



World Child & Adolescent **Psychiatry**

ISSUE 19, December 2020

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

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



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Chair's Column:

Dear Colleagues,

Welcome to the final 2020 issue of "World Child and Adolescent Psychiatry," the official journal of the World Psychiatric Association, Child and Adolescent Psychiatry Section.

2020 was not an easy year. Because of the COVID-19 pandemic, extraordinary measures, taken to protect the general population, have dramatically changed our lives. These changes have also affected the WPA. In 2020, all WPA activities, including the General Assembly, were moved online.

On the behalf of the WPA Child and Adolescent Psychiatry section, I would like to thank Prof. Helen Herrman (Australia), WPA President 2017-2020, for her continuous support of child and adolescent mental health. In this issue, you can read a paper by the immediate Past WPA President and learn more about the major WPA achievements under Prof. Helen Herrman's leadership.

I congratulate President-Elect Prof. Danuta Wasserman (Sweden), newly elected members of the WPA Executive Committee, and WPA Zonal representatives on their election.

Our section is looking forward to working with the new WPA President, Dr. Afzal Javed (UK), who put child and adolescent mental health at the center of his President's 2020-2023 Action Plan. In this issue, you can find more details about the plan, highlighted by Dr. Afzal Javed himself, and further discussed in Prof. Bennett Leventhal's (USA) editorial.

In 2020, "World Child and Adolescent Psychiatry" has decided to optimize its review process. Towards this goal, we have renewed and expanded our editorial board. I would like warmly to welcome new editorial board members: Dr. Tami Benton (USA), Dr. Hojka Kumperscak (Slovenia), Dr. Camille Noel (Belgium), Dr. Aniruddh P. Behere (USA), Dr. Marie-Aude Piot (France), Dr. Amy Gajaria (Canada), Dr. Bettina Bernstein (USA), Dr. Jonathan Lachal (France), Mr. Kenneth Stensen (Norway), Dr. Chetana Kulkarni (Canada), Dr. Jannike Kaasbøll (Norway), Dr. Jordan Sibeoni (France), and Dr. Rajeevan Rasasingham (Canada). We have also revised our submission guide, which can be found at the end of this issue.

In this issue, you will find papers from colleagues around the world: North America, South America, Africa, Europe, Asia, Australia and the Middle East. I hope this issue will help you, even in the face of travel restrictions, to feel like you have traveled around the world and met these colleagues in person.

The WPA CAP section is looking forward to working with you all in the new year. Have a Happy Festive Season and a Prosperous and Healthy 2021!

Happy Readings!

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





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Another New Beginning for Child and Adolescent Psychiatry

Professor Bennett Leventhal (USA)



To change something, build a new model that makes the existing model obsolete.”

— Buckminster Fuller

At this moment, it is very hard to think beyond the anguish and chaos of 2020. Certainly, the darkness and fear of the COVID-19 pandemic has forever changed the way we live and work. For children and their families, this has had a devastating impact around the world. Disrupted education, parental unemployment and the deaths of family members and friends has interfered with normal developmental processes in ways that do not yet fully understand. All of this has been compounded by astounding blunders, if not outright failures of too many political leaders. Failures in leadership have added to the risk of children being placed in harm's way due to disease, war, trafficking, forced migration, and so much more. Clearly, one can only hope that the end of 2020 will offer a new sense of hope and opportunity in a new, post-pandemic world.

In addition to death, COVID-19 infections appear to cause all manner of medical problems, including disruptions in brain function and psychiatric illness. Furthermore, the COVID-19 pandemic has once again highlighted how environmental stressors lead extraordinary challenges to mental health. Taken together, there have been dramatically increased numbers of referrals for clinical psychiatric services, along with growing rates of suicidal behavior, substance abuse, and other clinical conditions. Not surprisingly, young people, from infancy through the transitional years are the most widely affected. The overwhelmed healthcare systems are now asking questions about why there is inadequate capacity for mental health services for children, adolescents and their families. It is framed as a new question but for those of us working in child and adolescent psychiatry it is the same question being asked again.

It is perfectly obvious to many of us in Child and Adolescent Psychiatry that most psychiatric disorders begin in childhood and adolescence. Of course, this fact then means that most psychiatric disorders occurring in adulthood are actually chronic disorders from childhood. It only follows that providing appropriate levels of psychiatric services for children, adolescents, and their families is not only excellent secondary and tertiary prevention but also outstanding primary prevention, not to mention good care. Periodically, and in all sincerity, our colleagues in general psychiatry become aware of this reality and proclaim that it is time for a new, developmental approach to psychopathology but, somehow, this never gets implemented either in clinical practice or even in the standard clinical nosology. We can bemoan this situation and hope for a better tomorrow. Or, we can seize present opportunities for change.

One new opportunity comes from the incoming WPA President Afzal Javed. During his triennium as President, he has chosen to appoint WPA Working Groups to carry out work related to the President's 2020-2023 Action Plan:



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“There is an outstanding need to provide access to high quality mental health care in all countries together with a commitment to support psychiatrists and other mental health professionals in their important roles as policy makers, direct service providers, trainers and supporters of health care workers in primary and community health care.”

The key features of the Action plan are:.

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

For our new beginning, President Javed has chosen Child and Adolescent Mental Health as a key feature of the WPA 2020-2023 Action Plan. To this end, he has appointed the WPA Working Group on Child and Adolescent Psychiatry. This is an important commitment by the WPA. President Javed has appointed Norbert Skokauskas and Bennett Leventhal to co-Chair the Child and Adolescent Mental Health Working Group and be joined by colleagues from all over the world. There are so many places to begin but the Working Group has chosen start by focusing in 3 areas:

1. Global Advocacy
2. Capacity Building
3. Research in Child and Adolescent Mental Health

The Working Group will be in contact with both non-governmental organizations (NGO's) and governmental organizations engaged in work relevant to the Working Group's tasks. This will allow the Working Group to develop a broad base of support, as well as a large group of advocates for child and adolescent mental health around the world.

Most importantly, this is a time for Child and Adolescent Psychiatrists from all over the world to join in supporting the Working Group so it can address the issues important to our diverse community. It is our time to make a difference and to have our voices heard.

The Working Group will start its work in December 2020 and continue with its activities until the end of Dr. Javed's Presidential Triennium. However, the three years is just the new beginning. But, this time, it need not be the end. This is because the Working Group's existence may be continued beyond the three years, should it be considered helpful to WPA's overall program of activities and improves the prevention and care of youth with mental disorders.

So, the time has come for another opportunity to build a strong, international foundation for Child and Adolescent. In the words of Mother Theresa: “Yesterday is gone. Tomorrow has not yet come. We have only today. Let us begin.”



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CHILD & ADOLESCENT MENTAL HEALTH: A PRIORITY AREA FOR WPA's FUTURE WORK

Prof. Afzal Javed (UK), WPA President



It is gratifying to note that the WPA General Assembly approved the proposed WPA's Action Plan for the next triennium during their October 2020 meeting. The Action Plan for 2020-2023 defines emerging needs and priorities in different areas of mental health from a worldwide perspective & sets a framework for WPA's future work during the next three years.

The fact remains that only a minority of people with mental disorders receive any treatment or interventions despite a widespread acknowledgment of importance of mental health. There is still an outstanding need to improve access to high quality mental health care in all countries and to support mental health professionals in their important roles as clinicians, direct service providers, teachers, and supporters of health care workers in primary and community health care systems.

The key goals of the WPA's Action Plan include:

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

The 2020-2023 Action Plan also looks at targeted areas that need attention with input from various WPA components during the next triennium. It works within an international perspective focusing specifically on improving coverage of interventions to treat mental disorders, prevent mental disorders and to promote mental wellbeing including through relevant training of mental health and other professionals.

Child, Adolescent & Youth Mental Health comes up as a priority area in this action plan with a focus on future planning for improving attention to public mental health interventions to this population as well as advocating for specialised services for higher risk groups such as those with learning disability, autism & early onset of mental health disorders.

Child & adolescence periods are unique and formative times. These periods are crucial for developing and maintaining social and emotional habits & are vital for future mental well-being. Multiple physical, emotional, and social changes, including exposure to poverty, abuse, or violence, can similarly make children & adolescents vulnerable to mental health problems. Promoting psychological well-being and protecting adolescents from adverse experiences and risk factors that may impact their potential to thrive are thus critical for their well-being during these periods of developments and for their future physical and mental health in adulthood.

Some adolescents are at greater risk of mental health conditions due to their living conditions, stigma, discrimination or exclusion, or lack of access to quality support and services. This also includes adolescents living in humanitarian and fragile



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settings; adolescents with chronic illness, autism spectrum disorder, an intellectual disability or other neurological condition; pregnant adolescents, adolescent parents, or those in early and/or forced marriages; orphans; and adolescents from minority ethnic or sexual backgrounds or other discriminated groups.

Spread of COVID-19 around the world is further increasing the risk of developing mental disorders, relapse of existing mental disorders and poor mental wellbeing which requires action at all levels of health & social care. The unprecedented COVID-19 pandemic has upended family life and parents around the world are struggling with facing new challenges on a daily basis. Although recent literature suggests many adverse psychological outcomes of quarantine and other illness containment measures like loneliness, fears, anxiety and depression, the demands and psychological impact is likely to be greater for parents and children. Parents are caring for their children in stressful conditions, under high degree of economic uncertainty, attempting to work remotely with childcare responsibilities, keeping children busy and managing demands of home-based schooling with no clarity on how long the situation will last. Furthermore, looking after a child with special needs is an established risk factor for parental stress. Parental stress (i.e. the experience of distress or discomfort that results from demands associated with the role of parenting) is associated with increased parental mental health needs & high risk of development of psychiatric illness for parents as well as for children and adverse parenting outcomes.

It is hoped that the 2020-23 triennium will set new directions for all WPA components to develop guidelines and directions for future work. Adolescents with mental health conditions are particularly vulnerable to social exclusion, discrimination, stigma (affecting readiness to seek help), educational difficulties, risk-taking behaviours, physical ill-health, and human rights violations. Nearly 90% of the world's adolescents live in low-or middle-income countries. Suicide is a leading cause of death in older adolescents & many risk-taking behaviours for health, such as substance use or sexual risk taking, start during adolescence. There is no doubt that risk-taking behaviours can be both an unhelpful strategy to cope with poor mental health and can severely impact an adolescent's mental and physical well-being. Perpetration of violence is a risk-taking behaviour that can increase the likelihood of low educational attainment, injury, involvement with crime or death. Interpersonal violence was ranked the second leading cause of death of older adolescent boys.

It is therefore crucial to address the needs of adolescents with defined mental health conditions & for those who are living in highly vulnerable situations. Avoiding institutionalization and over-medicalization, prioritizing nonpharmacological approaches, and respecting the rights of children in line with the United Nations Convention on the Rights of the Child and other human rights instruments are key topics for such interventions. WHO's mental health Gap Action Programme (mhGAP) provides further evidence-based guidelines for non-specialists to enable them to better identify and support priority mental health conditions in lower-resourced settings.

Mental health promotion and prevention interventions will, additionally, set new directions for the future work for children & adolescents. These programmes require a joint & collaborative approach with varied delivery platforms – for example, digital media, health or social care settings, schools or the community, and varied strategies to reach adolescents, particularly the most vulnerable.

We believe that child & adolescent mental health and capacity building in several areas will continue getting due attention in WPA's future programmes. WPA is pleased to establish a working group to look at child & adolescent mental health needs. This group, headed by Prof. Bennet Leventhal & Prof. Norbert Skokauskas, comprises very experienced professionals in various fields of child & adolescent mental health. The group has started formulating plans and projects that we will share with WPA membership very soon & implement in different settings and countries. I personally rely on the WPA's section on Child & Adolescent Psychiatry for their dedication and support and look forward to receiving their recommendations during the next three years.



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WPA and child and youth mental health 2017-2020

Professor Helen Herrman (WPA President 2017-2020)

WPA's work in these three years aimed to expand psychiatry's contribution to improving mental health for people across the globe. We emphasized working with people living in adversity: with particular attention to the mental health of young women and men and the needs of families and children without ready access to care and support. We portrayed psychiatry as a discipline central to medicine and health care and vital to sustainable development in each country. WPA's response to the pandemic has drawn on these perspectives, as well as WPA's capacity as convenor.

We continued to work closely with people with lived experience and their families, worked hard to include gender and geographic diversity in all we did, and engaged with international organizations and policy-makers. Our revamped website www.wpanet.org and communications program have kept Member Societies and all those interested in WPA connected and informed. The new learning management system now has a critical role in WPA's emergency response as well as its education programs www.wpanet.org/education-portal-project.

A number of initiatives are relevant to children and youth, and some focus on them.

- The Service User and Family Carer Advisory Group www.wpanet.org/wpa-service-users-and-family-carers coordinated by Prof Michaela Amering included young people. It contributed to WPA's responses to emergency and to several projects during the triennium, including congress planning and participation and WPA's landmark program on supporting alternatives to coercion in mental health care.
- A WPA position statement, case studies and discussion paper on "Implementing alternatives to coercion in mental health care" www.wpanet.org/alternatives-to-coercion were developed in consultation with member societies. Work will continue in the light of these documents and consultations. One ultimate aim is to encourage early and appropriate intervention for young people with emerging mental ill-health.
- The WPA continued its collaboration with the World Health Organization (WHO) Department of Mental Health and Substance Abuse, including consultation on the WHO Commission on Non-Communicable Diseases, the WHO/United Nations International Children's Emergency Fund (UNICEF) initiative on Helping Adolescents Thrive, and the EQUIP workforce development in psychological interventions. WPA consulted on development of the WHO report on "Enhancing mental health pre-service training with the mhGAP Intervention Guide: experiences and lessons learned" coordinated by Prof. Norbert Skokauskas. This initiative is relevant to equipping psychiatrists and other health professionals to attend to the wellbeing of children and young people everywhere.
- A report led by Professor Roger Ng has been published [doi.org/10.1192/bji.2020.32] on collaborative work with the World Organization of Family Doctors (WONCA) on competencies in mental health for family doctors.
- An important external investment in our work has come from citiesRISE. www.wpanet.org/citiesrise We have worked in Nairobi, Chennai and Bogota with our Member Societies and their branches. This work locally and across cities has contributed in several ways to promoting the mental health of disadvantaged young people: by promoting mental health in schools; revising training and in-service curricula for psychiatrists and other mental health workers; and preparing the ground for implementing programs of perinatal care in scarce resource countries. This work is



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scheduled to continue in the next triennium, having been curtailed by the pandemic in early 2020. It records useful ways to engage psychiatrists and other mental health professionals in the community development approach to promoting mental health among young women and men in adversity.

- The Lancet-WPA Commission on Depression www.wpanet.org/the-lancet-wpa-commission-on-depres is due for publication in early 2021. Dissemination of the report and the continuing work of the Commission offer opportunities for health promotion, prevention, treatment and research in children and young people.
- As president of WPA, I co-chaired the World Economic Forum Global Future Council 2019-2020 on Technology for Mental Health, that aimed to promote the ethical adoption of technologies and worked to facilitate positive working relationships in the field.
- As the triennium reached its final months in 2020, the world experienced the impact of the COVID-19 pandemic, bringing extraordinary challenges for psychiatrists and their colleagues in the health professions. WPA responded by bringing together its member networks, access to experts and tools for sharing across regions. The Advisory Committee for Responses to Emergencies (ACRE) convened the leaders of several interested Member Societies to facilitate practical and concrete aid to Member Societies in need www.wpanet.org/acre. The group is fostering education, information collection and the development of local, national and international strategies to cope with the mental health consequences of emergencies. For example, we provided funding to colleagues in Nepal for outreach services to support child and adolescent mental health; and support for transport for community services in Vanuatu, replacing resources diverted during the emergency. One subgroup is supporting telepsychiatry and eMental health initiatives. ACRE has begun to function as a coordinating body for the assessment of emergency needs and the mobilisation of resources and direct support through Member Societies and partners.
- An online library of COVID-19 mental health resources (www.wpanet.org/covid-19-resources) has developed rapidly, with the support of WPA Member Societies and Sections. It provides access to the resources curated by them and other trusted partners, with materials in a variety of languages. It allows users to find many of the COVID-19 resources relevant to children and young people and others, created across regions and disciplines, all in one place. Accelerated development of the WPA education portal and Learning Management System (LMS) has promoted the launch of new education and training modules to support the emergency response. The first of these modules supports psychiatrists in using e-mental health tools. In addition to WPA curricula, the portal allows Member Societies and trusted partners to include courses developed by them and to use ancillary facilities like the webinar technology to support sharing in their regions. This has been requested and enabled, for example, in Central America. The portal also gives ready access to WPA's existing training materials, including the International Competency-Based Curriculum for Mental Health Providers on Intimate Partner Violence and Sexual Violence against Women, available in several languages.
- With the establishment of ACRE, member societies will be on standby to activate these procedures when they are again, inevitably, needed in future emergencies – with the more well-resourced among them able to offer further support to those with less.

WPA is fortunate in the support received from its Member Societies and Scientific Sections as well as its Secretariat, consultants and other components, and from the new sources of philanthropic and development support we set out to attract. I pay particular tribute to the active and creative work of the Section for Child and Adolescent Psychiatry. I am also grateful for the possibilities for continuity as the preparation for the new triennium encourages the extension of current initiatives, including the emergency responses.



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Interview with Felton James 'Tony' Earls MD

Dr. Earls is a child psychiatrist and epidemiologist, Professor of Social Medicine, Harvard Medical School, and Professor of Human Behavior and Development, Harvard T.H. Chan School of Public Health, Boston, USA

It is our pleasure and our privilege to interview you and thank you very much for agreeing to the interview. You are best known for "The Project on Human Development in Chicago Neighborhoods," funded by the National Institute of Justice, the MacArthur Foundation and the National Institute of Mental Health. Why did you choose to study causes and consequences of children's exposure to community and family violence and why this project was so successful?

For the past one hundred years, social scientists have observed marked variations in rates of violence across neighborhoods of U.S. cities. Violence has been associated with the low socioeconomic status and residential instability of neighborhoods. Although the geographical concentration of violence and its connection with neighborhood composition are well established, the question remains: why? What is it, for example, about the concentration of disadvantages that accounts for its association with rates of violence? What are the social processes that might explain or mediate this relationship? The extensive racial, ethnic, and social-class diversity of Chicago's population was a major criterion in its selection as a research site.

Could you tell our readers a little bit more about your "collective efficacy" theory?

The linkage of mutual trust and the willingness to intervene for the common good defines the neighborhood context of collective efficacy. It is hypothesized that collective efficacy is linked to reduced violence. We tested this hypothesis on a 1995 survey of 8782 residents of 343 neighborhoods in Chicago. Multi-level analyses showed that a measure of collective efficacy yields a high between-neighborhood reliability and is negatively associated with variations in violence, when individual-level characteristics, measurement error, and prior violence are controlled. Associations of concentrated disadvantage and residential instability with violence are largely mediated by collective efficacy. This finding represents a discovery that encouraged social scientists to design and test new interventions.

Were you able to apply this theory outside the US, what was your experience working overseas?

Yes, we carried a community-level, randomized control trial in Tanzania to increase local competence to control HIV/AIDS through actions (i.e. collective efficacy) initiated by children and adolescents aged 10 to 14 years. Representative groups from the 15 treatment communities reached mutual understanding about their objectives as health agents, prioritized their actions, and skillfully applied community drama ("skits") to impart knowledge about the social realities (e.g. stigma) and the microbiology of HIV/AIDS (e.g. importance of testing).



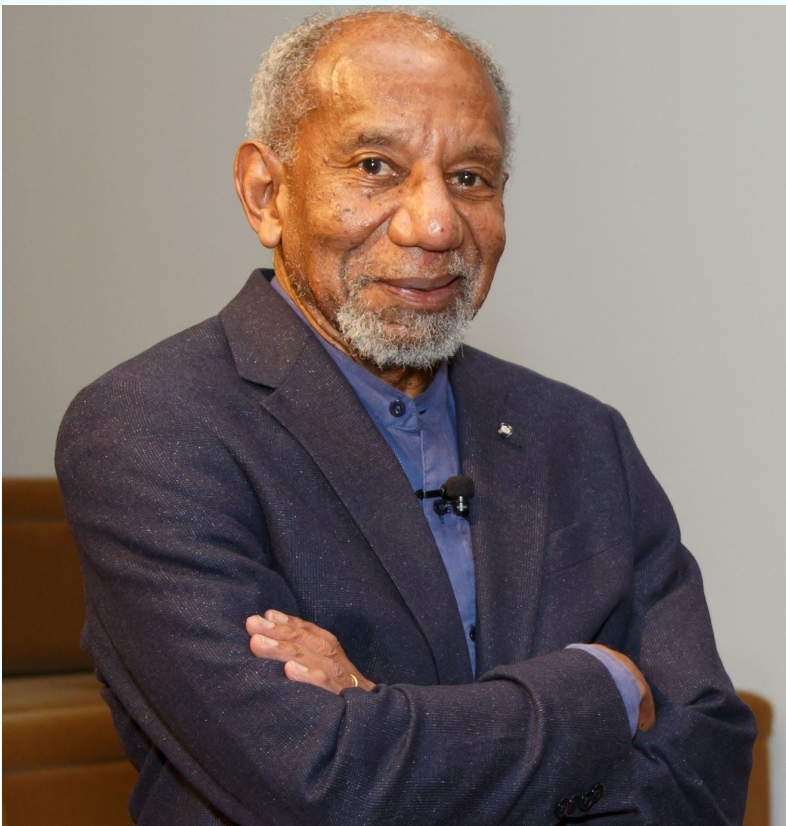
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Recently health (including mental health) inequalities, social justice and racism have received a lot of attention. What can child and adolescent psychiatrists do to address these issues?

They must insist upon and recognize their dependency, upon social science evidence. It is all too easy to assume that biological factors are measured with greater validity and reliability than behavioral and social factors. For much of what we do, however, social factors are of fundamental importance as causal determinants.



“Voice, Choice, and Action: Theential of Young Citizens to Heal Democracy” is the title of your latest book that was co-authored with neurobiologist, Mary Carlson. How can children and young people heal democracy? What is the role of grown-ups in this process?

They are more likely to be open to explore novel ideas than are adults. But they require adult nondominant guidance and inclusion as citizens in a multigenerational framework. Conceiving of children in this way is a tall task. Child and adolescent psychiatrists should play an essential role in fostering this societal goal.

Our book offers strategies for strengthening democracies by nurturing the voices of children and encouraging public awareness of their role as citizens. My work was inspired by the 1989 United Nations Convention on the



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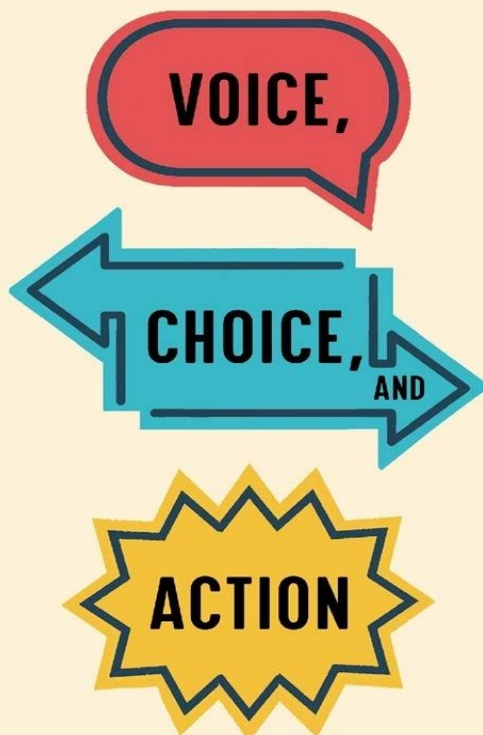
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Rights of the Child, and this book embarked on a series of international studies that recognized the voice of children in Europe (Romania), Africa (Tanzania) and South America (Brazil), and North America (USA).

Our journal is very popular among early career child and adolescent psychiatrists. What would be your advice to our colleagues who are just starting their careers in child psychiatry?

I am amazed at how little reading residents do. This applies to the history of our field as well as contemporary journal articles. How much of this is motivational or institutional is not clear to me. Lifetime habits are established during the early years of preparing for a career. It is unlikely that a clinician will be able to insist on research that improves clinical practice. I regard this reading as essential to closing the gap between scientific research and clinical care and practice.

Felton Earls & Mary Carlson



**The Potential of Young Citizens
to Heal Democracy**



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How Many Psychiatrists does it Take to Raise a Child?

Prof. Daniel Fung and Drs. Tor Phern Chern and Ong Say How (Singapore)

A child in Singapore as defined by the [Children and Young Person's Act](#) is someone under the age of 14. Worldwide definitions differ ranging from age of consent (which is 21 in Singapore) and is complicated by the period that defines adolescence. The development of the discipline of child psychiatry emerged from research surrounding child development and that of emotional disturbance and disabilities. Child psychiatry is a subspecialty of psychiatry while psychiatry is a medical specialty. There is much public confusion of this as many professionals including doctors think that psychiatrists and psychologists are interchangeable terms. The reality is that psychiatrists are specialist medical doctors while psychologists



are from a broad general field consisting of up to 20 different types and only clinical psychologists work in clinical settings like clinics and hospitals. This confusion is made greater in child psychiatry where most of the work does not involve medications which only the medical doctor can prescribe. In the English-speaking world, most psychiatrists will agree that child psychiatry started at the turn of the nineteenth century and became popularized through the child guidance clinic movement in the 1920s. Its goal was to prevent juvenile delinquency but also saw it important to foster educational interventions and protecting the child from abuse. The first textbook of child psychiatry was published in 1935 by Leo Kanner (who was also credited with

describing Autism) and the first Chair of Child Psychiatry was established in Missouri, USA occupied by E. James Anthony.

Child Psychiatry in Singapore officially began on 7th Apr 1970 under Dr Wong Sze Tai, when the Ministry of Health (MOH) opened the Child Guidance Clinic (CGC) at the Outram Road General Hospital (now known as the Singapore General Hospital) in a bungalow originally occupied by the Medical Superintendent. The



groundwork for establishing CGC was undertaken by Dr Ho Eng Siong (a Senior Registrar psychiatrist) and Mr Fred Long (psychologist) under the leadership of Dr Yap Meow Foo (the Medical Superintendent of WH). CGC operated initially on the equivalent of 2 days a week. Less than a year after starting the service the roof of the clinic collapsed as a supporting beam broke. The building was declared unsafe for occupation and the clinic moved to the Kallang Maternal and Child Health Clinic and resumed services on 17th

Mar 1971 with the equivalent of 3 days a week after the addition of a medical officer and social worker. CGC stayed in Kallang for 2 years and was providing full time services from 1972.





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CGC subsequently moved to a pre-war nurse's hostel (Annex building) at Russell Road at Alexandra Park and stayed there for the next 10 years. Patients were charged \$1 for subsidized referrals and \$35 for named referrals. Despite the multiple logistical and manpower challenges at the time, the mood was described as "exciting, with time for tea between cases" and "one of hope amidst great struggling".

From the beginning a team approach was adopted with all cases seen by the psychiatrist, psychologist, social worker, nurse, occupational therapist and even a remedial teacher from the Ministry of Education. New cases were discussed by the multidisciplinary team (MDT) during memorable lunchtime meetings to establish a management plan.

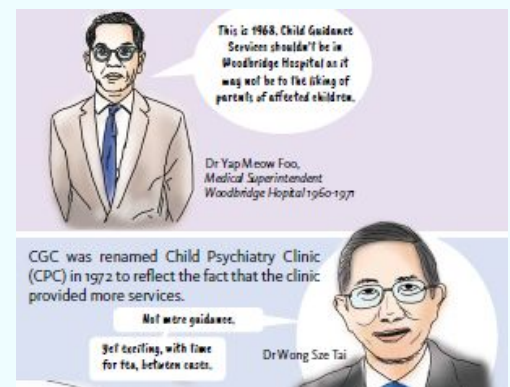
Under Dr Wong Sze Tai's leadership, CGC was renamed Child Psychiatry Clinic (CPC) in 1972 to reflect that the clinic provided more services than "mere guidance".

It moved in 1982 to a more conveniently located and expanded facility at the Institute of Health in Outram Road.

An observation room with a one-way mirror was set-up in CPC that allowed trainees and staff to observe assessments and therapy sessions. The sessions could also be recorded for teaching and evaluation purposes.

In 1993 the clinic went back to being called the Child Guidance Clinic in line with the establishment of the Department of Child and Adolescent Psychiatry and in 1998 it moved to its current location at the Health Promotion Board (HPB) building in the Outram Park campus.

There was a simultaneously a clear need for an inpatient Child Psychiatry service. Children and adolescents that required psychiatric admission were admitted to the adult wards in WH. This situation was far from ideal due to the custodial nature of WH at that time and there were efforts to have a Child Psychiatry inpatient unit at St Andrew's Hospital in Siglap in collaboration with Dr Stephanie Leonard before the Child Psychiatry Inpatient Unit (CPIU) was established in WH in 1980 initially under Dr Goh Choo Woon and then by Dr Pushpa Bose for the next 10 years.





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The CPIU was an 18 bedded unit converted from the old Matrons quarters and enjoyed a more homely atmosphere than the rest of WH. It was moved to the basement of block 3 in the new WH in 1993 and called the Child and Adolescent Inpatient Unit (CAIU) led by Dr Aw Soh Choo. In 2005 the inpatient ward was reorganized to allow for graded levels of care to allow disturbed patients and recovered patients to be at different ends of the ward with space set aside for sports and recreation. The new ward was renamed Sunrise Wing.

In 1993 the new WH was opened and the Department of Child and Adolescent Psychiatry was formed and headed by Dr Cai Yiming. Over the years the Department developed various services to address specific needs such as Children's One Stop Psycho Educational Service (COPES) which was led by Dr Daniel Fung. The Autism Clinic was set up to deal with behavioural and emotional problems in autism and led by Dr Sung Min. With the National Mental Health Blueprint, community teams were developed over 5 years spearheaded by the department but working across 3 hospitals, Woodbridge Hospital, Kandang Kerbau Hospital and National University Hospital.



Heads of Department of Child and Adolescent Psychiatry

Year	Head	Service/ Department
1970	Dr Wong Sze Tai	Child Guidance Clinic
1980	Dr Goh Choo Woon	Child Psychiatric Inpatient Unit
1982	Dr Pushpa Bose	Child Psychiatric Inpatient Unit
1993	Dr Aw Soh Choo	Child and Adolescent Inpatient Unit
1993	Dr Cai Yiming	Child and Adolescent Psychiatry
2007	Dr Daniel Fung	Child and Adolescent Psychiatry
2011	Dr Ong Say How	Child and Adolescent Psychiatry

Despite heavy clinical and teaching loads, CGC had a clear research agenda right from its inception. Dr Wong encouraged multi sectoral research well before it was popular to do so. One example was the work with the Ministry of Community Development on a prospective 4-year study of the effects of kindergarten versus home care for children as the government was encouraging women to go to work. The 1979 report was entitled "The Child and Changing Family Patterns in Singapore" and stated that children in kindergarten did better in mathematics and children at home had better language development but these effects were temporary. This research led to a white paper that was went up to then PM Goh Chok Tong and later led to the development of the National Family Council. It also received prominent attention in the mainstream media. CGC also collaborated with Dr Aileen Wong (later Senior Minister of State for Health) on research on low cost housing and children.





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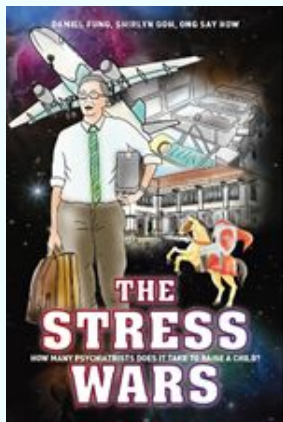
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A well-received series of books on issues in child mental health was published from 1998 by Times Books International on topics like "Help your Child to Cope - Understanding Childhood stress" and "Raise your child right - A Parenting Guide for the 0-6 year old". In 2008 the first local textbook on child psychiatry, "A Primer of Child and Adolescent Psychiatry" was published by World Scientific.



Child Psychiatry in Singapore has grown from an ad hoc, part time service to a full department with almost 100 staff of 12 consultants, medical officers and residents, clinical psychologists, medical social workers, occupational and other therapist with a full complement of nurses and administrative staff. From 550 children and families a year in 1980, CGC now sees just about 2500 a year. Services for the community were established more than 10 years ago alongside departments of child and adolescent psychiatry in several general hospitals.



Details of this history along with the cartoons you see here is part of a new graphic novel depicting the history through the eyes of an intrepid wannabe child psychiatrist which also answers the question that makes the title of this piece. How many psychiatrists does it take to raise a child. The answer of course is none as children are raised by parents in their families. The Stress Wars is a combined effort of psychiatrists of CGC and a group of young design students led by their teacher Ms Shirlyn Goh. It was launched at the IACAPAP Virtual World Congress 2020 from 2-4 Dec 2020. Details on how you can get a copy will be made available on the website www.iacapap2020.org



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Media Use in Children During the COVID 19 Pandemic: Between a Rock and a Hard Place

Dr. Aniruddh P. Behere (USA)

Introduction

COVID-19 disease caused by the novel SARS-CoV-2 virus was declared a pandemic by the World Health Organization on 11th March 2020. Since that time, it has led more than 55 million cases and 1.34 million deaths worldwide. Based on country specific data, the United States currently has the highest number of cases of any country at 12.2 million with more than 250,000 deaths. Consequently, this has severely disrupted our daily lives and has led to an enormous psychological, psychosocial and economic burden globally. The need for social distancing has had unprecedented effects on children. Their daily routines have been significantly disrupted because of abrupt school closures, disruption of daily routines, loss of social interactions and shift to online schooling. Furthermore, there is also growing evidence that social isolation has led to increased rates of anxiety and depression in children both as a result of quarantine and associated significant morbidity as well as mortality with the viral illness with unclear long-term effects.

Social distancing which has been widely promoted as a tool to avoid contracting and mitigating the spread of the virus has inadvertently and fundamentally shifted the norms and expectations around the use of screen and social media and has further pushed limits and increased exposure to overall screen time. Typical activities for children which are extremely important in the formative years including social interaction, play dates and extracurricular activities all came to a sudden halt during the pandemic.

Media use during the pandemic

With the onset of the coronavirus pandemic millions of children around the world were sent home after school closures to promote social distancing. Subsequently, home schooling and distance and remote online schooling became the new reality to millions of children around the world. This new expectation threw a wrench around rules and expectations for media use among children. Long hours were spent on virtual schooling on top of other habits like social media use and television viewing for entertainment. As expected, screen time limits were no longer being followed and, as parents and children tried to cope, rules and expectations on social media and other sources of entertainment were stretched.

Past studies have shown that the use of technology including social media may surge during times of crisis like mass shooting and in the immediate aftermath. The use of social media may further lead to worsening of anxiety and is likely to form a vicious cycle. During the initial few months of the pandemic there was a significant increase of TV viewing between the ages of 6 and 17 years compared to the rest of the population which is especially true for daytime viewing. Studies prior to the pandemic showed that kids between 8-12 years spent on average 4-hrs per day on screen and adolescents 12 years and up spent about 7-9 hours per day. Although media use had been changing in the digital era especially among adolescents, this exponentially accelerated with the onset of the pandemic with increased exposure to technology, media and social media.

Risks of excessive screen time in children

Excessive screen time and media use in children has been associated with several negative outcomes. In general, consequences of excessive media use can be broadly divided into two categories: first, direct effects of excessive use, including poor sleep, increases obesity, language and social delays and poor self-regulation and, secondly, the risk of exposure to content like hate speech and inappropriate sexual content. There is also growing evidence that there is a



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relationship between watching violent television programming and then subsequently violent actions and behaviors by children and should be discouraged as it can have a negative effect on a child's overall psychological development. There are also concerns that excessive media use can contribute to decrease in attention span and to preference for more immediate rewards and gratification. Additionally, evidence is emerging from a neurobiological perspective involving the activation of dopamine and reward pathways suggesting hypothetical mechanisms of addiction to screen, media and video games similar to what is seen in addiction to substances. Further there are reports that adolescents with more frequent social media use and less in-person interaction may report more feelings of loneliness as compared to peers.

Current strategies around media use

It is indisputable and important to highlight that there is a vast resource of invaluable content available for online teaching that may help with education, knowledge and development. Given all the risks and benefits it is also important to underscore that, rather than the quantity of time spent, it is the quality of the content that the kids use that is a better predictor of whether they will have a positive or negative outcome. What is paramount is striking that balance where it provides enough stimulation to help with their growth but does not impede them from engaging in other necessary and healthy activities.

With the current surge in COVID-19 cases and widespread recommendation of social distancing, video games and social media can provide for critical experiences when kids are craving social interactions with friends and families. It is also extremely important for parents to provide oversight, so that they can monitor both the time spent as well as the content that their kids are using. With the current restrictions in place especially in respect to outdoor activities, even the World Health Organization has made a statement and recommended active video games and online exercise classes as a way of staying healthy at home and simultaneously feeling connected.

Conclusion

There is no denying that we are in unprecedented times. The current pandemic has disrupted every aspect of life as we knew it. Some of the effects may be temporary, others long-lasting, and unbeknownst to us. The previous guidelines around screen time as recommended by a number of leading national and international organizations, although important, may not be entirely practical during these unprecedented times. Concretely trying to adhere to previous guidelines around screen time may lead to frustration given the time that children are spending online not only for entertainment but also to complete schoolwork which is being held in a virtual format. Instead of trying to focus on the quantity, we should be creative and highlight the importance of quality of time spent on online activities. It continues to be important to limit very young children's exposure to the media. There needs to be parental supervision and clear expectations regarding the use of screen and online activity. Every effort should be made to plan activities where there is participation of both children as well as parents together where each is actively engaged. Especially as we head into the winter season in the northern hemisphere, it is likely to become more challenging to conform to these norms and ultimately may come down to how we strive to maintain the delicate balance and try to get over this hurdle together, both as parents and caregivers.



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The urgent need for an interdisciplinary approach to pediatric mental health and addiction

Jean N. Westenberg, James S. H. Wong, Dr. R. Michael Krausz (Canada)

The COVID-19 pandemic is leading to increased substance use and deteriorating mental health symptoms. Amidst the chaos and uncertainty, youth represent a particularly vulnerable and at-risk group. Closures to daycares and schools, reduced access to health and social services, as well as the impoverished social connection and support caused by the self-isolation and quarantine protocols are having catastrophic consequences on the physical, social and mental health of children, adolescents, and young adults.^{1,2} The effects of the pandemic are only exacerbated and compounded by the deadly opioid overdose crisis, which has been devastating communities and families across the world. There is a pressing need to address the gap in the field of pediatric mental health and addiction, made even more urgent in this pandemic time. At the intersection of these two public health emergencies, healthcare systems globally must contribute to increasing quality care and treatment coverage for youth.

In the United States, drug overdose is currently the sixth leading cause of death among children and adolescents.³ In 2018 alone, 4,633 individuals between 15 and 24 years old died of a drug overdose in the US.⁴ Over 3,000 of those deaths, close to 70%, were due to heroin and other illicit opioids. Among children 1-4 years of age, there has been a 205% increase in the incidence of hospitalizations for opioid poisoning from 1999 to 2012 while in adolescents aged 15-19 years, a 176% increase was observed.⁵ In Canada, life expectancy at birth did not increase from 2016 to 2017, which is largely attributable to the opioid crisis, and more specifically attributable to opioid overdoses among young adult men.⁶ In the province of British Columbia, 81 adolescents (<19) and 1174 young adults (19-29) have overdosed since 2016.⁶ Among European Union member states, Turkey, and Norway, almost 20,000 deaths involving illicit drugs, primarily opioids, occurred in 2017 and 2018, roughly 8% of which were under 25 years of age.⁷

With the presence of high potent opioids in today's drug supply, any individual who uses illicit opioids is at risk of overdose. Individuals usually experience their first overdose around the age of 20 but only a small proportion of these young individuals receive any support in the form of counselling or behavioural services, and even fewer receive pharmacological treatment for their substance use.^{8,9} Instead, youth who come in contact with the health care system following an overdose are often detained, stabilized, and then discharged with little-to-no guidance or support. A nonfatal overdose provides the healthcare system with an opportunity to engage adolescents in addiction treatment and reduce their risk of subsequent opioid-related mortality. Timely treatment of youth with opioid use disorder (OUD) is critical.

Aside from the very real risk of overdose death, youth misusing opioids are vulnerable to a plethora of medical, psychological, and social complications. Substance use can have lasting effects on brain and behavior development, especially during adolescence, a sensitive period characterized by significant biological, cognitive, psychosocial, and emotional changes.¹⁰ Prescription opioid misuse in youth is significantly associated with all major risky behaviors, such as driving behaviors, violent behaviors, sexual behaviors, etc.¹¹ Similarly, opioid dependence is associated with an increased risk for self-harm, suicide, use of other substances, depression, anxiety, transmission of blood-borne viruses, and increased risk of bacterial infections.¹²⁻¹⁵ Moreover, lower social functioning and more suspensions and fighting in school are reported among students who initiate non-medical prescription drug use in middle school.¹⁶ The morbidity, social consequences, and mortality



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associated with untreated OUD among youth is evidently significant, and this must be met with relevant and appropriate healthcare services.

Yet, abstinence-based treatment, or no treatment, still seems to be the most common strategy in North America and in some parts of Europe. This has been imposed by a lack of specific expertise and resources in this domain. The low rates and very narrow range of pharmacotherapy accessible for youth compared to adults are driven in part by many providers who are unfamiliar with opioid agonist treatment (OAT), as well as a shortage of providers who are willing to prescribe medications for OUD among youth.^{17,18} OAT is viewed by some providers as a 'last resort' for youth, often waiting until young adults have first relapsed or until they have experienced severe adverse consequences.¹⁹ Conversely, pharmacotherapy with opioid agonists (methadone and buprenorphine) and antagonists (naltrexone) is the first-line treatment for adults.^{20,21} Even though few studies have examined the impact of OAT on adolescent development and the efficacy of these programs in this population, the preliminary evidence suggests that the use of methadone and buprenorphine are effective and safe for youth.²² The scarcity of the literature and the difficulty in finding relevant articles has been reflected in several reviews.²²⁻²⁴

Nevertheless, medical associations such as the American Academy of Paediatrics and the Canadian Centre on Substance Use and Addiction support the use of medication for adolescent and young adult patients with severe OUD, in combination with developmentally appropriate behavioural strategies on resistance skills, coping, problem-solving and interpersonal relationships.^{25,26} Psychosocial interventions must be appropriately integrated into the continuum of care for youth in order to address the early childhood trauma, complex familial situations, and co-occurring disorders that are prevalent in young individuals with substance use disorder.²⁷ A combination of psychosocial interventions and maintenance treatment strategies is essential for their recovery, treatment trajectory, and seamless transition to adult services.

This is a serious international challenge. The lack of research has severe consequences such as the lack of evidence-based interventions and development of clinical guidance in the treatment of these kids. Clinical practice guidelines would provide explicit recommendations for clinicians who are uncertain about how to proceed, overturn outdated practices and beliefs, improve consistency of care, and provide authoritative recommendations reassuring practitioners about the appropriateness of their treatment policies. To date however, most countries only have broad general guidelines for adolescent substance use disorder, focusing more on prevention or behavioural strategies than on addiction medications, which can be misleading or confusing for the specific treatment of high-risk opioid use in youth. The psychiatric and medical communities are not responding to the mental health and substance use needs of children, adolescents, and young adults from around the world. A lot of the recommendations driving the care and treatment structures are based on abstinence paradigm and ideological biases such as prohibition, rather than being based on the best interest of patients. We must do better. We must bring together the psychiatric community to address the gap within the field of pediatric addiction and concurrent disorders.

To continue this conversation, we are organizing an online event that will provide an opportunity for researchers, policy makers, and clinicians alike to address this public health crisis from different perspectives and share experiences in dealing with youth in the field of substance use. Join us on the 25th of January to discuss the system of care and the treatment paradigms for high-risk opioid using youth that are required for an effective response.



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Narrative Report of the COVID 19 Related Child and Adolescent Mental Health Activities in Nepal

Dr. Arun Raj Kunwar (Nepal)

With the start of the COVID 19 pandemic we witnessed a rise in COVID 19 related stress and associated symptoms in the children and adolescents attending the Child and Adolescent Psychiatry OPD at Kanti Children's Hospital. A countrywide lockdown was enforced on 24th March, 2020 when the second case of COVID-19 was detected in Nepal. After the lockdown there was a decline in the number of children and adolescents reaching the CAP OPD due to vehicle and movement restrictions. The lockdown ended officially on 21st July, 2020 but with limits in public gatherings. The schools were closed after lockdown and have not formally opened as of Nov, 2020. Some schools in rural settings have opened with safety measures in place, and most schools in urban settings have resorted to online classes. In the midst of these events, there were increased reports of CAMH related stress among students and teachers in schools. We started online interactions with different schools in Kathmandu. As we held sessions for these teachers and students, we realized that this was a problem throughout the country. With this we started working on developing a manual for COVID 19 Related Child and Adolescent Mental Health Problem Identification and Management .

We envisioned a short training which would be simple to understand but still be able to provide support to the children and adolescents, and thus have a meaningful impact in their lives.

The manual was developed based on principles of psychosocial support, along with mental health problems identification and management. The manual has two modules in training of trainers format::

1. First one for training on sessions with children and adolescents: on management of COVID 19 related stress and adjustment in present pandemic situations.
2. Second one for training on sessions with teachers, parents, caregivers, school nurses on providing psycho-social support to C&A on management of COVID 19 related stress and adjustment in present pandemic situations.

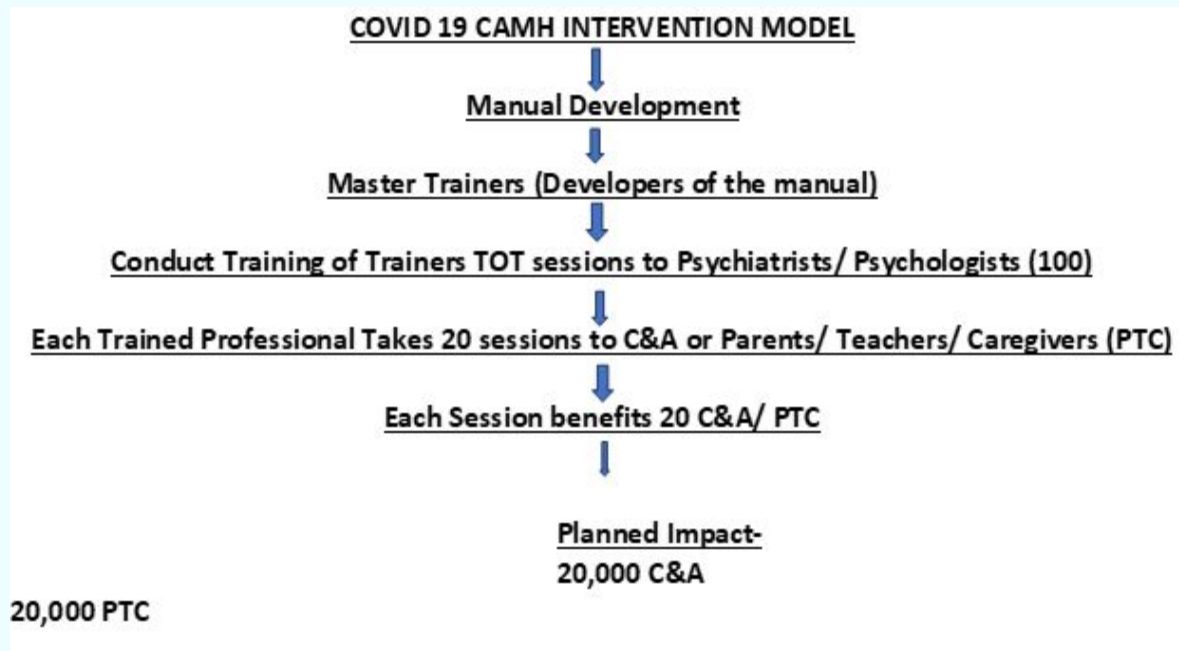
A few trial sessions were conducted in schools around Kathmandu valley and also some schools in remote districts such as Kailali. The feedback from the participants was positive.



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Development of Audio/ Visuals and Training Materials:

- Training Manual development completed
- Videos related to relaxation exercises and breathing exercises have been made. These have been made in Nepali, Bhojpuri and Maithili Languages.
- PowerPoint slides have been made in English and Nepali languages.
- A video on COVID 19 has been translated into Nepali with permission.

The video was developed by German society of psychology, the link is as follows:
<https://www.youtube.com/watch?v=gZFyjs4gNUs&t=42s>

Approval for the production of the video in Nepali language was obtained. A Nepali language script was developed by the team, and was recorded. The audio clip was sent back to the developers of the video and it was sent back to us in Nepali language.

- A workbook on COVID 19 has been included in the manual with permission. This was developed by Dr. Laxmi Shrivanti, Department of Child and Adolescent Psychiatry, National Institute of Mental Health and Neuro Sciences. The workbook is in English, and permission has also been obtained for Nepali translation.



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PROJECT PROGRESS:

As of 6th December, 2020, 5 months into the project, we have achieved the following results:

· Training of Trainers:

Total number of trainers: 100 (Psychiatrists, Psychologist and Counselors)

· Sessions by the TOT Recipients: Conducted over Tele-video

Total number of sessions: 1415

Total number of sessions conducted for C&A: 771 Total number of sessions conducted for adults: 644

- Total number of C&A reached: 16,571
 - Number of male children: 8,571
 - Number of female children: 8,000
- Total parents/ teacher and caregiver reached: 12,026
 - Number of male parents/ teacher and caregiver: 3,881
 - Number of female parents/ teacher and caregiver: 7,616

Total C&A and caregivers reached so far: 28,597

Other Activities:

- Along with the core project, the team members have also coordinated with UNICEF and various other corporate houses to conduct around 10 sessions
- Sessions for frontline workers at Kanti children's Hospital and mainly of Province 2 are also being conducted:
 - Session for health professional : 12
 - Number of health professionals reached: 132
- The Kanti team has conducted many webinars/ public service announcements/ more than 2-3 interviews to national TV/Radio

Further plan:

1. To train school nurses on providing psycho-social support to C&A on management of COVID 19 related stress and adjustment in present pandemic situations.
2. Expand the present training of C&A to reach 10,000 more children, parents, teachers and caregivers in next 3 months



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Covid-19 and CAP Training: The Unforeseen Crisis and Unexpected Opportunities

Dr. Asilay Seker (Turkey)

President-Elect, European Federation of Psychiatric Trainees

The world has been transformed enormously in the past year as a result of the Covid-19 pandemic, and the field of medicine was impacted like no other. Child and adolescent psychiatry (CAP) might not have seemed to be at the frontline at the first look, however being arguably the most biopsychosocial medical branch, it has been deeply impacted by the pandemic. And as is always the case, emerging members of the family, trainees, are the most vulnerable to these disruptive changes.

In this article, I will try to outline the situation of CAP training during the current pandemic and discuss novel methods of overcoming these adversities, mainly from an European perspective.

The natural reprioritization of the healthcare workforce due to the pandemic has had a highly negative impact on CAP training. The variety of cases [ab1] has narrowed remarkably, however the overall workload for CAP has mostly increased. Social distancing and face covering rules in majority of countries also changed the clinical experience noticeably: psychiatry in general is a field where observing facial expressions, gazes etc. is essential, sometimes being the core of an assessment in certain psychopathologies e.g. autism or age groups e.g. infants. Some countries did manage to implement Telepsychiatry in their practice, however with lack of frameworks and guidelines and without proper induction to this method, trainees have been struggling to adapt. Clinical rotations have been disrupted in some countries where trainees need to travel for certain units which are not commonly found in every training hospital, for example Substance Use Services. On top of these, CAP trainees in most low- and middle-income countries (e.g. Turkey, India) have been deployed to pandemic units, emergency clinics or other frontline medical services. All these changes have led to a significant disruption of good-quality clinical exposure for CAP trainees.

Physical meetings, teachings, workshops, and congresses have been minimized and most have been moved to online platforms. This can be compensated in some cases as will be mentioned further below, however has had more severely detrimental impact on certain areas of training where more hands-on activity may be required (e.g. psychotherapy training). The actual experience of face-to-face networking with colleagues, building connections for collaborations needed to be taken away. Even examinations (both written and OSCEs) went fully online in certain countries (e.g. the UK), which has already raised issues about the validity of online performance and evaluation.

Research activities, too, had to be adapted extensively to pandemic circumstances: Funding has become scarce and clinical research more challenging with patient mobility decreasing. The rapid 'Covidization' of research themes shifted the focus in many countries where it may be easier to receive grants for Covid-19 related projects.

These changes and many more have led many CAP trainees to the brink of burnout and causing them to struggle with their motivation and commitment to the field.



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Having said that, the pandemic has also come with a few silver linings as a way of unexpected opportunities.

One of the significant consequences of the pandemic probably happened with the non-clinical training opportunities. As a result of avoiding physical meetings, training activities have taken place over online platforms and therefore are able to accept a higher number of trainees, from different clinics, cities, or even other countries. Renowned clinics have opened their now digital grand rounds to a wider audience, virtual congresses and courses have become inevitably cheaper than the physical ones and easier to attend without having to travel. It is now common practice to have online content recorded and readily available to follow in one's own time. These platforms have led to revolutionary results in democratization of information for trainees in remote areas, smaller institutions, and more disadvantaged countries. In a nutshell, information has become much more 'accessible' in the locked down world.

However, teachings and courses are not sufficient to raise a competent child and adolescent psychiatrist. Training is analogous to a child's critical early years; certain connections and relationships need to be built within this period in order to have a successful future career. With this in mind, the European Federation of Psychiatric Trainees (EFPT) is organizing activities to continue professional networking under the current pandemic. The annual EFPT Forum was moved to an online format in 2020 with a focus on promoting cohesion among European psychiatric trainees. The feedback from the weeklong event reconfirmed that meeting and exchanging with colleagues are vital for training and dearly missed due to travel restrictions. To keep the network alive, the EFPT is also holding the monthly 'EFPT Virtual Sessions' where different topics are discussed under various formats with renowned experts in live sessions. The amount of interest in these events show that it is possible to keep trainees socially and professionally engaged even in the absence of physical gatherings. (More information can be found on efpt.eu or [@EFPTtrainees](https://twitter.com/EFPTtrainees) on social media.)

It is also highly important to receive structured feedback from trainees about their circumstances to plan more targeted interventions. The EFPT is gathering such information through 3 different surveys:

- 1- EFPT Annual Country Report Survey: modified to include questions about Covid-19
- 2- Early Career Psychiatrists in Europe during Covid-19 Outbreak: in collaboration with European Psychiatric Association
(https://docs.google.com/forms/d/e/1FAIpQLSeqMuSkf15YfGNgVbf5EN_LiVfJWFRvHkPeKIKetQhvfv-Pg/viewform)
- 3- EFPT Psychotherapy in CAP Training Survey: includes specific questions about psychotherapy training and practice in CAP during the Covid-19 pandemic (<https://www.surveymonkey.com/r/95Y66MD>)

In conclusion, it is evident that the pandemic has severely disrupted CAP training with the clinical aspect seeming more significantly affected. However, it has also compelled organizations, trainers, and trainees to find alternative ways to keep in touch and continue teaching/learning. As digital platforms have become the new 'norm', it looks like proper guidance on how to conduct clinical and training activities online is a pressing need. Finally, it is crucial to reach out to trainees for feedback, identify their precise difficulties and offer appropriate support to help them cope with the changing environment.



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Child and Adolescent Psychiatry Fellowship Training during the COVID-19 Pandemic

Dr. Chayanin “Jing” Foongsathaporn (USA)

The coronavirus disease 2019 (COVID-19) has undoubtedly affected our lives in nearly every aspect. When cases first began to rise in the United States of America, I was a third-year psychiatry resident at the University of Hawaii. Although the pandemic forced some changes to my adult psychiatry training, such as limiting the number of in-person visits and transitioning a majority of follow-up patients to telehealth, I adapted relatively quickly because I was already familiar with that particular outpatient setting. Since the COVID-19 began towards the end of my residency training, all I needed to do then was to apply my pre-existing skills and knowledge to the new COVID-19 adjustments and precautions. However, the shift to my child and adolescent fellowship training (subspecialty training) has posed a much greater challenge. Unlike residency, I must now develop new sets of skills while also tackling the additional hurdles of the ever changing, and seemingly worsening, pandemic.

There are several clinical skills that child psychiatry fellows need to learn; for example, interviews with pre-school and school-aged kids who may not be able to express much through words, interviews with adolescents who may not want to talk, and getting information from parents and teachers. I would imagine learning these new sets of skills is already challenging and doing it virtually adds another level of complexity. Psychiatric interviews with children as well as play therapy are challenging through telehealth. Family therapy has always been my area of interest but I keep asking myself 'how do I learn to do family therapy via zoom?' The traditional look-at-individual-in-the-eye is impossible in the virtual format. Simply put, our jobs require us to connect with patients to the greatest extent possible, and being unable to meet with patients in person significantly affects our abilities to do so.

Besides these learning-curve challenges, the volume of patients has also increased. Children and adolescents are struggling due to school closures, remote learning, lack of peer contact, and pandemic-related anxiety. There is also an increased risk of parental mental health, child maltreatment, and domestic violence. Currently, the number of children in our consult-liaison service has increased dramatically which seems to reflect the trend throughout the country. In response to this increase, my fellowship program has created a backup schedule to ensure that the single fellow working in the consult-liaison service maintains her own wellbeing and also to provide a high quality of care to our patients despite the high volume.

Additionally, physical distancing guidelines have made it more difficult for fellows to socialize with each other and to learn from each other's experiences. All didactic lectures are now held through video conferencing platforms. New fellows potentially feel isolated until an action plan organizes in-person group activities in conformity with physical distancing requirements. Moreover, professional conferences, such as the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP), have switched to the online platform. As someone who regularly attends these meetings, I often took advantage of the conference as a “work-related vacation.” The change of scenery was always welcomed, and connecting with colleagues from around the world made these conferences some of my best memories. That, of course, did not happen this year. On the bright side, I was able to attend more seminars than usual this year since they were all recorded and made available online -- hopefully this practice continues!



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At this point, it would be irresponsible for me not to acknowledge the few bright spots that the COVID-19 has unexpectedly brought to my training. Some parents have told me that their kids are now less anxious in therapy through zoom, which came to me as a surprise. The parents explained that commuting to the clinic and waiting in the lobby acted as an anxiety-provoking situation for their children. Through zoom, their children are in a much more comfortable environment because it is their home. Additionally, children who live far from the hospital or clinic can get care without worrying about their mode of transportation – something that I believe will become more important as the winter continues. Telehealth has proven to be a tool that provides greater access to mental health care, especially for underserved populations. In addition to the patient care, videoconferencing has also broadened the scope of didactic speakers and grand-rounds. Fellows can now learn from renowned experts who might not reside in the nearby local area.

As I finish writing this article, I look back and reflect on my training over the past several months. There are undoubtedly struggles that everyone must go through, but at the same time, there are new opportunities to grow professionally and personally. I am extremely grateful of the manner in which my program has both responded to the pandemic and continues to proactively improve the experiences of its fellows. For a while, I had been holding on to the regret of not being able to have traditional, in-person training with patients. But following a conversation with my program director, Dr. Neha Sharma, D.O., my perspective has completely flipped. I asked her opinion on how long these new measures will last, and she answered "Who knows? Maybe this is our new normal." She is absolutely correct. Whether or not conditions remain exactly the same, the COVID-19 has likely permanently changed how psychiatry, and medicine in general, will be practiced to some degree. And at the end of day, I am thankful that my training is right now and incorporates these additional hurdles. It forces me to not only learn the skills I need, but to also develop them in a way that adapts to different and unforeseeable situations. Has the COVID-19 made fellowship more difficult? Yes. Can it make me a better doctor? Yes. Every day, we teach kids to be resilient. It's time that we show them that we are resilient too.



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Child and Adolescent Mental Health (CAMH) in Australia

Dr Paul Robertson (Australia)

Australia is a secure, democratic country with strong systems of government and public service around health, education, social provision and employment. Six states and two territories form a Federation or Commonwealth (of Australia) governed by the Australian Commonwealth (or Federal) government. Within each state there are multiple Local Government Areas (LGA) with their own elected councils providing services. Australia has a population of approximately 25 million people with just over 20% aged under 18 years. Indigenous Australians (3-4 % population) have lived here continuously for over 50,000 years with contemporary Australia being born relatively recently through British colonisation about 250 years ago. Australia is a country of migrants from all over the world making it a multicultural society with 30% of the population born overseas. Both broadly, and for mental health, Australia maintains strong ties to Europe and the USA, particularly the UK and Ireland. Increasingly Australia's identity is shifting as it sees itself as part of the Asia-Pacific. We are closely aligned with our neighbour New Zealand.

CAMH Services

Mental health services, including CAMH, are funded by both State and Commonwealth governments through a range of mechanisms including State government funded hospital inpatient and outpatient services; Commonwealth funded *headspace* clinics; Commonwealth funded universal health insurance (Medicare) and government funded non-government organisations (NGOs) who deliver aspects of mental health care. It is a complex and somewhat confusing system but overall compares well internationally. Child and Adolescent Psychiatrists (CAP) and other child and adolescent mental health professionals work in a range of settings:

- State government funded CAMHS delivered through multidisciplinary teams (MDT) in (office-based) clinics or via community outreach to children and young people with severe and complex mental health needs (usually less than 1% of the under 18 population). Child and (more commonly) adolescent mental health inpatient units, if available, are located in CAMHS. Autism or neurodevelopmental assessment teams are also often part of CAMHS. Those CAMHS attached to paediatric centres will commonly provide a paediatric consultation liaison service. Most child and adolescent psychiatry training occurs through such CAMHS.
- Commonwealth funded *headspace* provides community clinic-based mental health care for youth aged 12 – 25 years. *headspace* clinics have emerged over the last decade or so and developed in line with the Youth Psychiatry Movement. They were originally designed as an extension of primary care but increasingly have moved to providing care for youth with more severe and complex mental health presentations. *headspace* also leads in innovative practices including school-based mental health and e-mental health services. Increasingly some child and adolescent psychiatry training is occurring within *headspace*.
- Office-based 'private practice' which is largely funded through a Commonwealth government health insurance system (Medicare) but often involves some 'out-of-pocket' expense for the patient. Medicare funds child and adolescent mental health delivered by psychiatrists, psychologists and other mental health professionals. There are some limited opportunities for child and adolescent psychiatry training in private settings.
- A range of other community settings which are typically NGOs funded by government to provide aspects of mental health care such as rehabilitation, family support and therapy intervention, indigenous mental health, alcohol and drug services and therapeutic residential care. A small number of child and adolescent psychiatrists work in these settings. There is limited child and adolescent psychiatry training in these settings.



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There are some interesting aspects of Australian CAMH to note:

- The emergence of Youth Psychiatry alongside traditional Child and Adolescent Psychiatry has seen the development of *headspace* and in some states the expansion of CAMHS to CY(outh)MHS with an increased upper age range to 25 years. This has been Australia's approach to 'transitional youth'.
- Infant psychiatry or infant mental health is well developed in many places in Australia and in some states, there are Infant Mental Health services within CAMHS. Many Australian CAP trainees receive training in infant mental health.
- Culturally and linguistically diverse (CALD) populations are common and there is a recognised need for cultural competence in all CAMH clinicians.
- For CAMH and Australia's indigenous population there are important issues of cultural trauma associated with dispossession and colonisation as well as the frequency multiple disadvantage experienced by this population.
- Early psychosis teams are often found as part of CAMHS/CYMHS and *headspace*.
- There are well-developed services around child and adolescent Eating Disorders.
- CAMHS based outreach teams (Intensive Mobile Youth Outreach Service - IMOYS) are well developed for high risk adolescents.

CAMH and Public Health in Australia.

Public health around CAMH is currently an interesting space in Australia. Australia is fortunate to have had two child and adolescent epidemiological surveys, the last in 2015 showing child and adolescent mental health disorders prevalence of 13.9 % for 4-17 year – 60% mild, 25% moderate and 15% severe. The epidemiology is comparable to other international estimates. Although Australia is recognised as having a well-resourced CAMH system there remains a substantial 'treatment gap' or shortfall of resources to need. Considerable effort is underway to consider how the system might be reorganised to better meet the population need across a spectrum from mild to severe disorders and within a tiered system of care from primary to specialist care that also includes prevention and early intervention. Several major investigations into mental health are currently underway - the Royal Commission into the Victorian Mental Health System and the Productivity Commission Inquiry into Mental Health.

Child & Adolescent Psychiatry

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a binational professional organisation representing Psychiatrists in both Australia and New Zealand. Child and Adolescent Psychiatry is a subspecialty within Psychiatry and are represented by the Faculty of Child and Adolescent Psychiatry (FCAP) within the RANZCP. All Child and Adolescent Psychiatrists are recognised general Psychiatrists and all Psychiatrists have some competency in CAMH. This arrangement has benefits through the larger professional body aiding advocacy for the profession and the community while at a clinical level it facilitates the management of adolescents across the transition to adulthood and young people where parental psychiatric illness is contributing. But it also has substantial disadvantages- the needs of child and adolescent psychiatry and



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CAMH can be overshadowed by adult psychiatry; the tendency to impose adult mental health solutions on CAMH and the demands of general psychiatry training crowding and distracting from subspecialty child and adolescent psychiatry training.

There are approximately 400 recognised Child and Adolescent Psychiatrists in Australia (about 10 % of all psychiatrists) with a gender ratio approximately equal for male and female. This gives the rate of 1.6 per 100,000 population (6.4 per 100,000 under 18). There are about 100 Child and Adolescent Psychiatrists trainees currently in Australia and many Child and Adolescent Psychiatrists are early career indicating a growing profession body.

Child & Adolescent Psychiatry Training

Training to be a Psychiatrist takes 5 years through the RANZCP training program. All psychiatrists in training complete 6 months of child and adolescent psychiatry, usually in the second year of training. For those trainees wishing to complete subspecialty Child and Adolescent Psychiatry training and be a recognised Child and Adolescent Psychiatrist they complete the last 2 years of the 5 year training in credentialled Child and Adolescent Psychiatry rotations, a series of work-based competency assessments and other training requirements (i.e. psychotherapy cases). There are challenging 'exit' exams to achieving Fellowship (recognition as a Psychiatrist) but no specific examinations for Child and Adolescent Psychiatry. All subspecialty Child and Adolescent Psychiatry trainees must complete a compulsory six-month inpatient rotation during the 2 years. The Child and Adolescent Psychiatry syllabus is similar to that in Europe and USA.

Broader Multi-Disciplinary CAMH workforce

More broadly the CAMH workforce includes well-trained allied health professionals including psychologists, psychiatric social workers, occupational therapists and speech pathologists as well as psychiatric nurses. Specialist education staff work in conjunction with CAMH but are usually employed and located within educational services rather than mental health. There are emerging professions in some specialist areas such as mental health dietitians and exercise physiologists with Eating Disorders. Paediatricians play a much greater role in the child and adolescent mental health workforce in Australia than elsewhere. There is increasing emphasis and development of a Peer Workforce and Carer Workforce of those with lived experience of mental illness or caring for family members with mental illness.

In summary Australian Child and CAMH is strong and has much to be proud of but there remains many challenges going forward if we are to meet the mental health needs of our communities' children and young people.





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CHILD AND ADOLESCENT PSYCHIATRY IN BRAZIL – HISTORICAL CHALLENGES, COVID-19 AND EMERGING WINDOW OF OPPORTUNITIES

Drs. Flávio Dias Silva and Ricardo Nogueira Krause (Brazil)

Brazil has been one of the countries most affected by the COVID-19 pandemic. Although we are only the sixth most populous country in the world, we reached the end of 2020 as the third in number of cases, and the second in number of deaths (1). As in other countries, the pandemic has hit us severely also in other aspects such as the economy – our Gross Domestic Product is expected to fall by between 5 and 6% this year, according to declarations of Brazil Central Bank to the lay media. These factors, added to that our country still has severe difficulties in structuring its health system, make us Brazilians fear even greater challenges in the coming years regarding mental health care, especially that of young people.

An understanding of Brazilian history may help readers to have a context to understand the impact of services provided by Child and Adolescent Psychiatrists.

Local mental health care scenario

Despite having one of the largest universal and integral health systems in the world, the SUS – Unified Health System, the lack of mental health resources in Brazil is enormous. With about 11,000 psychiatrists (2), the proportion of this professional per population is about 1/20,000 – a ratio that varies substantially according to the region of the country. Considering the population of children and adolescents, we are still a young country, with about 25% of our population under 18 years of age – something around 55 million individuals (3). For this age group, Brazil counts no more than 600 to 700 Child and Adolescent Psychiatrists (4), that is, 1 specialized professional for 120 to 130,000 children and adolescents. In fact, the professional and services gap is more evident when studying the population that needs care. It is estimated that about 7 to 12% of Brazilian children and adolescents suffer from some mental disorder, and of these, at least half would be severe types of disorders (5); the number of Child Psychosocial Care Centers (CAPSi), the main model of public care for severe cases, does not reach 250 units (6). Considering that each CAPSi is sized to serve about 180 patients, we can conclude that about around only one in every hundred mentally affected children should have access to specialized treatment.

The Ministry of Health has outlined some attitudes towards improving access to and quality of Brazilian mental health services. The National Mental Health Policy recently included the provision of specialized multidisciplinary outpatient clinics and the creation of CAPS specialized in the provision of psychopharmacological treatments. In 2020, during the Pandemic, a partnership with the Brazilian Psychiatric Association (ABP) has focused on providing permanent education strategies to health professionals – such as granting free registrations to the Brazilian Congress of Psychiatry and the joint creation of a streaming channel on mental health during COVID-19 pandemics (7). In addition, the ABP also contributed to the development of materials to the general population - a care booklet in the Pandemic, and a three-day streaming program on mental health problems (Mentalize program) (7). However, such initiatives are very small near the real challenges of care – so far there are only 50 specialized outpatient clinics, and no more than 2800 CAPS (all modalities) in the country (8). Underfunding indeed is a problem not adequately faced historically by any federal administration since the beginning of the system.

The gap in production of the needed human resource – trained available Child and Adolescent Psychiatrists appears not to be quickly solved. It takes a very long time to become a child and adolescent psychiatrist in Brazil (which is considered an area



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of activity, not a medical specialty) as it is necessary to first be a psychiatrist, and then, either be trained for an additional year, or undergo a test conducted by the ABP. There are no more than 100 training positions in the area in the country – and as a rule less than half of these vacancies are filled (9); in addition, according ABP official website, the number of applications and the approval rate in the ABP test has been extremely low, which makes the possibility of correcting specialist gap remote, at least in short-term. The encouragement to the Child and Adolescent Psychiatry field within the medical degree – which in thesis could increase the interest in the career – has also been rare, although the mandatory internship in Mental Health since 2014 opens a window of opportunities in this sense. There is an alarming number of unassisted or poorly assisted children because of the lack of specialized psychiatrists needed to serve the earliest age groups.

Although there are alternative pathways such as from pediatrics as an alternative to specialization from psychiatry, there might be differences in the training if not linked to general psychiatry, as the necessary body of knowledge for child and adolescent psychiatry includes pediatrics, neurodevelopment, anthropology, sociology and psychology, among other disciplines.

Child and Adolescent Psychiatry in academy

Despite the difficulties in health care and in the human resources formation, Brazil has produced important research in the field of Child and Adolescent Psychiatry. Important epidemiological surveys (10), the research of large cohorts such as The High Risk Cohort Study for Childhood Psychiatric Disorders (HRC) (11), the recent huge award of a Brazilian researcher to lead the “Identifying Depression Early in Adolescence (IDEA) project”(12), and the consolidation of the National Institute of Developmental Psychiatry (13) has led Brazilian researchers to relevant international recognition. The Portuguese version of the IACAPAP Manual for Child and Adolescent Psychiatry, is almost completed, and the IACAPAP World Congress in 2024, has been planned to occur in the city of Rio de Janeiro, in partnership with the national affiliate, ABENEPI – Association of Neurology and Child Psychiatry and Allied Professions.

ABENEPI began in 1967 to support child and adolescent psychiatrists as well as adult psychiatrists and neurologists who were not formally trained in specificities of children's psychological development but work in the field since a long time ago to face the extremely low number of specialists. The suspension of face-to-face events with migration to online interaction paradoxically favored an expansion of ABENEPI's spectrum of activity, decentralizing and enabling the transmission of knowledge to remote regions of the country through teleconferences and continuing education programs. The IACAPAP World Congress in 2024 is hoped to be a milestone in the history of Brazilian Child and Adolescent Psychiatry.

The impact of the COVID-19 pandemic on young Brazilians is still unknown. These effects are worrisome – like in any other country in the world - not only because suspected negative impact in children and adolescent emotions, but also because Brazil follows a heterogeneous at distance education policy for its children – some schools providing recorded classes, others live at conferences, and others (mostly in the public system) through the assignment of asynchronous tasks without supervision. An important Brazilian research initiative on the impact of the pandemic on Brazilian has been conducted by the University of São Paulo, a research known as "Youth in Pandemic" (14). Researchers will monitor emotions and behaviors of children and adolescents over 12 months, as well as situations that increase risk or protect them, from questions answered by parents. Children will also be invited to participate in an internet game that assesses the flexibility of their thinking. ABENEPI joins the Youth in Pandemic Project seeking to reach regions of extreme poverty that do not have access to the internet as well as ethnic groups that are difficult to approach such as indigenous populations.



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Final considerations

Brazil is a very heterogeneous country – multiethnic, with a high rate of social inequality, with different realities between regions. So, we are also contrasting in the field of Psychiatry of Childhood and Adolescence – immense difficulties in attention to the mental health of our young people, but intense effervescence in the academic field, with unique contributions in the scope of the psychiatrist's performance and the advancement of the specialty. The COVID-19 pandemic poses an additional challenge because it threatens the future of our citizens' mental health. Sensitizing our politicians to prioritize the approximation of academic excellence of Brazilian psychiatrists to community health services is an essential task of each actor involved in this context. The IACAPAP World Congress in 2024 can be an important moment of integration of Brazilian mental health professionals, other related national and international entities such as the WPA, academic community and political representatives, all in advocacy for better psychic development early in life.

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The value of qualitative research in child and adolescent mental health

Dr. Jordan Sibeoni (France)

Conducting qualitative research is becoming essential in child and adolescent mental health (CAMH). Nowadays, child and adolescent mental health professionals must try to see each patient's mental illness through the eyes of the patient and the family in order to enhance patients' and parents' empowerment, shared decision-making, and more globally patient and public involvement (PPI). Qualitative methods fit this societal evolution well, aiming as they do to describe and capture the lived experience in great depth.^{1,2}

Accordingly, there is an increasing qualitative literature in CAMH, from all over the world, covering different fields such as studies investigating clinical or psychopathological aspects among children, their families and healthcare providers; studies exploring mental health issues in the general population; studies describing treatment experiences and outcomes or ethnographic studies. Researchers from different backgrounds contribute to qualitative research in CAMH- nursing sciences, psychology, public health, science of education, sociology and anthropology to provide

What may be the root causes that so few child psychiatrists contribute to qualitative research?

Qualitative methods are also up to the challenge of collecting data from children and adolescents with psychiatric disorders. Doing qualitative research in CAMH is, at the same time, considering these children as active participants, and recognizing their right and autonomy to think. Yet, conducting interviews with this specific population requires creativity and innovative method such as photo-elicitation, to engage and empower them so to enrich the data.³

Child & adolescent psychiatry has always faced epistemological difficulties, illustrated by centuries-old debates between biological, psychological, anthropological, sociological or political theories. Qualitative methods, such as the IPSE (Inductive Process to Analyze the Structure of lived Experience) approach,⁴ make it possible to overcome this epistemological conundrum, to rethink child & adolescent psychiatric knowledge more freely and to bring new perspectives about prevention, diagnosis, phenomenology, treatment and understanding of mental disorders.⁵

Qualitative research is associated with the concept of theorization. Yet, it would be wrong to think that qualitative research can only generate new hypotheses or theoretical models. In fact, qualitative research, in medicine in general, in CAMH in particular, very often leads to developing practical models based on patients, families and caregivers' insights and lived experience.¹

Finally, for qualitative research to reach a wider audience and influence CAMH policies, mixed-method approaches and qualitative synthesis are to be more considered. On that matter, the World Health Organization (WHO) has recently affirmed the importance of synthesizing data from qualitative studies to help in the development of health policies and clinical practices.⁶

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Are pre-adolescent children drinking alcohol? Studies on child alcohol use disorder in Eastern Uganda

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Uganda is a low-income country in East Africa with more than 42 million inhabitants, equivalent to almost 180 people per square km. It ranks as 159 on the human development report index from 2020 and has 6 years of schooling on average. The human development index at 0.5 has been on a steady increase from 0.3 since 1990.

The research project: *TREAT Child Alcohol Use Disorder (C-AUD) in Eastern Uganda: screening, diagnostics, risk factors and handling of children drinking alcohol* funded by the Norwegian Research Council (TREAT C-AUD) (#285489) is a five year project, initiated in 2019, to answer questions regarding substance use in childhood, with an emphasis on alcohol use. The TREAT C-AUD research project is a collaboration between partners from Makerere University in Uganda, the University of Bergen and the Norwegian University of Science and Technology in Norway.

Alcohol and substance use disorders among pre-adolescent children is a neglected and under-researched area. Like many other sub-Saharan countries, Uganda has a comparably high alcohol consumption per capita and traditions of home brewing. Even if alcoholic beverages may play a social and cultural role, harmful alcohol use, which in certain cases lead to 'child alcohol use disorder', C-AUD, is related to mental health problems, physical damage, reduced social functioning and dependency. Early and excessive substance use also increases the risk of problems later in life. It is known that adolescents growing up under social deprivation, with violence or neglect, without adult care or among children living on streets may be more likely to use alcohol and other substances.

However, the use of alcohol among pre-adolescent children living under adult care in Uganda has not properly been investigated in the communities, school system, or health system. With two decades of social and health research experience in Mbale District, the TREAT Consortium raises the questions about the magnitude and the characteristics of alcohol and substance use among children in Eastern Uganda. Based on these observations the consortium has the following objective:

To investigate the magnitude of C-AUD and substance use in children, related clinical factors, and factors at household, community, school and health system level; and to suggest scalable changes in the health system for screening, diagnostic and treatment procedures in Uganda.

The TREAT C-AUD research project will document to which degree alcohol and substance use is a problem in the communities in Mbale District, Eastern Ugandan, and associated factors on the individual and system level. The project is approaching the research topic from comprehensive perspectives including quantitative and qualitative assessments. We will conduct a large cross-sectional study, interviewing caregivers and children, as well as investigating preventive and supportive mechanisms in the schools and the health system. The target group are children 6-13 years which is overlapping with the



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recommended age for primary school attendance. We are including children, community representatives, expert groups and stakeholders in the development of screening tools and in interpreting and disseminating the results. The assessment methods are adapted to fit the cultural context as well as to be relevant with regard to the COVID-19 pandemic. The development of research tools can be used by the health- and school-system for detection and handling of children having problems with alcohol and substance use. The project will yield insight in child and adolescent mental health issues relevant to understand child wellbeing beyond Mbale District. We believe this new insight will benefit health system and school system services for children and ultimately child health and wellbeing. Further, we believe alcohol and substance use among children deserves research and awareness in the wider societies.



TREAT C-AUD research project team in 2019



Update on Mental Health of Children in Beirut

Dr. Ali Haidar (USA), Dr. Fadi Maalouf (Lebanon)

Background

Situated on the eastern coast of the Mediterranean, Beirut is Lebanon's capital and its largest city with a metro area population of over 2 million. On August 4, 2020, the city's port was ravaged by one of the strongest non-nuclear explosions known to mankind (1). The devastating explosion resulted in the death of over 200 citizens, the injury of 6500, the immediate homelessness of 300,000 inhabitants, and the destruction of a big portion of the city's area with ripples of the explosion felt in other Mediterranean cities.

In addition to the damage sustained by the residential and touristy areas, the city's healthcare infrastructure was significantly damaged in the process with three hospitals sustaining severe damage and an estimate of 500 beds lost. Additionally, the country's national central drug warehouse suffered significant damages leading to direct loss or threat to stores of drugs essential for cancer and tuberculosis treatment as well as vaccines (2).

The explosion in itself came at a precarious time for the Lebanese capital as the economic and political situation had been already in free fall since October 2019. The country witnessed mounting political unrest and a governmental crisis, followed by a severe economic crisis with the foreign currency reserves plummeting and inflation rates rising significantly. The country was also faced with a banking sector crisis leading many citizens to lose their lifelong savings in the process and increasing stress, unrest, and the psychological burden on families.

Much like the rest of the world, Lebanon has also struggled to contain the COVID19 virus infection rate with intermittent lockdown measures furthering the stress of the economic situation and worsening mental health consequences of isolation. Moreover, a significant shipment of PPE being stored at the port was lost during the blast (2, 3, 4).

Effects on Children

Lebanon had been enduring a prolonged history of conflict, economic and political uncertainty even before the Beirut port explosion. Studies from Greater Beirut showed that one out of four adolescents suffer from a psychiatric disorder and 50% of those with a disorder, had an anxiety condition. Alarmingly, up to 94% did not seek treatment (5).

A recent national survey, the Psychopathology in Children and Adolescents in Lebanon Study (PALS), the first study to estimate the prevalence of psychiatric disorders among a nationally representative sample of children and adolescents, found that 32.7 % of children and adolescents (age 5 to 11) screened positive for a psychiatric disorder and only 5% were reported to ever seek help (6). Specifically, 6.2% of children and adolescents showed concerning depressive symptoms and 11.5% had suicidal ideations (7).

The extent of the effect on the mental health of children and adolescents has yet to be measured as data remains scant and the COVID pandemic limits access to psychiatric care. However, in an effort to understand the mental health impact of the explosion on children and adolescents, local researchers launched research studies aiming at investigating this impact. For example, a group of multidisciplinary researchers at the American University of Beirut (PI: F. Maalouf), launched the "Beirut Explosion Psychological Impact on Children Survey", an online survey that aims at recruiting parents of children aged 8 to 17 to complete different questionnaires inquiring about the degree of direct exposure and impact by the blast along with different mental health questionnaires. The aim is to assess the prevalence of depression and PTSD in those who were



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exposed to the blast. At the time of writing this article, the study is still ongoing and data has been collected on more than 700 children and adolescents.

UNICEF estimates the damage from the blast to schools in both public and private sectors in Beirut will affect 85,000 school-aged children, adolescents, and young people while the WHO identified emerging mental health needs as a major area for intervention and advocated for the allocation of a significant portion of aid budget for mental health services (8, 4).

The effect of the blast on children cannot be taken out of the context of the growing economic burden and the restrictions on access to psychiatric care brought in by the pandemic.

Lebanese society is undergoing a shift as the economic situation worsens and the standard of living for families adapts to the significant change not to mention the disruption to schooling in light of the pandemic.

In addition, research has shown that media plays a role in the aftermath of mass trauma. Exposure to distressing media images is linked to more posttraumatic reactions in children (9). The media in Lebanon covered closely the blast with graphic details that were shared on social media and were easily accessible to children of all ages. Direct exposure to disaster, separation from caregivers, exposure of children to mass media, and degree of community disorganization and loss of control are all factors that would increase the risk of Lebanese children and adolescents for mental health sequelae post-explosion.

Response

The National Mental Health Program (part of the Lebanese Ministry of Public Health), in partnership with various other collaborators, has laid out an action plan responding to the mental health needs of all people living in Lebanon. Some of the elements in this plan included: coordination of available resources, provision of psychological first aid, psychological support for frontline workers, provision of refreshers for screening processes for frontliners, a focus on youth and adolescents affected by the explosion via online messaging services, provision of information about natural reaction to grief and trauma to parents and directory for providers able to psychologically support those most affected by the blast (10).

Moreover, NGOs and UN agencies in Lebanon have taken up a significant role in mental health service provision since the beginning of the Syrian refugee crisis which has now expanded to also assist with the aftermath of the Beirut blast. For example, Embrace, an NGO managing the first suicide hotline for the country has expanded services to include psychological support after the blast (10).

UNICEF published a report of its efforts 100 days after the explosion where it reported having reached more than 7,200 children, parents, and primary caregivers with mental health needs in the aftermath of the explosion with plans for further outreach. It includes efforts at reconstructing damaged schools and relaunching child vaccination campaigns and assistance with nutrition and other health needs (8).

Academic medical centers also launched different initiatives to offer psychological support that is free of charge for all age groups including children and adolescents post-blast. For example, the Department of Psychiatry at the American University of Beirut Medical Center, launched The Trauma Assessment and Support clinic (TASC), a specialized multidisciplinary clinic for patients impacted by the explosion. Psychiatrists, clinical psychologists, and trainees volunteered and were involved in the treatment and provision of support for this population (11). TASC has also facilitated access to mental health care for people who were not in the psychiatric system prior to the disaster. Patients who were seen through TASC and were in need of long-term follow-ups were referred to receive other evidence-based interventions within the different specialty programs of the Department of Psychiatry at AUBMC or within the community.



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To speak of mental health in Lebanon without mentioning the refugee population currently calling Lebanon home would be an oversight, given how often those individuals suffer most from the aftermath of political and economic crises. Lebanon is home to over 1 million Syrian refugees and around 400,000 Palestinian refugees, many of whom are based in Beirut (12, 13). Refugee children remain a significantly vulnerable group in the aftermath of this economic and humanitarian crisis and need special attention as the country navigates this mental health crisis. Much more remains to be accomplished as the early phases of the acute trauma starts to lift and sequelae begin to surface. UNICEF estimates a need of 50 million dollars to rebuild affected schools of which only one-third has thus far been received while WHO proposed a budget of over 70 million dollars in August for healthcare-related responses.

On a final note, we must underline the resilience of the Lebanese youth. Teenagers and youth across the country were an essential element of relief efforts. From street cleaning to the distribution of first aid and coordination of assisting the injured, youths took an active role and consolidated a sense of community. Evidence from prior disasters shows a sense of community is a positive predictor of recovery and mental health (14).

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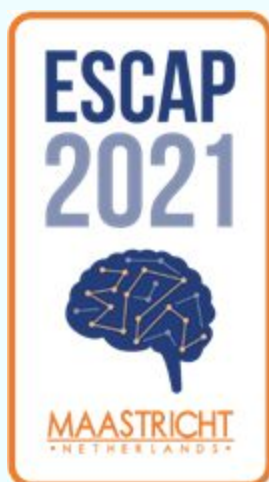




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