International Association of Child and Adolescent Psychiatry and Allied Professions

IACAPAP

Association Internationale de Psychiatrie de l'Enfant et de l'Adolescent et des Professions Associées

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Contributions to the IACAPAP *Bulletin*

President's Column

IACAPAP is playing an important role in international child mental health. Recognition of IACAPAP's status as a non-governmental organization in official relation with the World Health Organization has given us the opportunity to participate in activities that allow IACAPAP representatives to promote advocacy for child mental health services, training and policy. The international recognition of IACAPAP can be used by national societies to further national initiatives in these same areas. The work of IACAPAP members on natural disasters is one example, but others are noted later in this column. In this context, I want to thank the several IACAPAP members who participated in the development of the **Statement on Responses to Natural Disasters** (July 2005). The document, which can be downloaded from the IACAPAP website (www.iacapap.org), has been very well received.

This issue of the *Bulletin* contains articles on activities that reflect the diverse initiatives and commitment of IACAPAP member organizations and individuals who are aligned with IACAPAP. Among the activities that

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Secretary General's Column

After the Berlin Congress, the Bureau (The President, the Past President, the Treasurer and the Secretary General) has "met" on a regular basis using tele-meetings in order to keep up with all the current IACAPAP-issues.

In January 2005, the Executive Committee met for a board meeting in Cairo, where the majority of the EC members were present to prepare for the **WHO**, **IACAPAP** and the **WPA Presidential Global Programme on Child Mental Health**. A number of important issues were discussed in relation to accelerating regional IACAPAP activities, with the aim to support regional seminars in research, and regional training programs in order to promote the establishment of CAP in developing countries. One idea brought up at the EC meeting is to inspire the new generation of child and adolescent psychiatrists all over the world by asking for a new curriculum for training. By supporting this, IACAPAP could take an initiative in helping to design a new "world-wide" curriculum. With such a curriculum and support for planning in mental health policy, the new generation of child and adolescent

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It is with profound sadness that I must inform you of the death of Howard Cooper in an accident in Australia while practicing for a triathlon competition. Howard was a member of the IACAPAP Executive Committee and organizer of the forthcoming IACAPAP Congress in Melbourne. Howard was a person of seeming boundless optimism and energy, a keen intellect, and dedication to his work and profession. He was impressive in so many dimensions. Howard was Chair of the Faculty of Child and Adolescent Psychiatry of the Royal College of Psychiatry in Australia and New Zealand, and director of child and adolescent psychiatry training in Victoria. His is a very great loss for his colleagues in Australia, but a wider loss for the younger generation of child psychiatrists worldwide who will be our future leaders. Howard leaves a wife, Lindy, and three young children.

President's Column

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are highlighted is the very special work of **James Leckman** with Palestinian and Israeli colleagues, the development of a communications initiative, follow-up on the Donald Cohen Fellowship Program, and the reports on two important regional research training seminars hosted by the Eastern Mediterranean and the European Associations (**EMACAPAP** and **ESCAP**). The success of the Berlin Congress thanks to the magnificent efforts of **Helmut Remschmidt and colleagues**, in terms of attendees, scientific program and the substantial financial contribution it made to IACAPAP, will enable us in the coming years to pursue initiatives that will make a real difference to the state of child mental health training and services worldwide.

IACAPAP has collaborated with the World Psychiatric Association (WPA) on the Presidential Global Programme on Child Mental Health. This extraordinary initiative, conceived by Professor **Ahmed Okasha** and supported by **Tarek Okasha** and **Norman Sartorius**, is funded by the Lilly Foundation. The Programme enabled the development of materials that will have a longstanding impact on child mental health. IACAPAP members serve on the WPA Steering Committee. A task force on awareness chaired by **Sam Tyano** (IACAPAP Vice-President) prepared a manual on awareness that provides guidance on how organizations and countries can develop campaigns to heighten the awareness of the impact of child and adolescent mental disorders. This task force also prepared other useful information for parents, children, adolescents and other professionals. The task force on prevention chaired by **Helmut Remschmidt** (past-President of IACAPAP) developed several important background papers and resource materials on topics of interest in the area of prevention, including school drop-out. Three field trials with the aim to reduce school drop-out rates in Alexandria (Egypt), Nishnij Novgorod (Russia), and Porto Alegre (Brazil) were completed in 2005. The task force on treatment, chaired by **Peter Jensen** (IACAPAP Counselor) developed CBT-based manuals for the treatment of internalizing and externalizing disorders that can be used for training world-wide. Additionally, Dr. Jensen's task force supported the WHO effort to produce an Atlas of country resources for child and adolescent mental health (described below). Other IACAPAP Executive Committee members involved with the Programme are **Martine Flament**, **Barry Nurcombe**, **Ernesto Caffo**, **Per-Anders Rydelius**, **Kang-E Michael Hong** and **Amira Seif El Din**. I served on the Steering Committee representing the WHO. After the WPA meeting in Cairo this September, the materials will be available on a CD-ROM from the WPA or can be downloaded from the IACAPAP webpage. It is hoped that IACAPAP will take up the dissemination of materials and follow on activities from the Global Programme.

IACAPAP recently received a three-year grant from the **Lilly Foundation**. The grant will support the expansion of the "study group" model utilized by IACAPAP in years past to reach additional areas of the developing world, and to develop basic training materials that can be utilized by those involved in addressing the mental health problems of children and adolescents in the developing world. This is the first time that IACAPAP has had sustained grant funding and it is hoped that we can demonstrate our capability to use the funds in a constructive manner to lay the ground work for additional support from other sources. With the funds that IACAPAP now has as a result of the Berlin Congress coupled with the Lilly grant and other anticipated financial support, we can be responsive to needs identified by member societies consistent with IACAPAP's priorities for training, advocacy and fellowship support. We will provide more details about the Lilly-funded initiatives in future *Bulletin* issues. We expect that the current and anticipated funding in the future will provide enhanced opportunities for member organizations to participate in these new activities.

Jack Davis, a pioneer in therapeutic residential school development and former Director of the Grove School, has been a long time, staunch supporter of IACAPAP. Over decades he has been a presence at Congresses, provided sage advice to officers of IACAPAP, and championed the cause of children. He is also very proud of the accomplishments of his family, including the writings of his daughter, **Katie Davis**, which have been seen by many at IACAPAP Congress booths. Jack and his wife have also been very generous financial supporters of IACAPAP over the years. Prior to the Berlin Congress the Bureau voted to bestow a IACAPAP medal on Jack. This award has not often been given and recognizes Jack's unique contributions. We look forward to giving Jack his medal at the Melbourne Congress and inaugurating a lecture in his name and that of his wife, **Helen Davis**, at the meeting. The lecture will recognize the importance of literature and creativity in the mental lives of children.

At WHO I have just completed work on the **Child and Adolescent Mental Health Atlas** (see article). This project, which is a collaboration between WHO, IACAPAP and the **WPA Presidential Global Programme on Child Mental Health**, has pointed up the enormous gap in resources for child mental health worldwide. With global objective information gathered in one volume for the first time, it is hoped that advocacy for child and adolescent mental health training and services can be enhanced. It is recognized by all involved that the information at this time is relatively crude, but it is expected that future refinements and the involvement of more informants will lead to more accurate information at the country and regional level. The Atlas can be an important tool for regional and national organizations for the purposes of data gathering, and may give some national organizations the opportunity to initiate national legislation and program development in areas of training, service development, or policy. IACAPAP wants to support these efforts and will do its best to facilitate communication among national organizations. The Atlas will be available for downloading on the WHO website (www.who.int/publications) (and for purchase in hardcopy) along with another recent child and adolescent mental health publication on policy development (Child and Adolescent Mental Health Policies and Plans), which is part of the WHO Mental Health Policy and Service Guidance Package.

Over the next several months I am looking forward to travel to China, Korea and Japan. In these countries I will be

meeting with national organizations and helping to promote child and adolescent mental health. During this time I will be hosted by Dr. **Yi Zheng** and colleagues in China and **Kang-E Michael Hong** and colleagues in Korea. **John Sikorski** (IACAPAP Treasurer) will join me in my travels to China. Earlier this year I attended a unique regional meeting in Brazil. This was the first time that FLAPIA held a joint meeting with colleagues in pediatrics and neurology. The meeting was a great success and is perhaps a model for how we may proceed with fostering collaboration in the future. Drs. **Luis Rohde** (IACAPAP Assistant Secretary-General) and **Salvador Celia** (IACAPAP Counselor) were very active in the development and implementation of the meeting.

Dr. Celia was elected President of **FLAPIA**…congratulations! In October I will be in the Congo for an exceptional regional meeting of professionals involved with child mental health. **Brian Robertson** (IACAPAP Adjunct Secretary) is key to the development of this meeting.

I hope that you will mark your calendars for the IACAPAP Congress in Melbourne, September 10 to 15, 2006. This promises to be an excellent educational opportunity with unique features reflecting new initiatives in response to global issues.

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Secretary General's Column

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psychiatrists could be guaranteed a good level of individual training, be interested in research, and have tools for program implementation. The European model from UEMS could be an example for an international CAP curriculum. In order to enhance such regional activities and communication within IACAPAP, the EC decided to institute the following committees: a **Communication Committee**, chaired by **Phyllis Cohen** and **Andres Martin**; a **Committee for Research and Training**, chaired by **Helmut Remschmidt** and co-chaired by **E-Kang Michael Hong**, and a **Finance Committee**, chaired by **John Sikorski**. The Communication Committee shall also be active in supporting the IACAPAP fellowship programmes. The great responsibility put on individual shoulders when planning for international congresses was discussed. From all the experiences achieved during the planning for the recent congresses in Stockholm 1988, in Israel 2000, in India 2002 and in Berlin 2004, **Ernesto Caffo** suggested the EC form a permanent committee in order to train people to organize congresses.

The following national associations have been recognized as full members of IACAPAP: **Asociacion Mexicana de Psicoterapia Psicoanalitica**, A.C.; **Iranian Academy of Child and Adolescent Psychiatry** and **Slovenian Association for Child and Adolescent Psychiatry**. IACAPAP also welcomes Dr **Liliya Butenko** and Dr **Igor Martsenkovsky** from Ukraine, Dr **Bouden Asma** from Tunisia and Dr **John Fayyad** from Lebanon as individual/associate members.

In the preparations for the forthcoming General Assembly at the Melbourne Congress in 2006, The President has asked **Kari Schleimer** to chair the Nominating Committee (**Kari Schleimer**, **Kosuke Yamazaki** and **Helmut Remschmidt**) for the next EC.

In April 2005, a **President's Letter** was sent, by regular mail, to the Presidents of all the national member organisations in order to give updated information on IACAPAP activities, especially regarding the Melbourne 2006 Congress.

For your information, from September 1st, my e-mail address will be **per-anders.rydelius@ki.se**. My previous address, peranders.rydelius @kbh.ki.se, will be automatically linked to the new address for at least one year.

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Secretary General, IACAPAP

Regional Events

Second EMACAPAP Research Methodology Seminar

Sharm El Sheikh, Egypt
February 27 to March 3, 2005

The Second EMACAPAP Research Methodology Seminar was held in Sharm El Sheikh from February 27th to March 3rd, 2005. The Seminar was supported by IACAPAP, the Italian Foundation for Children (Foundation CHILD), WHO, and the Child Mental Health Association of Egypt. Its clinical focus this year was on anxiety disorders in children and adolescents.

Thirty-seven participants attended the five-day training course, representing ten countries in the region (Algeria, Egypt, Iraq, Jordan, Lebanon, Morocco, Palestine, Syria, Tunisia, and Yemen). Three presidents of international organizations were also in attendance: Professor **Ahmed Okasha** of the World Psychiatric Association, Professor **Myron Belfer** of IACAPAP, and Professor **Ernesto Caffo** of ESCAP. In addition, Dr. **Srinivasa Murthy** represented the Eastern Mediterranean Regional Office of WHO. The Seminar was enriched with valuable participation from faculty members **James Leckman** and **Phyllis Cohen** from the Yale Child Study Center, **Phillip Graham** from the London Institute of Psychiatry, **Andreas Warnke** from Germany, and **Bennet Leventhal** from the University of Chicago. They served as both teachers and mentors for the trainees.

In a plenary address Professor Okasha presented the WPA Presidential Global Program on Child Mental Health, with its three task forces of prevention, treatment and awareness.

The participants were child psychiatrists, adult psychiatrists interested in child psychiatry, and psychologists. Many of them are key persons in their respective countries, managing child mental heath in governmental or non-governmental organizations with a key objective of ensuring long-term sustainability, particularly in light of the dearth of child psychiatrists in the Arab world. One third of the participants attended the previous research methodology seminar the year before. An objective of the seminars is to keep key

persons oriented to the state of the art in the particular areas of discussion, with the hope of making up for the scarcity of child psychiatrists in the region. To this end, two thirds of the participants were invited to prepare in advance a protocol of research covering an area related to anxiety disorders, projects subsequently presented and constructively critiqued at the Seminar.

The senior delegate from the participating countries presented the state of knowledge and care for anxiety disorders in the respective country, with an emphasis on the availability of necessary facilities and resources. As reported in the evaluation by participants at the end of the training, this particular session was one of the meeting's highlights. It was especially helpful to exchange information related to the availability of facilities and services in the countries of the region.

The Organizing Committee developed a new approach in this seminar. Faculty members worked with three to four participants to discuss their protocols and to advise them on the most appropriate approach, and how to optimally use specific instruments and methodologies in their research. This approach was very effective and was conducive to forging closer relationships between faculty and participants.

Mornings were dedicated to reviews of the scientific literature related to anxiety disorders, and afternoons to the ethics of research and to an approach to writing and publishing scientific manuscripts. Professor **Phyllis Cohen**, in addition to presenting case studies to discuss separation anxiety, presented a short biography of her husband, the late Professor **Donald Cohen**, founder of EMACAPAP during his tenure as president of IACAPAP. Professor Caffo discussed the two presentations from Yemen and Lebanon related to PTSD and coordinated a debate on the controversies of PTSD in children and adolescents. Professor **Bennett Leventhal** provided a very useful session on the indications and use of anxiolitic drugs, and Professor Belfer discussed anxiety disorders across life span. Professor **James Leckman** presented a state-of-the art lecture related to OCD, and distributed to participants several tools to reliably assess anxiety disorders. Prof. Graham presented a useful talk on child psychiatric clinical interventions in general, and regarding anxiety disorders in particular.

As it was important to provide participants with specific skills to manage anxiety disorders. Professor Warnke demonstrated his approach to implementing Cognitive Behavioral Therapy (CBT). The Egyptian group in turn provided participants with a CBT manual in Arabic (developed by Professor **Peter Jensen** and colleagues at Columbia University, as part of the Presidential program of WPA.) At the end of the five-day seminar, all participants received a CD with the presentations in the training, and including the CBT manual in Arabic courtesy of Professors Jensen and Okasha.

The afternoons of the last three days were dedicated to the participants presenting their research proposal, with competition for the **EMACAPAP Donald Cohen Research Award** running very high. Four proposals were selected to receive awards. The winners came from Egypt, Morocco, Tunisia, and Syria.

As a concrete and most gratifying result of the Seminar, and in keeping with its goals of sustainability and forging of working relationships, a **follow-up regional meeting** was held in Lebanon soon after the Sharm El Sheik Seminar. During the four days in **Tripoli** (March 12–16, 2005), members of the Egyptian delegation now served as trainers and moderators to 23 participants from the Lebanon, United Arab Emirates Syria, and Yemen.

The EMACAPAP Bureau would like to express its gratitude to all participants, faculty members and trainees, with a special *grazie* to Professor **Ernesto Caffo** for his ongoing support to conduct this training on a regular basis in the Region – and a warm *shukran* (thank you) for his unwavering support for EMACAPAP in its goal of promoting mental health for the children of the Middle East.

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Fifth European Research Seminar in Child and Adolescent Psychiatry

Monasterio Santa Croce
Bocca di Magra, Italy
April 10–15, 2005

The Fifth European Research Seminar was a joint venture of ESCAP, IACAPAP, and the Foundation Child, chaired by **Ernesto Caffo** (Modena, Italy).

The European Research Seminars are intended for junior child and adolescent psychiatrists who wish to pursue a research career. The aims are to provide basic knowledge in key aspects of research design in child and adolescent psychiatry, skills in presenting research to colleagues, and skills in commenting on the research of others. These aims are achieved in a week's course that combined lectures by experts in the morning with small research groups in the afternoon. The seminar also provided an opportunity for future researchers to meet with colleagues across Europe and therefore incorporated a program of social events that included two formal dinners and a trip to local attractions.

The theme of the Fifth Research seminar was: **Clinical Research: Design, Assessment and Evaluation**. The seminar was attended by 30 colleagues from 21 European countries. It started on Monday, April 11, and was introduced by **Ernesto Caffo** (President of ESCAP and the Foundation Child), **Myron L. Belfer** (President, IACAPAP), and me. All participants introduced themselves and were allocated to project discussion groups in the afternoon. It is a rule in these seminars that every participant is expected to present a research project that is discussed in small groups in the afternoon.

The lectures began with a general introduction into research in child psychiatry by **Philip Graham** (London, UK). His theme was: "Research in child psychiatry: A historical account" (1963–2005). This presentation was followed by a lecture by **Paul Lombroso** (Child Study Center, New Haven, USA) on "How to choose a research project."

The lectures went on every morning until Friday, April 15, covering the following topics: "Design and conduct of multi-center clinical trials" (**Giovanni Fava**, Bologna, Italy), "Knowledge about clinical intervention" (**Philip Graham**, London, UK), "From clinical work to clinical trial in pediatric psychopharmacology" (**Larry Scahill**, Child Study Center, New Haven, USA), "Writing research articles" (**Janice Naegele**, Wesleyen University, Connecticut, USA), "Evaluation of CAMH services – use of the HONOSCA in the UK" (**Elena Garralda**, London, UK), "Clinical studies in genetics" (**Johannes Hebebrand**, Essen, Germany), and "Evaluation studies of complex interventions in child and adolescent psychiatry" (by me).

Discussion groups in the afternoon were chaired by the different speakers. There were three, sometimes four discussion groups in the afternoon, and all the research projects of the participants were discussed. The aim of these discussions is to enable participants to leave the seminar with a realistic research design that can be carried out under local circumstances, available resources and limitations.

We had a nice conference dinner on Wednesday, April 13, and an excursion to Porto Venere in the afternoon on Thursday, April 14. Every participant received a certificate of attendance, and there was an extremely good and stimulating atmosphere throughout the whole week. The seminar was evaluated by the participants who found the lectures and the discussions in the afternoon groups extremely helpful and thus gave an excellent feedback.

The aim of exchange of clinical and research experiences among participants from many different countries was fruitful and rewarding. The participants came from the following countries: **Albania** (Kosovo), **Belgium**, **Denmark**, **Estonia**, **Finland**, **France**, **Germany**, **Greece**, **Hungary**, **Ireland**, **Israel**, **Italy**, **Lithuania**, **Norway**, **Romania**, **Serbia** and **Montenegro**, **Slovenia**, **Spain**, **Switzerland**, **Turkey**, and the **United Kingdom**.

Special thanks were expressed by the participants to lecturers who provided excellent reviews of their topics, and to Prof. Ernesto Caffo for making this meeting possible through support of the Foundation Child.

On a personal note, for me as the organizer of the scientific program, this Fifth European Research Seminar was again an extremely rewarding experience.

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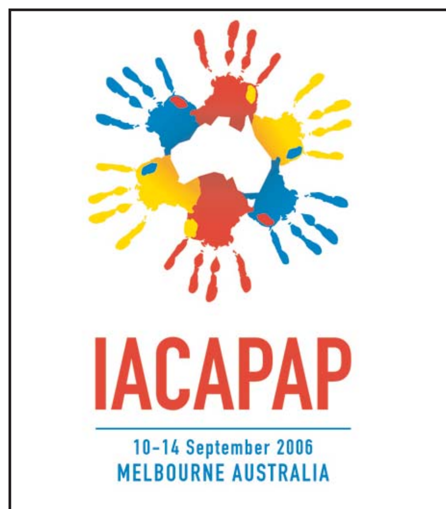
On the Road to Melbourne 2006

17th IACAPAP Congress Melbourne, Australia

Melbourne Convention Centre,
September 10–14, 2006
www.iacapap2006.com



The field of child and adolescent mental health in Australia has been fashioned, like the rest of society, by migration. Early professional influences were mainly from Great Britain and the United States. In recent years the influence of post-war migration from across Europe and Asia as well as the burgeoning of trade, travel and communications has led to a lively, diverse field grappling with the experiences of children in a multicultural society. Australian mental health professionals have strong links throughout Asia and the Pacific and these will be reflected in the scientific and social programs.

The scientific program will feature International and Australasian leaders in infant, child and youth mental health, who will present new knowledge from a wide range of research approaches; from the social sciences to biology, emphasising both quantitative and qualitative approaches, from epidemiology to contemporary treatment outcome designs. The overarching theme is the continued endeavours of clinicians to help improve the lives of children and families, relieve symptoms and impairment, and remove barriers to individuals achieving their potential in life. A feature of the program will be the ability to interact with presenters. The Program Committee invite you to present your work and participate in workshops, symposia, brief presentations and poster sessions. Keynote presentations will bring together information and highlight the cutting edge of clinical and research efforts.

You can be sure the 17th World Congress of IACAPAP in the antipodes will be stimulating and memorable. Please make a note of the dates and consider submitting a presentation or poster.

Under the theme, ***Child and Adolescent Mental Health: Nurturing Diversities***, the scientific program will showcase the exciting variety of approaches that are being developed to help children and their families. As well as keynote addresses and state-of-the-art lectures, the program is designed to help participants discuss the issues and develop their skills through master classes, symposia and interactive poster sessions. Speakers will include, among others, **Peter Fonagy**, **Ian Goodyer**, **Scott Henggeler**, **James Leckman**, **Helmut Remschmidt**, **Matt Sanders**, **Hans Steiner**, **Fiona Stanley** and **Michael White**.

You will be surprised by Melbourne's design innovation, the Australian landscape, and the unique animals, from fairy penguins to lyre birds and platypuses. Restaurants and art galleries highlight Melbourne's success as a multicultural and welcoming city – over a quarter of its three million people were born outside Australia and all languages are spoken.

The Congress Committee and the Congress Hosts, the Faculty of Child and Adolescent Psychiatry RANZCP

and the Australian Infant, Child, Adolescent and Family Mental Health Association, warmly invite you to attend the 17th World Congress. After this visit, you will want to return!

The Melbourne 2006 Organizing Committee
www.iacapap2006.com

Come On Down (Under)!

If you have ever met an Australian overseas, you have invariably been told many stories of kangaroos in the backyard, exotic wildlife, and tall stories of bush living. If you've ever watched TV with Australian characters, you are likely to be aware of broad accents, colorful colloquial expressions, and of course, the occasional khaki clothes and reptile wrestling.

Fact or fiction, you ask? Well, the upcoming IACAPAP Congress in Melbourne may be your opportunity to discover the true Australia, which does include some of the above (though tall tales are somewhat of a national pastime), but also so much more. This is an opportunity to see cosmopolitan Melbourne, a lovely, vibrant multicultural city that is truly charming, and uniquely Australian; a place for galleries, coffee shops and boutique shopping, surrounded by stunning national parks, wineries, and only a short plane trip away from Sydney, the beautiful beaches of Queensland, and the wonders of the outback.

Most importantly, though, it is an excellent opportunity to enjoy the IACAPAP Congress. As a psychiatry resident with a keen interest in child and adolescent psychiatry, I have high hopes for gaining a greater appreciation for this fascinating field. I would urge other residents and trainees to join me in grabbing this excellent opportunity to learn, mingle, and see our beautiful country.

So I invite anyone with an interest in child and adolescent psychiatry to attend the 17th World Congress of IACAPAP Conference in September of 2006. We would love to have you, and assist you in creating your own Australian story.

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Welcome to Australia!

Attending the IACAPAP 16th World Congress in Berlin in 2004 was a wonderful experience for me and I'm very proud that the next IACAPAP meeting is in my home country. During the 2004 Congress program I was able to share research and work experiences with delegates from around the globe. The presentation of such a diverse range of papers helped me to gain a fresh perspective on my own work.

I admit I am biased, but I do think of Melbourne as one of the most wonderful places in the world. There is a great diversity of culture and everyone is made to feel welcome.

There are many things to keep you entertained during your stay. The City of Melbourne has lots of exciting festivals throughout the year, and there are wonderful cafes, restaurants and art galleries to visit. Melbourne is a city of fashion and if it's shopping you're after, Chapel Street is the place to be.

If you are lucky enough to catch a game of Australian rules football at the Melbourne Cricket Ground, it will be an experience of a lifetime.

For those brave enough to ride on the old rollercoaster at Luna Park on St. Kilda, you will see some of the best views around. There are also many beautiful parks around the city where you can just sit and reflect on your experiences of the Congress.

The Congress has outstanding keynote speakers such as **Fiona Stanley**, who was awarded as *Australian of the Year* in 2003. This award is a celebration of the accomplishments and contributions of outstanding Australian citizens and each year an inspirational role model is nominated by the Australian public. So the Melbourne Congress is certain to provide you with exciting professional as well as social experiences. I personally, and we Aussies all, look forward to having you with us *Down Under*!

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Atlas for Child and Adolescent Mental Health Resources: Global Concerns:

Implications for the Future

The World Health Organization, in partnership with its Regional Offices and assisted through collaboration with the **International Association for Child and Adolescent Psychiatry and Allied Professions** and the **WPA Global Presidential Programme on Child Mental Health**, has for the first time systematically documented the status of services development, training and policy for child and adolescent mental health worldwide through the Atlas project.

The child and adolescent mental health ATLAS project is one of a series of Atlases documenting mental health services resources developed by WHO and collaborators. The child and adolescent mental health Atlas presented some unique challenges that reflect the current status of child and adolescent mental health services worldwide.

1) absence of an identifiable national focal point for child and adolescent mental health services;
2) fragmentation in the service systems responding to the needs of children with mental disorders;
3) great disparities in the services available in the private versus public sector; and
4) lack of appropriate systems for data gathering.

Specific issues related to the assessment of child and adolescent mental health services include:

1) *Epidemiological data*. The capacity to gather consistent, meaningful epidemiological data is largely absent in developing countries. The failure to use standardized nomenclature and methodologies has also hindered the ability to compare data across societies. Lastly, there is ongoing debate about the utility of certain diagnostic categories for children and adolescents.
2) *Definition of the need for services*. Assessing impairment in children and adolescents is a complex task

involving the need for culture-specific tools, agreement on criteria for impairment, and the implications of disorders for a reduction in the ability to be productive.

3) *Identifying the full range of services that might be provided to an affected individual in different service sectors.* Child mental health needs are often inter-sectoral or present in systems other than the health or mental health arena. Children with mental health problems are often first seen and first treated in the education, social service or juvenile justice systems. Since a great many problems of youth are identified in the education sector these problems may or may not get recorded as mental health problems or needs. Thus, since services are often under the jurisdiction of ministries other than health, it is difficult to collect and aggregate this disparate data and correlate it with individual or community need for services. Further, some programs are targeted to specific problems and come under the sponsorship of non-governmental organizations which often deliver services independent of government oversight.

Given the challenges of data gathering and the gaps in available data, the **Child and Adolescent Mental Health Atlas** (www.who.int/publications) was published with the primary purpose to stimulate additional data gathering in a systematic fashion and to encourage the development of needed child and adolescent mental health policy, services and training.

The information gathered for the child and adolescent mental health resources ATLAS was collected through a survey instrument designed specifically to gain information on youth services, training activities, and provider resources in all regions of the world. Despite concerted efforts meaningful information was obtained from only 66* countries in comparison to the ability to find substantial data for adult mental health services in all 192 countries (Mental Health Atlas – 2005, WHO). There are multiple reasons for the difficulties encountered.

1) The questionnaire covered a wide range of topics and it was difficult for one person to complete. Key informants were used to gather information rather than attempting to use any uniform source for data. This was done in an effort to obtain data from the individual(s) thought to be most informed about the available resources.
2) There are so many gaps in available services that potential responders were discouraged about the data to be offered.

Process: The questionnaire was developed by WHO in consultation with professional organizations and piloted in three countries. The questionnaires (available in English, Spanish and French) were sent to key informants. The list of key informants was derived from multiple sources.

1) WHO regional and country level child and adolescent mental health contacts.
2) WHO Regional Advisers for Mental Health
3) The national societies belonging to the International Association for Child and Adolescent Psychiatry and Allied Professions.
4) After two rounds of solicitation a third round was conducted in the context of the Global Programme on Child and Adolescent Mental Health which elicited some additional responses.

Limitation: A limitation to the study was the use of key informants who were thought to be the most knowledgeable in their country but who might have come from differing perspectives.

Note:

1) For some countries multiple responses were obtained. When there were multiple responses the information provided was reviewed and the most internally consistent response was incorporated into the survey database.
2) Concern with the low response rate was discussed with others involved in this type of survey and it was determined that it is particularly difficult to obtain responses in the area of child and adolescent mental health due to the factors noted in the introduction.

Region	No. of Countries*	No. of Respondents	Population Percentage
AFRO	46	15 (32.7%)	(34.4%)
AMRO	35	9 (25.7%)	(46.8%)
SEARO	11	3 (27.3%)	(71.1%)
EURO	52	25 (48.1%)	(64.7%)
EMRO	21	8 (38.1%)	(38.5%)
WPRO	27	6 (22.2%)	(87.7%)

Global Reporters At Large

The Trial: On Being a Muslim Woman Child Psychiatrist – in Houston

It happened during our inpatient rounds on the adolescent psychiatry unit. The team was talking to a patient in the lounge area when one of the other patients called out, "Hey, look what's happening on TV." The urgency in his voice made us all turn to look at the second plane crash into the twin towers. Stunned, we all stared as a historic moment played on. This ghastly image would be repeated again and again, until it would be seared into the memories of all Americans and millions of people the world over. We knew something had happened that should not have. What we did not know is how it would continue to have repercussions, not just in its near future, but for years afterwards, and in many more ways than one.

Why do I write this now, four long years later? Perhaps, I have seen this event play out in multiple subtle ways all through my training. Perhaps, living in the very multi-cultural city of Houston, I have seen the domino effects in a large number of both Muslim and non-Muslim families. Or perhaps I have listened to children, in their words and play and actions, tell their own story in a post 9-11 world.

Psychiatry is strange in the way it gives us access to the innermost, spontaneous thoughts and feelings of people. Some days later, after the ill-fated moment played out on the unit, one of my patients (someone I had a fairly good therapeutic alliance with) came up to me and said incredulously "You are a Muslim?!" Needless to say I was taken aback; the realization was as surprising to me as to him. Yes, I was, have always been; only that it had been almost a part of my genetic makeup, like my brown eyes, or my female form – unquestioned, unsurfaced. I grew up in Pakistan as a Muslim, trained to become a doctor, and came to the United States for my residency. My identity was my M.D., or so I believed, and my efforts, hard work and achievements or lack thereof would be the only variables that would differentiate me from others. Through the course of the day, I realized, sadly enough, that was no longer the case. That nine-year-old boy refused to talk to me thereafter, despite all my efforts, and in the process left a chilling truth for me to come to terms with. I am a Muslim and will have that ocean to cross many times both in my professional and personal life.

As I became more aware, I started hearing more stories. A distant relative living in New York had to take her four-year-old son out of school for six months because his name was Osama. Did she change his name? No, and I often wonder how this little boy feels growing up in the Bronx. Another nine-year-old boy, from a religious Muslim family, refused to say his prayers because of a wish not to be associated in any way with the "terrorists." The boy, causing great distress to the family, said, "I told my friends that I was cool, I wasn't one of them." Several adolescent girls who wore the scarf (*hijaab*) as an integral part of their identity, took it off, living thereon a life of conflict between guilt at forsaking their religion and fear of discrimination. At social gatherings, several parents took me aside to ask me how to deal with their children, most of whom were confused, scared, traumatized at school, and questioning the life their parents' lead as peaceful Muslims. Though there was burgeoning information around that time that focused on dealing with children in the midst of a national traumatic event, there was none that I could find on how to appease the Muslim children who were facing confusion on multiple levels. There was the occurrence of a national calamity that they shared with the other American children. Alongside however, they faced a change in attitude as perceived from peers, a fear of discrimination and emotional bullying, urgency as seen in their parents' concerns, and confusion over their religious beliefs now being criticized and questioned publicly and otherwise. In a number of cases. Muslim children were uprooted from a life they knew to one where one or more members of family were put in jail, deported, or simply harassed by immigration personnel.

The repercussions continue: at a free Muslim community clinic, we have observed an upsurge in the prevalence of depressed men and anxious women. Women complain of suddenly having to work, most of them for the first time in their lives, as their husbands continue to lose their jobs. Suddenly there is no one to look after their children who are being moved from a life of stay-at-home mothers to babysitters, day care and after school centers. Adolescents, screened for psychiatric symptoms, report significant anxiety, mostly in response to a stressful home life and parental psychiatric symptomatology, often untreated. In the Houston area, drug abuse is steadily rising in the Muslim youth. A probable cause may be the emotional unavailability of parents; the closely supervised kids now being left on their own devices. Religion, previously a protective factor, has become for many a source of conundrum in the aftermath of 9/11: in the form of wars, in the raising of rebellious youth or fervent zealots.

A quick look at the website for the "Physicians for Human Rights" yields abundant information on the state of mental health of children in war torn areas. Neighboring countries are also suffering the effects. Children are growing up with disillusionment, anger and a general mistrust of the developed countries and the progress they represent. As more families migrate from the US back to their countries of origin, children and adolescents raised in the US struggle to maintain their American identities. This has its own pitfalls: Adolescents from wealthy families can take with them remnants of a "drug culture" as a souvenir of sorts to carry from their stay in America. Pakistan, for example, has seen an upsurge in drug abuse in the last three to four years, the choice of drugs moving from "hashish" in the past to ecstasy and amphetamine use, mostly at rave parties.

The world today is slowly and surely moving towards globalization and the events playing out in "foreign" lands are beginning to have impact all over. As immigration into and out of the US continues at a rapid pace, and as the face of United States becomes more multi-cultural than ever before, we face a responsibility towards children's mental health that is more international in its scope. The horrific attacks of September 11, 2001, have generated a lingering aftermath that transcends culture, nation and religion. It stays alive in the form of traumatized children and adults, and in the subtle emergence of discrimination and malcontent both in the US and outside. It continues in the shape of ongoing war and the accompanying

violation of a child's basic right to non-violence. Over and beyond it lingers and grows in the form of American immigration regulations that treat friend and foe alike, and powerfully deter the practice of universal mental health care for our children.

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Finding My Way in the Holy Land

A life – even one's own – is too complicated a thing to hold in the mind, and this is why we need to identify with stories of others living in our time. It is only through the sharing of these cultural narratives that we can give coherence and meaning to our existence.

Ethan Watters, Urban Tribes

This past February, **Harvey Kranzler** kindly invited me to present at a child psychiatry conference in Israel. Having never been across the Big Pond, let alone to the Middle East, I eagerly accepted.

A Texan in Tel Aviv, immediately I was struck by the local citizens, many wearing evidence of their faith, and signaling allegiance to particular sects. Coming from a land plentiful in denominations, I was used to different groups wearing different clothes or even more subtle markings. Yet something more vital was in operation than I had anticipated.

As I made the quick bus ride to Jerusalem, appreciation for this holy land became more apparent. Not so much because of the temples or famous artifacts, but because of the exquisite citizenry. Throughout my stay, I encountered individuals mindful of their present and their past, something I, and perhaps many Americans, have relinquished. Many of us don't really know from whence we came, and so have identities steeped in shorter, more recently derived local traditions.

So, on my first evening in Israel, I was afforded an opportunity to attend *Shabbat* (Sabbath dinner) with a local family. In this family of five, father was a Rabbi and headmaster of a highly respected local *Yeshiva* (religious training school), mother was an early-childhood psychologist, and their three daughters spanned teenage years with one now in her early twenties. What was striking to someone so unfamiliar with such rich traditions was the quality of the social fabric in this home. All of the children participated in the preparation of this meal, and father led prayers and observances throughout its entirety, intertwining past and present. As the girls spoke, though, I found myself most moved. They adhered to these practices, aspired to spend their days with others who shared similar convictions, and indeed lived them when far away. Specifically, the oldest daughter had spent a year helping in a Russian orphanage, and sought to return. Hers was not a dutiful penance, but rather recognition of what was needed now on our planet.

I could only choke on my mental meanderings of the different world views and social fabrics extolled by the Paris Hilton wannabe's so prevalent in my local villages.

The following day granted a similar meal with a diverse group of adults, yet similarly tightly bound. This, a group of intellectuals from at least four continents, examined all those political and religious topics that fester conflict. Yet, no matter the topic, or the consensus, not once was I impelled to reach for my (absent) sidearm, or to urge someone to "take it outside." This meeting was girded in safety, blessed with the sanctuary afforded by prideful identity.

So what resounded throughout, and within, was the value of tribal identity so well codoned deep in our DNA, yet too often neglected now that one can travel half way around the world in a matter of hours. Tribe, according to *The American Heritage Dictionary of the English Language*, 4th Ed. (Houghton Mifflin, 2004) seems now lost to me. I'm aware of no past ancestral ties Etruscan, Sabine, or Latin, nor from any of the 12 tribes of ancient Israel, nor from an ancient Greek phyle. But if "tribe" refers to a unit of sociopolitical organization consisting of a number of families, clans, or other groups who share a common ancestry and culture and among whom leadership is typically neither formalized nor permanent, perhaps I do regain tribal status – as a child psychiatrist. This affords much:

> Those who have a connection with a tribe or heritage have less neurosis, and for those who still have a tribe left to reconnect to, doing so can dramatically raise self worth, and give a sense of value and real of meaning to life. (Andy Thomason, August 13, 1999, http://www.suite101.com/article.cfm/fourth_world/24071/3)

In psychiatry, large Freudian tribes and then Jungian, Kohutian, Kleinian and such factions emerged. More recently, it's been perhaps more tribal federations – psychotherapeutic and psychopharmacologic. The rational among us would argue that this isn't a tribal debate, but rather a scientific one – the "data" will reveal what is "right" and what we should all practice to best benefit our patients. But rain dances were, for many years, the extant tool to effect weather. Our science cannot be accelerated alone by our will.

What a 20-something Jewish woman illuminated for me was that a core prideful identity would weather any tempest, be it forced migrations or even genocidal ambush. For many of us, our tribal identity seems uncertain, as our geographic roots have been unearthed. But we are not required to abandon our religious core, or any other tribal attributes which well suit us. Rather, as mobility, longevity, and wider options become more accessible to all of us, we contend with a different dilemma: choosing and adhering to those tribal vestiges that will define us, that will foundation our core. What is proposed is that reverence of the past, yielding direction for the present and future, and that preserves our prideful heritage, be considered. Freud sought medicinal cures in his day, but found them unhelpful, so instead refined a different tribal dance, which benefits us still. Child psychiatrists "know" that resistance, defense mechanisms, and transference are as real as basal ganglia. So, too, we know that the brain is susceptible to illness, same as other bodily organs. Our appreciation for mental facts, and their biologic correlates, distinguish us from other medical tribes. Our psychiatric ancestors have not led us astray, but have instead provided us

directions helpful to our patients. Fulfilling our mission – seeking the compelling metaphors, illuminating reframes, and the magical tinctures – cultivates prideful identity. Such identity affords vision. Our promised land awaits.

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The Trouble with Tippies

This is probably an unusual contribution for the *Bulletin*, as the book I review here is not a psychiatric text, and I am not a psychiatrist. In fact, the book is a novel, and I am a student at the high hchool in a tiny Canadian village in Nova Scotia called Tatamagouche. Why is this book review in this journal, you may ask? It is a book about an autistic person, and I am autistic.

The author of *The Curious Incident of the Dog in the Night-Time* (Doubleday, 2003) had extensive experience with autistic children and the story is written as if it were composed by Christopher, an autistic child. The introduction states that

> …herein lies the brilliance of Mark Haddon's choice of narrator: The most wrenching of emotional moments are chronicled by a boy who cannot fathom emotion.

Although using a fictional autistic person as an author may be a literary trick, it brings much more than clever writing. I assume that Haddon wrote the book to help people to understand how autistic people think and why they do the things that they do.

The story begins with Christopher's finding a dead dog. It had been skewered by a garden fork and Christopher decides to investigate the canine murder so that the guilty person or people can be appropriately punished. During his investigations, he slowly uncovers some skeletons in the family closet. He discovers letters from his mother who, according to his father, is dead, and realizes that his father had been lying to him all along. He finds out that his mother is currently living with Mr. Shears, and that they had had an affair even before she left. Finally, he discovers that his father had killed the dog. He logically deduced that his father could also kill him, and runs away to live with his mother, throwing not only himself but also his entire family into utter chaos. The way he copes, and occasionally does not cope, reveals a lot about the way he thinks.

Mostly, the author managed to produce an accurate description of autism. Technical details are noted with extreme precision, even if they are completely irrelevant to the story. For example, once when Christopher has his pockets checked, he gives a list of all of the items in them, and even provides a picture of a wooden puzzle piece that was found. There are many other instances of autistic tendencies. The author has Christopher explain why he carries a multipurpose folding knife with him, why he likes dogs, and why he can't tell lies in equal detail. I can say that all of these are good descriptions of autism. I can understand wanting a knife around, although I find that a sharp tongue produces results that are just as good with less trouble. I like robots and computers in the same way as Christopher likes dogs, and it took me a very long time when I was young to begin to tell lies. (The delayed lying was probably because such a socially intricate method of avoiding punishment never occurred to me.) These are only some of the examples that I could mention here; there are many more.

The book does have some important flaws, though. Christopher describes several important scientific principles and other such things in great detail, such as why the sky is not all stars. All of the explanations given are quite logical, though some of them are technically incorrect. Christopher displays an advanced understanding of mathematics, and I would expect his level of scientific comprehension to be the same. Also, he has a habit of beginning sentences with prepositions!

The story also uncovers Christopher's everyday problems with ordinary people. I call this "The Trouble with Tippies" – Tippies being people who are typically wired and therefore not autistic. Most books are written about the problems that tippies have living with autists. This story provides a viewpoint that is not often expressed, namely an autist's challenges in having to live with tippies. Christopher has communication difficulties. He asks people direct questions without informing them about background information which is required to give an answer. Problems also occur when tippies say things that they do not literally mean. The book did not mention the embarrassing "fish out of water" feeling that autists sometimes experience when surrounded by tippies. I think that this might be what a tippy would feel if he was trying to have a conversation with someone wearing a Halloween mask. Autists do feel embarrassed but I think tippies misinterpret it as shyness and indifference, and our usual accuracy and bluntness is interpreted as rudeness. I have learnt this through careful scientific observation, but Christopher is younger and has not had much opportunity to observe tippies in their natural habitat. In the story they seem to spend a lot of time shouting at him.

On the whole, this is a very good book. It does not provide anything in the way of detailed analysis of autism, but it conveys a thorough understanding of the subject. It would be perfect for lending to people to help them to understand what autism is like, and excellent for having around the office to remind child psychiatrists about their patient's point of view.

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An American (Child Psychiatry Resident) in Paris

In September 2004 I spent some time in Paris, and what follows are the impressions – the good, the bad and the ugly – that French child and adolescent psychiatry made on me, an American, but one who also happens to be a French citizen courtesy of his parents. Of course this is a personal and impressionistic piece, not journalistic: I do not presume to state conclusive facts or even opinions on the state of French child psychiatry. My experience there was a narrow and unique one, but it does perhaps reflect some larger realities.

How did I get there? As part of my child and adolescent psychiatry fellowship program, we trainees have an elective month in which to pursue our own unique clinical or academic interests. Although the activities chosen can run the gamut, we are gently encouraged to travel abroad to obtain a sense of how child psychiatry is practiced elsewhere in the world and in the process interact with our international colleagues.

As a tri-national hybrid mostly raised and educated in the United States, this elective month was a wonderful opportunity to do what I have always wanted to since entering psychiatry: to see how psychiatry is practiced in my countries of origin, France and Switzerland (Swiss, too, through mom). As a first year child fellow, albeit with four years of adult psychiatry training already under my belt, I barely know my elected field. Rather than seeking to refine my skills or acquire a specialized training experience abroad, I wanted an elementary exposure to child psychiatry elsewhere. And so, through the IACAPAP network and the gracious help of its far-flung members I was able to organize an itinerary for Paris and Geneva.

Some of my time in Paris was spent at the **Centre Alfred Binet**, where I was warmly welcomed by the director, medical director and their colleagues. The Centre is part of the larger Association of Mental Health (ASM) in the 13eme arrondissement, or Paris' 13th district. The Centre represents the child and adolescent department of the ASM and serves infants to adolescents, a similar arrangement to a community mental health center in the United States. In the U.S., a community mental health center often implies treatment in the settings of poverty or low income. In contrast, the Centre serves a fairly wide swath of society of both French nationals and immigrants (mostly Chinese, Sub-Saharan African and Arab) of varying socio-economic levels. They consult to about 2000 children with about 800 referrals per year. One-third of these are self-referred, nearly two-thirds from daycares and schools and from private practitioners of various specialties, and about one-tenth from hospitals or social services.

The Centre has a psychoanalytic orientation with many of its clinical staff in the membership of associations recognized by the International Psychoanalytical Association. In France, citizens have "*le libre choix*" or freedom of choice in selecting their physicians. As such, no one is mandated to go to the Centre for services. Those that choose to do so, do so freely and (*Vive la France*!) without charge.

My first reaction: I was envious of the depth of services they offered, not so much in regards to types of services, but more so regarding the level of integration, teamwork and continuity of care. Teams are organized in a multi-disciplinary fashion, with a psychoanalyst medical doctor, psychologist, speech therapist, occupational therapist, social worker and secretary. Services offered include individual therapy, play, language, and psycho-educational group therapies, psychodrama, speech and language and occupational therapies, educational assistance, extended day services, and a day treatment hospital. These outpatient teams are reminiscent of how inpatient ones are organized in my own center. In our outpatient world, the various elements of the team are available but rarely as seamlessly and efficiently connected.

Surprisingly, individual therapy is exclusively provided by a doctoral level clinician (medical doctor or psychologist) and consists of longer term dynamically-oriented therapy two or more times a week. In my center, therapy is done by social workers or doctor trainees like me, and twice weekly therapy, though existing, is usually undertaken in times of crisis. Some of these issues are social, political or economic, rather than purely clinical. As in France, there are too few doctors or psychologists to meet the existing need for individual therapy. In our center the gap is being filled by other allied professionals. In addition, our orientation is shifting away from psychodynamic to behavioral or cognitive behavioral treatments, although psychodynamically-informed treatment does continue.

On the one hand, the French luxury of having a doctoral level therapist is wonderful for the patient, but on the other, providing exclusively psychodynamic therapy, when individual therapy is undertaken, does not allow for the delivery of other types of treatment, including ones that may be better indicated based on research data for certain diagnoses. Since the Centre is psychoanalytic in orientation, treatment follows a theoretical model rather than existing evidence, CBT, for example, was sadly not provided.

It may come as no surprise to most readers that medications are rarely used in France. One colleague explained how "we do not follow the North American model here," while intimating that other centers in Paris may do so, although clearly less so than in the US. In its day hospital, one that can hold up to twenty-five children, only three were on medications. In my geographic area, this number would elicit the perception of under-treatment. I saw children in the outpatient clinic and day hospital whose clinical presentations and diagnoses would certainly warrant medication use in America.

This was slightly discomfiting, as the degree of continuity, follow-up and integration of systems that I saw made for reliance on medications less readily justified. For example: the day hospital ran daily from 9:00 a.m. to 5:00 p.m. There were some patients who attended fully, but there were other patients who attended only a few days or hours, while the rest of their time was integrated with the school. The use of the day hospital was thus titrated to their ongoing needs. Moreover, their average length of stay was seven years(!) Such seamlessness and shifting integration and continuity of care are virtually unheard of in the States.

Referring back to therapeutic issues, one that wounded my French pride, and that seemed to be rearing its ugly head from the past – much like the slain serial killer rising out of the bathtub in which he's been seemingly drowned after much effort – is the issue of the "frigid mother"

in the development of autistic spectrum disorders. It seemed that during a case discussion, an undue focus was placed on the mother's cold interaction style. This was not explained as the etiology outright, but I did have an uncomfortable sense of traveling to an earlier and accusatory era we had made much progress in leaving behind.

One other surprising element was the lack of familiarity with evidence base practice and with research issues. Data show that psychiatric care in the States is often delivered without being tethered to evidence, so this is not unique to one country or treatment center. And in fairness, the Centre is attempting to initiate research projects in the psychodynamic area.

But one project proposed and discussed would not stand the usual research or scientific scrutiny that exists here. In brief, the project consisted of an active treatment group prospectively identified as having "inconsolable behaviors" (rather ambiguous criteria for entry), which would receive individual/parent-child therapy; the comparator group, care as usual, would be retrospectively identified, i.e., chart review, as having been inconsolable in the past, its current functioning to be compared to the treatment group's functioning post therapy. It was surprising that a premier center in an international city would have a lack of facility with research approaches, a well overdue naïveté around methodology and design matters.

And now to speak fondly of insurance companies, which is admittedly hard to do. As a result of insurance pressures, psychiatrists and psychiatric facilities in the States have had to change their ways. Often the care feels short-changed, such as getting one day approved for admission after a suicidal event. And yet, insurers also expect treatment to reflect data (if only as an additional reason not to pay!). Insurers that will not pay for gabapentin for bipolar disorder do reflect the standard of care, rather than the psychiatrist who insists on prescribing it. Sometimes, relying on our own professional judgments and theoretical constructs without outside forces can lead to self-reinforcing but inaccurate diagnostic and treatment approaches. Though I prefer the French system overall for delivery of care, given its universal nature, there is an element of complacency that may in part reflect the absence of this particular sort of systemic pressure. I was no longer sure that the seven year length of stay was an entirely good thing.

In sum, I admired the team approach, the degree of integration of services, the treatment of the child in the least restrictive setting and in a manner well integrated into his quotidian, non-treatment world, the skill and experience level of the therapist-doctors, the overall accessibility and quality of services available to patients and their families, and the reluctance to use medications in a cavalier fashion.

What I liked less was the over-reliance on one theoretical model and the belief in the certainty of its efficacy, the overly judicious approach to medication (my own cultural bias, *bien sur*), and the unfamiliarity with research issues.

If I had my druthers, I would use the Centre's approach as a foundation and superimpose it with alterations imported from America. This view of course truly represents the American in me: the wish for the imposition of our ideas–the good the bad and the ugly–as the same-old post-war globalization story. I found through this wonderful travel opportunity that in America, just as in France, bad habits die hard. We have much to learn from each other, much to do for children on both sides of the Atlantic.

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Letter from Montevideo

Child Psychiatry in the Health-Education Interface: The Uruguayan Experience.

It started out as a good idea among people with the desire to help children with any kind of emotional or behavioral problems, but very soon we were confronted with reality: there were more children with psychiatric disorders than we had at first suspected. As with most Latin American countries (with the exception of Chile), Uruguay does not have an epidemiological study that shows the prevalence of psychiatric disorders in our child and adolescent population.

The regrettable truth is that we have to use data from other countries to try to grasp our own reality. According to the last population census in my country, Uruguay has almost 400,000 children between the ages of six and 12, and if we consider different reports for this same age group, 12 to 20% of these suffer some kind of psychiatric disorder of at least mild intensity. In 1993 an epidemiological study from Chile reported a prevalence of psychopathology of 16% in the elementary school age group, with only 13% of these identified children receiving treatment. We can only suspect that our reality is somewhat similar, meaning that 60,000 children are suffering from some kind of psychiatric disorder in our country, but only some six thousand receive some kind of treatment. And so we ask ourselves, why? More to the point: what can we do about this state of affairs?

Among other reasons, the answer lies with the adults, those who are close to these children and do not recognize risk factors or pathological signs. But how could they, as no one has taught them to do so? So we ask ourselves again, who are these significant adults? The answer is simple: parents and teachers.

So we turn to numbers once more, and although Latin American Countries have a school drop out rate before fourth grade of at least 45%, Uruguay can proudly say that virtually 100% of our children finish the sixth grade, so teachers come in contact with most of our grade school population and could make potentially formidable allies.

Teachers have the best conditions to be "detectors" of psychopathology in childhood because they spend at least four hours a day with kids both in learning and play scenarios; they have the possibility to learn "normal patterns," and this makes for first class mental health agents. Of 400 teachers surveyed by us, 95% stated that they had not received training to detect psychiatric disorders in classroom settings, or to cope with behavioral and emotional disorders in their students. So with all this in mind we decided, in 1998, to carry out a psycho-educational program for teachers called "The Teacher as Mental Health Agent."

The objective was to show teachers how to detect signs and symptoms for probable psychiatric disorders. We also included coping skills to deal with these problems.

We started out with ten-hour workshops divided into two five-hour long modules covering two subjects:

1) The teacher facing a student with low academic performance, and
2) The teacher facing a student with disturbing behavioral problems.

By the end of the workshops, the teacher was able to recognize signs and symptoms of the most prevalent psychiatric disorders in childhood and adolescence, such as disruptive disorders, ADHD, anxiety and mood disorders. They also learned algorithms to reason probable causes of low academic performance and coping techniques to use in the classroom setting.

We must acknowledge that all of this was possible because of the hard work of decoding and fitting psychiatric language into teachers' everyday lingo.

Once the workshop ended, teachers could attend 60 hours of in-depth courses to acquire more coping tools for the classroom setting. These courses were given by a multi-disciplinary group composed of a psychiatrist, cognitive behavioral therapist, occupational therapist, and a teacher specialized in both speech therapy and learning disabilities (**Alicia Gómez**, Ph.D., co-director of our Psycho-Educational Program).

We can proudly say that to this day, 3,200 teachers and professors have taken the basic workshops and 400 of them have gone on to the in-depth courses throughout the country. This experience has enabled us to travel to different cities and towns within Uruguay because it is important for the teachers that the psychiatrist visit the school no matter where it is. We are also proud to say that the workshops have been given in cities in Argentina and Colombia.

We are continually assessing our workshops and have found that participants have found them to be useful, so much so in fact, that they have been able to change the way they see their students' behavioral problems, reducing the level of aggression, and feeling more secure facing difficulties within the classroom.

We hope that our local experience in Uruguay can motivate psychiatrists to approach educators in order to grow together for the benefit of children everywhere.

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On the Disconnect Between Science and Society:

A Medical Student's Report

I had the pleasure of attending the American Academy of Child and Adolescent Psychiatry's 51st Annual meeting in Washington D.C in the fall of 2004. As a medical student with an interest in autism, I chose to attend a series of talks focused on autism spectrum disorders. During one of these talks, **Eric Fombonne** from McGill University in Montreal discussed the epidemiology of autism, with particular attention to the disputed relationship between autism and the mumps, measles and rubella (MMR) vaccine and its mercury-laden vehicle thimerosal. He made convincing arguments both for the absence of an epidemic of autism, and against a causal relationship between immunizations and autism. As I listened, I was acutely aware that the hard evidence and responsibly argued scientific theory that he presented had not reversed the widespread public conviction that a causal relationship between immunizations and autism does exist. Later, I had a drink with Dr. Fombonne, as well with as Drs. **Fred Volkmar** from Yale, **Joaquín Fuentes** from San Sebastian, Spain, and **Marc Woodbury-Smith** from London. Sitting with this group was an honor, and I felt very much at the heart of the world's autism research. As far as I could tell, there was no suggestion that the group disagreed with Dr. Fombonne's earlier statement: Neither the MMR nor thimerosal have caused an epidemic of autism. But if this group of world experts in the area were all in basic accord, why then had this view not swayed the population at large?

During the second of the American presidential debates, John Kerry (remember him?) stated emphatically: "I believe in science." He did not say "I believe science," rather "I believe in science." The distinction is an important one. Consider the difference between the following statements: "I believe John Kerry" and "I believe in John Kerry." The former statement is one that accepts what Kerry says, whereas the latter is a statement that expresses blanket acceptance of everything that Kerry is, does, and stands for. However, the point of science is to eliminate the need for blanket convictions and unargued beliefs of this kind, and instead to provide evidence and reasoned argument.

Kerry is an advocate for science, but I suspect that his statement was the tip of a population-wide opinion iceberg. There is a widespread conviction that science is a belief system, indeed a belief system in competition with other belief systems, something to "believe in." There are many reasons why people may not believe Fombonne's arguments that there is no relationship between the vaccines and autism. These include the anecdotal nature of most reports, generalizations of first-hand experience ("my child had the MMR and then developed autism, therefore the MMR causes autism"), conspiracy theories, the publication of the controversial article by Wakefield, et al. in the 351st issue of *The Lancet* (and which was subsequently withdrawn by the majority of its authors.)

But the Kerry-style Belief in Science, or in the *Weltanschauung* of Science, is not so very different from these other beliefs, such as a Conspiracy of Power (which rather implausibly implicates the mild-mannered academics with whom I had a drink), a religion that tells us that science is evil, or at any rate unnecessary, or some other over-heated conviction. For all of these gigantic World Views have this much in common: there is no need to look at the evidence or consider the often-difficult details of the argument. All we have to do is look at the general outline of the claim, considered apart from any evidence, and believe in it.

What is the difference between a cheap scientific *Weltanschauung*, in which we are invited to believe, and the carefully thought out, empirically tested claims of good science? As I sat in the subsequent lectures, and later walked through the conference hall filled with posters and exhibitions, I tried to shift my mind into thinking of science as an all-encompassing belief system. I tried to think of the seminar leaders as the priests of a monolithic esoteric knowledge, of the poster displays as the inspired tomes, or of the drug reps as the purveyors of magical potions. But somehow this metaphor wouldn't work for me, except perhaps in the case of the potion purveyors.

The evidence against the fashionable claim that medical science in general and psychiatric medicine in particular is just another set of beliefs backed by authority and power came to me as I wandered around, watching the heated discussions, the conflicting ideas and arguments, and the collaborative excitement that pervaded the whole meeting.

Later, as I explored the science section of the American History Museum of the Smithsonian, I saw the history of many of the tragedies and triumphs of science: displays devoted to the rise and fall of DDT and the carbonated fluorocarbons (CFCs); a collection of images of the impact of America's weapons of mass destruction on Japan; the bulky awkward grandparents of the modern computer. But above all I saw the methodology and consequences of science on display, and I fully believe that it was full disclosure that I was witnessing (albeit retrospectively.) I decided that, to me at least, it was the combination of full disclosure so evident at the Smithsonian displays, with the dynamic and creative collaborations I had seen back at the AACAP meeting, that defined and embodied good science. I also felt that if the public could just see this "good science" at the heart of the advice they were being given, they could perhaps begin to believe science, without having to believe in it.

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National Society Profiles

This new feature in the Bulletin is an opportunity to tell a wide audience about the work of IACAPAP's national societies. If you are interested in featuring your society, please contact Myron Belfer.

Association of Child and Adolescent Mental Health – Turkey

The Association of Child and Adolescent Mental Health in Turkey was founded in 1991. There are five committees (adolescent, infant, training, public education, ADHD) working within the Association. The aim of the Association is to provide services, such as prevention, public education, consultation for schools, training and research in the field of child and adolescent mental health in Turkey. It wishes to improve the scientific level of such services as well as to help develop the field of child and adolescent psychiatry as an area of specialization in Turkey. A special emphasis is on training, both in terms of quantity and quality.

The Association is the only organization representing the field of child and adolescent psychiatry in Turkey. There are approximately 120 specialists working in the field of child and adolescent psychiatry. The Association has worked to achieve specialty status for the training and accreditation of child and adolescent psychiatry consistent with the UEMS standards. To maintain standards, a National Efficiency Board was established. This board was among the first in Turkey to set standards and is now providing examinations in the specialty. The training period needed for child psychiatry specialization is five years including 12 months of general psychiatry and six months of pediatric neurology. A log book for the evaluation of trainees is a requirement.

Since 1994 the Association has been publishing the Journal of Child and Adolescent Mental Health. The journal is a peer-reviewed Turkish journal with English abstracts and is published in three issues per year. Aside from the Journal, three books have been published. A recent initiative of the Association has been to work with the Ministry of Health to establish a National Mental Health Policy. A policy document for the Mental Health of Children and Adolescence has been prepared by the Association.

To achieve the stated goals, the Association arranges conferences, seminars, convenes meetings and publishes materials for public and professional education. Every year a National Congress of Child and Adolescent Mental Health, and an Adolescent Psychiatry Symposium are organized by the Association in collaboration with different university departments. The Association actively works with schools. Child rights is a central concern to the Association especially within constitutional law. Much is done to raise public consciousness regarding issues such as child rights. Another concern is to publicize potential positive and negative effects on child and adolescent mental health from family structure. Parenting courses are open every year to educate the parents about healthy child-rearing practices. Special effort is given for the development of child and adolescent mental health services in the primary health care settings. The adolescent committee has taken a leading role in a collaborative project with the Ministry of Health and is supported by UNICEF and UNFPA to establish Youth Centers and integrate mental health services with the other services in these Centers. In 2003, with UNFPA funds, the situational analysis of a representative sample of adolescents, both developmentally and clinically, was completed and a policy document was presented to the Ministry of Health and Ministry of Education.

The Association reaches out to other organizations with similar interests both within Turkey and internationally, including ESCAP, ISAPP and IACAPAP.

Specific activities include:

- Arranging meetings to promote preventive and curative mental health.
- Facilitating psycho-social education through direct work with families in the context of communities and overall preventive mental health programming.
- Facilitating the development of mother and child health centers and primary care centers capable of providing child and adolescent mental health services under the Ministry of Health. The emphasis is on "family centered preventive mental health" services.
- Fostering the establishment of biopsychosocial development programs focussed on children's rights and the overall welfare of children.
- Support of pilot programs to facilitate age-appropriate cognitive development and social stimulation for infants, children and adolescents.
- Advocacy for early diagnosis and treatment of mental disorders.
- Development of programs, seminars and conferences focussed on children suffering from physical and sexual trauma, children and adolescents living on the streets, juveniles in trouble with the law, and special needs children with physical handicaps.
- Publication of booklets and brochures to inform children and adolescents about mental health issues. These are widely distributed.
- The provision of in-service education in many settings, including schools, local governments and the media.
- Arranging continuous medical education programs and continuous professional training.

Submitted by: **Prof. Dr. Bahar Gökler**, former President, Association of Child and Adolescent Mental Health of Turkey.
The current President of the Association is **Dr. Füsun Çuhadaroglu Çetin**

Calendar

From Parents to Children: The Impact of Parental Mental Illness on Their Children.
Under the auspices of ESCAP
September 23–25, 2005
Athens, Greece
www.parentsonchildren.gr

Eighth Biennial Conference of Indian Association for Child and Adolescent Mental Health,
"Pharmacological and Psychological Therapies"
November 24–26, 2005
Lucknow, India, www.childindia.org

Joint Annual Meeting of the American and Canadian Academies of Child and Adolescent Psychiatry (AACAP and CACAP),
Sheraton Centre Toronto
October 18–23, 2005
www.aacap.org

International Association for Child and Adolescent Psychiatry and Allied Professions Congress 2006,
September 10–14, 2006
Melbourne, Australia
www.iacapap2006.com

Eighth International Congress: Autism Europe
August 31–September 2, 2007
Oslo, Norway

International Society for Adolescent Psychiatry and Psychology Congress.
"From adolescence to adulthood: Passages and transitions, continuity and discontinuity"
July 4–7, 2007
Montreal, Canada

International Congress of Pediatrics
August 25–30, 2007
Athens, Greece
www.icp2007.gr

Miscellaneous Announcements

Ethics as a Means of Overcoming Hatred and Paranoia, a paper by IACAPAP Executive Committee member **Jocelyn Y. Hattab** of Jerusalem, was delivered in London in the spring of 2005. Interested readers can get a copy of this presentation by directly contacting the author at Jocelyn@vms.huji.ac.il

Contributions to the IACAPAP *Bulletin* are encouraged and welcome. Please contact IACAPAP Communi-cations Committee Co-Chair Andres Martin (andres.martin@yale.edu) or IACAPAP President Myron Belfer (Myron_Belfer@hms.harvard.edu) with potential contributions or specific inquiries.

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17th IACAPAP Congress

Melbourne Australia

Melbourne Convention Centre

September 10–14, 2006

www.iacapap2006.com