World Child & Adolescent Psychiatry

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World Psychiatric Assocation

Child and Adolescent Psychiatry Section

Official Journal

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

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Editorial Column

Dear Colleagues,

Welcome to the new issue of "World Child and Adolescent Psychiatry," an official journal of the World Psychiatric Association, Child and Adolescent Psychiatry Section (WPA CAP).
With this issue we celebrate the fifth anniversary of establishment of the journal. The editorial board has engaged in a discussion with WPA leadership and section's members about the future of the journal. The editorial board has received several proposals from world-famous publishing agencies that would like to collaborate with us. Some of them suggested "World Child and Adolescent Psychiatry" to become an open-access peer- reviewed journal.
There is no doubt that "World Child and Adolescent Psychiatry" will continue to evolve through the times. We will choose the publishing form that best meets current global child mental health needs: not only wealthy institutions and well-established professionals should be in a position to share their thoughts with the world, but also young colleagues and specialists from the poorest countries, where, indeed, child mental health needs are greatest.
In addition, we believe that "World Child and Adolescent Psychiatry" has role in promoting child and adolescent psychiatry within the WPA. We are an active section, and WPA President Dinesh Bhugra and WPA incoming president (2017-2019) Prof. Helen Herrman are very supportive towards the child, adolescent and youth mental health agenda.
But who will be the next (2019-2011) WPA President?
The next WPA General Assembly will be held in Berlin, Germany on the 10th of October 2017. There are three candidates for the WPA President-Elect post: Edgard Belfort (Venezuela), Afzal Javed (UK), and Michelle B. Riba (USA). We asked all candidates the same questions, and in this issue you can find their answers. We hope that the interviews (which we have not edited) will help national societies to make their final decisions, if they have not made them already.

As always there are many diverse readings in "World Child and Adolescent Psychiatry."
Prof. Bennett Leventhal's editorial has become a traditional section of the journal, as have in-depth interviews with prominent leaders in the medical field. Mindful of the growing importance of primary care integration and care delivery models for geographically remote and/or otherwise resource-challenged locations, we interviewed Dr. Joseph Humphry, who has done a lot for primary care in places we may know very little about: Saipan, The Republic of Palau, Guam, American Samoa, and the island of Lānaʻi, Hawaiʻi
I also wish to thank all the authors who have contributed to this issue and the "World Child and Adolescent Psychiatry" editorial board.

Happy Readings!

Prof. Norbert Skokauskas (Norway)
Editor, "World Child and Adolescent Psychiatry" Secretary,
World Psychiatric Association, Child and Adolescent Psychiatry Section
http://www.wpanet.org/
N_Skokauskas@yahoo.com

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Chair's Column:

Through the Looking Glass:
A Perspective on Child and Adolescent Psychiatry through the Eyes of WPA CAP

Prof. Bennett L. Leventhal (USA)

Alice, in her journeys detailed by Lewis Carrol, visited worlds of mystery and confusion, some of which were the result of her fantasy and some derived from her distortions of the confusing world around her. While these stories were filled with excitement, pleasure and even incredible problem-solving and learning, there were also moments of terror. Despite much scientific progress in recent decades, Child and Adolescent Psychiatry has been on a similar journey. Let me try to share that with you.

Child and Adolescent Psychiatry has a long history of being hidden or misunderstood. We have seen battles between the Red Queens and White Queens (there have been kings, too) of various theories. And, we suffered from the knowing smiles of Cheshire Cats who have been rarely right but never in doubt. Indeed, when our colleagues in general psychiatry, pediatrics, and other areas of primary care, look at us, what do they see? Sadly, they often see colleagues and practices that are as strange and confusing as the experiences of Alice as she peered through the "looking glass" and wandered through Wonderland. They have little sense of who we are and what we do. But, unlike Alice, they do not marvel at what we do, and they are not remotely curious about examining the wonders of the disorders we diagnose and treat. Rather, Child and Adolescent Psychiatrists have become those "people" to whom they turn when there is no other explanation for the challenges that face their patients. Our colleagues often don't distinguish us from psychologists or other professionals in our field, let alone have any sense of how we differ from the myriad of "therapists" who offer all manner of "treatments." As a result, there are countless times when youth and parents have been told that, "There is nothing wrong with you so we are going to have you see a child and adolescent psychiatrist." This is confusing to patients and families and does little to enhance the image or credibility of our work.

To what extent do we contribute to this problem? Sadly, not in a small way. In practice, we remain somewhat invisible by providing most service in private consulting rooms, and, even when working in larger hospitals and clinics, "for the sake of protecting privacy," we keep our records – including our wisdom about etiology and treatment – in "confidential" records. This practice not only adds to shame and stigma for our patients by letting others know that if "you know what we know," it will bring harm to our patients and their families. The situation sounds a bit grim and it is made worse by a lack of understanding of Child and Adolescent Psychiatry by our colleagues in general psychiatry. So, this leads us back to Alice as we examine our progress as a profession and as the WPA Section on Child and Adolescent Psychiatry over the past 6 years.

"Who in the world am I? Ah, that is the great puzzle!"*

Child and Adolescent Psychiatry studies and provides care those individuals with early onset, often chronic, psychiatric disorders. Child and adolescent psychiatric disorders are among the most prevalent of all medical conditions affecting youth, with the possible exception of infectious diseases (many of which contribute to psychiatric symptoms and illness.)

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Prof. Bennett L. Leventhal

Chair's Column (cont.1):

From an epidemiologic perspective, close to 50% of the population will develop a psychiatric disorder at some point in their lifetime, with 75% of all psychiatric disorders beginning before the end of adolescence, and with comorbidity being the rule rather than the exception. Given the early onset of these conditions, it requires the special skills of Child and Adolescent Psychiatry to do research, conduct diagnostic studies and provide treatments early in life. With this unique identity, Child and Adolescent Psychiatry has sought a clearer and more prominent role in the larger world but also in the world of the World Psychiatric Association. Despite the fact that we were once all children and that developmental psychopathology is essential to all parts of psychiatry, Child and Adolescent Psychiatry has long been nestled, almost anonymously, among some 60+ WPA sections with marginal notice in WPA policy or WPA leadership. Sadly, this is not terribly unusual, as many large national psychiatric societies, including the American Psychiatric Association (APA) in the US, treat this critical component of medical practice and science in the same way. And, if that were not bad enough, many countries fail to even identify Child and Adolescent Psychiatry as a bona fide medical specialty. Alice is surely right, "…that is a great puzzle."

"Curiouser and curiouser."*

What is the problem here? The World Health Organization (WHO), as well as various research studies, have been quite clear that psychiatric illness is one of the leading causes of disability in the world, and the clear majority of these disorders begin in childhood and adolescence. And, did we mention that psychiatric disorders are amongst the most prevalent of all disorders affecting youth? This fact makes it even more curious that the WPA, the APA, and the world hardly take notice of Child and Adolescent Psychiatry. This is in spite of the fact that for many years, and especially the past 6 years, the WPA Section on Child and Adolescent Psychiatry (WPA CAP) has dramatically increased its activity and created a forum for Child and Adolescent Psychiatry around the world. Despite a lack of resources and external support, WPA CAP has been a persistent and, perhaps, relentless advocate for Child and Adolescent Psychiatry. During this period, dozens of Child and Adolescent Psychiatrists have flocked to "join" WPA CAP. This means that they have signed up for the email list and joined in WPA CAP "sponsored" sessions at many WPA regional meetings. WPA CAP has also developed and presented sessions on various topics at other international meetings, including the American Academy of Child and Adolescent Psychiatry (AACAP). Similarly, in order to help its widely geographically distributed membership feel connected, the three current WPA CAP leaders have made sure to hold a "WPA CAP Section Meeting" at any meeting in which at least one of WPA CAP Officer has been present. As a result, Child and Adolescent Psychiatrists around the world have not only met with the WPA CAP leadership but also been able to provide direct input into the affairs of the Section.

Perhaps the most visible activity for WPA CAP has been the creation of the Section's "journal," World Child and Adolescent Psychiatry. Under the extraordinary leadership of Norbert Skokauskas, the Editorial Board has created an e journal that has been distributed not only throughout the WPA but around the world to Child and Adolescent Psychiatrists and professional societies on every continent. It has exemplified the willingness of Child and Adolescent Psychiatry to declare its principles and practices around the world. World Child and Adolescent Psychiatry has given a face and voice to WPA CAP and the profession.

It is not at all curious that this hard work along with constant lobbying of leadership in the WPA and other organizations has made a difference. The increase in WPA CAP activity and apparent numbers has led to recognition of WPA CAP as at least a small force that demands some attention in organized psychiatry.

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Prof. Bennett L. Leventhal

Chair's Column (cont.2):

While we don't yet have a seat at the table of power, we are moving in the right direction. Our seemingly impossible task does not seem so impossible anymore

Alice laughed. 'There's no use trying,' she said: 'one can't believe impossible things.'
'I daresay you haven't had much practice,' said the [Red] Queen. 'When I was your age, I always did it for half-an-hour a day. Why, sometimes I've believed as many as six impossible things before breakfast." *
It often seems that the future for Child and Adolescent Psychiatry is quite impossible. But, that is not an acceptable option, especially in this era when so many of our youth are faced with the horrors of violence and forced migration, along with the challenges of psychiatric illness. Add the service needs to the amazing advances in genetics and developmental neuroscience, Child and Adolescent Psychiatry has never been in a better position to be a full partner in the practice of medicine. And, more importantly, Child and Adolescent Psychiatry can play a major role in identifying and addressing some of the most pressing public health needs in the world today. After all of these years of trying to find a place in the world of patient care and medical services, we now have the opportunity to step forward. But, as in the past, this outcome will not come easily. We must re-dedicate ourselves to the solid principles and actions that have gotten us here:

1.Research that is methodologically sound and provides the evidence for understanding the etiology, prevention and treatment of Child and Adolescent Psychiatric disorders.
2.Prevention efforts that understand that developmental processes provide enormous opportunities to prevent illness, pain and suffering before it begins.
3.Evidence Based Treatments that are made available to children around the world
4.Training for junior and senior colleagues that represents the highest standards in the basic and applied biological, psychological and social sciences.

It has long been said that Child and Adolescent Psychiatry will remain a small part of the care of children. But, recent years and a lot of effort have shown that to not be the case. Once and for all we must declare that Child and Adolescent Psychiatry is and will continue to be a critical specialty in medical practice – not just a part of psychiatry but an essential part of the healthcare for all children and adolescents around the world. It is not impossible! Indeed, we have made a strong step forward but there is more to be done. So, we MUST follow the advice of the Queen and think of many impossible things each and every day. Thinking of the impossible is easy. Making them happen is a bigger challenge. But, we have shown that we are up to the task.

"Alice: Would you tell me, please, which way I ought to go from here?
The Cheshire Cat: That depends a good deal on where you want to get to.
Alice: I don't much care where.
The Cheshire Cat: Then it doesn't much matter which way you go.
Alice: ...So long as I get somewhere.
The Cheshire Cat: Oh, you're sure to do that, if only you walk long enough." *

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Prof. Bennett L. Leventhal

Chair's Column (cont.3):

Now, the time has come to set the agenda for the next portion of our professional journey. We have choices to make. We can take Alice's choice of "I don't much care where" we go. Or, we can set a new agenda for Child and Adolescent Psychiatry. But, we cannot do this alone. It will surely require making the impossible possible by:

1. Connections

Keeping Child and Adolescent Psychiatrists around the world connected so we can have a shared agenda to address the needs of the profession and our patients.

2. Collaboration –

Building a strong collaboration network among the Child and Adolescent Psychiatry societies so that we can harness our shared efforts to be more efficient and effective

3. Communication

Telling our story and advocating for our profession and our patients with other medical groups, policy makers and families.

4. Commitment –

Maintaining a solid and unbending commitment to our principles

It has been an arduous journey to get to this point in time for Child and Adolescent Psychiatry. But, we are here and we are healthy. As the Cheshire Cat suggested, we got here because we did "walk long enough." But, the journey is not over. And, the best is yet to come. I hope you will join me and your colleagues from around the world as we build an even better Child and Adolescent Psychiatry for ourselves, for those who will follow in our footsteps and for the children, adolescents and their families who depend on us for the best in psychiatric healthcare.

*from — Lewis Carroll, Alice in Wonderland

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Interview with candidates for WPA president-elect

Dr. Edgard Belfort

1. *What made you decide to accept the nomination for the WPA Presidency?*

"My institutional identity, my experience, and understandings acquired during the time I have been at the WPA (22 years), as well as the passion and credibility of a discipline that is scientific and humanistic. And because I also have the competencies to continue the achievements, challenges and advances in the field of psychiatry and mental health."

2. *What are the greatest challenges our field is facing?*

"Promotion and prevention of Mental Health.

Education in all its context, for the patient, family, caregivers, community, and health team professionals, both in undergraduate and postgraduate programs.

We need to work hard to promote research and educational programmes to take advantage of our member's great knowledge and experience. We also need to focus on publishing to disseminate research worldwide. To accept and include mental health programs in governments policies agendas according their cultures and particular needs. To emphasize the Anti Stigma programs and positive image recognition of the psychiatry professionals."

3. What is the WPA's role in overcoming them?

"The psychiatric discipline must be of the first level therefore the training of the psychiatrist must be a priority.

To clarify the roles and logistical aspects which require leadership in the field of mental health.

To enhance our psychiatric programs incorporating different organizations, governmental and non-governmental, academicals and obviously the health sector to consolidate a position statement on an intercontinental alliance for integrated mental health.

To take advantages of resources, researches and mental health innovations.

To incorporate needs, interests and patients 'voice, as main principles for the mental health care."

4. *You have been a member of WPA Executive Board for almost 6 years. What achievement are you most proud of?*

"To have worked jointed with a team achieving a WPA Position Statement on high quality Training: "Principles and Priorities for a Framework for Training Psychiatrists".

World Psychiatric Association (WPA) for the benefit of our patients places the highest importance on the quality of training for psychiatrists at all levels. This includes undergraduate, post-graduate and continuing

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medical education (CME). In this sense, this WPA document wants to offer guidance to the national member associations for developing their own training curriculum, but also bearing in mind about their needs for adaption of the curriculum according to their own unique needs and background.

Implement in collaboration with WPA Member Societies and components, educational programs along the lines of clinical and research areas of needs and relevance to the fields of psychiatry and mental health.
Prepare and disseminate written educational tools and translations from English to Spanish."

5. “World Psychiatry” is the number 1 ranked journal in Psychiatry. How “World Psychiatry” success can be expanded to other WPA “products” and activities?

"Maintaining the standard of excellence and openness, promoting and disseminating evidence-based scientific information through networks and media channels.
To continue selecting the best possible authors in the field of mental health."

Interview was conducted by "World CAP" Editors

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Interview with candidate for WPA president-elect

Dr. Afzal Javed

1. *What made you decide to accept the nomination for the WPA Presidency?*
"I have been working for WPA for the last two decades and have served this organization in different key positions including current role as executive committee member.

WPA Positions:
- Secretary for Sections World Psychiatric Association (WPA) (2011-To Date)
- Member Operational Committee on Planning (2014-To Date)
- Member Operational Committee on Nominations (2005-2008)
- Member Operational Committee on Ethics (2008-2011)
- Member WPA Task Force Best Practices in Working with Service Users and Carers (2008-2011)
- Co-Chair of the WPA Task Force on Brain Drain (2006-2008)
- Founder Co-Chair WPA Section on Developing Countries (2007-2011)

My role in international psychiatry is likewise highlighted by my involvement and work with a number of global professional organizations engaged in the uplift of mental health across the globe such as;
•President World Association for Psychosocial Rehabilitation (WAPR) (2012-2015)
•Founding Secretary General Asian Federation of Psychiatric Associations (AFPA) (2009-2013) & current President Asian Federation of Psychiatric Associations (AFPA) (2017- To Date)
•Advisor & Founder Secretary General of South Asian Forum on Mental Health & Psychiatry (SAF) (2002 - To Date)
•Advisor SAARC Psychiatric Federation (SPF) (2005 - To Date)
•Chairman Pakistan Psychiatric Research Centre, Fountain House, Lahore, Pakistan (20010- To Date)

At a national level, I have been actively involved in lead administrative roles in my present employment and have served the UK Royal College of Psychiatrists in a number of capacities including Deputy / Associate Registrar, member College Council, member Education & Training committee, member Board of International Affairs and Chairman of West Midlands Division of the College. I believe my expertise in international psychiatry & skills in leadership roles at national, regional and worldwide positions certainly supports my aspirations for future WPA responsibilities. I would therefore feel very confident to lead WPA and to achieve my proposed action plans and work intentions.

Furthermore with my professional training & educational achievements, clinical & academic profile, experience of working both in low and high income countries, I am convinced that I meet the requirements for the position of President Elect (WPA) and am confident that if given a chance, I will lead this organization in a commendable way. Additionally the support I enjoy from WPA leaders, colleagues, friends and my family reinforces my commitment, obligation and devotion for my upcoming tasks at WPA.

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(Interview with candidates for WPA president-elect, Cont. 1)

2. *What are the greatest challenges our field is facing?*
"Psychiatry is currently facing a number of challenges. In my views pressing needs for the profession include;
•Improving image of psychiatry as a medical specialty in clinical, academic & research areas and promoting the concept of public mental health as an agenda for action
•Highlighting the prominence of psychiatrists while working with other professionals in health, legal and social aspects of care
•Ensuring WPA's positive & helpful engagement with member societies and WPA components
•Promoting equal and constructive relationships with other mental health organizations (regional & international, professional, non-professional, voluntary and NGO groups); and with other international groups working in the field of mental health
•Engaging with patients, carers and families in building a confident and confiding relationship
•Supporting & contributing to education, research and training needs especially in low income countries (for example requesting a member society from a high income country to adopt and support 1-2 low income countries in these areas)
•Demonstrating a commitment of WPA's work to the highest ethical standard and keeping transparency, openness and fairness as the guiding regulatory principles
•Ensuring non-biased and inclusive work policies of WPA regardless of preference for gender, religion, socio-economic status or regions
•Working to promote psychiatry as a promising medical career for undergraduate medical students."

3. What is the WPA's role in overcoming them?

"Although our profession may be seen to be under threat, there are also a number of opportunities that can help us consolidate psychiatry as an inspiring branch of medicine. There is thus a strong need to unite and strengthen our discipline in an inspirational way

WPA being the umbrella organization for psychiatrists worldwide and the lead professional organization assumes major responsibilities for leading the profession. Beside many other obligations, this can only be achieved with the help of a leadership that is credible and enthusiastic about working with all components of WPA.

I therefore firmly believe that WPA should look for a dependable leader who has:
- A voice that raises the profile of the profession
- A strategic vision to engage professionals and professional organizations in a common stand
- A perception of international work and future needs of the profession
- A commitment to work with others and respect others' viewpoint
- A trustworthy and responsible reputation
- And last but not the least, who understands WPA's work and commitments

I am confident that if given a chance, I will lead this organization in a creditable & admirable way through my working with member societies, zonal representatives, scientific sections, affiliated organizations and WPA leaders to strive for the uplift of our profession."

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(Interview with candidates for WPA president-elect, Cont. 2)

4. *You have been a member of WPA Executive Board for almost 6 years. What achievement are you most proud of?*

"My current position in the Executive Committee of WPA (as Executive Secretary for Scientific Sections) strongly supports my positive contributions to WPA work in general and to elevate the position of WPA scientific sections in particular. My role in this lead position has confirmed my enthusiastic & passionate profile not only as a resilient leader but also as a frontrunner for future WPA work.

While sharing the credit for all these accomplishments with the sections leaders, I do believe that my lead role has been acknowledged as my humble contribution towards achieving an excellence in this regard. This indeed demonstrates my inspiring and enthusiastic profile for my future role in this organization.

I am undoubtedly delighted with the current developments in the working of sections that highlight and focus on the principles of engagement, commitment & autonomy. It is heartening to note that;
•Over the last two trienniums scientific sections have emerged as important components of WPA - reaching an impressive total of 72 Sections in 2017l
•I have been able to provide a clear direction to the sections for their functioning and contributions in different scientific & organisational areas.
•I have kept a regular contact with section leaders and have organised regular section officers meeting along with starting Intersectional sectional forum at our international meetings.
•Furthermore publication of Advances in Psychiatry (Vol 4) is going to highlight the current work of sections in their respective fields of mental health."

5. "World Psychiatry" is the number 1 ranked journal in Psychiatry. How "World Psychiatry" success can be expanded to other WPA "products" and activities?

"The success of World Psychiatry clearly shows that if we select right people for the jobs, there will be no regrets. The World Psychiatry owes a lot to its current editor, Prof Mario Maj, who comes with a wealth of experience not only in academic and research areas but also as one of WPA's most successful past presidents.

It is therefore a need of the time that WPA should have appropriate & suitable leaders for its different components & elect those who could deliver what is required and needed for our profession and Association."

Interview was conducted by "World CAP" Editors

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Interview with candidate for WPA president-elect

Dr. Mchelle B. Riba

1. *What made you decide to accept the nomination for the WPA Presidency?*

"This is a critical time for the WPA, joined by its member societies and partners, to develop collaborations and linkages to address the global burden of mental health and substance abuse disorders. We need strong leaders to develop partnerships between low, middle and high resources countries, to help develop educational projects and advocate for improved prevention and treatment strategies.

I have served as President of the American Psychiatric Association; President of the American Association of Directors of Psychiatric Residency Training; President of the Association for Academic Psychiatry; Pacific Rim College of Psychiatrists Board of Directors; and Liaison to the Japanese Society of Psychiatry and Neurology. I have served the WPA as WPA Secretary, Scientific Publications; Zonal Representative; Chair, WPA sections: Psycho-Oncology and Palliative Care; Psychiatry, Medicine and Primary Care. These international and national and leadership positions and my roles at the University of Michigan, where I have served as Associate Chair, Education and Academic Affairs; Director, Psych-Oncology Program; Associate Director, Depression Center have provided me the experiences and solidified my skills towards presiding as WPA President."

2. *What are the greatest challenges our field is facing?*

"I surveyed a number of my esteemed colleagues in the Child and Adolescent Psychiatry Division at the University of Michigan what they viewed as the greatest challenges that our field is facing. I would like to share their thoughtful responses:

•The long-term psychiatric sequelae of childhood sexual and physical abuse, which includes heightened risk for suicide—and the importance of universal prevention and early intervention.

•Role of poverty, war, racism (between and within seemingly similar ethnicities) as etiological factors to childhood psychiatric disorders. There is also a huge dearth of cultural aspects of mental illness

•Development of the need for early interventions- targeted to stage of brain maturation (e.g. critical periods) and adaptable by circumstance (e.g. child abuse, neglect, poverty, etc.)—that can be easily disseminated to optimize mental health and well-being

•Need for access to care in rural areas

•Need for increased education for primary care providers in mental health screening of children (mental health first aid)

•Need for increased education of school personnel in mental health screening (mental health first aid)

•Need for increased education of clergy and religious leaders in mental health screening

•Quality assessment and assurance in child psychiatry

•The effects of social media on the psychological identity, wellbeing and adaptive coping of youth

•Innovative strategies to reduce stigma to pursuing/accessing mental health services globally and how cultural and religious practices may impact access to mental health care

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3. What is the WPA's role in overcoming them?

"The WPA must ensure that all member societies share and participate in the assessment of needs and in the short term and long term solutions. We must continue to be an organization that respects, trusts and understands the importance of collaborations and partnerships between low, middle and high resourced countries and upholds the values on education, research and psychiatric services development. Our linkages with WHO, the World Medical Association, other UN agencies and member societies and psychiatric organizations are keys to overcoming some of the greatest challenges we face. Together, we can optimize evidence-based care; showcase model clinical programs that are working to improve access care; utilize community partners; and help triage and prevent illness in our youngest patients. "

4. *You have been a member of WPA Executive Board for almost 6 years. What achievement are you most proud of?*

"There are many reasons to be proud but probably the achievement I am proudest of is the opportunity to mentor so many young psychiatrists around the world who are interested in writing and seeing their work published. It has been incredibly gratifying to meet so many young trainees who are eager to make a difference in their work and are looking for guidance, support and mentorship. It is most humbling to be able to help and engage the next generation of psychiatrists.

This has been my most rewarding achievement-- to have gained the trust and admiration from so many young colleagues"

5. "World Psychiatry" is the number 1 ranked journal in Psychiatry. How "World Psychiatry" success can be expanded to other WPA "products" and activities?

"What has been most remarkable in this rise of World Psychiatry has been the work ethic and the phenomenal genius of Editor Mario Maj. His drive, determination, commitment and sense of purpose in elevating our journal to this position is one of the most singularly important achievements of the WPA.

We can learn much from this method of diligence, focus, and adherence to the highest level of excellence. These are the principles that can be expanded to other WPA "products" and activities. He has been an incredible role model. We must and should aspire to incorporate these characteristics into the WPA ethos. "

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The Media and Suicide: '13 Reasons Why'

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

It is widely accepted that irresponsible, sensationalist media reporting and portrayal of suicide has serious negative consequences and can lead to "copy cat" acts and contagion. So what is the impact of the controversial yet widely accessible Netflix series, "13 Reasons Why?"

There is no evidence yet that, since the series has been broadcast, the rates of suicides among young people have increased. Netflix has included disclaimers and warnings at the beginning of the series. Are these enough to reassure us that no harm will be done? Or is the series likely to raise the risk of suicidal acts?

In countries where infectious diseases and chronic illnesses are reasonably controlled, suicide is the second leading cause of death in young people. Suicide prevention tops national mental health policies and programmes. That literature, film and media can influence the rates of suicide is not a new idea. In 1774, Goethe wrote "The Sorrows of Young Werther." The book was banned in many European countries as its publication was followed by an increased number of suicides emulating the death of the novel's tragic hero. Since then, the imitative behavior and contagion linked to suicide have often been referred to as the "Werther effect."

In the early 1970's, Phillips described, in the general population, increased suicide rates after the suicides of famous people. He noted that following Marilyn Monroe's death by suicide, the rates of suicide increased by 12% in the month of August 1962.

More recent studies clearly point to an association between media portrayal of both "non fictionalized" and "fictionalized" suicide and increased rates of suicide in young people.

In Germany, in 1981 and 1982, a six-episode weekly TV series showed a 19 year-old student committing suicide by throwing himself in front of a train. In the 70 days that followed the TV series, there was a 175% increase in the suicide rate among 15-19 year-old youth. A similar effect was demonstrated after the second broadcast.

The Oxford Centre for Suicidal Studies prospectively studied the influence of an act of self-harm (paracetamol overdose) portrayed in a popular TV series. In their study, involving 4430 subjects from 49 hospital emergency departments and an additional 1047 subjects from 25 psychiatric emergency services,

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(The Media and Suicide, cont. 1)

the researchers found a 17% increase in self-harming behaviours in the first week after the broadcast and a 9% increase in the second week. The increases in paracetamol overdoses were particularly striking.

A Taiwanese study showed increased rates of suicide after media coverage of a TV celebrity's death by suicide.

In a meta-analysis of 42 studies, Stack and colleagues showed that suicides of famous people attracted a greater rise in the general population's suicide rates and that fictitious suicides attracted less imitative behaviour than did reporting of real suicides. TV reports of suicides seemed to be less powerful than newspaper reports of suicides.

In the '1 March 2009 edition of "The Observer" newspaper, Carol Cadwalladr, a well-known UK journalist, wrote of the Bridgend phenomenon and a suicide cluster that appeared to be linked to media coverage and possible internet networks. In a region where statistically, only two to three young people would be expected to commit suicide during a one-year period, there were 25 cases. There was evidence of persistent national and international media presence, detailed reports of the young persons' funerals, and large photos of the young people who had died repeatedly shown in the newspapers and in TV reporting. Once the reporting stopped and/or became more responsible, the suicide trend ceased. Or so it seemed. But the fact remained that, within a particular year, the suicide rate of the small Welsh town increased tenfold.

There have always been opposing views about the reasons for youth suicidal behaviour. More than 100 years ago, Durkheim wrote about social causes being at the root of suicidal behaviour and about the inevitability of some suicidal acts. Some other retrospective studies found no relation between media reporting and increased rates of suicide

Overall, media-related suicide studies have found increased rates of suicidal acts associated with glamorized reporting of suicides. This is the case with respect to both news items and fiction.
The Netflix series, "13 Reasons Why," was released in the US in March 2017 and was available across the world soon afterwards. It is based on a book, first published in 2007, by Jane Asher. It is a story about a high school girl who commits suicide after leaving 13 recorded audiotapes to be distributed amongst her friends. The heroine aims to take revenge against her friends whom she perceives to have bullied her prior to her death. The final act of suicide is shown in great detail.

The cinematic quality of the series is undisputable, with excellent acting amid a backdrop of convincing fictionalized "reality." All studies of media related suicides indicate that "copy cat" acts are more frequently found among those who identify with the suicide victim by age, sex and aspiration. The attractive and highly intelligent but troubled teenager portrayed in this series shares much in common with a whole range of young people. Her suicide is offered as a solution to seemingly insurmountable teenage problems. The fictional aims of the suicidal act are revenge and vindication. Clinicians interviewing young people who have attempted suicide often find that teenagers do not understand the finality of death and somehow imagine that they will be around to witness the aftermath. The series reinforces this idea with the voice-over

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(The Media and Suicide, cont. 2)

and enduring presence of the heroine despite her having killed herself. The series simplifies the act of suicide as having direct causal links with particular life events, whereas any suicidal act is much more complex. Throughout the series, there is no worthwhile reference to mental illness in either the heroine or her family. Most young people who commit suicide have a psychiatric illness, but media glorification of such acts may lead to suicidal contagion even in young people who are not ill.

In “13 Reasons Why,” there is no evidence of the protagonist seeking or receiving professional help, and the school counselor and parents are portrayed as ineffective. It is indeed difficult to imagine how an increasingly depressed and desperate young person could summon the energy to plan and orchestrate what is a complicated web of messages to her friends. The heroine’s suicidal act is shown in detail, but as others have already pointed out in their commentaries (see Gould, M. Medscape interview, June 15th, 2017) the actual moment of death is romanticized and bears little resemblance to the gruesome reality of such an act. Ultimately, the narrative glamorizes suicide and does little to responsibly bring the issues to the attention of a wider audience. The entire series is not unlike the inappropriate fictionalized shrine set up in the school of the young girl who commits suicide.

Mental health professionals in many countries have already voiced their dissatisfaction and have warned against the potential harm of the programme particularly for younger teenagers, who are more vulnerable, and for those who are likely to watch the films without any parental guidance.

Professional and responsible broadcasting and reporting includes scentific information about suicide trends, achievements in treatment and prevention, and individual stories of succesful tretament. Suicide should be demystified as a phenomenon and counterbalanced with individual stories of young people who have contemplated suicide but have met life’s challenges by succesfully resolving their problems. Of course, one is not denying the fact that suicide is a serious health and social issue, but the media can help by reporting responsibly. These aspects of responsible reporting should be included in media and film studies.

In summary, the risk of imitative acts depends on the quality and modes of media reporting. Detailed accounts of methods to commit suicide, repetitive reporting, and suicides of celebrities and TV personalities increase that risk, especially when such reports and programs reach a large and vulnerable audience. Viewing restrictions – albeit laudable – are impossible to fully implement. It is false to assume that suicidal acts would take place irrespective of exposure to inappropriate material. Equally, there are no studies indicating that glorifying suicide improves public awareness thus improves prevention. Changes in the reporting of suicidal acts in our newspapers and magazines have led to tangible reductions of suicide contagion.

The same principles should apply to films and TV, particularly now that the market has widened and is more difficult to regulate.

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Primary Integration for Child and Adolescent Psychiatry

Interview with Dr. Joseph Humphry (USA)

1.Thank you very much for agreeing to this interview. It's truly our pleasure and our privilege to have you as part of this issue of World CAP. Would you be able to tell us a little bit more about yourself and the important work you have done in global and rural primary care?

For the last 37 years, I have been a safety net provider practicing medicine in a multi-ethnic disadvantaged community in Hawai'i. The year prior to settling in Hawai'i, I was hired by the University of Hawai'i (UH) to establish an elective for UH residents in Saipan, a small Micronesian Island in the Western Pacific, now the Capital of the Commonwealth of the Northern Marianas Islands. I have also had the opportunity to be a consultant in chronic disease management in the US-affiliated jurisdiction (The Republic of Palau, The Federated States of Micronesia, and the Republic of the Marshall Islands, Guam and American Samoa) for many years.

Even though I have my formal training in internal medicine, I have always practiced in a setting that included seeing children and infants. I have special interest in diabetes and have been a member of the American Diabetes Association for 30 years and involved at the state and national levels in developing programs to improve diabetes care through team-based care.

During my formative years as a medical student, I spent 2 summers providing care in a remote village in the Sierra Madre mountains in Mexico in the early days of the Hesperian Foundation*. During my fourth year in medical school, I had 5-month electives in the Tamil Nadu District in Southern India and at the Universidad de Medellin, Columbia. My experience with third world medicine started very early in my medical career.

2. Can you share your thoughts on the importance of psychiatry's – and specifically child and adolescent psychiatry's – integration into primary care?

First, I would like to share my perspective as a primary care provider. Over the last 40 years, psychiatry has seen dramatic changes. Two of the most significant changes are: 1) the initial separation of psychiatric medicine from internal medicine and pediatrics and 2) the understanding that behavioral health is related to biochemical and structural changes in the brain. Historically, psychiatry was analytic and time-intense. There were several schools of thought, and irrespective of the approach, care was delivered through a "50-minute hour." Patients with severe mental illness were institutionalized.

* This experience occurred after my second and third years in medical school and was through the invitation of David Werner, author of "Where There Is no Doctor." The "clinic" was in a village that was 17 miles from the nearest paved road and reachable only by a jeep road. There was no running water or plumbing. We provided care for the smaller villages scattered higher in the mountains. Corn and beans were grown with slash-and-burn fields on the sides of the mountains. I had previously had a couple of years of high school Spanish. During my fist summer, I taught myself Spanish while reading under the light of a kerosene lantern, and I cared for patients during the daytime. David taught me how to pull teeth, introduced me to the clinic for a week, and then left me on my own for the summer. It was a very steep learning curve for a person who had never actually treated a patient!

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Structural brain and advancements in understanding of brain biochemical pathophysiology expanded our knowledge of mental illness and introduced targeted drug therapy. Like psychiatry, internal medicine and pediatrics have expanded disease categories, classifying previously "healthy individuals" with labels: hypertension, hyperlipidemia, obesity and prediabetes. Likewise, children who previously may have been "difficult" now have appropriate diagnoses such as Autism Spectrum Disorder and Attention-deficit Hyperactivity Disorder (ADHD).

I recall in the late 1980s when the evidence from randomized trials recognized hypercholesterolemia. The diagnosis labelled millions of otherwise normal individuals with a potentially serious condition. Suddenly, the primary care provider assumed the responsibility of having to effectively manage this condition with diet alone, as at that time medication therapy was only in clinical trials. As a primary care provider, we could test for the elevated cholesterol, but totally lacked resources to effectively control cholesterol through dietary modification. Both in medicine and psychiatry, the expanding populations with potentially treatable conditions extended well beyond the knowledge and resources at the primary care level.

The solution to the primary care dilemma of having to manage an expanding population is not to expand the number of specialists to meet the demand. That approach clearly will not happen with child and adolescent psychiatry due to cost and access. In addition, the primary care provider has an essential role in caring for the whole patient. Psychiatric conditions do not happen in isolation. Patients have other conditions and external factors often related to home and school. The primary care provider has a much better chance of having knowledge of the environmental factors contributing to a mental illness.

The primary care provider is often the first provider contact for patients who have behavioral and mental illnesses. Not infrequently, the condition may have existed for some time and may have been recognized by the school and/or parents. At times, a patient has already received intervention through counseling, special classes or referrals to social services prior to medical interventions.

Not all primary care providers are equal. Their experience and training directly impact ability to recognize and manage mental illness in their patients. When I was a medical director for the largest health plan in Hawai'i, 20% of the primary care physicians prescribed 80% of the psychoactive medications. Those who did not prescribe obviously managed patients who could otherwise benefit from medication or referral. Those providers who frequently prescribed may not have had the knowledge to correctly prescribe. Opioid prescribing, often for patients with associated mental illness, is in epidemic proportions in the US, but the prescribing patterns leading to the crisis involve only a limited number of primary care providers. As a primary care provider and former director of an alcohol and substance abuse residential program, I frequently see psychiatrists prescribing multiple psychiatric medications to patients' dependent on alcohol or controlled substances. Behavioral health specialists are not all trained in addiction medicine and are often not even aware of the dual diagnosis. Patients often seek psychiatric care as they are in denial of their drug dependency. Primary care providers often assume that the addiction is being managed by the psychiatrist who is prescribing medication.

The pot is brewed! We have more patients, more diagnoses, more medications and more opportunities to impact the care of those suffering from mental illness. The challenge is to provide a delivery system that uses the strength of both the child and adolescent psychiatrists, who are in very short supply, and the primary care providers, who are the first and often only line of contact with the patient.

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3. Practically speaking, what makes this integration happen, and what do you think the biggest barriers have been towards achieving it?

The greatest barrier to change is inertia. The health care system has grown too entrenched and too complex for individuals to successfully implement change. Physicians play a large part in resisting change. As a group, they are rather conservative, obviously bright, and also frequently independent thinkers. I recall years ago at a conference, the speaker reported on a survey of physicians who were asked to rank themselves against their peers on the quality of care they deliver. The average physician ranked him/herself in the 85th percentile. Physicians' perceptions are that there is little room to improve the quality of their current performance. An integrated delivery system has a great chance to make the situation worse rather than better. This fact is particularly true when every physician, conceptually, has a different fix to the problem with access to specialty care.

Physician leadership clearly plays a role. Behavioral health integration is a complex system change, and the vast majority of physicians are not "systems" people. In the US, accountable care organizations require a physician group to lead system transformation. It is a great method to have physicians on board and engaged in the transformation process, but this approach often leaves a void when it comes to creating the best out-of-the-box systems change and implementing this change in the most efficient manner.
Lana'i Community Health Center is part of the intervention group in a Centers for Medicare and Medicaid Services (CMS) initiative, the Million Hearts Cardiovascular Disease (CVD) Risk Reduction Model. CMS provides the intervention group with several tools and educational webinars to guide the desired systems changes. My physician logic would expect that leadership of such initiatives to reduce CVD would be turned over to cardiologists, working through The American College of Cardiology. Instead, CMS has outsourced the responsibility to Deloitte. The Deloitte web page states:
"These days people can be obsessed with chasing the next big thing. And they'll often go to great lengths to find it. But what if by chasing the next big thing you're missing the opportunities that are right under your nose?" Deloitte specializes in system changes that bring results. As previously stated, system change in the complex health care delivery system is not an easy task. When it comes to our delivery system, identifying the problem or problems is the easy part. With luck, all concerned may also have a common vision of the solution. Getting to primary care/behavioral health integration is the major challenge.

I have opted to discuss barriers before solutions. The solution needs to be both common and custom made. I spent 22 years as a medical director of Hawaii's largest insurance company and have been responsible for several systems-changing interventions to improve quality. A number were initiated prior to our currently popular approach (which is a very poor method to effect change) to link delivery system changes to payment. Changing systems at a macro level clearly creates winner and losers. Effective programs often resulted in unforeseen consequences and frequently were either poorly implemented at the local level or not implemented at all. Behavioral health integration needs to occur on the macro level (as a common solution) to improve care for large populations. The change must be also done at the local level (as a custom solution) with appropriate buy-in and commitment from direct-care providers. As much as physicians are an independent group, a desire to help patients and improve the population's health bonds most physicians to a common goal. There is a compelling argument that a system that taps into the skill of both the primary care provider and the child and adolescent psychiatrist will improve care for the population and provide a more rewarding experience for the providers involved in the system change.

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(Interview with Dr. Joseph Humphry, cont. 3)

The first component critical to successful program implementation is knowledge of the providers' and staff's belief in and commitment to the system change. Success does not require commitment from every team player, but at the very least from the leadership of the organizations involved. For most providers and other team members, better care is a stronger motivator than increased revenue

The second component is an equal partnership between the child and adolescent psychiatrist and the primary care provider. The relationship, obviously, requires transparency, mutual respect, collegiality and trust. Done correctly, the child and adolescent psychiatrist can improve the care of substantially more patients than could otherwise be possible in a traditional model, and the primary care provide will be integrally involved in providing the high-quality care. Change takes time and commitment. Both parties need to discuss their available time commitment and understand their respective core competencies. An assessment of community and school resources and the size of the at-risk population helps in the design of the system change.

The third component is a highly efficient team at the primary care level that is the platform for vertical integration with the child and adolescent psychiatrist. Primary care no longer effectively functions with autonomous practitioners and staff members. As with child and adolescent psychiatry, there continues to be a shortage of providers in most settings. In addition, management of chronic diseases complex behavioral health conditions requires a team approach to achieve high quality care. Frequently, I have observed that, in health care, a team involves providers with specific roles: i.e., physician, nutritionist, health educator, nurse, medical assistant, etc. Teams need to practice being teams. Each team member has his/her own strength and role, but there are overlapping roles and responsibilities that need to be identified and leveraged to maximize efficiency and effectiveness. Treat the patient first. A patient with more than one medical or behavioral health problem may need to be involved with more than one team member to obtain the best outcome. Best outcomes also require a careful care plan that insures that the patient gets a consistent message from each team member. Cross training expands the patient's options and improves the team's efficiency. The child and adolescent psychiatrist then becomes a remote member of the team except in large organizations where a full-time specialist may be on site.

In the next section, I will discuss in more detail the elements of full integration of care. Before moving on, I would stress that engaging an outside consultant who has training in change management maybe very cost effective. If the organization elects to develop and implement their own model, there needs to be a clearly identified group responsible for planning, implementing, refining and sustaining. And again, I would stress that success only comes with leadership's full support.

4. Can you describe how you might envision the ideal primary care clinic of the future, and how child and adolescent psychiatrists might support such a vision?

"Patient centered care" has been a common buzzword in the US healthcare industry for almost a decade. Unfortunately, the metrics associated with the term focus more on health care as a service industry. Open scheduling and patient portal availability, patient satisfaction and relationship with the primary care provider (phycisin's panel of patients) define the quality of service.

The primary care clinic primary goal is to provide outstanding healthcare as measured by outcomes.

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(Interview with Dr. Joseph Humphry, cont. 4)

Donald Berwick, in his plenary address, "Escape Fire," presented at the Institute for Healthcare Improvement's annual meeting in 1999, identified three essential health care delivery system elements: access, science and relationships. The elements keep the patient in the center of the delivery system's design. A highly effective team is required to address all patients' health care needs, to improve access and to insure efficiency. In addition, health information and communication technology will change the team's approach to delivering health care and improving patient outcomes. Often, the expectation is that the technology will make the change; however, the technology should not be the driver, but rather a tool to increase access, improve quality and reduce cost.

Chronic care for behavioral health and other medical conditions requires both acute interventions and continuous maintenance. Communication technology facilitates the movement of care to the community and the home. Information gathering no longer requires an office visit and an interval history, although office-based care may still optimize outcomes for many patients. Patient-generated health data (PGHD) plays a much greater role in community and home-based care. Interventions are based not on a set schedule but on the patient's health care needs. Communication technology dramatically increases access.

In the model, access is not merely defined as having the door open, but by having a relationship that allows the patient to feel comfortable coming through the door. The greatest deficiency in today's health care delivery system is the inability to focus on building the relationship before prescribing the treatment plan. Relationships are a greater challenge in diverse populations with different cultures and languages. Effectively using language and words to describe emotional distress are particularly challenging in accurately assessing and treating mental health conditions. Relationships require an investment of time and are built on trust. Our US healthcare delivery system is exquisitely well designed to have the doctor-patient relationship fail.

Effective primary care requires that the patient has a relationship with the team and more specifically one or more team members. With a high functioning team, the trust established with individual team members is transferred to the whole team. Team members need to show care, concern and commitment to maintaining the relationship and following a common care plain with a consistent message and approach. With common conditions, evidence-based protocols provide efficiency and effectiveness. Team members have different strengths and expertise. Thus, a complex patient may see multiple team members, while other patients may only need a single primary member.

The team's composition is not as important as its function. I often dream of the health care team having the same level of coaching as a championship basketball team. Every team member has a position and responsibility, but to be effective, there is the constant ability to shift roles and responsibilities based on the situation. In health care, no team member is available all the time, and team members do not uniformly share the same knowledge or expertise. Access is being able to promptly reach a team member, who can then help to find the best evidence-based solution.

Physicians' time is very costly from a financial perspective and is often in short supply in a busy practice. To effectively address this issue, in caring for a diverse population or any population, I would like to focus on the community health worker (CHW). Many patients from diverse cultures fail to access care or comprehend the care plan. For patients with chronic conditions such as diabetes, outcomes are determined by the amount of time invested in developing self-management skills.

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(Interview with Dr. Joseph Humphry, cont. 5)

The CHW inherently has the communication skills and the ability to invest more time in patient care than does the provider. While not having the same education and knowledge as other team members, the CHW nevertheless has easy access to other team members and can address simple question with either an informal discussion or a scheduled provider encounter that both the CHW and patient can attend.
The CHWs are also critical in moving care from the office to the home. They are trained in using communication technology.

LCHC currently uses Bluetooth-enabled glucose meters and blood pressure cuffs. Our elderly patients may not be experienced in smart phone technology, but this inexperience rarely limits their desire to share the monitoring results or the analytic graphs of the data. Our CHWs are initially surrogate patients, setting up and uploading the data. Over time, our elderly patients become self-sufficient with the technology. In relation to behavioral health, similar assessments are available through survey tools that measure mood, quality of life and other metrics. Again, PGHD becomes a critical component of the delivery system.

Measuring outcomes is essential to the health care delivery system. To date, our ability to measure outcomes has been severely limited by data unavailability and stakeholder resistance to measuring true outcomes. Most of what we measure are process measures captured in claims data. If people want to live long, healthy lives, then the system needs to directly measure disease free longevity and quality of life. While I will not spend much time related to longevity, as it does not impact child and adolescent psychiatry or pediatrics significantly, quality of life is clearly an essential component of effective behavioral health intervention. The 36-Item Short Form Health Survey (SF 36) is a general, well-established quality of life measure. I am certain that there are a number of surveys specific to pediatrics and pediatric psychiatry. These surveys can easily be built into our existing information system and available either as a provider-administered survey or PGHD.

Like the primary care provider, the child and adolescent psychiatrist is an expensive limited resource whose time must be used wisely. As a specialist, the child and adolescent psychiatrist would be a member of multiple teams. As with any team, the vertically integrated role may vary slightly, but would have four primary components:

1: Providing brief phone consults to the primary care team in a timely manner (within two days). These consults would provide answers to simple questions without needing a full consult (i.e., - whether to increase the dosage of a medication for a patient known to both providers) or help to stabilize a complex problem until a full consult can be arranged.

2: Providing telehealth consultation, with the primary care team also at bedside, for diagnosis and treatment of complex and serious mental illness.

3: Providing knowledge – via articles, recommended webinars, or specific (video-teleconferenced) lectures – on topics selected by the child and adolescent psychiatrist and team.

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4: Sharing responsibility for the quality of child and adolescent psychiatric care provided at the primary care level; developing protocols and decision trees to be followed by the team for common problems that may or may not need referral; and selecting quality metric surveys and other measures related to behavioral health outcomes. In support of this role, it would be ideal for the child and adolescent psychiatrist to have access to the information and quality reporting system.

5. Do you have any other advice for child and adolescent psychiatrists, as we try to make our services more accessible to rural communities and low/middle income countries?

Certainly, in the US, providers and communities need to put mission before money. Our current delivery system absolutely defies logic, and yet change comes very slowly and often without the desired results. I believe that most other countries have delivery systems that provide health care rather than profit, and therefore change is better aligned with the welfare of the patient and the population. There is great inertia when financing is the primary barrier. Start small and smart. Do the right thing for the patient and measure the outcome. Others may be slow, but they will notice. Make systems scalable. It is good to solve a problem for a single community, but doing so does not insure overall accessibility of a limited resource, the child and adolescent psychiatrist.

Think out of the box in using information technology and communication technology. I have a slide set on a project in India using questionnaires for prenatal care by CHWs. They take a picture of the patient; GPS provides the patient's location; and the educational information (in the patient's language) is transferred back to the patient. Building the system costs money, but sustaining the system is cheap if it is used by many. It may be wiser to modify existing technology than purchase new technology. In making decisions related to technology, it is best to have one system for many providers and patients. That is the one time that you need to go upstream for advice on system change and financing. Healthcare funders do not want to pay for expensive technology for small populations.

Finally, get a systems person involved in the design and implementation of the system. Among my favorite groups of people are chief financial officers. Their responsibilities extend well beyond finance. They are responsible for assessing operations and putting efficient systems in place to reduce cost and improve quality. Those principles need to be applied to health. Our healthcare systems often lack efficiency, while the banking industry exemplifies efficient systems. We can learn from others.

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Preventing and addressing post-accident psychosocial problems in Fukushima by applying lessons learned from Scandinavian countries' experiences with post-Chernobyl accident countermeasures

Dr. Ikumi Futamura and
Dr. Tastuo Ujike (Japan)

On March 11, 2011, a nuclear power plant accident occurred at Fukushima Daiichi Nuclear Power Plant in Fukushima prefecture, Japan. This unexpected incident caused great confusion for most people in Japan. Because psychological problems caused by nuclear disasters are potentially chronic and serious, we explored effective countermeasures to prevent psychological harm from this accident.

To obtain relevant knowledge and for information-gathering, we reviewed the impact of the Chernobyl nuclear power plant accident that occurred 30 years ago. The Chernobyl accident contaminated not only Russia, Ukraine, and Belarus (at the time, part of the former Soviet Union), but also extensive areas in other parts of Europe. However, between countries, there was variability in rate and degree of recovery after the accident. In the former Soviet countries such as Ukraine and Russia, a pessimistic and passive attitude towards life and, an excessive perception of danger persisted for a long time. On the other hand, in the Scandinavian countries, although many people were affected psychologically, a countermeasure system helped people to maintain and improve health in a relatively short period. Therefore, in considering possible countermeasures for Fukushima, we conducted inquiries to compare the post-Chernobyl accident responses of the former Soviet Union and of the Scandinavian countries, with different political structures and economic conditions.

From August 29 to September 7, 2016, we visited Finland Radiation and Nuclear Safety Authority, Stockholm University Centre for Radiation Protection, Oslo University Institute of Clinical Medicine, The Norwegian University of Science and Technology (NTNU) Psychology Department/Norwegian Radiation Protection Authority, and NTNU Children's Psychiatrics Course. We obtained useful information and insights from experts in their respective fields.

We found significant reported differences in how people perceived risks. Although, from an early stage after the nuclear accident in Japan, the risk of internal exposure (from radiation sources taken into the body) was kept low, anxiety about the risk of external radiation (emitted from sources outside of the body) was high, and extensive areas centered around Fukushima Prefecture were decontaminated. On the other hand, in Scandinavian countries, although internal exposure risk and establishment of standard values for radioactive materials in food were emphasized and prioritized, external exposure risk was not regarded as much of a problem, and decontamination work was not done in most areas. However, as spatial radiation doses were not necessary higher in Japan compared with Scandinavia post Cherynobyl-accident, there seemed to factors besides just the physical values underlying the greater psychological anxiety and perception of risk found in Japan.

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What kind of countermeasures can be taken, then, to appropriately lower people's anxiety ? Here, I will use the term, "the state of information communication" as a key concept in sharing insights gained from this inquiry. The first point is the necessity of "accurate and appropriate information communication tailored to the subject." Although openly conveying accurate information is indispensable to establishing a trusting relationship and preventing unnecessary anxiety, this alone is insufficient. Even if experts and authorities accurately and openly inform people about actual radiation measurements and scientific findings and contemporary views, unless the information is easy to understand and responsive to recipients' questions, the result will be as if there had not been any communication at all.

The second point is the necessity of "ongoing information communication by reliable people and organizations." It is quite common for different experts and government officials to visit the affected area and to offer lectures and discussion meetings. On the other hand, such visits are usually brief, and the people communicating are often replaced. When the communicators are inconsistent and/or only briefly involved, it is challenging to establish a trusting relationship and to resolve people's doubts, uneasiness, and dissatisfaction. A trusting relationship between communicator and receiver, and creativity in the content and process of communication are crucial. The third point is the necessity of "information communication tailored to each individual." The quality and quantity of necessary information may vary depending on the receiver's age, family composition, occupation, and hobbies, even within the same area. Countermeasures after radioactive disasters should therefore strive not only to lower the direct physiological impacts of radioactivity but also to enable everyone to live as happily and contentedly as possible .

We obtained extremely useful insights and advice through this process of identifying potential countermeasures for Fukushima. It is, of course, impossible to simply compare Japan with the Scandinavian countries, as the Chernobyl accident and the Great East Japan Earthquake differed in various ways. Moreover, there may be other factors that may render the Scandinavian countermeasures ineffective if implemented in Japan without adaptations for local culture and society. However, it is undoubtedly important for us to learn from the enormous amount of information and insights accumulated from countries affected by the Chernobyl accident.

I would like to sincerely thank the many experts who have partnered with us and given us extremely useful information and insights, and many others from around the world who have shown interest in this project and offered additional insight and advice.

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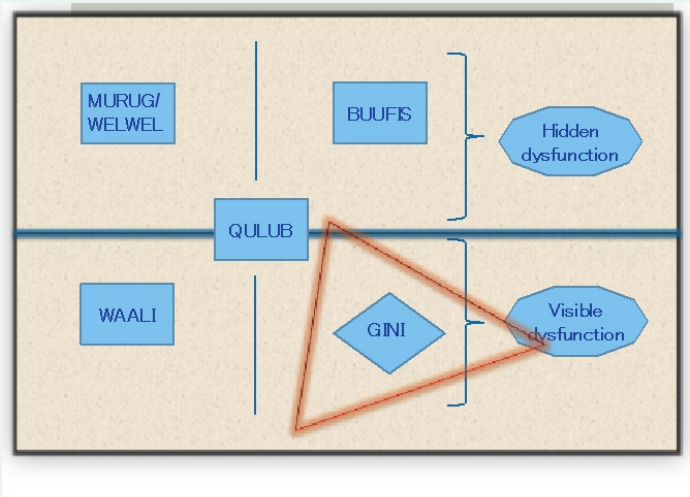
Somali Mental Heatlh

Ayan Bashir (Medical Student, Bergen, Norway)

In increasingly multicultural societies, there is a need to understand other cultures` attitudes towards mental health and to what degree these affect utilization of mental health services. This report is based on a literature review about Somali immigrants' attitudes towards and understanding of mental health and health care services. Literature about this matter was scarce, but ten relevant studies were found. They had been conducted in different Western countries such as the UK, Finland, the US and Norway. Findings in different studies were much alike. Six Somali concepts about mental health were examined in the studies: Waali, Buufis, Gini, Welwel, Murug and Qulub. Gini and Waali are serious disorders that can give rise to psychotic symptoms and are obvious mental dysfunctions. The disease Gini is distinct and different from the other diseases because of its etiology. Evil spirits, also called Gini, cause this disorder and its remedy is the Quran and traditional healing. Waali means "crazy." It can be caused by milder mental disease and can be addressed through standard medical treatment. It seems impossible to distinguish these two illnesses based on the symptoms, but they clearly have different causes and therefore need different treatment according to cultural beliefs.

Other findings were that, despite the high incidence of psychological disorders among Somali immigrants, there was an underuse of mental healthcare services. They would rather seek comfort in the traditional and familiar treatments, such as Quran healing. Possible explanations for not seeking medical aid include stigma and inappropriate labelling of those with mental disorders. According to a Somali proverb: "the crazy man can only become less ill, but never cured." When someone suffers from a visible mental disease, there is a perceived pervasive change preventing them from ever becoming fully valued members of the society again. Imagine the pain of never belonging. Other barriers to seeking help are communication problems and lack of cultural similarity in the host country.

To sum up, the studies have not been able to explain if and how Waali and Gini are distinguished and in what situations psychotic symptoms are treated traditionally or seen by a medical officer. More research is needed to give appropriate medical treatment, while respecting the patients` religious and cultural beliefs.



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Psychiatry of the XXI century: issues and innovative decisions (Kiev, Ukrane)

Prof. Irina Pinchuk (Ukraine)

The international scientific conference, “Psychiatry of the XXI century: issues and innovative decisions,” was held in Kyiv, Ukraine, on April 27-29, 2017. The conference has become a landmark tradition among mental health specialists. It has become a platform for networking and exchange of updated information, knowledge, and experience to improve the quality of patient care and promote further research.The conference was organized by the Ukrainian Psychiatric Association; the Scientific Research Institute of Social and Forensic Psychiatry and Drug Abuse of the Ministry of Health of Ukraine; and RIMON, charitable foundation research innovation in medicine.The conference brought together about 500 experts in mental health from all regions of Ukraine and was attended by international experts from the UK, Germany, France, the Netherlands, Norway, Lithuania, Turkey, Israel, the USA, Australia and Switzerland. All presentations were translated into English and Ukrainian and broadcast online.

The international speakers included: Helen Herrman (Australia), Bennett L. Leventhal (USA), Norbert Skokauskas (Norway), Bruno Falissard (France), Tali Levanon (Israel), Dennis Ougrin (UK), Hartmut Berger (Germany), Ihor Koutsenok (USA), Albert Feldman (Israel), Cuhadaroglu Fusun (Turkey), Aram Hasan (The Netherlands), Jeannette Lely (The Netherlands), Robert Teltzrow (Germany), Robert Van Voren (Lithuania), Rob Keukens (The Netherlands), Deauville Yodkayte (Lithuania), Marijke van Zhenabik (The Netherlands), Loek Dijkman (The Netherlands), and Liliya Korallo (UK); and the speakers from Ukraine included: S. Gluzman, I. Pinchuk, L. Yureva, I. Martsenkovsky, O. Levada, O. Chaban, O. Khaustova, H. Pilyahina, V. Mushuev, M. Pustovoit, V. Korostiy. O. Osokina, V.Tchaikovsky, A. Shut, V. Horbunova, and V. Klymchyk.
The conference included symposia, workshops and seminars on most mental health topics, including the state mental health strategy for Ukraine; mental health aspects of military operations and emergencies; diagnostic and therapeutic challenges, especially involving comorbidities; postgraduate training in Ukraine; mental disorders in children and adolescents; developmental disabilities; and young scientists’ activities.
The conference was opened by Professor Irina Pinchuk, Chief Specialist of the Ministry of Health of Ukraine and Director of the Ukrainian Institute for Social and Forensic Psychiatry and Narcology, and Drug Abuse of the Ministry of Health of Ukraine. In his opening remarks, Professor Pinchuk noted that the Conference takes place at time when the entire medical community must painstakingly work every day on large-scale tasks such as reforming the state’s healthcare system. The war in the East has affected many citizens, and internally displaced persons and persons from the occupied Anti-Terrorist Operation (ATO) zone put additional stress on all existing services, including mental health services. In this context, the mental health system must implement modern approaches and shift focus from inpatient to outpatient community mental health services.

Ambassadors, deputies of Ukraine, the Minister of Health of Ukraine and the Deputy Minister of the Ministry of Social Policy spoke words of support for the conference. The scientific part of the conference began with a presentation from Professor Helen Herrman, who is President-Elect of the World Psychiatric Association. Her presentation was devoted to the theme, "Promoting the mental health of women and girls in adversity: Psychiatrists as partners for change." Professor Herrman noted that combining specialists’ multi-level efforts can create an effective system for the prevention and treatment of mental health problems among women and girls. Covering a complementary topic, Professor Pinchuk, presented on "Mental health of women of the XXI century", and noted that the role of women in modern society includes not only educating children. Today, women and men are both members of the military.

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(Meeting report, Kiev, Ukrane, cont.1)

However, a large number of responsibilities and roles, low socioeconomic status, violence, stress, and gender discrimination are risk factors for mental disorders among women. In his speech entitled, “Psychiatry in Ukraine: 40 years later,” Ukrainian Psychiatric Association President Semen Gluzman noted that Ukrainian psychiatric school has faced challenges in its development, having gone through times of prohibition and repression. Unfortunately, psychiatry at the time of the Soviet Union was often used as a punitive tool. 40 years have seen many positive changes. However, it is critically important to remember history and to respect predecessors. During the conference, the Ukrainian Psychiatric Association has traditionally been awarded prizes. Tali Levanon, Head of the Israel Trauma Coalition, described the coalition’s experience in addressing psychotrauma and creating a hotline for victims of terrorist acts. Hartmut Berger, in the report, “Evidence-based recommendations on psychosocial treatment in cases of severe mental disorders,” provided an update from the Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde (DGPPN) working group on protocols for the treatment of severe mental disorders. Professor Ihor Koutsenok presented an interesting report, covering research and clinical aspects, on use of cannabinoids in medicine. Professor Koutsenok also presented on drug treatment approaches in the context of the justice system and pointed out that the treatment of persons with substance dependence and criminal behavior should strive for not only drug treatment and remission but also reduction of criminal recidivism. Prof. Bennett L. Leventhal presented a plenary lecture on "ADHD: disorder of lifespan" and participated in the Symposium, "Child and Adolescent Psychiatry Curriculum and Curriculum Development." In the symposium, “The knowledge transfer: from research to clinical practice,” Professor Norbert Skokauskas presented the project, “UNA partnership: new opportunities for young scientists.” In the symposium, “International experience in the rehabilitation of PTSD,” Robert Teltzrow presented the Project of the Council of Europe: training of psychologists for working with PTSD in eastern regions of Ukraine. Of interest, the symposia, “Closed social care institutions – from isolation to integration” and "Psychosocial help for patients with mental disorders in the XXI century," brought together heads of social departments from all regions of Ukraine and 160 directors of social care homes. Robert Van Voren presented the report, “Outcomes of the December 2016 assessment of social care homes in Ukraine under auspices of the Ombudsman for Human Rights of the Verkhovna Rada.”

Professors H. Herrman and I.Pinchuk

Also of interest was the symposium dedicated to young psychiatric scientists’ activities. The moderators of the symposium were Professors H. Herrman, B. Leventhal and N. Skokauskas. The young researchers presented their research papers and received valuable advice for improvement. All participants noted the relevance of the reports and the high level of organization of the conference.

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International Conference on Autism & Neurodevelopmental Disorders 2017 (**Thimphu, Bhutan**)

Saima Wazed Hossain (Bangladesh)
Aneeqa R. Ahmad (Bangladesh)
Nazish Arman (Bangladesh)
Dr. Muhammad Waqar Azeem (Qatar)

The International Conference on Autism & Neurodevelopmental Disorders 2017 was held in Thimphu, Bhutan from April 19th to 21st. The conference was co-hosted by the Ministry of Health, Royal Government of Bhutan and the Ministry of Health & Family Welfare, People's Republic of Bangladesh, with the technical support from the Shuchona Foundation, the World Health Organization, South-East Asia Regional Office (WHO-SEARO), and Ability Bhutan Society. The overall theme of the conference was developing effective and sustainable multi-sectorial programs for individuals, families and communities living with autism spectrum disorder (ASD) and other neurodevelopmental disorders (NDDs) in the region and globally. Delegates from 31 countries from six continents attended the conference.

The inaugural ceremony of the Conference was held on 19th April 2017 at the Royal Banquet Hall, Thimphu. Her Majesty The Druk Gyaltsuen, Jetsun Pema Wangchuk graced the inaugural session along with Her Excellency, Sheikh Hasina, Honorable Prime Minister, People's Republic of Bangladesh, His Excellency Dasho Tshering Tobgay, Honorable Prime Minister, Royal Government of Bhutan, and Dr. Poonam Khetrapal Singh, Regional Director, WHO-SEARO, along with other distinguished guests and participants. Dr. Yolanda Liliana Mayo Ortega, founder and Executive Director of Centro Ann Sullivan del Peru, delivered a Special Presentation at the inauguration, titled, "The power of two: families and professionals working as partners for children with autism to become independent, productive and happy."

The three-day Conference consisted of thematic panel discussions on community based services for achieving early identification, delivering interventions, developing comprehensive and supportive education programs, accessing employment opportunities and training, and ensuring rights and supported independent living for individuals with autism and other neurodevelopmental disorders in the community.

The High-Level Discussion on Day 1 of ANDD2017, featuring regional directors and representatives of the United Nations International Children's Emergency Fund (UNICEF), the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP), United Nations (UN) Women, the United Nations Educational, Scientific and Cultural Organization (UNESCO), the International Organization for Migration (IOM), the International Labour Organization (ILO), and WHO as well as ambassadors, country representatives and expert speakers, was Chaired by Her Excellency, Sheikh Hasina, Co-Chaired by Dr. Poonam Khetrapal Singh, and moderated by Ms. Saima Hossain, WHO Champion for Autism in South-East Asia. The discussion on Enabling countries to successfully address autism and other neurodevelopmental disorders as part of their Sustainable Development Goals focused on our common aspirations and not only set the tone of the conference, but the powerful remarks by speakers paved the way for an effective way forward so that children and adults with neurodevelopmental disabilities can be included in the global development agenda.

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The first thematic panel of the Conference was focused on community-based services for achieving early identification of autism and other neurodevelopmental disorders. This specific panel was split into two separate sessions, with the first session focusing on Screening vs. Diagnostic Evaluation and the second session focusing on Screening and Diagnosis through the health system. Since early identification is extremely important, the experts recommended that recognizing developmental conditions in a timely manner, providing early intervention, and involving the parents and caregivers are key in improving long term outcomes.

Day 2 of the Conference began with panel discussions – involving experts, caregivers, and self-advocates from across the globe – on interventions and education services. The first session was conducted in two parts, discussing Models for Intervention Services and Evidence-based Intervention Programs. The experts on this panel discussed the success of various community-based intervention models for individuals with neurodevelopmental disorders and their families. Subsequently, the panel on Education focussed on how individuals with autism and other neurodevelopmental disorders have varying levels of skills and benefit from maximum time with same age typically functioning peers. Self-advocate Dr. Stephen Shore emphasized the need for various models for appropriate education and the full spectrum of resources needed for inclusion in all settings.

The Special Session, held on Day 2 of the Conference, featured the experiences of 3 self-advocates, Dr. Stephen Shore from the USA, Daniel Giles from Australia, and Qazi Fazli Azeem from Pakistan. The speakers focused on the importance of self-advocacy, and each shared their unique journeys to becoming self-advocates. While all three speakers are on the spectrum, their life experiences, age of diagnosis, and interventions received were stark reminders of how unique each individual with ASD truly is and the importance of a customized approach. The speakers emphasized the importance of developing a sense of self and having self-awareness as part of the process of becoming effective self-advocates. The special session was chaired by Shri Faggan Singh Kulaste, State Minister, Ministry of Health and Family Welfare of India, and co-chaired by Beda Giri, Executive Director, Ability Bhutan Society. The Honourable Prime Minister of Bhutan, Dasho Tshering Tobgay, also attended the session and made brief remarks.

The final day of ANDD2017 featured two thematic panels focused on the importance of creating employment opportunities and facilitating supported independent living for individuals with ASD and other NDDs. Equal opportunity is now recognized as a human right, and the right to gainful employment and independent living is an important but often overlooked aspect of ASD and other NDDs. The experts, parents and self-advocates on these two panels shared their successful models for preparing for and securing employment, making decisions, and living as independently as possible.

Day 3 featured a Round-Table Discussion and the launch of the WHO-SEARO regional collaborative framework for addressing autism in a way that is cost-effective, systematic, structured, coordinated, and feasible for low-resource countries. The panellists of the Round Table included representatives from regional government organizations, civil society organizations, international organizations, and renowned professional and academic bodies. The session was Chaired by Dr. Thaksaphon Thamarangsi, Director, Noncommunicable Diseases and Environmental Health, WHO-SEARO and Co-Chaired by Dr. Samai Sirithongthaworn, Deputy Director General, Ministry of Public Health, Thailand. The discussion was initiated

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by Dr. Nazneen Anwar, Regional Advisor (Mental Health & Substance Abuse), WHO-SEARO, who presented a short overview of the WHO collaborative framework. She highlighted the challenges in the South-East Asia region, e.g. the treatment gap; lack of awareness and policies; stigma; paucity of financial, institutional and human resources; andneed for a coordinated response for inclusive development. In addition to panel discussions, 11 technical workshops were held concurrently during the Conference days and afforded a much-needed opportunity for informal discussion with international experts, government representatives, caregivers and self-advocates. The workshops focused on various diagnostic and intervention tools such as: Social Attention and Communication Surveillance (SACS), presented by Prof. Cheryl Dissanayake; the Jasper Model for inclusive learning, presented by Prof. Connie Kasari; the Early Start Denver Model, presented by Prof. Giacomo Vivanti; and WHO-Autism Speaks' Parent Skills Training program, presented by Dr. Shekhar Saxena and Dr. Andy Shih. Other workshops during ANDD2017 focused on different ways that practitioners in different countries, including India, Bangladesh, Bhutan, Malaysia, and South Korea, are addressing ASD and NDDs.

Additionally, the Early Childhood Development Task Force (ECD TF) of the Global Partnership on Children with Disabilities (GPCWD), whose Secretariat is at UNICEF, held an informal side event and shared materials about program priorities. Participants discussed the inclusive ECD programs they have developed with colleagues in their respective countries (Bangladesh, Bhutan, Singapore, India, Indonesia, France).
ANDD2017 brought together more than 250 participants from around the globe and represented a diverse group of stakeholders, including researchers, academicians, practitioners, self-advocates, caregivers, legislators and bureaucrats, heads of states, ministers, high-level government officials, and development partners. The closing ceremony featured remarks by Regional Champion for Autism, Saima Wazed Hossain, and concluded with the adoption of the Thimphu Declaration, which promised inclusiveness; which promised to build and strengthen national capacity to address ASD and other NDDs; which promised to strengthen information systems and research in this field; and which called upon all stakeholders – government and civil society – to address ASD and NDDs. It invited development partners to facilitate cooperation and collaboration to implement the Declaration in accordance with the SDGs.

His Excellency Dasho Tshering Tobgay, Prime Minister of Bhutan at the inaugural session

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The 4th Child and Adolescent Psychiatry Review Course (Jeddah, Kingdom of Saudi Arabia)

Dr. Khalid Bazaid (Canada/Kingdom of Saudi Arabia)
Prof. Muhammad Waqar Azeem (Qatar)

The first Child and Adolescent Psychiatry training course in the Kingdom of Saudi Arabia (KSA) was organized in Jeddah, 15-17 April 2013. The second training course was organized in Jeddah, 18 - 20 April 2014. The third training course was organized in Jeddah, 19 - 22 April 2015. Kingdom of Saudi Arabia is one of the most populous countries in Middle East, 27 million with almost half of the population includes children and adolescents. There are very limited resources regarding child and adolescent psychiatry (CAP) education in the country. After the success of the consecutive review courses, the 4th child and adolescent psychiatry review course was held in Jeddah, Saudi Arabia from April 10th to 12th, 2017. This course was organized this year for the first time in collaboration with Jeddah Psychiatric Hospital, Ministry of Health, Saudi Arabia.

The CAP postgraduate training in Middle East is not well established if compared to North America or Europe. Hence quite often junior doctors and trainees from the Middle East go to the North America to avail of post graduate child and adolescent training in psychiatry. In these circumstances, there is an urgent need to have a short and intense CAP training course in the KSA and the Middle East until the world class CAP fellowship program is established locally. The distinguished speakers who presented in this event were; four recognized national speakers Dr. Nawaf Alharthi, director of the organizing committee (Director of Jeddah Psychiatric Hospital, Ministry of Health, KSA), Dr. Saad Alkhateeb (Jeddah Psychiatric Hospital, Ministry of Health, KSA), Dr. Hani Abualross (Jeddah Psychiatric Hospital, Ministry of Health, KSA), Dr. Tahani Alqassem (King Faisal Specialist Hospital and Research Center, Jeddah, KSA), in addition to three international speakers Professor Muhammad Waqar Azeem (Chair, Department of Psychiatry, Sidra Medical and Research Center, Qatar / Weill Cornell Medical College, Cornell University), Dr. Ahmad Almai (Head of Child and Adolescent Psychiatry, SKMC, Abu Dhabi, UAE), and Dr. Khalid Bazaid, director of the course (Children's Hospital of Eastern Ontario / University of Ottawa, Canada).

Dr. Khalid Bazaid (Canada/Kingdom of Saudi Arabia), the course director

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(Meeting Report: The 4th CAP review course, cont. 1)

The audience was diverse and included child and general psychiatrists, pediatricians, family physicians, psychologists, social workers, nurses, trainees and medical students. This was important, as in the Middle East there is handful of child and adolescent psychiatrists and children with mental health needs quite often are seen by adult psychiatrists, pediatricians, and other allied professionals.

The course was aimed at educating the audiences, the common child and adolescent psychiatric disorders. The various topics covered included: Introduction to Child and Adolescent Psychiatry, Assessment and Interview of Child and Adolescent, Mental Status Examination of Child and Adolescent, Adolescent Psychotic Disorders, Depression in Children & Adolescents, Disruptive Disorders, Autism Spectrum Disorder, Pediatric Anxiety Disorders and PTSD in Children and Youths. The 2nd day was allocated for in depth review of ADHD.

Based on the success of this course, the organizers are planning to have this course next year and years to come. No doubt, such courses improve the local services by improving mental health providers' knowledge base and clinical skills and ultimately contribute to a better children's health.

The 4th Child and Adolescent Psychiatry Review Course in Jeddah

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14th Biennial Conference
Indian Association of Child and Adolescent Mental Health (IACAM)

Theme : Positive Mental Health for Children and Adolescents
Date : 10, 11 & 12 November, 2017
Venue : Swabhumi, The Heritage Plaza, Kolkata

Organizing Chairperson
Dr. Devashish Konar
M: +91 9434009113 9732221712
E-mail: devkon59@yahoo.com

Organizing Secretary
Dr. Sanjay Garg
M: +91 8961561392
E-mail: sgarg243@yahoo.co.in

From 10th to 12th November 2017 Kolkata will host the 14th Biennial National Conference of the Indian Association for Child and Adolescent Mental Health (IACAM) at Swabhumi, The Heritage Plaza. In the field of child and adolescent psychiatry, this is the most important academic activity, occurring once every two years. The theme of the conference is Positive Mental Health for Children and Adolescents. The conference has been co-sponsored by the WPA.

Top brass scientists working in the field are expected to meet and chart the course of regional child and adolescent mental health with a public health perspective. National and International leaders in the profession are being invited to deliver plenary and keynote addresses.

The first day of the conference will involve continuing medical education (CME) and will host the country's most popular teachers, who will deliberate on topics related to prevention in child and adolescent psychiatry. The following two days will include award paper presentations, plenary sessions by leaders of the profession, symposia, workshops, free paper presentations and poster sessions.

Prof. Savita Malhotra, who has been the IACAM's driving force, will deliver her keynote address, entitled "Child Mental Health: National Perspective," which will focus on the journey so far, the current state, and future directions. India has many strengths as well as challenges with respect to child mental health (CMH) services. While carving our path, we need to ensure that it is innovative, relevant and appropriate for India. For example, CMH is a discipline that requires a holistic approach in keeping with our philosophical tradition of holism. There is need for serious thinking on how to approach our strategies and action plans. Her presentation will cover issues related to expansion and consolidation of child mental health services.

Kolkata, the city of joy, is famous for its cultural, aesthetic and culinary indulgences. So, in addition to being academically rigorous, it is expected to be a charming conference that should be experientially rich. Kolkata has a very strong mental health tradition, which this conference will further enhance and link with the rest of the country and world.

Contact persons: Dr. Devashish Konar Organizing Chairperson (devkon59@yahoo.com)

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Child and Adolescent Psychiatry in the Middle East

Carolyn Clausen, MSc (Norway)
Dr. Khalid Bazaid (KSA/Canada)
Prof. Muhammad Waqar Azeem (Qatar)
Prof. Norbert Skokauskas (Norway)

The Middle East Academic Child and Adolescent Psychiatry Study

This study has been designed with the intention of meeting the call for further assessment of child and adolescent mental healthcare in the Middle East, a call made by various organizations, including the World Psychiatric Association. We are encouraged by the success of our previous study in the Far East, which was also kindly supported by Professor Norman Sartorius (Child and adolescent psychiatry in the Far East, Clin Neurosci, 2015 Mar; 69(3): 171-7).

As we all know, the Middle East has a strong emphasis on family, culture and tradition, while also upholding a growing professional demand for research, technological innovations and education. Almost half of the Middle East region's population consists of children under the age of 15, and another 20% are ages 15-24. Several countries within the region experience violence, and other crises, increasing the need to focus on the physical and mental well-being of the people, particularly with a predominantly young population.

With the young population continuing to grow rapidly, there is a need to investigate the current status of Child and Adolescent Psychiatry (CAP) services and how best to achieve appropriate future services for youth of the Middle East.

This study, aims to assess gaps in mental health service distribution and provide recommendations for how best to achieve appropriate future services for youth, by mapping the current status of CAP and CAP training systems in the Middle East.

We would like to invite our colleagues in the region to participate, as we believe your experience and knowledge would help to optimize CAP training in the Middle East.

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