



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

World Psychiatric Association

Child and Adolescent Psychiatry Section

Official Journal



Photo: Horseshoe Bend (USA)

WORLD CAP Editor and Section's Secretary
Prof. Norbert Skokauskas (Norway)

Section's Chair
Prof. Bennett Leventhal (USA)
Co-chair Dr. Gordana Milavi (UK)

Assistant Editors:
Prof. A. Guerrero (Hawaii, USA)

Dr.T.Hirota (Japan-USA)



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

The Table of Contents:

Editor's Welcome (Prof. Norbert Skokauskas).....	2
Chair's Column (Prof. B.Leventhal).....	3
Leaders from around the World:	
<i>Australia:</i> Interview with Dr. Kowalenko, the Chair, Faculty of Child and Adolescent Psychiatry, Australian and New Zealand College of Psychiatrists.....	6
<i>Japan:</i> Interview with Dr. N. Fukuchi, 5 years after the 2011 Tohoku earthquake and tsunami.....	10
WPA initiatives:	
Safeguarding Children and Adolescents (Dr. G. Milavić).....	13
Child and Adolescent Psychiatric Systems of Care Around the World:	
Updates from <i>Canada</i> (Prof. Peter Szatmari).....	14
Updates from the <i>UAE</i> (Dr. Ahmad Mohammed Al Mai).....	16
Updates from <i>India</i> (Prof. Savita Malhotra).....	18
Updates from <i>USA</i> (Prof. Anthony Guerrero).....	21
Meeting Reports:	
<i>Canada:</i> 22nd World Congress of the International Association for Child and Adolescent Psychiatry and the Allied Professionals (IACAPAP) - from the Congress Chair (Dr. C.Wilkes).....	22
<i>Qatar:</i> The 2016 World Innovation in Health Summit in Doha (Dr.Munir).....	24
<i>Serbia:</i> The Fourth National Congress of the Serbian Association for Child and Adolescent Psychiatry and Allied Professionals (Dr. M.P.Milovančević).....	26
<i>Spain:</i> AEPNyA/AACAP Congress (San Sebastián, Spain) (Prof. B.Leventhal).....	28
<i>Japan:</i> The Japanese Society of Psychiatry and Neurology Congress (Dr. R.Louie).....	29
Future Meetings and Announcements	31



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

Editorial Column

Dear Colleagues,

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

"World Child and Adolescent Psychiatry" remains the only one WPA journal dedicated to global child and adolescent mental health. It serves as a platform to reflect on important past events, to share new ideas, and to disseminate future plans. The journal aims to keep a geographical balance, and to give opportunities to our colleagues from all around the globe to share their views and perspectives. In addition, the journal has several regular sections, including the WPA CAP Chair's Column, Leaders from Around the World Interviews, Trainees' Corner, etc. Currently, all publications to "World Child and Adolescent Psychiatry" are by invitation only. However, starting with the next issue we are planning to have a new section where brief communications from our readers will be published.

Coming back to the section "Leaders from around the World,"- in this issue you will find an interview with Dr. Nick Kowalenko, Chair, The Faculty of Child and Adolescent Psychiatry, The Royal Australian and New Zealand College of Psychiatrists (RANZCP). It is an insightful interview with a good dose of humor and a highly recommend read. WPA CAP Chair's Column as always is creative, and motivating.

This issue also features an interview with Dr. Fukuchi regarding disaster psychiatry. This important topic has been neglected for too long, and we are very pleased to have it covered from a Japanese perspective. Dr. Gordana Milavić, co chair of the WPA CAP, highlights the Child Safeguarding WPA initiative. In 2014, Prof. Dinesh Bhugra, WPA President, initiated several initiatives, and now we plan to publish materials relevant to child and adolescent mental health.

In this issue we have two reports from the Middle East: one country-specific from the UAE and one related to Qatar-based WISH Foundation's global initiative. I hope our readers will enjoy reading other reports and brief articles on child mental health around the globe.

As always, I would like to thank all the authors in this issue and my editorial team: Prof. B. Leventhal (WPA CAP Chair), Prof. A. Guerrero (Assistant Editor, Hawai'i, USA), Dr. T. Hirota (Assistant Editor, USA/Japan), Dr. G. Milavić (Co-chair WPA, CAP, UK), Dr. Jibril Abdulmalik (Nigeria), A. Prof D. Fung (Singapore), Dr. M. B. Moyano (Argentina), Prof. D. Anagnostopoulos (Past Chair, WPACAP, Greece), Dr. M. Tateno (Japan), Prof. S. Malhotra (India), Prof. S. Honjo (Japan), Prof. P. Szatmari (Canada), Prof. L. Viola (Uruguay), Prof. S. C. Cho (S. Korea), Prof. D. Puras (Lithuania), Dr. V. Storm (Australia), Dr. J. Fayyad (Lebanon), Dr. S. Tan (Malaysia), Dr. N. V. Tuan (Vietnam), Prof. P. Joshi (USA), Prof. A. Sourander (Finland), Prof. E. Belfort (Venezuela).

Happy readings!

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



<http://www.wpanet.org/>

N_Skokauskas@yahoo.com



World Child & Adolescent Psychiatry

ISSUE 10, May 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

Prof. Bennett L. Leventhal (USA)

Chair's Column:

"I've Got a Secret"



After a 5 year hiatus, I recently acquired a television. I am told by my patients and my own children that such an act was foolish and "so last century" as one no longer needs a TV to watch movies, sports, the news or even old television shows. One of these old shows was "I've Got a Secret," which was popular in the United States in the 1960's and re-created as late as 10 years ago, along with similar programs that enjoyed international success in Australia, Japan, and the UK. The show involved a celebrity panel asking questions of a "contestant" in order to guess their "secret"; if the contestant "stumped" the panel, they won a prize. The humorous pursuit of a usually idiosyncratic "secret" was the entertainment value of the show.

For those who have read this far, you may be wondering what do my crass consumerism and an old television show have to do with Child and Adolescent Psychiatry? And, I must admit that it is a very good question. But, I am sure that you will not be surprised that I have determined that both have a great deal to do with Child and Adolescent Psychiatry.

Please consider for a moment that you are a guest on "I've Got a Secret." And, assume that your secret is that you are a professional who has completed many years of training and dedicated your life to a career in Child and Adolescent Psychiatry. Would the panel be able to correctly guess your secret? Sadly, I rather suspect that they would not. Is there a real chance that they would consider the possibility that psychiatric disorders are among the most prevalent ailments in childhood? What is the likelihood that they would guess that almost 50% of the world's population will have a psychiatric illness in their lifetime? Would they think to ask if 75% of these illnesses begin before the end of adolescence and if 50% begin before the end of childhood? Is there any real chance that they would realize that the vast majority of children in the world who have one of these disorders will face long periods, or a lifetime, of pain and suffering and that most will never be evaluated or treated? And finally, will they know that there are evidence-based treatments that can reduce psychiatric, medical and social morbidity associated with these illnesses? Because the answer to all of these questions is "no," there is good news and bad news. The good news is that if you were a contestant on "I've Got a Secret," you would have won the prize. The bad news is that the celebrity panel, along with healthcare providers and policy makers may never know your secret.

Why is there so much secrecy about Child and Adolescent Psychiatry, the children we provide care for and the illnesses that we treat? The reasons for this are manifold. Let's consider a few:

1. Small Number of Child and Adolescent Psychiatrists

While it is not entirely clear how many Child and Adolescent Psychiatrists there are world-wide, the estimate is something in the neighborhood of 20,000. If approximately one half of the world's six billion citizens are children and adolescents, then there is one Child and Adolescent Psychiatrist for every 300,000 youth.



World Child & Adolescent Psychiatry

ISSUE 10, May 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

Prof. Bennett L. Leventhal
Chair's Column (cont.1):

If the point prevalence of psychiatric disorders in children and adolescents is 20%, then each of us is responsible for the care of 60,000 patients before we can even think about preventive care. Currently, we cannot begin to meet the needs of all these patients. But, we could. However, because we are often secretive about what we need, the resources are unlikely to become available in the near future.

2. Maldistribution of Child and Adolescent Psychiatrists

Even in parts of the world where there are large numbers of Child and Adolescent Psychiatrists, there is a marked maldistribution in favor of large urban areas. As an example, despite the relative plethora of Child and Adolescent Psychiatrists in the US (some 10,000), there are many counties without a single Child and Adolescent Psychiatrist, and some children are as much as 5-6 hours from the closest one of our colleagues. At a global level there are many countries, especially but not exclusively in the developing world, with no Child and Adolescent Psychiatrists or less than a handful – these countries include the largest: China and India. As a consequence, if the clinicians are not there to identify psychiatric illness, then “it does not exist” and remains an invisible problem for the healthcare systems and policymakers.

3. Children and Adolescents are at Exceptional Risk

Child and adolescents are a unique population that is especially vulnerable to disasters along with social and economic upheaval. One half of the more than 300 million migrants trying to escape war and poverty are children and adolescents. As a result of this displacement, their health is in jeopardy, they are often victims of abuse and trafficking, and their development is irreparably damaged – due to lack of food, safe water, education, as well as the safety to play like children and develop. This burgeoning tragedy is increasing the need for Child and Adolescent Psychiatry, along with other professionals who treat psychiatric illness. If the resources are simply not there, then the unseen problems of trauma and developmental disruption go unnoticed except by the millions of suffering children and their families.

4. History of Secrecy and Isolation from the World of Medicine

Sadly, we have brought some of this isolation on ourselves with a long history of not integrating our clinical practices in the larger healthcare systems. We have created “secrets” by insisting upon separate medical records, while also whispering about who and what is being treated. We have kept secrets and encouraged our patients to keep secret by isolating our practices, our records and even our treatments from our colleagues.

5. Stigma

It is well-established that stigma and bias plays a major role in the secrecy of Child and Adolescent Psychiatry. In order to avoid the bans of stigma, we, along with our patients, have hidden with a feeling of shame about psychiatric illness. There is a misguided belief that if we hide psychiatric illness from the world, our patients and their families will be protected from stigma. That approach has not worked very well thus far. And besides, the presence of psychiatric illness in an individual is usually one of the worst-kept secrets. Being secretive does not mitigate stigma and bias; in fact, the converse is true



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

Prof. Bennett L. Leventhal

Chair's Column (cont.2):

6. We are Terrible Messengers

We, as Child and Adolescent Psychiatrists have done a terrible job of telling our story. We have been awful in helping our patients, families and communities understand the nature and treatment of psychiatric illness. And, we have done an even worse job of advocacy in the halls of government. Despite a few successful efforts, no one in the cancer or diabetes communities, for example, would tolerate the lack of services or, when they are present, the low quality of training, professional services and clinical resources that we "accept" for psychiatric illness. Our "secret" is denying resources for our practices while also denying our patients the care that they need.

I am sure that my colleagues (and hopefully, readers) can add much more to this list; I hope you will. But, before I move on, I must not skip my promised comments about "crass commercialism." In both affluent and developing countries, where there is a consistent, pressing need in the public sector, many of our colleagues choose to work solely in private offices or consultation rooms. All too many decline to see the poor and disenfranchised child and adolescent patients who so desperately need our care. Is this crass or practical? You must decide.

The time has come for us to decide if we want to keep playing "I've got a Secret?" I hope not. But, it is hard to bring an end to the silence and secrecy. What can we do? Oddly enough, it is not so hard:

- A. Join, support and be active in local, national and international professional organizations. Strength in numbers and shared resources will help us influence policy and create the tools to change our public image at a global and local level.
- B. Speak Up! A single voice can also be powerful. You must plan ahead and be prepared to talk about psychiatric illness in public settings, whenever there is the opportunity (at the dinner table, on an airplane, at social events) with the respect and dignity it deserves. Who can tell our story better than you?
- C. Help our colleagues, friends and the media create a sympathetic and compassionate image of children and adolescents suffering with psychiatric illness. Our children deserve the same empathy as those with cancer, diabetes and any other illnesses that afflict children. You have good and powerful stories to tell. Tell them!
- D. Advocate for our cause at every opportunity. Participate in political processes so that our patients get their fair share. Advocacy requires time and money, but if you are not seen and heard, then the needs of our patients and practice will not be seen and heard – they will be secret! You must advocate to be heard by those who set the policy.
- E. Educate yourself to be an up-to-date, evidence-based practitioner who is also a knowledgeable, skilled respected physician and full partner in healthcare for children.

Given my recent experience with my new television, I also suggest you consider watching television – you may choose other means to "stream" the content. You may begin with Paddy Chayefsky's 1976 film, "Network" in which broadcaster Howard Beale becomes frustrated with the callousness of the world. He bucks the system. It is time for us to have the courage to make our case just as loudly and clearly that the current approaches to child and adolescent psychiatric illness are no longer acceptable and to join Howard Beale in proclaiming:

"I am mad as hell and I'm not going to take this anymore."



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal



Interview with Dr. Nick Kowalenko

**The Chair, Faculty of Child and Adolescent Psychiatry,
Royal Australian and New Zealand College of Psychiatrists**

Many thanks for finding time for this interview. Could you please tell us a little bit about yourself? You have a Ukrainian surname, but you were born and raised in Australia?

Yes, my surname is Ukrainian.

Oddly enough most Australians didn't have a clue about the existence of Ukraine until the recent Russian annexation of Crimea. As a boy growing up I would tell my mates that I was Russian! At least I didn't have to explain where Ukraine was and why it was part of the USSR, but wasn't Russian, and the complex geopolitics that accounted for this (all a bit complicated when you are 10 years old). Once my Ukrainian father overheard me expressing my version of my identity to my peers and was quite horrified, and a little betrayed! My mother and sister were born in Germany and German is my mother tongue. I was born and raised in Australia. Unlike my peers, I always had two Easters: one Orthodox (Eastern rites) and one Western Christian (Roman rites). That meant a lot of eggs! Wooden painted ones, coloured ones and my favourite ones: chocolate!

I was a young boy in the 1960's during the Cold War. At school, my fellow students who knew about my parentage would rib me about having a Communist father and a Nazi mother! This led to my visceral understanding of the impact of name-calling. For a refugee family like mine, the realities of displacement and its shadows were never far away, even though my parents had chosen to come to Australia because it was as far as you could be from Europe!

How many child and adolescent psychiatrists are there in Australia, and what are the major challenges that the field is facing?

Of the nearly 5000 psychiatrists and trainees in Australia and New Zealand, 450 are child and adolescent psychiatrists, who are members of the bi-national Faculty of Child and Adolescent Psychiatry (FCAP).

There are 97 trainees currently undertaking advanced training. Major challenges in our field include:

(i) Health reforms that include changes in funding arrangements (Activity Based Funding) for inpatients, and major changes in the delivery of both specialist and primary mental health care services in the community (in public and private practice). (ii) Implementing high quality treatment universally, including quality prescribing in Paediatrics, General Practice and psychiatry. (iii) Advocacy for child and adolescent mental health where, although there have been advances for youth, similar progress has not been achieved for younger children's mental health needs. (iv) Evaluating the change to a competency based framework for training. (v) Leveraging population health strategies to achieve prevention and early intervention. (vi) Advocacy to address the impact on children of immigration detention.



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

(Interview with Dr. Kowalenko, Cont. 1)

What about academic child and adolescent psychiatry?

There are nearly 20 professors of child and adolescent psychiatry in Australia and New Zealand. Members of the Faculty of Child and Adolescent Psychiatry are exceptionally active in research and other academic activities. Although not an exhaustive list, the following areas were identified as the key areas of research for members of the Child and Adolescent Psychiatry faculty. Childhood disorders including Attention Deficit Hyperactivity Disorder, Eating Disorder, Juvenile Bipolar Disorder, Anxiety Disorders, Obsessive Compulsive Disorder, Tourette Syndrome, are some of the examples of disorder specific research being undertaken by FCAP members.

Developmental Psychiatry as well as Intellectual Disability and co-morbid Mental Health Disorders have received much attention with projects ranging from universal developmental surveillance for early identification of developmental and behavioural problems, to research into developmental disorders such as autism spectrum disorder. Consultation and Liaison Psychiatry topics with research focussing on unexplained somatic symptoms, conversion disorder, chronic pain, paediatric liver disease etc. have also been the focus of recent and ongoing research by members. Research projects in the context of inpatient settings have included the use of diagnosis in acute Child and Adolescent inpatient units, predictors of outcome following inpatient treatment, metabolic syndrome in young mentally ill patients on antipsychotic medication to name a few.

Early identification and treatment of early onset psychosis, gender identity issues, internet addiction, cyber safety and cyber bullying as well as educational methods for training and disseminating family focussed practice in the context of children of parents with mental illness (COPMI), mental distress among university students and psychiatric ethics etc. have also received research attention. In addition, a number of educational and training modules have been developed by members of the faculty and one such example is in the field of disability and co-morbid mental health. Several projects have focussed on the perinatal period including perinatal anxiety and depression, oxytocin, maternal sensitivity and infant outcome measurement development as well as e-health interventions for maternal depression etc. Community based projects have included suicide prevention, and determinants of health and wellbeing in adolescents in rural New South Wales.

Several members of the faculty have been involved in research examining interventions, and some of the examples include Family Skills Clinic, Emotion-based Social Skills Training (EBSST) for autism, Trauma focussed therapies, Family Therapy programs, combined pharmacological (SSRI Vs Placebo) and psychological (CBT) treatment for young patients with anxiety disorders, SSRIs in Autism Spectrum Disorders, Parent Child Interaction Therapy (PCIT) for disruptive behaviours in early childhood, Comprehensive Behavioural Intervention for Tics (CBIT), Acceptance and Commitment Therapy (ACT) program for children with anxiety disorders, Stepping Stones Triple P Project, Whole School Intervention for Adolescents with Behavioural and Developmental Issues, Early Start Denver Model (ESDM) in pre-school children with autism, Attachment based Cognitive Behaviour Therapy (A-CBT) for separation anxiety disorder, Circle of security model adapted for Aboriginal parents, an integrated care model for child and adolescent service provision to children attending special educational schools, collaboration with School-Link to provide health promotion and preventative programs including Cool Kids and Mind Matters etc.



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

(Interview with Dr. Kowalenko, Cont. 2)

Several neurobiological and neurocognitive projects are also under way including neuroimaging studies in autism as well as conduct disorder and eating disorders, in addition to research examining the genetic underpinnings of ADHD, autism, OCD, Tourette Syndrome, etc.

What about research and clinical services focused on the needs of indigenous youth?

Indigenous children and youth have poor mental health in Australia (Aboriginal and Torres Strait Islander peoples) and New Zealand (Maori peoples) with significantly higher rates of self-harm and completed suicide than their non-indigenous counterparts. They also experience considerably higher rates of mental disorders, child protection notifications and out of home care placements, incarceration in juvenile detention, trauma, poverty and poor educational outcomes.

There is a dearth of research into indigenous young people and their communities. This is beginning to change. Young indigenous people's mental health needs and experience of trauma is becoming better recognised in indigenous communities and mental health care is beginning to improve, although presentations often occur very late in the course of illness and there is considerable stigma.

There are training opportunities in mental health services that specifically address indigenous young people's mental health in Australia and New Zealand, although not very many. A number of indigenous child and adolescent psychiatrists, including some very distinguished ones, provide outstanding leadership. Our faculty has a child and family Aboriginal and Torres Strait Islander (ATSI) Committee that leads professional development. RANZCP has a reconciliation action plan to increase indigenous psychiatrist numbers.

Could you tell us a little about the training required to become a child and adolescent psychiatrist in Australia?

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) conducts training and exams for doctors wanting to qualify as psychiatrists. The psychiatry training program takes a minimum of 5 years full-time training. In the final 2 years, trainee psychiatrists can choose to undertake a Certificate of Advanced Training in child and adolescent psychiatry and undertake a series of supervised training placements in inpatient and community settings. The College also oversees training and accreditation for overseas-trained psychiatrists who wish to work in Australia and New Zealand. Once such accreditation is achieved, and comparable recognised advanced training is certified, membership of our faculty is available.

What kind of influence have your colleagues had on nearby island nations?

In the western Pacific, some islands are as big as continents but most are small island nations. In our vicinity there is an extraordinary diversity of nearby island nations, both in the Western Pacific, in the Indian Ocean and to our North.

In 2013, my colleagues in Melbourne invited Professor Olayinka Omigbodun to Australia and took this opportunity to hold a two day meeting (modelled on IACAPAP's Study Groups) with CAMH leaders from seven (7) Pacific Island Nations, prior to our annual scientific meeting. Suzy Dean, IACAPAP's Oceania representative, enlisted strong and highly effective NGO support to enable delivery of our first ever Pasifika study group. Our colleagues from these low- and middle-income countries very strongly identified with the struggles and solutions they all encountered in addressing CAMH not only in their island nations but also in Nigeria! They identified very strongly with Olayinka's experiences!



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

(Interview with Dr. Kowalenko, Cont. 2)

In our bi-national faculty my New Zealand colleagues have a long history of providing CAMH services to their Maori and Pacific Island populations. In 2015, these links led to establishing a partnership with the Pasifika Medical Association and the Vanuatu Medical and Dental Association to hold our first annual scientific meeting in the independent Pacific Island nation, Vanuatu, alongside the Pasifika Medical Association Annual Meeting. We also delivered a two day Pasifika Study Group meeting for 21 professionals from 8 Pacific Island nations. Dr. Chia Granda, from Hawaii, assisted with a focus on trauma and recovery, as cyclone Pam had so severely damaged Vanuatu and its people only a few months earlier. In a number of Pacific Island nations, at least 50% of the population is aged under 19 years!

A one year volunteer pilot program is currently underway to clarify how best to support CAMH developments in Vanuatu through clinical supervision, education, regular practice support visits, mentoring and on-line conferencing. Our Faculty represents colleagues from diverse backgrounds. A number come from Sri Lanka and a group with strong ties to their homeland recently piloted a CAP training for adult psychiatrists there using some of the resources developed by Dr. Henrikje Klasen, and have also been using the MOOC. Planning for initiatives in Papua New Guinea and Fiji are underway.

While a consistent focus on the Western Pacific and Indian Ocean islands is recent, there have been pioneers over the past 30 years our College, in our Faculty, in the Pacific, Asia and globally, such as Francis Agnew (WPA, Oceania), Ernest Hunter, Marie Bashir, Victor Storm, Winston Rickards, Barry Nurcombe and of course Helen Herrman, who is well known to WPA members.

In Hong Kong on May 7 and 8, 2016, the Faculty held a conjoint conference with the Hong Kong College of Psychiatrists that attracted 70 participants, with half of these being psychiatrists and allied professionals in Hong Kong and half from Australia and New Zealand. Our Faculty will join the Asian Society for Child and Adolescent Psychiatry and Allied Professions this year to better network with our local colleagues. Our Faculty members and our trainees are excited about these developments, are training more in the region and are growing influence. We have much to learn in our neighbourhood.

Later this year, our bi-national conference will be held on another island (Australia's southernmost), Tasmania, with a theme of "The Geography of Childhood", September 30 – October 3. I welcome you all to our Annual meeting, join us and explore the beauty of Tasmania!



THE GEOGRAPHY OF CHILDHOOD:
How place maps the child's internal world

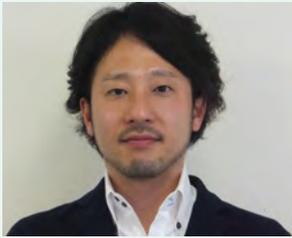
HOBART FUNCTION AND CONFERENCE CENTRE | 30 SEPT – 3 OCT 2016



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal



5 years after the 2011 Tohoku earthquake and tsunami /Disaster Psychiatry/

Interview with Dr. Naru Fukuchi

Dr. Fukuchi, first of all, thank you very much for agreeing to do an interview for "World CAP." It is our pleasure to interview you. Before we discuss details of your work in Tohoku region, Japan, could please tell us a little bit about yourself?

I initially started working as a paediatrician in the northern area of Japan. I was mainly engaged in the assessment of developmental problems in infants and young children. A few years following my career as a paediatrician, I changed my major to psychiatry and have since worked in the field of community mental health ever since. I also obtained a Ph.D. in Public Health for suicide prevention in rural areas of Japan. Shortly after the earthquake and tsunami in Japan in 2011, I went to the affected areas and provided mental health care for the victims. Since then I have been deeply engaged in the field of disaster psychiatry.

I am currently working in the Miyagi Disaster Mental Health Care Centre, the main facility that focuses on the care and the recovery of people affected by mental health problems caused by the Great East Japan Earthquake in 2011.

Could you please describe how the earthquake and tsunami in March 2011 impacted the city and the psychiatric hospital you were working at that time? Could you also tell us what your role was for the first couple of weeks and for the first couple of months, respectively?

At the time of the disaster in March 2011, I was working as a child psychiatrist in a hospital where I served as the chief psychiatrist in the child psychiatry unit. Despite the fact that the hospital was built just 4 years prior to the earthquake (and thus it was considered a new building), the damage due to the earthquake was so tremendous that a large part of the ceiling fell down and the water pipes were ruptured, leading to severe water leakage. I was relentlessly providing emotional support, and I continued treatment for 20 hospitalized children on the unit at that time. Because no information was available, children were not aware of this unprecedented disaster immediately following its occurrence, and they did not exhibit any signs of emotional disturbances. Along with serving as a physician, my other roles there were to provide them with accurate information and brief psycho-education and to contact their families.

After I confirmed that the number of inpatients requiring emergent/urgent medical and psychiatric care decreased, I decided to go out of the hospital to provide mental health care for people in the community. I joined the local support team and went around the disaster areas. We went to the evacuation sites and cared for survivors. We wore pink parkas to identify ourselves as mental support team members and approached them to offer mental health support, but they declined our offer despite the fact that many of them obviously seemed upset and confused due to this disaster. We did not realize that there was this degree of stigma against mental health services. We took off our pink parkas the next day and cleaned the floors of evacuation sites so that people in the community could trust us and reduce their resistances to access to mental health services when required. Most of the evacuation sites were school gyms. There were some children who gathered nearby the power outlets at the evacuation sites and who played portable video games all day.



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

(Interview with Dr. Fukuchi, cont.2)

They were mostly playing fighting games. I tried to talk to them, but most of them did not pay much attention or even look at me. After many visits, they slowly opened up to me and their attitudes changed. They told me that their parents were away to take care of their damaged houses and also that their parents were very busy getting the official documents required for financial support from the government. I thought children could not find anything to make them feel safe while parents were unavailable and they thus seemed to be trying to escape into the virtual world. They seemed to be fighting with monsters just as they were struggling to survive.

My role for the first couple of weeks was connecting survivors with mental illness to medical institutions and giving survivors appropriate psycho-education. A couple of months later, my role changed. I started to assist supporters who did not have knowledge of mental health. I also began managing the Miyagi Disaster Mental Health Care Centre, the new facility that could provide people in the community with mental health services in the long run.

Please tell us what psychiatric problems, symptoms, and diagnoses you saw during those periods? What were the challenges and obstacles in providing mental health support/care? How did you deal with them?

We found some people who had mental health problems prior to the disaster and who had not been receiving appropriate treatment. For example, they were socially withdrawn due to an autism spectrum disorder or due to negative symptoms of schizophrenia. In some of the communities affected by the earthquake and tsunami, families of these individuals were ashamed of them and tried to hide them in their houses. Many of them, therefore, received no mental health care. However, given that all residents, including these individuals, had to escape from the affected areas to survive, they ended up evacuating to the school gyms and appearing in public. Most of them eventually returned to their destroyed houses or escaped in their cars due to their difficulties engaging with people in the community.

According to our data, the number of residents who started showing signs of mental disorders, including schizophrenia and depression, shortly following the disaster and who received our support, increased considerably right after the disaster. Residents who did not initially show psychiatric symptoms and who tried to endure their painful situation started exhibiting depressive symptoms a few years following the disaster. The number of clients who have had depression after the disaster has been increasing these days.

The rural areas were most heavily affected due to this disaster, where insufficient medical institutions and public awareness of mental health disorders existed. Due to this lack of awareness, residents in these areas had strong stigma against mental illness and tended to refuse conversations with regards to mental health. To overcome this challenge, we attended local events, such as agricultural events and festivals, to understand the culture of the community, and then, through these events, we could have opportunities to speak on mental health problems related to the disaster. We also arranged several social gatherings for the residents, including tea parties, cooking events, and mah-jongg tournaments, where we attempted to provide them with opportunities to learn about mental health problems.

Would you be able to describe the differences in psychiatric signs, symptoms and problems that you currently see five years after the disaster in comparison with ones you encountered during the acute and sub-acute phases of the disaster?

I met many individuals who talked about their emotional experiences at the evacuation sites. They vividly



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

(Interview with Dr. Fukuchi, cont.2)

described their experience in forceful tones. In hindsight, I think they were in a hyperarousal state at that time due to emotional trauma. Traditionally, following their belief that affecting others by showing emotions is rude, Japanese tend to hide their emotions. They often are not willing to speak to others about their experiences and their feelings, even though they have just experienced tragic accidents or disasters. Although huge numbers of residents were affected by the disaster, we were challenged by the fact that most people did not desire to seek help from medical and psychiatric facilities. Younger elementary school children started opening up and speaking about their experiences a few years after the disaster. Their parents and teachers became surprised by this fact, because these children were preschoolers who could not fully express their feelings in the moment of the disaster because of their lack of verbal abilities. At that time they instead showed behavioral problems, including excessive crying and enuresis. I think the process of speaking to mental health professionals is important for these children to deal with their experiences and the associated emotional trauma.

Could you please describe your current work and future projects you would like to accomplish at the Miyagi Disaster Mental Health Care Center?

I would like to put my efforts in support of children, since they bear the future in the disaster affected areas. Although there are several ways to support their well-being, I think providing psychoeducation with the aim of enhancing their resilience is most important of all. If they could appropriately acquire healthy coping skills and subsequently adapt to any stress caused by the 2011 disaster, they would likely cope well with future potential difficulties and challenges. We have been consistently holding workshops for high school students in some cities located in coastal areas where the earthquake and tsunami hit in 2011. These workshops include discussions about how to rebuild their cities, lectures about how to cope with stress, and relaxation technique practice sessions. We also have been holding outdoor camp activities for elementary school children. For safety reasons, the camping facility is not located in coastal areas. The camping programs include cooking, outside play, group talks, campfire experiences, and psychoeducation on disaster mental health. We use traditional Japanese toys, such as "picture story" and "blowing pipe," for psychoeducation. The psychological burdens on children following camp participation seem to be reduced, suggesting that these activities might be useful for improving the psychological well-being of children who experienced the 2011 disaster.



Nawatobi in camping



Psychoeducation session



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal



SAFEGUARDING CHILDREN AND ADOLESCENTS: Progress Report of the WPA Child and Adolescent Task Force

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

At the September 2014 XVI World Congress of Psychiatry in Madrid, WPA President Professor Dinesh Bhugra established children and adolescents' well-being and protection from abuse as one of his main priorities for his forthcoming presidency. Child abuse prevention is a global moral and economic priority, and the WPA CAP Scientific Section has focused, in the past year, on developing a policy document that will transcend regional and cultural boundaries and that may serve as a blue print for both practice and policy. I am pleased to report on the WPA CAP working group's progress on child protection and safeguarding. The working group, jointly led by the WPA CAP Scientific Section and the American Association of Child and Adolescent Psychiatry (AACAP) with the enormous help of Immediate Past AACAP President Professor Paramjit Joshi, gained momentum following the October 2015 AACAP Meeting in San Antonio. Top specialists in the field of child abuse and violence, Judith Cohen (Professor of Psychiatry, Allegheny Health Network, Drexel University College of Medicine, Pittsburgh) and Jeanette Scheid (Associate Professor, Department of Psychiatry, West Fee Hall, Michigan State University) - both of whom are actively involved in developing and maintaining AACAP's Child Abuse Resource Centre - agreed to guide the working group and to help develop resources encompassing the objectives set out for the WPA CAP task force. Professor Bennett Leventhal and his Department at the University of California, San Francisco (UCSF), have involved Chuan-Mei Lee, MD, MA, Child and Adolescent Psychiatry Fellow at UCSF, who has been working hard at collating already available materials from different parts of the world.

WPA CAP endorses and promotes the principles of the UN Convention on the Rights of Children and specific legislative frameworks - where they exist - aimed at child safeguarding. More specifically, the task force's main objectives include defining general concepts and nomenclature, raising awareness across different cultures and regions, describing the impact on development and mental health, and making broad recommendations for practice and policy. Lessons learnt from countries where child safeguarding has gained legal and practice prominence need to be shared so that mistakes can be avoided and successful policy making and practice can be implemented. The working group plans to present their final results at the WPA Regional Congress in Cape Town in November 2016. More recently, Milica Pejović-Milovančević, Associate Professor at the Institute of Mental Health and University of Belgrade, Serbia and Professor Suaad Moussa, of the University of Cairo, Egypt, have joined the international collaborative group. They will present findings from their respective countries and describe their experiences implementing new policies and procedures where none had previously existed. WPA CAP Section, with the WPA's help, will take on the role of consulting and seeking endorsement from its members and disseminating the resources. The CAP Section will commit to the implementation of policies and recommendations outcomes through their regional representatives. If you are interested in contributing to the task force's work, please contact Dr. Gordana Milavić, WPA CAP Co Chair at gordana.milavic@slam.nhs.uk. We look forward to hearing from you.



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal



Transforming Youth Mental Health Services in Canada: YouthCan Impact

Prof. Peter Szatmari MD

& Joanna Henderson PhD, Amy Cheung MD, Kristin Cleverley RN, PhD, Gloria Chaim MSW, Lisa Hawke PhD (Canada)

The objectives of this report are to provide a brief overview of youth mental health and addiction (MHA) services in Canada and to outline an example of an innovative model of Integrated Collaborative Care Teams (ICCTs) that might effectively address health system gaps. A focus on engaging and enlisting community partners in the process of system transformation is highlighted.

Recent work from the province of Ontario has found that the burden of disease associated with MHA disorders is more than 1.5 times the burden associated with all cancers and more than 7 times that associated with all infectious diseases. Mental health related presentations to the emergency department of general hospitals and in-patient hospitalizations has increased between 35-45% in the last decade while rates for non-mental health related conditions has been stable or declined over the same time period (Canadian Institute of Health Information 2015). The most common disorder requiring such crisis treatment is mood and anxiety disorders (CIHI 2015).

Wait lists many mental health services are between 3-9 months in the province of Ontario. Major contributors to that burden are the high prevalence of disorder, its early onset and long duration across the lifespan. Adolescence is a particularly vulnerable time for the development of mental disorders, which affect approximately 20% of this group. These disorders are also associated with considerable morbidity, mortality, and long term health care and personal costs. Approximately 90% of all ill-health in adolescence can be ascribed to mental disorders and 75% of all adult mental disorders start before age 16.

It is widely acknowledged that most youth do not receive evidence-based treatment in a timely fashion, resulting in substantial impairment, poor quality of life and disruptions to achieving developmental milestones. Two recent landmark publications on youth MHA care concluded that service capacity to this population is substantially limited by multiple barriers including lack of resources, restrictive access criteria, distance, and being open in the evening and weekends. As a result, only 25–30% of youth with MHA disorders access specialized treatment.

We recently conducted a series of interviews with key informants, including youth and parents, enquiring about their current experiences of the MHA system and their thoughts about a “developmentally sensitive” system.



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

(CAP in Canada cont.1)

Significant gaps and barriers to engagement of youth in accessing mental health and addiction services were identified as prime reasons for lack of engagement as well as personal experiences that suggest that services for this demographic are not “youth friendly”. We also learned from our interviews with youth and their families that the MHA system is characterized as fragmented into sector silos, under-resourced, inefficient, and unresponsive. This creates a significant crisis of access and engagement for youth needing developmentally-sensitive, youth-oriented MHA services.

It seems that the very people who would benefit most from early intervention are perhaps the least well served by Canada’s current MHA system. There is a clear recognition that a radical transformation of the MHA system for youth in Canada is urgently needed.

This crisis is not due to a lack of research evidence on effective treatments. On the contrary, the last decade has seen a plethora of new, methodologically rigorous randomized control trials on effective MHA interventions for youth (12-25 year of age). Few of these interventions however have been evaluated as part of an integrated “system of care”, effectively bringing together these elements into a more complex psychosocial intervention. On the other hand, such models do exist elsewhere (Hespey in Australia) but these have not been evaluated using methodology appropriate for clinical trials. The critical problem lies with inadequate evaluation and implementation of effective evidence-based systems of care focused on a broad range of MHA challenges working effectively across multiple real world settings.

There appears to be wide-spread agreement that access to community-based collaborative care models in a space designed by youth themselves is crucial. Coming to hospitals or mental health clinics carries a stigma for youth that reduces the possibility of access and engagement. Accordingly, working with youth, families, and diverse hospital and community partners we have developed and implemented an Integrated Collaborative Care Team (ICCT) model which consists of several linked components: a walk-in community-based clinic that serves as the focus of a “one-stop shop for MHA services; access to primary health care; the use of multiple mental health mobile apps employed with clinician support; peer support; case navigators; family skills and support groups; and clinician-guided (high-intensity) interventions for high risk clinical situations— all co-located in a youth-friendly space. This community based stepped-care model (called YouthCan Impact) is expected to increase access to timely, evidence-based mental health services and will in an integrated manner ensure continuity of care – thereby improving youth and family outcomes (including symptoms and functioning) – as well as perform better as a system with lower costs.

One of the lessons that we have learned about the process of addressing these system gaps is the importance of recognizing local service configurations and constraints as we designed the service. The ICCT represents a partnership between several hospitals and community agencies using their own resources to participate in the model. Encouraging partners to join a common culture while at the same time respecting their unique strengths has required careful consideration. In addition, finalizing standardized pathways of care and standardization of measures to guide clinical decisions and outcome measures has taken some time to consolidate. Finally, we have recognized that the perspectives of parents and youth are sometimes different and that both need to be incorporated. Despite these challenges it has been possible to integrate these diverse perspectives into a single model. We are currently evaluating this ICCT model in a randomized control trial model comparing change in levels of impairment, symptoms, parent and youth satisfaction and cost-effectiveness to standard out-patient care.



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal



Child and Adolescent Psychiatry in the United Arab Emirates (UAE)

Dr. Ahmad Mohammed Al Mai (UAE)

Development of Services

In 1971, six of the emirate states united in a federation and became known as the United Arab Emirates (UAE), subsequently joined by Ras Al Khaimah in 1972. Since then, the UAE has made enormous progress in the development of an impressive health care system. Early on, the need for psychiatric care became clear, and, in many areas, services were slowly established under a federal system, primarily as departments within general hospitals. Over the past 15 years or so, the demand for children's psychiatric services became ever more apparent. Initially, limited-scope child and adolescent psychiatry services were only offered within public hospitals' general psychiatry departments. There were no available training programs for child mental health professionals, so providers were recruited mostly from Europe and North America. As the demand for child and adolescent psychiatry services increased exponentially, both government and private entities responded with a recognizable expansion of treatment programs. Though still in its infancy, child and adolescent psychiatry is rapidly developing within the region. The general public and the government continue to focus on the significant numbers of children with developmental disorders, autism spectrum disorders, attention deficit hyperactivity disorders and early childhood psychiatric disorders. In many of the Emirates, increasing numbers of centers offer services from specialty-trained professionals. In addition, several facilities, including the renowned Zayet Higher Organization in Abu Dhabi, cater to children with intellectual disabilities and physical handicaps. However, inadequate numbers of child psychiatrists and limited collaboration between public and private entities hinder the delivery of larger scale comprehensive services.

While currently there are no child and adolescent psychiatric inpatient units, new dedicated pediatric hospitals like Jalila in Dubai and Danat Al Emarat in Abu Dhabi have plans to develop specialized child and adolescent psychiatric services and possibly inpatient units. The Department of Child and Adolescent Psychiatry (CAP) is a division of the Sheik Khalifa Medical City Behavioral Science Pavilion (BSP), which is UAE's largest psychiatric healthcare facility, with 125 inpatient beds, subspecialty (including child and adolescent) psychiatric services, and a full complement of multidisciplinary services, but no child inpatient unit. Adolescents can be admitted under stringent circumstances. There are plans to open satellite clinics in primary care or ambulatory care facilities.

Development of Psychiatry Education and Training

The UAE is a member of the Arab Board of Medical Specialties. The Arab Board for General Psychiatry was created in 1992 to establish the guidelines for residency training programs and board certification in that



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

(CAP in UAE cont.1)

specialty. Significantly, there was an absence of any accredited child and adolescent psychiatry training programs and little consistency in any training available. Therefore, the child and adolescent psychiatrists currently practicing in the Arab countries received training in North America or Europe.

In late 2014, at the recommendation of the Arab Board President, a committee for creating the child and adolescent psychiatry subspecialty fellowship was formed. One subcommittee created the standards and guidelines for training and accreditation, and the second subcommittee set board certification examination standards. Over an 18-month period, committee members hailing from differing training backgrounds were tasked with establishing standardized guidelines and credentialing criteria that were eventually approved by the President of the Arab Council for Medical Specialization. Subsequently, regional training institutions were invited to apply for accreditation. Subspecialty program candidates must be board certified in general psychiatry after completing accredited residency training. The child and adolescent psychiatry fellowship is a two year program, after which the candidate must pass all three exam sections (written, oral, and clinical) in order to achieve board certification.

Development of Public Awareness and Professional Collaboration

In recent years, child mental and behavioral health professionals have made significant strides towards increasing public awareness. Culturally, there is still some stigma surrounding mental health issues, and professionals may be limited in their ability to mandate treatment when mental health needs are identified. There has been significant exposure centered on "Wadeema's Law" following the brutal death of an 8 year old girl at her parents' hands. This tragedy led to the establishment of child protection and mandated reporting laws and greater cooperation between educators, healthcare professionals and law enforcement. The media – via regular television offerings – regularly covers child mental and behavioral health issues and provides public awareness announcements indicating where parents can seek information and treatment for families and children.

On a professional awareness level, the Gulf Child Mental and Behavioral Health Society was established in 2014 to unite professionals in the field and to provide an opportunity for members to collaborate on regional, national and international research and developments.

The UAE has become a popular destination for medical conferences, and over the past 4 years there has been an annual International Child Mental and Behavioral Health Care Conference, which has grown exponentially. The most recent conference in January 2016 was the largest gathering of child mental and behavioral healthcare specialists outside of North America. Sponsored by His Excellency Sheikh Nayan Bin Mubarak Al Nayan, the conference has focused on a specific theme each year and has attracted an impressive lineup of keynote speakers and guest lecturers who are leaders in their field.

All in all, Child and Adolescent Psychiatry in the UAE is progressing towards an academically focused medical specialty guided by evidence-based best practices.



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal



Prof. Savita Malhotra
(India)



Dr. Susanta K. Padhy
(India)

Child and Adolescent Psychiatry in India

Thirty-one percent of India's second-highest-in-the-world population of 1.25 billion are children below 14 years. A quarter of India's population are adolescents, who in turn constitute 20% of the world's 1.2 billion adolescents. India has a rich heritage of philosophy, art, culture, tradition, and values and a considerable diversity of languages, religions, social practices, and levels of development across the country's regions. In addition, strong family systems, good social support, traditional child rearing practices, spirituality, and strong beliefs in ancient values and religion positively influence child and adolescent mental health and development.

However, low and middle income countries (LAMIC) are challenged by poverty and under-nutrition, unemployment, poor obstetric care, high antenatal and perinatal mortality and morbidity, high infant- and under-five mortality and morbidity, epilepsy, and brain infections and unfavorable social indices such as high prevalence of child labor, child marriage, child trafficking and prostitution, low human development index, domestic violence, and physical and sexual abuse. Less than 25% of children and adolescents with psychiatric disorders receive any treatment at all, and the World Health Organization (WHO) estimates an overall treatment gap of more than 90% for child and adolescent psychiatric disorder. Child and Adolescent Psychiatry in the country has had a slow beginning, followed by troughs and triumphs in the post-colonial era.

PRE-MILLENNIUM Era (BEFORE 2000):

The Tata Institute of Social Sciences in Mumbai founded India's first child guidance center (CGC) in 1937. Subsequently, the Indian Council for Mental Hygiene founded additional CGCs, including schools and residential homes for youth with intellectual disability, in big cities. In the 1950s a few medical colleges responded to the country's needs for child and adolescent psychiatric care. In 1956, Dr. Erna Hoch, a Swiss psychiatrist trained in the existential tradition, established child psychiatry at Nurmanzil Psychiatry Center, Lucknow. During this period, there was considerable importance given to Hyperkinetic Syndrome of childhood. IN 1957, All India Institute of Mental Health (now called National Institute of Mental Health and Neurosciences, or NIMHANS) established a CGC and focused on children with Autism Spectrum Disorder features. In 1969, our center, the Postgraduate Institute of Medical Education and Research (PGIMER), Chandigarh, opened a CGC in a general hospital psychiatric setting and aimed to offer comprehensive management to children with psychiatric disorders. Thereafter, Non-Government Organizations led a further expansion of CGCs in the country. Until 2003, there were a total of 164 child guidance clinics mostly located



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

(CAP in India cont.1)

in large metropolitan cities, managed by a meager professional and paraprofessional staff numbering approximately 400, and offering services that varied in scope and coverage.

Policy and Programs: At the national level, in 1972, the Government of India (GOI) formulated the Integrated Child Development Scheme (ICDS) as its flagship program, with objectives a) to improve the health and nutritional status of children age 0-6 years, b) to lay foundations for psychological, physical and social development of the child, and c) to reduce infant and child morbidity, mortality, malnutrition, and school drop-out. Two years later, the GOI formulated the National Policy for Children, which aimed for: protection of children against neglect, cruelty, and exploitation; prohibition of less-than-14-year-old children's employment in hazardous occupations; establishment of facilities for special treatment, education, and care of children with physical and mental challenges. In 1982, the National Mental Health Program (NMHP) was launched; while it did not directly address child mental health issues, included social development as one of its objectives. In 1983, the National Health Policy envisaged building of child and maternal health facilities and provision of school health services as important tasks, with equal emphasis on preventive and curative aspects. In the latter half of the 1980s, the GOI promulgated the National Policy on Education and Child Labor (Prohibition and Regulation) Act and Integrated Education for Disabled Children Program. In 1986, the Juvenile Justice Act provided for the care and protection of abandoned, neglected and delinquent children. In 1999, the National Trust Act, an act for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities, aimed empower persons with disabilities to live as independently as possible within the community. These programs' impact was not entirely satisfactory, however, due to many reasons, including deficient implementation and lack of coordination and monitoring.

Training and Research: In 1980, the Indian Council of Medical Research (ICMR), the national statutory body to support and regulate medical research in the country, identified Child Mental Health (CMH) as a priority research area and supported the first multi-centric study on clinic-based epidemiology of child and adolescent psychiatric disorders in India. ICMR reaffirmed support for child and adolescent psychiatric (CAP) research in the eighth five-year plan of the GOI. In 1983, WHO developed four manuals – specifically tailored to India – on Child Mental Health and Psychosocial Development for primary care physicians, primary health workers, teachers, and workers in children's homes. Subsequently, in the mid-1980s, the Indian Psychiatric Society (IPS) formed a Child and Adolescent Psychiatric (CAP) specialty section and organized regional and local continuing medical education (CME) workshops, trainings, and seminars. In 1988, the First National Level Workshop in CAP was organized under the leadership of Dr. Savita Malhotra at PGIMER, Chandigarh. This workshop focused on India's child mental health needs and priorities, including forming a national society of child and adolescent mental health. In 1989, the National Institute of Mental Health and Neurosciences (NIMHANS) Bangalore conducted the 5th Indo-US Symposium on Child Mental Health. In 1991, the Indian Association for Child and Adolescent Mental Health (IACAM) was formed and registered as a professional society affiliated with the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP). Subsequently in 1992, the National Academy of Medical Sciences (NAMS) identified CAP as a specialty, supported national-levels CMEs in the subject, and formulated structural guidelines for the specialty. These developments paved the way for systematic epidemiological and community-based research, socio-culturally relevant assessment instruments and methodologies in CAP research, and greater interest in training in India.



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

(CAP in India cont.2)

POST-MILLENNIUM Era (post-2000):

Accelerated growth occurred during this period. The IPS recommended and approved the reorganization of Child and Adolescent Psychiatry as a sub-specialty in India. In 2002, the NAMS recommended including the CAP fellowship in the National Board's subspecialty courses. Certain centers excelled in child psychiatry training and research, including the NIMHANS in Bangalore; the PGIMER in Chandigarh; the Central Institute of Psychiatry (CIP) in Ranchi; King George Medical College (KGMC) in Lucknow; Christian Medical College (CMC) in Vellore; and Niloufer hospital in Hyderabad. The services at PGIMER and CMC Vellore were integrated with general psychiatric and pediatric services, whereas NIMHANS, Bangalore provided comprehensive care in a mental hospital setting. In 2002, the PGIMER Department of Psychiatry's organizing of the IACAPAP International Congress in New Delhi increased child and adolescent psychiatry's visibility in public and government circles. A greater number of psychiatry departments in institutions or medical colleges, both in government and private sectors, began to establish separate facilities for children's mental healthcare. The Medical Council of India now mandates all psychiatry departments offering the MD in general psychiatry to have child psychiatry services.

In due course, the number of postgraduates showing special interest in child psychiatry by taking up research or optional postings increased. In 2011, NIMHANS Bangalore established the first Doctor of Medicine (DM) subspecialty three-year course in Child and Adolescent Psychiatry, and in 2014 PGIMER Chandigarh did the same. NIMHANS Bangalore and CMC Vellore subsequently began one-year Post-Doctoral Fellowship (PDF) courses. In 2003, India participated in the WHO Child Atlas Project. India's research in the areas of temperament and acute and transient psychosis received global recognition. At the same time, high-quality research in epidemiology, childhood-onset schizophrenia, development of India-specific psychometric instruments, affective disorders and pervasive development disorders influenced further growth of the discipline.

India progressed in computer and mobile technology and became a world leader in information and communication technology. Keeping pace with this development, Dr. Savita Malhotra and her team recently developed a model telepsychiatry application for providing mental health care in remote areas in the three hill states of North India. This application is a knowledge-based decision support system capable of diagnostic and management support to non-experts. It has tremendous potential to empower non-specialists to diagnose and treat child mental health disorders in the community with minimal supervision from the expert specialist.

Policy and Programs: In 2003, the National Mental Health Program (NMHP) was re-strategized, with inclusion of a school mental health program (SMHP) in its agenda, although SMHP is yet to show a nationwide impact. In 2009, India became one of 135 countries worldwide to make education a fundamental right of every child. While India's Constitution provides children ages 6-14 years the right to a free and compulsory education, providing all children with universal education supported by adequate infrastructure is still a distant dream.

Manpower: At present, there are about 4000 general psychiatrists, and only less than two dozen qualified child and adolescent psychiatrists for India's children and adolescents, who constitute nearly 50% of the total population of 1.25 billion. The number of adult psychiatrists who practice significant child psychiatry will



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

(CAP in India cont.3 and CAP in the US)

likely not exceed 200 for the whole country. There are currently only three centers for subspecialty training in child psychiatry. Child psychiatry training in general adult psychiatry and pediatric training is grossly lacking.

CAP as a specialty is significantly challenged by the gross shortage of child and adolescent psychiatrists and child clinical psychologists, social workers, and special educators; unequal distribution of resources; lack of public awareness about child mental health issues; difficulties in accessing care; unavailability of country-specific, effective, and evidence-based intervention models; and absence of a unified comprehensive policy and funding resource.

Some of the conventional solutions include creating supplementary resources to strengthen and increase manpower and opening of subspecialty services and teaching courses in Child and Adolescent Psychiatry. However, integrating child mental health services with some of the other, better established services such as general psychiatry and pediatrics and using newer technologies and paradigms like telepsychiatry could prove to be more effective solutions in the longer term. Overall, there is a strong need for advocacy, coordination, strengthening of Child and Adolescent Psychiatry services and training, and preventive child mental healthcare.



An Update from Hawai'i, USA

Prof. Anthony Guerrero (Assistant Editor; State of Hawai'i, USA)

Healthcare reform towards affordable healthcare is an important initiative in the USA. The State of Hawai'i has been ahead of the rest of the nation in terms of universal healthcare coverage via the Prepaid Healthcare Act of 1975 and recognition of the "medical home" (credited to pediatrician Dr. Calvin Sia) in providing for early detection and intervention.

However, not dissimilar from the rest of the nation, there have been challenges in child and adolescent mental healthcare availability and accessibility. These challenges led to the State's educational and child and adolescent mental health systems being under a federal consent decree throughout much of the 1990s and 2000s. In Hawai'i, there are also mental health disparities in particular affecting indigenous and other underserved youth in the diverse population.

Contemporary solutions to improve early access and intervention, in a system that involves both private and public insurance coverage, include expanded integration with primary healthcare and with schools, telepsychiatry, and culturally focused treatment programs.



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal



22nd World Congress of the IACAPAP

Dr. Chris Wilkes (Congress Chair, Canada)

On September 18 to 22nd 2016, Calgary, in Alberta, Canada, will host a joint meeting of the 22nd World Congress of the International Association for Child and Adolescent Psychiatry and the Allied Professionals (IACAPAP) and the 36th Annual Conference of the Canadian Academy of the Child and Adolescent Psychiatry (CACAP). An IACAPAP World Congress has not been in Canada since 1954, and this joint meeting – with over 70 countries represented – promises to be the world's most prominent meeting for child and adolescent mental health and psychiatry. The Congress, whose theme is "Fighting Stigma: Promotion of Resiliency and Positive Mental Health," will focus on policies addressing social determinants of health, including poverty and childcare, housing, and employment challenges; and will cover evidence-based best practice, education and research.

The Congress's opening will include a First Nations tribute. Canada has become increasingly aware of the harm done to many Aboriginal peoples around the world over the last 150 years. In Canada alone, forced cultural change, forced relocation, and residential schooling affected an estimated 150,000 children. In 2008, Canadian Prime Minister Stephen Harper created a Truth and Reconciliation Process Commission and officially apologized to our First Nations people. More recently, in 2015, the government made 94 recommendations to address the social inequalities, poverty, and service access difficulties faced by many of our First Nations people. Currently, Aboriginal male youths' suicide rate of around 124/100,000 is six times that of Non-Aboriginal males in Canada. So with the goal of opening new doors for healing for many Aboriginal and indigenous children and families around the world, key Congress symposia will address these issues of injustice and disparities.

According to the World Health Organisation, mental disorders account for 13% of the Global Burden of Disease. Between 10 to 20% of Canadian children and adolescents have a diagnosable disorder, but less than 25% ever receive appropriate treatment. Three times as many youth age 15 to 24 years die from suicide than from all forms of cancer combined. Congress distinguished congress keynote speaker Professor Pat McGorry from Australia will therefore discuss the importance of early intervention for major mental health disorders, including psychotic and mood disorders. As more than two-thirds of adults with mental disorders experienced onset of these disorders during youth, the care system is indeed challenged to develop policies and to deliver services optimally geared towards transitional youth between 16 to 24 years of age.

Congress distinguished congress keynote speaker speakers like Dr. Bruce Perry and others will address childhood adversity in a "trauma informed," eco-biodevelopmental framework and will emphasize the importance of healthy attachments and relational buffers in mitigating the effects of toxic life stress on genetic expression of disease throughout the lifespan. Such diseases include cardiac disease, diabetes, liver failure, cancer, and mental health and addiction problems. In short, the traumatic spectrum disorders emphasize that we are the metabolic end products of our sensory perception.



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

(IAACAP meeting in Canada, cont. 1)

It is expected that Congress participants will include a diverse variety of professionals, including psychiatrists, psychologists, social workers, nurses, teachers, occupational and recreational therapists, policy makers, governmental and non-governmental service managers, service users, and sponsors. The four-day Congress offers a diverse educational forum, including outstanding keynote lectures on the latest research policy developments, and related papers; as well as symposia, in-depth workshops and posters. Of course Calgary is the eastern gateway to the majestic Rocky Mountains, so there are many outdoor activities to be enjoyed at Calgary's Heritage Park and the nearby spectacular mountain resorts of Banff and Lake Louise. Please join us in this exciting and important educational event, where you will make new friends and see old colleagues.

IACAPAP 2016

FIGHTING STIGMA: PROMOTING RESILIENCY AND POSITIVE MENTAL HEALTH

The 22nd International Association for Child and Adolescent Psychiatry and Allied Professions World Congress
36th Annual Conference for the Canadian Academy of Child and Adolescent Psychiatry
Calgary TELUS Convention Centre | September 18-22, 2016 | Calgary, Alberta, Canada

*"As far as we can discern, the sole purpose of human existence
is to kindle a light in the darkness of mere being"*

– C. G. Jung



www.iacapap2016.org

Tourism Calgary



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

Autism Forum at the 2016 World Innovation in Health Summit in Doha Will Examine Policy Changes in Coping with Autism Spectrum Disorders

Dr. Kerim M. Munir (USA) and Dr. Muhammad Waqar Azeem (Qatar)

As chair and co-chair of the Autism Forum at the World Innovation Summit for Health (WISH), sponsored by the Qatar Foundation (www.WISH-Qatar.org), we are very pleased to announce the WISH 2016 conference being held on 29-30 November, in Doha, Qatar. WISH is a global initiative of the Qatar Foundation for Education, Science and Community Development (QF). It has evolved into a key platform for the dissemination of healthcare innovation and best practices worldwide.

In 2007, the United Nations representative from Qatar – Her Highness Sheikha Moza Bint Nasser Al-Missned (on the right), Consort of His Highness Sheikh Hamad Bin Khalifa Al-Thani – successfully proposed a United Nations General Assembly resolution creating “World Autism Awareness Day.” This day, recognized on April 2nd every year, now encourages all Member States to take measures to raise awareness about autism throughout the world. Further, on World Autism Awareness Day in 2016, the United Nations General Assembly convened an expert panel that emphasized that children and adults with autism and neurodevelopmental disorders have a special place at the heart of the United Nations Sustainable Development Agenda and implementation of the Sustainable Development Goals.



Her Highness Sheikha Moza Bint Nasser Al-Missned

The WISH Autism Forum will outline the opportunities and hurdles facing the struggles around autism spectrum disorder (ASD) today, spanning the most recent developments across various sectors, including education, medicine, and social policymaking. The Forum will present a global framework for action through evidence-based policy innovation, and will promote the adoption of effective health and education interventions that emphasize inclusionary and family-oriented care. The intent is to highlight specific actions for policy makers that can be adapted to local, national and regional contexts. A backdrop of global case studies across the health, education, and social sectors will also be presented. The goal is to raise awareness and enhance knowledge of ASD by understanding the cultural needs and barriers to best practices in order to facilitate development of shared therapeutic models.

Egbert Schillings, the CEO of WISH, emphasized that “Autism is a big, messy, complicated subject, especially when you factor in the panic that’s been unleashed by the spread of false notions of a link between the condition and childhood vaccines. While those debates continue to rage in certain circles, those affected are dealing with a completely different set of problems, which is that there are not enough services and resources for autistic people and their families.”



Lord Darzi of Denham

The Right Honourable Professor, the Lord Darzi of Denham, Chairman for the Institute of Global Health Innovation at Imperial College London, is the Executive Chair of WISH.



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

(WISH Autism, cont.1)

In addition to the Autism Forum, the WISH 2016 Summit will feature seven groundbreaking research forums that highlight and address some of the world's most pressing healthcare challenges. These include interdisciplinary, evidence-based forums on topics including Healthy Populations, Precision Medicine, Economic Benefits of Investing in Health, Cardiovascular Disease, Accountable Care and Behavioural Insights.

There are a number of additional promising ASD initiatives underway in Qatar. In 2015, a National Autism Working Group was created within the Ministry of Public Health. This group was comprised of stakeholders from around the country including child psychiatrists, developmental pediatricians, speech therapists, occupational therapists, psychologists, educators, administrators and, most importantly, family members. This group is charged with creating a National Autism Plan based on six pillars: awareness; early recognition and screening; diagnosis and assessment; interventions; school services; and transition to adulthood. The World Health Organization has collaborated closely with this group in finalizing the National Autism Plan, which will be launched at the end of 2016. The Qatar Foundation for Education, Science and Community Development is also planning to open a state-of-the-art school, the Renad Academy, for children with ASD. The Qatar Biomedical Research Institute (QBRI) is also currently undertaking the first ASD prevalence study in Qatar, which will help to better identify service needs in the country.

WISH is aiming to create tangible and long-lasting solutions in healthcare advocacy, policy, research and delivery. In keeping with this objective, the project is designed to build a network of health experts and to facilitate an interdisciplinary approach, as well as best practices that can transform healthcare policies and systems globally. We will look at ideas that are evidence-based, scalable, and sustainable and that have already been implemented somewhere in the world – and work out how to implement them far more widely.



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal



The Fourth National Congress of the Serbian Association for Child and Adolescent Psychiatry and Allied Professionals: The Look to the Future

Dr. Milica Pejovi Milovan evi (Serbia)

& Dr. Gordana Milavić (UK)

The Congress, entitled, "Mental Health of Children and Adolescents - The Look to the Future," was held on the magical mountain of Zlatibor, in the middle of Serbia, from May 12-16 2016. This Congress followed three very successful previous Congresses. This recent conference continued the tradition of excellent lectures in a great setting and included prominent invited professionals as well as Serbian colleagues. This year we were greatly pleased to hear lectures from Prof. Panos Vostanis (UK), Prof. Norbert Skokauskas (Norway), Dr. Gordana Milavić (UK), Dr. Vaska Stancheva Popkostadinova (Bulgaria), Dr. Tomislav Franic (Croatia), Dr. Vlatka Boričević Maršanić (Croatia), Dr. Hojka Gregoric Kumperescak (Slovenia), Dr. Nirvana Pistoljevic (Bosnia&Hercegovina), Dr. Branko Aleksic (Japan), and Dr. Marija Raleva (FYROM) and many others. More than 200 participants from Serbia and the region participated in the Congress, which included 17 plenary lectures, 11 symposia, one round table discussion, three workshops and two poster sessions. The Congress was organized with the full support of the UNICEF office in Serbia and had a special focus on early development and early intervention. Two workshops focused on early developmental assessment and evidence-based early intervention, especially for autism spectrum disorder.

In Serbia and the wider region, insufficient attention is paid to the children and youth's mental health issues. There is no systematic, comprehensive, or coherent research that contributes to understanding Serbian children and youth's mental health concerns. It is therefore very important that professionals working with children and adolescents enhance their professional abilities and improve their knowledge through continuing education. The Congress aimed to advance knowledge and skills in the field of children and young people's mental health and to facilitate exchange of experiences among experts from home and abroad. The Congress was also an opportunity for multidisciplinary and multisectorial collaboration around services organization and child and youth mental health policies.

The Congress began with a workshop dedicated to our leading teachers and professors who started child and adolescent psychiatry in Serbia. We presented pictures of interviews with Professors Nevenka Tadic, Ksenija Kondic and Svetomir Bojanin during the opening ceremony. All of the Serbian CAP community are their descendants and successors of their pioneering work.



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

(Serbian congress, cont.1)

The Congress continued to represent the whole Western Balkans region. Colleagues from Slovenia, Croatia, Bosnia & Herzegovina, Montenegro, Former Yugoslav Republic of Macedonia (FYROM), and Serbia presented the current status of CAP with regards training, services, legislation, etc. Congress participants agreed upon future research collaboration, professional exchange, and many other important activities. Given our common languages and shared experiences, we agreed that we must represent ourselves more robustly in international organizations and collaborations.

The Congress was a renewed opportunity to exchange our experiences and knowledge and a chance to collaborate with mental health professionals from abroad. It was also a good opportunity to have in-depth discussions on selected topics, to get to know each other better and to start new cooperative initiatives. We truly believe that our Congress was enlightened not only by new research and clinical expertise, but also by new contacts, friendships and collaborations. Participants also had the opportunity to enjoy Serbian cultural music and trumpet orchestras. We hope to continue our work on improving the child and adolescent mental health while promoting continuing professional education.



From left to right: Dr. Vlatka Boričević Maršanić (Zagreb, Croatia), Dr. Tomislav Franic (Split, Croatia), Dr. Jasminka Markovic (Novi Sad, Serbia), and Dr. Milica Pejović-Milovančević (Belgrade, Serbia)



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

AEPNyA/AACAP Congress (San Sebastián, Spain)

Prof. Bennet Leventhal (WPA CAP Chair, USA)

The combined AEPNyA/AACAP Congress took place in Donostia/San Sebastián Spain from 1-4 June 2016. Asociación Española de Psiquiatría del Niño y del Adolescente (AEPNyA) celebrated its 60th Annual Meeting, chaired by its President, Josefina Castro, while the American Academy of Child and Adolescent Psychiatry (AACAP) joined in this collaborative meeting. There were more than 700 colleagues from 32 countries around the world who shared in a rich series of presentations covering virtually all areas of child and adolescent psychiatry. The Congress took place in the unique environment of the Basque region of Spain and in the very special, beautiful city of Donostia/San Sebastián, the 2016 Cultural Capital of Europe. The AEPNyA/AACAP congress was co-chaired by J.Fuentes, MD and B. Leventhal, MD. The program included a clinical practicum on Mind-Body Interactions, three day-long courses (Psychopharmacology, Mood and Anxiety Disorders and Neurodevelopmental Disorders) along with State-of-the Science Lectures and Symposia. In addition, there were over 140 scientific posters presented by senior and junior faculty and trainees. Most sessions included colleagues from at least two countries in order to generate broader perspectives on the issues. Along with the formal presentations, there was ample time for colleagues from around the world to meet and share their ideas and experiences as well as engage in vigorous discussions.

There were 156 attendees from the US, and 91 of them were AACAP members. These numbers were consistent with overall registration, for which only 40% were members of either AEPNyA or AACAP.

Throughout the Congress, a unique set of events took place, called EUSKADI GazteChildren 2016. Chaired by San Sebastian native and WPA CAP member, Joaquin Fuentes, these were multiple sessions in which speakers from the AEPNyA/AACAP Congress donated their time to offer presentations on various issues in child and adolescent psychiatry to members of the Donostia/San Sebastián community. EUSKADI GazteChildren 2016 was open to professionals and parents, and simultaneous translation was provided into Basque, Spanish, and English so that it would be accessible to all. In addition to parents and professionals, community leaders and policy makers attended the sessions.

This meant that EUSKADI GazteChildren 2016 shared knowledge and skills with many stakeholders in the region and was a very successful program for advocacy and education. This generous and thoughtful contribution from our colleagues from around the world was much appreciated by those in attendance. We congratulate AEPNyA on its 60th Anniversary.

The AEPNyA/AACAP was a wonderful and enriching professional experience for all who attended the Congress and EUSKADI GazteChildren 2016.



From left to right: Dr. Young Shin Kim (USA), Dr. Gordana Milavić (UK) and Prof. Bennet Leventhal (USA)



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

The Japanese Society of Psychiatry and Neurology (JSPN) Congress "Psychiatry as a Global Startup: Japan and the World"

Dr. Ryan Louie (USA)

The Japanese Society of Psychiatry and Neurology (JSPN) welcomed a world of psychiatrists to their 112th Annual Meeting, held on June 2 - 4, 2016 at Makuhari, Japan. As a Psychiatry Resident from the United States, I express my sincere gratitude to JSPN Congress President Dr. Kazuhiko Nakayama, JSPN President Dr. Masatoshi Takeda, and the JSPN staff for providing me and fellow international colleagues with the wonderful opportunity to participate as a JSPN Fellowship Award recipient.



The Meeting was a most unique and meaningful experience, with a group of international psychiatrists from around the world gathering together with colleagues from Japan. The Fellowship Award Symposia consisted of two main topic tracks: Women's Mental Health, and a Case Vignette on Taijin kyofusho (Interpersonal Fear Disorder). Each presenter enlightened the audience with highlights of both similarities and differences in mental health issues among their countries. Members of the Japan Young Psychiatrists Organization (JYPO) led by President Dr. Toshitaka Ii, and Dr. Ryoma Kayano from the WHO Centre for Health Development, facilitated stimulating discussions and collaborative brainstorming with the international participants. Symposia question-and-answer sessions, small group discussions, social gatherings, and an Awards Ceremony provided diverse settings to meet new colleagues and exchange ideas. At the conclusion of the Meeting, Drs. Hidehiro Oshibuchi and Toshiko Kamo of the Tokyo Women's Medical University gave presentations and tours of their Department of Psychiatry and the Institute of Women's Health.

From a personal perspective, I gained new knowledge and new inspiration from this JSPN gathering of psychiatry colleagues from Japan and around the world. In my presentation, titled "Women's Mental Health in the United States: Examples from Academia and Workplace Psychiatry using a "Startup Thinking Model," I combined my interests in the psychiatry of entrepreneurship and women's mental health and academia, to demonstrate that the pathway towards positive change for current issues in the United States (and elsewhere) happens when dialogues cross-over between traditional boundaries of thinking. Mental health, startups, and academia all share a common narrative in regards to women: that the challenges and opportunities faced in each field can serve as teachable moments for each other to build upon. Commonalities spanning across disciplines include issues such as gender inequality, funding and pay gaps, stereotypes and role expectations, stigma, and the need for more women mentors.

The Startup Thinking Model begins with empathy, followed by learning across cultures and fields, leading to innovation and action. The conversations generated at the Meeting provided the seed and the momentum for future new collaborations for starting up.



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

(Meeting Report: JSPN Congress, cont. 1)

The World Psychiatric Association, Child and Adolescent Psychiatry Section (WPA CAP), held a session on international perspectives on CAP training and service organization (see photo below).



From left to right: Dr. Masaru Tateno (Sapporo, Japan), Prof. Norbert Skokauskas, WPA CAP Secretary General, (Trondheim, Norway,) Prof. Masatoshi Takeda, WPA Secretary for Scientific Meetings, (Osaka, Japan), Prof. Taku Saito (Sapporo, Japan), Dr. Takahiko Inagaki, (Shiga, Japan) and Prof. Anthony Guerrero, WPA CAP, Assistant Editor (Honolulu, USA)

The 112th Annual Meeting of the Japanese Society of Psychiatry and Neurology succeeded wonderfully with their theme of "Psychiatry - Honest and True - Pilgrimage to the Origin". With the leadership of the JSPN and the World Psychiatric Association fostering new idea exchange, collaborations, and expanding the network of globally-minded psychiatrists, I am excited about new possibilities and innovations for psychiatry. To understand each of our own countries and the diversity of mental health challenges, we travel and exchange knowledge internationally, so that our true origins create a new unified source to share, to inspire, and to thrive.



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

Special ECAP (European Child + Adolescent Psychiatry) issue

A special issue is being prepared of the official ESCAP journal, European Child + Adolescent Psychiatry (ECAP) on epidemiological, diagnostic, treatment and prevention aspects of mental health problems in child and adolescent refugees.

The journal is now calling for papers for this issue.

Potential authors/investigators are requested to contact one of the guest-editors, all representatives of the ESCAP young refugee initiative:

Dimitris Anagnostopoulos, Athens – dimitris1952@gmail.com

Matthew Hodes, London – m.hodes@imperial.ac.uk

Norbert Skokauskas, Trondheim – n_skokauskas@yahoo.com

This ECAP special issue follows up a first assessment of the needs of young refugees arriving in Europe, published in January 2016, titled What mental health professionals need to know.

The 113th Annual Meeting of the Japanese Society of Psychiatry and Neurology

Date June 22 – 24, 2017

Venues Nagoya Congress Center

President Prof. Norio Ozaki (Nagoya University Graduate School of Medicine)

The Japanese Society of Psychiatry and Neurology, Hongo Yumicho Bld.5F, 2-38-4, Hongo, Bunkyo-ku, 113-0033, Tokyo E



World Child & Adolescent Psychiatry

ISSUE 10, June 2016

WPA, Child and Adolescent Psychiatry Section's Official Journal

World Child & Adolescent Psychiatry

WPA, Child and Adolescent Psychiatry Section's Official Journal

Editor: Prof. Norbert Skokauskas (Norway) N_Skokauskas@yahoo.com

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

Editorial Board: Prof. Bennett Leventhal (Chair, WPA CAP, USA), Dr. Gordana Milavic (Co-Chair, WPA CAP, UK), Prof. Dimitris Anagnostopoulos (Past Chair, WPA CAP, Greece), Prof. S.Malhotra (India), Prof. D.Fung (Singapore), Prof. S.Honjo (Japan), Prof. P.Szatmari (Canada), Prof. L.Viola (Uruguay), Prof. S.C.Cho (S.Korea), Prof. D.Puras (Lithuania), Dr. V.Storm (Australia), Dr. J.Fayyad (Lebanon), Dr. S.Tan (Malaysia), Dr. M.B.Moyano (Argentina), Dr. Jibril Abdulmalik (Nigeria), Dr. N.V.Tuan (Vietnam), Dr. M. Tateno (Japan), Prof. Paramjit Joshi (USA), Prof. Andre Sourander (Finland), and Prof. Edgard Belfort (Venezuela)