



# ***World Child & Adolescent*** **Psychiatry**

ISSUE 14, August 2018

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

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



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

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



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## **Chair's Column:**

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

First, I would like to thank our regular and new readers for their feedback, critical suggestions and support. We very much appreciate you taking the time to write us, to suggest new topics to be covered by the journal. As in every other issue, we have new contributors in this issue. Dr S. Younus (Pakistan), one of the very first child and adolescent psychiatrists to be trained in Pakistan, shares her perspectives on challenges in child and adolescent mental health and child and adolescent psychiatry. This issue features editorials, in-depth perspectives, interviews, conference summaries and updates, and descriptions of programs from around the World.

The editorial board is also pleased to acknowledge that, while the number of journal authors is growing steadily, the journal's audience is growing too. The journal is produced by child and adolescent psychiatrists; however, it is read not only by psychiatrists, but also by allied professionals, decision makers and even some parents of patients. The journal is freely available online, and we share the journal with many colleagues around the World. At the moment, we continuously decline large publishing companies' offers to become yet another open access journal. While open access may well suit other journals, the editorial board of "World Child and Adolescent Psychiatry" believes that journals like ours should be free for both readers and authors. There are already many good open access journals, and "World Child and Adolescent Psychiatry" has already found its niche and its readers.

Like all previous issues, this issue is a product of teamwork. I would like to thank deputy editors Prof. Anthony Guerrero and Dr. Tomoya Hirota, all Editorial Team members for their input and support for this issue: Prof. Bennett Leventhal (USA), Dr. Gordana Milavic (UK), Prof. Dimitris Anagnostopoulos (Greece), Prof. S.Malhotra (India), Dr. D.Fung (Singapore), Prof. S.Honjo\* (Japan), Prof. P.Szatmari (Canada), Dr. J. Abdulmalik (Nigeria), 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. M.B.Moyano (Argentina), Dr. N.V.Tuan (Vietnam), Dr. M. Tateno (Japan), Prof. Paramjit Joshi (USA), Prof. Andre Sourander (Finland), and Prof. Edgard Belfort (Venezuela), Prof. Bruno Falissard (France) and Dr. Vlatka Boričević (Croatia).

Last but not least, we wish to thank WPA President Prof. Helen Herrman for her hard work in supporting the child and adolescent mental health agenda and for sharing updates on the Action Plan in this issue.



Professor Norbert Skokauskas,  
WPA CAP Chair, Norway





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## **The Action Plan**

**WPA President, Prof. Helen Herrman**



As the one-year milestone of my WPA presidency all too quickly approaches, I am delighted to share with readers just one of the ways in which we are bringing to life the 2017-2020 Action Plan. With each new term of Presidency at WPA, an Action Plan is implemented that builds on the Association's preceding work and refreshes focus on how we can increase psychiatry's positive impact on mental health globally. Our 2017-2020 Plan focuses on how we can strengthen the contribution of psychiatrists in regional or national responses to conflicts, emergencies and adversity. In particular, it provides a targeted strategy for reaching people, particularly young people, who face adversity and disadvantage.

Earlier this year, we took our first major steps toward executing this strategy when WPA representatives met in Madrid with colleagues from citiesRISE and the Juan José López-Ibor Foundation to discuss its practical implementation. Over two days, 17 leaders representing the three organisations – including Chair of WPA's Child and Adolescent Psychiatry Section Norbert Skokauskas – worked together to plan and define the necessary actions, people, resources and knowledge required to move ahead. We made good progress. Our vision of “a world in which young people are supported to grow up, develop resilience and lead productive lives by mainstreaming mental health,” provided a good starting point for our planning. We talked about how, through our collective efforts, we can link local action with our global network to accelerate uptake and spread of best practices and approaches – and build conditions in society that support psychiatrists to contribute to community efforts in practical and creative ways. We considered how WPA working in partnership with citiesRISE, the Foundation and others might best support those at high risk of developing mental health problems (for any reason) and those who are already experiencing mental health problems. We talked about how, through prevention and promotion, we can also support those without health problems.

A long-term goal of WPA has been to develop and leverage partnerships that will enable psychiatry to have a stronger, clearer voice in the mental health sphere. Recognising the role of technology in today's world, we made a commitment to consult with innovators in the development and use of digital technologies in psychiatry. This recognises the opportunities technology provides to harness the energies and commitment of young people working to improve mental health in cities and their surroundings. Many organizations have worked for a long time to tackle the global challenges in mental health that also concern WPA. By utilizing the citiesRISE platform, mobilising the professional knowledge and resources of WPA, and collaborating with the Juan José López-Ibor Foundation among others, we have a very real opportunity to effect change. Community resilience and early action are critical for responding to mental health needs in adversities and emergencies – and through this program WPA will enable psychiatrists to play their critical role as advocates, facilitators, trainers and clinicians. I look forward to continuing contact with the Section as we develop the program's activities.



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## **Child and Adolescent Psychiatry Research Training**

**Prof. Bennett Leventhal (USA)**



Child and Adolescent Psychiatry is a medical discipline that address child and adolescent development and well-being, as well as variations that lead to developmental psychopathology. Many have suggested that Child and Adolescent Psychiatry is the very embodiment of the practice of the “art” of medicine and it requires clinicians to be more “intuitive” and deduce meaning from the behavior and language of the youth in our care. The assumption here is that children and adolescents cannot ably speak articulately for themselves and that there is not an empirical base to lead us to the understanding clinical material available to the practitioner. Regrettably, these sorts of assumptions may lead to misunderstanding about the disorders in the domain of Child and Adolescent Psychiatry as well as diminished appreciation for the work of Child and Adolescent Psychiatry and its practitioners. In turn, this leads to policy decisions that place our patients at a distinct disadvantage with diminished access to care, substandard care when it is available, and inadequate accommodations to the associated disabilities, as well as stigma and discrimination.

From where do these problem emanate? While the misperceptions of Child and Adolescent Psychiatry and developmental psychopathology are often in the eyes of the beholder, Child and Adolescent Psychiatrists and our colleagues in related disciplines have played roles in the creation of the problem. And, we can play roles in the solutions.

First, we must start with definitions: “Medical practice” is not an “art.” Rather, it is the careful and informed application of empirical data to foster well-being while also preventing and treating morbidity and mortality, including that associated with developmental psychopathology. Many excellent practitioners are “artful” in the practice of medicine but art without data is negligence, if not fraud. “Well-being” is the capacity to appropriately adapt to the environment in order to sustain homeostasis and the continuous, orderly developmental progression to health, the experience of personal satisfaction and the maintenance of supportive interpersonal relationships all of which contribute to a positive sense of self and community. “Developmental psychopathology” is a perturbation in brain development that disrupts behavioral, emotional and/or cognitive function, consequently interfering with adaptation. So, how is this all relevant to Child and Adolescent Psychiatry? Like many medical and scientific disciplines, Child and Adolescent Psychiatry began with astute observation of clinical phenomena: histories, signs and symptoms. These observations were reported by parents, educators, philosophers, clinicians, scientists and others. This diversity led to massive and diverse set of conclusions about clinical significance and causality/etiology of behaviors and syndromes. This collection of anecdotes took place over the course of millennia and provided the foundational data for the field. However, it was the application of the scientific method – rigorous testing of hypotheses, including the null hypotheses - to these data that marked the beginning of the medical practice of Child and Adolescent Psychiatry. As with most other medical specialties, it is not entirely clear when this began but it is now clear that the scientific method is vitally important Child and Adolescent Psychiatry. Equally importantly, the depth and breadth of this research is equal to that in other areas of medicine suggesting that Child and Adolescent Psychiatry is



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worthy of the respect and a meaningful place in the “house of medicine,” medical practice and the medical community. As is often the case, advances in science and practice come with “good news” and “bad news.” So it is for Child and Adolescent Psychiatry. Our recent history, and in some cases, our present, was focused on anecdotes/single case reports. That this was central to our past is understandable but it is not good news that, for many of our colleagues, this model persists in the present. The good news that there is a rapidly developing corpus of empirical research to support the practice of Child and Adolescent Psychiatry. This comes from Child and Adolescent Psychiatrists and colleagues in related disciplines such as psychology, neuroscience, neurology, pediatrics, education, to mention a few. And, often this science is the product of multidisciplinary teams that reflect the nature of the knowledge and current standards of practice in Child and Adolescent Psychiatry. This is good news for the field and even better news for our patients.

But, alas, with the strong empirical base for our field comes some very particular challenges. As it turns out, much of the research supporting our understanding of human development and developmental psychopathology is not conducted by Child and Adolescent Psychiatrists. Why is this the case? Quite frankly, training in Child and Adolescent Psychiatry remains seriously lacking of critical elements:

1. Few programs are diligent in requiring their trainees to read the literature
2. And for most those that require disciplined reading of the literature, they fail to teach their trainees how to read the scientific literature.
3. Fewer training programs have the capacity to give their trainees experience with research
4. Even fewer training programs have the capacity to provide training in research methods and practice.
5. Trainees in other disciplines, especially psychology, are well-trained in the conduct of research so our trainees learn to defer to them on matters of science.

This is not idle speculation. I have visited training programs and with trainees all over the world and repeatedly found that they may have read a textbook or two and heard of “Little Hans” but did not recognize the name “Michael Rutter” and never hear of the Isle of Wight, Dunedin, MTA, TADS or other important studies. And, those that recognized this iconic work, few knew little of the details. Of course, this means that is a very rare Child and Adolescent Psychiatrist who complete training with the ability to successfully compete in the research world. Those that successfully enter research careers do often have

PhD's and/or complete post-doctoral research training, if it is available. Of course, they also have to be lucky enough to find a faculty position in Child and Adolescent Psychiatry research. Taken together, this represents nothing short of a crisis for Child and Adolescent Psychiatry.

If we are to manage our future, we must increase the number of Child and Adolescent Psychiatrists who can and will do research. A few, select training programs around the world are doing this. These programs are treasures that must be supported but the output is too small. While more research training programs develop, there are other opportunities that offer some hope for Child and Adolescent Psychiatry research. A few examples include:



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1. **Child and Adolescent Mental Health/Psychiatry MSc Course, Institute of Psychiatry, Psychology and Neuroscience (IOPPN), King's College, London:** Just celebrating its 30<sup>th</sup> Anniversary, the IOPPN Course lasts 2 years. It has a distinguished faculty that teaches a broad curriculum and provides experience in conducting research with experienced mentors

2. **International Training Seminar in Child and Adolescent Psychiatry, Fondazione Child, Italy:** The 15<sup>th</sup> edition of this course will take place in Rome in 2019. This is a full week long seminar for junior Child and Adolescent Psychiatrists from around the world (26 countries on 6 continents last year). It includes some 25 didactic sessions and colloquia presented by 20+ international faculty. In addition, there are daily mentoring sessions in which trainees can present and develop their research ideas with faculty mentors. Not only do the trainees learn research methods but they also build a network of colleagues to support their future work. The entirety of the tuition, room and meals are provided at no charge to trainees by Fondazione Child.

3. **Helmut Remschmidt Research Seminars, International Association of Child and Adolescent Psychiatry and Allied Professions (IACAPAP):** This is a biennial short course that takes place at the time of the meeting of IACAPAP. A distinguished international faculty discusses a major theme on which there are research presentations. Then senior mentors provide guidance for the trainees on their own project. In the process, trainees meet faculty and colleagues from around the world who can support their future research endeavors.

4. **Kyiv Research Training Seminar in Child and Adolescent Psychiatry, Kyiv, Ukraine:** Under the direction of Irina Pinchuk, Director of Ukrainian Research Institute of Social and Forensic Psychiatry and Drug Abuse, this course brings together both international and Ukrainian faculty. It provides basic training in the principles of research in Child and Adolescent Psychiatry. Largely focused on junior faculty and trainees from Eastern Europe and Central Asia, this seminar is an exciting opportunity to build research infrastructure in this region. The courses provide a ray of hope but they must be seen as just a beginning. And, rather than being the source of research training, they must come to supplement Child and Adolescent Psychiatry training program experiences. The trainees must then be taught how to apply this evidence base (perhaps artfully) to their practice. Implicit in this work is the understanding that education does not stop at the end of training but the well-prepared trainee should be an excellent consumer of science throughout their career.

Einstein said, "Imagination is the highest form of research." Will we have the courage to imagine a different future for Child and Adolescent by carrying out a mandate to conduct and consume research as an integral part of Child and Adolescent Psychiatry? That remains to be seen. But, if we don't participate in and effectively utilize the science that underlies our work, we will likely perish as a profession. And, that will surely be bad news for us and for those who depend on us for care.





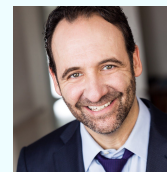
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## **“BORN TO BE WILD”**

### **Interview with Professor Jess Shatkin (USA)**



*1. First of all, would you tell us a bit about yourself and also explain what made you decide to write this book?*

I am the Vice Chair for Education and Professor of Child & Adolescent Psychiatry and Pediatrics at the NYU School of Medicine. I see patients at NYU, Bellevue Hospital, and Rockland Children's Psychiatric Center. I lead our child & adolescent psychiatry fellowship, direct our weekly grand rounds, and am the founder and director of the national's largest child and adolescent mental health undergraduate studies program at the NYU College of Arts and Science (which instructs over 4,500 students annually) in 48 unique, full-credit college courses. I have also hosted “About Our Kids,” a weekly call-in satellite radio program broadcast across North America on SiriusXM's Doctor Radio, Channel 110, for the past 10 years.

I was driven to write this book by my own life experiences (including the death of a close friend during childhood due to risky behavior) and based upon my clinical experience as a pediatric psychiatrist. I was fortunate to have a pretty stable and happy childhood myself, although I was surrounded, as most kids are, by risk and made plenty of bad decisions. As my own children entered adolescence, I became much more interested in this topic (as one does!), and I found that I had plenty to learn.

*2. We are aware that there are several books previously published that tried to provide readers with an in-depth understanding of teens. How is your book different from previously published books?*

What makes “BORN TO BE WILD” different from prior books is not the attention it pays to the adolescent brain; rather, it is the focus on adolescent decision-making and risk-taking that separates “BORN TO BE WILD” from the pack. Understanding neuroanatomy and neurophysiology is important in helping us to know our children better, but we will only help keep them safe if we understand not only the brain, but also evolutionary biology, peer relationships, life experiences, and the myriad ways we variably interpret data at different times in our lives. These factors are at the core of “BORN TO BE WILD”, and they make the book a vital companion to all that has come before.

“BORN TO BE WILD” reveals the “Wow!” of adolescent decision-making and risk-taking. Unlike the books that have come before, it's not only about brain science. Rather, through clinical vignettes and deeply personal tales of adolescents, parents, and the scientists themselves, BORN TO BE WILD uncovers how this research came to be, why it matters, and how we can translate it into a life preserver for our children.





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Interview with Prof. Shatkin (Continued)

*3. I was impressed by a wide range of information on teens in this book, including historical understandings of teens' risky behaviors, and updated scientific findings (neuroscience, intervention studies, etc). Could you share challenges you faced in writing up this book?*

I think the biggest challenge I faced was relearning much of what I had been taught as a student and resident over the many years that I studied human development. It's terribly exciting and a bit frightening to realize that what you thought you understood isn't entirely correct. It's great to be in a field where you can keep learning and question your assumptions, of course, but it's also a bit scary – we want to “get it right” and understand things as they truly are so that we can help our patients, but sometimes our prior learning and assumptions get in the way. So along with reading hundreds upon hundreds of studies and dozens of books, I also verified a lot of what I was newly coming to understand by speaking to the researchers who did the work and who are leading us to a new understanding of adolescence. Excerpts from my discussions with these scientists are also featured in the book.

*4. Assuming that the majority of readers of our journal are professionals caring for children and adolescents with mental illness, would you explain how they can utilize knowledge and skills from this book in their clinical practice?*

The book itself is written as a bit of an exploration, taking the reader into this new way of thinking about adolescence. In the first two chapters, I describe how adolescents really think about risk and risky behavior. In the next three chapters, I describe what we now understand about why adolescents actually take risks, and I give many examples along the way.

In chapters 6 and 7, I describe how adolescents make decisions, which pulls on the field of behavioral economics; and finally, in the last three chapters, I lay out new strategies that we can use with our patients, our children, in schools, and in society in general to address risk effectively in kids. While the societal and school-based strategies may take many years to accomplish, there are many individual-level strategies that we can employ with our patients right away – using behavioral parent management techniques, for example, enhanced supervision, managing screen time, reframing how we reward our teens, and the cognitive strategies we employ when talking to our kids about risk are all described.

Many of these techniques will be a departure from business as usual for our colleagues, as some were for me when I began using them. The take home point is that we need to stop bombarding our kids with risk statistics and focus more on the emotional salience of risk and practicing with the use of effective strategies to mitigate risk.



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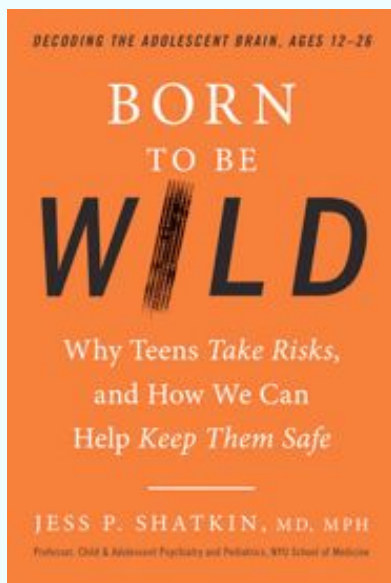
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Interview with Prof. Shatkin (Continued)

*5. What projects are you currently involved in child and adolescent mental health field? Could you also share with readers your aspirations in this field for the next 3-5 years?*

At heart, I am a clinician and medical educator. Through my work with undergraduates, a number of research interests have emanated, including an intervention designed to enhance college student resilience, and a second focused on improving college students' sleep. My group has published pilot studies in each of these areas, and we are now engaged in randomized, controlled trials. I also continue to see patients each day, supervise and teach residents and medical students, and write and speak about my work throughout the U.S.. Over the next 3 – 5 years, I hope to continue these endeavors, further identifying strategies that work to improve the resilience of college students, and train my new Dalmatian puppy to be a therapy dog.

*Interview was conducted by Dr.T. Hirota (Deputy Editor)*





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## Ask About Trauma

Dr. Ghiasuddin (USA)



Dr. Helen Hermann has made girls and young women's mental health a priority for her term as president of the World Psychiatric Association. With that charge, let us spend some time looking at some of the challenges girls face globally, and what we as child psychiatrists can do to foster resilience and healthy lifestyles.

In the United States, the #metoo (The MeToo) Movement began in October 2017, after the allegations of sexual harassment and assault against media mogul Harvey Weinstein became public. Scores of women became empowered to speak out about their own experiences with sexual abuse, a topic that is commonly hidden behind shame, fear and stigma. The movement has encouraged awareness and empathy about the topic, especially as it relates to young and at-risk women. The discussion around sexual harassment and abuse has spread internationally, and a spin-off movement of MeTooK12 focuses on preventing sexual abuse in the kindergarten through 12<sup>th</sup> grade school settings.

How large is the impact of sexual abuse? Global estimates of around 120 million girls under the age of 20 (about 10% globally) experience some form of sexual abuse (estimates for boys is roughly a third of that), with some countries as high as 34%. In the United States, approximately 17-25% of girls under the age of 18 have experienced some sort of sexual abuse. That is 1 out of every 4 girls. Think about how many patients we see everyday. Do those numbers jive with your clinical experience? If not, it may be because sexual abuse is something that carries a significant amount of fear, shame, guilt and stigma with it, and patients may not feel comfortable or safe talking about it. Or perhaps we as providers are uncomfortable with the topic and we dance around it as well.

So what can we do? As child psychiatrists, we are in a unique position to serve as developmental facilitators for youth who are dealing with a variety of challenges: substance use, school failure, chaotic and abusive home environments, mood disorders, psychosis. Many times, these young people are in need of support and guidance from a stable, responsible adult when no one else is available to fill that role. Many of the youth in our clinic access our services more frequently and regularly than they do their pediatrician or family medicine physician (places where they might otherwise seek advice about issues regarding sexual health and safety).

With that being the case, I encourage all clinicians who work with young people to do the following:

- **Ask about sexual health and provide education on safe and healthy sexual practices:**

In many cultures and communities, this is a taboo topic that may not even be discussed properly in the school setting, let alone the home setting. The child psychiatry clinic is an appropriate place to provide this type of anticipatory guidance.



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- **Ask about trauma:**

Become comfortable bringing up this topic with your patients in a safe and reassuring way, keeping in mind the stigma and shame that comes with being a victim of sexual (or any kind) abuse. Intimate partner violence (date rape or assault) should also be discussed. Become familiar with your local laws regarding reporting any abuse that has been disclosed (in the United States all healthcare providers are mandated reporters when there is suspected abuse in children).

- **Become familiar with local agencies that specialize helping young people heal from sexual trauma.**

Many child psychiatrists are experts in providing evidence-based, trauma focused psychotherapy. However, community, peer and family support can also be of tremendous help and should be offered when available.





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## **Why We Need Compassion Training for Children in Schools: The Case for Compassion**

Dr. Richa Bhatia (USA)



A latency age, underweight child sees 'fat hanging' from her or his body. An attractive, well-educated acquaintance thinks her or his face looks like a 'cabbage'.

How often do you hear someone criticize or put down their own appearance, their work, their body, hair or other attributes? Over the years, I have noticed one common theme. People of all ages, whether age 7 or 77, seem to be exhibiting excessive self-criticism and a lack of self-compassion. Children are not born self-critical. They may acquire this from well-meaning, self-critical or critical parents, teachers or others around them. Many people mistakenly believe that self-criticism helps them stay motivated and keeps them accountable to themselves, but, research has shown that excessive self-criticism has detrimental effects on psychological well-being, mood and self-worth. Excessive self-criticism is linked with increased risk of depressive, anxiety disorders, poor body image, obsessive compulsive disorder and poorer coping skills. Among female adolescents in grades 9-12 in the U.S. during 2013, 1 in 5 seriously considered attempting suicide in the previous 12 months. Besides other traits and symptoms, excessive self-criticism is a core feature present among many suicidal teens, and it's not surprising given low self-worth is characteristic of depression. However, excessive self-criticism seems to have become a problem with a life of its own. It is worthwhile noting that excessive self-criticism has been found to be a predictor of depression and is associated with poorer response to psychotherapy treatment for depression. Not only psychiatric patients, but, seemingly healthy and high functioning people seem to be engaging excessively in self-criticism as well. High achievers and women appear to be affected by this malady at somewhat higher rates, but, overall, excessive self-criticism affects people from all walks of life.

The antidote to self-criticism is self-compassion. While many treatments for depression, anxiety, eating disorders, obsessive compulsive disorder need to be medication based or biological, and it is important to implement suitable treatment interventions for each individual, however, given lack of self-compassion is affecting a significant proportion of people, we also need system-based, preventative interventions in addition, to address this growing lack of self-compassion in the world.

Let's examine the other side of compassion- compassion towards others. Self-compassion and compassion towards others are closely inter-twined. In addition to the high rates of depressive and anxiety disorders across the world, we are in the midst of other epidemics or impending epidemics.

One of these epidemics is of bullying. Bullying is highly prevalent at workplaces as well as schools. A UK anti-bullying group mentions alarming statistics, such as 45% of young individuals found to have been bullied during childhood or teenage, and 36% of young individuals concerned about getting bullied at school or college.<sup>3</sup> Bullying erodes self-esteem, negatively impacts mood and functioning, leads to



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## *Compassion training (continued)*

anger, resentment and increases risk not only of bullying behavior among the victims, but also, of depressive, anxiety symptoms and suicidality. Research shows that the harmful sequelae of bullying can persist into adulthood.

An epidemic of loneliness is also looming large over the western world. Britain appointed its first loneliness minister earlier this year. The 19<sup>th</sup> Surgeon General of the United States, Vivek Murthy, announced loneliness as an epidemic in the United States. Reviews of studies show that loneliness is linked with increased risk of coronary heart disease, stroke and early mortality. A recent study showed that young people who were lonely were also more likely to have been bullied as children. Excessive self-criticism, shame, fear of rejection have been linked with loneliness.

In addition to bullying and loneliness, we all are aware of many parts of the world ravaged with years of crisis, conflict and trauma. Not to mention daily, relatively minor instances of compassion deficit many of us encounter, such as road-rage, microaggressions, and the like.

While there are undoubtedly many complex biological, psychological, environmental and social factors that underlie the above-mentioned problems and I do not wish to simplify these or insinuate that one intervention can address all of these, however, one common theme that underlies at the core of these different problems is a deficit in compassion- be it compassion towards others or compassion towards self. We do see and hear about wonderful acts of compassion all the time, however, overall, the world seems to be going through a compassion deficit.

We often think of compassion as a basic, simplistic or moral value, and sometimes for this reason, people may dismiss or ignore its value, but, compassion has the potential to transform several aspects of these epidemics. The benefits of compassion have been proven by research. Compassion training has been linked to neural changes in brain areas associated with 'social cognition and emotional regulation', such as parts of the parietal cortex and dorsolateral prefrontal cortex (DLPFC). Moreover, compassion is trainable

### **Benefits of Compassion Training:**

What is compassion? Compassion means noticing someone's suffering, with a strong desire to relieve that suffering. Compassion training teaches compassion towards self as well as others. Different methods of compassion training have been tested in research. Studies show that compassion training decreases anger, rumination, even depressive and anxiety symptoms. Compassion training benefits both the giver and the recipient of compassion. Compassion training improves positive emotions, ability to self-regulate, social connectedness, and prosocial behavior. Compassion training has been shown to have positive physiological effects, specifically, an improvement in heart rate variability.

Many people have an easier time being compassionate towards others than towards their own selves. However, without self-compassion, there develops a deficit in the net compassion reservoir eventually, leading to a decline in the ability to be compassionate towards others. Self-compassion allows the



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## *Compassion training (continued)*

recognition that suffering, mistakes and failures are universal and are part of the human condition. It allows for acceptance, non-judgement, while making one more aware of shortcomings as well as strengths. Self-compassion is an antidote to self-criticism. Self-compassion has been shown to confer enhanced resilience, a more stable sense of self, protection against PTSD, more positive body image and 'body appreciation' and better interpersonal relationships.

Some schools have started mindfulness training for children and teens, however, at this time, we need more than mindfulness. And, compassion training also involves a component of being mindful. Regular compassion training in schools can address the bullying epidemic. Greater compassion towards self and others enhances social-connectedness and thus, could benefit the loneliness crisis. The ability to be self-compassionate has also been shown to confer positive coping skills, so, there is potential for its benefit in the arena of substance use as well. Until every individual learns how to practice compassion towards self and others, it would be difficult to address each of these growing public health concerns on an individual basis.

Why don't we teach compassion at schools when it not only improves all domains of individual emotional well-being, but also, can alter neural connectivity to build greater altruism? Aristotle once said- '*Educating the mind without educating the heart is no education at all*'. While we are teaching children extensive details of geography, history, math (which may certainly be beneficial in the long-term and help intellect), we need to prioritize training our future generations in practicing compassion, so, that the path to a peaceful, healthier and happier world can be paved, starting now. Childhood is the time when rapid brain growth and development is taking place; the brain is like a sponge in terms of learning and grasping new concepts, skills and tools. Happiness, psychological and physiological well-being, life-satisfaction are all positively influenced by compassion towards others and compassion towards self. Given compassion can help create positive emotions, greater self-regulation, social connectivity, life-satisfaction, and can decrease violence, bullying, abuse, depressive, anxiety symptoms, stress and loneliness- compassion training is the need of the hour. Imagine how powerful it would be if every child learnt to practice compassion at school, the way every child learns to read or write. Compassion training is not a luxury for our world anymore, it is a necessity.



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## **mhGAP in Preservice Training in Child and Adolescent Mental Health**

Prof. A. Guerrero (USA) and Prof. N. Skokauskas (Norway)

### *Mental health disorders in children and adolescent are common*

The estimated 2.2 billion children and adolescents constitute nearly one-third of the world's population. Approximately one fourth of youth have experienced a mental health disorder during the past year, and about one third across their lifetimes. Of all mental disorders, about half begin to develop before the age of 14 and by the age 25, 70% of all mental disorders have begun to develop.

### *There are effective strategies to help children and adolescent with mental health disorders*

The last decade has seen a rapid expansion of scientific knowledge in the field of child and adolescent mental health and has provided a new understanding of the underlying pathology of mental disorders in children and adolescents.

### *Relatively few health and allied professionals are trained to help children and adolescent with mental health needs*

Even today more than ever, we know how to manage (though not yet cure) many mental health disorders. However, many children and families are not getting help.

There remains a wide gap between available health systems capacity and resources. What is urgently needed, and what is available to reduce the burden is far apart. Only 1% of the global health workforce provides mental health care and only a fraction of it is with children and adolescent. Recognizing the imperative to provide services for people with mental, neurological and substance use disorders and their carers, and to bridge the gap between available resources and the large need for these services, the WHO Department of Mental Health and Substance Abuse launched the Mental Health Gap Action Programme (mhGAP).

WHO launched its Mental Health Gap Action Programme (mhGAP) in 2008, and the first Intervention Guide (mhGAP-IG) in 2010. mhGAP-IG provides evidence-based guidance and tools for assessment and integrated management of priority MNS (mental, neurological and substance use) disorders. mhGAP-IG implementation in any pre-service training remains very limited. This is a missed opportunity to expand the number of knowledgeable service providers not only in low and middle income countries.

Preservice training is training that takes place in undergraduate and graduate programs prior to becoming a professional.





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An Informal Consultation Meeting on mhGAP in child and adolescent mental health training took place on the 25th of July, 2018 during IACAPAP. The aim of this meeting was to bring together professionals responsible for and involved in preservice mental health training, to update them on mhGAP-IG, and to explore future opportunities to use mhGAP-IG.

Several pre-service training areas were discussed at the meeting including: using mhGAP-IG as a guide for medical students during clinical placements, introducing mhGAP-IG in public/mental health master's programs, using mhGAP-IG in pre-service training for nurses, psychologists, social workers, and other allied professionals

A total of 31 teaching child and adolescent mental health specialists attended, representing 21 countries. If you would like to receive more information about the meeting please contact Prof. Norbert Skokauskas at [norbert.skokauskas@ntnu.no](mailto:norbert.skokauskas@ntnu.no)

References available on request.





## **Mapping the CAMHS-AMHS Interface across European Mental Health Services – insights from the MILESTONE project**

Giulia Signorini (Italy), Lesley O'Hara (Ireland), Bernardo Barahona Corrêa (Portugal), Véronique Delvenne (Belgium), Gwen Dieleman (Netherlands), Roberta Dochnal (Hungary), Katarina Dodig Čurković (Croatia), Rosa Calvo (Spain), Nestor D. Kapusta (Austria), Gerasimos Kolaitis (Greece), Sabine Loos (Germany), Fiona Mc Nicholas (Ireland), Julie Nordgaard Fredriksen (UK), Santosh Paramala (UK), Moli Paul (UK, Austria), Eva Pollak (France), Diane Purper-Ouakil (Germany), Frédéric Russet (France), Aurélie Schandrin (Germany), Silvia Schneider (Germany), Ulrike ME Schulze (Germany), Swaran P Singh (UK), Cathy Street (UK), Sabine Tremmery (Belgium, Netherlands), Helena Tuomainen (UK), Therese van Amelsvoort (Germany), Jörn von Wietersheim (Germany), Giovanni de Girolamo (Italy) for the Milestone Consortium.

### **Milestone Consortium:**

Swaran Singh, Helena Tuomainen, Jason Madan, Moli Paul, Cathy Street, Dieter Wolke, Jane Warwick, Priya Tah, Alastair Canaway, James Griffin, Rebecca Appleton, Amanda Tuffrey, Anna Wilson, Charlotte Gatherer, Leanne Walker (University of Warwick, UK); Giovanni de Girolamo, Giulia Signorini, Alessandro Ferrari, Elisa Gheza, Cecilia Ferrari, Laura Rivolta, Flavia Levi, Maria Cataldo, Lidia Manenti, Giorgia Morini, Adriana Pastore, Cecilia Toselli, Pamela Varvara (Saint John of God Clinical Research Center, Italy); Paramala Santosh, Natalie Heaney, Jatinder Singh (Kings College London, UK); Diane Purper-Ouakil, Frédéric Russet, Virginie Maurice, Véronique Humbertclaude (Centre Hospitalier Universitaire de Montpellier, France); Athanasios Maras, Larissa van Bodegom, Mathilde Overbeek (Yulius Academy, Netherlands); Ulrike Schulze, Jörg M. Fegert, Paul Plener, Melanie Saam, Ulrike Breuning, Renate Schepker, Michele Noterdaeme (University of Ulm, Germany); Sabine Tremmery, Gaëlle Hendrickx (Katholieke Universiteit Leuven, Belgium); Fiona McNicholas, Aleksandra Gronostaj, Rachael McKenna (University College Dublin, Republic of Ireland); Tomislav Franić, Nikolina Davidović (University Hospital Split, Croatia); Kate Lievesley, Federico Fiori (HealthTracker Ltd, UK); Frank Verhulst, Gwen C Dieleman, Suzanne Gerritsen (Erasmus Medical Centre, Netherlands); Andrea Wohner (concentris research management GmbH, Germany)

Adolescence is a time of particular vulnerability to mental illness. Early intervention by health care professionals is of importance, however, only around a third of young people actually access Child and Adolescent Mental Health Services (CAMHS). Lack of appropriate service provision as well as minimum symptom thresholds contribute to this disparity. Disruption of care is also likely once young people reach the upper age limit of CAMHS, a problem linked with the way in which mental health services have been structured.

### **A mapping initiative**

An international comparison of service provision can help improve the understanding of best practices regarding service structure and accessibility, and for reducing financial and organizational barriers to care. This is one of the aspects that the MILESTONE project (see <https://www.milestone-transitionstudy.eu/>) has attempted to portray: a recent online survey (Signorini et al 2017, 2018, see the website) mapped systematically the configuration, characteristics, and activity of CAMHS as well as the interface with Adult Mental Health Services (AMHS) in Europe.

Complementary with this quantitative approach, a comparison of 14 EU member states experiences has been conducted, enabling a more exhaustive discussion of CAMHS-AMHS interface lights and shadows, which affect continuity of care for young people with mental health problems in Europe. A European expert panel meeting on child and adolescent psychiatry services was hosted as part of the MILESTONE



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project in Madrid at the start of the project (2014). Experts from 14 different European countries were invited to give presentations on the situation in their country, with a special focus on the CAMHS-AMHS interface: a very brief summary of these reports is shown below. All experts joining this initiative consented to be part of data collection and their contribution is acknowledged here (Table 1).

## **Austria**

Transition from CAMHS to AMHS occurs at the age of 18. While there are no official guidelines to advise on the process of transition between services, good transition is facilitated by a legacy of working relationships between CAMHS and AMHS professionals.

## **Belgium**

Outpatient mental health services are available to young people up to the age of 18 years. Psychiatric inpatient services for young people aged 15 to 23 years are placed in general and psychiatric hospitals. There are no specific policies guiding the transition from CAMHS to AMHS.

## **Croatia**

The transition boundary in Croatia has recently moved from 21 years of age to 18 years of age. However, it is reported that this shift in boundary has not been systematically applied with many services operating in a 'grey area'.

## **Denmark**

The transition boundary between CAMHS and AMHS varies across the five regions in Denmark, ranging from 18 to 21 years old. There are no national guidelines for the transitional care. It is estimated that approximately 400 young people were referred from CAMHS to AMHS in 2013; in the year 2012 1,649 patients were discharged from CAMHS.

## **France**

There is no upper age boundary of care in CAMHS but AMHS can take care of adolescents aged 16 and above. Recently, specific inpatient and outpatient facilities for adolescents have been created, called 'Maison des Adolescents' (MDA). Although transitional care between CAMHS and AMHS is planned in some regions, there are no systematic guidelines or policies around transition, with some young people with enduring mental health needs undergoing multiple transitions (e.g at 16 years and later towards 20-25 years via CAMHS, adolescent facilities and AMHS).

## **Germany**

Although the provision of child and adolescent mental health care in Germany differs from many other European countries being provided through private physicians on an outpatient basis, problems associated with transition from CAMHS mirror those of elsewhere. It is reported that there is a lack of awareness, understanding or knowledge between CAMHS and AMHS and this is complicated and perpetuated by a lack of communication between the two services.



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## **Greece**

The shared location of CAMHS and AMHS lends itself to some successful transitions between services as good relationships between CAMHS and AMHS clinicians are helpful to the process of transition. Nonetheless, there are no formal policies or guidelines on transition, there is limited coordination and communication between services which has resulted in a lack of awareness and understanding between CAMHS and AMHS.

## **Hungary**

Young people attend CAMHS up to the age of 18. With regards to transition between services, there are no specialized transition planning, policies or guidelines for the process.

## **Ireland**

Transition age boundary is 18 years. In terms of transition, while A Vision for Change (Government Publications Office, 2006) has emphasised the importance of improving the continuity of treatment within mental health services, this seems to be happening on a limited scale.

## **Italy**

In Italy, CAMHS serve all patients aged between 0 and 18 years suffering from mental or neurological disorders. If the majority of CAMHS users is represented by individuals aged 4 to 7 years, with frequencies dropping by 12 and 14 years old, the majority of the 800,000 adult users of 163 Departments of Mental Health are older than 40 years of age.

## **Netherlands**

At the age of 18, young people attending 'CAMHS-only' trusts are transferred to a different organisation for AMHS. Service-users at the Mental Health Care Trusts also transition at 18, but in these cases patients usually stay within the same Trust. However, there is increasing awareness of the need to attend to the transitional period and a working group has been established to produce guidelines on transition.

## **Portugal**

A lack of communication between CAMHS and AMHS serves to perpetuate the split between services and impede successful transition. At the time of the meeting, there were no official guidelines regulating the transfer of care from CAMHS to AMHS. Young people aged between 16 and 18 tend to fall into uncertain territory between CAMH services and adult mental health services.

## **Spain**

In terms of transition from CAMHS, each local Autonomous Communities (AC) has defined a maximum age, above which the young person is referred to AMHS. In some communities the CAMHS transition boundary is 14 years old, while in other ACs the transition boundary is up to 16 or 18 years old.





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## UK

It has been recognised that the treatment approaches of CAMHS and AMHS are not similar and a lack of understanding about each other's service persist (Singh et al 2010). Various initiatives with potential to improve transitional care for young people have been developed. These include the Children and Young people's Improving Access to Psychological Therapies (CYP IAPT), a national transformation programme underpinned by a strong focus on young people's participation in service development and promoting children and young people being able to self-refer to CAMHS; the National Institute for Health and Care Excellence (NICE) producing guidelines for transition (NICE 2016).

## Discussion

Epidemiological data from different European countries suggest that CAMHS across Europe face significant challenges in terms of resourcing and lack a coordinated structure to facilitate effective transition between CAMHS and AMHS. However, detailed information regarding the level and appropriateness of CAMHS services across Europe is lacking. The authors of this paper used an opportunistic setting (an expert meeting, where child psychiatrists from different European countries presented on child mental health services in their country) to draw together knowledge about CAMHS-AMHS interface strengths and weaknesses: these inputs have been used to carry out a systematic mapping of CAMHS in all 28 European countries (see Signorini et al., 2017, 2018).

## Future directions

The increase in child poverty, social exclusion and enforced migration places children across Europe at even greater and unequal mental health risks. Initiatives such as the European Alliance for Investing in Children (<http://www.alliance4investinginchildren.eu/>) is a power lobby to fight for improved targeted and universal measures to ensure affordable, accessible, effective services for children and their families across Europe. Child mental health services have not yet joined up to this. Ongoing clinical and academic links between countries is essential to try and identify country and culture specific risks and protective factors in our fight against rising tide of child mental illness, along with a renewed focus on mental health promotion. The MILESTONE Study is one such initiative, and will provide unprecedented data and information to improve the quality and efficacy of mental health care for young people.

Table 1 – Country experts for the MILESTONE project consultation meeting in Madrid initiative

Country	Name of the participant	Affiliation at the time of the meeting
AUSTRIA	Eva Pollak	University Clinic for Child and Adolescent Psychiatry at the Medical University of Vienna
	Nestor D. Kapusta	Medizinische Universität Wien Universitätsklinik für Psychoanalyse und Psychotherapie
BELGIUM	Véronique Delvenne	Head of Child and Adolescent Department in Hopital Universitaire des Enfants Reine Fabiola in Brussels



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CROATIA	Katarina Dodig Čurković	Unit for Child and Adolescent Psychiatry, University Health Center in Osijek, Croatia, School of medicine, Osijek, Croatia
	Tomislav Franic ( <i>MILESTONE team</i> )	"Child and Adolescent Psychiatrist, Assistant Professor of Psychiatry, Department of Child and Adolescent Psychiatry, School of Medicine, University of Split"
DENMARK	Julie Nordgaard Fredriksen	senior consultant of Psychiatric Centre Hvidovre and member of Danish Psychiatric Associations Research committee; University of Copenhagen and Region Zealand · Early Psychosis Intervention Center
FRANCE**	Diane Purper-Ouakil, Frédéric Russet MT ( <i>MILESTONE team</i> )	MPEA1, St Eloi Hospital CHRU Montpellier
	Aurélie Schandrin MT	SUPA, La Colombière Hospital CHRU Montpellier
GERMANY	Sabine Loos	Department of Child and Adolescent Psychiatry and Psychotherapy, University of Ulm
	Silvia Schneider	Mental Health Research and Treatment Center at Ruhr-University Bochum
	Jörn von Wietersheim	Department of Psychosomatic Medicine and Psychotherapy, University of Ulm
GREECE	Gerasimos Kolaitis	Associate Professor of Child Psychiatry Director, Department of Child Psychiatry Athens University Medical School "Aghia Sophia" Children's Hospital
HUNGARY	Roberta Dochnal	Hungarian Society for Child and Adolescent Psychiatry; University of Szeged
IRELAND**	Michael Fitzgerald	Trinity College Dublin, Ireland
	Fiona McNicholas, Lesley O'Hara MT	School of Medicine and Medical Science Health Sciences Centre, University College Dublin
ITALY**	Giovanni de Girolamo MT	Saint John of God Clinical Research Center, Brescia
MALTA*	Joseph Spiteri	President of Maltese Association of Specialists in Psychiatry
THE NETHERLANDS	Therese van Amelsvoort	Department of Psychiatry and Psychology Maastricht University
PORTUGAL	Bernardo Barahona Corrêa	Portuguese Society of Psychiatry and Mental Health, NOVA Medical School/Universidade Nova de Lisboa, and Champalimaud Foundation, Lisbon
SLOVENIA*	Maja Zorko	Slovenian Psychologists Association
SPAIN	Rosa Calvo	Spanish Society of Child and Adolescent Psychiatry, Hospital Clinic Barcelona
UNITED KINGDOM**	Dame Sue Bailey	President of The Royal College of Psychiatrists
	Moli Paul, Cathy Street, MT	Division of Mental Health and Wellbeing, Warwick Medical School, The University of Warwick
INTERNATIONAL PROJECTS	Martine De Clerck, Isabelle De Schrijver	co-directors of Action for Teens and project-coordinators of ADOCARE Project



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## **Challenges in Child and Adolescent Mental Health: An International Perspective**

Dr S. Younus (Pakistan), Prof. A. Guerrero (USA), Dr. G. Milavic (UK), Prof. P. McGorry (Australia), Prof. M.W. Azeem (Qatar), Prof. T. Frodl (Germany), Prof. B. Leventhal (USA), Dr S.H. Ong (Singapore), Prof. N. Skokauskas (Norway)

The scarcity of child and adolescent psychiatrists was highlighted in 1962 when the mythical ratio of 1 child and adolescent psychiatrist to 10,000 children was proposed for Canada. In the decades since, the discipline has flourished, and the ratio has been adjusted in many countries; however, this ratio has not been achieved in most of the countries. This scarcity makes the role of child psychiatry more challenging and starkly different from that of other medical specialties. It is pivotal that child and adolescent psychiatrists act as leaders in their discipline, advocate for the cause, train allied professionals and create innovative solutions.

As many as 10-20 percent of children and adolescents worldwide experience mental disorders, and most of them cannot access optimal resources due to various reasons. In order to provide better resources to these individuals, solutions need to be customized locally. It is important for physicians to understand the local perspective of the challenges, identify and define specific problems and then formulate a creative, impactful, and evidence-based plan for the region. To be effective, these plans must also be socioeconomically and culturally appropriate.

Several examples highlight diverse practices that can be utilized to solve this global crisis.

Qatar is a small country with a population of about 2.3 million, with approximately 350,000 children and adolescents. It is a multicultural country where the local Qatari population represents only 14% of the total population. Qatar has very limited mental health services with almost no child psychiatrists as of couple of years ago and no child and adolescent psychiatry inpatient beds. To counter this deficiency, a child and adolescent psychiatry department was developed at a brand new 400-bed pediatric and women's hospital. This department is now providing outpatient and consultation liaison services to children and adolescents with mental health conditions. The inpatient services and child psychiatry training program will be developed in the near future. Due to the needs for mental health services in the school system in the country, the department has developed a formal referral system from schools in order to encourage better collaboration with mental health professionals, early identification and appropriate management of these children. To cater to the needs of this multicultural population, special care has been provided towards availability of multilingual staff and language interpretation services. It is worth mentioning that Qatar has a National Mental Health Strategy 2013-2018. In addition, the country has launched the National Autism Plan in April 2017, with implementation of goals over 5 years.

Singapore, with a total population of 5.61 million, is a multicultural country with a relatively smaller percentage of the population under age 18 years and a relatively smaller psychiatrist-to-patient ratio. Due to this relatively larger workforce and an overall better health infrastructure, the identified problems in the country are different from those of other countries under discussion. The consultation liaison services in general medical hospitals were not as comprehensive in the early stages of the development of child and



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adolescent mental health services in Singapore; therefore, there were gaps in managing children with comorbid medical and mental health problems that required a multidisciplinary approach. This gap was managed by streamlining the liaison services at a single tertiary care pediatric hospital in the country. A referral algorithm was created, keeping in view the existing overlap of services provided by psychology and social work teams. Easy-to-use referral forms were created for primary care physicians, who were provided with regular communication about their use and application. Training was provided to both senior and junior physicians, nurses and other staff members about identification and basic management of children who present with challenging behaviors and who may require psychiatric help. Complementing this consultation liaison model in medical/pediatric hospitals is a community-based mental health program aimed at providing mental health services to children and adolescents in public and mainstream schools for ages ranging from 6 to 17 years. Funded under the auspices of the country's National Mental Health Blueprint in 2007, four such teams have since been developed, with all teams operated by three hospitals with child and adolescent psychiatry departments

Hawai'i is a small US state with a population of approximately 1.4 million. While mental health resources may appear to be close to adequate in urban areas, the unequal geographical distribution of these resources creates a scarcity for thousands of children and young people living on neighboring islands. The challenge is to provide accessible resources for those in need. Tele-psychiatry services have been developed on islands to make this access possible. A core requirement of providing this service is the presence of trained professionals on the ground to facilitate implementation of treatment plans and manage emergency conditions. To provide better access, a program was initiated to integrate behavioral health into existing primary healthcare services. Through this program, local primary healthcare personnel, with the help of a child and adolescent psychiatrist sited in remote areas, started managing mild to moderate conditions on their own. The severe conditions were referred to the child and adolescent psychiatrist, who provided consultations and guided ground personnel for further management.

The United Kingdom has the world's largest and the oldest free-at-the-point-of-delivery healthcare system, which is funded through the taxation system. The National Health Service (NHS) is considered to be an exemplary service, providing all services free of cost to all its citizens. Recent years have seen a growing demand with a major shortfall in the budget allocated to NHS in general and to child and adolescent mental health more particularly. A recent survey of NHS Trusts in England reported that only 14% of children referred to CAMH services received immediate services; 58 percent were allocated to waiting lists, and approximately 28 percent were not provided with any services. In order to tackle the growing need in light of dwindling resources, a government-led strategy 'Future in Mind' was published. It highlighted the importance of prevention and early detection of child and adolescent mental health disorders and brought to light the need to improve access to services and build capacity through involving teachers in schools in addressing the mental health needs of children.

Australia, on the other hand, is a country with a population of approximately 24 million with a little less than a quarter of its population being under the age of 18 years. Recent literature suggests that, despite the highest incidence and prevalence of mental health disorders in the adolescent phase, only 21.8% of Australian adolescents and young adults between the ages of 16-24 years accessed professional help. The child and adult services in Australia were historically not able to provide optimal and accessible care to





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children and particularly those young people between the ages of 18 and 25 years. With the aim of facilitating a smooth transition to adulthood, Headspace, an enhanced primary care model for youth mental healthcare, was launched in Australia in 2006. The services are aimed at promoting and providing early mental health interventions for youth aged 12-25 years. This system is now operating in approximately 100 communities in Australia and provides services for over 100,000 young people. Mental health access has been greatly improved, especially for some traditionally hard-to-engage subgroups. As a step up from primary care, Orygen, a youth health service, was set up for youth with severe and complex mental health presentations that require specialized and longer term treatment. This program has the capacity to provide both acute and community services to approximately 700 young individuals per year from a catchment area of 1 million population.

By contrast to these countries, Pakistan is a densely populated country with a population of 207 million, approximately 53 % of which is under 18 years of age. Extrapolating from the global statistics, one can estimate that around 10 million children and adolescents need mental health services, while there are only four trained child and adolescent psychiatrists in the entire country to cater to this need. Pakistan is plagued with various societal challenges, chiefly terrorism and poverty. Furthermore, basic healthcare is allocated paltry resources, leading to a lack of focus on the mental health challenges faced by society. The lack of financial resources, coupled with the absence of policies related to mental health, means that almost no investment is made to build child and adolescent mental health capacity in the country.

Pakistan has taken baby steps in child and adolescent psychiatry, including a newly established, first-in-the-country inpatient child and adolescent unit at King Edward Medical University in Lahore, Pakistan. In December 2014, The College of Physicians and Surgeons of Pakistan (CPSP) approved the fellowship in child and adolescent psychiatry at a national level for various academic institutions in Pakistan. The Aga Khan University in Karachi, Pakistan has two of the four child and adolescent psychiatrists in the country and is therefore a good candidate to initiate a child and adolescent psychiatry training program. A curriculum has already been designed and approved by the University's Postgraduate Medical Education Department to initiate the fellowship in child and adolescent psychiatry. The university is now training one clinical fellow every two years. The number may seem small, but the goal of the fellowship is to train leaders in child and adolescent mental health who can advocate for the cause and create innovative ways of dealing with the crisis at hand. This training program also has the capability to be disseminated in the other two universities where the remaining two child psychiatrists practice under the auspices of CPSP. In the last decade, numerous international presentations and peer reviewed publications have been prepared by child psychiatry professionals from the country.

When sharing experiences from different countries, it becomes apparent that the mental health needs of children and adolescents are likely not met anywhere in the world. It is incumbent upon child and adolescent psychiatrists and allied professionals to take on a lead in destigmatizing child mental health, developing services and building capacity across health structures. Better outcomes can be expected with collegial efforts of professionals across the globe, with the broader goal of providing optimal mental health care for children and adolescents.



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## **Recent developments in Child and Adolescent Psychiatry in India**

Professor V. Sagar and Dr. E. Sharma (India)

### **Introduction**

India has approximately 40% of its population of 1.2 billion under the age of 18 years. The burden of mental illness in Indian children and the significant gap in access to treatment has been reported in the recent literature. The growth of Child and Adolescent Psychiatry (CAP) as a specialty in Psychiatry has happened in a very gradual manner over the past five decades. This article focuses on the recent developments in clinical services, training, research and policies related to CAP in India.

### **Clinical services**

The National Institute of Mental health and Neurosciences (NIMHANS) has recently extended its CAP outpatient services to 16- and 17-year old adolescents. In addition, a 24-bed inpatient facility named Adolescent Psychiatry Centre (APC), the first of its kind in India, started in the year 2015.

Special clinics have recently been initiated in institutions like NIMHANS and Jawaharlal Institute of Postgraduate Medical Education and Research (JIPMER), Pondicherry. The special clinics at JIPMER include a multidisciplinary monthly follow-up clinic for children with ASD, with the Paediatrician, Child Psychiatrist, Speech Pathologist and Occupational Therapist providing input; a multi-disciplinary child crisis counselling centre; and an adolescent mental health clinic. NIMHANS has initiated the following special clinics:

- o Weekly clinic for children with Specific Learning Disorders
- o Aasare Clinic for Parents of children with emotional, behavioural or learning problems. The term aasare is from the local vernacular language, Kannada, and means support.
- o Swatantra clinic for children referred from Child Protective Services. The term swatantra is also from the local vernacular language, Kannada, and means independence.

### **Training**

A 3-year Doctorate of Medicine (DM) in CAP is available in two institutes in India: NIMHANS, India and Postgraduate Institute of Medical Education and Research (PGIMER), Chandigarh. Postdoctoral Fellowship (PDF) training is available at NIMHANS; JIPMER; Christian Medical College (CMC), Vellore; Vijayawada Institute of Mental Health and Neurosciences (VIMHANS), Vijayawada; and Asha Hospital, Hyderabad. The PDF course duration is 1 year in all institutions except CMC, Vellore (where the duration is 2 years). Admission to these courses is open to candidates who have completed their postgraduate degree (MD/DNB) in Psychiatry. Recently NIMHANS has initiated a 6-month certificate course for child and adolescent therapy and family therapy. This course will be provided to clinical



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psychologists. A 6-month fellowship in child and adolescent mental health for mental health professionals from South Asian Association for Regional Cooperation (SAARC) countries will commence shortly at NIMHANS. This course is being planned to empower mental health professionals with skills to provide preventive, promotive and therapeutic interventions in child and adolescent mental health across the SAARC countries.

## **Research**

Child mental health research is still in its nascent stages in India. The realm of assessments and evaluations has largely been driven by adaptation of existing Western concepts and philosophies. Growing up in a multi-cultural and multi-linguistic country and facing challenges arising from the changing social structure where there is less emphasis on large joint families and more emphasis on nuclear individualistic families, poses unique experiences and psychosocial challenges for the developing child/adolescent. Cultural diversity is also reflected in the gene pool and consequent neurobiology. There has been a systematic effort across child and adolescent psychiatry centres in the country to gear research – both etiopathological enquiry and service-based research – towards addressing these differences.

Probably the two of the largest research endeavours have been undertaken at the National Institute of Mental Health and Neurosciences, Bangalore. The Consortium on Vulnerabilities to Externalizing Disorders and Addictions (cVEDA) is an Indian Council of Medical Research (ICMR) and Medical Research Council UK (MRC)-funded project. It aims to study, using an accelerated longitudinal design, a developmental cohort of around 10,000 individuals aged 6-23 years, across 7 recruitment centres in India. The idea is to identify 'risk,' as a complex function of exposure and individual vulnerabilities, to identify effective preventive and therapeutic targets for mental health. "Early psychosocial predictors of child mental health: longitudinal study of shared and distinctive risk and protective factors in UK & India" is another ICMR-MRC jointly funded study. The focus here is on infancy and early childhood (pregnant mothers to children 2 years of age) to identify prenatal, parental, caregiving environment and developmental processes that influence behavioral and cognitive outcomes in children and families over time.

With a view towards addressing child and adolescent mental health service needs and gaps, the Department of Child and Adolescent Psychiatry, NIMHANS has been running a Community Child and Adolescent Mental Health Services (CCAMHS) project for the past 4 years. The project entails a comprehensive plan to provide community-based child and adolescent mental health with a promotive, preventive, and curative focus in urban and rural sites through direct service delivery and through training and capacity building of child care workers at various levels of the healthcare system. Through these activities, the project aims to design service delivery and capacity-building models that could be used throughout the country.

The National Institutes for the Empowerment of Persons with Intellectual Disabilities (NIEPID) at Kolkata and Secunderabad have been leading the pack in the areas of intellectual and other developmental disabilities. In recent years, research at these institutes has focused on development of culturally valid assessment and intervention tools, identification of mental health problems in persons with intellectual disability, a school readiness package for early childhood inclusive education, a toolkit for assessing work



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competencies among post-secondary and pre-vocational students, and e-learning accessibility models for rehabilitation professionals to assess and plan services. The New Delhi birth cohort at the All India Institute of Medical Sciences (AIIMS), New Delhi, has been following up children and identifying predictors of non-communicable and mental health diseases from early life growth patterns. AIIMS has also been working on parent-mediated, computer-based and non-computer based early interventions for cognitive control deficits in Attention-deficit Hyperactivity Disorder. Across other premier child and adolescent mental health service centres in the country – JIPMER, Pondicherry and the CIP, Ranchi – service-oriented research has been priority. Early identification of autism, broad autism phenotype and neuropsychological functioning in autism, have been prime research activities at St John's Medical College and Hospital, Bangalore.

Developmental disorders form the largest chunk of children/adolescents presenting to mental health services in India. Probably, the inadequate awareness about and 'visibility' of other kinds of childhood mental health problems contributes to low help-seeking. Consequently, research has largely been channelled towards 'risk,' 'early development,' and 'early interventions.' Given the unique and dynamically changing psychosocial scenario in the country, these research foci are likely to soon discover interesting findings.

## **Policies, legislation and health programmes**

Children and adolescents account for greater than one third of the population of India. Recent statistics from the National Mental Health Survey of India, 2016, have revealed an approximately 8% prevalence of mental morbidity among adolescents. There has also been a calamitous increase in reports of crimes against children and suicides. There have been persistent efforts by the central and state governments in India to enact statutes and programmes for the safety and benefit of children and adolescents. India is a signatory to the United Nations Convention on the Rights of the Child, which has the best interests of the child at the heart of its philosophy. The multiple risks of nutritional deprivation, infectious diseases, and developmental challenges and disorders are aptly covered by flagship programmes of the Indian government – the Rashtriya Bal Swasthya Karyakram (RBSK) and the Rashtriya Kishor Swasthya Karyakram (RKSK). The former focuses on early child health, while the latter focuses on adolescent health. The RKSK, launched in 2014, looks at nutrition, sexual and reproductive health, mental health, prevention of injuries and violence and prevention of substance abuse; it aims to address these issues via adolescent participation and leadership, equity and inclusion and strategic partnerships.

An act that has been under the scanner recently is the Protection of Children from Sexual Offences (POCSO) act, 2012. The act aims to protect children from sexual assault, sexual harassment and pornography and to provide for the establishment of special courts for trial of such offences. A salient feature of this act is mandatory reporting, whereby any person (including the child) who knows about the likelihood or occurrence of any offence under this act must provide information to a special juvenile police unit or local police. Child friendly provisions have been given due importance, especially the prevention of re-victimization of the child through repeated contact with law enforcement and questioning about the abuse experiences.





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The Juvenile Justice (Care and Protection) Act, 2015, was enacted to consolidate and amend the law relating to children alleged and found to be in conflict with the law and children in need of care and protection. The act endeavors to achieve these goals by catering to the basic developmental needs of such children through proper care, protection, treatment, and social re-integration; by adopting a child-friendly approach in adjudication; and by advocating for children's best interest and rehabilitation through processes provided and institutions and bodies established. The act lays down requirements and procedures for establishing child welfare committees and for assessing children charged with heinous offences, in terms of their mental and physical capacity to have committed the offence, their ability to understand the consequences of the offence, and the circumstances in which the child allegedly committed the offence. The act abides by the general principles of care and protection of children and includes the principles of presumption of innocence, best interest, family responsibility, institutionalization as a measure of last resort, fresh start, and diversion towards developmentally appropriate and safe occupations.

In 2007, India ratified the United Nations Convention on the Rights of Persons with Disabilities. The act to give effect to this convention is the Rights of Persons with Disabilities Act, 2017. In addition to mental illnesses and intellectual disability in children/adolescents, the act has, for the first time, included specific learning disorders in the realm of disability. India has also been keen on free and compulsory education of all children. This right is codified in the Right of Children to Free and Compulsory Education Act, 2009.

Overall, there has been a move all over the country towards recognizing the special needs and vulnerabilities of children and adolescents and addressing them in a protective and 'best interest' framework.

**References available on request**



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## **The Internet and Forming the Superego**

Dr. Steven R. Williams (USA)

It is well established that children incorporate their more meaningful people in their lives into their values and psyche. For this reason, parents are cautious about with whom and where their children may be. Naturally, if the parents have less contact or presence with their children, the void will be filled by the immature choices of the children. This can sometimes guide them into a less than healthy developmental trajectory.

Whether a child is in a refugee camp or at home on the computer, some oversight is needed in order to assess what is meaningful in the child's life. Young children who are more isolated from parental figures and adults may be more vulnerable. The early incorporation of an unhealthy superego may sometimes be the beginning of long-standing psychopathology. Which children are more at risk? The children in refugee camps or in the more impoverished parts of the world or an adolescent spending most of his time in his bedroom alone on the Internet? Cultural and religious sensitivities would obviously need to be considered.

A child's easy access to the Internet is a relatively new phenomenon. One could argue that this new phenomenon contributes to the formation of their superego. The Internet provides a wide selection of topics and issues that a child or adolescence might gravitate towards. Social media and video games may be significant preoccupations for children. Some of these interests may obviously lead to an unhealthy superego. For this reason, a closer assessment of a child's or adolescent's superego should take place. If there are clinical concerns, an early intervention might prevent future psychopathology.

There is a dearth of research and literature on the subject of superego formation and the Internet. An interesting question would be, are there differences between a young adult's superego who used the Internet from a young age compared to young adults who did not have access to the Internet as a child or adolescent? Nonetheless, the use of the Internet by children and adolescents has significant clinical relevance and clinical assessments need to take this into consideration. Many of their heroes are found on the Internet.



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## **The Annual Psychiatric International Conference:**

### **“Ukrainian psychiatry in the fast changing world”**

Prof Iryna Pinchuk and Prof.. Semyon Gluzman (Ukraine)

Psychiatry in the USSR was the most closed (restricted from the public) medical specialty. The complete political and informational isolation of the country from the civilized world was compounded by the deliberate self-isolation of the entire psychiatric system, which was represented by the "sole correct" concept of Moscow professor A.V. Snezhnievsky. Dissidence in Soviet psychiatry was persecuted.

International diagnostic seminars, conducted in the 1960's and 70's under the aegis of the WHO, clearly demonstrated the differences between the Soviet diagnostic system and treatment approach and the more generally accepted ones.

The Soviet Union break-up provided an opportunity for new post-Soviet countries to get acquainted with modern psychiatric science and practice, not distorted by the influence of unsubstantiated Soviet concepts. The most active country, in this regard, was Ukraine, where translation, publication and dissemination of modern world psychiatric literature was started in 1991. The Ukrainian Psychiatric Association (UPA) was actively engaged in this process. The state and governmental structures did not take part in this process. Other post-Soviet countries also received part of these books from Kyiv. In total, over the past several years, over 130 books on mental health subjects have been translated from English, French, German, Dutch and Polish.

On April 25-27, 2018, an annual psychiatric international conference, "Ukrainian Psychiatry in a Rapidly Changing World," organized by the Ukrainian Research Institute of Social and Forensic Psychiatry and Drug Abuse of the Ministry of Health of Ukraine and the UPA, took place in Kyiv, Ukraine. For the first time in the history of Ukrainian psychiatry, the conference had the status of a Co-Sponsored Meeting of the World Psychiatric Association and received accreditation from the European Accreditation Council for Continuing Medical Education (EACCME) for 18 Credit Points.

The conference is a unique scientific, educational and social event that has traditionally been the most important event in the calendar of mental health specialists from all over Ukraine.

This year, more than 400 medical practitioners, psychologists, social workers and lawyers from different regions of Ukraine, as well as specialists from the USA, Germany, England, Norway, Lithuania, and the Netherlands, took part in the conference.



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The music band of Lviv Regional Clinical Psychiatric Hospital opened the conference. The first plenary lecture, "Ukrainian Psychiatry in a Changing World," was presented by the President of the UPA, Dr. Semyon Gluzman.

Director of the Ukrainian Research Institute of Social and Forensic Psychiatry and Drug Abuse of the Ministry of Health of Ukraine and Director of the Addiction Transfer Technology Center in Ukraine, Prof. Iryna Pinchuk, presented a model of the mental health system in Ukraine, a situational analysis, and a conceptualization of a programmatic-targeted approach to reforming the mental health system in Ukraine.

Within the framework of the conference were discussed topics such as the organization of psychiatric care provision, the protection of elderly people's mental health, the diagnosis and therapy of hyperkinetic disorders in children and adolescents, the diagnosis and therapy of eating disorders, realities and training needs, mental health protection in the context of war and in the occupied territories, psychiatric addiction medicine and psychosocial rehabilitation of persons with mental disorders.



From left to right:

Professor B. Leventhal (USA), Professor N. Skokauskas (Norway), Prof. S. Gluzman (Ukraine), N. Pryanikova (Ukraine), Professor I. Pinchuk (Ukraine), WPA President-Elect Dr. Afzal Javed (UK)

As usual, young Ukrainian researchers, doctors and clinical psychologists presented their research works, which aroused great interest from authoritative colleagues from the Western countries during open and long-lasting discussions.

The President-elect of the World Psychiatric Association (WPA), Dr. Afzal Javed, and the Chair of the Child and Adolescent Psychiatry Section of the WPA, Professor Norbert Skokauskas, took active part in the conference.

In his report, Dr. Afzal Javed spoke about the program and action plan of the World Psychiatric Association. Professor Norbert Skokauskas delivered a plenary lecture on "Global Challenges and Innovation in Child and Adolescent Psychiatry." At the end of the conference, ways to deepen the cooperation of the WPA with the UPA were discussed with Dr. Afzal Javed. Following tradition for these April conferences in Ukraine, the UPA held their annual awards ceremony. Dr. Moisey Tantsura, whose name was given to the UPA award, saved many patients of the Kyiv city psychiatric hospital (named after





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I.P. Pavlov) from inevitable death during the Second World War and during the occupation of Kiev. The award theme was: "For decent behavior in non-decent situation."

This year, the award named after Dr. M. Tantsyura for high professionalism, humanity and respect for the rights of patients, was presented to the doctor-in-chief of the Donetsk regional psychiatric hospital (Slavyansk Donetsk region), Yuri Smali, who organized the rescue of patients from the hospital in the region with ongoing military conflict, where soldiers and peaceful inhabitants are killed.

The award named after Professor Vadim Bleykher, who ventured to introduce the first evidence-based diagnostic method in psychiatric assessment under the harsh pressure of the Moscow "School of Slow Schizophrenia," was presented to clinical psychologist and young scientist of the Ukrainian Research Institute of Social and Forensic Psychiatry and Drug Abuse of the Ministry of Health of Ukraine, Yuliia Yachnik, for a prominent contribution to the development and establishment of clinical psychology in Ukraine in 2018. The award named after Stanislav Kostyuchenko, a young talented Ukrainian doctor and researcher who, unfortunately, prematurely died, is annually presented to a young Ukrainian researcher, doctor or clinical psychologist, and in 2018, it was presented to psychiatrist, priest, and Associate Professor Serhiy Kirilyuk for successful research in the field of depression.

The award named after the famous prison physician, F. Haas, is usually presented in honor of humanism and high professionalism in working with convicts, and in 2018, the award was given to the head of the department for the re-socialization of convicts of the Western Interregional Department for the execution of criminal sentences and probation of the Ministry of Justice, Sergei Kuzmich (Lviv Oblast).

The award named after Nicola Andry (Psychiatric Anti-Award) is presented for actions or publications that negatively impacted the development of the psychiatric system in Ukraine. In 2018, this award was given to the management staff of the Insider Project of the ICTV television channel (Kyiv). In April 2018, this channel broadcasted a program created under the influence of a group of Ukrainian Scientologists.

In the continuation of the established tradition, the next psychiatric international conference is planned on April 2019 in Kyiv.



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## **2nd Croatian Congress on Children and Adolescents Mental Health: “Mental Health of Children and Adolescents – Wealth of the Nation”**



**Dr. Vlatka Boričević Maršanić (Croatia)**

The 2nd Croatian Congress on Children and Adolescents' Mental Health, entitled “Mental Health of Children and Adolescents – Wealth of the Nation,” was held in Zagreb, May 18-19, 2018. The Congress was organized by the Croatian Society for Infant, Child and Adolescent Psychiatry, Psychiatric Hospital for Children and Adolescents Zagreb and Child Protection Center for Children and Youth Zagreb, and was under the patronage of the President of the Republic of Croatia Ms Kolinda Grabar Kitarović, the Ministry of Health and the Ministry for Demography, Family, Youth and Social Policy.

The Croatian Society for Infant, Child and Adolescent Psychiatry was established in 1991 during the Independence War in Croatia, and it soon joined the International Association for Child and Adolescent Psychiatry and Allied Professions' (IACAPAP) and the European Association for Child and Adolescent Psychiatry (ESCAP).

The scientific program of the congress was opened by Professor Füsün Çetin Çuhadaroglu (Turkey), Secretary General of the IACAPAP, with a plenary lecture on mental health policy for children and youth, and by President-Elect of the ESCAP Professor Dimitris Anagnostopoulos (Greece), with a lecture on mental health needs of refugee children and the necessity of the collaborative work - a European perspective. Prof. Norbert Skokauskas (Norway), Chair of the Child and Adolescent Section, World Psychiatric Association, in his lecture, addressed the future of child and adolescent mental health.

Invited speakers from the southeastern European region were Hojka Gregorič Kumperščak (Slovenia), Milica Pejović Milovančević (Serbia), Marija Raleva (FY Republic of Macedonia), and Marija Burgić Radmanović (Bosnia and Hercegovina).

Croatian experts in CAMS, Ivana Pavić Šimetin, Marina Ajduković, Miranda Novak, Nada Anić, Andrijana Kovačić, Vlasta Rudan, Dubravka Kocijan Hercigonja, Ivica Šain, Marija Posavec, Ljiljana Tirić Čihoratić, and Asja Palinović Cvitanović, had inspiring and informative lectures on intersectoral CAMH policy, epidemiology of mental health problems in Croatian youth, impact of socioeconomic deprivation on CAMH in Croatia, CBT in the treatment of mental disorders in youth, dental care in children with autism spectrum disorders, challenges of diagnosing dissociative disorders in children and adolescents, day hospital treatment for children and adolescents in Istra and collaboration of the hospital



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and local community, education of children and adolescents with mental disorders and support of school doctors for youths with mental health needs.

The experts from the Child Protection Center for Children and Youth Zagreb with Director Prof. Gordana Buljan Flander held a round table on intersectoral collaboration in cases of abuse and neglect of children and youth and the adverse consequences of not reporting child maltreatment.

Child and adolescent mental health reform is under way in Croatia, with strong commitment from the Ministry of Health; the Ministry for Demography, Family, Youth and Social Policy; the Ministry of Education; the Croatian Public Institute of Health and health institutions throughout the county; and with implementation of the guidelines of the Twinning Project, "Ensuring optimal health care for people with mental health disorders (CRO MHD)."

About 180 participants from Croatia and the region participated in the congress, which included plenary lectures, symposia, round table discussions, poster sessions and workshops. The Congress was the opportunity to exchange experiences among experts and clinicians from home and abroad and to advance knowledge and skills in the field of child and adolescent mental health. It was also a good opportunity to start new cooperative clinical and research initiatives. The multidisciplinary audience, representing health care, education, and social welfare, participated actively in discussions and formulated suggestions and initiatives on how to address challenges of the organization of services, clinical practice and research, and promotion and prevention in the field of CAMH.

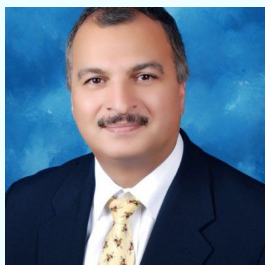
The Croatian Society for Infant, Child and Adolescent Psychiatry will continue to work on improving child and adolescent mental health in Croatia in collaboration with professionals from many disciplines involved in the care of children and youth.



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## **Mental Health in the The United Arab Emirates**

### **Dr. Ahmad Mohammed Al Mai (UAE)**

In its 6th iteration, the International Child and Family Behavioral Health Conference was held in Abu Dhabi, UAE on March 1-3, 2018. The conference was chaired by Dr. Ahmad Almai, Head of Child Psychiatry Service at Sheikh Khalifa Medical City in Abu Dhabi under the Arabian Child and Adolescent Mental Health Association ([www.acamha.com](http://www.acamha.com)).

The event took place at Abu Dhabi Jumeirah Etihad Towers hotel.

The scientific program contained institutes delivered by members of the WPA Section of Child and Adolescent Psychiatry, King Saud University, King Faisal Hospital and the research center of Saudi Arabia. Other participating organizations included the Saudi Psychiatric Society, Emirates Psychiatric Society and the National Rehabilitation Center of Abu Dhabi.

Keynote speakers included President-Elect of the WPA Dr. Javed Afzal, Director of the National Rehabilitation Center of UAE Dr. Hamad Al Ghaferi, President of the Saudi Psychiatric Society Dr. Mahdi Al Qahtani and celebrity singer Nawal.

The conference, which is now considered the largest child and adolescent mental health event in the region, attracted close to 1000 attendees and involved over 120 lectures, 24 workshops, more than 50 new research papers in oral and poster formats and close to 100 speakers focusing on the theme of bridging scientific research with clinical practice. Speakers and attendees came from the region and from Europe and North America. Speakers represented a variety of disciplines and included child psychiatrists, therapists, nurses, general psychiatrists, psychologists, counselors, teachers and more.

One of the conference's main aims was providing sessions and intensive training workshops, covering both biological and clinical aspects of research, to prepare future generations of scientists in the region. The newly established Arab Board committee for child and adolescent psychiatry held a meeting to establish examination procedures for graduating child psychiatrists in the region. Two programs have been accredited so far in the region. Workshops covered both child and adult psychiatry topics, including Autism, ADHD, CBT and board examination preparation. This board will play a leading role in graduating future generations of qualified child and adolescent psychiatrists.





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**The Research Centre for Child Psychiatry, University of Turku is pleased to  
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## **NordCAP 2018**

The conference program includes lectures, workshops and poster presentations on innovative and timely research projects including large-scale epidemiological studies and digitalized interventions promoting mental health as well as preventing and treating mental health problems. The Preconference focuses on the global child and adolescent mental health challenges.

This meet provides an excellent opportunity to share knowledge and network with academics and other professionals working in the field of child and adolescent mental health.

Further information on the programme including registration is available at:

<http://ty.fi/nordcap>

For more information contact us at: [nordcap@utu.fi](mailto:nordcap@utu.fi)

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**ORGANIZING COMMITTEE**  
Andre Sourander, Marjo Kurki,  
Terhi Luntamo, Jarna Lindroos,  
Maarit Tammelin  
**CONTACT:** [nordcap@utu.fi](mailto:nordcap@utu.fi)  
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[www.iacapap2020.org](http://www.iacapap2020.org)



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Editor: Prof. Norbert Skokauskas (Norway) [N.Skokauskas@yahoo.com](mailto:N.Skokauskas@yahoo.com)

Prof. Anthony Guerrero (USA) and Dr. Tomoya Hirota (Japan),

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