



# **World Child & Adolescent Psychiatry**

ISSUE 9, December 2015

**WPA, Child and Adolescent Psychiatry Section's Official Journal**

Photo: Jeddah

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## Editorial Column

Dear Colleagues,

Welcome to the final 2015 issue of "World Child and Adolescent Psychiatry," an official journal of the World Psychiatric Association, Child and Adolescent Psychiatry Section (WPA CAP). 2015 was another busy year for WPA CAP, and using this opportunity I wish to thank all the members who have contributed to the section's activities including this journal. "World Child and Adolescent Psychiatry" is committed to disseminating news in support of the growing importance of child mental health on the world stage. We aim to reach as many as possible child and adolescent psychiatrists and also to give a voice to our colleagues from all around the world. While we are not striving, at this point, for peer-reviewed journal status along the ranks of World Psychiatry (the WPA's official journal, the impact factor of which grew from 3.896 in 2009 to 14.225 in 2014 under Prof. Mario Maj's brilliant leadership), we aim to disseminate news, ideas, experiences, and opinions, more so than scientific studies per se. The journal has several sections, but always the same two sections get more attention than others. The interview section is popular not because we ask interesting questions, but because interesting people, true leaders have agreed to be interviewed, including the presidents of the WPA Prof. Norman Sartorius (past president), Prof. Dinesh Bughra (current president) and Prof. Helen Herrman (president elect).

This issue features an interview with Dr. Matt Muijen. Dr. Matt Muijen is the Programme Manager for Mental Health at the WHO Regional Office for Europe. He is responsible for planning and coordinating mental health policies and strategies, research, dissemination and implementation in Europe, and is working actively with many countries and organizations. The other section which is always widely discussed is the editorial by Prof. Bennett Leventhal who is WPA CAP Chair. His editorials can be sharp and provocative, but always positive, creative, and motivating. This time his editorial "When It is Hard to Know What to Say..." is a call to action for all of us. It identifies a global issue that WPA CAP must address. Therefore, we are proposing to form a task force to identify resources and guidelines in the regions that can help children and families at risk. Anyone interested in participating in this urgent and important activity, please contact the editor at the e-mail below.

As always, I would like to thank all the authors in this issue and my editorial team: Prof. B. Leventhal (WPA CAP Chair), Prof. A. Guerrero (Assistant Editor, Hawai'i, USA), Dr. T. Hirota (Assistant Editor, USA/Japan), Dr. J. Abdulmalik (Assistant Editor, Nigeria), Dr. G. Milavić (Co Chair WPA, CAP, UK), A. Prof. D. Fung (Singapore), Dr. M. B. Moyano (Argentina), Prof. D. Anagnostopoulos (Past Chair, WPA-CAP, Greece), Dr. M. Tateno (Japan), Prof. S. Malhotra (India), Prof. S. Honjo (Japan), Prof. P. Szatmari (Canada), Prof. L. Viola (Uruguay), Prof. S. C. Cho (S. Korea), Prof. D. Puras (Lithuania), Dr. V. Storm (Australia), Dr. J. Fayyad (Lebanon), Dr. S. Tan (Malaysia), Dr. N. V. Tuan (Vietnam), Prof. P. Joshi (USA), Prof. A. Sourander (Finland), Prof. E. Belfort (Venezuela) and Prof. John "Jack" McDermott Jr. (USA)\*.

May I wish you a Happy Festive Season and Prosperous 2016!

Prof. Norbert Skokauskas Editor,  
"World Child and Adolescent Psychiatry"  
Secretary, World Psychiatric Association, Child and Adolescent Psychiatry Section



\*Prof. John "Jack" McDermott Jr. passed away on December 6th, 2015





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**WPA CAP Chair's Column:**

## ***When It is Hard to Know What to Say...***



*Prof. Bennett L. Leventhal (USA)*

While violence is not new to the human condition, the seeming recent onslaught of random acts of violence all over the world is surely having an impact on all of us. For sure, bombings in Beirut, Iraq, Afghanistan and Syria, along with assaults on individuals in Paris, Africa and the US, as well as the downing of commercial aircraft are having a direct and terrible impact on those who are wounded and killed. But we also know that the devastation extends well beyond these victims to include the families, friends, communities and nations who are wounded in the process. One result of this sort of violence, most recently in the Middle East, Europe and Africa, has also led to an immigration crisis that is only aggravated further by economic disadvantage of unprecedented magnitudes. While the crisis in Europe has received the most visibility in the lay media, random acts of violence, economic disparity and mass immigration are not new and still pose major challenges on and between each continent. Taken together, the violence, deprivation and displacement are heartbreaking and dreadful. And, as we have seen recently, these events are full of unspeakable horror. This leaves many of us in pain but also baffled and not quite knowing what to say and even less about what to do.

Most relevant to Child and Adolescent Psychiatry is the recognition that these recurrent events have dramatically changed the world in which our children live. Children have always been the most vulnerable members of our communities, from the travails of childbirth, infection, malnutrition, inadequate medical care, lack of education and much more. And, historically, children and adolescents have always suffered even more in times of war and other catastrophe. Despite the efforts of many, the vulnerability of children remains a central concern for us as do the adverse results of the persistent violence and deprivation.

Is the current situation so novel? Perhaps. In an unprecedented fashion, many children and adolescents who previously seemed "protected" and not apparently in harm's way can now readily become victims. Children and adolescents are now constant victims of this onslaught of violence; they are either injured themselves or bear witness (directly or indirectly) to violence perpetrated on their friends and family. Instead of the unseen, indifferent actors such as infection, it is now men, women and sometimes their own peers who deliver injury and death in their buses, their schools, their markets, their playgrounds, their homes and almost every place else where children live and learn. It is impossible for contemporary children to know whom to trust and where they can feel safe. Such a situation is inherently disruptive to healthy development. It is not hyperbole to conclude that every child and adolescent in the world today is in jeopardy as a result of this pandemic of violence and deprivation. While we may not be experts in politics or economics, our clinical skills and wisdom see a crisis that demands our attention and our voice. But, this is surely one of those times when it is hard to know what to say and even harder to know what to do. It is sometimes painfully difficult for each of us to find our own unique voice in which to speak. No matter how we say it, the time has come for us to deliver a very deliberate, constant message in which we reject violence and protect youth and families. This message must be consistently delivered loudly and repeatedly in every forum that we can find.



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Prof. Bennett L. Leventhal

**Chair's Column (cont.1):**

While what to do next may be beyond our current evidence base, we can be bearers of simple, relatively straightforward messages that can be delivered to warring factions, governments, NGO's and anyone else who will listen; actually, we should deliver these messages even more vigorously to those who don't appear to listen:

1. *Violence is an intrinsic evil for which there can never be justification, be it political, social, religious, or cultural.*
2. *Violence and deprivation adversely impact children in many ways*
3. *Children and adolescents must receive special protections as they are especially vulnerable to the effects of violence and deprivation.*
  - a. *Children require protection from being a direct victim of injury*
  - b. *Children also require protection from witnessing violence and deprivation*
  - c. *Both direct experience and witnessing violence have a harmful impact on developing youth.*
4. *In order to protect children, it is important to protect their families and the communities that support them, including special efforts to keep families safely together.*
  - a. *Migrating families are especially vulnerable*
  - b. *We must not forget vulnerable families left behind or choosing to stay behind in war zones and other communities of great need.*
5. *Children and adolescents have special health care needs*
  - a. *They must be protected from the dangerous elements in the environments, including inclement weather.*
  - b. *They must have consistent access to safe drinking water and adequate nutrition.*
  - c. *They require the regular attention of appropriately trained healthcare personnel.*
  - d. *Emotional health care must be an intrinsic part of the healthcare delivered to children*
6. *Children and adolescents require safe environments in which to learn and play.*
  - a. *Fear and trauma are not restricted to declared war zones*
  - b. *Many vulnerable children and families live very close to our own homes. We must reach out to those in our own countries and communities and protect them.*
7. *It is everyone's responsibility to find safe havens for youth all over the world by providing resources and services as well as by bringing them into our communities and homes.*
8. *We must speak out vigorously against those who deny or rationalize the impact of these horrific events on our youth as well as those who act as proponents of discrimination, rumor-mongering, prejudice, xenophobia. Such individuals and groups must be labeled for what they are: facilitators and perpetrators of violence and deprivation to youth and families.*

Do we have a message when our hearts are torn and when it is hard to know what to say? Some of the aforementioned suggested messages may fit well for some of us. Yet, there may be other messages that should be considered. But, in the end, we have to speak clearly because we know for sure that if we are silent and do not act then we are part of the problem and not a part of a solution. And, failure to act and find safe havens which can support healthy development in our children is not only our collective failure in the present but also our failure to protect the future.



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**"The role of a WHO Regional Office in Europe is to work closely with countries and to support implementation of Action Plans..."**



**Interview with Dr. Matt Muijen**

The Programme Manager for Mental Health at the WHO Regional Office for Europe

*It is nice to be able to interview you, and we thank you very much for the opportunity. What is the main role of the World Health Organization (WHO) Europe, Mental Health Program (MHP)?*

The role of a Regional Office is to work closely with countries and to support implementation of Action Plans that have been endorsed by our Regional Committee, which is the European equivalent of the World Health Assembly. The European Region has 53 Member States, and resolutions of the Regional Committee give us a mandate. We now are working towards the objectives of two resolutions. The first endorsed the conference declaration in Bucharest in 2010: "Better Health, Better Lives: Children and Young People with Intellectual Disabilities." We will report back on this resolution in September 2016. More recently, in 2013, was the adoption of the World Health Organization (WHO) European Mental Health Action Plan. Of course, we also contribute to the implementation of World Health Assembly resolutions such as the ones on autism and dementia. More than half of the European countries, mostly in the Eastern part of the Region have requested our support with the drafting of policies, and in a few we are actively involved in service development. During 2015, we visited about 10 countries and wrote reports advising on the challenges and suggesting how to move forward. Typical issues are the future of large mental hospitals, the lack of staff, underfunding and financial disincentives such as rewarding days in hospital. It would be misleading to suggest that countries always follow our recommendations, but the recommendations often lead to adjustments. The important opportunity for WHO is that we are respected as objective, and as such we have access to policy makers and have credibility.

*How do you set priorities and how they are shaped by the recent European refugee crisis?*

Priorities can be set by our Regional Director, who has been elected by countries. She recently decided that we should start a survey about conditions of people with intellectual and mental disabilities living in institutions, and some 35 countries so far have committed themselves. Priorities can also be decided by countries themselves, who agree on a biennial work plan. High on the list is the need to create a competent primary care workforce that can diagnose and treat depression, and to support the development of community services. The refugee crisis has taken everyone by storm. Last week WHO Europe organized a high level conference in Rome on this theme, and many countries expressed concern about the mental health needs of refugees. I am always aware about the very broad meaning of 'mental health' in this context, and that the priority is often to deal with psycho-social needs such as housing, food, schooling and especially basic security. However, we should not ignore the need to treat acute or chronic mental disorders, both in children and adults.



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Interview with Dr. Muijen, cont.1

Someone recently said that the prevalence of PTSD is grossly exaggerated, and is probably not higher than 10%. I pointed out that 10% of 1 million refugees might test mental health systems in countries that are struggling to cope with existing demands of their current populations.

*Do you have opportunities to work on child and adolescent mental health problems in Europe?*

We have addressed this issue somewhat with the work on intellectual disabilities, which is the mainstay of child psychiatry in many Eastern European Countries, and young people's wellbeing is addressed in the European Mental Health Action Plan, but in all honesty, I am aware we have not given this area the attention it deserves. An explanation, not an excuse, is that in many countries child and adolescent psychiatry is fragmented and under-resourced, even when compared to adult psychiatry. For example, in most countries a large component of child mental health is the responsibility of municipalities. These are very difficult for us to reach, since there are so many spread around countries, and challenges are often local and crossing multiple sectors. At a European level, Child and Adolescent Mental Health Services (CAMHS) are also not well-organized, so we lack connections. I have worked with some organizations representing child psychiatry, but unfortunately the work has proven difficult to sustain. We are open to start a dialogue and to set up some initiatives, since the subject deserves more attention.

*Why is the WHO no longer directly involved in research activities?*

It depends how you define research. Basic research is not our mandate, but identifying best practice and disseminating information is. We collect and publish national data, and we produce reports on subjects such as suicide and epilepsy. Last year we were shortlisted for a Horizon 2020 project, but like most, we failed, which was frustrating because the project had the potential to drive service change in several countries. Some research is done on our behalf by our collaborating centers, of which we have about 15 in Europe, although none focused on child psychiatry. This absence of dedicated centers is clearly an omission. I need to reflect on this, and would welcome a connection.

*How closely does the MHP collaborate with other institutions, for example, the European Commission, the World Psychiatric Association (WPA), and national governments?*

We are strong on this point, and we work closely with all of the above and more. We have recently convened a meeting with agencies representing staff groups active in mental health with the objective to agree upon shared priorities and to combine activities. It is telling that this was the first meeting at a European level of its kind. We have a close partnership with the European Commission (EC), and also with (Organisation for Economic Co-operation and Development) OECD and the Council of Europe. It is not the meetings that matter for their own sake. In the end, the question is how much value they add, and what they achieve. My experience is that a joint representation by international agencies, such as WHO and EC together is taken much more seriously than each on its own. Our mandates are slightly different, so we make an impact from different angles.





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(Interview with Dr. Muijen, cont.2)

*What are the MHP's main challenges for the next 5 -10 years?*

It is a fast changing world, with growing expectations on what the mental health sector should cover, even ignoring the question of what comprises the mental health sector. Up until about 10 years ago, we were focusing on deinstitutionalization and the development of community services. Now population mental health, including promotion and prevention and the interface between mental and physical disorders, are emerging as priorities. More and more people are included as suffering from mental health problems, probably due to a combination of growing stress and more flexible definitions of mental health, and expectations are growing. We are asked questions not only about stress and computer games, the interface between employment and mental wellbeing and health at schools, but also about specialist subjects such as autism, ADHD and dementia. It will be necessary to consider the limits of what can be achieved by the public mental health sector and what the boundaries are between government and personal responsibilities and the public and private sector. Facilitation of this debate will be an exciting opportunity. Our WHO EURO health strategy, Health 2020, raises many of these issues.

*And for those who don't know you, could you tell us a little bit about yourself and how you got to be involved in the WHO Europe?*

Life is a pyramid scheme, and I got here by a great deal of chance. After training as a psychiatrist in Amsterdam and then Cambridge, I became the psychiatrist of a team in London that was part of the first randomized study of the effectiveness of community care in the UK. It was a fascinating experience that taught me a lot about clinical pilots and research. Following this, I became Chief Executive of the Sainsbury Centre for Mental Health, which combined policy, research, service development and training. I worked with some superb people there, and we were politically quite influential. By some luck, at the right time the WHO job came up, and one could argue that it has been an international continuation of my work at the Sainsbury Centre. I have done it for 11 years and it has been tremendously exciting, but the question now is, what next?



This interview was conducted by Prof. Skokauskas and Prof. Guerrero.





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## **7th International Congress of Child and Adolescent Psychiatry in Iran**

Dr. Mehdi Tehranidoost,  
Dr. Rozita Davari-Ashtiani,  
Dr. Katayoon Razjouyan  
(Iran)

Shahid Beheshti University of Medical Sciences, in collaboration with the Iranian Academy of Child and Adolescent Psychiatry (IACAP), orchestrated the 7th International Congress of Child and Adolescent Psychiatry, held on 12-14th May 2015 in Tehran, Iran. Since 2002, IACAP has conducted various workshops and didactic courses and has successfully and continuously held seven international congresses every other year in Tehran and other cities of Iran.

The main theme of this congress was youth violence prevention and mental health promotion. Violence exposure is unfortunately pervasive among youth, irrespective of age, country of origin, and culture. It stunts psychological development and causes behavioral and emotional problems in youth, who eventually carry these problems into adulthood. Thus, one of the most important duties for policy makers, professionals and all people is global reduction and elimination of violence and aggression.

The scientific programs focused on: child and adolescent aggression, parent training in domestic violence, child and adolescent substance abuse, approach to child abuse in Iran, autism spectrum disorder, child and adolescent bipolar disorder and psychopharmacological considerations in children with medical illness.

Renowned keynote speakers Prof. Raymond Bakaitis (USA), Prof. Panos Vostanis (UK) and Prof. Murad Bakht (Canada) presented on topics related to the Congress' main theme. Child and adolescent psychiatrists also had an opportunity to present latest findings on different topics.

Additionally, eight workshops covered: assessment and diagnosis of child abuse, sensory integration in autism spectrum disorder, child anger management, role of parenting in ADHD behavior management, diagnosis and treatment of ADHD in adults, leadership and authority in groups: a group relations experiential workshop, approaches to sexual developmental problems in children and social skills training in children with autism spectrum disorder.

More than 300 professionals – mostly from Iran but also from Switzerland, France, the Netherlands, the United States of America, Pakistan and Bangladesh – attended the Congress, which included nearly 70 oral presentations and more than 400 poster presentations.

The key issues in child and adolescent psychiatry in Iran are mental health promotion in children, adolescents and their families; and education, research and care in collaboration with other organizations. We hope to network and collaborate with other countries and organizations in developing joint programs that can translate the latest findings in education and research.



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## **Trainees' Corner**

### **Out of sight, out of mind?**



Dr. Raissa Tanqueco  
(United States of America)

Hawai'i is known as a tropical paradise, with its year-round sunshine and beautiful stretches of beaches. Tourism is the major source of income, and any deviation from Hawai'i's image of perfection is viewed with hostility, embarrassment or indifference.

However, psychiatrists practicing in Hawai'i are forced to confront – often on a daily basis – the reality of homelessness. In the United States, since 2011, Hawai'i has ranked first in terms of number of homeless per capita per state (Cocke, 2015). Sadly, Native Hawaiians (indigenous to Hawai'i) and other Pacific Islanders are significantly and unacceptably over-represented (at 51%) among Hawaii's homeless.

Ambrose (2013) identified economic (high cost of living, low minimum wages), social (high levels of immigration and migration from the Pacific region), and geographic (limited land) reasons behind the high rate of homelessness in Hawai'i. Cost of housing and cost of living are 149% and 65%, respectively, above national average.

While Hawai'i, as the first state in the nation to have enacted laws insuring near-universal healthcare coverage in the 1970s, is known for its progressiveness and overall relative accessibility of healthcare and social services, it has been challenged – like many other states – with securing the necessary resources and implementing effective policies towards addressing this growing challenge. The National Law Center on Homelessness and Poverty ranked Honolulu ranked eighth nationwide (out of 273 cities) for unfriendly policies (e.g., illegalization of overnight sleeping at most parks, retrofitting of bus stops, displacement from tourist sites, etc.) against the homeless.

Minors constitute approximately one-quarter of homeless service clients in Hawai'i. What is the impact of homelessness on children and youth? The National Child Traumatic Stress Network (NCTSN) emphasized that homeless children, when compared to non-homeless children, are twice as likely to get sick, to go hungry, to repeat a grade, and to have learning disabilities and three times as likely to have emotional and behavioral problems. By the time homeless children reach age eight, one in three has a major mental disorder. What further contributes to the stress of homelessness? Unfortunately, children in homeless families are commonly exposed to violence and other potentially traumatic events (McGuire-Schwartz, 2015), and by age 12, 83% of homeless children have been exposed to violence (National Center on Family Homelessness, 2008). Low-income children exposed to four or more adverse experiences such as neglect and abuse are at increased risk of learning and behavior problems (Burke, 2011). Additionally, homeless youth have higher rates of substance use (Greene, 1997).



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(Trainees' corner, cont.1)

Hawai'i is not an isolated island experiencing the issue.

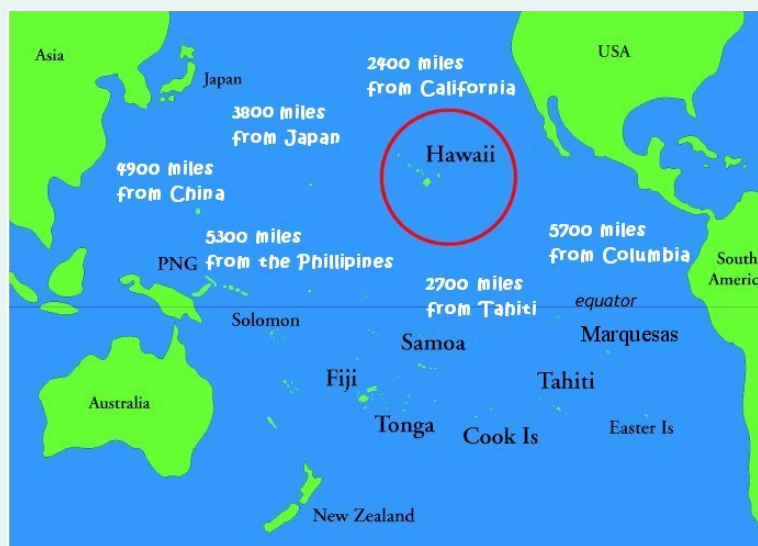
In the U.S., an estimated 580,000 people are homeless, 15% chronically so, spending time between emergency rooms, jails and shelters at a cost of no less than \$30,000 per year (U.S. Interagency Council on Homelessness). How much would this estimate translate to the current 14,282 individuals served by the homeless services system in Hawai'i in 2014 and could this money more effectively be spent in homelessness prevention programs?

It is clear that homelessness has profound effects on mental health. Multiple forms of ongoing trauma, numerous stressors and risk factors, and continuous struggles to meet basic needs perpetuate homelessness as a complex issue, particularly for children. Cohen (2011) suggests that when traumas are ongoing, the therapist needs to validate safety concerns and actively help the parent and child develop realistic safety contingencies that are consistent with the youth's developmental abilities and living situation. Trauma-focused cognitive behavioral therapy can address potential sequelae of violence exposure through its various components, including: psychoeducation, parental engagement and parenting skills, relaxation skills, affective modulation skills, cognitive coping skills, trauma narration and processing, in vivo mastery of trauma reminders, conjoint child-parent sessions and safety enhancement. In parallel, immediate housing, without preconditions of sobriety or compliance, can provide the stability needed for treatment engagement. Pathways to Housing CEO Dr. Sam Tsemberis, quoting from a Mother Jones article, stated: "Why not treat chronically homeless people as human beings and members of our community who have a basic right to housing and health care?"

A multi-pronged approach must therefore be employed to address homelessness, not only in Hawai'i, but in all parts of the globe. As a trainee hoping to learn and implement solutions to this challenge, I hope that this article will stimulate collaboration among colleagues from other nations and communities dealing with homelessness and displacement in children.

Dr. Raissa Tanquedo is a 2nd year resident at the University of Hawai'i John A. Burns School of Medicine Psychiatry Residency Training Program.

References available upon request.





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## Family Mental Health

Use of The Family Model to support family focused practice in mental health services  
'Matching service to need'

Dr. A. Falkov (Australia)

The Family Model (TFM) is a visual illustration of the 6 key elements (Domains) involved in understanding how mental illness in a parent/carer can affect their parenting and their children. In turn, children's needs can impact on parents & other family members in various ways. TFM formed the key conceptual framework underpinning the Crossing Bridges programme and has since been adapted, elaborated and used in individual work with families, as a framework for training and to inform research and policy.

TFM is also being used to develop a (Family Mental Health) module at the University of Oslo/Akershus Postgraduate Masters in Mental Health (MH) course. Piloting will commence in early 2016 and expressions of interest are invited to participate in an evaluation of the implementation of the training course in different service settings in different countries.

### Background

All individuals who experience mental ill-health are, or have at some point been, part of a family. Families play a vital role in everyone's experience of mental illness and ill-health, which, in turn, has a critical and enduring influence on family life. The ways in which psychiatric symptoms interact with and are influenced by the affected individual's unique constellation of relationships will determine onset, course and prognosis of any illness. Mental illness has profound implications for the affected individual and for that individual's network of family and social relationships.

### Scope

The prevalence of adult carers who experience MH problems and the associated impacts of their symptoms on their offspring is now well described, as is the impact of children's difficulties (especially chronic physical and MH difficulties), on parents/carers mental health. There is also compelling evidence for the early onset and lifetime persistence of mental health problems and disorders, as well as role played by resilience, in altering life course trajectories in a positive direction.

Given the prevalence of mental illness, major implications ensue, not only for individuals and families, but also for society as a whole. Psychiatric disorder in one or more individuals within families is therefore a significant public health issue with implications for affected individuals (children, young people and parents), for families, as well for service design and delivery.

### A broader (family focused) approach to practice

A '2-Generation' approach has potential to re-shape current individual-focused services via a broader approach in which the interplay between an individual's psychiatric symptoms and that person's network of key relationships can be acknowledged and incorporated into assessment and care planning. This strategy supports intervention at an earlier age as well as stage of onset, with associated reduction/prevention of lifespan persistence and cross-generation transmission. Any approach which reduces onset, impact and persistence of mental health problems in individuals will have clinical, life quality and economic/cost benefit advantages for families, service providers and for society generally.





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(Family Mental Health, cont.1)

## **The Family Model**

TFM provides a conceptual framework to support a broader approach to practice. It does this by facilitating thinking about affected individuals within their relationship context and by providing the requisite foundation knowledge and associated skills to improve family focused practice for staff in mental health and social care services.

## **Key Principles**

The mental health and well-being of children and adults within families in which an adult carer is mentally ill are intimately linked in at least six ways:

1. Adult/parental mental illness can adversely affect the development, mental health and, in some cases, the safety of children (an adult/parent-to-child influence).
  2. Children, particularly those with emotional, behavioural or chronic physical difficulties, can precipitate or exacerbate mental ill-health in their parents/carers (a child-to-parent influence).
  3. Growing up with a mentally ill parent can have a negative influence on the quality of that person's adjustment in adulthood, including their transition to parenthood (a childhood-to-adulthood family lifespan influence).
  4. Adverse circumstances (such as poverty, lone parenthood, social isolation or stigma) can negatively influence both adult/parent and child MH (an environment-to-family influence), but resilience means that negative outcomes are not inevitable.
  5. The quality of contact/engagement between individuals, families, practitioners and services is a powerful determinant of outcome for all family members (a service-to-family influence).
  6. The above five principles and their interactive relationships all occur within a broader social network encompassing cultural and community influences (a broader, more distal, environment-to-family influence).
- These principles highlight the key areas of relevance and the inter-connections between mental illness, parenting, and children. They also demonstrate the links over time between childhood and adulthood and across generations.

## **Key components**

TFM consists of 6 key elements (Domains) and the associated interconnections between them (represented by 10 arrows). The Domains include adult/parental illness; children's development & MH; parenting & family relationships; risk & resilience; services (for adults & children); and a broader culture & community (ecological) Domain.

TFM illustrates visually the bidirectionality and interdependence between the Domains with arrows. It emphasises the reciprocal role of relationships in determining both good & poor outcomes for all family members when a parent/carers/family member is affected by a mental illness.

How these core components interact with and influence each other determines the quality of an individual's adjustment within his or her family, as well as the adequacy of the whole family's adaptation to living with a mentally ill member.

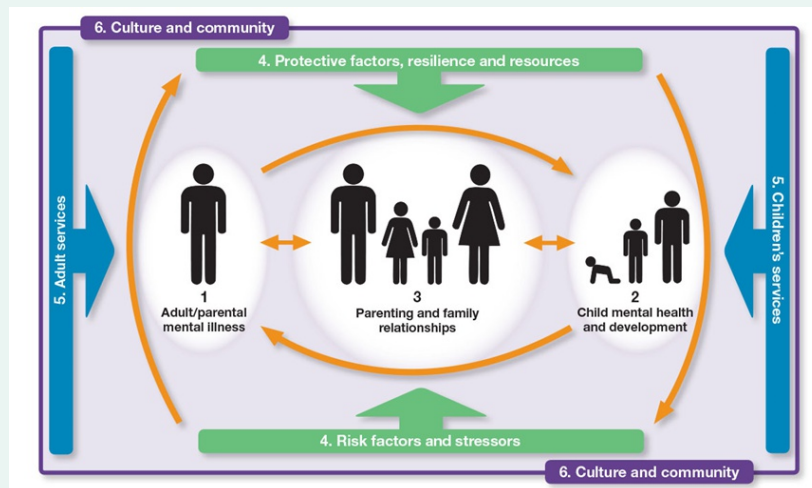


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(Family Mental Health, cont.2)



How these core components interact with and influence each other determines the quality of an individual's adjustment within his or her family, as well as the adequacy of the whole family's adaptation to living with a mentally ill member.

## Lifespan and generational perspective

As well as conveying the relevance of relationships within current family circumstances, TFM also conveys a dynamic perspective of relationship interactions over time (a longitudinal/developmental approach). For example, how multiple factors within and between individuals and their environments interact across the lifespan and between generations. It does this by encouraging thinking about a retrospective ('looking back') and a prospective ('looking forward') approach to practice. Information about need, risk and resilience is used to inform support strategies, treatment plans and recovery. This is based on the evidence linking early adversity with later susceptibility to psychiatric disorder and difficulties in the transition to parenthood – the intergenerational transmission of risk and resilience.

TFM thus provides a comprehensive framework which illustrates the interactions between a parent's illness, the quality of parenting, the parent/child relationship, the individual attributes and needs of a particular child, and the genetic liabilities, family factors and broader social/community supports that will collectively determine the quality of a child's adjustment at any time point. The interplay between individual, family and environmental vulnerability and resilience will amplify or ameliorate the emergence of any difficulty or disorder over time. Given the interplay between family relationships and psychiatric symptoms, the family (regardless of its format, membership etc.) is a valid and justifiable target for intervention. Inevitably, creating an integrated, family focused, MH system of care requires broader reform (3). This includes sustained effort on many fronts, including development and use of evidence – from quantitative population-based public health (how many families? how much impact?) to treatment and prevention (what works, for whom, and how?); to alliances and partnerships for advocacy with consumers and carers across the spectrum of health and social care agencies. Inter-country alliances and partnerships will be an important addition to existing initiatives.



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## 2nd Global Students' Conference of Biomedical Sciences focuses on child and adolescent mental health

Dr. Andrija Jekić (Serbia)

In support of important initiatives among academic institutions globally to provide education in biomedical scientific research, the Second Global Students' Conference of Biomedical Sciences was held from 15th to 18th October 2015 in Belgrade, the capital of Serbia.

Conference goals for attendees were 1) acquiring basic research knowledge, 2) learning presentation skills 3) sharing knowledge and skills with other attendees, 4) networking for the future work, and 5) translating contemporary biomedical science knowledge. Additionally, our conference provided undergraduate, graduate (PhD-level), and postgraduate biomedical sciences students with an opportunity to present and discuss their research findings with colleagues and leading experts from various fields. The conference stimulated global and international collaboration. From a competitive pool of 340 applicants from all over the world, the Scientific Board selected the 218 conference attendants, including 93 presenters.

All participants were honored to attend academic lectures: Autism spectrum disorder (ASD) – from early recognition to successful intervention by Milica Pejovic Milovancevic, MD, PhD (Serbia); Depression in children and adolescents: theory and treatment by Gordana Milavić, MD, F.R.C. Psych. (UK), Networking by Oscar Franco, MD, PhD, FESC, MFPH (Department of Epidemiology, Erasmus MC, Rotterdam, the Netherlands); Saturated fatty acids and cardiometabolic risk – a fresh look of available evidence by Rajiv Chowdhury, MD, PhD (University of Cambridge, United Kingdom).





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## **WPA Child Abuse and Violence Prevention Initiative**

Dr. Gordana Milavić (UK)  
Co Chair , WPA CAP

The WPA CAP Section has been tasked by the President of the WPA, Professor Dinesh Bhugra (UK) to develop a practical approach to managing child abuse and violence across countries. The WPA Child and Adolescent Psychiatry Section has set out to define a set of outcomes at four key levels:

1. At an undergraduate level focusing on medical students with the aim of raising awareness
2. At a specialist training level aimed at learning about the impact on development and mental health, with an emphasis on mental disorders arising / associated with abuse
3. CME /CPD aimed activities for practicing psychiatrists
4. At a broad service level with documents, policies and clinical guidelines aimed at primary mental health and allied disciplines, allied medical specialties and the voluntary sector, bearing in mind each country's legal context, respective government policy including settings when resources are very limited available.

The WPA CAP Section Officers, with the enormous help of Prof. Paramjit Joshi, immediate past AACAP (American Academy of Child and Adolescent Psychiatry) President, met with the AACAPs leading experts in the field of child abuse and violence during the most recent AACAP meeting in San Antonio in October 2015. Judith Cohen M.D., Professor of Psychiatry, Allegheny Health Network, Drexel University College of Medicine, Pittsburgh and Jeanette Scheid, Associate Professor, Department of Psychiatry , West Fee Hall , Michigan State University - both of whom are actively involved in developing and maintaining AACAPs Child Abuse Resource Centre- have agreed to help develop resources encompassing the objectives set out for the WPA CAP task force.

The main aim is to produce a tool which is simple and practical to use and applicable, in some form, even in settings where services are nonexistent. The working group is currently looking at what is already available at a global level and are linking with other international organizations. It is envisioned that some of our completed work will be published via WPA channels.

The WPA CAP Section, with the help of WPA leadership, will take on the role of consulting, seeking endorsement from its members and disseminating the resources. The CAP Section will commit to the implementation of the policies/outcomes through their regional representatives. We are working to a timetable of 12 months from now on.

If you are interested in contributing to the work of the task force please contact Dr Gordana Milavic, WPA CAP Co Chair at [gordana.milavic@slam.nhs.uk](mailto:gordana.milavic@slam.nhs.uk). We look forward to hearing from you.





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## The World Psychiatric Association International Congress in Taipei

Prof. B. Leventhal, WPA CAP Chair

The World Psychiatric Association International Congress (WPAIC) was held in Taipei, Taiwan from 18-22 November at the Taipei International Convention Center. Adjacent to the iconic Taipei 101 tower, the meeting included over 2,000 colleagues from around the world in a meeting that was in collaboration with the 4th Asian Congress of Schizophrenia Research and the 4th Congress of the Asian College of Neuropsychopharmacology. While was a broad based psychiatry congress, WPA CAP was well represented by the presence of many section member, including section Chair Bennett Leventhal, MD, and Co-Chair, Gordana Milavic, MD.

Keynote Speakers in Child and Adolescent Psychiatry included Rutger Van der Gaag (Developmental Disorders (Autism and ADHD ) in Adulthood), Kathleen Merikangas (Bipolar Disorder), and Edmund Sonuga-Burke (Progress in ADHD Neuroscience). Additionally, there were State-of-the-Art Lectures on "Early Intervention as a Priority for World Psychiatry" (Helen Hermann) and "Developing Oxytocin as a Candidate for Novel Therapeutics of Autistic Deficits in Social Intervention and Communications (Hidenori Yamasue). There were also a number of symposia on a variety of issues in child and adolescent psychiatry, including the WPA CAP Symposium on Comorbidity Linked to Mood Disorders with Young Shin Kim (Risk Factors for Suicidality in ASD), Bennett Leventhal (Psychopathology and Suicidality in Bullying), Eunjoo Kim (Relationships between Tics and Mood Disturbance), and Gordana Milavic (Bipolar Spectrum Disorder and Cormorbidity) (see photo bellow). In addition, WPA CAP section officers spent time in discussions with WPA leadership making progress in advancing the agenda of the Section and the visibility of CAP related issues for WPA. Also included in the Congress was a wonderful tour of the National Palace Museum and a gala dinner at the top of Taipei 101. In short, WPAIC was a wonderful opportunity for WPA CAP to be participate in the science, education and policy development in world psychiatry. Being present, visible and active have been a hallmark of WPA CAP and, once again, we have succeeded in making a mark and extending our reach.





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In memoriam. Prof. Jack McDermott Jr.

Prof. Anthony Guerrero (USA)



The World CAP editors join our colleagues in grieving the loss of Dr. John ("Jack") F. McDermott, Jr., who passed away in his home city of Honolulu on December 6, 2015.

An internationally recognized legend in our specialty, Dr. McDermott was former Chair of the WPA-CAP Section, Professor and Chair Emeritus of the University of Hawai'i John A. Burns School of Medicine (UH-JABSOM) ) Department of Psychiatry, former Editor of the Journal of the American Academy of Child and Adolescent Psychiatry, and former Director of the American Board of Psychiatry and Neurology.

World CAP is grateful for the opportunity to have interviewed Dr. McDermott in its December 2012 issue ([http://www.wpanet.org/uploads/Sections/Child\\_and\\_Adolescent\\_Psychiatry/W\\_CAP%202012%20Dec.pdf](http://www.wpanet.org/uploads/Sections/Child_and_Adolescent_Psychiatry/W_CAP%202012%20Dec.pdf)) In this interview, he reviewed our specialty's developments in the past several decades and the growing understanding of the pathophysiology of psychiatric disorders. He also discussed his role in training the first generation of child and adolescent psychiatrists in Indonesia in the 1970's, and the thesis of his recent book (Peoples and Cultures of Hawai'i: the Evolution of Culture and Ethnicity, co-edited with Dr. Naleen Andrade), which describes the "stew pot" model that has profound implications for the global future of our specialty.

Dr. McDermott was a friendly, humorous, and deeply compassionate person who served as "'one of the most important mentors I've ever had'" to many of us in the specialty. He launched the careers of many psychiatrists - especially from underserved and minority backgrounds - who have in turn done pioneering work in addressing mental health disparities, locally, nationally, and globally.

We welcome letters and reflections from colleagues whose lives have been touched by Dr. McDermott.

Pictured: UH-JABSOM Psychiatry Chairs since the medical school's founding in 1965: John F. McDermott, MD (in the centre), Anthony Guerrero, MD , Naleen Andrade, MD; Walter Char, MD (seated).





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60º Congreso de AEPNYA – una iniciativa compartida con la AACAP  
60<sup>th</sup> Congress of AEPNYA – a shared initiative with the AACAP



Junio / June 1 - 4, 2016

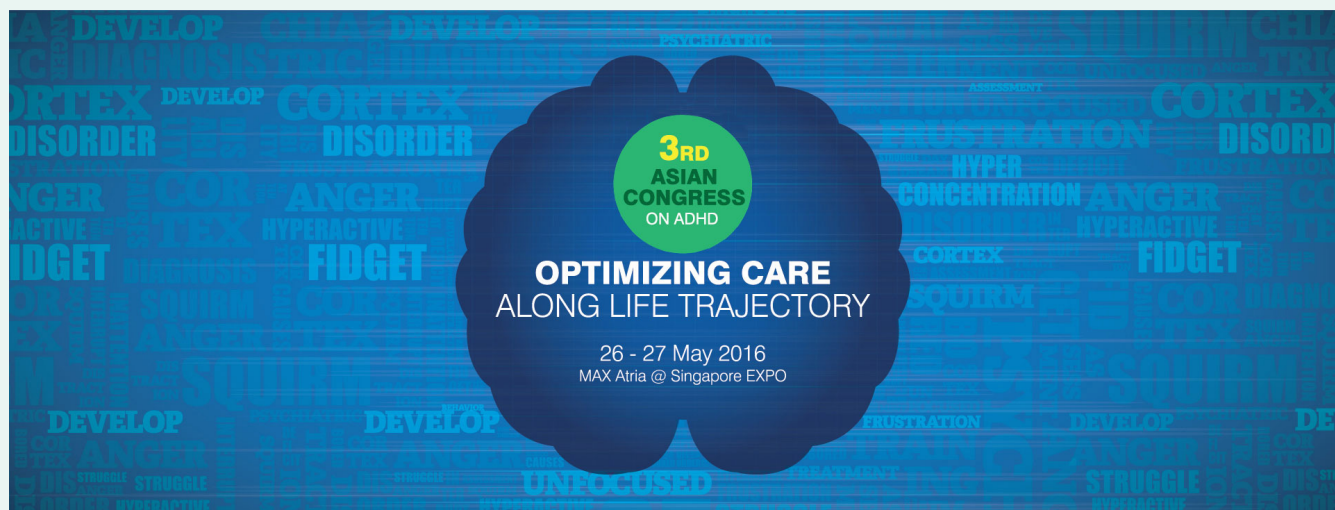
**ABSTRACTS DEADLINE!!**

**SYMPOSIA & CLINICAL PRACTICA: 15th. DECEMBER 2015**

**POSTERS: 15th. JANUARY 2016**

Donostia / San Sebastián (País Vasco – Basque Country / España - Spain)

Capital Europea de la Cultura 2016  European Capital of Culture 2016



**3<sup>RD</sup> ASIAN CONGRESS ON ADHD**

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## **4<sup>th</sup> International Child and Family Behavioral Health Conference**

**ADNEC | Abu Dhabi, United Arab Emirates**



**Save the Dates**

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Prof. John "Jack" McDermott Jr. passed away on December 6th, 2015