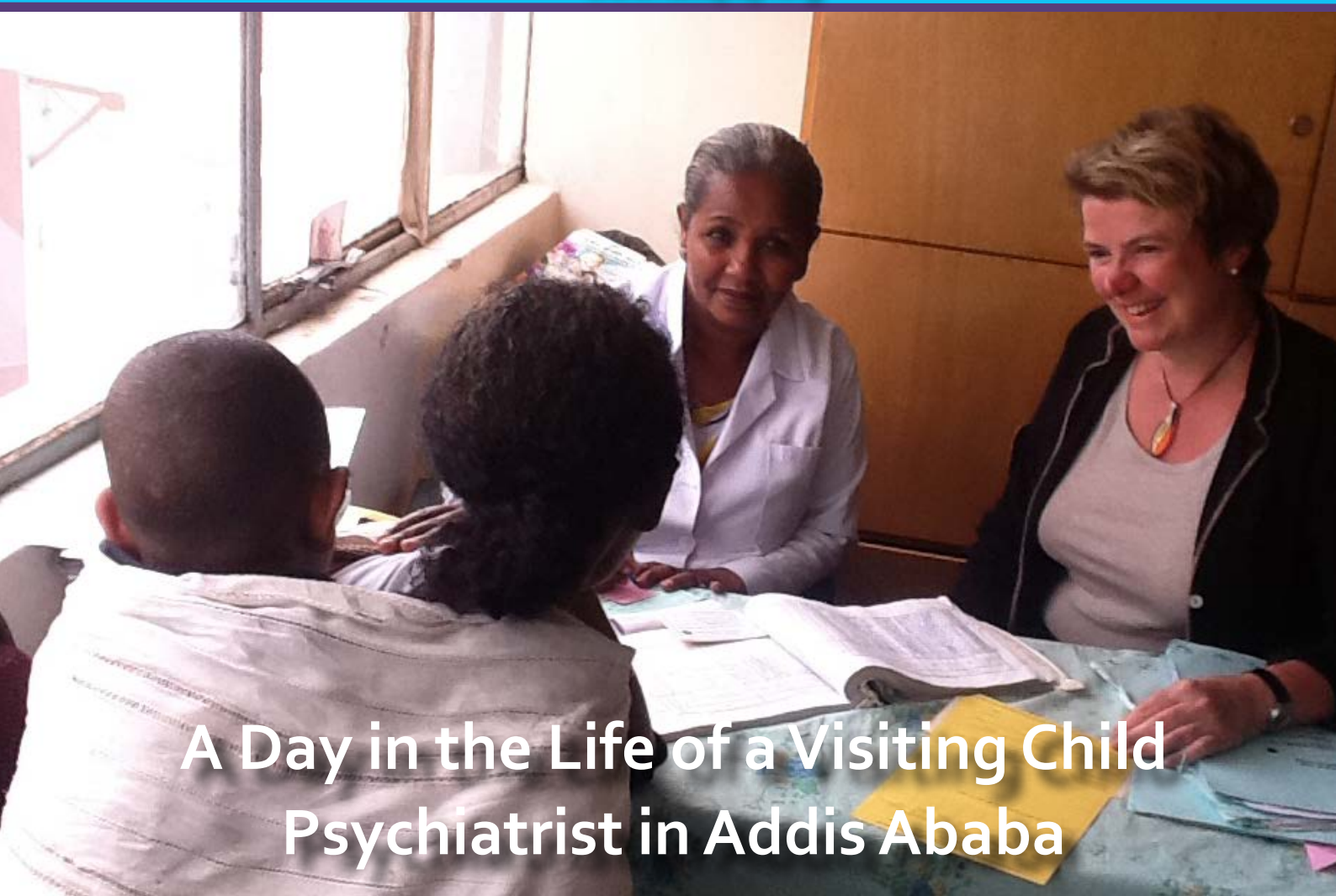


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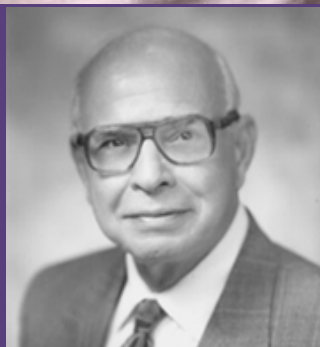


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**A Day in the Life of a Visiting Child
Psychiatrist in Addis Ababa**



**E James Anthony
(1916-2014)**

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President's column

WE MISS JAMES

Last December the 10th, our dear colleague James Anthony passed away after a long and fruitful life. James has been president of IACAPAP from 1970 to 1974, after Serge Lebovici and John Bowlby.

Belonging to a different generation and living on a different continent, I unfortunately never had the possibility to meet him personally. His passing has given me an opportunity to talk to older colleagues who knew him well, and to read some of the numerous papers he wrote. I have learned a lot, from a personal and a professional point of view.

James Anthony was born and educated in India and traveled to England for medical training. He started his clinical practice very abruptly in the tragic context of the Second World War. He went then to Hong Kong, where he organized care for some Japanese children who survived Hiroshima. In 1958, after several years in London, he was recruited to the United States. In 1980 he became President of the American Academy of Child and Adolescent Psychiatry. He trained as a psychoanalyst and was a pioneer of group therapy, which he developed during the war. He was well known for his interest in resilience.

Through this extraordinary life he retained an incredible curiosity, a unique talent for being permanently surprised by the world and by human beings. In one of his interviews, he was struck "by the extraordinary aspects of life, the uncanny, the numinous and the magical." Virginia Quinn Anthony, who survives him, in an answer to my condolences, told me "As you know he was supporter and leader in organizing IACAPAP Study Groups, funded by his foundations and friends. On a trip to an African country, he asked if he could go inside the women's tent, and he was allowed, and talked with some women and asked if anything had changed in their lifetimes..."

Because IACAPAP has a long history, because we live in different countries and continents, we have the opportunity to learn from other places and from other times. This is inestimable. James Anthony, thank you for all what you were. You are still among us, and this is for a long time.

Bruno Falissard

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Fighting Stigma, Promoting Resiliency and Positive Mental Health



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Canadian Academy of Child and
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IACAPAP Textbook of Child and Adolescent Mental Health



Editor
Joseph M. Rey



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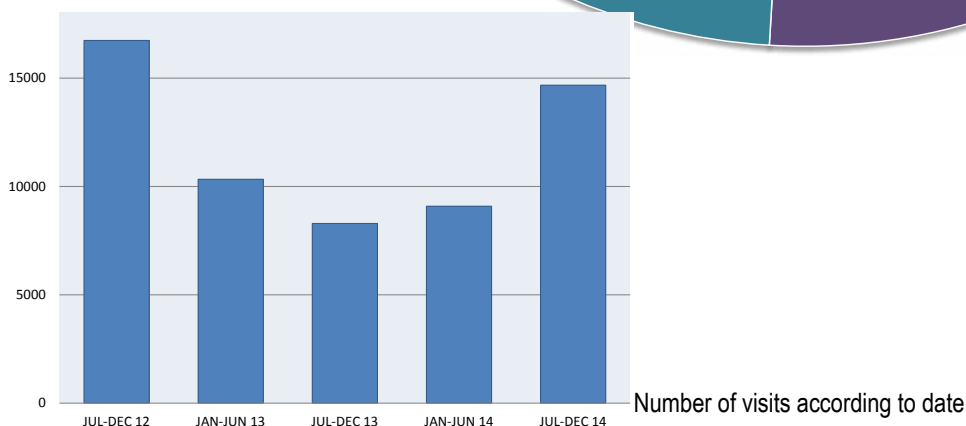
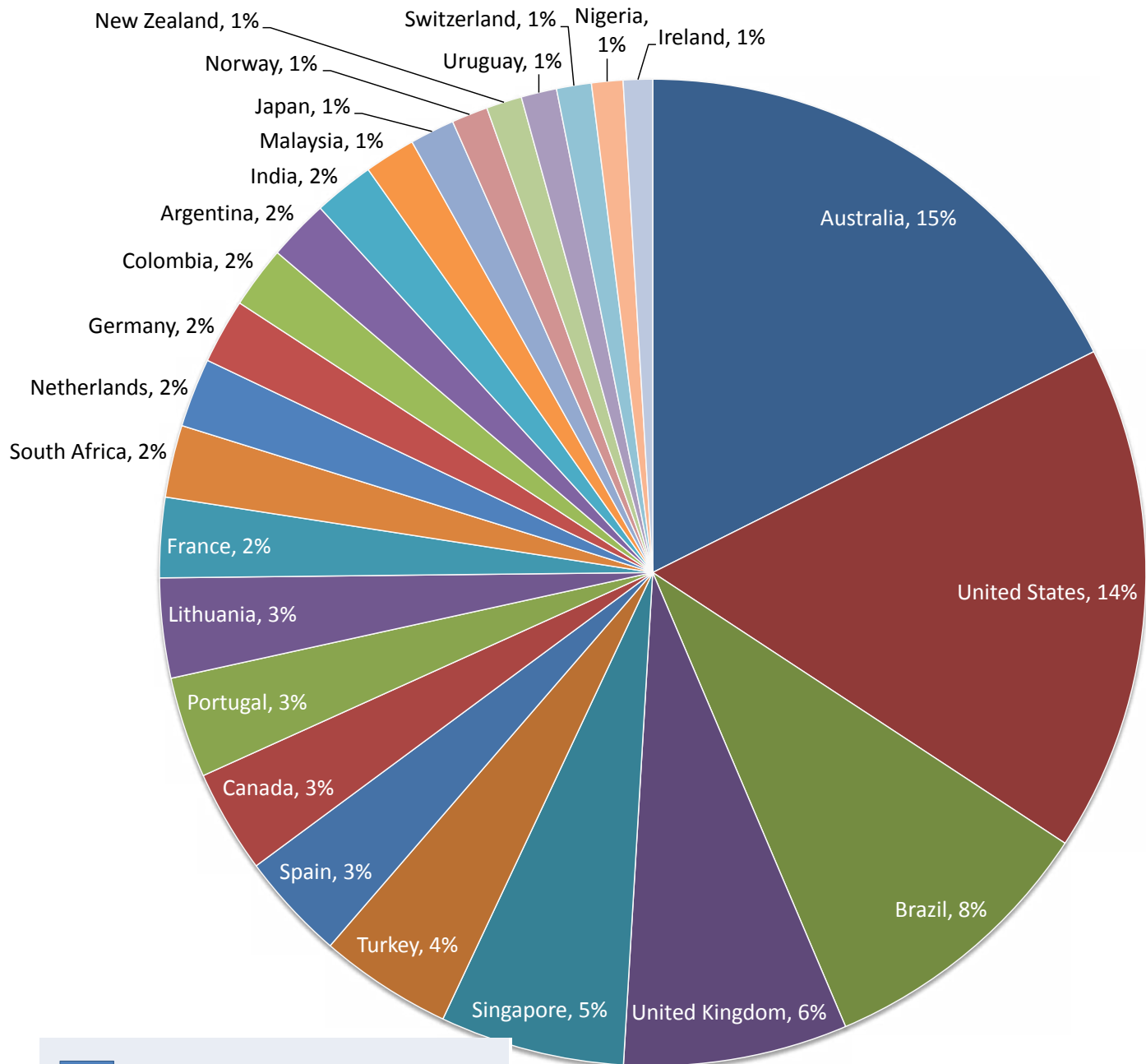


- 49 CHAPTERS
- MORE THAN 100 CONTRIBUTORS FROM THE 5 CONTINENTS
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UPDATE ABOUT THE eTEXTBOOK

Website activity

Since 1st July 2012, there have been 59,118 visits to the textbook (14,671 in the last six months). The distribution according to country of origin of the 25 most frequent are depicted in the graphic. The figure at the bottom shows the change in the number of visits according to date from the time of publication.



Additions for the 2015 edition

The 2015 edition of the textbook will be posted at the website before the middle of the year. Several new chapters will be added or updated. Among others, these will include (a couple more chapters are still in preparation):

- Updated chapter on borderline personality disorder by Lionel Cailhol et al
- History of childhood by Peter N. Stearns
- History of child psychiatry by Joseph M. Rey et al
- Delirium in children by Jan N. M. Schieveld et al.
- Clinical quality and patient safety by Daniel Fung et al.

Translations

It is expected to also add this year more chapters in French and a few in Portuguese.

Self-evaluation and teaching aids associated with the eTextbook

Students and teachers using the e-Textbook have requested an expansion of the resources in the Textbook: more self-directed learning activities, self-assessment exercises, and teaching materials. To meet these demands, a new team has been set up incorporating two new Associate Editors, Julie Chilton (USA) and Henrikje Klasen (The Netherlands). Some of the aids to be developed in conjunction with the contributors of each chapter will include (some of these have been included already in recent new or updated chapters):

- Practical exercises
- Multiple choice questions
- Interactive case studies
- PowerPoint slides for teaching
- A repository of teaching materials already existing on the Internet

These resources will be made available gradually as they are developed.

How can you contribute?

You may contribute to the development of any of these resources. If you wish to do so, please contact Julie Chilton:

julie.chilton@yale.edu

COMING SOON

CHAPTERS IN PORTUGUESE AND NEW CHAPTERS IN ENGLISH

History of child psychiatry J.10

A DAY IN THE LIFE OF A VISITING CHILD-PSYCHIATRIST IN ADDIS ABABA

(late November 2014)

The author, **Henrikje Klasen**, took six months leave from her job as Head of Training in Child Psychiatry in The Hague, Netherlands, to move to Ethiopia with her family.

There she supports the Psychiatry Department of the University of Addis Ababa in the development of their child mental health services. Here are some of her experiences approximately one month into her stay.



Daylight hours are precious in Addis, so we try to get up around 6 AM as morning dawns. The city awakes with barking dogs, cocks crowing and the sun slowly cutting through the rising morning mist. It is still quite cool and we clearly need our fleeces as we leave the house around 7:20 to walk our daughter to school. Just outside our house we are held up by a herd of sheep, asking ourselves where in this vast and busy city they might find a suitable grazing ground. It is easier for the five young donkeys that are well established at the roundabout next to the new, huge, condominium blocks we pass soon after. We cross a river, where a few men and women are already busy washing themselves and their clothes, before we reach the lovely oasis of the German School, set in beautiful gardens. Our daughter is greeted from all sides and quickly disappears amongst her friends. The open-air cafeteria of the school serves a delicious “makiato” (macchiato), an Ethiopian specialty ever since the Italian occupation in the 1930s and 1940s. We treat ourselves to a cup before embarking on my least favorite part of the day. I need to catch a mini-bus to the hospital and as it is already almost 8 am it is about the worst time of the day to take public transport. The air is thick with dust, smoke and exhaust fumes. Most mini-busses are full already; every now and then there is a free space and the conductor (usually a young boy) shouts the destination from the window. However, I am usually too slow to catch the empty seat and the door slams in my face. After a quarter of an hour, as the next bus approaches a middle aged woman who had been observing me, takes pity and resolutely pushes away the crowds to get me a seat. I breathe a sigh of relief as I crouch down in a little space above the tire and quietly thank the woman, who gets on the bus with me.

“Yekatit 12” is a big academic general hospital with a vast array of buildings in incongruous styles and colors. Everything is overshadowed by their newest acquisition, a huge ten-story white building, which still needs to be inaugurated. Psychiatry only has an outpatient service, which serves the local adult population, but also has a supra-regional function as the only specialist child and adolescent mental health service in the country. All psychiatric specialist trainees rotate here for a few months of child and adolescent mental health (CAMH) training, as do some junior mental health nurses. Medicine and psychology undergraduates regularly come to observe and there are advanced plans to start some clinical research, such as an adaptation of assessment tools and treatment packages. Unfortunately the child psychiatrist (one of two in the country!), who has been working here, was a victim of his own success and now leads the university’s psychiatry department, leaving no specialist child psychiatrist working here.

Despite my morning adventures I am the first doctor to arrive, so I have some time to talk to the nurses and psychologists, who are there already. Two of the mental health nurses have recently completed a psychology degree—one at master level, but despite her qualification as clinical psychologist, she is not given much appropriate work and feels under-utilized. Part of

the problem is that she is among the very first psychology graduates in the country and has yet to find her role; the other problem is space, as the staff—two general psychiatrists, one or two residents, two psychologists and about five mental health nurses and medical officers—only have three rooms to share and see patients. As is often the case, psychiatry is housed in one of the scruffiest buildings of the hospital; with the shiny new building just being completed we hope to be rehoused soon. There is little or no hope we will get into the new building but we have been promised 10 rooms in a lovely bungalow at the back of the hospital, which would be a great improvement. Apparently the plastic surgeons, who are there now, want to keep their old ward as well as some extra rooms in the new building; tough negotiations are ahead. The psychiatrists fear they don't have a chance against the surgeons, let's wait and see. Some things appear to be universal after all...

Soon the first year resident and his supervisor, a newly qualified consultant in general psychiatry, arrive. We start with a teaching session. The resident reports the case of a 23-year-old female waiter he saw the previous day. For the past few months she had suffered from bouts of excessive daytime sleepiness, often just nodding off for a few minutes, whenever she sits down. She sleeps well at night and reports no psychosocial stressors. The young consultant asks me if I have any questions and I ask quite vaguely about mood, epilepsy and the nature of the sleep episodes. As I finish, the young consultant takes over the questioning. Quickly and systematically she drills the resident on the gaps of his presentation: personal history, social history, drug and alcohol use, thought disorder, timing, frequency and muscle tone during the sleep episodes, hypnagogic hallucinations, sleep terrors, formulation, differential diagnosis, further investigations, suggested treatments... Wow! It reminds me of my time as a trainee at the Maudsley. It seems that the resident had already decided on the diagnosis of narcolepsy and in the absence of sleep laboratories and stimulants in Ethiopia, had started the patient on

imipramine, which—so he informs us—suppresses REM sleep, which typically occurs too early on in the sleep cycle in narcolepsy. Quite impressive knowledge really, but the young consultant recommends further history and EEG when the patient comes next to exclude other diagnoses, in particular epilepsy, depression and substance abuse. After all, as every doctor learns, common problems are common... and rare ones are rare... I must say, I can only admire the quality of the teaching—it was an excellent training session—also for me!

Next, we start seeing patients. There are two new patients and a number of follow-ups scheduled for each doctor in the morning session. Patients come in early and just wait to be seen in order of arrival. The rooms and waiting areas are not particularly child friendly. There are almost no toys, no play-areas or pictures, not even color pens and paper. The doctor wears a white coat and sits behind the desk. I sit in to supervise the trainee and sit next to him. Fortunately all patient notes are written in English and, as the trainees are used to foreign supervisors, they pause after each section of the interview to fill me



Ethiopia is a land-locked country with a population of about 96 million from more than 14 ethnic groups; almost half (44%) of the people are younger than 15 years. The ancient Ethiopian monarchy maintained its freedom from colonial rule with the exception of a short-lived Italian occupation from 1936 to 1941. In 1974, a military junta, the Derg, deposed Emperor Haile Selassie (who had ruled since 1930) and established a socialist state. Torn by bloody coups, uprisings, wide-scale drought, and massive refugee problems, the regime was finally toppled in 1991. A constitution was adopted in 1994, and Ethiopia's first multiparty elections were held in 1995. A border war with Eritrea late in the 1990s ended with a peace treaty in December 2000.

in on the history. A few patients this morning are particularly memorable. First we see an 8 year old boy. After short introductions, his mother sends him out of the room and tells us that when the boy was in kindergarten (age 5/6) she left him alone for a few hours. When she came back he seemed disturbed. Later on she found lacerations round his anal area. The boy had always denied that anything had happened to him, but ever since the incident he had become hyper alert, scanning the rooms he is in. His school performance dropped, he could no longer concentrate and developed behavioral problems. He had been seen in the clinic for a couple of years (each time by a different resident) and had been tried on imipramine, amitriptyline and risperidone. He had developed memory problems and a tremor as side effects of the medication. Everyone who saw him asked him about the incident but he had not confided in anyone. The current resident tries the same strategy with the same result. I suggest that the new clinical psychologist could see the boy individually for a number of sessions to build up his trust, but the resident feels skeptical. I might need to discuss this with the consultant at a later stage. For now we are at least reducing the boy's medication, give some parenting advice for the behavioral problems and a follow-up appointment. This is the third boy with suspected sexual abuse I have seen in this clinic in just two weeks.

Then an 11-year-old boy, Fekadu (all identifying information has been changed), comes in with an adult male, who turns out to be a relative of the boy from Addis; the boy lives about 300km away, in the country. The boy is quite dirty and poorly dressed in clothes that are far too small. He is a terrible sight, jerking and twisting the whole time, hardly able to utter a word or to stay in his seat. I suspect cerebral palsy but the movements do not look quite typical. I see the resident listening to Fekadu's heart: "Now why might he do this?"... something stirs deep in my memory... Finally the resident tells me that the boy had been quite normal until the age of 7; even though the relative did not know of any infectious disease at the start of the movement disorder, he suspects

Sydenham's Chorea, particularly as he could hear a heart murmur. This time it is my turn to say "wow, I have never seen this before". Again the iPad comes in handy and I google that Sydenham's Chorea was one of the most common psychiatric presentations in Europe before the wide use of antibiotics. While easily treated at the time of the infection, now, 4 years later, the usefulness of antibiotics is questionable and treatment is mainly symptomatic, with haloperidol and valproate most commonly used. We test for streptococcal antibodies to see whether they can still be found and just hope that in Fekadu's case the illness might still be self-limiting, as it often is. We also make a referral to cardiology and hope the relative will take him there before his return to the countryside.

The next patient is very typical for our clinic, where about 50% of children present with some form of learning disability, sometimes in the context of epilepsy, infectious disease or with autistic features (or, of course, in combination). A 7-year-old boy, Yohannis, from outside Addis comes with a severely autistic picture and developmental delay. He makes no eye contact, hardly speaks, does not seem to recognize

people, does not respond to his name being called, holds his hands over his ears and behaves in a hyperactive way. He sleeps badly and can be physically aggressive. No school will take him as there is no special needs education provision outside the capital. He is just too disruptive to attend normal school, where class sizes of 80-90 children are quite frequent. He comes for a repeat prescription of risperidone, which has made life more tolerable at home. The remarkable thing, which I hear frequently, is that according to parents his development was quite normal until he was about 4 years old (including talking, playing with others and interacting). I am not sure, whether he has some sort of acquired problem (maybe due to an infection or epilepsy), which presents with an autistic picture, or whether parents just did not recognize early signs of autism as they are not alert to them.

The following patient is Dawit, another profoundly disabled 8-year-old. In contrast to the previous patient he makes good eye-contact but shows little adaptive functioning and communication. He runs through the room, picks up items, plays for a while with toys offered and tries to grab items from the examiners in quite an angry, oppositional way. The story is a sad one. Apparently he lost all his skills in only 4 months. In first grade he was the top student in his class—of 80-90 pupils. By the end of year 2 he was number 3. Since the summer holidays he is supposed to be in 3rd grade, but 4 months ago, at the beginning of the new school year, he started having seizures and slowly started losing his previously acquired skills. Parents took him to the local health center (which has no child mental health provision) as well as to the “holy water”; neither helped. The family is not from Addis, so it took a while to organize a trip to the capital to have him assessed here. We conduct some blood tests today to exclude an ongoing infection and start anti-epileptic medication even before an EEG can be arranged (there is a 1-3 months waiting list). We hope to arrest the decline



but there is little hope Dawit will recover the functions already lost. A boy, who might have well been one of the top contributors to his community will now spend his life needing care from others; very sad. When I ask psychiatry trainees why so few of them are interested in CAMH they tell me about children like Dawit, who make them feel hopeless and sad. They see child psychiatry as a discipline predominantly dealing with learning disabilities and mental retardation.

The last patient of the morning is Michael, a bouncy 7 year old, who looks at me with bright, curious eyes. He runs around the room, almost climbs out of the window, touches everything and won't sit still for a moment. Only when I show him my box of toys can I capture his attention for a while. He interacts well, shows reciprocity and compliance in the play, learns little patters in the game and even repeats some English words. After a few minutes, however, he is off again, almost knocking the (broken) computer off the table and exploring some books on the shelves. At last his mother gives him her phone and he starts a computer game, which finally calms him down. The story is surprisingly typical of children with ADHD: he did all right in kindergarten, where he was allowed to play and move around the class. As soon as first grade started and he was expected to sit still, things went wrong. He was first punished and eventually dismissed from school. At the age of

7 he has already been expelled from three schools and there seems no hope that another school will take him. And so, this bright little guy might never get the education he deserves. Methylphenidate is not available in Ethiopia, although some ask relatives to send it from abroad at high cost to the family. Psychosocial interventions, like sitting children with ADHD in the front of the class, giving them extra attention and short tasks are impossible given the huge class sizes. Teachers are not prepared to disrupt everyone's learning for the sake of one child. Eventually we prescribe imipramine, an evidence-based third line medication for ADHD with more side effects and a smaller effect size than methylphenidate. It seems the best option given the circumstances. We also write a note for school, hoping he will find one that will have him.

It is about 12:30 by the time we finish the clinic. All in all it was an average caseload for a morning. Doctors tend to work in 2-3 rooms, each seeing 5-8 patients in a morning. Repeat prescriptions are often done by the “health officers” (a profession in between nurse and general practitioner). In the afternoons patients can be seen for psychotherapy, but that rarely seems to happen. Given that this is the only dedicated child mental health service in the country, it is actually surprising that it is not busier. It seems many patients, parents and referrers are just

not quite sure about the existence of this service and about the benefits it could offer.

As my own projects and teaching have not started yet, I decide to spend the afternoon at the academic department at the Black Lion University Hospital, where a group of Canadian academics are teaching today. It is a fasting day today (there are more than 200 fasting days a year in Orthodox Christian Ethiopia) and most of my colleagues have brought their own packed fasting lunches.

Therefore I walk down to Arat Kilo Square by myself to get half a pizza on the way (another bit of Italian heritage). The air and weather are unrecognizable compared to this morning. The sky is bright blue, the air crisp and clear, there is a slight breeze and it is, oh, so sunny. It is like the perfect summer day on the North Sea and the weather is like this almost every single day. I love this little walk around lunchtime, passing the National Museum, where 3 million year old Lucy reminds us that Ethiopia truly is the cradle of humanity, on to St Mariam's Church, where people cross themselves on passing and all shapes and manners of Ethiopian crosses are being sold. I catch a mini-bus just before reaching the busy corner where newspapers are rented out for 10 minutes at a time to avid job seekers and others who cannot afford a paper of their own.

It is a brisk walk up-hill from the bus stop to Black Lion, past the heavily armed Libyan Embassy and the Red Star monument, commemorating the Derg (“Red Terror”) dictatorship during the 1980s. The walk still leaves me breathless as does the climb to the six floor, where the psychiatry department is located (all lifts are out of order again)—The 2,500m altitude need some getting used to. The department of psychiatry at Addis Ababa University will soon celebrate



its 50th anniversary and is quite a success story. A Dutchman, Professor Giel from Groningen, who remains much revered, established it. For many decades it was staffed by a handful of dedicated psychiatrists who were either expatriates (often Dutch) or Ethiopians trained abroad. They did well in research and, starting in the 1960s, participated in many international multicenter (mainly epidemiological) studies. These were the days when psychiatrists doubted the universal existence of illnesses like “psychosis” and wondered about the existence and expression of mental health problems in other cultures. They soon found out that while the expression and even course of disorders might show cultural variation, many severe mental illnesses and their epidemiology were surprisingly similar in much of the world. These studies put Ethiopia on the map of global mental health research and has remained at its heart ever since. The present PhD program is popular and successful; the department currently has 16 PhD students from various disciplines. At the moment the main concern is the huge mental health treatment gap, the difference between those in need of mental health treatment and those actually receiving it. At the moment this gap is about 90% in many low and middle income countries and WHO programs like the mental health global action program (mhGAP) try to address this. Ethiopia is one of the forerunners in its implementation and research on this method. Unfortunately they are only implementing the parts of mhGAP dealing with adults; children have been left out so far. Including children in the mental health care provision in this country, particularly in the mhGAP program, is very close to my heart; if I could contribute to this, I would feel very happy.

Apart from research, the development of

their psychiatric postgraduate training scheme has been a great achievement for the department. This started about 11 years ago and the training is supported by Toronto University, that send a team of two consultants and one resident three times a year to teach at the department for one month at a time. They also assist with curriculum development and the exams. They are here at the moment and the topic this month is psychodynamic psychotherapy and post-traumatic stress treatment. At the beginning of their involvement they were teaching large parts of the curriculum, now they focus on topics where few teaching resources are available in Ethiopia. Psychotherapy is one of these areas. I decide to attend a few of their teaching sessions to get an impression of the style and level of teaching. As the psychiatric teaching program is well taken care of, I am concentrating on developing child mental health teaching for pediatricians. There are many more pediatricians than psychiatrists; if all of them had a good base in child mental health, that would go a long way.

I leave the hospital around 5pm, as I have two minibuses to catch and want to be home before dark. The journey back is uneventful. I even get to sit in the front seat during my second bus ride—a rare treat. Back home my husband and daughter eagerly await me. My daughter joined the drama group at school and because they had started practice before our arrival an additional role was created just for her in the “Christmas Carol”—she is happy and excited about this. But Christmas is not the only event that is keeping us busy now, in late November. Sinterklaas has arrived in the Netherlands and our daughter begs to see his daily news online. Of course we oblige and so, after dinner, we watch the show on the iPad. During the final minutes we have a power cut. Thankfully the iPad is still working and we get the candles, before settling our daughter in bed. The power is quite reliable, but about once a week we have a couple of hours of candlelight in the evenings—quite romantic really.

Without electricity there cannot be any more work, so we just sit and reflect about the experiences of the day. My partner enjoys his new role as househusband after 38 years in the Dutch Navy and he has his own stories to tell: of night-guards, who want to read him their poetry; of school-children trying to practice their English with him, and of helpful Ethiopians making sure he doesn't get ripped off in the market. We feel very grateful about being here and sharing some time with these wonderful people in this fascinating multi-faceted country. Just over one month gone and four months to go.



Autism Spectrum Disorders in Europe (ASDEU)

Understanding about autism will get a boost as universities, charities and expert institutions from 14 European countries come together in a major new program. Autism Spectrum Disorders in Europe (ASDEU) has been funded by the European Commission to research autism diagnosis, prevalence and interventions and to improve care and support for people with autism.

ASDEU is a three-year program run by a consortium of 20 groups from 14 countries. ASDEU has received 2.1 million euros from the Directorate-General of Health and Consumers of the European Commission (DG-SANCO) to increase understanding of, and improve responses to autism. ASDEU will:

- Study the prevalence of autism in 12 countries in the European Union
- Analyse the economic and social costs of autism
- Review existing arrangements and develop proposals for early detection programs
- Train professionals
- Validate biomarkers for the disorder; and

- Improve understanding of diagnosis, comorbidity, and effective care and support for adults and senior citizens with autism.

In the field of public health, ASDEU will also collaborate with European Autism Interventions – [A Multicentre Study for Developing New Medications \(EU-AIMS\)](#) to improve quality of life and prognosis for people with autism.

The ASDEU consortium partners are:

- Program leader: The Rare Disorders Research Institute (IIR), a Centre of the Institute of Health Carlos III (ISCIII), Spain
- Medical University of Vienna, Austria
- Autism Europe, Belgium
- Ghent University, Belgium
- Bulgarian Association for Promotion of Education and Science, Bulgaria
- Aarhus University, Denmark
- University of Oulu, Finland
- University Toulouse - Jean Jaurès, France
- The State Diagnostic and

- Counselling Centre, Iceland
- The IRCCS Stella Maris Foundation, Italy
- National Health Institute Doutor Ricardo Jorge, Portugal
- University of Warsaw, Poland
- Dublin City University, Republic of Ireland
- Victor Babes National Institute of Pathology, Romania
- Foundation Bio-Advance, Spain
- University of Salamanca, Spain
- London School of Economics and Political Science, UK
- King's College London, UK
- National Autistic Society, UK.

The project leader, Manuel Posada, Director of the Rare Diseases Research Institute (ISCIII), Spain, will be supported in his management role by the ISCIII and the Spanish Foundation for Health and International Cooperation. Joaquin Fuentes, from Policlínica Gipuzkoa in Donostia/San Sebastián, Spain, will act as scientific advisor to the ASDEU project leader. The project will officially begin on February 15th, 2015.

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EDITORS

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From Research to Practice in Child and Adolescent Mental Health has been shaped to reflect the mental health needs of children and adolescents in low and middle income countries. It also includes chapters on topics based on research and practice in high income countries which may have global implications. The first section of the book takes a child and adolescent mental health services perspective encompassing epidemiology, mental health needs, and relevant policy issues. The second section summarises research findings into the mechanisms for problems frequently encountered in child and adolescent psychiatric practice: schizophrenia, mood disorders, and sleep problems. The third and last section is about interventions and practice. It describes the treatment gap between low and middle income countries in relation to child and adolescent mental health and shows how professionals or lay people may be trained to effectively deliver interventions.

This monograph has been produced for the 21st congress of the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP) to be held in Durban, South Africa, in August 2014. This is the first congress of IACAPAP in Africa and it takes place at an appropriate time in view of the continent's burgeoning child population, significant economic growth and wish to improve the populations' health.

The world population balance is shifting. Rich, developed countries' inhabitants are becoming older while people in low and middle income countries are becoming younger, so much so that a large proportion of the world's youth now lives in these countries. Another shift is also taking place in youth-rich countries: their leaders are increasingly concerned about improving the mental health of their people and realize the need to train more and better professionals to deal with these problems. This book is a key source of information for policy and practice that would be useful for professionals in training and leaders when addressing these issues.

Joseph M Rey, University of Notre Dame Sydney & University of Sydney

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Rowman & Littlefield Publishers, May 2014

The 7th Scientific Conference and Annual General Meeting

Bangladesh Association for Child & Adolescent Mental Health

Dr Nafia Farzana Chowdhury

Fellows and members of BACAMH at the end of the Conference

On November 25-26th, 2014 the 7th Scientific Conference and Annual General Meeting of the Bangladesh Association for Child & Adolescent Mental Health (BACAMH) took place in Shahid Dr Milon Hall of Bangabandhu Sheikh Mujib Medical University (BSMMU), Dhaka. The theme of the conference was "Child and Adolescent Mental Health in Bangladesh: Connectivity". In Bangladesh, roughly 45% of the population is under the age of 18 years. Around 15% of the children have psychiatric disorders. There is an extreme lack of resources and of mental health services for children and adolescents, leading to a vast gap between need and service provision. Connectivity is required for the best use of existing resources, to establish new facilities and to develop services.

The Conference was inaugurated by National Professor M R Khan; Patron of the Bangladesh Association for Child & Adolescent Mental Health (BACAMH).

There were two workshops this year, one conducted by Dr Murad Bakht on "Engaging Three Generations of the Family in ADHD Management: An Approach to Psychosocial Intervention". Dr Bakht is from the Department of Child Psychiatry, Brampton Civic Hospital, Ontario, Canada. Dr Selina Fatema Binte Shahid, an Assistant Professor of Clinical Psychology at BSMMU, Dhaka conducted the second workshop on "Academic Problems in Children" which included role plays. This workshop highlighted the types and causes of academic problems in children and the management of these problems. Both of the workshops were informative and interactive. As BACAMH tries to focus on and emphasizes quality research in child and adolescent mental health, a short introductory training course on "Conducting Research in Child and Adolescent Mental Health" was run by Dr Muhammad Zillur Rahman Khan, Assistant Professor at the Department of Child, Adolescent and Family Psychiatry, National Institute of Mental Health (NIMH), Dhaka.

While the BACAMH encourages young psychiatrists it also believes in tradition and celebrates the contributions of our senior members. Last year BACAMH introduced a lecture (oration) in memory of the late Psychiatrist Syed Kamaluddin Ahmed. This year the oration was given by Professor Mohammad Waziul Alam Chowdhury on "Urban Lifestyle and Mental Health Problems in Children and Adolescents in Bangladesh". According to the UNICEF, Dhaka is the





Opening of the scientific conference in the presence of the National Professor MR Khan and Professor Abdus Sobhan along with the BACAMH Executive

9th largest mega city in the world. Rapid urbanization has had an impact on mental health. Stress related to urbanization needs to be addressed in preventive mental health efforts.

The keynote speech was delivered by Professor Mohammad S I Mullick, President of the Association. In his presentation he emphasized the utilization of existing child and adolescent mental health services (CAMHS), the need to establish more services, to develop a achievable, affordable and needs-based national CAMHS policy and strategic plan and, finally, convincing policy makers to adopt and implement such policy. Theme papers were presented by Professor Mohammad Faruk Alam and Dr Murad Bakht. They highlighted on feasible and practicable team building and exchanging experiences between developing and developed countries.

There were ten free papers on diverse topics in two sessions, presented by different disciplines, such as clinical psychology, psychiatry and pediatrics.

The Annual General Meeting held on the second day of the conference featured lively discussion and exchange of views between executive members and fellows of the association. Dr Mohammad Saleh Uddin, a trainee psychiatrist and fellow of BACAMH who was awarded

the Donald J Cohen Fellowship and joined the IACAPAP world congress in Durban, South Africa this year, was congratulated. This year BACAMH also established its first branch in the Sir Salimullah Medical College and Mitford Hospital, Dhaka. At the conclusion of the event, the newly elected Executive Council members and branch committee members of the Sir Salimullah Medical College and Mitford Hospital, Dhaka were introduced. The Association hopes to establish further branches in the main government medical college hospitals.

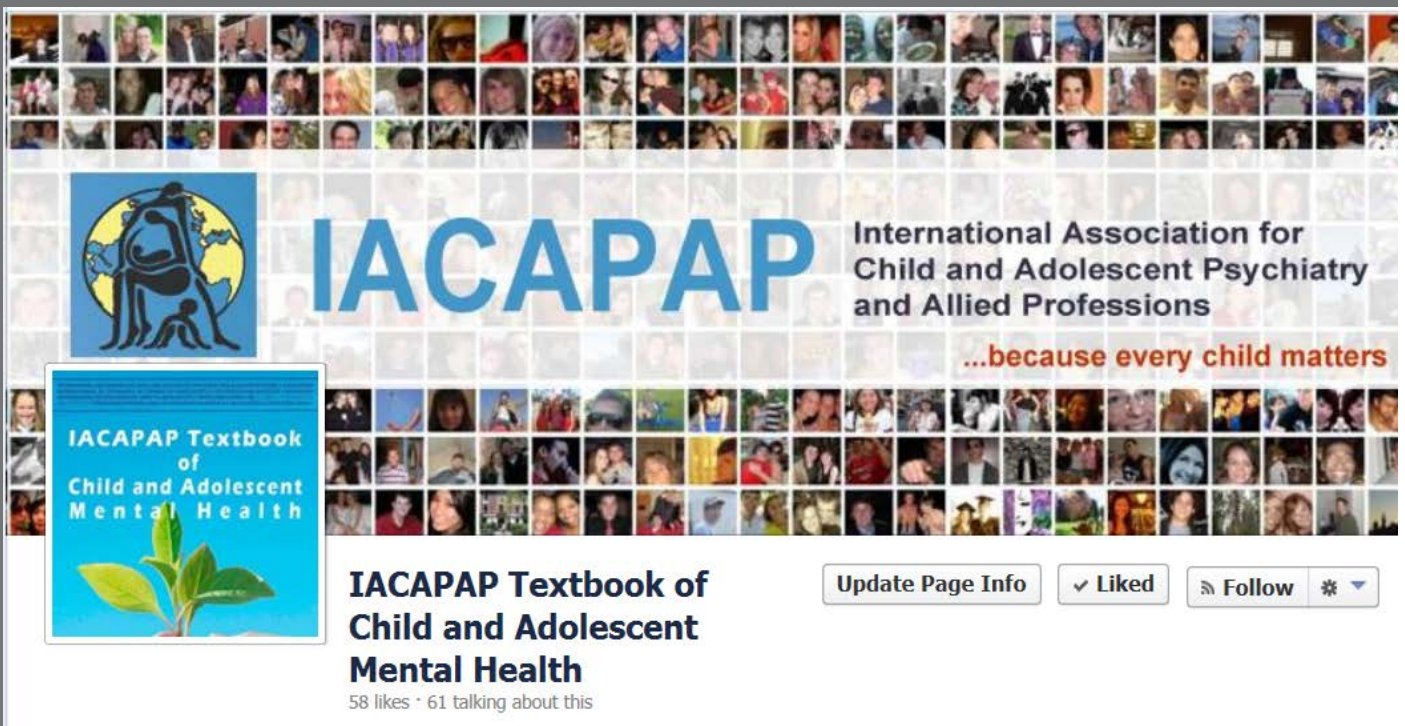
The conference ended with the announcement of the 8th Scientific Conference and Annual General Meeting, which will be held on 24th and 25th November 2015 with the theme "Child and Adolescent Mental Health in Bangladesh: Clinical Perspectives".

Professor Md. Waziul Alam Chowdhury (left) being presented with the Syed Kamaluddin Oration Award



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To facilitate readers' interaction and involvement, a Facebook page exclusively dedicated to the Textbook has been created. It is hoped that such a facility will enable readers to interact with each other, the editor and contributors as well as making comments and suggestions, and receive Textbook-related news.

To access this facility click on the figure.

SINGAPORE ESTABLISHES A SECTION OF CHILD & ADOLESCENT PSYCHIATRY

Dr Say How Ong



The Singapore Section of Child & Adolescent Psychiatry office bearers 2014 (left to right: A/P Daniel Fung, A/P John Wong, Adj. Assist. Prof Say How Ong, Dr Cheong Sing Tian, Dr Lionel Lim, Dr Celine Wong, A/P Sze Tai Wong).

Child & Adolescent Psychiatry in Singapore officially began in 1970 when the Ministry of Health opened the country's first child guidance clinic in the now defunct Outram Hospital. The clinic is presently sited on two locations—one in the main hospital (Institute of Mental Health,) and another in the central district. Since then, it has grown from an ad hoc, part-time service to a full department with 12 consultants, six medical officers, six clinical psychologists, three medical social workers, and a full complement of nurses and administrative staff. In the last ten years, coinciding with an increasing demand for child mental health services in the public sector, child and adolescent consultation-liaison psychiatric services have also taken root in two other hospitals—the National University Hospital Systems and the Kedang Kerbau Women's & Children's Hospital.

The local psychiatry fraternity believes that the future of child and adolescent psychiatry in Singapore lies in the integration of child mental health services from both public and private sectors, and strengthening the

links with community agencies to enhance mental healthcare for the young. Collaboration with several key players such as social services and the education ministry is crucial as these organizations have a common interest in helping children and youths but due to their different background and working framework, close collaboration sometimes could not be organized effectively. In the hospitals, there is also a greater need for research collaboration among various medical disciplines and professionals both locally and internationally.

Improving existing medical education and cultivating the younger generation of doctors and psychiatrists has also been the mission of the teaching faculty. With the addition of a third medical school in 2013 and the implementation of the National Psychiatry Residency Program in 2010, the medical education landscape in Singapore is set to change. Currently, different hospital systems have their own separate child psychiatry residency programs and private psychiatrists have very limited role in training the psychiatrists

of tomorrow. Much could be achieved in child and adolescent psychiatry training if there were more synergy and collaboration.

On 26th Nov 2014, the Section of Child and Adolescent Psychiatry was established under the auspices of the College of Psychiatry, Academy of Medicine Singapore. The Section currently has 19 active Academy members. Together with non-members, the number of child and adolescent psychiatrists in Singapore totals 35. Fellows and members must have completed an approved training program equivalent to a certificate of advanced training in an accredited child mental health centre overseas or had formal training in the local advanced specialist training program, or be accredited in a post graduate education and fellowship program (such as the ACGME-I Residency 5th year elective in child & adolescent psychiatry). Broader admission criteria were intended to ensure better representation and inclusion of eligible psychiatrists into the Section. Office bearers include the chairman, vice-chairman, secretary and four other members. As the Section does

not hold financial assets, the committee does not have a treasurer.

In addition to aligning and executing priorities in accordance with the College's strategic plan, the goals and objectives of the Section include to:

- 1) Promote awareness of child and adolescent mental health in Singapore to reduce stigma in children, adolescents and their families seeking psychiatric treatment
- 2) Develop and coordinate training programs in child and adolescent psychiatry, together with appropriate educational organizations, as part of professional development for psychiatrists and trainee psychiatrists
- 3) Facilitate professional networking and collaboration with other professionals in the fields of health, education, legal system and social welfare
- 4) Promote a high standard of clinical practice in child and adolescent psychiatry
- 5) Promote research and keep up-to-date current advances in child and adolescent psychiatry
- 6) Be an advocate in child and adolescent mental health issues, and an authority in public and administrative policies.

Child and adolescent psychiatry in Singapore has seen rapid changes over recent years especially in mental health policy, in re-defining medical education, in greater research collaborations, and in the development of new clinical services. With over thirty practicing child and adolescent psychiatrists in both the public and private sectors, it is timely for us to bring our sub-specialty to the next level, and contribute to the greater good of the children and youth. In 2014, the Section has officially submitted an application to become a full member in IACAPAP.

Award to Füsün Çetin Çuhadaroğlu, IACAPAP Secretary General



The American Academy of Child & Adolescent Psychiatry (AACAP) presented the 2014 inaugural Ulku Ulgur MD International Scholar Award to Dr Füsün Çetin Çuhadaroğlu from Turkey.

The Ulku Ulgur, MD International Scholar Award recognizes a child and adolescent psychiatrist or a physician in the international community who has made significant contributions to the enhancement of mental health services for children and adolescents. The award was established in 2013 under the name of a distinguished AACAP life member.



Adj. Assist. Prof Say How Ong presenting at the inaugural meeting to the College of Psychiatry in Nov 2014 to propose the forming of the Section of Child & Adolescent Psychiatry in Singapore.

IACAPAP 2016

Fighting Stigma, Promoting Resiliency and Positive Mental Health



The 22nd International Association for Child and Adolescent Psychiatry and Allied Professions World Congress (IACAPAP)



36th Annual Conference for the Canadian Academy of Child and Adolescent Psychiatry (CACAP)

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

C. Jung

September
18-22
2016

Calgary TELUS Convention Centre
Calgary, Alberta, Canada

Save the dates!

Welcome to the first E-News for the 22nd International Association for Child & Adolescent Psychiatry and Allied Professions World Congress (IACAPAP 2016) and the 36th Annual Conference for the Canadian Academy of Child and Adolescent Psychiatry (CACAP 2016).

As the Chair of the 2016 Congress, I invite you to join us in Calgary, Canada (September 18-22, 2016) at the Calgary TELUS Convention Centre. This is the second time that the IACAPAP World Congress has been hosted in Canada with Toronto being our first host city in 1954.

Mark your calendars and in the coming months we will be sending more information about the congress, including the Call for Abstracts, how to register, program and accommodation details, and sightseeing opportunities.

I look forward to seeing you in Calgary in 2016 and we encourage you to share this email with your colleagues and friends so that they can join the mailing list to receive congress updates and news.



Dr Chris Wilkes
IACAPAP 2016 Chair and CACAP President

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[Experience Summer in Alberta - video link](#)

When

September 18-22, 2016

Where

Calgary, Alberta, Canada





Venue: Calgary TELUS Convention Centre

Accommodation: Calgary Marriott Downtown Hotel

The Calgary Marriott Downtown Hotel will be the headquarters for IACAPAP 2016. Connected to the Calgary TELUS Convention Centre and located in the heart of the city's restaurant district, the hotel will be offering a special discounted rate for IACAPAP attendees. Booking information will be available in the fall of 2015.



Sponsorship Opportunities

The IACAPAP and CACAP congresses offer remarkable opportunities to showcase your goods and services to a target audience of child psychiatrists and representatives from the allied professions of nursing, psychology, social work, paediatrics, public health, education, social sciences and other related fields from around the world.

There are a number of ways you can support the congress. For information on sponsorship opportunities, please contact Marilyn Lawrie, Sponsorship Sales Manager, at opportunities@iacapap2016.org.

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Abu-Dhabi, UAE

The 3rd International Child Mental & Behavioral Health Conference

Hesham Hamoda, MD, MPH
Ahmad Almai, MD

The conference hosted more than
600 attendees and featured over
60 lectures

In its third iteration, the International Child Mental & Behavioral Health Conference was held in Abu Dhabi, UAE on Jan 23-24, 2015. The conference was chaired by Dr Ahmad Almai, Head of the Child Psychiatry Service at Sheikh Khalifa Medical City in Abu Dhabi, together with Dr Adel Karrani, President of the Emirates Psychiatric Society.

The event convened at the Emirates Center for Strategic Studies and Research with an opening ceremony where IACAPAP's Vice-president Dr Hesham Hamoda delivered a keynote address entitled "Child and Adolescent Psychiatry in the 21st Century: Challenges and Opportunities". The event was held this year under the patronage of HE Sheikh Nahyan Bin Mubarak Al Nahyan, Minister of Culture, Youth and Community Development, whose lecture stressed his high hopes that the conference would positively impact child and adolescent mental health care and ignite research throughout the UAE and the region.

The conference, which is now considered the largest child and adolescent mental health event in the region, hosted more than 600 attendees and over 60 lectures focusing on this year's theme of "Healthy Child, Healthy Family, Healthy Society". Speakers and attendees came from throughout the UAE but also from Oman, Saudi Arabia, Kuwait, Qatar, Bahrain, Australia, Canada, UK and the US. Speakers represented a variety of disciplines including general physicians, therapists, nurses, psychiatrists, psychologists, counselors, teachers and more. New research posters and oral presentations were also a highlight at the conference.

A series of pre-conference workshops also took place covering autism, ADHD and board examination. In addition, a meeting for the newly formed Arab Board in Child and Adolescent Psychiatry was held during the conference. This board will play a leading role in graduating future generations of qualified child and adolescent psychiatrists.



Above, attendees at the opening ceremony. Left: IACAPAP's welcome at the opening ceremony delivered by Dr Hesham Hamoda, IACAPAP Vice-President.



**The 8th Congress of the Asian Society for Child
and Adolescent Psychiatry and Allied Professions
(ASCAPAP)**

&

**18th Malaysian Conference of Psychological Medicine
(MCPM)**

19-22 August 2015, Kuala Lumpur, Malaysia

*Embracing challenges,
providing solutions*

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The 1st Arab and Eastern Mediterranean Infant Mental Health Meeting

Kuwait, November 12-15, 2014

Hesham Hamoda, MD, MPH & John Fayyad, MD & Bibi Alamiri, MD, SM



From left to right: Amira Seif-Eldin (EMACAPAP president), Bibi Alamiri (KACAMH president), Hesham Hamoda (IACAPAP Vice-president), Noora Alnouri (local arrangements chair) and John Fayyad (EMACAPAP Secretary General)

The first ever meeting in the region dedicated to infant mental health brought together more than 200 participants from Kuwait and the region

The International Association of Child and Adolescent Psychiatry and Allied Professionals (IACAPAP) together with the Eastern Mediterranean Association of Child and Adolescent Psychiatry and Allied Professionals (EMACAPAP), the Kuwait Association for Child and Adolescent Mental Health (KACAMH), and the Kuwait Developmental League organized this meeting that took place in Kuwait City, November 12-15, 2014. This meeting, the first ever in the region dedicated to infant mental health, brought together more than 200 participants from Kuwait and the region. The meeting took place at the Kuwait Center for Mental Health and was funded by the Kuwait Foundation for the Advancement of Science.

Despite the importance of infant mental health and its long term effect on healthy development, it is rarely discussed, even among healthcare professionals. This meeting provided participants with an overview of infant mental health and aimed to bridge the gap between theory and practice in this area. Renowned experts in the field like Tuula Tamminen from Finland and Mary Margaret Gleason from the US presented the latest findings in our understanding of infant mental

health in engaging and interactive sessions. The workshop also included lectures on career development, such as designing a research study and writing scientific papers, presented by John Fayyad and Hesham Hamoda respectively. The meeting also witnessed presentations from local speakers on early detection of autism and screening for developmental delays in Kuwait.

As has been the tradition with international IACAPAP study groups the event also brought together 15 junior researchers in infant mental health who were selected competitively and worked with experienced mentors to further develop their research proposals. Zeinab Ghattasi from Tunisia, Fadi Halabi from Lebanon, and Eman Fouad from Egypt won the three research awards respectively. The meeting also witnessed a rebirth for EMACAPAP, whose officers met during the event and started planning for the next meeting—on child abuse—to be held in Alexandria, Egypt in May 2015.

This meeting would not have been a success without the tremendous effort of the local organizations, KACAMH and Kuwait Developmental Medicine League that ensured the highest level of organization and excellence.

This effort was reflected in the high attendance and the positive feedback received from all participants. Special thanks to the local arrangements chair, Dr Noora Al-Nouri, resident at the Kuwait Board of Psychiatry.

No meeting is complete without an engaging social program and this meeting did not fail to impress. Despite several organized activities like visiting a traditional Kuwaiti Souq, a gala dinner and another dinner on a traditional Kuwait boat, the highlight of the social program to many was the music played on the piano by Dr Fayyad while the attendees sang together in Arabic, English and French.



DAW: Dream a World A Novel, Low-Cost Cultural Program to Counter High Dropout Rates and Conduct Problems in Kingston, Jamaica

Jaswant Guzder MD

DAW: Dream a World, is an action research project inspired by the needs of Jamaican children who are growing up in a post slavery context and in a country with one of the highest murder rates and lowest suicide rates in the world. The project began in 2006 in a garrison community elementary school in inner city Kingston, Jamaica, incorporating 60 children (30 index and 30 controls) over three years. Index children (at risk) were identified at age 8 based on the presence of seriously disruptive conduct and failing at school. The aims of the project were to work with the children at risk with cultural therapists, artists and teachers, emphasizing literacy and self-control. Cultural therapies are art based therapies which culminate in a performance piece of music, dance and art yearly in a three year intervention.

The intervention with the first cohort was successful in retaining the entire treatment group at school and in reducing externalizing and internalizing symptoms. The intervention integrated teachers from the elementary schools, allowing a knowledge transfer model for teachers by providing models, tools and psycho-educational strategies for the participating teachers.

The intervention begins with a two-year summer program and refuelling during the year with a bi-weekly meeting with the children. Children are taught to work in groups, use mindful exercises, eat a meal and go on outings to expand their horizons outside their community. The arts intervention includes use of poetry and writing a script for a dance performance piece reflecting their experiences, including witnessing of violence, their hopes and dreams of moving beyond their traumatic experiences. Supervision of

teachers and therapists is provided by the research team and the focus group sessions with staff are videotaped for feedback and review.

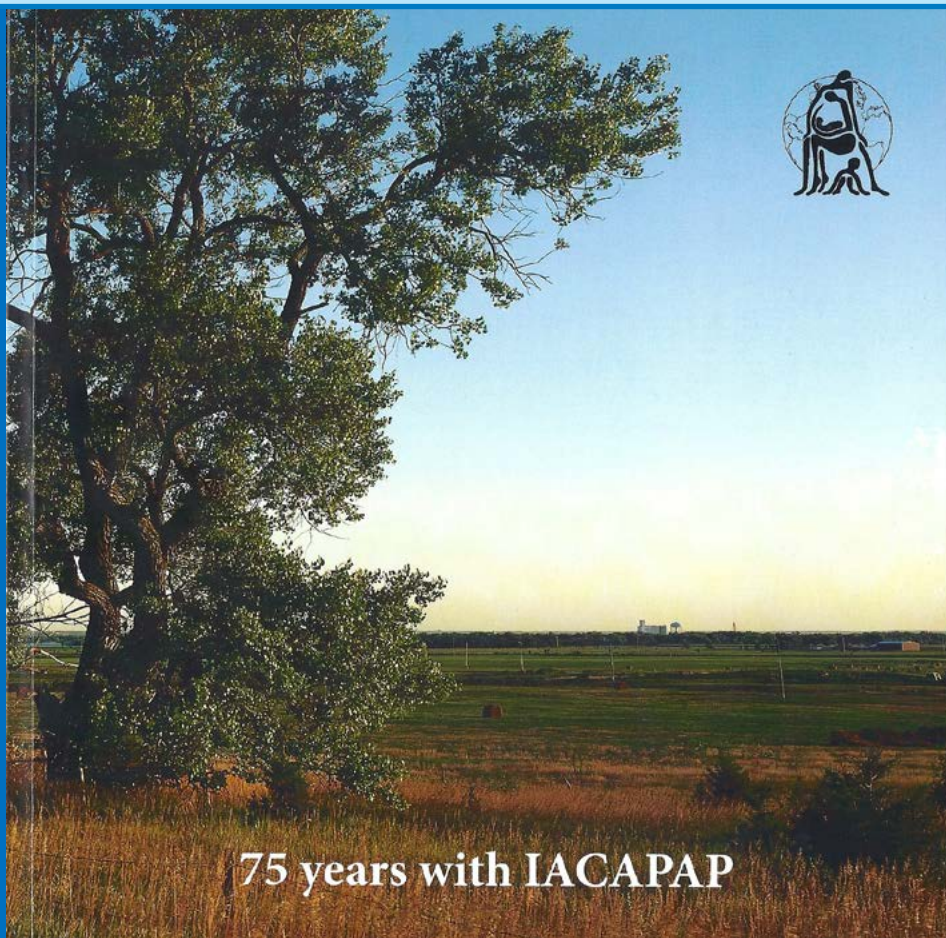
Teacher's perceptions of these disruptive children have moved from marginalization to engagement, and the academic achievement of the index students has been significant. The project also noted the varied gender trajectories of these children and raised questions about the vulnerability of girls who are exposed to early trauma in these violent communities and within their families. These families have largely avoided involvement with school and perceive any mental health intervention as highly stigmatizing but accepted DAW as helpful for keeping their children in school in a society where early dropout rates, substance abuse and early pregnancy are high.

ARE YOU A 'FRIEND' OF IACAPAP?



If not, click on the picture and become a friend of IACAPAP in Facebook to receive the latest:

- International news about child and adolescent mental health
- Research findings
- News about grants, fellowships and conferences
- IACAPAP news.



The History of IACAPAP

By Kari Schleimer MD, PhD

This book, with many illustrations, describes the history of the association from its foundation and early times highlighting the many people who contributed to the development of IACAPAP, the congresses, publications, teaching activities and much more.

To obtain a copy (20 €) email Kari Schleimer kari.schleimer@bredband.net



Caring for Children and Adolescents with Mental Disorders in Chile

Advances and Challenges

Matias Irrarrazaval MD, MPH

Chile is an upper-middle income country with a rapidly expanding economy and concomitant social and cultural changes. Chile had the fastest-growing economy in Latin America during the 1990s and has weathered well recent regional economic and political instability. Nowadays, the country has the highest ranking in the Human Developmental Index in the region, above Brazil, Mexico and Argentina, and the largest average income per capita, comparable to Poland and Portugal.

Among other Latin American countries, Chile exhibits high health indicators. The average life expectancy is 79 years compared to the regional average of 76 years. The under-five mortality rate for both sexes is 9 per 1,000, similar to the USA and half the rate for the rest of Latin America. In addition to these indicators, there have been steep transitions in health conditions and health priorities. During the 1960s, malnutrition was of epidemic proportions affecting 37% of children under 6 years. Currently, malnutrition in the same group has been reduced to 3% and in fact we are confronting the opposite problem: obesity in children has increased markedly over the past decades, from 7% in 1987 to 22% in 2011. This reflects the health transitions the country is experiencing, moving from acute infectious diseases and nutritional

deficiencies as the predominant causes of morbidity and mortality to the predominance of non-infectious chronic diseases. Therefore, the country is experiencing significant lifestyle changes that also reflect on child mental health.

Child Mental Health in Chile

The results of the first national epidemiological study of child and adolescent psychiatric disorders became available in 2012.¹ The overall prevalence of disorder found was 23%, higher in females (26% vs 19% in males), and in children aged 4-11 years (28% vs 17% in adolescents). Disruptive and anxiety disorders were the most common conditions followed by mood disorders. The high prevalence of ADHD (10% among 4-11 year-olds) is a cause for concern. Compared to other international epidemiological studies these rates suggest a higher prevalence of disorders in Chile compared with the rest of the world, although this might have been due to methodological differences. These epidemiological findings may reflect economic disparities in Chile, the highest of all OECD countries. Children and adolescents have the highest rate of poverty of all age groups and low socioeconomic status is associated with mental health problems.

To what extent are mental disorders in children and adolescents indicators of the suffering and difficulties that afflict

the “new, almost-developed, Chile”? To what extent does this “new epidemic” expresses the impact of the social transformation linked to an accelerated (and unequal) modernization process? How is Chile taking care of these problems? There is no doubt that mental disorders in children and adolescents are a real problem that should not only be a public health priority but also the subject of public debate about the kind of society we want for our children.

Mental Health Policy, Planning and Legislation

No mental health policy existed in Chile before 1990. The first national mental health plan was promulgated in 1993. Child mental health was not explicitly included although it was part of the plan as a component of prevention and treatment of specific mental disorders. The plan was updated for the period 2000-2010 including specific programs for child and adolescent mental health in the areas of child abuse, ADHD, substance use disorders, depression and schizophrenia.

The second reform, the regime of explicit health guarantees (*Acceso Universal con Garantías Explícitas—AUGE*), became law in 2004 and was implemented in 2005. The AUGE reform was a health program conceived within a social-guarantee framework that established the free coverage—with a

quality guarantee—of sixty-nine health conditions by both the public and private health systems. Currently the program includes 80 conditions, four of them related to mental health: depression and bipolar disorder in people older than 14 years, substance misuse in people younger than 20 years, and schizophrenia.

In relation to depression, AUGE has made possible the treatment of almost 800,000 people from 2005 to 2013. As a result of this program 75% of the people in the public health system do not have to pay for depression treatment. The program offers different treatment plans depending on the severity. If the depressive episode is of mild or moderate severity an outpatient package is offered, comprising medication, psychosocial interventions or both, and including admission to a hospital if needed, with an out of pocket cost of US\$18 yearly. In case of severe depression, the patient must be reviewed by a psychiatrist within 30 days who decides about the level of services needed. The maximum co-payment in this case is US \$75 yearly.

Change of Focus: Prevention is Better (and Cheaper) than Treatment

The government has recognized that to be sustainable and to avoid the negative consequences of rapid economic development, a strong economic growth requires equality of opportunity and a comprehensive social protection. Furthermore, numerous studies documenting the critical role that living conditions play in a child's early years, influencing social determinants of health, have convinced government officials to develop a health promotion and prevention system for the whole population throughout the life cycle, with a comprehensive network of services based on a human rights framework. The network is being built progressively, starting with young children and the elderly. "*Chile Crece Contigo*" (CCC), launched in 2007, is a cross-cutting initiative led by the Ministry of Social Development that also involves the Ministries of Education and Health. It is a universal social support system that aims to promote equal development opportunities for children (0-4 years old) and prevent disease through accessible pre-school education programs, frequent preventive health checks, improved parental leave, and increased child support programs. Currently, the

system covers more than one million children and 80% of the population from 0 to 4.²

CCC has been running for seven years and has improved and increased services supporting early childhood development. Developmental clinics have been established in more than 90% of the national territory and 1,800 free daycare centers have opened, increasing the number of accessible preschools by more than 300%. The program has also raised unexpected political awareness about the benefits of investing in early childhood development and education. The government has introduced universal free pre-kindergarten for all 4 year olds and this may be extended to include children aged 3 and even 2 years of age. As a consequence, it has been estimated that 3,000 to 6,000 mothers would have the opportunity to work and a reduction in poverty by 1% to 2%.³



Is this Enough?

While the positive value of the aforementioned initiatives is recognized, the national mental health system has focused on treatment programs without articulating a clear institutional framework. Chile does not have a plan or national mental health policy for children and adolescents, and without a clear regulatory framework it is difficult to ensure that the different public mental health policies are linked to the real needs of children and adolescents. This is a strong incentive to redesign policies and the network of health and social protection. However, this cannot be done exclusively by the health sector. Mental health—more than any other area in health—is intertwined with social determinants to such an extent that the boundaries between the social and the mental get blurred. In addition, a feature of the new social risk structure is that the different forms of social vulnerability tend to focus on the younger age groups.

This forces us to rethink the questions. It is neither about creating a larger or smaller welfare state, nor of increasing

savings or social spending in a time of economic hardship, the problem today is to redefine health and social priorities in the long term, and to design cost-effective programs based on the best available evidence.

Chile needs a major reorientation of social policy and human development programs. The challenge is how to combine social protection and social welfare policies and programs throughout the lifespan considering the developmental characteristics of children. This is what has been named elsewhere "a social investment welfare state" that aims to invest in the potential of children today to ensure the welfare state tomorrow. In that discussion, mental health is a key area.

There is consensus on the need to provide child and adolescent prevention and treatment modalities consistent with the physical, psychological and social changes that characterize these stages. This requires reconfiguring the logic of health services and social protection, but also to build a new adequate regulatory framework. In that sense, what might be some of the steps to move towards a new policy for child and adolescent mental health in Chile?

1. Create a mental health act. In Chile, like in many other countries, the stigma of mental illness and disability is an everyday issue resulting in discrimination at school, at work, etc. Chile does not have a law that protects the rights of people with mental illness or disability and to promote social integration. While in 2001 a new regulation protecting certain rights during psychiatric hospitalization was enacted, the regulation does not meet international standards. On the other hand, a mental health law may help to ensure financial sustainability of policies and programs.
2. Develop a national plan for child and adolescent mental health. While the National Health Strategy included issues of mental health, this area is not fully represented. The plan should be explicitly extended to child and adolescent mental health and include citizen participation through patient and family associations. Developing a mental health plan would be a milestone in the progress of our country towards full compliance

with commitments on the rights of children and adolescents. In addition, a framework should be put in place to promote greater inter-sectorial coordination for the implementation of programs of promotion, prevention, treatment and rehabilitation of mental disorders. Currently, despite the progress ascribable to the National Policy for Children and Adolescents 2001-2010, the coordination between health, education and justice is still limited.

3. Promote the integration of mental health in primary health care. There are huge inequalities (social and geographical) in the distribution of budgets, human resources and infrastructure in the access and delivery of mental health services. Integrating mental health into primary health care is the most viable way of closing the gap and ensuring that children and adolescents get the care they need.
4. Expand the treatment coverage of mental disorders in children and adolescents. The AUGE program

covers only those older than 15 years when more than half of the mental disorders start before that age. On the other hand, mental disorders represent only 5% of the conditions included in the AUGE program, yet they explain more than 20% of the burden of disease.

5. Increase the budget for mental health in the public system. The current budget (2% of the total health budget) is insufficient for the complete implementation of the National Plan of Mental Health and Psychiatry. WHO recommends that this expenditure should be between 5-10% of the total health budget. As a consequence, some of the priority issues have not been properly addressed. Furthermore, most of these resources are intended for adult mental health. In fact, child and adolescent mental health services have a lower implementation level than those of adults, and the number of outpatient and community services is still inadequate.
6. Improve training in child and adolescent mental health. Despite

the high prevalence of mental disorders, undergraduate health professions' curricula only dedicates 2-5% of the time to mental health. Primary care professionals have poor access to training in this area, and there are no training programs for primary care professionals.

It can be concluded that Chile has made much progress in mental health care but still has a long way to go, particularly in regards to children. The high prevalence, social significance and economic cost of mental disorders in the context of lack of specific policies, a limited budget, and the absence of an adequate legal and institutional framework make this problem one of the most important.

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Reference Centre for Rare Diseases with Psychiatric Expression & Early Onset Schizophrenia, Paris

Anne-Catherine Rolland

I asked Dr Angele Consoli, Head of the [Reference Centre for Rare Diseases with Psychiatric Expression and Early Onset Schizophrenia](#) in Paris (Department of Child and Adolescent Psychiatry, Head: Professor David Cohen; Pitié-Salpêtrière Hospital /Pierre et Marie Curie University), to describe the focus of this clinical centre's research. This is a summary of her answers.

Created in 2007, this is the only centre in France approved in the field of rare diseases. It specialises in uncommon conditions with psychiatric manifestations, early onset schizophrenia, and catatonia in young people. The main areas of research interest of the centre are:

- The clinical characterization of genetic pathologies with psychiatric manifestations
- Clinical, etiological and treatment studies of schizophrenia with childhood onset
- Clinical, etiological and treatment

studies of catatonic syndromes in adolescents

- Auto-immune diseases with psychiatric presentation, especially auto-immune catatonic conditions, and their treatment.

We have been assembling a large early onset schizophrenia cohort. Only one childhood onset schizophrenia cohort has been studied at the international level—by Judith Rapoport's team at the National Institute of Mental Health, US. While in psychiatric research substantial effort has been dedicated to the clinical characterization of patients, little is known about early onset schizophrenia. The recent discovery of rare gene copy number variations, which greatly increase the risk of schizophrenia and other neurodevelopmental disorders (autism, intellectual disability, epilepsy), demonstrates that a better understanding of the childhood forms of schizophrenia could be critical to progress in this domain.

We are also building a cohort of children and adolescents with catatonic syndromes to examine prospectively. This includes phenomenology, aetiology, associated medical conditions, psychiatric diagnoses, auto-immune and genetic aspects, response to treatment and changes over time. From 1993 to 2014, 90 individuals aged 12 to 18 were prospectively admitted for treatment of catatonic syndromes and are included in this cohort—the largest one available.

Finally, we are recruiting patients older than 12 years with Prader-Willi syndrome for treatment studies, focusing on a randomized, double-blind, eight-week trial of topiramate for symptoms of irritability-impulsivity, hyperphagia and self-mutilation/excoriations. To date, 70 patients have been included in this cohort.

Regarding pharmacotherapy, other studies are underway on the risk of osteoporosis associated antipsychotic treatment as well as other side effects.

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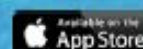
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E James Anthony (1916-2014)

On December 10, 2014, E James Anthony MD, FRCPsych, passed away and we were told it happened peacefully. With his death the IACAPAP family and child psychiatry all over the world have lost a great teacher, an outstanding researcher, mentor, initiator, and a warm-hearted person devoted in a special way to his patients and their families. James Anthony was a remarkable man in many respects and had great influence on the development of child and family mental health all over the world. He was President of IACAPAP (1970-1974), President of the American Academy of Child and Adolescent Psychiatry (1981-1983) and Honorary President of IACAPAP (since 2001).

James Anthony was born in Calcutta and was educated by Jesuits, before migrating to England to study Medicine. He attended the medical school at Kings College during the Second World War and was confronted in his first position with the psychiatric problems of returned servicemen. At that time he became also interested in group therapy and worked together with SH Foulks. Later he went to Hong Kong as Chief Medical Officer for Southeast-Asia and was engaged in building up care centres for Japanese children who had survived the Hiroshima bombings. After his return to England he continued his training in psychiatry and child adolescent psychiatry at the Maudsley Hospital in London and was awarded the gold medal from the University of London. In his early work as child and adolescent psychiatrist he was influenced by Jean Piaget, Anna Freud, Erik Erikson, John Bowlby and Aubrey Lewis. He liked to talk about his mentors and was especially impressed by the work of Jean Piaget, with whom he spent some time in Geneva. He underwent psychoanalytic training in London and was, together with SH Foulks, the founder of

group therapy. Both published the influential book *Group Psychotherapy: The Psychoanalytic Approach*, which is considered a milestone in group therapy.

During his Presidency of IACAPAP he initiated international study groups to train psychiatrists and explore the situation of children and families in different cultures and under different socioeconomic conditions. This has been continued by successive IACAPAP presidents. He was also the organizer and President of the 1974 IACAPAP World Congress in Philadelphia with the main focus on “children at risk”. Children at risk and children in danger were major topics throughout his scientific career, starting with the children survivors of the after Hiroshima bombing and later on to children of psychotic parents and children in unfavourable circumstances.

In 1958 he migrated from England to the United States and was appointed to the world’s first endowed chair of child psychiatry, the Blanche F Ittleson Professorship at the Washington University in St Louis, Missouri. He established a remarkable Centre of Child and Adolescent Psychiatry and initiated there outstanding research projects funded by the NIMH and several foundations.

James Anthony was a prolific writer. He authored 320 research articles and about 20 books, many of them translated into other languages. Together with Colette Chiland he was the editor of the IACAPAP book series “The Child in his family” (1970-1986). He was a member of the British, St Louis, Chicago, and Washington DC psychoanalytic societies.

He was married to Ethel Frances (Aust) until her death in 1983. They had four children, 11 grandchildren, and 10 great grandchildren. He was then married for 30 years

to Virginia Quinn Anthony, former executive director of the AACAP, who is mourning this loss with her son, her family and the Anthony Family. This mourning is shared by the IACAPAP family worldwide.

The Honorary Presidents of IACAPAP

Helmut Remschmidt

Colette Chiland

Myron Belfer

Personal memories

James Anthony has been a friend forever, if I may say so. Others will pay homage to the scholar; I want to speak about the friend. I met him in Dakar in 1973 at an IACAPAP Study Group (he had started these study groups). It was also my first encounter with IACAPAP. I think my first one-to-one talk with him was in the water—as soon as the first working session was over, the two of us rushed into the sea. The water looked dark because of the black color of the sand and the cloudy sky of the season called “hivernage” or “overwintering” in Senegal. We both were very keen on swimming. At that meeting, I was appointed assistant editor of the IACAPAP book, James being the editor-in-chief and Cyril Koupernik the co-editor. They told me it was going to be a light commitment for a short time... It turned out to be a heavy duty for twenty years. So, we worked together; I was in charge of the French edition and had to translate James’s English. That was a delight. James wrote truly marvelous English, not a professional medical language, anonymous, empty of life.

James was very creative. I remember the Congress of AACAP in San Francisco where he organized a session about exceptionally gifted children; the session itself was exceptional. He also valued a variety of viewpoints and longitudinal studies. He knew French, though through the years he lost the ability to speak but was able to read it.

He had the opportunity to spend a year in Geneva, near Jean Piaget. He said that he had learned a lot from Piaget’s clinical method of questioning children. But, at the end of the year, he got ‘affect hunger’: “The air in Geneva is saturated with Piagetian thought, and for the student no other air seems available, so he must breathe it or perish. For me, it was always imbued with the freshness of mountain air. There was no stale clinic smell about it. But the higher you went, the more tenuous it appeared to become and less fitted to sustain psychological life as I knew it. I felt that one could die psychologically of such ‘affect hunger’.” This paragraph gives an idea of James’s style of writing. He had also a very personal style in child psychotherapy: he did not play with the child; he let the child play before him, just making very circumspect comments.

He wanted me to continue sending him my papers and recently, apropos of gender and the craziness of the denial of biological reality, he wrote to me with his usual humor: “Are people becoming more crazy, or is it just us?” I wrote back that I would use this remark as the epigraph for my next book.

James was a person you could never forget once you met him. In spite of my sorrow today, I am smiling at him and to all he gave me and to so many others.

Colette Chiland

E James Anthony (first row, center)
in the midst of the IACAPAP family
(Italy, 2001)



I was always grateful to James Anthony—he was the one who proposed me for IACAPAP at a quite young age, after I together with my wife visited him in 1976 at St Louis, Missouri. I was impressed when he showed us a brand new, modern and elegant building with air conditioning and many rooms in the yard of his department. When we asked him how he was able to achieve this, he said: “this was very easy, I treated successfully a girl with anorexia nervosa and her grandmother sponsored the building”. I was coming from Berlin (West-Berlin at the time) and he told me later that some of his young colleagues, who were not very familiar with the political situation in Europe, suspected I could be a spy. When some years later, in autumn 1978, my department and full chair of child psychiatry and neurology at the Freie Universität in Berlin was officially opened, I invited him to the event and he gave an excellent paper on “Children of Manic- Depressive Parents”; he was wearing during his talk a sweater and sneakers—his luggage had been sent to Tel Aviv and arrived a few days later.

I have also many memories of times together with James and Ginger in Italy (Dozzy, Venice) and many other places including the IACAPAP San Francisco Congress following the sudden death of Irving Philips. In 2001, I had the privilege of handing over the certificate to James Anthony appointing him as IACAPAP honorary president.

His death inspired me to think of many joint meetings and events that can hopefully give some comfort to Ginger and all those mourning his death. According to the German poet Jean Paul (1763-1825): “The only paradise from which we can not be driven out, is our memory “. So let us be comforted and consoled by remembering James Anthony.

Helmut Remschmidt



Please join us in New York for the joint meeting of the International Society for Adolescent Psychiatry and Psychology and the American Society for Adolescent Psychiatry, March 26-29, 2015, at the New York Marriott East Side Hotel.

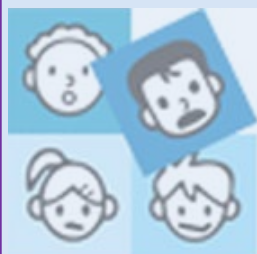


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