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

World Psychiatric Association,
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Chair's Column:

Dear Colleagues,

Welcome to the final 2018 issue of "World Child and Adolescent Psychiatry," an official journal of the World Psychiatric Association, Child and Adolescent Psychiatry Section (WPA CAP). 2018 was the first year for the new WPA CAP board, and I thank my new colleagues for their work. It is important to note that not only has the board changed, but in 2018 we welcomed many new members, including early career child and adolescent psychiatrists from both high and low–middle income countries. We are happy to publish, in this issue, several short papers prepared by new members from Switzerland, Indonesia, Pakistan and the USA.

With the great sadness, we also must remember that, in 2018, we lost Dr. John Fayyad (Lebanon). Dr. Fayyad was well known for his work in Lebanon and he was an active editorial board member of "World Child and Adolescent Psychiatry." John will be missed by all who were fortunate enough to work with him, for his competence, courtesy and his friendly personality.

In 2018, WPA CAP section was pleased to learn that WPA President-Elect Dr. Afzal Javed decided to have child and adolescent mental health as one of his presidential initiatives. In this issue, Dr. Afzal Javed shares his plans with our readers.

In 2018, WPA CAP section members represented the section at all major mental health events: the IACAPAP bi-annual World Congress in Prague, Czech Republic, the AACAP Annual meeting in Seattle, USA, and the WPA World Congress in Mexico City, Mexico. This issue features reports and papers reflecting some section members' activities from these congresses. In 2018, the WPA CAP section co-sponsored research training courses for young child and adolescent psychiatrists; these trainings were held in Italy and Ukraine. In 2018, the WPA CAP section launched its new website, and we invite to you check for the latest updates at http://www.wpa-cap.org.

The WPA CAP section is looking forward to working together with you all in 2019.

May I wish you a Happy Festive Season and Prosperous 2019!

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

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Vision for the future

Prof. Afzal Javed (Pakistan/UK): WPA President-Elect

The WPA Planning Committee, chaired by President-Elect Professor Afzal Javed of Pakistan, has identified several potential focus areas for the WPA Action Plan 2021-2023. These include:

- Identifying needs for targeted groups with special emphasis on age 0-25 years (children, adolescents, persons with intellectual disability, refugees and patients with chronic and enduring mental health problems)
- Exploring needs for dealing with co-morbidity issues in psychiatry and developing strategies to deal with other medical & health professionals /organisations
- Developing partnerships for joint collaborative work & strengthening partnerships with various professional & non-professional organisations working in the field of mental health
- Developing capacity building & training policies in global mental health (focusing on teaching of psychiatry for medical students)

It appears that there are several opportunities for the child and adolescent psychiatry (CAP) section to play an important role in supporting the WPA Action Plan, particularly: for the 0-25 years age group, for persons with intellectual disability, for other vulnerable youth, in support of liaison with other organizations, and in support of training and workforce development.

While the WPA has no less than 70 sections, the CAP section addresses issues related to a large segment of the world's population: approximately one-quarter of whom are under age 15 years; approximately 40% of whom are under age 25 years; and exactly 100% of whom either are currently or were previously children!

The WPA-CAP Section officers commend President-Elect Javed and the Planning Committee for highlighting the role that our organization and our specialty can play in the "advancement of psychiatry and mental health for all peoples of the world." We call all those interested and able to formally join the WPA-CAP section (http://www.wpanet.org/joinSection.php?section_id=11) and to help the WPA-CAP section in supporting the WPA's action plans, through scholarship, networking, education, and services.

This presidential initiative was summarized by Prof. Guerrero (Deputy Editor)

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A psychiatrist journey to the East

Can progress and tradition coexist in attitudes and beliefs about mental health?

Dr. Esperanza Y. Salinas (USA)

A MID-LIFE crisis and a need to push boundaries, determine my grit, travel and explore different cultures led me to the path I am on now. My current work has given me the opportunity to widen my personal and professional perspectives in unique and challenging ways. I came to the East not knowing what to expect. What I found was a very complicated and fascinating people both stoked in tradition and history, and driven by a hunger for modernism and progress. I see this in every corner of my interactions and experiences here. From the homeless person asking for a handout ("no need for cash a WeChat transfer would do") to the brilliant Autistic individual who was content with his differences until his social deficits interfered with his successes at university. This writing reflects my perspective, as an expat and a psychiatrist working abroad, on the attitudes and beliefs about mental health here, with particular focus on stigma and bias.

The term stigma, as defined by Merriam-Webster, is a mark of shame or discredit and bias is a personal judgement of a positive or negative prejudice towards an idea or another person. For the sake of this article we will focus on negative bias. Both stigma and negative bias originate external to the person as thoughts from others with the usual result of inducing shame. In the East, the synonym for shame is the "loss of face"' and, indeed, "saving face" is a cornerstone of successful interactions. Through the different uses of "face" I will examine stigma and bias by juxtaposing traditional and progressive views of mental health

The terms "saving face or losing face" are complex and difficult to understand both because of the interactions themselves and because of how 'face' is used in the interaction. "Saving face" can play a role in either reinforcing or reducing stigma in mental health illness and mental health treatment. Some aspects of "face" serve to reduce stigma while other aspects serve to reinforce it.

I experience my clients accepting certain symptoms as part of an illness in order to make it easier for them to seek and accept treatment and rejecting other symptoms thereby rejecting help and healing. Both this acceptance and rejection of symptoms and treatment is motivated by "saving face," one serves to reduce stigma while the other serves to perpetuate stigma and bias. For example traditional views of suffering and distress dictate this to be a private matter, a subject that should not be discussed freely especially with an outsider. A sense of shame becomes associated with suffering as it is viewed as a shortcoming and considered a flaw or "face losing" expression. The general attitude is "I must appear strong and capable and not burden other people" at all costs. This contrasts with the progressive emphasis on success and upward mobility, that allows an individual an exemption to embrace treatment and hence recognition of shortcomings and flaws. Hence it is "face saving" to address those issues that may be interfering with

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academic success, concentration, energy, and vitality and in this way taking care of one's mental health is embraced as a way forward in life.

Take for example, the young man who was clearly diagnosable with Autism Spectrum Disorder. He came to see me after getting suspended from his graduate program for a semester secondary to a misunderstanding largely due to a social and communication impairment. After discussing my findings with him, he said to me "I am not autistic because I do well in school." He rejected the diagnosis and explained, while his peers were socializing he was studying and excelling academically – demonstrating face saving qualities of perseverance, diligence and self-sacrificing all venerated characteristics from a traditional and "face" making framework. This aspect of his illness allowed him to be himself, and look good in others eyes, with minimal bias against his shortcomings and little attention paid to his differences. Only until the social characteristics of Autism interfered with his university studies that he wanted to understand and correct the issues. Nonetheless, the traditional "face saving" part of him would not allow him to have a diagnosis of Autism. There was shame in "having a diagnosis" having been diagnosed with something was "face losing" for him. Eventually the progressive part of him, which emphasizes that education and hard work are keys to success and upward mobility, was the impetus to seek treatment. He came to terms with the diagnosis as he sought to understand how his self-image a self-sacrificing and good student could have been suspended and this image be inconsistent with the universities understanding of him.

In the same vain, ADHD is viewed as a disorder that interferes with academic success and therefore something to address. This is the progressive or "face saving" aspect. However, the use of medications to treat ADHD is "face losing" and frowned upon because having these symptoms is seen as a weakness of character that should be corrected through willpower alone. Traditional beliefs dictate that the symptoms of ADHD (distractibility, hyperactivity, inability to focus, and inattention) should be corrected by fortifying the character or should be within one's control.

Stigma and bias exist in the tension between traditional views of health and modern views of society, well-being, and success. Although the concept of "face" is entrenched in societal norms here, similar constructs are seen in other cultures (i.e. in groups of people who have been historically marginalized, whether due to race or class).

As a psychiatrist I am always trying to find ways to help my clients identify the "face saving" attributes of treatment in order to help them embrace acceptance, change, and understanding of their symptoms while also maintain their connection to their communities of support. Assisting clients in this way, with this understanding, serves to help them heal in a truly holistic way.

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The Stigma of Mental Health Service Use in Child and Adolescent Psychiatry

Dr. Jing Chayanin Foongsathaporn (Thailand/USA)

Born and raised in Southeast Asia, I have undeniably felt and witnessed the stigma surrounding mental healthcare. In Thailand, the stigma towards psychiatric patients and treatment remains almost tangible. Even my own mother, a dentist and wife of an internist, expressed reservations when I first told her that I dreamt of becoming a psychiatrist in middle school. Many years later, I voiced that same dream to medical school peers, only for them to respond with jokes like, "Oh, you're going to treat crazy people."

According to the Merriam-Webster dictionary, stigma means "a mark of shame or discredit." The medical community has identified the stigma surrounding psychiatry as a likely key factor in impeding access to and utilization of mental health services. Negative public attitudes towards psychiatry unfortunately carry heavy influence and commonly impact both the patients' and their parents' decisions. Fear of social devaluation and rejection often forces parents to feel less inclined to seek mental health services available to their children. For patients and parents brave enough to pursue appropriate mental treatment and stand up to the stigma, social responses can be devastating and take many forms. Common examples include the children and their families being shunned by members of their communities, social distancing between the child and peers, and parents enduring blame for their child's condition. There is a study that found more public support for parents of children with asthma than for parents of children with mental health conditions.

Childhood and adolescence play pivotal roles in social-emotional-behavioral development. Thus, failure to address mental health needs could carry life-long effects. For children with mental illnesses, access to mental health services can drastically benefit their developmental trajectories. Pharmacological treatment has been shown to alter neurochemical status in patients' brains, affecting mood, irritability, hyperactivity and many other symptoms. Similarly, psychotherapy improves insight, behaviors, and emotional difficulties evidenced through brain imaging that have identified brain changes in people after undergoing psychotherapy. Children deserve not to be judged for their mental illness, and they certainly should not have to sacrifice their well-being for the perception of their neighbor.

Although the stigma within child and adolescent psychiatry has recently gained growing recognition, recognition remains only the first step towards tackling the overall issue. As a trainee who will become a child psychiatrist in the near future, "to educate" is one of the most important tasks. I found myself enjoyed educating parents about their child's mental health condition when I rotated in acute hospitalization unit as a second-year general psychiatry resident at University of Hawaii, USA. For many parents, mental illnesses are often frightening, complex, and overwhelming. It is our duty as psychiatrists to properly educate patients and their families and to provide a level of understanding necessary for them to truly embrace the road to recovery. By educating them about etiology, prognosis, and treatments, parents obtain a degree of preparation and optimism that might be more crucial than any prescription.

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In addition to educating patients and parents, I believe education tailored towards the general public will arguably play an equal, if not greater, role in eventually eliminating the stigma. Although a complete shift in public perception will undoubtedly take time, the issues concerning child mental illnesses might be more relatable to the average person than originally assumed. For example, the World Health Organization (WHO) estimates that 10%-20% of all children and adolescents experience some form of mental disorder. Such a high percentage implies that almost every person knows or has encountered at least one child with a mental disorder. These children are in every school and every community. By providing the general public with basic understandings of mental health, our society will hopefully no longer see mental illnesses as some abstract concept, but instead, sympathize with a fellow classmate or neighbor.

Aristotle once said, "Educating the mind without educating the heart is no education at all." I am hopeful that, by providing education about mental health, the public will understand more and open their hearts to our psychiatric patients. I cannot help but feel inspired and empowered by the ongoing efforts to create a long-lasting change in the fight against stigma. Hopefully one day, when a medical student informs her classmates that she wants to become a child psychiatrist, she will not be met with a joke, but rather, "Oh, you're going to make a real difference in children's lives."

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Internet Gaming Disorder - ICD 11 and my perspective

Dr. Kim Le (Australia)

As a child growing up in Adelaide, South Australia, I always wanted to work with computer games but also wanted to study medicine. Despite choosing medicine, I was able to combine my medical career with my love for computer games through gaming disorder.

One of the first lessons I learnt in medical school from my university professor was, *"in 10 years, what you know now about medicine will be different"*. After achieving my medical degree, I decided to pursue psychiatry training following a chance meeting with a patient who was addicted to the online game "World of Warcraft". This was 2008. I realised that this patient was sharing their mental illness with their online avatar, and this inspired me to take up specialist training. Ten years later, we now have "gaming disorder" (GD) in the World Health Organisation ICD-11.

My university professor was right.

In my advanced psychiatry training I decided child psychiatry would best compliment my path in gaming disorder research. Even when I worked with adults, I always found the developmental aspects fascinating, and even more fascinating when you explore how people develop their online persona in an online game.

In 2015, I was awarded an Australian federal government grant to investigate gaming disorder in Singapore, at the Institute of Mental Health (IMH). When I was interviewed by the Australian grant panel for the funding, I brought in an original Nintendo Gameboy, the infamous "grey brick", a relic of my childhood. I told the panel, "Handheld devices connected to the internet are now being placed in the hands of children around the world. We have no idea what effect this has on their development and ultimately their mental health. I believe that Australia is largely oblivious to this problem. We have no dedicated clinic here in Australia."

I remember at the time, even I was still not convinced that online games were addictive and that GD was a legitimate disorder. I was very fortunate to have this formative overseas experience, it was a real catalyst for my career in this field.

Prior to leaving Australia I created the CGI Clinic website to document what I was doing and to share information. I learnt in video games to document or "save" the game often, especially after each objective, goal or quest was completed. Just like in games, it's important to collect badges like grants and awards because this will unlock hidden doors and characters to help you on your ultimate quest. Spending time in Singapore was like being in another world in a video game. I had the freedom to explore this world. Not only did I reach out to the key researchers in the field in Singapore, I also reached out to contacts in South

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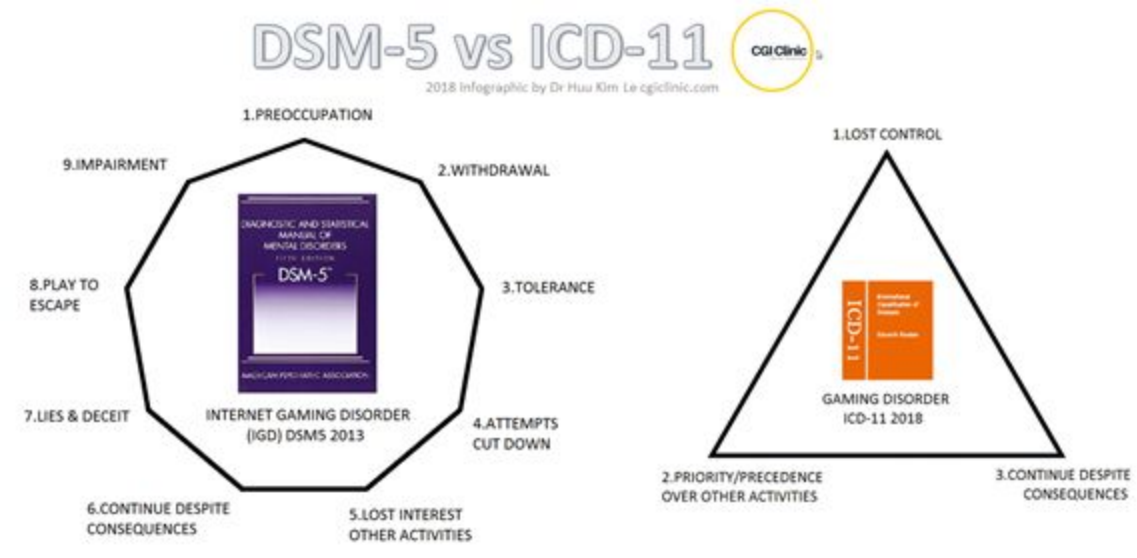
Korea and India. I tried my best to make my way to China, famous for their paramilitary-style camps as therapy for GD, but to this day that country remains a hidden world to me – like a bonus level in a game.

I spent six months in the Singapore national adolescent internet gaming addiction clinic. The Singaporean Department of Education and Ministry of Health actively work collaboratively to treat GD. This opened up my eyes to the mental health consequences of online gaming in children and adolescents. It was in this clinic, that it became clear to me that GD was a legitimate problem and that we need more prevention and treatment programs back in Australia.

When I returned to Australia, I gave a TED[x] Talk titled 'The spell of digital immersion' about my experience. As a consultant child and adolescent psychiatrist I see an increasing number of young patients who have an unhealthy relationship with internet gaming and smartphones. When I first started, I was the only psychiatrist in my home town actively treating gaming disorder. Since the release of WHO ICD-11 in June 2018, referrals from paediatricians and general practitioners have quadrupled. There has certainly been increased awareness of the problem since it was globally recognised and more people are seeking help. Interestingly, prior to the release of ICD-11 I was using the DSM-5 proposed criteria for "Internet Gaming Disorder" (Note: IGD is not an official diagnosis but listed as a "Condition for Further Study" in DSM-5), which is characterised by 9 criteria as opposed to the WHO GD diagnosis which has 3 core criteria. In May 2018, I had just completed an assessment for a teenage boy with gaming problems but didn't complete the letter to the referring physician. By the time I completed the letter the new ICD-11 criteria came out, and this boy did in fact meet the criteria for the diagnosis. The new ICD-11 criteria will have a significant clinical impact not just in terms of awareness and help seeking, but more patients will be diagnosed with this disorder.



In Singapore, we published data from the clinic which showed that ADHD was the most common comorbidity with GD. I am seeing this problem in Australia too; children who find it hard to concentrate

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on their academic tasks. Children can spend hours in front of a screen but struggle to get past the introduction in a book. This reflects the demands of attention, i.e. sustained focus in order to complete a task is much different to that of the passive visual attention for an electronic screen.

Ten years ago, the Australian Government introduced the "1:1 laptop policy" dubbed the "technology revolution" that would see each Australian student with their own laptop computer. This was supposed to catapult the Australian education system into the 21st century. However, the Organisation for Economic Co-operation and Development (OECD) Programme for International Student Assessment (PISA) studies show that there is no evidence that 1:1 laptops improve educational outcomes. In fact, high performing students may benefit from internet technology, but the children who cannot read and write will do the activity which is easiest to them i.e. play online games. The Australian education system continues to fall in the global education rankings, but we still hold onto this belief that technology is the future and is essential. It's not that simple.

Although more boys play online games and present with gaming disorder, I see teenage girls with problems turning off their smartphones, poor sleep hygiene and subsequent concentration. The Australian Department of Health statistics suggest that approximately four per cent of Australian teenagers have addictive problems with their internet and electronic gaming use. This data also showed that girls were having more addictive problems than boys. I believe that this is a red flag that smartphone devices and not just online games are also programmed for addiction.

I believe that in the future, there will be a need for all mental health clinicians to consider a "bio-cyber-psycho-social" model of formulation (a term I coined as a trainee). As more people spend the majority of their time in the virtual world, this will affect their ability to function and contribute to the real world. We have reached a tipping point, whereby our society is acknowledging this as a problem and the reason for this is the smartphone. Smartphone use is now ubiquitous around the world and the app designers knowingly program our devices for addiction for financial gain. I have since visited other countries such as Japan, who was instrumental in the gaming disorder proposal in ICD-11. The commonality especially among the Asian countries is the dichotomy where local industries rely on technology advancement for their economies and at the same time, there is an urgency to prevent or treat their youth who will be their workforce for the future. Australia is already suffering from a rapidly ageing population with strict immigration policies. Not only are we at risk of our young talent moving overseas, we are experiencing a "brain drain" where our youth are increasingly deciding to spend their lives in the online world and not contributing meaningfully to economic systems.

My advice for fellow child and adolescent psychiatrists who might be interested in specialising in internet gaming disorder, is to become involved.

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Child and Adolescent Refugee Mental Health

Dr. Vikas Gupta (India/USA)

Worldwide, several countries have had refugees for a myriad of reasons, including war, persecution, death of loved ones, and other psychosocial adversities. Before, during, and after migration, refugee children share many risk factors that predispose them to mental health problems. Stressors that render refugees particularly vulnerable, in comparison to other migrant populations, include exposure to war and other events that triggered the migration, perilous journeys, uncertainties in the asylum process, adjustment to a new culture, and discrimination. These stressors can be further complicated by mental illness, including Post-traumatic Stress Disorder (PTSD), depression or anxiety in children or their parents. During the past few years, large numbers of accompanied (with parent or caregiver) and unaccompanied minors (below age 18 years) have sought refugee status in host countries. Just in the European Union, the numbers of asylum-seeking minors (below age 18) were 385,000, 398,000 and 213,000 in 2015, 2016 and 2017, respectively.

A systematic review of 47 studies between January 1990-October 2017 in European countries found point prevalence rates of 19-52.7% for PTSD, 10.3-32.8% for depression, and 8.7-31.6% for anxiety disorders. The variable prevalence rates are explained by different exposures and differences in family and psychosocial contexts prior to migration, during migration and after migration. Children and adolescents comprise the most vulnerable group among asylum seekers and refugees. Mental health outcomes for children and adolescents post migration are significantly influenced by the availability of services and interventions, by resilience and coping ability, and by social and family support. Another systematic literature review of studies from 1990-2003 concluded that more research was required on interventions, specifically on their efficacy and cultural relevance.

With an increasing number of unaccompanied refugee minors, who are especially vulnerable, the prevalence rates of mental disorders have been increasing even further. Given that the mental health of children is shaped by contact with parents and by parents' mental health, interventions should include contact with parents, improvement in parents' mental health services, ongoing contact with native culture, and culturally sensitive mental healthcare, which is often challenging to insure due to inadequate cultural training in countries that host refugees from far off countries. Child and adolescent psychiatrists need further training in refugee mental health because of increasing refugee populations globally. Given the transgenerational impacts of adversities associated with migration, further studies should look at interventions and strategies to alleviate the risk of mental illness among child and adolescent refugees.

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Competency in global mental health - trainee's perspective

Dr. Ali Haidar (Lebanon/USA)

In preparing to write this opinion, I tried to locate any guidelines internationally or locally; however, little has been published on the subject of trainees' competency in global child and adolescent mental health.

One way to approach this topic would be to first delineate the meaning of "global." It seems that a generally accepted model of global psychiatry experience involves trainees going to medically underserved areas of the world and evaluating a maximal number of patients or providing other medical professionals with new knowledge or skills in psychiatric assessment and management.

With stigmatization of mental health conditions across the globe and a paucity of mental health professionals, there is huge need for collaboration on a global level, and trainees' willingness to be involved in global mental healthcare is an asset to the psychiatric community worldwide. "Global" electives or "field work" may be appealing for trainees who hope to improve conditions for populations who would otherwise lack access to mental health care.

However, is it necessary or sufficient to go for a month or two to a psychiatrically underserved area? What happens to the communities after the trainees leave? How were the people managing their needs before the arrival of outside "experts?" Trainees must maintain awareness that populations have their own vessels for resilience. Different cultures have their own ways of handling emotional adversity and trauma. The management of major psychiatric diagnoses is influenced by biological impacts on illness phenomenology and responses to medical management. Family, community, and individual responses to illness also vary between communities. Interventions that are aligned with one's cultural beliefs or rooted in tradition are generally received more positively than those that are not. Trainees should understand the cultural and familial systems of the communities they are visiting. Their assessments should identify the strengths, resources, and solutions available within those communities rather than focus on deficiencies perceived from their own frame of reference. Most importantly, the focus should be on building the community's management skills to provide long-term benefit beyond any services directly rendered by the trainee during the time-limited rotation.

You don't need to travel to an underserved area of the world to practice global mental health. Global mental health practice starts the day you set foot in any clinic in this globalized world.

Training is already a challenging endeavour, where physicians need the time to focus on acquiring clinical skills and mastering knowledge. By focusing on cultural subtleties in the physician-patient encounter, you can uncover endless opportunities to better the treatment relationship. This approach only requires the trainee to strive for a better understanding of where patients are coming from, what their habits are, and what works for them. I would argue that global mental health is something for us to practice every day as culturally aware mental health providers with curiosity and sensitivity as the basis of our approach to patients.

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Child and Adolescent Psychiatry and Psychotherapy in Switzerland

Dr. Matthias Köster (dr.matthias.koester@hin.ch)

About Switzerland

Switzerland, a federal democracy in the center of Europe, has a population (as of the end of 2017) of 8.48 million people. Switzerland has diverse cultural regions, four official languages, strong financial and economic ties to neighbouring countries, a high flux of foreign workers from Europe and the rest of the world, and a high number of pupils who are immigrants or who hold dual citizenships.

There is a high degree of immigration of qualified workers in areas of demand, including psychiatry and child psychiatry. Many doctors and nurses come from neighbouring countries like Germany, France, Austria, Italy, and elsewhere. In Switzerland, there is relative social peace, low unemployment rates (2.4%, with a regional range from 0.6 to 4.3%), and well-built infrastructure, including extensive public transport and regional school networks. State schools have integrated social workers, remedial teachers, speech therapists, school psychologists, and paediatric doctors who try to find solutions for pupils with special needs.

Still, there is a need for more inclusion-focused policies in Switzerland. The UN human rights report of 2015 (CRC/C/CHE/CO/2-4, 2015) promotes the priority of a civil society for children across sectors, with sufficient resources allocated to implement, monitor and evaluate the human rights situation, and with a need for more participation of children and civil society organisations. Implementing this priority in Switzerland would be somewhat counter to the traditions of self-financing that are fine for the privileged but not for the majority. At the same time, this economic tradition leads to less bureaucracy and improves decentralised efficiency. As in other parts of the world, the socially less privileged, particularly migrant, refugee, and asylum-seeking children, are under pressure and at risk for mental health problems. Their needs demand active attention on all levels of society.

The health of youth in Switzerland

The Zürich Epidemiological Study of Child and Adolescent Psychopathology Study (ZESCAP) of 1994 (Steinhausen, 1998) showed that 22.5% of pupils between first and ninth grade had a psychiatric disorder in the six months prior. Half of the disorders were anxiety disorders. 12.5% of the pupils had comorbidities. Unfortunately, there is no updated survey providing national-level epidemiological data, which is much needed in view of the fact that psychiatric diseases are one of the main causes of unemployment and marginalisation, with associated societal costs.

According to the 2018 Schweizer Gesundheitsbefragung (Swiss Health Survey), 7.8% of young men ages 15-24 years and 13.2% of women in this same age group had major depression of moderate or severe magnitude. Rates of adolescent suicide (still one of the main causes of death in this age group) dropped from above 20/100000 in the 1995-1999 period to around 11/100000 currently. According to the Swiss Children with Special Health Care Needs study of 3325 children in the community, 18% had special

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health care needs and 6.2% used psychiatric services. Lower income families are more prone to reduced health-related quality of life.

The Swiss healthcare system

Somewhat in contrast to gate-keeping systems in the Netherlands or the United Kingdom, people can potentially reach specialists relatively easily. I personally get contacted by parents, adolescents, social workers from schools or social services departments, school psychologists, clinic colleagues, house doctors, and paediatricians. The decentralised referral system can be a blessing – especially for well-functioning families – or a curse.

Psychiatry & Psychotherapy in Switzerland

There is a long tradition of social and child psychiatry and systemic and humanistic psychotherapies alongside classic psychiatric disciplines. Ambulatory mental health structures for the young were started in 1871 in Zürich. Moritz Tramer (originally from Austria), who coined the term child psychiatry, founded the world's first modern journal of child psychiatry "Zeitschrift der Kinderpsychiatrie" in 1933 and wrote the first systematic child psychiatry textbook in 1942. Zürich also established one of the first child psychiatry day clinics in Europe in 1975. On the contrary, eugenic practices, where children and families of minorities and mental health problems were victimized, were prevalent until the 1970's.

In 2017, there were 481 ambulatory child psychiatrists, yielding a citizen/child psychiatrist ratio of 17631/1 according to statistics of the Foederatio Medicorum Helveticorum (FMH), the national organisation of doctors in Switzerland.

To provide integrated psychiatric-psychotherapeutic treatment, the psychiatrist has a unique freedom in the choice of treatment setting that is still financed by healthcare insurance . To provide only psychotherapy, the psychiatrist must write a report before the 40th session. Therefore, there is relative autonomy in directly and flexibly working with families by process-oriented shared-decision making and common-factor therapy techniques.

In this context, there is somewhat of a risk of child psychiatrists choosing to serve a less demanding cluster of patients and potentially not serving a significant population of patients with higher needs.

Specialisation in child and adolescent psychiatry and psychotherapy

Specialist training in child and adolescent psychiatry and psychotherapy involves six years of obligatory specialisation after medical study. Swiss child psychiatrists regard psychotherapy as one of the most important parts of specialization and emphasize common factors, such as warmth, respect, change process, understanding, and cultural sensitivity, as core features of therapeutic professionalism.

This training includes four years of child psychiatry with inpatient and ambulatory rotations (at least two years of the latter). One year of research or youth forensics can be integrated into the six years.

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In Switzerland, child psychiatrists are the next lowest earners, next to paediatricians, and it appears that many child psychiatrists have high idealism as they enter the field.

Challenges for the Swiss & European health and social systems

Within the national parliament and the federal health department, there is movement to centralise powers on what doctors can do and on healthcare financing. Medical organisations are concerned that such centralisation may result in lower quality of services, mainly for poorer people. Before any healthcare system changes are made, it would be important to ascertain the health of youth nationally and in each cultural region, find solutions on a regional (Kanton) level, engage in open discussions on what to finance on a national level and what every citizen should be entitled to, insure that mental health services are adequately funded, decide which services could appropriately be performed by non-physician providers, develop a user-friendly system for tracking outcomes, and ultimately preserve the doctor-patient relationship and patient privacy.

I personally hope for a European and perhaps even a global movement that gives organisational support for all nations and regions and that helps to identify mental health and social policies that yield the healthiest outcomes.

The challenge in Switzerland is that strong conservative and nationalistic movements oppose almost everything linked to the European Union (EU) or universal values such as child protection legislation guaranteed on a potentially transnational base.

As a grandchild of war-torn families highly affected by the extremes of fascist and communist suppression, I hope the European people hold universal values high and engage in the protection of democratic, transnational, and multilateral solutions.

In advocating for care, education, empowerment, children rights and non-violent treatment for even the most vulnerable, child psychiatrists clearly play an important role in achieving these solutions.

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Child & Adolescent Psychiatry in Pakistan: Current Scenario & Future Direction

Drs. Nazish Imran, Muhammad Waqar Azeem, and Afzal Jave

With a population of over 200 million people, the Islamic Republic of Pakistan is one of the most densely populated developing countries in South Asia. 52.5% of Pakistan's population are under the age of 25 years, and approximately 32% are under the age of 14 years. The World Health Organization's (WHO's) assertion that countries with the highest proportion of children and adolescents are often the ones that lack child and adolescent mental health policies and services certainly holds true for Pakistan. Low income countries like Pakistan face a multitude of social adversities, including poverty, malnutrition, rapid urbanization, educational deprivation, drug abuse, crime, and terrorism, all of which increase the risk of youth mental health problems. While the country cannot afford to ignore the mental health of this large population, only a small percentage of the country's total annual budget is spent on health including mental health; furthermore, there is no specific allocation for child and adolescent mental health.

Current Scenario:

Epidemiology:

Lack of indigenous research in child and adolescent mental health has been a major hindrance for resource allocation and service development in the country. A recent survey of 5-11-year-old school children attending mainstream private and community schools in Karachi found the prevalence of mental health problems to be much higher than reported from developed countries. Almost 34.4% of children were rated by parents and teachers as being in the abnormal category on the Strengths and Difficulties Questionnaire (SDQ). A much earlier study done in Lahore estimated the point prevalence of emotional and behavioral problems in school children to be 9%.The prevalence of Intellectual Disability in the country is 19.0/1,000 for serious levels of disability and 65.3/1,000 for mild disability).[6] Significantly higher levels of child psychiatric difficulties and disabilities have far reaching consequences for the country's future.

Referral Pathways:

In Pakistan, there are no formal referral pathways for children and adolescents suffering from psychiatric conditions. Therefore, parents are at liberty to consult (or not) any type of provider. The majority of youth present for mental health services after having visited faith healers and spiritual leaders. Referrals from schools, general practitioners and pediatricians are infrequent due to poor mental health literacy among teachers and doctors.

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Outpatient Services:

The growth of child & adolescent psychiatry services has been very gradual over the last 2-3 decades. Only three tertiary care centers in urban areas offer dedicated child and adolescent psychiatry outpatient services in Pakistan. The situation becomes even more alarming with almost non-existent services in rural areas, where most of the country's population lives. The largest chunk of children and adolescents presenting for mental health and multidisciplinary team services in Pakistan are diagnosed with developmental disorders. The problem of service delivery is further compounded by a lack of critical mass of professionals – including psychiatrists, psychologists, general practitioners, nurses, speech therapists, occupational therapists, and paramedics – trained to deliver mental health services for vulnerable children. Stigma is another major barrier to accessing limited child mental health services. During the past few decades, there has been steady growth, especially in major cities, of centers for children with special needs and autism. Many non-governmental organizations also provide services for children who have suffered trauma and abuse.

Inpatient Services:

The country's sole dedicated child and adolescent psychiatric inpatient unit was recently established at King Edward Medical University. In most instances, children and adolescents requiring psychiatric hospitalization are admitted to adult psychiatric units, which are not appropriate environments for treating this vulnerable population.

Mental Health Promotion and Prevention Services:

Reports of significant improvement in mental health awareness through school mental health programs and improvement in maternal mental health have led to public health, advocacy, and other innovative approaches to improve child mental health services in Pakistan.

Training:

Training opportunities for psychiatry and allied professions like psychology are gradually increasing in various academic institutions in the country. In 2014, the College of Physicians and Surgeons Pakistan (CPSP), which is the main certifying body for post-graduate training in the country, announced the approval of Child and Adolescent Psychiatry Fellowship (FCPS) training in the country; however, a training program has not yet materialized. With College faculty's recent focus on child psychiatry, there is hope that training in this specialty will start soon. Agha Khan University in Karachi has also approved a curriculum for child and adolescent psychiatry training. Very few pediatricians get any exposure, during their post-graduate training, to children with psychiatric problems. Absence of a formal examination in psychiatry at the undergraduate level also means that most physicians have limited knowledge of mental health issues. Specific training of psychologists and nurses in child and adolescent mental health is also unavailable in the country. In the last few years, the Association of Physicians of Pakistani Descent of North America (APPNA) MERIT has organized regular online lectures on various pediatric mental health issues by experts from the developed world. These lectures have been well received and have helped to build capacity in Pakistan.

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Research:

Child mental health research is still in nascent stages in Pakistan. Pakistani researchers have become more involved in presenting their research on child and adolescent mental health topics at various prestigious international conferences, including the American Psychiatric Association (APA), the World Psychiatric Association (WPA), the American Academy of Child and Adolescent Psychiatry (AACAP), the Royal College of Psychiatrists, and the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP). The number of publications from the country on child and adolescent mental health has also increased significantly during the last decade.

Legislation:

The country's current mental health law embodies modern concepts of mental illness, treatment, rehabilitation, and respect for civil and human rights and was promulgated on 20th February 2001. Following passage of the 18th amendment, health became a provincial responsibility, and each province had the task of securing appropriate legislative approval for healthcare funding from the respective provincial assembly. So far, only the provinces of Sindh and Punjab have made some progress in funding local mental healthcare, and practical implementation of this system still lags. Lack of implementation of the Mental Health Act leads to inadequate resources. In most emergencies, families are the only support system available for patients. Following a major pedophilia scandal in Kasur district in Punjab in 2016, a bill was passed by the Senate that criminalized, for the first-time, sexual assault against minors, child pornography and trafficking. Previously, only rape was criminalized.

Future Direction & Possible Solutions:

Pakistan, despite limitations of inadequate budget for healthcare, poor literacy, poverty, low governmental priority for mental health, and significant stigma associated with youth mental illness, has started taking many small steps in the right direction in relation to child and adolescent mental health. The development of a child and adolescent psychiatry fellowship to produce the next generation of child and adolescent psychiatrists will hopefully make a difference for children, youth and families most in need. Research in child and adolescent mental health is encouraging, but there is a serious need to have community-based, methodologically sound research to obtain data on prevalence of common psychiatric conditions in youth and on effectiveness of various interventions in the local context. A task shifting approach, involving non-mental health professionals in addressing pediatric mental health, can be very helpful. There is an urgent need to develop school mental health services. In this regard, a randomized controlled trial to assess the effectiveness of the WHO Regional Office for the Eastern Mediterranean school mental health manual-based training of teachers is currently underway in Lahore. There is a need to train general physicians and pediatricians in addressing child and adolescent mental health issues. Developing pediatric-psychiatric liaison services can help in early identification and intervention. An increase in mental health budget allocations and implementation of the Mental Health Act are important priorities. A strong political will is required from all stakeholders to address child and adolescent mental health related issues in the country. Everyone stands to gain if the country's large population of youth grows up confident, secure and happy.

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Child & Adolescent Psychiatry in French Polynesian

Prof. Bruno Falissard (France)

The 11th of May 2018, in Papeete (Tahiti Island), was "Mental health and suicide prevention day." At this occasion, the new mental health plan was presented during a conference entitled, "Mental Health and Suicide Prevention Plan: Which steps forward in France and around the world for French Polynesia."

French Polynesia is an overseas collectivity of the French Republic; it is thus a part of a high-income country and should therefore benefit from a high-level health care system. However, French Polynesia is composed of 118 islands and atolls, among which 67 are inhabited. The organization of health care is thus a considerable challenge: it is quite impossible to provide specialized medical care in all these locations. For this reason, and because there are much fewer child and adolescent psychiatrists there than in the rest of France, there is an absolute necessity for some disruptive innovations in terms of mental health organization.

Child & Adolescent Psychiatry in Indonesia

Dr. Fransiska Kaligis (fransiska.kaligis@ui.ac.id)

Indonesia is an archipelago consisting of 17,000 islands and 34 provinces. 33.9% of Indonesia's total population of 257.6 million are below age 18 years, and 9.1% of the total population are between ages 13 and 17 years. Based on United Nations Development Programme (UNDP) data, Indonesia is categorized as lower-middle income country. Rapid socioeconomic development has resulted in a significant epidemiological transition. Mental disorders appear to be leading contributors to disease burden in Indonesia.

According to data from the Global School Health Survey, 5% of Indonesians ages 13-17 years had considered suicide in the preceding 12 months. Also, according to data from the National Basic Health Research Studies (Riskesdas), 9% of Indonesians ages 15-24 years reported an emotional disorder. Moreover, 1.7% of Indonesians greater than or equal to 15 years of age has a severe mental disorder (e.g., psychosis/schizophrenia).

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The most common child and adolescent mental health problems in clinical setting are Attention-deficit Hyperactivity Disorder (ADHD), Intellectual Disability, Autism Spectrum Disorder, mood disorders, psychotic disorders and anxiety disorders. Despite the significant number of mental disorders, insufficient data are available to provide the context or define the likely determinants, knowledge of which is critical to informing policy and practice.

Additionally, the media has reported on various adolescent issues, including bullying, fighting, sexual violence, suicide, and use of tobacco, alcohol, and other substances. The prevalence of tobacco use among people more than age 10 years is 56.7% for males and 1.9% for females. The World Health Organization (WHO) estimates that, among people ages 15-29 years in Indonesia, 14% currently use tobacco and 4% currently use alcohol. 21% of children and adolescents experienced bullying one or more times in the previous 30 days.

Although people in Indonesia recognize mental health to be a significant issue, there is poor understanding of mental disorders. Views towards mental disorders are also rather stigmatizing. People tend to think that mental health problems only include severe mental disorders and that these problems can only affect others. Therefore, many children and adolescents with mental health problems do not present for treatment or may visit other resources (e.g. spiritual leaders) before going to mental health professionals.

Resources for children's and adolescents' mental health in Indonesia are still inadequate. There are only 60 child psychiatrists in Indonesia, and they are based mostly in big cities. There are only 50 mental health hospitals in Indonesia, and only a few of these hospitals have child and adolescent units. Even though child and adolescent mental health training is integrated into medical school curricula, the portion and duration dedicated to child mental health is very limited. Therefore, medical doctors generally have an insufficient understanding of child and adolescent mental health problems. In psychiatric residency training, the duration of the child and adolescent psychiatry module is 3 to 6 months. There are national standards for child and adolescent psychiatry curricula within general psychiatry training, but not all nine residency training centers available in Indonesia have met that standard. Sub-specialty training in child and adolescent psychiatry is another 2 years after graduation from a general psychiatric residency program, and currently only two centers offer the sub-specialty training. The Indonesian Psychiatric Association, Section on Child and Adolescent Psychiatry organizes annual continuing medical education seminars and workshops, through which health professionals can update their knowledge on the diagnosis and treatment of mental health problems. Moreover, through the Indonesian Child and Adolescent Psychiatry and Allied Professions (AKESWARI) organization, multidisciplinary professionals gather to educate community members and thereby raise awareness of the importance of mental health in children and adolescents.

In conclusion, there are many challenges in improving child and adolescent mental health in Indonesia. This task requires multidimensional linkages between mental health professionals and other allied professions; translation of research into evidence-based services; and a focus on prevention and mental health promotion.

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Sidra Medicine-World Innovation Summit for Health (WISH) Child, Adolescent and Perinatal Mental Health Event (Doha, Qatar)

Dr. Karen Lim (Qatar), Dr. Salma Malik (Qatar), Dr. Ahsan Nazeer (Qatar),

Dr. Felice Watt (Qatar), Professor Muhammad Waqar Azeem (Qatar)

On 15 November 2018, Sidra Medicine, a premier hospital and research center located in Doha, Qatar, alongside the World Innovation Summit for Health (WISH), hosted a successful event. The event started with Dr. Afzal Javed, President-Elect of the World Psychiatric Association (WPA), presenting Sidra Medicine's Dept. of Psychiatry's Grand Rounds, entitled "The Future of Psychiatry: World Psychiatric Association and Its Action Plan," followed by a panel on "Global Perspectives on Child, Adolescent and Perinatal Mental Health."

During his Grand Rounds presentation, Dr. Javed discussed the WPA's objectives, mission, challenges and opportunities as well as proposed action plans. The Grand Rounds was well-attended by guests from national and international institutions, including Sidra Medicine, WISH, Hamad Medical Corporation, the American Embassy and the Qatar Foundation.

During the panel, experts from around the world shared their experiences with initiatives and challenges facing child, adolescent and perinatal mental health providers who aim to provide the best patient-centered care possible. The panel highlights included Professor Muhammad Waqar Azeem, Sidra Medicine's Chair of Psychiatry, sharing how Qatar is developing excellent services to help individuals with Autism Spectrum Disorder; Dr. Afzal Javed speaking about international mental health strategies and goals; Dr. Bibi Alamiri, founder of Almanara, a child and adolescent mental health center in Kuwait, and Dr. Chithramalee De Silva, Director of Mental Health in Sri Lanka, discussing how challenges, even with limited resources, can be overcome successfully.

Dr. Felice Watt, Sidra Medicine's Division Chief of Women's Mental Health, advocated for early intervention with pregnant women. Ms. Sultana Afdhal, CEO of the World Innovation Summit for Health (WISH), also shared her thoughts on the public's mental health understanding in Qatar. Mr. Iain Tulley (National Lead for Mental Health and Well-Being of Qatar) discussed various mental health issues and opportunities in Qatar.

The discussion sparked interest amongst audience members and stimulated questions and discussion on how the world can better serve women, children and families in the local and international community.

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To conclude, Professor MW. Azeem, Ms. Afdhal, and Mr. Tulley presented a memento to Dr. Afzal Javed in recognition of his outstanding service and leadership in the field of Psychiatry.

Figure- Sidra Medicine-WISH Panel, 15 November 2018. Sidra Medicine Auditorium, Doha, Qatar. From left to right: Dr. Salma Malik (Training Director, Child and Adolescent Psychiatrist, Sidra Medicine, Qatar); Dr. Karen P. Lim (Facilitator, Child and Adolescent Psychiatrist, Sidra Medicine, Qatar); Dr. Sawssan Ahmed (Facilitator and Perinatal Psychologist, Sidra Medicine, Qatar); Dr. Felice Watt (Division Chief of Women's Mental Health, Sidra Medicine, Qatar); Dr. C. De Silva (Director of Mental Health, Sri Lanka); Dr. Afzal Javed (President Elect WPA); Ms. Sultana Afdhal (CEO, World Innovation Summit for Health); Dr. Bibi Alamiri (Founder of Almanara Center, Kuwait); Mr. Iain Tulley, National Lead for Mental health and Well-Being (Qatar); Prof. MW. Azeem (Chair, Dept. of Psychiatry, Sidra Medicine, Qatar).

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The 59th annual meeting of The Japanese Society for Child and Adolescent Psychiatry (JSCAP)

Dr. Bernhard Weidle (Norway)

The 59th annual meeting of the JSCAP took place October 11 to 13, 2018 at Tokyo University in Tokyo, Japan. The meeting included, in addition to two days of presentations in the Japanese language, one day of international sessions presented in English, to promote exchange between international and Japanese participants.

The international session was chaired by Professor Yukiko Kano and Professor Shuntaro Ando from the University of Tokyo. Participating presenters came from various universities and hospitals from Japan, China, Taiwan, South Korea, Turkey and Norway.

A highlight of the international session day was a fascinating and moving special lecture on "Pathways to a More Peaceful and Sustainable World: The Transformative Power of Children and Families" by Professor James F. Leckman from the Yale Child Study Center and Yale School of Medicine, USA.

For me, as the only participant from a Scandinavian country, it was a great pleasure to give a presentation about "Treatment of Obsessive–Compulsive Disorder in children and adolescents: overview and new developments in Norway." Norway has a unique approach, with health authorities supporting dissemination of evidence-based psychological treatments, namely cognitive-behavioural therapy with exposure and response prevention, for children and adolescents with OCD. In addition, it was an even greater pleasure to meet such an engaged and interested audience, with many questions for the presenter.

Photo: Tokyo University campus

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The first mhGAP-IG pre-service Training of Trainers and Supervisors course in child and adolescent mental health

Dr. Ashmita Chaulagain (Nepal/Norway)

Background

The World Health Organization (WHO) Mental Health Gap-Intervention Guide (mhGAP-IG) is an evidence-based tool that includes clinical decision-making protocols for assessment and integrated management of priority mental, neurological, and substance use disorders, primarily in low and middle-income countries. While mhGAP-IG is widely used in many countries to provide in-service training to primary health care workers, its integration in pre-service training is also important. Application of mhGAP-IG materials, concepts and approaches in pre-service training will provide future health professionals with core skills in mental healthcare before assuming clinical service roles.

The first WHO mhGAP-IG Pre-service Training of Trainers and Supervisors course in child and adolescent mental health was held from 21st-23rd November 2018 in Kiev, Ukraine. This workshop was organized by the UNA (Ukraine, Norway and Armenia) Partnership, with technical support from WHO. The workshop brought together decision makers and clinical educators from postgraduate and undergraduate teaching institutions from different countries to discuss how mhGAP-IG can be used to strengthen pre-service training and to receive training on the mhGAP-IG module on child and adolescent mental and behavioural disorders.

Workshop Organization

A total of 25 decision makers and clinical educators from postgraduate and undergraduate teaching institutions from four countries – Armenia (2), Kazakhstan (2), Kyrgyzstan 2), and Ukraine (19) – attended the workshop. Dr. Daniel Chisholm, Program Manager for Mental Health, WHO Regional Office Europe; Dr. Neerja Chowdhary, Technical Officer, WHO headquarters; and Professor Norbert Skokauskas, from the Norwegian University of Science and Technology, facilitated the workshop.

Workshop outline

On the first day of the workshop, Professor Norbert Skokauskas provided an introductory presentation on mhGAP pre-service education. Subsequently, Dr. Daniel Chisholm and Dr. Neerja Chowdhary presented on the Mental Health Gap Action Programme. Representatives from Armenia, Kazakhstan, Kyrgyzstan, and Ukraine also presented challenges and opportunities in psychiatry and child and adolescent psychiatry training in their respective countries.

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Using the WHO mhGAP Training of Trainers and Supervisors manual as a main resource, Dr. Neerja Chowdhary then facilitated training on the mhGAP child and adolescent mental and behavioural disorders manual. The participants learned about adaptation of the child and adolescent module for pre-service training with respect to: common presentations, specialist services, psychosocial interventions, follow-up frequency, and other adaptations.

During the second and third day of the workshop, participants learned about using of the mhGAP manual to provide basic assessment and management of child and adolescent mental and behavioural disorders. The lectures were followed by practical sessions, including small group discussion, facilitator and video-based demonstrations, and role-plays to facilitate a better learning process. The participants also learned about assessment of student competencies. There was continuous discussion in between the training sessions. The participants showed keen interest in discussing and understanding how to use the mhGAP-IG.

Conclusion

During the three-day workshop, participants acquired not only new knowledge but also concrete ideas on: how to strengthen and enhance teaching programmes with the mhGAP-IG, how to ensure that accreditation requirements and guidelines can be optimally met with implementation of mhGAP-IG components, and future collaborative projects on mhGAP in pre-service training. Participants from all countries expressed interest in customizing and implementing mhGAP modules in their respective educational programs.

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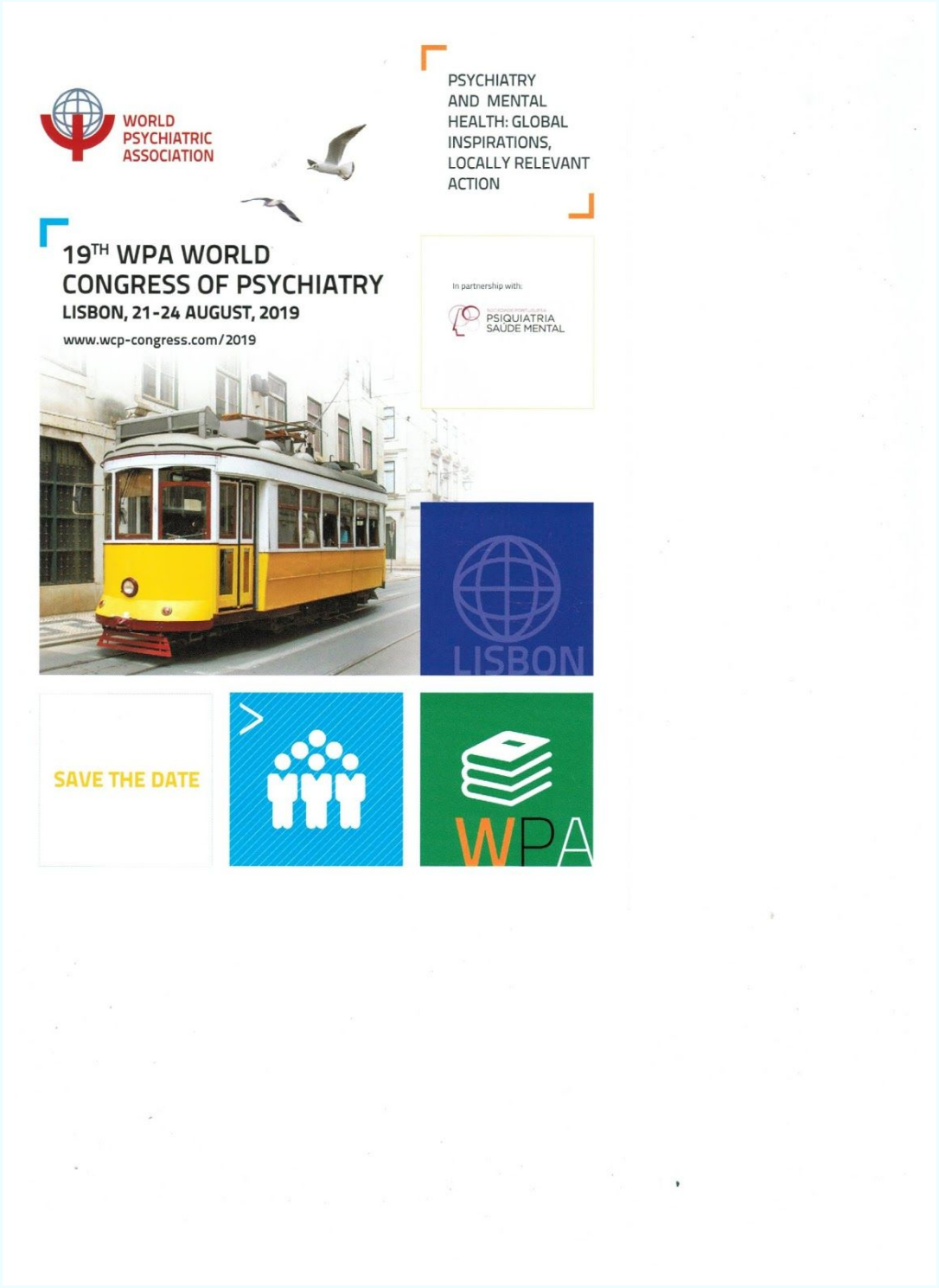
Future meetings



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