



# **World Child & Adolescent Psychiatry**

ISSUE 16, September 2019

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

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



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## Chair's Column:

Dear Colleagues,

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

In this editorial, I would like to bring your attention to the paper, "Shaping the future of child and adolescent psychiatry," initiated by the WPA CAP section. For the very first time, all international associations and other major players in the area of child and adolescent psychiatry have produced a joint document that highlights the future vision for child and adolescent psychiatry.

Child and adolescent psychiatry is in a unique position to respond to the growing public health challenges associated with the large number of mental disorders arising early in life, but some changes may be necessary to meet these challenges. In this context, the future of child and adolescent psychiatry was discussed, in this paper, by the leadership of the WPA CAP Section, the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP), the World Association for Infant Mental Health (WAIMH), and the International Society for Adolescent Psychiatry and Psychology (ISAPP); the UN Special Rapporteur on the Right to Health; representatives of the WHO Department of Mental Health and Substance Abuse; and other experts. The group took this opportunity to outline four consensus priorities for child and adolescent psychiatry over the next decade. The full paper can be found at <https://capmh.biomedcentral.com/articles/10.1186/s13034-019-0279-y>

On a different note, I would like to congratulate the organizers and especially the President of Congress, Prof. Helen Herrman (Australia), Scientific Committee Chair Prof. Norman Sartorius (Switzerland), and the Portuguese team, led by Maria Luísa Figueria and Pedro Varandas, for a very well organized WPA World Congress, which took place in Lisbon. The World Congress was a great success and also hosted the annual section's meeting. At the WPA CAP section's meeting, we welcomed our new members, and I am very pleased that several of them already are contributing to the current issue. If you are still not a member of the WPA CAP section, please visit our webpage to learn more about the section and how to join it: <http://www.wpanet.org/child-adolescent-psychiatry>

WPA moved to a new website, and our section's materials, including all past issues since 2012 of World Child and Adolescent Psychiatry, are gradually being transferred from the old to the new website.

Happy Readings!

Prof. Norbert Skokauskas (Norway) Editor,  
"World Child and Adolescent Psychiatry"

Chair, World Psychiatric Association, Child and Adolescent Psychiatry Section





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## **WPA ACTION PLAN A WAY FORWARD**

Prof. Afzal Javed (Pakistan/UK): WPA President-Elect & Chair WPA's Planning Committee  
2017-2020

Psychiatry is currently facing several challenges, and, although our profession may be seen as being under threat, there are many opportunities that can help us consolidate psychiatry as an inspiring branch of medicine. WPA is the umbrella organization for psychiatrists worldwide and thus has a major responsibility for leading the profession. This leadership can only be achieved through full participation from our membership and engagement of our professional colleagues.

WPA Action Plan for 2021-23 defines emerging needs and priorities, from a worldwide perspective, in some specific areas of mental health. There is an outstanding need to provide access to high quality mental health care in all countries and to support psychiatrists in their important roles as policy makers, direct service providers, trainers and supporters of health care workers in primary and community health care systems.

The key features of the Action Plan are:

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

The proposed Action Plan will look at targeted areas that need attention and input from various WPA components during the next triennium. It will work within an international perspective focusing specifically on promotion, interventions and teaching and training of mental health professionals. This Action Plan will also build on the previous Action Plan to ensure continuity in the WPA's work.

Salient features of the Action Plan 2020-23 include the following:



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Psychiatry and Public Health:  
Promoting Mental Health, Healing  
Mental Illness through public  
mental health approaches

Youth Mental Health:  
Identifying needs for targetted  
groups including children,  
adolescents, persons with  
Intellectual disability, refugees and  
patients with chronic and enduring  
mental health problems

Exploring needs for dealing with  
co-morbidity issues in mental  
health and developing strategies to  
collaborate with other medical and  
health professionals

Developing partnerships for joint  
collaborative work and  
strengthening partnerships with  
other mental health professional  
organisations

Capacity building and training  
(special focus on medical students,  
young psychiatrists & allied  
professionals) and supporting  
training policies in global mental  
health

Continuation and completion of  
Previous Action Plans

## Psychiatry & Public Mental health

Public mental health is assuming an important place in the delivery of general health care. It involves a population mental health approach, which includes assessments, efforts to improve outcomes, coordination of different levels of mental disorder prevention, and mental wellbeing promotion. Evidence shows that programmes improving population mental health through coordinated work with a range of public and other organisations, local communities and individuals show a great impact.

The suggested action plan includes:

- Raising awareness, acceptance, and prioritization of public mental health in national health policies
- Promoting public mental health intervention grant proposals
- Ensuring public mental health training programmes
- Integrating mental health care into chronic disease management and prevention and engaging with primary and general health care systems.



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## **Children, Adolescent & Youth Mental Health: Identifying needs for targeted groups (0-25 years of age), including children, adolescents, persons with learning disability, refugees, and young adults with chronic and enduring mental health problems**

Mental disorders are the single most common cause of disability in young people. First onset of mental disorders usually occurs in childhood or adolescence, although treatment typically follows several years later. The evidence shows that around 70% of mental disorders begin before the age of 25. The adolescent years are a critical time, when mental health needs promotion, and mental health problems need intervention. If left untreated, mental disorders can impede all aspects of health, including emotional well-being and social development, and leave young people feeling socially isolated, stigmatized, and unable to optimize their social, vocational, and interpersonal contributions to society. There is ample evidence that addressing mental health problems early in life can decrease emotional and behavioural problems, functional impairment, and contact with all forms of law enforcement. It can also lead to improvements in social and behavioural adjustment, learning outcomes, and school performance in later life and prevent development into chronic disorders. The promotion of child and adolescent mental health is a worldwide challenge, but a potentially rewarding one.

Wars and natural disasters have led to the refugee population reaching numbers not seen since the Second World War. The current data show an increasing prevalence of mental disorders in the younger population going through migration and displacement. International organisations generally focus on providing food and shelter, but much more needs to be done to support this younger population and to address their mental wellbeing.

The failure to address child and adolescent mental health problems, including developmental and intellectual disorders, especially in low-resource settings, adds significantly to major public health issues and inflicts far-reaching consequences.

Evidence shows that a substantial proportion of adult mental health problems originate early in life and has long-lasting effects beyond childhood and adolescence. There are significant gaps in what we know about how best to treat mental illness in children and youth. There is inadequate support for research into developmental neurobiology; the causes of mental illnesses; and the most effective, safest and best-tolerated treatments. The stigma of mental illness, together with the outdated models of child and youth mental healthcare, illustrate the negligence of our society.

Some of the proposed work will thus include:

1. Supporting epidemiological work exploring the prevalence of mental health problems in the targeted population



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2. Promoting early detection for psychosis and developing crisis intervention centres for adolescents
3. Screening and brief intervention in primary care for substance and alcohol misuse among adolescent and youth populations
4. Developing school-based social and emotional learning programmes to prevent psychosocial and conduct problems in childhood; preventing school dropouts; and promoting programmes for school mental health. Parenting interventions for preventing persistent conduct disorders in children and dealing with mental health problems among youth
5. Workplace screening for early detection of mental health problems among the young workers and promoting wellbeing in the workplace
6. Implementing collaborative care for mentally ill patients with other medical co-morbidity

## **Dealing with co-morbidity issues in psychiatry and developing strategies to engage with other medical and health professionals**

Comorbidity is one of the most important issues facing health systems in the world today, and the single disease approach cannot address this problem appropriately. Patients with multiple long-term conditions are becoming the norm rather than the exception, and the number of people with comorbidities is set to increase in coming years.

Comorbidity in mental illnesses is gaining significant importance in our day-to-day practices. There are two key populations with comorbidities, and each of these populations requires a distinct approach:

- Those who have comorbidities mostly due to increased life expectancy and therefore a longer exposure to risk factors.
- Those who have comorbidities mostly from more intense exposure to risk factors, particularly smoking, alcohol, physical inactivity and obesity. This intense exposure is due to a combination of life challenges, including persistent and widening inequalities.

Patients in both groups face complex physical, social and emotional problems and are more likely to have mental health difficulties. It is important to address these issues of comorbidity as a priority. While many lives may be saved in the short term from improved management of comorbidities, the system-wide action



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that is needed to address comorbidities will take longer to implement, and the benefits will be seen over a longer period.

The WPA needs to discuss these issues from a worldwide perspective and focus on promotion, interventions, teaching, and training of mental health professionals in these areas. Proposed actions include:

1. Supporting epidemiological work exploring prevalence of other medical co-morbidities in the targeted population
2. Developing guidelines for programmes involving joint work with non-psychiatrist professionals
3. Early detection for co-morbid conditions in mentally ill patients and early recognition of mental health problems in the context of chronic medical illnesses
4. Screening, preventing, and initiating early treatment of such disorders.
5. Capacity building, with strategies for teaching and training psychiatrists and other mental health professionals and non-psychiatrist colleagues about joint work
6. Planning joint research activities and developing policy documents for improving mental health care in sub-speciality settings

## **Developing partnerships for collaborative work and strengthening partnerships with mental health organisations**

Health is a complex phenomenon, which needs joint work among different health professionals to benefit patients and provide the best available care.

There are mutual benefits to all stakeholders working jointly if patients are the prime beneficiaries of such efforts. Psychiatrists adhere to the principles of joint work based on fundamental principles of shared vision, equity, transparency, mutual benefit and respect. Trust, transparency, and accountability are key to getting joint-work projects off the ground.



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The WPA would therefore like to explore opportunities for partnerships with medical professionals such as general physicians, neurologists, paediatricians, geriatricians, cardiologists, diabetologists and other allied specialities in medicine; NGOs; and non-medical mental health organisations.

Proposed activities may include:

- Collaboration and liaison with mental health organisations, NGOs, and other non-medical mental health organisations in identifying initiatives for joint work
- Inviting other organisations to WPA congresses and developing links for joint work in teaching, training, and capacity building
- Planning joint research activities and developing policies for improving mental health care in sub-speciality settings
- Developing capacity building and training policies in global mental health

## **Developing Capacity building and training policies in global mental health**

The optimal approach to building capacity in mental healthcare around the world will require partnerships between professional resources and promising health-related institutions.

These partnerships need to: be sustainable, develop quality in clinical care and research, and build a productive environment for professionals to advance their knowledge and skills.

Fostering the continuous improvement of psychiatric education and training among medical students is an equally essential step in this process and a premier objective of the WPA

## **Continuation and completion of the Action Plan 2017-2020**

Previous WPA Action Plans, particularly the 2017-2020 Action Plan, set out strategies for expanding the contribution of psychiatry to improved mental health across the globe. Three characteristics frame the strategic intent of the Action Plan: continuing WPA's contribution to developing the profession of psychiatry; addressing critical mental health topics; and attracting new investment to support this work. Mental health promotion and prevention and treatment of mental illness are also incorporated into the plan.



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The plans formulated in 2017-2020 will be implemented through current partnerships and new funding. This plan is actualized through a strategic framework based on three dimensions:

- Impact on population groups
- Facilitation of activities
- Partnerships and collaboration.

The identified population groups are young girls and women and all young people having mental health problems resulting from adversities.

## **Way Forward**

All areas covered in the proposed Action Plan are high priority. However, due to time limitations and scarcity of resources, only specific areas may be addressed. During the current triennium, expert working groups will start pilot projects in different areas of the Action Plan. Once the findings of these pilot projects are available, we will seek funding to implement these ideas in different settings and countries.

It is hoped that the 2021-23 Action Plan will generate interest among all WPA components to develop guidelines and directions for future work and seek higher mental health services budgets from relevant sources.

WPA is optimistic that it will receive support, active input, and advice from our membership in setting these priorities and making a real difference in mental health.



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## On Building Walls

Professor Bennett Leventhal (USA)



Many of us have been stunned over the past several years with images of immigrants fleeing their homes and countries to find safety and security. We mourn the tragic deaths by drowning in the Mediterranean, by terrorism in Syria, Iraq, Myanmar, and Africa, and by neglect in the United States. All-too-often, these victims are innocent children. And, it appears that the notion of compassion for desperate children and their families is vanishing like the polar icecap. This is not good for anyone but especially children and families. We tend to think that we are separated from this tragedy by fate, national boundaries, or walls. But, we are not.

Sadly, the failure to protect children and families is not new. Nor, is the tendency to demonize those who try to escape from terror and abject poverty. It is this latter notion that justifies the building of walls to separate us from our brethren. A recent example is the proposed wall at the US Southern Border that separates children from their families as well as Americans from one another and from friends around the world. While it is easy to be critical of one country, new nationalistic leaders on every continent share his enthusiasm for walls.

A few years ago, I visited Berlin and the remnants of the Berlin Wall. This wall not only separated parts of Germany from one another but was also a symbol of the Iron Curtain that separated Eastern from Western Europe. The deteriorating remains of the Wall are appropriately adjacent to a museum on the site of the former Nazi Gestapo Headquarters. The Wall is not only an ugly blemish in an otherwise lovely city; it is also a historical scar that reminds us of the pain, suffering and, ultimate futility of building walls. On the old Berlin Wall and, in the adjacent museum, are photos and stories of children and families who were cruelly separated. There are memorials to many who died trying to make the dangerous passage across the Wall, as well as those who succeeded in destroying the Wall. In the adjacent museum are photos of the criminals who built other walls for the ghettos, gas chambers, and crematoria, as well as how their victims were murdered within those walls. Pain and suffering are omnipresent in the photos. Equally impressive is how the pain is palpable to the visitors visiting the Wall from all over the world as they examine the scene with the quiet reverence that it deserves. No one leaves the environs of the Berlin Wall without the clear lesson that walls cruelly create many more problems than they solve.

Children are the major victims of the international "build-a-wall" mentality. Just examine the migrant camps in the US, North Africa, the Middle East or Asia. Here, children and families face poor hygiene and sanitation, malnutrition, and lack of basic medical services. Children are most vulnerable to these horrific health conditions; many are dying and of those who survive, many will have adverse developmental outcomes,



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especially after factoring in the absence of schools, separation from families, and trauma from exposure to violence.

We now live in a connected world, in which walls are neither effective nor tolerable. A world in which children of all ethnic groups and nationalities are harmed rather than protected by barriers and various forms separation from family and peers. They are the daily victims of xenophobia, racism, nationalism, stigma, and bad public policy. These children need our attention and help, now.

In 1963, US President John F. Kennedy galvanized the world by standing in front of the aforementioned Berlin Wall and said, "Ich bin ein Berliner." Now, it is our turn to take a similar stand:

1. Declare that, *we are all children of our larger world.*
2. Commit to the ideas and the practice that *the health and well-being of each child is important to us* and deserves our prompt attention.
3. *Object strongly to camps and compounds* as well as other political and social devices that separate and harm children.
4. *Work closely with our medical and community colleagues* to develop practices and policies that provide all children with nutritious food, clean water, sanitation, healthcare, and schools in a safe, family-oriented environment.
5. When we cannot get the children from behind the walls, *crossover the walls to share our expertise and skills* by directly providing for their well-being until we can bring the children and families to safer settings.

Some 300 years ago, one of our wise scientific forbearers, Sir Isaac Newton, anticipated our problem when he said, "We build too many walls and not enough bridges." Let's follow Newton's advice. As clinicians and concerned citizens of our very small and fragile planet, we must build bridges, not walls, in order to connect peoples so, together, we can achieve common goals for children and families, including health, positive child development, peace, prosperity, and happiness. Let the bridge building begin!



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## **Our Kids are Wired, For Better or Worse**

Jamarie Geller (USA) and Dr. Aniruddh Behere (USA)

### **Introduction**

According to Marshall McLuhan in his critical exploration of culture and media ecology, “there can only be disaster arising from unawareness of the casualties and effects inherent in our technologies.”

The exponential pace of advancements and change in technology and media today may well have stunned McLuhan himself, and there is no more worthy cause for greater awareness than the health and wellbeing of our children.

It is important to explore the potential benefits and dangers of technology to guide recommendations and policy. Additionally, as healthcare providers who have the evidence base, we need to discuss with caregivers a safer and more productive use of technology. As they are the probably the most used and discussed, here we will focus on the Internet and social media as both a potential help to children and how they can be a threat to healthy development.

### **Prevalence of Internet Use**

One in three Internet users worldwide is a child. American children spend an average of 8-11 hours per day with some media interaction, and 84% of children and teenagers have access to the Internet, one-third in their bedroom. However, in some other areas of the world, access is different. In some parts of Africa and Asia, less than 25% of the population is even connected to the Internet, and fewer than half the children in Serbia and the Philippines use the Internet by themselves. Around the world, though, the primary way children access the Internet is through a smartphone. Children and adolescents across the globe use the Internet for a variety of purposes. One difference in use between cultures that has been found is that children in Western countries seem to access health information less than the rest of the world. The way the Internet is used may be more similar across cultures than many other forms of technology, as largely speaking, the available content and applications are the same. For instance, there are only seven countries in the world where Facebook is not the most popular social networking site. There still may be culturally-driven differences in the ways these sites are used, as found in a study of Korean and American students that found that the latter held larger, but looser social networks. Another study suggests some Asian cultures' social media use was more collectivist than that of Western societies, with kids showing more benevolent behaviors.

### **Benefits of Internet Use**

The World Wide Web, as the name implies, represents a gateway into a nearly limitless expanse of information, cultures, and people. Despite the recent demonization of technology and social media, there are of course ways it enhances the lives of children. Of the most compelling advantages, one is that the Internet extends access to useful content, the outside world, and healthcare services.

Children who cannot attend school every day for whatever reason can benefit from online educational materials, including many organized home-schooling programs. There are even high schools entirely run on an online



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platform. This can improve a child's chances of graduating despite personal barriers such as disabilities and mental health challenges, and systemic obstacles like physical access and school systems and communities with few resources.

There is also an argument to be made for the educational benefit of games and programs available through the Internet. This may especially benefit children with less access to playmates in the non-virtual world, like those in rural communities or without siblings.

There is a huge disparity between the world's population and the number of healthcare professionals physically able to serve them. According to the WHO, 45% of the world's population lived in a country where there was less than one psychiatrist per 100,000 people. It is thought that children and adolescents suffer from an even larger deficiency of access to mental health care. In recent years, an approach to beginning to narrow this gap has been the advancement of telehealth. For instance, one study demonstrated the efficacy of treating ADHD via telehealth visits in a controlled trial. Pediatrics, psychotherapy, and child protective services are also increasingly utilizing telehealth models to augment service area. Access to the Internet can overcome physical and social barriers to care, improving physical and mental health outcomes for children and adolescents around the globe.

There are also applications available for phones and tablets that can monitor and, in some cases, help treat mental and physical health problems. For instance, diabetes can now be managed with the aid of applications, as can mental health concerns. One systematic review found significant reductions in depression, stress, and substance use with the utilization of programs delivered in smartphone applications. This offers a new way children and teenagers can monitor their health, research different healthcare concerns, and in some cases, connect with professionals to improve physical and mental wellbeing.

Of value to many children, the Internet and advent of social media widen the pool of potential social connections tremendously. Kids who would normally not be able to connect with one another have a platform for relationship. This can create vast global networks of children and adolescents using the platform for social justice, leadership, cultural exploration, and friendship that was previously not possible.

## **Dangers**

Increased access, of course, does not come without risk. The Internet is rife with content that can be harmful to young minds, and access to nefarious players that can pose a real threat to kids' safety. Where violent, sexual, and otherwise inappropriate contents are regulated to some extent in movies and television, the same is untrue of the Internet.

In some cases, parents and caregivers can safeguard devices programs against adult content, but this is not always available, nor are they infallible. Additionally, the Internet provides an endless deluge of hate speech, quarrels that turn threatening, and even advertisements that contain suboptimal messages to kids unfettered. There are also far too many instances of predators who have connected with children, yielding tragic consequences. It is important to



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encourage caregivers to monitor their children's devices for unsuitable and dangerous use. Also, we need to educate children about how to stay safe.

Constant access to the Internet has brought about concerns for increased access to violent content and an increase in violent behavior. One meta-analysis found that violent video games, which allow children to virtually participate in all kinds of hostile and combative activity, increases aggressive thoughts and actions.

A recent study suggests that cyberbullying, the practice of verbally attacking via social media or other online platforms has been experienced by 20-40% of American children. Unfortunately, victimization in this way is strongly correlated with suicidal thoughts and actions and has been implicated in some adolescent and child deaths. These trends warrant more policy surrounding monitoring kids' activity and education about how to manage inappropriate use.

There also exists increasing isolationism in many societies around the world, which can, in part, be blamed on the replacement of more intimate, direct contact with virtual relationships. This may blunt a child's social learning, ability to interact with other children and adults in a meaningful, socially appropriate way, and deprive kids of much-needed physical contact with others. In one study, frequent Internet users were found to be lonelier, more socially deviant, and to lack social and emotional intelligence.

In addition to the possibility of Internet addiction, the habit-forming nature of technology has several other implications. One outcome is the displacement of physical activity and time with friends and family by screen time. One study found a correlation between screen time and Metabolic Syndrome in adolescents, which is just one of many findings suggesting children are spending more time with technology, and less getting physical exercise.

## **Neurobiology**

One of the more extensively studied neurological phenomena involving the Internet is the activation of reward systems with the responsiveness of computers and other devices. When goal-directed behavior is successful, the ventral tegmental area of the midbrain releases dopamine, and this happens repeatedly when online or playing a video game - a program or device continually responds to our clicks, bathing the reward pathways with dopamine. Studies suggest the mechanism of addiction to the Internet and video games is similar to that of drugs.

There also may be a low-grade, more insidious version of this patterned response contributing to a child's craving for more interaction with technology. This is only exacerbated by the purposeful production and dissemination of programs and content developed with the intention of capitalizing on these tendencies. "Click bait," or catchy titles meant to immediately grab one's attention, games with endless levels, and the tailoring of applications and games for all different interests and ages has made the world of one smartphone, tablet, or computer into an addiction-sustaining abyss.



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## **Future direction**

In the developed world, technology is literally all around us. Cars and airplanes have built-in television sets and wireless Internet. The landscape of how we interact with each other and the environment is changing at mind-numbing pace. However, it is important that we continue to investigate the impact technology has on children so we can ensure these tools are used for optimal growth and development.

Of note, caregivers and healthcare professionals play important roles in guiding children's use of technology. Healthcare providers should be up to date on the current research and recommendations and have a good sense of how children and adolescents in their community are using technology. Further, it is important to address children's screen time and monitoring Internet use, discussing concerns and recommendations with parents and caregivers. 4% to 8% of children and teens have problems limiting their internet use, so parents should be available to provide structure and set boundaries. There are even applications available to help limit screen time. Using safety features like parent-control options can help protect kids from inappropriate content, and caregivers should have conversations with children and teens about safe use and the dangers of sharing information.

The pace of advancing technology shows no signs of slowing. However, with more attention to its effects, protective policies in place, and healthcare providers, teachers, and caregivers staying engaged and vigilant, we can keep kids safe and optimize their development. As with any tool or resources, young people have access to, education regarding proper use and limits are of utmost importance.



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## GLOBAL MENTAL HEALTH AND TRAINEES



Dr. Aliye Tugba Bahadir (Turkey)

*A strong mind always hopes, and has always cause to hope.*

Thomas Carlyle

As described by Koplan et al. (2009), Global Health (GH) is “an area for study, research and practice that places a priority on improving health and achieving equity in health for all people worldwide.” Globalization of the world’s economy is shaping GH, and morbidity and mortality is influencing countries’ economic development. GH has increasingly become a topic of interest in the last two decades.

Global Mental Health (GMH) refers to the implementation of the principles of GH to the area of mental health. GMH has an undeniably important place in GH: According to the WHO’s Global Burden of Disease 2004 update report, unipolar depressive disorders (UDD) constituted the third leading contributor to global disease burden worldwide. One person dies from suicide every 40 seconds. By 2030, it is expected that UDD will be the leading contributor to disease burden globally. Disability-Adjusted Life Years (DALYs) for a disease refers to the sum of years lost to premature mortality (YLLs) and years lived with disability (YLDs). Results of the Global Burden of Disease Study 2010 revealed that mental and substance use disorders were the leading cause for YLDs worldwide. Mental and substance use disorders account for 7.4 % of global DALYs (the fifth leading contributor) and 22.9% of global YLDs (the leading contributor).

Currently, it is evident that providing mental health globally is an arduous task. Shortage of mental health workers, fragmented service delivery models, stigmatization of mental disorders, lack of research capacity for implementation and policy change are the problems that contribute to the mental health treatment gap observed in low and middle-income countries (LMIC). Based on data obtained by the Delphi method, Collins et al. (2011) listed 6 goals related to 25 challenges for GMH: 1 A) Identifying root causes, risk and protective factors, B) Advancing prevention and implementation of early interventions, C) Improving treatments and access to care, D) Raising awareness of the global burden, E) Building human resource capacity, F) Transforming health systems and policy responses. Since cultural context influences the description of normalcy or disorder, a culturally sensitive approach would increase the success of mental health implementations worldwide.

Collins et al. highlighted the top five GMH priorities, based on disease burden reduction, impact on equity, immediacy of impact, and feasibility, and recommended that these priorities guide the development of research and policies. These priorities are: integrating screening and core packages of services into routine primary health care, reducing the cost and improving the supply of effective medications, providing effective and affordable community-based care and rehabilitation, improving children’s access to evidence-based care by trained health providers in LMIC (related to goal C above), and strengthening the mental health component in the training of all healthcare personnel (related to goal E above).



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Ordóñez and Collins emphasized the 4 cross-cutting themes that spanned across 6 goals and 25 challenges previously identified by experts in this field:

- 1) Researchers and decision-makers must have a life course approach to execute research and action on these challenges and goals.
- 2) Initiatives related to mental, neurological, and substance use disorders cannot be resolved within isolated health care and must be addressed across the health system and in different sectors.
- 3) Evidence-based interventions must be implemented.
- 4) Context is important; namely, the effect of environmental exposures and experience on risk, resilience and interventions should be comprehended.

The importance of Child and Adolescent Mental Health (CAMH) is clear when our focus is on the future and when we consider the fact that the average age of onset of mental disorders is in childhood and adolescence. CAMH initiatives are extremely important in preventing adult mental disorders and in advancing prevention and implementation of early interventions (Goal B).

Besides challenges, there are also significant opportunities in GMH. The most exciting opportunity (Patel et al, 2016) is that investigating mental disorders in diverse populations worldwide might lead to new realizations related to the etiology of mental disorders. This kind of breakthrough would be transformational in terms of understanding the disorders and guiding the development of new interventions.

Academic institutions present opportunities that constitute a real reason for hope in GMH. Both faculty and trainees can take a constructive role in actualizing GMH goals. Residents and faculty can work together with multidisciplinary teams worldwide and support the development of novel and feasible programs in LMIC. Residents can take active roles in healthcare professional education on psychiatric disorders. Senior faculty can supervise trainees and draw a road map in terms of both research and sustainable care delivery [GA1] programs. It is essential that GMH research be related to policy-making to resolve the mental health treatment gap in LMIC.

Trainees are both the ones that need to be educated and in turn the ones that can take action in terms of GMH. It is important to highlight some of the elements of GH curricula for trainees: clearly described objectives and coverage of cultural competency and language challenges, frequently encountered ethical scenarios, and program sustainability. GMH related projects provide opportunities for residents and trainees to cultivate skills to diagnose and treat psychiatric disorders in diverse cultures, to build up research skills, and to discover potential solutions for mental health gaps. GMH experiences can also lead residents to reflect on etiology and nosology of disorders and optimal allocation of mental health services. Trainees would gain enormously from an appropriately prepared GMH curriculum.

Partnerships and international collaborations are foundational in improving child, adolescent and adult mental health globally and ensuring healthier and happier future generations.



## Vaping Update: What Clinicians Need to Know About E-Cigarettes

Dr. Amanda O'Kelly (USA)

Vaping (use of e-cigarettes) is rapidly expanding around the world. Much is unknown about the health risks of vaping, and new information is coming quickly. Here is a brief summation of relevant information for clinicians on e-cigarettes and vaping, including facts on the dramatic rise in use, especially among youth, as well as the recent cluster of severe vaping-related illness which has sickened hundreds and has been linked with one death over the last 2 months in the US.

### Vaping 101:

Devices for vaping come in many forms. Collectively referred to as e-cigarettes, this category includes e-cigs, vape pens, vapes, mechanical mods, pods, and tanks. Some products are disposable or resemble combustible cigarettes, while newer generations include rechargeable devices such as Juul, which resembles a USB-drive, holds the majority of e-cigarette retail market in the US and is very popular among youth. A liquid solution, also referred to as "e-liquid," is loaded into the combustion device and heated, releasing an aerosol the user inhales. E-liquids contain variable amounts of nicotine, with a standard Juul cartridge containing roughly the equivalent of a pack of cigarettes and larger e-liquid pods capable of delivering more. Solutions also contain many additives which have not been well-studied as inhalants in their aerosolized form (e.g. acetals and other potential lung irritants). Some data suggests flavorings, which are very popular in the US, may alter chemical processing in the lungs, but much remains unknown regarding the long-term health effects of first and second-hand exposure to e-cigarette vapor. Notably, e-cigarettes can also be utilized to vape other substances, most commonly cannabinoid products (derived from marijuana, such as THC (tetrahydrocannabinol) or CBD (cannabidiol)), and other waxes or oils.

Users are often unaware what they are inhaling. Over 97% of commercially available e-liquids contain nicotine and some product lines such as Juul are not available in nicotine-free versions, yet 2/3 of youth surveyed believed that e-liquid was "just flavoring" and nicotine-free. Indeed, the term "vaping" implies the emission of vapor (a gas in its pure form), and many who use the products erroneously believe they are inhaling harmless water vapor. In fact, this is not true, and users are subjected to unknown risks related to inhaling an aerosol containing particles from the chemical solution as well as the device itself (e.g. metal heating coil).

Many people underestimate the risks of vaping, and e-cigarette use is rapidly increasing. While thought to be less harmful when compared to the many risks associated with combustible cigarettes, vaping is not harmless. As noted, the direct health effects and long-term effects of exposure to these products is unknown. The



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addictive potential, however, has clearly been demonstrated, and while e-cigarettes are marketed as a smoking-cessation tool, there is no evidence to support this claim. Troublingly, multiple studies point to the potential for the opposite effect, leading clinicians and public health experts to believe we may be faced a new generation of nicotine addicts – discouraging news after years of declining use in many areas of the world. Even more discouraging to proponents of child and population health, vaping is most popular with young people, including many who have not previously used nicotine products. A 2018 US national survey entitled *Monitoring the Future* revealed over one in three high school seniors reported vaping in the past year, reversing decades of progress in decreasing nicotine use. In the author's practice, adolescents regularly report vaping, or knowing "Juil fiends" and kids "Juuling" in their schools. Compounding the problem is the lack of available treatment, as there has not been a concomitant expansion of nicotine addiction resources to keep pace with the expanding use, especially among young people.

Vaping has been recently linked to severe respiratory illness and seizures. In early 2019, the US Food and Drug Administration (FDA) began to investigate almost 200 reports of seizures related to vaping, with no findings released as of this writing. Causing greatest concern is the recent spate of severe respiratory illness linked to e-cigarette use. Over the last 2 months in the US, there have been over 300 cases of severe vaping-related lung disease and two deaths attributed to vaping. While many patients reported vaping cannabis products, public health officials are still investigating the potential causes. No product or ingredient has been identified as the causative agent, but high levels of vitamin E acetate (an oil derivative of vitamin E) have been found in many samples and represents one additive of interest. The vaping-related respiratory illness at times began gradually, with symptoms including chest pain, shortness of breath and difficulty breathing, with some patients reporting vomiting, diarrhea, fever or fatigue. In many cases, symptoms progressed, resulted in ARDS (acute respiratory distress syndrome), requiring mechanical ventilation or ECMO (extracorporeal membrane oxygenation) and prolonged hospital stays. Traditional workups have been negative for common causes including infection. While data is still being collected, treating physicians have described the pattern of lung injury as consistent with chemical injury. Dr. Parker of West Virginia University, reports a potential for multiple manifestations of vaping-related lung injury, including potential diagnoses of lipoid pneumonia, cryptogenic organizing pneumonia, and alveolar hemorrhage syndrome. Previous case reports have described lipoid pneumonia related to inhaling marijuana oil and with use of e-cigarettes, and a recent Center for Disease Control report described a cluster of patients diagnosed with lipoid pneumonia associated with vaping.

As new information continues to emerge, e-cigarette users are urged not to vape illicit substances or liquids not obtained from a reputable retailer, and to avoid tampering with the liquid or devices themselves. Those that do not already use nicotine products should avoid e-cigarettes entirely.



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## What do Child and Adolescent Psychiatrists Do?

### How Do They Do What They do?

### And, Why?

Dr Hinemoa Elder and Prof Bennett Leventhal

For many, there is a considerable lack of clarity about the role of child and adolescent psychiatry in the healthcare systems around the world. Some are not clear of the skills necessary to practice child and adolescent psychiatry and the nature of the illnesses treated. What follows is the first of what we hope will be a series of articles describing what child and adolescent do, how they do it and why.

*"Except for his behavior with you, there is nothing wrong with your child so I am going to send you to see a child psychiatrist,"* said the pediatrician to the distraught parents of a child with impulsivity, attentional and social problems.

*"The child psychiatrist has toys and children like to go play with them and talk about their feelings,"* the teacher says to the parents of a child falling significantly behind in school work.

The popular perception of Child and Adolescent Psychiatry may be that we are kind people who "play" with children who don't really have problems. This could not be further from the truth. Yes, we are kind people. We are also skilled medical professionals who work with children and their families to treat the most disabling of disorders to affect children and adolescents.

Child and Adolescent Psychiatrists are physicians who have completed full medical training, including internship and residency plus an additional specialist fellowship. This extra training focuses on understanding human development, its variations and perturbations. With this focus, Child and Adolescent Psychiatrists study and treat illnesses by placing the children's challenges, symptoms and strengths in a development context. This includes understanding how aspects of brain function contribute to illness and how the evolving child's and family's function and experience interact with the many aspects of the environment. Overall physiology and the social-cultural world of the child and their carers are also incorporated into a comprehensive understanding of the child and his/her needs. This is a complex process that requires extensive training, the detailed medical psychiatric assessment of each child and their environment, alongside the application of treatments that are sensitive to the child's developmental level and the physiologic and environmental resources available to support the child's move to healthy adaptation and growth.



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Is there “nothing wrong” with the children cared for by child and adolescent psychiatrists? Of course not! The World Health Organization has repeatedly pointed out that psychiatric disorders create amongst the greatest disease burden in the world. And, it is now well-established that 75% of these disorders have their onset in childhood or adolescence. Further, like most other medical conditions, psychiatric disorders are syndromes for which there is not one specific, known cause. Rather, the understanding of psychiatric conditions highlights the importance of robust formulation that encapsulates the multiple interacting, contributing factors. And there are effective treatments. Indeed, there are excellent, safe therapeutic interventions for most child or adolescent-onset disorders that can be provided by child and adolescent psychiatrists.

Do child and adolescent psychiatrists “just play with children?” Of course not! But, we are playful and do use play to help children present their symptoms more clearly and to help them understand and participate in treatments. We are also physicians who take careful histories, conduct physical examinations, order appropriate laboratory tests, and prescribe medically necessary treatments.

Since the environment is a critical part of childhood and adolescence, child and adolescent psychiatrists are particularly adept at bringing these factors into the diagnostic and treatment process. The natural environment of the child includes caregivers, families as well as community resources such as schools, other activities such as sports, music, art and cultural and religious practices. To better understand and assist the child, the child and adolescent psychiatrist must consider and, often, interact with these elements of the child's life. Indeed, Child and Adolescent Psychiatrists learn how to safely and respectfully enter the child's world.

So, how does this work out day-to-day in the life of a Child and Adolescent Psychiatrist? Some work in hospitals and medical clinics having day-to-day interactions with pediatricians and other healthcare professionals, others work in offices and clinics and still others work in community settings. We will begin this series of articles about the work of child and adolescent psychiatry in New Zealand where a unique culture requires unique skills of practicing child and adolescent psychiatrists.



Dr Hinemoa Elder, *Te Aupouri, Ngāti Kurī, Te Rarawa, Ngāpuhi*<sup>1</sup>.

I am standing in the *tomokanga*, the entrance, of *Hoani Waititi marae*, a traditional Māori meeting house. Waiting for the *karanga*, the call, that will draw us forward and which I will respond to. This is our fourth year of annual *wānanga*, meetings, with the total immersion *Kura*, a school where all subjects are taught in our language *Te Reo Māori*.

What am I talking about? Well, this is one of the things I do. As a child and adolescent psychiatrist. I have a range of roles and responsibilities all focussed on developmental and intergenerational thinking and



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experience. Focussed on prevention, as well as early intervention and best outcomes, as defined by our *tamariki mokopuna* (children and teens), their *whānau* (extended families) and communities.

These roles require me to be in the community, available and visible, participating in community activities which build positive Māori identity, such as speaking our language and attending cultural events which celebrate our resilience. These include *Kapa haka* performance, and *waka ama*, traditional paddling competitions. These are woven throughout my life and an essential part of my work. It gives me a deep current understanding of the realities of our families lives and it builds trust that I walk the talk. And believe me our people do not have a great deal of trust in mental health services. Why would they? We have disproportionate rates of compulsory treatment, in some areas 6 times the rate of non-Māori, for the same diagnosis and severity of illness and much higher rates of seclusion. Our male suicide rates are twice that of non-Māori. So you can begin to see why there might be a sense of futility in the community about mental health services.

My developmental lens is vital wherever my work takes me. Whether working in the children's hospital, in our acute and mother-baby unit, providing a developmental perspective on our NZ Mental Health Review Tribunal, or in child and youth forensic court reports as well as under our specific legislation for Intellectually disabled offenders, or advocating for indigenous peoples mental health on the world stage. In addition, I bring this approach to my role as the Māori strategic leader of Brain Research NZ, a Centre Of Research Excellence of the "ageing brain." As a child and adolescent psychiatrist, developmental concepts make perfect sense to me. In these various contexts, they continue to be highly relevant. For one thing, the brain starts ageing from the moment of conception. And, I am not alone in this opinion. Neuroscience increasingly shows the links between early experiences, from the womb onwards and their important influence on risks of developing neurodegenerative disorders later in life.

Empowering school students, our children and teens with knowledge via these community activities and relationships, meeting them where they are most comfortable, means we are already working in prevention. These *wānanga*, meetings in traditional settings, are also invaluable in challenging conventional thinking around what the concept of the "ageing brain" or "mental illness" might mean. Indeed, it enables fruitful debate about the meaningful practice of child and adolescent psychiatry. This is essential in informing research and clinical practice that is salient for our communities.

Standing there, about to walk on to the *marae atea*, I am exquisitely aware of all the stories and all the people that have guided me to this precise moment. Have you ever had one of those moments where you felt all the strands of your life coming together? And deep inside, you know you are exactly where you are meant to be and doing exactly what you are destined to do? Time stands completely still. You see and feel all the experiences that had brought you to that precise moment. Finally everything makes sense? This is one of those. For me, child and adolescent psychiatry was a very natural fit for my aspirations for my people, our own self determination of our healing. While we are overrepresented in all mental health statistics, I will not fall into



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the trap of identifying us in that way. Rather, focussing energy on consistently bringing the resilient cultural factors and interventions, critical for engagement and sustained robust therapeutic relationships to the fore.

What follows as we move forward is an extraordinary exchange, a *pōwhiri*, a ritual of encounter. It is a time-honoured tradition. We travel across the *marae atea*, the open space in front of the house and then inside the metaphorical body of the ancestor, of the *wharenuī*, of the meeting house.

I am often in these settings as a kind of matchmaker between our cultures, our ethnic cultures, our cultures of work, our generational cultures. As on many previous occasions, I know this is the first *marae wānanga* for some of our neuroscientists and clinicians. Some have told me they feel anxious and fearful of causing offence. And slowly over time, over each *wānanga*, they grow in confidence. Using their *pepeha*, cultural introductions I have supported them to learn. Relaxing and tuning into *whakaaro Māori*, Māori thinking. The students are also shy, respectful and over the last few years, they have gradually engaged more and more in describing their own interests and questions. For our researchers and clinicians these lived experiences build cultural competency. We build a shared sense of contribution and citizenship. We work hard to build real relationships between our Māori community partners whether it is with the neuroscientists or colleagues at the Faculty of Child and Adolescent Psychiatry in the Royal Australia and NZ College of Psychiatry, where we have also had annual cultural competency training on *marae* for the last 3 years, forming part of our CPD.

There are so many potent reasons to do this right. Encouraging our students to consider careers in science, in Psychiatry, seeing themselves in these kinds of jobs and seeing how they would improve them. Improving our research and clinical practice so it can deliver real benefit for Māori and that these relationships with Māori communities are sustained.

Breathing the same air has an extraordinary osmotic effect. Breaking down barriers, learning from each other, seeing beyond titles, beyond ages, beyond stereotypes. It is essential, too, for our psychiatrists practicing in Aotearoa NZ and our trainees. Māori patients and *whānau* (extended families) need a culturally informed approach, this improves outcomes and job satisfaction for the health practitioners. It is now legally required by our Health Competence Assurance Act 2003.

One of the most potent things I talk about in my work is viewing our *tamariki*, our children, as ancestors of the future. This invites a different sense of connection and accountability to the importance of optimising their development given their influential future role. I reflect on this often. Of course we are all ancestors of the future. And when we seek to explore the developmental experiences within ourselves and the *whānau* we work with an ancestral frame of reference it sheds new light on the crucial importance of the developmental lens in psychiatry and how much child and adolescent psychiatry has to offer.





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In future issues, We will provide more articles about the robust and varied practices of a singularly important medical specialty, Child and Adolescent Psychiatry. We will capture the exciting, challenging and gratifying work of this group of developmentally focused, clinically devoted medical practitioners. If you want to learn more about Child and Adolescent Psychiatry, or have a story to tell, write to us. We look forward to sharing the work to which we and many others have dedicated their professional lives.

## <sup>1</sup>Glossary

*Māori*: indigenous peoples of Aotearoa NZ

*Tomokanga*: entrance

*Marae*: a traditional Māori meeting area

*Kura*: a school where all subjects are taught in our language

*Tamariki mokpuna*: children and literally grandchildren

Whānau: extended family

*Kapa haka*: suite of traditional modes of performance

( [www.maoritelevision.com](http://www.maoritelevision.com) ; search for *te matatini*)

*Waka ama*: polynesian outrigger canoe paddling ([www.wakaama.co.nz](http://www.wakaama.co.nz))

*Marae atea*: open space in front of the whareniui, the building where the meeting is held

*Pōwhiri*: welcome ceremony

*Marae wānanga*: marae based learning experience

*Whakaaro Māori*: Māori ways of thinking





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## **CHILD AND ADOLESCENT PSYCHIATRY ACROSS THE EAST AND THE WEST: AN EVOLVING MOSAIC LANDSCAPE**

Dr Ramya Mohan (UK/India)

It has been an eventful three years. Three years of life adaptation, constant learning and expanding my horizons with Child and Adolescent Psychiatry –clinically, scientifically, culturally, socio-demographically, economically, emotionally and personally. A roller-coaster of cross-cultural perspectives whilst working simultaneously with two cultures, two healthcare systems and two continents.

Being a senior Child and Adolescent Consultant with the NHS (National Health Service), I have faced new challenges on a daily basis requiring constant reappraisal and personal development. I have considered these challenges as excellent opportunities for building on my professional and personal skills while working with a dedicated multi-disciplinary team. Three years ago, I took a momentous decision.

Bengaluru is one of the Indian metros, with the highest rates of emotional and behavioral difficulties in young people. There is a huge void in the availability of specialty- trained and certified Child and Adolescent Psychiatrists aimed at supporting children and young people with emotional, behavioural and mental health difficulties.

Hailing from Bengaluru and having done my schooling and medical training in India before moving to Europe as a young adult, I have always had a strong wish to share my expertise and work with my home community. The glaring gap in board-certified Child and Adolescent Psychiatrists in India (likely less than a handful) focusing on supporting children and adolescents made me consider and implement a flexible career arrangement between India and the UK since August 2016. I am now a flexible Consultant Child and Adolescent Psychiatrist in the UK, whilst actively supporting community development work in India through a mix of awareness building work (including media work), anti-stigma/discrimination work, community-based music and art events and grassroots clinical work.

I made a conscious choice involving significant travel even within India to build on my experience –to work across traditional pockets of the city in parallel with areas with a global outlook. During this transition, my training and experience in the UK held me in excellent stead from a clinical, quality and people's management perspective. What it did not prepare me for was the ground reality – socio-demographics are different. India is a young country, with the majority of the population being under 25. The cultural and social fabric is diverse across the massive subcontinent. There are differences in family relationships and community living. Cultural variability includes different mental health presentations, service user expectations, minimal public health infrastructure and the economic /lifestyle divide. The Indian dichotomy – rich/poor, rural/urban, educated/illiterate – is highly complex. This has been a gradual learning process over years, supported by my familiarity/ability to converse in at least four of the twenty actively used local languages, early years in India and being able to recognize and identify with societal norms and expectations.



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Healthcare systems and delivery are very different in the UK and India. One has a standardised public healthcare system (the NHS) and the other is a mix of privatized and governmental healthcare. Economic capability plays a big role in easy and speedy access to high-quality healthcare - both systems have their pros and cons.

Awareness about child safeguarding varies across the east and the west and across settings (healthcare, education and the voluntary sector). The educational sector has adopted many standardized approaches in India-Curricula. Currently, the mental health infrastructure in India is rudimentary and focused in the metros, the wider system is largely reliant on robust family/community support and goodwill.

The past three years have seen a sea of change in India's outlook to mental illness and legislation. I feel fortunate to have been part of this momentous era of change and outlook. Since 2015/6, India has accepted long overdue legislative measures like decriminalisation of suicide and homosexuality, addition of the third gender, opening up of opportunities to transgender individuals, initiation of the Mental Health Act and inclusion of a degree of outpatient mental healthcare under private insurance.

At the NHS, I continue to consolidate my service development, clinical leadership and management experience in the context of a dynamic National Health Service. At the same time, having worked closely with the trust business development managers and UK Trade and Investment, I have gained an excellent understanding of developing a viable business strategy, managing finances and budgeting issues in challenging international projects.

Working with the media across Europe & Asia (ranging from the BBC Arts & Culture, BBC Asian Network, LBC etc in Europe to NDTV, Aaj Tak / India Today in India) on large scale awareness projects around Child and Adolescent mental health, I have learnt to tailor key messages to my audience and culture, whilst retaining a global perspective. I have spoken about the mental health of the nation post- Brexit, British-Asian Mental health and the use of the creative arts to support mental health in youth and communities across the UK and India. I have written articles/contributed to expert media panels during the global "Blue Whale" gaming epidemic and adolescent mental health endemic in India.

What I realized was that the creative arts were a binding factor, a universal language to support mental health awareness, fight stigma/taboo/discrimination and normalize diversity. Music is a universal language across cultures and barriers. Alongside clinical projects, I have initiated multiple research and community-based projects bringing art and music together with the mind. In 2015, based on years of insights, I founded iMANAS London, an organisation created to promote the integration of Medicine, Creative Arts and Neuroscience for individual and community development on an international platform.

Exploring the way in which we can harness the mind and brain's potential, iMANAS London has pioneered and continues to deliver its message/work through projects that bring Science, Medicine and the Arts together through focused East-West projects on a global platform.



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## **European Federation of Psychiatric Trainees: A Journey of Trainees Creating Together**

Dr. Asilay Şeker (Turkey)

### **What is EFPT and How Does It Work?**

The European Federation of Psychiatric Trainees (EFPT) is an independent, non-profit, umbrella organization founded in 1992, for European national psychiatric trainees' associations (NTA). The organization currently represents psychiatric trainees from 38 European countries. These NTAs are from all specialties of psychiatry, the main ones being general adult and child/adolescent psychiatry.

The primary objective of EFPT is to enhance and harmonize standards of psychiatric education and training across Europe by working in partnership with relevant international and/or national bodies. The Federation also aims to promote the creation of national trainee associations in all European countries.

As a permanent member of the European Union of Medical Specialists (UEMS) Board of Psychiatry and of Child and Adolescent Psychiatry, the EFPT actively participates in both the development of educational guidelines and the evaluation of psychiatric training institutions in Europe.

EFPT operates through the Board of Directors and Working Groups (WGs). While the Board mostly deals with management and budgeting as well as representation in certain partner organizations, WGs are the backbone that produce the collaborative work. [A1] Currently, there are 7 active WGs: Research WG, Psychotherapy WG, Psychiatry Across Borders (PAB) WG, Maintaining and Establishing a National Trainee Association (MENTA) WG, Leadership WG, Exchange WG and Child/Adolescent Psychiatry (CAP) WG.

The scope of WGs is spectacularly broad and encompasses online Survey studies, presentations in international congresses, assistance of countries with NTA management, webinars, and much more.

Each year, EFPT organizes a Forum where delegates and observers from member NTAs and occasionally visiting trainees from non-member countries get together. For the recent few years, EFPT also hosts trainees from non-European countries with the 'Overseas Programme,' which enables trainees from all over the world to come and see EFPT activities on site.

During the Forums, EFPT offers a variety of activities from scientific lectures to workshops, clinical visits and poster presentations as well as leisure events like city visits and the popular tradition of 'International Night.'

Throughout the time in between Forums, EFPT trainees keep in touch online to continue the projects and keep the network alive.



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## CAP within EFPT

CAP trainees in EFPT are represented by the Child/Adolescent Psychiatry Working Group. The Chair of the WG is elected by votes of the member NTAs during the General Assembly, held during the annual EFPT Forum. This is different from other WGs where chairs are elected within the WG.

The CAP WG chair is a member of the EFPT Board of Directors as the CAP Representative/Secretary. This privileged position is a demonstration of EFPT's recognition of the significance of the CAP trainee community in the EFPT. This arrangement allows CAP trainees to have an individual voice within EFPT and enables partnership with external CAP organizations.

CAP WG focuses on supporting CAP trainees with networking, professional development and organizing projects that are of interest of CAP trainees. Some of the running and soon-to-start projects of the CAP Working Group include:

- Psychopharmacology Survey: A survey to explore the current usage of psychopharmacology and off-label prescriptions in CAP.
- CAP in GAP Survey: A survey to explore CAP rotation models for adult psychiatry trainees.
- Dysgraphia Survey: A survey to explore processes in diagnosing the disorder.
- CAP Video Project: A video project by trainees and experts to promote CAP and enhance recruitment.
- Psychotherapy in CAP Survey: A survey to explore the training and practice of psychotherapy in CAP
- First Assessment Survey: A survey planned and implemented in collaboration with the ESCAP

Results from survey studies are presented in various congresses as symposia or posters. Articles can also be written depending on the plans of the study group.

In addition to the above mentioned WG projects, the CAP Working Group actively participates with several organizations to promote CAP trainees and uncover new opportunities. Examples of participation include:

- UEMS-CAP: Up to 2 CAP Representatives attend annual UEMS-CAP meetings and work with the Union on different projects including the CAP Day at the annual EFPT Forum. During the CAP Day, lecturers, including, but not limited to, one UEMS-CAP representative, joins EFPT trainees for keynote presentations on CAP topics.
- ESCAP: In 2018, EFPT started a collaboration with ESCAP and became a contributing organization for the ESCAP 2019 Congress in Vienna. Both organizations continue to work actively on joint projects to maintain a strong relationship.
- EPA: EPA-CAP Section has endorsed a symposium with EFPT-CAP WG on CAP training for the upcoming EPA 2020 Congress in Madrid.



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## **EFPT-CAP WG and WPA-CAP Section**

As the EFPT CAP Secretary, I have recently attended the WPA-CAP Section meeting during the WPA 2019 Congress in Lisbon. It was delightful to see that EFPT was very warmly welcomed as one of the representatives of the future of CAP and that my enthusiasm to have an active relationship with the Section was reciprocated. I was very impressed with the work being done by the section and really inspired by all the top names still working relentlessly to improve the image and service of CAP.

We, as the EFPT and the CAP WG, believe that reaching out to larger-scale organizations is very important. Through future collaborations and support from the WPA-CAP Section, we hope to contribute to improving CAP training in Europe.

On behalf of EFPT, I thank the WPA-CAP Section for enhancing our visibility by this article and encourage all the readers to check out our website [efpt.eu](http://efpt.eu) or send an email to [caprepresentative@efpt.eu](mailto:caprepresentative@efpt.eu) for more information. As our motto says, we hope to work hand in hand for 'shaping the future of psychiatry'.



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## **CAMH around the world**

### **Child and Adolescent Psychiatry in Nepal**

Drs. Utkarsh Karki, Gunjan Dhonju, Yugesh Rai, and Arun Raj Kunwar

#### **Introduction**

Nepal is one of the low-middle-income countries in South Asia. Nepal's population is 30 million people, of which 40 - 50% are children and adolescents. Fifteen to twenty percent of this population suffers from some form of mental health problem. Nepal has recently undergone a decade-long conflict, followed by a major earthquake in 2015, along with yearly seasonal natural calamities. Being a country of great topographical and cultural diversity, Nepal has many challenges. Meeting the population's mental health needs is a challenge that has been insufficiently addressed and prioritized. Child and adolescent mental health (CAMH) in Nepal is even more neglected, despite children and adolescents comprising almost half of the population. Nepal does not have a mental health act; the document is still at a policy level and under further consideration.

#### **Epidemiology**

There has been no nationwide epidemiological study on mental health in Nepal. Studies are limited to specific geographical areas of the country. In most areas of the country, only children who have severe intellectual or cognitive deficits and psychosis have been identified as suffering from mental health problems. The needs of children with other mental illnesses have been virtually unaddressed.

#### **Referral pathways**

The first points of contact for most of the population, including children and adolescents, are the traditional healers; faith healers; religious healers such as priests, monks, and shamans; and witch doctors. This help-seeking pathway stems from the socio-cultural and religious beliefs that mental illnesses are a result of possession by gods or evil spirits, or a result of black magic, curses, or sins from the past life. If no improvement is noted, the next points of contact are the local health service providers or urban hospitals. However, because of poor practitioner awareness of mental health issues in children, the detection rate of mental health issues is poor, and there is typically a delay in referrals. Visits to general health practitioners result in treatment for physical ailments without inquiry into and detection of mental health issues. When general health practitioner treatment does not help, patients may be sent or self-referred to tertiary centers, where again, after initial evaluation by general medical practitioners, they are finally referred to mental health professionals. Multiple visits to different types of service providers delays not only the identification of mental health issues but also implementation of required



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interventions. These delays result from poor awareness of available service providers and poor referral guidelines for children and adolescents with mental health-related problems. These delays lead to loss of time, significant economic burdens, and an increase in the morbidity of this population. Many such children may not even reach the centers where appropriate mental health services are available.

## **Outpatient and Inpatient Services**

Child and Adolescent Psychiatry (CAP) outpatient clinic, under the leadership of Dr Arun R. Kunwar, has been running within Kanti Children's Hospital (KCH), Kathmandu, since July 21, 2015. KCH is the first and only government-run children's hospital in Nepal that provides specialized services to children, and CAP is one of the few specialized services that has been running in this hospital. In 2018, CAP outpatient department (OPD) at KCH provided service to 2477 children, of which 1529 were males and 948 were females. The most common diagnoses were Anxiety Disorder (524), Intellectual Disability (403), Autism Spectrum Disorder (259), ADHD (215) and Dissociative Disorder (173).

The goals of this CAP clinic are to develop as a National Centre of Excellence in CAMH, to provide comprehensive treatment for any type of mental health problem, and to develop as a teaching and learning center to increase resources for services to children with mental health needs. The plan includes, by the end of 2021, completion and full integration of a new child psychiatric building within the KCH complex. The service is operated as a collaborative development project, jointly supported by Child Workers in Nepal (CWIN), FORUT Norway and the KCH/Ministry of Health and Population. Besides this clinic, CAP services are provided only in a few other private clinics and medical colleges in the capital city. The rest of the country is devoid of any CAP services. Children and adolescents who need in-patient services are housed within adult wards. There are no such facilities for younger patients.

## **Mental health promotion and prevention Services**

There are very few community outreach programs for CAMH. Kanti CAP along with a few other NGOs have done some work focused on providing some CAMH awareness in schools and rural communities. Kanti CAP also conducts: regular supervision visits to the CWIN, a child helpline for psychosocial counselors, telepsychiatry (mainly telephone consultations and follow up) for children in remote areas, and courses on CAMH in various schools and radio programs to raise awareness of CAMH. The Kanti CAP, along with CWIN, UNICEF and Ministry of Health, has started a pilot program in Mithila Municipality, Province 2, to train community-level health service providers and paraprofessionals in the health system of Nepal for early detection, management and referral of CAMH problems.

## **Training**



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Psychiatry training in Nepal is a 3-year program. There are 12 training centers, which are located mainly in urban areas. An exit examination and submission of a thesis are required to complete the training. Then, one must pass the specialization examination held by the medical council to practice as a registered psychiatrist. There are currently about 45 psychiatric residents in training. There is no standardized training program for CAP in Nepal. Training and clinical experience in CAP vary widely among different training centers. Usually, the training centers do not have a child psychiatric clinic, and none have a child and adolescent psychiatry ward. Trainees are sent to KCH for postings in CAP. In addition, some medical colleges send psychiatric trainees to experience rotations in India, which has specialized CAP training programs.

Dr. Gunjan Dhonju has completed his one year of Postdoctoral Fellowship (PDF) training in CAP from the National Institute of Mental Health and Neurosciences (NIMHANS) in Bangalore, India and is currently working in KCH. Dr. Utkarsh Karki is in his third year of Doctorate of Medicine (DM) training in CAP at NIMHANS. Clinical psychologists working in KCH are posted for six months of training in child psychology at NIMHANS.

## **Research**

Research on child and adolescent mental health in Nepal is very limited. Most of the studies that have been done were in the aftermath of the decade-long political conflict and the recent major earthquake of 2015. There are few studies published in the literature; the majority of the clinical studies are retrospective chart reviews or cross-sectional studies conducted by NGOs. Currently, there are two ongoing PhD projects. The first Ph.D. project is titled "Epidemiological study on emotional and behavioural problems of school going children (6-18 years) of different ethnic groups," and will provide data on the prevalence and types of problems in the child population of Nepal. The second Ph.D. project is titled "Development and validation of ADHD diagnostic scale for children in Nepal." Another study, which is clinic based, is titled "Longitudinal follow-up of patients receiving psychotropics in KCH," and is ongoing.

## **Legislation**

In 2017, new mental health policy was adopted, and it includes five priorities: to ensure easy availability and accessibility of basic quality mental health services for all citizens; to prepare necessary human resources in order to deliver mental health and psycho-social services; to protect the fundamental human rights of people with psycho-social disability and mental illness; to enhance public awareness to promote mental health and combat stigma resulting from mental illness; and to promote and manage health



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information systems and research. These are general policies in relation to the mental health of the overall population and not a specific policy that targets the mental health of children and adolescents.

The government of Nepal has various laws related to children in the child protection act. Other related acts are the child labor (prohibition and regulation) act, the education act, the disabled person's act, and the health act. Although the laws are available in the constitution, in practice, the implementation has not been satisfactory. The children's act of 1992 has laws that are against the use of children in armed conflict, child marriage, child labor, child trafficking, and child abuse; and for protection and care of the disabled children. However, these problems are still prevalent in the country. Dr. Arun R. Kunwar is also part of the National Mental Health Policy working group and has advocated integrating CAMH in overall health systems. This strategy has been incorporated in the new policy draft and is awaiting approval from the Government of Nepal.

### **Future directions and possible solutions**

The government of Nepal needs to conduct programs on CAMH to increase awareness among service providers and the general population. There is a need to ensure that the basic needs of children are met and to develop and enforce a mental health act, with prioritization of CAMH. Adequate training of community level health paraprofessionals is needed to ensure early detection, basic psychosocial intervention, and timely referral for child and adolescent mental health issues.

Any intervention or research in the area of CAMH needs to be mindful of socio-cultural aspects; thus, any tool used needs local adaptation and validation. Legislative reforms and strict enforcement of laws for child protection are needed. The educational sector needs reforms to ensure child-friendly learning environments and promotion of child and adolescent mental health. The organizations involved need to have training in CAMH. The traditional healers who are usually the first point of contact need to be made aware of CAMH issues. This awareness can ensure an improvement in the pathway of care for children and adolescents in need of mental health services. Overall, a holistic approach needs to be taken for the promotion of CAMH, since it is not an independent entity and is deeply connected with various factors in the biological and environmental domain



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## **Child and Adolescent Psychiatry in Greece**

Drs. Konstantinos Kotsis, Ioanna Giannopoulou, Dimitris Anagnostopoulos, Eugenia Soumaki

Greece is still facing the consequences of a nearly 10-year profound financial and humanitarian crisis. The long-term recession, loss of income, high unemployment and influx of unaccompanied refugee children as well as migrant children with their families have put enormous strain on the public health sector in Greece and brought new challenges to child and adolescent mental health services (CAMHS), which face staff shortages and extreme budget cuts. Currently, there is a national shortage of psychiatric beds, particularly for adolescents, which means that in an “extreme emergency” they are admitted to adult mental health units. On the other hand, there are huge variations in the availability of CAMHS and facilities, which are mostly located in Athens and large cities, leaving most rural areas without child and adolescent psychiatrists working either in either the public or private sector. Acquiring new knowledge through clinical experience has been enlightening in thinking about innovative approaches to delivering mental health services and about how the services should be optimally reorganized. The Hellenic Society for Child and Adolescent Psychiatry (HSCAP) took on an active role in promoting changes within the field of Child and Adolescent Psychiatry (CAP) in Greece.

### **Recent developments in child mental health care in Greece**

According to a national report published by the Ministry of Health (MoH) in June 2018, a smoothly functioning mental healthcare system needs more than 1,200 new personnel and 208 new structures, including 28 specialized units for children and adolescents. Increased awareness of the importance of child and adolescent mental health, notwithstanding limited access to public CAMH care, led the MoH to develop a new national strategic plan for CAMH care, focusing on: (a) empowering of understaffed CAMH services, (b) developing new services in areas of high need, (c) expanding innovative services such as mobile units and telepsychiatry to deliver specialized mental health care to remote communities, (d) establishing one inpatient unit per Regional Health Authority so that children will not need to be hospitalized miles away from their family, and (e) opening, at last, an in-patient Adolescent Unit in Athens (the plan for one had been suspended since 2010). To meet the above objectives, the MoH secured funding to cover the vacancies and advertised more than 20 CAP posts in the public sector.

Furthermore, in the last 2 years, the National Telemedicine Network, set up by the 2nd Regional Health Authority, started the implementation of child telepsychiatry services, allowing three different general hospitals to consult to health units on the islands of the Aegean Sea. This novel effort insures accessibility of CAMH care in remote communities where mental health services are grossly scarce.

Finally, the recent reorganization (2017) of the administrative structure of public mental health care and the sectorization of mental health services is yet another positive development, despite several identified pitfalls.



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The newly introduced intermediate administrative level aims at planning and developing new services according to local needs and better management of resources within the sector and region, for the benefit of patients. The regional mental health committees (responsible for 2-4 sectors), with decision-making powers, constitute the new intermediate administrative level, between sectoral mental health committees and the MoH-Mental Health Department. The representation of service users in the sectoral mental health committees, for the first time, recognizes the importance of their involvement as partners in designing and monitoring services. The reorganization of sectors according to local socio-demographic indicators and the ensuring of overlap (previously non-existent) between adult and child mental health sectors is expected to improve care through comprehensive intervention for the family if needed and continuity of care from childhood to adulthood.

## **New developments in training in Child and Adolescent Psychiatry**

Recently (as of 2018), there were fundamental changes in CAP training. CAP specialty training now lasts 5 years and comprises 1 ½ years of basic training in psychiatry (12 months) and neurology (6 months), preferably in pediatric departments or hospitals, and 3<sup>1/2</sup> years of rotational training in CAP: 2 years in a hospital out-patient unit, 9 months in an in-patient unit and 9 months in a consultation-liaison unit. All trainees are expected to participate in on-call duties, which provide essential experience in dealing with emergencies. The introduced changes are important, as they fulfill the requirements of the European Union of Medical Specialists Section on Child and Adolescent Psychiatry (UEMS-CAP). A structured training curriculum developed on the basis of the UEMS-Logbook ensures mastery of required knowledge and skills, a minimum caseload, adequacy of supervision, and national uniformity in training.

Moreover, the recent change (following the HSCAP's longstanding demand) of the specialty's name from "Child Psychiatry" to "Child and Adolescent Psychiatry," is considered an important step to strengthening the position of the CAP specialty, as semantics of the word "child psychiatry" (a single word in Greek) may imply a subspecialty of either psychiatry or paediatrics, and, misleadingly, that child psychiatrists help only children up to the age of 14 years (the cut off age for paediatrics, which recently has been extended its scope to the age of 16 years) and not specifically older adolescents.

CAP specialty training in Greece is facing some other problems, such as limited numbers of training centers and available training posts. Despite the brain drain in Greece, most of our young colleagues choose training at home; therefore, there are long waiting times to enter training, and most trainees start their training at age 35 years or above. Minimum standard requirements were set up to ensure the quality of the training, and following its recent evaluation, it is anticipated that the number of certified training CAP centers and training posts will increase.



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## **Hellenic Society of Child & Adolescent Psychiatry**

The community of child and adolescent psychiatrists is represented by the HSCAP, established, in 1983, in Athens and currently with approximately 400 members. The HSCAP organizes, every two years, a national conference and contributes to Continuing Medical Education through thematic seminars, some using live video streaming so as to increase accessibility to colleagues who do not reside in Athens. The HSCAP publishes the journal "Child and Adolescent Psychiatry" and a newsletter that informs the members of all activities, legislative updates, and other important topics. Members of the HSCAP participate in various task force committees or working groups set up by Ministerial decree (Ministry of Health, Ministry of Education, Research and Religious Affairs, Ministry of Justice, Transparency and Human Rights) and provide direction on child mental health issues and CAP training. The HSCAP's assistance to various Ministries has been instrumental in service planning, prioritizing needs for CAMHS development, setting up Children's Advocacy Centers for forensic interviewing following allegations of child sexual abuse, designing new services for young people at risk for re-offending, promoting mental health in schools, and CAP training. Finally, the HSCAP has contributed to a committee set up by the MoH on justifying financial resource allocation and reimbursement of therapies through the National



## **“For a stronger family”- a national program for the support of children of parents with mental disorders in Croatia**

Dr. Vlatka Boričević

Children of mentally ill parents have a higher risk of developing mental illnesses over the course of their lives. This increased psychiatric risk is due partly to genetic influences and partly to an impairment of parent-child interactions. Furthermore, these families often face challenges stemming from parents' low educational status and unemployment or under-employment, poverty, inadequate housing, marginalization, and discrimination. Children of mentally ill parents face a higher risk for abuse. The accumulation of such adversities forms the greatest threat to parenting quality and healthy child development. Interventions aimed to prevent transgenerational transfer of risk address families' knowledge about the illness, children's psychosocial resilience, parent-child and family interactions, stigma, and social network support. The basis of all preventive strategies is effective treatment of parental illness. Since families of children of parents with a mental illness have a variety of needs in different domains, interventions aimed at improving parenting quality should include a variety of services delivered via a comprehensive and coordinated approach.

With the aim of providing support for families facing adversities, the Ministry of Demographics, Family, Youth and Social Welfare and the UNICEF office in Croatia has initiated the national program for the support of families at risk. The program's specific aims for the 2017 to 2020 period include:

Education of professionals from different sectors (social welfare, health, law enforcement, justice, education) on families at risk and emphasis on the facts that parental mental illness is one among many adversities that families can face and a strong risk factor for adverse psychosocial outcomes among offspring

Development and improvement of tools to assess parents with mental disorders and to assess their children's' safety, well-being, and risks

Preventive and treatment interventions for parents with mental disorders and their children.

Development of national guidelines on multisectoral collaboration in working with families in risk.

The program will provide education for about 1400 professionals and support for 5500 families and 29 000 children. This program, through investment in experts and development and expansion of family-oriented services, aims to support the most vulnerable families and children.

The educational program covers: common presentations of mental disorders in parents and children; systematic assessment – based on information from parents, children, teachers, therapists, and other service providers – of strengths and vulnerabilities in parenting and child development; design of an integrated and customized preventive



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care plan; linking families to and coordinating childcare, community health, and social welfare services; effective communication with parents and children; and motivational interviewing skills.

With a strong focus on the whole family, the program has initiated improvements in adult mental health services. The program has also facilitated collaboration among all sectors in sharing information, planning support and care, and implementing and evaluating interventions.

Adverse life circumstances can be overcome through timely and high-quality support. Seeking support is not a sign of weakness, but of responsibility. Families of parents with mental illness encounter many adversities. Society is responsible for providing support for these families. This national program offers better and more efficient care and optimizes development for children in this vulnerable population group.



## **Meeting report**

### **Strengthening and enhancing mental health and psychiatry pre-service curriculum: a follow up meeting, 3-4 June 2019, Kyiv, Ukraine.**

Ashmita Chaulagain (Nepal /Norway)

#### **Background**

With growing recognition of challenges posed by the worldwide burden of mental illness and the scarcity of mental health care in many low-resource settings, global mental health (GMH) has been increasingly identified as a training priority. Equally important is strengthening mental health and psychiatry curricula to make sure that training programs build future medical professionals' knowledge, skills and attitudes that can be applied to a wide range of mental health conditions. Recognizing this priority, the Ukraine, Norway and Armenia (UNA) partnership project organized a two-day meeting on "Strengthening and enhancing mental health and psychiatry pre-service curriculum" from 3-4 June 2019 at Taras Shevchenko National University (TSUNK), Kyiv, Ukraine. This meeting was also a follow-up meeting after the first pre-service training of trainers and supervisors for the Mental Health Gap Action Program-Intervention Guide (mhGAP-IG). This initial meeting was held on November 2018 in Kyiv, Ukraine, and it received technical support from the World Health Organization, Geneva, Switzerland.

The aim of this follow-up meeting was to bring together decision makers and clinical educators from postgraduate and undergraduate teaching institutions and to provide an overview of mental health and psychiatric curricula, identify curricular gaps, and provide recommendations for improving existing curricula.

#### **Meeting Organization**

A total of 22 professionals from postgraduate and undergraduate teaching institutions from five different countries: Armenia (2), Georgia (1), Kyrgyzstan (1), Norway (2), and Ukraine (16) attended the workshop. Four enthusiastic psychology students from Kyiv, Ukraine also participated at the meeting. Professor Norbert Skokauskas, Project Coordinator of UNA partnership project from Norway and the Research Chair from Norwegian University of Science and Technology chaired the meeting. Professor Irina Pinchuk, UNA Project Coordinator from Ukraine and Vice President of the Ukrainian Psychiatric Association and the Director of Ukrainian Research Institute of Psychiatry Ministry of Health of Ukraine co-chaired the meeting. The meeting was also attended by Professor Semen Gluzman, President of the Ukrainian Psychiatric Association.



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## Meeting Outline

On the first day of the workshop, Professor Norbert Skokauskas explained the UNA partnership project and its previous activities to strengthen partner countries' mental health and psychiatric curricula, especially through adaptation and implementation of WHO's mhGAP-IG. Professor Skokauskas also mentioned that it is important for decision makers and educators to understand which part or module of mhGAP-IG could be useful to strengthen the university's mental health and psychiatric curriculum. He also highlighted that, as psychiatrists are busy in clinical work, and psychologists are engaged in most of the research work, it is necessary to bring them together in a common platform to promote awareness about what psychiatrists and psychologists are studying and to find an area for collaboration.

Professor Norbert Skokauskas' remarks were followed by Professor Irina Pinchuk's presentation on mental health statistics, services, and psychiatric education in Ukraine. Subsequently, educators from different teaching institutions (Kristine Avetisyan, Associate Professor at the Department of Medical Psychology at Yerevan State Medical University, Armenia; Eka Chkonia, Professor, Department of Psychiatry, Tbilisi State Medical University, Georgia; Mikhail Popkov, Associate Professor, Department of Medical Psychology, Psychiatry and Psychotherapy, Kyrgyz Russian Slavic University State Medical University, Kyrgyzstan; Svitlana Paschenko, Deputy Dean on Science and International cooperation and Associate Professor, Faculty of Psychology, Taras Shevchenko National University, Kyiv, Ukraine; Oksana Kopchak, Professor, Head of the Department of Neurology and Psychiatry, Kyiv Medical University, Ukraine; Yevgen Denysov, Docent, Department of Psychiatry, Psychotherapy, Narcology and Medical Psychology, Donetsk National Medical University, Kramatorsk, Ukraine; Oleksandr Filts, Professor, Head of the Department of Psychiatry and Psychotherapy, Faculty of Postgraduate Education, Danylo Halytsky Lviv National Medical University, Lviv, Ukraine; Galyna Ya. Pyliagina, Professor, Head of the Department of Psychiatry, Psychotherapy and Medical Psychology; and Stainslav Chumak, Assistant Professor, Department of Psychiatry, Psychotherapy and Medical Psychology from Shupyk National Academy of Postgraduate Education, Ukraine) presented on mental health and psychiatry pre-service curricula teaching processes, and mhGAP-IG implementation at their respective teaching institutions.

The educators' presentations continued until the second day of the meeting, and from the presentations and the discussion, the challenges and recommendations for strengthening and enhancing mental health and psychiatry pre-service curricula were identified. The participants highlighted these challenges in teaching psychiatry and mental health curricula:

- i. Inadequate financial resources and consequent inadequate access to updated medical literature and modern technology



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- ii. Curricula from the Soviet period.
- iii. Lack of medical student interest in psychiatry.
- iv. Lack of enough time for teaching psychiatric curricula.
- v. Lack of competency among academic staff to equip medical students with updated knowledge and skills.
- vi. Communication challenges in teaching foreign medical students.
- vii. Lack of mhGAP-IG translations into local languages.

Similarly, the participants also provided some recommendations, including:

- i. Ensure systematic and distinct improvement in the mental health content of undergraduate and postgraduate medical education programs.
- ii. Bring the education of mental health specialists in line with modern world standards.
- iii. Strengthen mental health professionals' role through standardization of specialist training.
- iv. Develop international cooperation.
- v. Communicate with the local WHO for the translation of mhGAP-IG.
- vi. Adapt and implement the mhGAP-IG.

The two-day meeting not only enabled decision makers and educators to learn about each other's teaching institutions' mental health and psychiatry pre-service curricula but also equipped them with ideas on how to strengthen and enhance their teaching programs. Similarly, this meeting was noted as a historical event, as, for the first time, the faculties of psychiatry and psychology of different universities from Ukraine gathered together and explored areas of possible collaboration.





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## The 15th International Training Seminar on Child and Adolescent Psychiatry

Drs. Isuri Upeksha Wimalasiri (Sri Lanka), Ravivarma Rao Panirselvam (Malaysia), and Camille Noël (Belgium)



### Introduction

Fondazione Child for Study and Research into Childhood and Adolescence organized the 15th International Training Seminar on Child and Adolescent Psychiatry. This seminar aimed to facilitate knowledge exchange between junior and senior colleagues, to build research skills, and to promote academic career development in child and adolescent psychiatry.

The training seminar was held in Rome, Italy at Villa Aurelia from 12th to 17th, May 2019, and at the Ministry of Health on 14th May. Forty-seven trainees from 29 countries all over the world were selected after an extensive screening process.

Twenty senior faculty members, including eminent professors, world-renowned psychiatrists, and experienced researchers from reputable academic institutions all over the world, conducted the lectures. A few of the eminent academics included:

- Prof. Norman Sartorius, President, Association for the Improvement of Mental Health Programmes, Geneva
- Prof. Ernesto Caffo, Professor of Child Neuropsychiatry, University of Modena and Reggio Emilia
- Prof. Bennett Leventhal, Professor of Child and Adolescent Psychiatry, University of California San Francisco

### Nature of Participation

The 47 trainees were divided into groups where they could discuss research ideas with mentors and gain insight into the most current and relevant areas in Child and Adolescent Psychiatry. Trainees had an ample amount of time to meet colleagues from other countries and to share knowledge and experience related not only to psychiatry but also to sociocultural aspects of care.

At the end of the session each trainee did brief presentation on the research topic they discussed in the mentoring groups.



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Our schedule was also packed with 24 lectures and 4 colloquia over the one week. These sessions covered, in breadth and depth, updates in classification systems, neurosciences and research methods. Despite being intensive, each session approached the topic with a fresh perspective to improve existing understanding.

The faculty were nothing short of amazing. While being accomplished in their field, they mentored the trainees with warmth and genuine interest. It was not uncommon for them to stay beyond the session or join us for a meal, where they had the opportunity to address our doubts and share some laughs. There was palpable interest in getting to know each other.

It was noteworthy that, throughout the seminar, trainees were only allowed to speak in English and to sit next to a participant from a different country. Although these requirements initially seemed daunting, we adapted to them and quickly bonded with our colleagues over many similarities in values, interests (especially food), and challenges faced in our respective countries.

## **Best Practices**

On 14<sup>th</sup> of May 2019, trainees and lecturers representing Fondazione Child met the Italian Minister of Health. The minister highlighted the need for strengthening child and adolescent psychiatric research and clinical facilities, as improving child and adolescent mental health has been identified as a key health investment. The minister requested that representatives of all countries convey this message and proactively improve child and adolescent psychiatric research and clinical facilities at their respective institutes.

## **Recommendations**

This training seminar should continue for the simple reason that it effectively mobilizes the best in the world to learn how to care for young people's well-being. It is recommended that the seminar continue to be led by diverse, spirited faculty. For future seminars, a slightly more relaxed schedule with more hands-on activities interspersed between the lectures could better facilitate learning.

## **Individual Comments**

“All of the lectures were very innovative and insightful. However, ‘Contribution of genetics to Brain Development and Psychopathology’ and ‘Genetics of Developmental Psychopathology’ by Prof. Stephen Sanders and ‘Neurodevelopmental Disorders’ by Prof. Bennett Leventhal kindled my research interests and curiosity very much. My main research interest is neurodevelopmental disorders; hence, these lectures bore a quintessential significance to my brewing research ideas.

“This seminar was one of the most insightful and worthwhile experiences I have had so far had in my career. It was the first time I had individualized time to work with and share knowledge with a group of international mentors with such caliber and discuss my research ideas with a group of colleagues belonging to multiple nationalities and



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countries. It broadened my viewpoint of research and provided me with a chance to identify clinical practices and research methods that are applicable to Sri Lanka. I would recommend this training seminar to any psychiatry trainee who is interested in the branch of child and adolescent psychiatry.”





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## Comprehensive National Autism Programs State of the Art Symposium, 19<sup>th</sup> World Congress of World Psychiatric Association, Lisbon, Portugal

Ms. Saima Wazed Hossain (Bangladesh), Prof. Golam Rabbani (Bangladesh), Dr. Kinzang P. Tshering (Bhutan), Dr. Samai Sirithongthaworn (Thailand), Dr. Helal Uddin Ahmed (Bangladesh), and Prof. Muhammad Waqar Azeem (Qatar)

### Introduction

Autism spectrum disorder (ASD) is a challenging issue not only for professionals but also for countries, planning to support these families. It is a multi-faceted complex disorder and has variations in presentation to the point where the phrase, “if you have met one person with autism, you have only met one person with autism” is a familiar adage among experts. In the last 10 years with the annual celebration of World Autism Awareness Day on 2<sup>nd</sup> April, the demand from families and stakeholders has necessitated that a more comprehensive approach be undertaken, which involves the clinical and social aspects. Such approach also needs to ensure that individuals on the spectrum not only be identified as early as possible, and receive evidence-based interventions, but also be given every support for assisting them reaching their full potential and leading happy and fulfilling lives. However, this is easier said than done. Both high and low resourced countries are faced with a growing dilemma. They, therefore, turn to mental health experts for much-needed guidance. Unfortunately, clinician's knowledge outside the purview of their practice is limited in most cases. For this reason, at this year's Annual Congress of the World Psychiatry Association (WPA), a State-of-The-Art Symposium on Autism that showcased national comprehensive strategic plans for ASD was held. Thanks to the progressive thinking of President-Elect Dr. Afzal Javed, this unique symposium showcased four national strategic plans. This is also in line with WPA 2021-2023 Action Plan which includes building services for individuals with ASD around the globe. Bangladesh, Bhutan, Qatar, and Thailand are the very few countries that have a national multi-sectoral government plan to address ASD. Key developers of the plan provided attendees with an engaging summary of the main thrusts of these plans in Lisbon Portugal on the 24<sup>th</sup> of August 2019.



From left to right in above photograph:  
Dr. Helal Uddin Ahmed, Prof. Golam Rabbani,  
Ms. Saima Wazed Hossain, Dr. Kinzang P.  
Tshering, Dr. Samai Sirithongthaworn and Prof.  
Muhammad Waqar Azeem



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## The Bangladesh Model

Bangladesh is a southeast Asian developing country with three-tier health care delivery system. Although little was known prior to the international conference in 2011, autism is now part of mainstream discourse due to immense awareness led by the families and continuous political support by the government. Despite the challenge of limited resources, limited understanding, and tremendous stigma within families, a National Strategic Plan for Neurodevelopmental Disorders (NSP-NDD) including ASD was developed in 2016 by the Institute of Community Inclusion and Shuchona Foundation.

The prime objective of the NSP-NDD is to raise the priority of autism and other NDDs in the health, social and economic development plan at the national level, across all government sectors and through the involvement of all relevant stakeholders, especially the families. The aim for the health system is to increase its capacity to meet the behavioral, communication and educational needs of individuals by multi-sectoral approach. The plan strives to integrate monitoring and promotion of child development into primary health care services, ensures early detections, interventions, and management, and promote research for further evidence. It recommends changes to existing national laws and policies to adapt a strength-based approach with a focus on the needs of all persons with disabilities. Encompassing the work of 16 ministries, the NSP-NDD is a multisectoral, convergent plan that focuses on a horizontal approach that is applicable for low resource countries. The NSP-NDD is sustainable and cost-effective and helps create an equitable community.

## The Bhutan Strategic Plan

A landlocked country in the Himalayas, the Kingdom of Bhutan has made remarkable progress over the past decade with significant improvement in the health indicators. With an increase in the prevalence of childhood disabilities including autism, the lack of data and the urgent need for ensuring health services in every community through their three-tiered health system have been an impetus for the development of services for persons with disabilities. Strengthening of the primary health-care system to identify autism in the early ages, making effective interventions, and involvement of the community are critical areas in providing services for these individuals and families.

In April 2017, the International Conference on Autism & Neurodevelopmental Disorders (ANDD2017) witnessed not only the adoption of the Thimphu Declaration by participating countries, it also launched the *WHO Collaborative Framework for addressing ASD in the South-East Asia Region* and brought much needed political attention to the issue in Bhutan. It led to the development of the National Strategic Plan for ASD & NDD by Shuchona Foundation funded by WHO-SEARO and with support from experts at the Ministry of Health and families. This Strategic Plan is developed in line with the four strategic areas of the *WHO Collaborative Framework* and is based on 11 guiding principles for a life course approach. The Plan provides a logical framework for a matrix of activities that outline the role and function of stakeholders, identify lead agencies and potential partners, methods



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for progress monitoring and research-based interventions which can be incorporated into the existing (or planned) national development projects and programs.

## The Qatar National Autism Plan

A small country with a population of about 2.8 million, Qatar has approximately 500,000 children and adolescents. Over the last few years, there has been an outcry by the public about the lack of services for children with autism. In 2015, under the auspices of the Ministry of Public Health, National Autism Plan Working Group was created. This workgroup has stakeholders from around the country including public and private providers, schools, government agencies and most importantly parents and families of individuals with autism. This group identified the main focus areas and created 6 task forces. The task forces and workgroup met regularly for 2 years to successfully develop the national autism plan which was released by the country's Prime Minister on April 17, 2017. This is first of its kind national autism plan in the Mena Region with 5-year implementation strategy, including short term, mid-range, and long-term goals.



## The 6 pillars of Qatar's National Autism Plan

## Thailand's National Autism Plan

Thailand, a country in South Asia, has historically addressed child development survey as part of their public health program, through their Ministry of Public Health. In 2015, data showed a marked increase in the number of ASD, from 1 per 1,000 in 2005 to 6 per 1000 in 2015. In order to respond to increasing demands, the National Autism Plan, also called "Autistic Road Map" has been developed.

The Ministries of Public Health, Education, Social Development & Human Security, and the Ministry of Interior collaborated in providing services across the lifespan for individuals with ASD. Historically, Surveillance and Promotion for Child Development through the Ministry of Public Health has included the creation of several unique instruments: Developmental Surveillance and Promotion Manual (DSPM), Developmental Assessment for



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Intervention Manual (DAIM), Thai Early Developmental Assessment for Intervention (TEDA4I) for assessing and guiding intervention in children from birth to five years. The developmental surveillance project launched in 2015 revealed higher rates of suspected delayed development than those reported in the national statistics in every age group. Coupled with the shortage of child psychiatrists and pediatricians, long waiting lists for autism diagnosis became a challenge for the Thai public health. Accordingly, research to develop a tool tailored for early detection of ASD in Thai children was initiated. Through a 3-phase process, the Thai Diagnostic Autism Scale (TDAS) was developed by experts for early diagnosis of children between ages of 12-48 months with suspected ASD. After ensuring validity and reliability of the tool, the TDAS has been implemented in Health Sector 1 throughout all four regions of Thailand.

By enabling a range of health professionals to identify ASD using the TDAS, the Thai approach has enabled early identification, reduced wait time for identification of needs, leading to expedited referral for Early Intensive Intervention and empowerment of caregivers. School-aged children transition to appropriate educational services and also receive the benefit of private sector collaboration through technologies for communication and adaptive skills. Goals for self-sufficiency into adulthood include the development of Autistic Guardian Home and Job Coach Project under the Ministry of Social Development & Human Security, and the Ministry of Interior respectively. In addressing lifelong needs for individuals with Autism, through innovations of relevant agencies, Thailand is ensuring an improved quality of life is possible for individuals with ASD.

## **Conclusion**

It is clear from the national strategic plans for ASD presented at the symposium, that when the political commitment exists, and experts collaborate proactively with families to become formidable stakeholder group, an essential resource is the product. The national government plans for autism presented are comprehensive, based on the life-long needs of individuals and their families and aligned with international resolutions and conventions. A multi-sectorial approach that addresses every aspect important to families living with ASD is at the core of each strategic plan and can be a good guidebook for other countries and regions to emulate. It is evident that this approach will not only positively impact the ASD community but will also ensure that disability and mental health support is effectively included in every government's economic and social development agenda.

During the 19<sup>th</sup> World Congress of Psychiatry in Lisbon, two interrelated working groups on ASD and Intellectual Disability (IDD) have been established. In the next triennium, these workgroups will produce documents on policies, services and education/training which will help in improving the lives of individuals with ASD and IDD around the world.



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## ESCAP Congress report

Drs. Milica Pejovic Milovancevic (Serbia), Laura Kehoe, Konstantinos Kotsis (Greece), Dimitris Anagnostopoulos (Greece)

The 18th International Congress of the European Society for Child and Adolescent Psychiatry (ESCAP) took place in Vienna, Austria from 30 June -2<sup>nd</sup> July 2019. The congress was held in collaboration with the Austrian Society of Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy (ÖGKJP) and was based on the theme, "Developmental Psychiatry in a Globalized World." Over 1600 child and adolescent psychiatrists and allied professionals from 71 countries descended on a very hot Vienna during the three-day event. They were treated to an array of 7 keynote and 18 state of the art talks, 80 symposia and two special lectures, and over 400 posters presenting the most cutting-edge research in the field.

Congress president and ESCAP Board member Andreas Karwautz developed a well-balanced scientific and social program. In the opening ceremony, he highlighted four special topics that were related to the history of Vienna and that he incorporated into the program: Nazi history and child psychiatry, substance abuse, the role of psychotherapy, and suicide in the context of transport[GA1]. All participants enjoyed staying in royal Vienna and experienced the spirit of the best child and adolescent psychiatry (CAP) practice worldwide and the beauty and art of Vienna.

The congress venue was the beautiful Hofburg, the royal palace where the glamorous Empress Elisabeth of Austria, Sisi, spent her Habsburg court life at the end of the nineteenth century. No less glamorous was the opening ceremony, with the Austrian Boys and Girls choir blessing participants with their voices and Harpist and singer Sophie-Theres Völkl playing on our heartstrings.

### Scientific highlights

Speakers renowned in the field of CAP took to the stage to present their current views of psychiatry in our globalised world. Bringing technology to the forefront, Lucia Valmaggia introduced participants to the immersive world of virtual reality and its use to treat psychosis and other mental health issues. Next was Dickon Bevington, who, with his colleagues in the UK, have developed the AMBIT project that aims to bring communities of healthcare providers together to improve the lives of 'hard to reach' youth. Otto Kernberg majestically sat on stage and simply spoke to the audience about recent developments in psychoanalytic treatments. Meanwhile, Hans Steiner gracefully praised the work of several colleagues when summarising key aspects of how a person's anger can push them to commit criminal acts and how the justice and legal systems, as well as the diagnostic criteria of these asocial behaviours, need to be refined for our modern society. Anke Hinney spoke of the advances being made in the big data world of genetics and genome-wide association studies in relation to eating disorders. Michael Pluess reminded us of how everyone is different in terms of environmental sensitivities and how the development of children needs to be considered in relation to these sensitivities. Franc Resch spoke about new morbidities and changing risks in a changing environment.



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We thank all speakers who took the time to present, as well as the state of the art and symposium organisers. The congress would not exist without you.

## Special lectures and symposia

Hans Asperger was a pioneer in the field of autism and Asperger syndrome, which is a term still in use today. However, recent revelations have positioned Hans Asperger in the racial policies of the Nazi regime. A packed special state of the art lecture and discussion group was held, chaired by Hans Steiner, a former student of Hans Asperger. Historian Herwig Czech talked on the topic 'Hans Asperger, National Socialism, and "race hygiene" in Nazi-era Vienna.' Another historian and author Edith Sheffer then presented her findings from her recent book, 'Asperger's Children: The Origins of Autism in Nazi Vienna.'

Thomas Niederkrotenthaler gave a special lecture on 'Suicide in adolescents in the United States after the release of "13 reasons why": Time series analysis and implications for prevention and policy'. It highlighted the concerns surrounding suicide not only in the United States but in all nations and how this information and social impact can affect suicide rates worldwide.

Helmut Remschmidt gave a special lecture on 'The fundamentals of responsible research: Theory and practice.'

The United Nations Office on Drugs and Crime (UNODC) also delivered a symposium on drug prevention in adolescents.



Andreas Karwautz, congress president



Attendees at the ESCAP general assembly

## Social event

The gala dinner was organised at the iconic Vienna Town Hall. Barbara Helfgott took to the stage with her voice and violin. 11-year-old Soley Blümel, with her piano performance, reminded the audience of Mozart's talent, and Brigitta Karwautz "lifted the roof" with her operatic voice and performance.



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## New board

The congress also marked a significant moment in our board: President Stephan Eliez, who had been president for 4 years, stepped down from the position and handed the reins over to Dimitris Anagnostopoulos. Also, during the congress, ESCAP took the opportunity to hold a General Assembly, where all our member countries were invited to vote on ESCAP issues and raise points of focus. During the meeting, four existing members stepped down from their two-term commitment and thereby opened up five new positions on the board. ESCAP is delighted to announce the newly elected board members: Anne Marie Råberg Christensen from Denmark, Joerg Fegert from Germany, Konstantinos Kotsis from Greece, Manon Hillegers from the Netherlands, and Eniko Kiss from Hungary.

## Research academy

The third official meeting of the Research Academy (RA) took place ahead of the congress on 28-29<sup>th</sup> June. The RA is a specialised two-day event organised by Johannes Hebebrand, head of the research division and editor-in-chief of the *European Child & Adolescent Psychiatry (ECAP)* journal, senior organiser Paul Klauser from Switzerland, and junior organiser Alexis Revet from France. The three organisers put an excellent program together, bringing in four international speakers and selecting 20 young clinician-scientists, representing 14 ESCAP member countries. The RA aims to promote research excellence and collaborative work among young clinician-scientists in the field of CAP. Previous years have proved to be successful, with a collaborative article about to be published in the ECAP journal. This year is no exception: the post-workshop collaborative, ongoing project will study routine assessments on outpatients having first contact with a CAP. The group hopes to involve members from the European Federation for Psychiatric Trainees (EFPT) and the European Union of Medical Specialties (UEMS), CAP section.

The theme of this year's RA was 'Novel technologies for diagnostic assessment and treatment in child and adolescent psychiatry: history, current development and future perspectives.' The organisers chose this theme because of the exponential growth of new technologies that can be applied in CAP. Participants were treated to four expert talks: Lucia Valmaggia discussed virtual reality and its use in the clinic for a diverse range of mental health issues, Frank Verhulst spoke of assessment processes in CAP and highlighted the importance of multiple informant assessment, Johannes Hebebrand discussed genome-wide association studies and the big data world, and lastly, Ulrich Reininghaus introduced participants to mobile health applications and ecological momentary assessments.

## Special thanks

ESCAP thanks the wonderful organising of CPO-Hanser, especially Kerstin Birth, who headed the team. ESCAP thanks all exhibitors for taking the time and effort to be part of the congress. Also, ESCAP thanks our collaborators, EFPT, UEMS, and IACAPAP, for their presence and for communicating to their members information about the congress. The next ESCAP congress will be in Maastricht, The Netherlands, 27-29<sup>th</sup> June 2021 and will have the theme, 'Networks in Child and Adolescent Psychiatry.'



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## Future meetings

[www.iacapap2020.org](http://www.iacapap2020.org)



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

20 – 23 Jul 2020 | Singapore

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

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**IACAPAP 2020 SINGAPORE**



The International Association for Child and Adolescent Psychiatry and Allied Professions



Section of Child & Adolescent Psychiatry



INSTITUTE of MENTAL HEALTH  
National Healthcare Group



Singapore Psychiatric Association

**19TH WORLD CONGRESS**  
of the World Association for Dynamic Psychiatry (WADP)



**PEACE AND AGGRESSION**  
A SOCIAL CHALLENGE FOR  
PSYCHIATRY AND PSYCHOTHERAPY

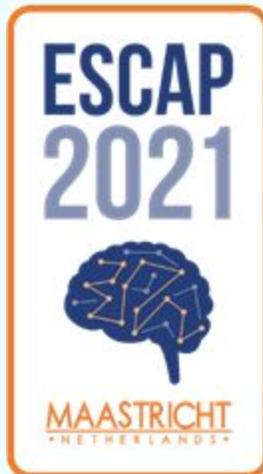
Berlin – Germany | 31st March – 4th April 2020  
Information and Registration: [wadpinternational.com](http://wadpinternational.com)



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19th International Congress  
of ESCAP Maastricht

**NETWORKS IN CHILD AND  
ADOLESCENT PSYCHIATRY**

27-29<sup>th</sup> June 2021

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