as the DJ Cohen Fellowship Program, the Helmut Remschmidt Research Seminars; special initiatives like the iCAMH, the MOOC, the eTextbook, the ATLAS Project and other World Health Organization (WHO) activities; the WPA Presidential Program on Child Mental Health in cooperation with IACAPAP and WHO; and the IACAPAP Declarations and Statements. The purpose of these declarations and statements is: to advocate for the promotion of the mental health and development of children and adolescents through policy, practice and research (IACAPAP webpage). One of the ways in which this mission is fulfilled is through the publication of declarations and statements. These are advocacy documents that are produced over time and that are widely disseminated to policymakers, child and adolescent mental health professionals, ministries of education, health and youth.

2.2 Two remarkable worldwide projects

(1) The Atlas project

In 1999, Benedetto Saraceno was Director of the Department of Mental Disorders and Substance Abuse at the WHO in Geneva. Ernesto Caffo, a prominent Italian child psychiatrist from the same region of Italy as Dr.



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Saraceno, proposed that a child psychiatrist be added to the staff to support the development of child mental health at WHO. Donald Cohen, the Director of the Yale Child Study Center and a friend and colleague of both Drs. Caffo and Myron Belfer suggested that Dr. Belfer might be seconded to WHO. A meeting was arranged, and an agreement was struck for a three-month secondment with financial support from Dr. Caffo. Dr. Belfer's Harvard Department Chair, Dr. Arthur Kleinman, agreed and was supportive. The three-month secondment evolved into a five-year secondment and the opportunity to build a child mental health/child psychiatry presence at WHO. Prior to this time there had been many prominent child psychiatrists and psychologists participating in WHO programs, but none had been seconded to the Department. John Orly had the child psychiatry portfolio, but, other than the "Life Skills Program" and some other initiatives, there was no formal program. The secondment led to participation in the 2001 World Mental Health Report and a global child mental health contest. The contest yielded numerous essays and pictures that led to the WHO publication of "Through Children's Eyes," which dealt with recognition of child mental disorders and stigma. A second product was "Caring for Children with Mental Disorders." This resulted from a conference convened with many IACAPAP country representatives, and it laid out the challenges to delivering child mental health services. WHO had been developing the ATLAS project, a series of studies of mental health resources in countries around the world. The ATLAS project (Atlas: Child and Adolescent mental health resources) resulted in data that showed the overall lack of data regarding child mental health resources and the significant barriers to accessing care. The document has been used for advocacy for many years. Interestingly, the products of the project have had an enduring impact. The support of WHO allowed Dr. Belfer to travel worldwide to talk about the importance of child and adolescent mental health and engage in program development.

(2) WPA Presidential Child Mental Health Program in cooperation with IACAPAP and WHO

In 2002, Ahmed Okasha, who was, at that time, president of WPA, initiated the Global Presidential Program on Child Mental Health. This was a joint venture of WPA, IACAPAP, and WHO. The program was supported by an unrestricted three-year grant from the Lilly Foundation. The aim of the program was, following the "study group model" of IACAPAP, to reach mainly low-income countries and to develop basic training materials that could be utilized to address mental health problems of children and adolescents. Myron Belfer reported on this program in the IACAPAP Bulletin (No. 16, fall 2005) and stated: "The program enabled the development of materials that will have a long-standing impact on child mental health". Several IACAPAP members served on the WPA steering committee, which was chaired by Ahmed Okasha and Norman Sartorius.

There were three task forces: (1) on awareness, chaired by Sam Tyano (Israel), (2) on prevention, chaired by Helmut Remschmidt (Germany), and (3) on treatment and services, chaired by Peter Jensen (USA). The task force on awareness prepared a manual that provides guidance on how organizations and countries can develop campaigns to heighten the awareness of the impact of child and adolescent mental health disorders. This task force also prepared other useful information, in several languages, for parents, children, adolescents, and other professionals. The task force on prevention developed several background papers and resource materials on the topic and carried out three field trials with the aim of reducing school drop-out in Alexandria (Egypt), Nishnij Novgorod (Russia), and Porto Alegre (Brazil). The field trials were completed in 2005 with the result that, in all three locations, school drop-out rates could be remarkably reduced. The task force on treatment and services



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developed CBT-based manuals for the treatment of internalizing and externalizing disorders that can be used for training worldwide. In addition, this task force supported the WHO effort to produce an atlas of country resources for child and adolescent mental health.

The results of the program were reported at the WHO World Congress of 2005 in Cairo and published in 2007 in the book, "The Mental Health of Children and Adolescents. An Area of Global Neglect," edited by Helmut Remschmidt, Barry Nurcombe, Myron L. Belfer, Norman Sartorius & Ahmed Okasha (Wiley & Sons, Chichester, West-Sussex).

2.3 Future perspectives

- (1) The training activities should be continued, intensified and made inclusive of mental health workers from developing countries.
- (2) Aside from the eTextbook, other publications could be prepared and distributed online. The current generation of trainees is very eager to learn, especially by using digital media. One of these publications could be a series of case studies.
- (3) A relatively new approach to diagnostics and therapy in child and adolescent mental health (CAMH) is telepsychiatry. This modern technology can be used to reach patients and families also in remote areas and it offers interactive interventions and is also an important training tool in psychotherapy (cf. Ramtekkar, 2019).
- (4) Child and adolescent psychiatrists need to expand further their role as advocates for children, adolescents, and families in relation to their mental health. This will, however, require an active policy that goes beyond preparing declarations.
- (5) Regional coordinators of CAMH organizations should try to find volunteers in their countries and form active working groups in collaboration with professional organizations.
- (6) A crucial issue is the development of a sustainable system for funding international research projects, training seminars, and study groups.

One prominent colleague out of a group of experienced child psychiatrists who were asked to tell their most remarkable personal experience during their affiliation with international child and adolescent psychiatry (CAP) organizations put it as follows: "To discover that children are the same all over the planet, facing the same problems in their life."



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3. Personal experiences and initiatives

After having finished my studies in medicine, psychology, and philosophy, I started my training as a child and adolescent psychiatrist at the Philipps University in Marburg in 1968. After my qualification as a CAP specialist and after having finished several research projects, I was offered to take over as chair of child psychiatry and neurology at the Freie Universität in Berlin. There, I was able to establish, in an old building, a modern clinical department, including a research unit and a special school for handicapped and psychiatrically disturbed children. The modern equipment of the research unit allowed us, as early as in 1978, to transmit biological data (e.g. heart frequency and EEG) by telemetry from the schoolyard opposite of the clinic to the research laboratory. This equipment was also helpful for therapeutic measures. At that time, this was a really futuristic perspective. Journalists from the newspapers, "Sunday Times," who had visited the department, entitled their comprehensive report of March 12, 1978, "Berlin's clinic 1984," with reference to George Orwell's famous book. In 1980, I went back to Marburg (where I had come from) to take over as chair of child and adolescent psychiatry, a position which, in 1958, was the founding chair of this discipline in Germany.

In 1978, I was appointed as officer of the IACAPAP Executive Committee, in which I held several positions until I was elected president of this organization in 1998 at the 14th IACAPAP World Congress in Stockholm. I served as ESCAP president from 1995 to 2004, and there was an overlapping time period when I was both ESCAP president and IACAPAP president. From 1998 until 1999, I was chairman of the WPA Section of Child and Adolescent Psychiatry. In this role, I organized, together with the secretary, John Corbett, at each WPA meeting, a special symposium on child and adolescent psychiatry topics.

As I have always had a special interest in international relations, my major experiences and initiatives can be summarized as follows:

- Chaired the WPA- Section of CAP (1989-1999);
- Served as special Professor of Psychiatry at the University of Birmingham (1993-1996);
- Founded in 1998, and sustained until today, the international research seminars for young scientists, which, since 2006, have been named the Helmut Remschmidt Research Seminars. So far, these have been carried out approximately one year prior to the next IACAPAP congress: in Istanbul (2007), Beijing (2010), Paris (2012), Stellenbosch/South Africa (2013), Calgary/Canada (2015), Czech Republic (2017), and Singapore (2019);
- Organized and served as President during the 11th ESCAP Congress 1999 in Hamburg/Germany;
- Initiated the Donald Cohen Fellowship Program for young researchers at each IACAPAP World Congress (in 2004);



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- Served as scientific Director of the WPA Presidential Global Program on Child Mental Health in cooperation with the IACAPAP and the WHO (2002-2005);
- Organized and served as President during the 16th IACAPAP World Congress in Berlin in 2004. This congress was, so far, the largest IACAPAP congress, with 2,700 participants;
- Founded the journal, "European Child and Adolescent Psychiatry" (ECAP), together with Philip Graham and Herman van Engeland (1943-2016) in 1992.

In conclusion, it was a great honor and pleasure to serve in so many international functions and to come into contact with so many outstanding mental health workers from countries all over the world. Many of them became close friends or mentors, and – sad to say – many of them are no longer among us. I only want to pay homage to the latter ones: James Anthony (1916-2014), Gerald Caplan (1917-2008), Salvador Celia (1940-2009), Colette Chiland (1928-2016), Donald Cohen (1940-2001), Didier-Jacques Duchet (1916-2010), Herman van Engeland (1943-2016), Dick Arnold van Krevelen (1909-1979), Jakob Lutz (1903-1998), Klaus Minde (1933-2016), Hilde Mosse (1912-1982), Irving Philips (1922-1992), Winston Rickards (1920-2007), Kari Schleimer (1933-2016), Albert Solnit (1919-2002), Walter Spiel (1920-2003), and Sula Wolff (1924-2009).

I had close relations and cooperations over the years with all of them, who had a great impact on the development of international child and adolescent psychiatry.



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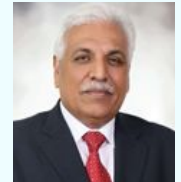
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WORLD PSYCHIATRIC ASSOCIATION 2020-23 ACTION PLAN

Child, Adolescent & Youth Mental Health: A Priority Area

Professor Afzal Javed

WPA President-Elect & Chair WPA's Planning Committee 2017-2020



The WPA Action Plan for 2020-23 defines emerging needs and priorities, from a worldwide perspective, in some specific areas of mental health. Given that globally, only a minority with a mental disorder receive any treatment, there is an outstanding need to improve access to high quality mental health care in all countries and to support psychiatrists and other mental health professionals in their important roles as policy makers, direct service providers, trainers and supporters of health care workers in primary and community health care systems. The rapid spread of COVID-19 around the world is further increasing the risk of developing a mental disorder, relapse of an existing mental disorder and poor mental wellbeing, which requires action at a population level.

The key features of the Action Plan are:

- *To promote psychiatry as a medical specialty in clinical, academic and research areas and to promote public mental health as a guiding principle*
- *To highlight the specific role of psychiatrists in working with other professionals in health, public health, and legal and social aspects of care*
- *To ensure WPA's positive engagement with member societies and WPA components, mental health professionals & general health care workers*

The Action Plan for 2020-2023 looks at targeted areas that need attention and input from various WPA components during the next triennium. It will work within an international perspective, focusing specifically on

improving coverage of interventions to treat mental disorders, prevent mental disorders, and promote mental wellbeing including through training of mental health and other professionals. This Action Plan will also build on the previous Action Plan to ensure continuity in the WPA's work.



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The six areas of the WPA Action Plan 2020-23



Child, Adolescent & Youth Mental Health

One of the salient and important areas for the proposed action plan is child, adolescent & youth mental health. As per current evidence, mental disorders are the single most common cause of disability in young people. Most of the lifetime mental disorders arise before adulthood. If left untreated, mental disorders impede all aspects of health, including emotional well-being and social development, and leave young people feeling socially isolated, stigmatised, and unable to optimise their social, vocational, and interpersonal contributions to society. Mental disorders during childhood and adolescence also result in subsequent impacts in adulthood and increase risk of adult mental disorders.

Certain groups of children, adolescents and young people are at higher risk for mental disorders and poor wellbeing. These include girls and young women, persons with learning disabilities, the homeless, refugees, young carers, young offenders and young adults with chronic physical health problems. Wars and natural disasters have led to the refugee population reaching numbers not seen since the Second World War. International organisations generally focus on providing food and shelter, but much more needs to be done to support this younger population and to address their mental wellbeing.

Childhood and adolescence therefore represent the most important life stages to treat mental disorders early. There is ample evidence that addressing mental disorders early in life can decrease emotional and behavioural problems, functional impairment, and contact with all forms of law enforcement. It can also lead to improvements in social and behavioural adjustment, learning outcomes, and school performance in later life and prevent development into chronic disorders. Childhood and adolescence also represent the most important life stages to prevent mental disorders from arising by addressing risk factors and promoting mental wellbeing by addressing protective factors. Child adversities are particularly important to address given they are responsible for one third of adult mental disorders.



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However, despite the existence of effective interventions, most children and adolescents with mental disorders receive no treatment even in high income countries. Similarly, a range of effective interventions can prevent mental disorders from arising and can promote mental wellbeing but are not implemented. This implementation failure, particularly in LMICs, results in wide ranging impacts on health, education, social relationships and ability to conform with the law.

A range of opportunities exists to improve implementation of such interventions during childhood and adolescence. One opportunity exists in the form of digital technology, although excessive screen time is also a risk factor for mental disorder and poor mental wellbeing. Groups at higher risk for mental disorders and poor mental wellbeing require targeted approaches to prevent widening of inequalities.

Some of the proposed work will focus on groups of children, adolescents and young people that are at higher risk of mental disorders and poor wellbeing and may include:

1. *Implementation of effective interventions to detect and treat mental disorders at an early stage in childhood and adolescence, given that most lifetime mental disorders arise before adulthood*
2. *Implementation of effective interventions to treat and prevent child/parental mental disorders during pregnancy and the perinatal period*
3. *Implementation of effective parenting interventions, which treat behavioural disorders, prevent mental disorders and promote child/parental wellbeing*
4. *Implementation of effective pre-school and school-based interventions to treat mental disorders early, prevent mental disorders and promote mental wellbeing*
5. *Early detection for psychosis and crisis intervention centres for adolescents*
6. *Workplace screening for early detection of mental disorders among young workers and promotion of wellbeing in the workplace*
7. *A series of educational multidisciplinary programmes highlighting the challenges and opportunities for digital child and adolescent psychiatry services*

Other dimensions of the 2020-23 Action plan, including public mental Health, dealing with co-morbidity in mental health, capacity building, partnership with other professional organisations especially associations & societies working for children & adolescents, are also relevant in terms of future work for children & adolescents.

All areas covered in the proposed Action Plan are of high priority. However, due to time limitations and scarcity of resources, there will be greater focus on specific areas. The WPA has established working groups that have started formulating plans and pilot projects in different areas of the proposed Action Plan outlined in this



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document. Once the findings of these pilot projects are available, we will share these reports & seek funding to implement these ideas in different settings and countries.

It is hoped that the 2020-23 Action Plan will generate interest among all WPA components, especially our WPA section on Child & Adolescent Psychiatry, to develop guidelines and directions for future work and will result in increased mental health services budgets from relevant sources. I am pleased that Prof Norbert Skokauskas, chair of this section, and his committee are actively involved in further discussions about such proposals.

Last, but not the least, WPA looks forward to receiving support, active input, and advice from our membership in setting these priorities and making a real difference in mental health.



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About the social role of child and adolescent psychiatrists in times of epidemic

Professor Bruno Falissard (France)



An outbreak is inevitably associated with a high level of mass anxiety, affecting all strata of a population whatever their social condition and age. Child and adolescent psychiatrists, because they are recognized as having some form of authority concerning the management of anxiety, thus have a social role to play in times of an epidemic.

Spontaneously, the first reaction of a mental health professional in such a circumstance is to communicate with empathy, acknowledging publicly the distress of all. But there is a risk with this attitude: the risk to express too much of our own negative emotions and thereby to potentiate collective anxiety that can be counterproductive on all points of view. Because the situation is more complex than it seems to be, we have to be careful and rational, and the best thing to do is surely to begin with a close examination of facts.

In terms of public health, what are we experiencing right now?

We are facing a pandemic, a globalized epidemic that, in terms of morbidity and mortality, is of an intermediate severity: more severe than the annual flu epidemic, and less severe than the Ebola fever epidemic. This pandemic is particularly harmful in old people with comorbidities (mortality rate about 10% after 80) and much less in young people (mortality lower than 0.1% before 40). Strong political decisions (staying at home, hygiene measures, testing, etc.) are dramatically effective to stop the propagation of the virus. When such decisions are taken, the health impact of the epidemic is real but moderate. For instance, in France, a country particularly affected, the increase in mortality for 2020 due to the epidemic will likely be about 5% (30000 additional deaths for an annual number of deaths about 600000), and the loss in "disability-adjusted life year" will be much lower.

In terms of mental health, what are we experiencing now?

We are typically in a situation of intense chronic stress, and we know with a high level of evidence that this is a risk factor for anxiety and mood disorders. The economic crisis that is emerging in most countries will make things even worse, so we could have an increase in suicidal rates in the forthcoming months. But we have here only the big picture, with important details lacking, and these details do make all the difference.

The nature of this anxiety that is progressively taking over the planet is not the classic neurotic anxiety that is found in most therapists' offices. This anxiety is in line with something that can be everywhere but that cannot be seen; this anxiety is in line with one of the 4 major collective fears (war, natural disaster, food risk, and health crisis). Because of this, anxiety is also spreading like an epidemic, and we have to stop it because anxiety is painful and can lead to irrational behaviors.



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Concerning children, they experience the situation in quite a different way: children have a different relationship than adults to diseases and death. Most of the time, in the context of an epidemic, children will be anxious mainly by proxy. Indeed, parents overwhelmed by anxiety are in a difficult position to remain the powerful and secure persons that their children need.

Child and adolescent psychiatrists are in a delicate position

Because of renewed intrafamilial violence, because of a discontinuation of in-person schooling, and because of their parents' anxiety, many children and adolescents will suffer from the epidemic. But they will likely suffer much less than adults, and they are relatively unaffected by the virus itself.

So taking this reality into account, how should we, child and adolescent psychiatrists, respond publicly to this epidemic situation? Should we keep our usual posture of advocacy, shouting loud and clear that "children suffer too," "that the young have been sacrificed to save the old" as we often have heard it? The answer is, perhaps, "No." "No" because it is not fair and because it is counterproductive in adding anxiety to anxiety.

We have to be professional; we have to stick to facts and to apply what we know about psychopathology.

We do experience, all of us, old and young, a difficult situation. It is definitely not a disaster like a war or a tsunami, but still a difficult situation. The good news is that this situation can be considerably improved by adopting simple behaviors that protect each other.

We are under stress, and we are experiencing a massive collective fear. Because of this, some of us became anxious or depressed, but some others found unexpected resources within themselves. Concerning children, some will be in trouble too, but it is most often because of adults' anxiety that they will develop problems. So if we, adults, really want to protect our children in these difficult times, we have to focus on behaviors that protect each other, and we have to force ourselves to live as we usually did "before." In particular, we have to do our best to put away all those negative emotions that don't help us in any way and that can disturb those we love. And child and adolescent psychiatrists should take the lead in that regard.



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Covid tips around the world

Dr. Tjhin Wiguna (Indonesia)

Resolutions for a life and practice post-pandemic

1. I will continuously spread positive facts and evidence-based health information to our children and families now and forever
2. I will work against Hoax in the social media and put evidence-based information to the community especially related with health and mental health
3. I will give the best telepsychiatry services to our children, adolescents and families to keep them healthy and prosperous
4. I will keep encourage our children and adolescents to study and never give up even in the hard times by sending them wise study quotes and supportive stories through Instagram or others social media
5. I will always be grateful to God Almighty that gives me chances to help, support and writing these resolutions that might inspire children, adolescents and families about our meaningful connectedness
6. I will always put high commitments to take care our mother earth so that our next generation would have a better place to live
7. I will keep taking care my family and love them unconditionally
8. I will keep teaching my students and residents by using e-learning methods
9. I will let my patient to contact me any time in need by keeping my cellphone active all day
10. I will keep telling myself and my family to stay at home and so do my students and patients

Lifesaving tips learned

1. Stay at home and to take advantage of telepsychiatry services
2. Put face mask and other personal protective equipment when meeting patients and let them understand that it is good for them and us
3. Keep our hand clean every time to avoid the viral transmission
4. Ask every child, adolescent and everyone to wash their hand appropriately by teaching them the hand washing steps regularly
5. Avoid crowded places and aware about people with virus carrier but without any symptoms



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Covid tips around the world (continued)

Dr. Jibril Abdulmalik (Nigeria)

Resolutions for a life and practice post-pandemic

1. I will continue to invest time and energy in public awareness campaigns
2. I will commit to encouraging and providing emotional support for colleagues at work
3. I am dedicated to exploring how best to deploy mobile health applications to expand access to quality care for the hard to reach.
4. Family is everything - treasure every moment and spend quality time with them
5. I will focus on nurturing and building resilience in children and adolescents - because life will always throw us curve balls
6. One world, one humanity - we are interdependent and we all need each other
7. Spread hope and positive vibes, it may be all someone needs to hang in there during tough times
8. Its a privilege to participate in social gatherings and interact with other people - invest more in social relationships
9. We should participate actively in politics - because elected politicians can enhance or threaten our health, peace and global security
10. Invest more in networking, building partnerships and collaborations with colleagues; and mentoring young colleagues

Lifesaving tips learned

1. Stay humble and make do: When the chips are down, we can really get by with very little
2. Physical lockdowns should not translate into social isolation. We can stay connected using technology, with friends, family, and colleagues via video calls and chats
3. Avoid anxiety-provoking news and fake but alarming messages via social media. Jealously guard your emotional tranquility.



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COVID-19, Digital Epidemiology, and Digital Mental Healthcare

Infrastructure Development

Dr. Gerald Busch (USA)

Prior to Covid19, the global burden of mental health and addictive disorders was estimated at more than 1 billion people globally, with 20% of the global burden of disease resulting from mental disorders. The Covid19 pandemic is exerting the dual pernicious effect of a potential global increase in mental health problems while simultaneously restricting access to established mental health delivery systems. There is evidence of an incipient public mental health crisis that needs to be addressed.

Mental healthcare infrastructure was already insufficient with regard to service delivery, especially in Lower Middle-Income Countries (LMIC), where there may be 1-2 psychiatrists for the entire country, in comparison with a 200-fold higher proportion in higher income countries. In the United States, prior to the pandemic, less than half of those with mental illness received needed care (over 10 million adults), with over 70% of youth diagnosed with Major Depression not receiving the care they need.

The challenge to public mental health has been recognized since the Wuhan outbreak. Rising concern regarding the impact of Covid19 on global mental health is clear. The effect of quarantine on mental health includes an increase in post-traumatic stress symptoms, confusion, and anger. The psychosocial stressors associated with quarantine include longer quarantine duration, infection fears, frustration, boredom, inadequate supplies, inadequate information, financial loss, and stigma. There was a substantial decline in mental health after the first month of lockdown. One survey of 44,000 indicated that 18% of respondents had thoughts of self-harm or suicide during lockdown.

The difficulty, during the pandemic, with traditional mental health service provision, within the context of an already inadequate mental health service delivery system, has led to the logical and earnest call for technological solutions for psychiatric service delivery and public mental health interventions. This renaissance in technologically facilitated psychiatric service delivery has already begun in the sudden and widespread use of telepsychiatry and virtual office visits, and the field of digital psychiatry holds special promise. Telepsychiatry requires active and intensive clinician involvement, thus allowing accessibility; yet, telepsychiatry remains limited in relying on a short-supply workforce to deliver care to millions of individuals.

The use of digital psychiatry interventions holds particular benefit for service delivery due to its properties of accessibility and scalability. The level of intimacy that individuals currently have with their digital devices allows self-representation and interaction with the digital universe, as well as a level of trust and immediate engagement with digital “apps” or applications. Thus, apps that provide mental health monitoring and countermeasures to distressing symptoms such as anxiety or depression are immediately accessible and easily engaged.



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Furthermore, these apps are scalable, in that they are easily widely broadcast through commonly available app stores.

With regard to technological limitations in LMICs, and limitations in app use due to reduced digital healthcare literacy or competence, most have cell phones with "SMS" (short message service or text message) capability. Although not necessarily "smartphones," these devices are capable of sending and receiving text messages. Text messages have been effectively used for depression screening in rural India and among refugees in Zimbabwe and the Democratic Republic of the Congo. Multiple other studies in LMICs showed the benefit of text messaging to deliver diagnostic and support interventions.

The Lancet Commission on Global Mental Health and Sustainable Development has emphasized the need to scale up mental health care, and, in particular, the potential of digitally delivered mental healthcare services. Digital interventions are effective in reducing suicidal ideation. The high level of digital engagement in youth creates the significant potential to close the mental health gap through the use of evidence-based digital mental health resources. Children and younger individuals may have a particular aptitude to engage in digital mental health interventions when needed due to the advanced digital literacy of their generation. An intriguing possibility in the design of digital mental health interventions involves the involvement of the user in the "co-development" or refinement of a mental health app.

One additional digital element is necessary for the effective development and administration of digital mental health apps and interventions: the application of digital epidemiologic measures to target populations. Digital epidemiology relies on large data sets and the use of machine learning to elucidate complex correlations. The emergence of digital phenotyping has provided a means to obtain data-driven objective measures of individual function, gathered from aggregated smart-phone data as well as from wearables or sensor-devices, as opposed to data obtained by self-report. However, for the purposes of obtaining epidemiologic measures in LMIC settings, the mass SMS text administration of brief measures (e.g. PHQ9) could establish a baseline from which the impact of a digital intervention may be measured. Currently, mental health surveys are labor intensive and must be based upon a limited sample population. Mental health surveillance could instead be done by text message/response. Significant expansion of standard sample size is possible with text messaging of survey questions. Baseline data, with measures such as Kessler-6, can provide a means to assess the impact of a public health intervention. The language of the Kessler-6 or selected instrument would need to be adapted to the community. Through proactively applied digital epidemiology, the impact of the interventions may be ascertained and adjusted accordingly.

References available upon request.



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Child and Adolescent Psychiatry in Belgium

Dr. Camille Noël and Professor Véronique Delvenne (Belgium)

With three national languages (Dutch, French and German) and two cultures (Germanic and Latin), child and adolescent psychiatry (CAP) in Belgium relies on different theoretical models blended in our clinical practice. On one hand, we use the Anglo-Saxon model with references to international classifications (DSM, ICD), evidence-based medicine, and biological, genetic and cognitive models more frequently in the Flemish CAP culture. On the other hand, we appreciate the francophone model inherited from psychoanalytic and systemic theories in the French CAP culture.

The Belgian health system is based on the principle of social insurance (Bismarck-type of health care insurance) characterized by solidarity, without a selection of risk. More than 99% of the population is covered by this compulsory insurance system for a very broad benefits package. The National institute for health and disability insurance (RIZIV-INAMI) supervises the application of the compulsory health insurance and allocates budgets to the sickness funds, that are not-for-profit bodies financing the health care costs of their members. Lastly, there is no gatekeeping: patients have free access to all tiers.

Starting from a number of adult psychiatric beds per inhabitants among the highest in OECD countries (in 2019, Belgium had still 60 adult psychiatric hospitals with 13 800 adult beds), the reform of the child and adolescent mental health national policy in 2015, grounded on the objectives of the WHO's comprehensive mental health action plan, organizes care networks (collaborating with social, legal and school sectors and family/peer associations etc.) and crisis- and ongoing mobile teams. Based on a bio-psycho-social model, its global approach is centered on the child and her environment and integrates all sectors and partners in the field of childhood and youth in a collaborative approach (educators, social workers, youth justice, peer groups, parents associations, GP, pediatricians, disability sector). Dialogue, transparency, openness, participation, and involvement of children and adolescents and their parents are essential to the decision process.

The missions of the new policy include early detection, orientation, diagnosis, and treatment in collaboration with other life sectors related to the child or adolescent. Mental health disorders are addressed adjusted for the developmental level. In coordination with maternity, neonatal and pediatric services, particular attention is paid to detect early signs of developmental disorders in early childhood. Cooperation is fostered with adult mental health care in order to prevent a gap in the transition period, targeting youths aged 16-23 years old. Mobile teams are implemented in crisis situations and complex and ongoing care situations. The patient should be treated, as much as possible, in their environment. First-line workers must be supported and included. Hospitalization must be restricted to acute situations when treatment at home is impossible or undesirable. Social reintegration is the goal of treatment.

In addition, the child and adolescent mental health reform incites both cultures to dialogue and work together: for instance, the CAP mobile team and the perinatal platform aiming at vulnerable parents for both Dutch- and French-speakers in Brussels. Belgian CAP could substantially benefit from this theoretical diversity: the clinician's



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and the research approach, the dimensional and the categorical approach, to pay attention to the complex and multidimensional challenges inherent to CAP (e.g. familial, contextual, functional dimensions).

Besides, the unifying principle of the clinical approach stems from its practical purpose, including patient care. The clinical method that considers listening to subjectivity and singularity must be taught to CAP trainees. It involves listening to the child and surrounding systems, including cultures and social and societal conditions. Additionally, evidence-based modes in diagnosis and treatment must be taught to CAP trainees. However, the historical, societal, environmental and above all developmental contextualization must be taken into account as well.

The current qualitative research movement rehabilitates the researchers' and clinicians' subjective position as well as the knowledgeable position of the patient, depositary of an individual and narrative truth. The research paradigm on the living, on the human, thus draws near to anthropological dimensions. This human dimension, defined by the ministry as *skills* and *attitudes*, must be part of the CAP training as well.



Improvement of addiction treatment workforce in Ukraine within Ukraine Addiction Technology Transfer Center

Dr. Yulia Yachnik (Ukraine), Prof. Irina Pinchuk (Ukraine), Prof. Igor Koutsenok (USA)

In Ukraine, the estimated prevalence of substance use disorders in 2017 was 5.99%, which encountered 2,582,640.50 population. It is estimated that 1.09% of the adult population inject drugs. Injecting drug use accounted for around 25% of all new *human immunodeficiency virus* (HIV) infections in Ukraine in 2017 and HIV prevalence among people who inject drugs (PWID) was estimated at 21.9%.

Substance use treatment in Ukraine is characterised by the diversity of services, a biologically oriented model of care in state institutions, use of therapeutic approaches with a lower or doubtful level of evidence along with evidence-based practices, low level of psychosocial care for opioid agonist treatment (OAT) clients. Among PWID there were 27% on OAT and 25% on antiretroviral treatment. Scaling up of OAT, especially among PWID, is needed to optimise HIV prevention and treatment goals in Ukraine.

An assessment of the training needs among substance use treatment specialists has shown a strong interest in new knowledge and skills in examining and treating substance use disorders, including OAT, but existing training courses and programs often do not cover complex issues that are of interest to specialists.

With the ultimate goal of building a sustainable partnership focused on reducing the individual and societal impacts of HIV and substance use disorders in Ukraine consistent with the *President's Emergency Plan For AIDS Relief (PEPFAR)*, the *Substance Abuse and Mental Health Services Administration (SAMHSA)* and Addiction Transfer Technology Center (ATTC) Network mission, the Ukraine ATTC was established in 2018 and currently is based in Taras Shevchenko National University of Kyiv. Ukraine ATTC is dedicated to building and supporting a well-trained, recovery-oriented, diverse workforce in order to improve outcomes of substance use disorders treatment and reduce substance-related problems in the country. Taking into account the existent significant HIV epidemics in Ukraine and the increasing rates of substance use disorders, the Ukrainian ATTC aims towards the development and support of professional workforce, fosters local and national alliances for the broad introduction of the recovery-oriented evidence-based addiction treatment methods, models and strategies.

For ensuring support and developing up-to-date action plans the Advisory board was established with 30 active members, who are representatives of national and international stakeholders, policymakers and education providers.

During 2,5 years of Ukraine ATTC operation there were conducted following activities: 2 days opening conference, 16 (2&3 days) training, 2 intensive 5 days training of National Trainers, 3 lectures, 2 workshops (1 day), 2 Advisory board meetings. In total there were provided 342 hours of face to face education. Additionally, to ensure technology transfer, there were 292 hours of after training supervision and support. The cumulative number of participants was 704.



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To scale up education activities and knowledge dissemination the training of National Trainers on Substance use, mental health and HIV in 2019 and 2020 were conducted. There were 25 applicants in 2019, 20 were certified, 10 specialists were selected for *United States* study visit based on their performance and English proficiency in 2019. In 2020 there were 30 applicants and they are currently on their way to certification. The certification as National Trainer requires the fulfillment of several obligations, among them: participation in face-to-face training (40 hours), pre and post-training video recording of mock sessions with patients, participation in group supervision (10 hours), provision of at least two training under supervision.

Within the program in 2019, 20 candidates to National Trainers conducted 24 training and trained 440 specialists. Training was aimed to increase knowledge and skills on HIV and *substance use disorder (SUD)* syndemics, HIV and SUD treatment and motivation enhancement in HIV and SUD treatment specialists and case managers on different levels of HIV care, expected influence on engagement in HIV testing, *antiretroviral* therapy (ART) treatment engagement and adherence.

Due to Covid-19 situation worldwide, all public events have been postponed for an undefined period. Therefore, the online educational platform for specialists working in the addiction field within Taras Shevchenko National University of Kyiv was organized. This allowed continued educational work in accordance with ATTC mission, 6 webinars were already conducted and 10 more are planned in the nearest month. It is planned to develop fully online courses based on the Universal Treatment Curriculum (UTC) Modules.

Target audiences of Ukraine ATTC education activities included SUD treatment providers (addiction psychiatrists, psychiatrists, psychologists, social workers, addiction counselors), GPs, HIV treatment providers, policymakers from Primary Health Care (PHC) and the *Ministry of Justice (MOJ)*, first responders from Emergency State Service and Military forces (military psychologists, chaplains, officers on moral and psychological support), school psychologists and educators and psychological services providers for veterans.

Ukraine ATTC closely collaborated with the University of California San Diego (UCSD), USA and invited trainers from UCSD, University of California Los Angeles (UCLA), University of Minnesota.

Also, Ukraine ATTC managed to create a close partnership with universities in Ukraine.

Today focus of Ukraine ATTC attention relates to the implementation of evidence-based principles and best educational practices within academic settings. 4 university representatives were certified in 2019 as National Trainers in Substance use, mental health and HIV and 7 university representatives have been trained in the second generation of National trainers. During this time, university representatives had modified existing curriculums. Several curriculums with changes (based on UTC) for Family doctors were adopted in the National Medical Academy of Postgraduate Education.

Ukraine ATTC is aimed at further facilitation of changes in curriculums for ensuring sustainability in the educational sphere in the long term. 3 brand new curriculums for CME were developed within the Institute of Psychiatry of the Taras Shevchenko National University of Kyiv. These programs were created on the basis of the Ukraine ATTC experience in previous training, feedback from participants and the opinions of national trainers - university representatives, and also taking into account the absence of such programs in Ukraine at the level of postgraduate education at medical universities and academies. Thus, the following topics were selected: i)



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Practice of Motivational Interviewing. ii) Diagnosis and treatment of mental disorders comorbid with substance use disorders. iii) Screening and brief interventions for substance use disorders. Each of these programs is designed for 30 hours of training and includes information from the relevant Universal Treatment Curriculum (UTC) modules, as well as ATTC developments.

The pre-service educational program "Psychiatry and Addiction Medicine" for 4th-year medical students was developed and adopted within the Institute of Psychiatry of the Taras Shevchenko National University of Kyiv. The program is designed for 90 hours and includes 20 hours based on UTC.

Additionally, the scope of work of Ukraine ATTC was expanded to Central Asia in 2019 and the Training "The Modern Science of Addiction and Science-based Treatment Modalities for Substance Use Disorders" was conducted in The Republic of Kazakhstan.

Now, Ukraine ATTC closely collaborates with the International Consortium of Universities on Drug Demand Reduction and the International Society of the Substance Use Disorders Professionals.

The Ukraine ATTC experience shows that the technology transfer model is suitable and effective for substance use and HIV workforce in Ukraine.





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Community-based developmental checkups and school survey in Hirosaki, Japan during the COVID-19 pandemic times

Drs. Tomoya Hirota (Japan/USA), Manabu Saito (Japan) and Masaki Adachi (Japan)

1. Community-based child development check-ups and school surveys in Hirosaki city, Japan

In this article, we briefly introduce our community work, including the Hirosaki Five-year-old Children Developmental Health Check-up (HFC) and school surveys. These two works are conducted annually in collaboration between Hirosaki University and the municipal departments (the Department of Disability and Welfare and the Board of Education) in Hirosaki city. We will then provide recent updates on our work and our plans in the context of the COVID-19 pandemic.

2. The Hirosaki Five-year-old children Developmental Health Check-up (HFC)

The HFC launched in 2013 and has been conducted annually ever since. The check-up targets a total population of 5-year-old children in Hirosaki city. Hirosaki city is in the northern part of Japan's main island, and the total population is approximately 170,000. The annual births in this city are approximately 1200.

The checkup consists of two phases: the screening phase and the in-person assessment phase. The initial screening phase is conducted using the combination of several internationally validated questionnaires to broadly identify children with possible developmental challenges in social, emotional, and behavioral domains. The assessment is provided for children with these developmental concerns to detect children with neurodevelopmental disorders in the city and provide adequate services and interventions. Using data that accumulates each year, we have recently published our study findings on the frequency of autism spectrum disorder among 5-year-old children in this city and the patterns of co-occurring neurodevelopmental disorders.

3. School survey in public elementary and middle schools in Hirosaki city

To further our understanding of social, emotional, and behavioral development of school-age children and adolescents (from 7 to 15 years of age), we conduct the school survey in all public elementary and junior high (middle) schools in Hirosaki city once every year. In the school survey, both students and their caregivers provide data on the students' mental health, including social-emotional-behavioral challenges as well as internet use behaviors and related problems, and well-being through questionnaires, many of which are validated scales. Over the last couple of years, we have also been measuring adolescents' social capital (social norms, interpersonal



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trusts, reciprocity/mutual supports) to better understand the contextual effects on the students' social-emotional-behavioral challenges and development.

4. Our efforts to maintain our work during the COVID-19 pandemic

Five-year-old checkup: The participation in the screening phase was not affected this year, as the screening was changed from the paper-pencil survey to the web-based survey in 2019. We conducted the in-person assessment this spring by increasing the number of days of the assessment from 4 to 9 days and securing a more spacious facility for the assessment, including the child and parent interview, cognitive testing, and motor assessment. Social/physical distancing was maintained among participating children and families throughout the assessment days. To reduce any potential risks for infection, temperature checks, hand washing, disinfection of the rooms, and mask-wearing were implemented. Only children who were undergoing the assessment in the exam room were allowed to remove masks. There were very few absences of children and families who were scheduled for the assessment. We plan to conduct the assessment in fall this year again using the same procedures.

School survey: We determined that we will modify the frequency and the content of the questionnaires in the students' survey. More specifically, to reduce the students' burden and secure their academic time that was affected due to the school closure that occurred in spring 2020, we omitted a number of items in the questionnaire. Instead, we decided to focus on the use of specific scales measuring their emotional states and behaviors (internet use, for example) and conduct this shorter survey thrice this academic year in order to shed light on if and how their emotional states and behaviors change over time. In the parent survey, a few questions inquiring about the effect of the pandemic on the household (economic effect, for example) will be added.



Photo: HFC staff

Dr. Saito is the project leader responsible for the five-year-old child developmental checkup. Dr. Adachi is the project leader responsible for the school survey. Dr. Hirota is a researcher involved in these two projects.



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Meeting announcement: World Congress of the International Association of Child & Adolescent Psychiatry & Allied Professions (IACAPAP)

Dr. Say How Ong (Singapore), *Organizing Chairman*, 24th World Congress of IACAPAP

It is my great pleasure to announce that the 24th World Congress of the International Association of Child & Adolescent Psychiatry & Allied Professions (IACAPAP) has been postponed and converted to a virtual conference which will take place from 2nd - 4th December 2020. Organized on an entirely digital platform, the virtual conference will boast some seven keynote and plenary sessions as well as eleven state-of-the-art lectures, and with more than sixty break-out sessions. Among the over 100 international and regional speakers include eminent professors, scientists and clinicians such as Michael Meanny, Eric Chen, Michael Hong, Gabrielle Carlson, James Hudziak, Guilherme V. Polanczyk, Olayinka Omigbodun and Daniel Fung, to name a few. The virtual conference will also feature a suite of services typical of a live congress such as e-posters, messaging boards for Q&As and personal connections, as well as a virtual exhibition space. Staggered timing schedules of the conference sessions have also been planned to allow delegates from different time zones to participate in live sessions while having access to recorded sessions by earlier speakers from a different time zone. The first thousand registered delegates would also receive a complimentary electronic or print copy of the IACAPAP monograph. With registration fees starting from USD95, the organizing committee hopes to attract a greater participation from medical students, residents and early-career professionals.

Since the outbreak of the COVID-19 pandemic, many countries have mounted an early and effective response in order to bring the virus spread quickly under control. However, many countries are not out of the woods yet as millions of lives are still being impacted, many in a disproportionate way depending on their racial ethnicity, socio-economic and physical health status. Healthcare professionals including psychiatrists and allied health professionals have stepped up during this health crisis and many have been deployed to medical isolation facilities to support local and national efforts in their fight against COVID-19.

The IACAPAP congress organizing committee has successfully organized an introductory webinar entitled "COVID-19: Child and Adolescent Mental Healthcare: Disruption of Evolution?" on the 20th July 2020 to mark the original date of the live congress. Attended by more than 900 participants from 103 countries, the webinar has garnered very positive feedback with participants hoping for more webinars of this nature being organized. The opportunity to connect and interact through webinars is therefore very timely and a god-send for us because coming together physically is impossible due to ongoing travel restrictions during the pandemic. Virtual conferences and webinars thus allow us to continue sharing, discussing and learning from one other so that we can work together against any future threats and disasters, be they man-made or natural.



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The organizing committee welcomes you to our very first IACAPAP virtual conference from 2nd - 4th December 2020.

www.iacapap2020.org

24th World Congress of the International Association for Child and Adolescent Psychiatry and Allied Professions


Starting from the Beginning
- Laying the Foundation for Lifelong Mental Health

2 - 4 December 2020
Virtual Congress




IACAPAP 2020
SINGAPORE
VIRTUAL CONGRESS

Organised by:




IACAPAP
International Association for Child and Adolescent Psychiatry and Allied Professions



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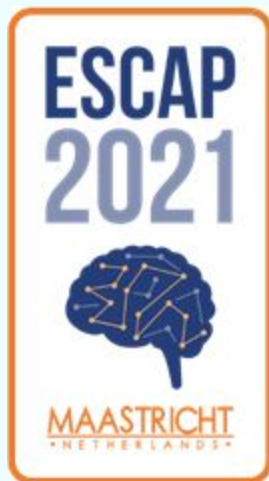




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19th International Congress
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27-29th June 2021

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