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IACAPAP

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COMPREHENSIVE AUTISM CARE SYSTEMS IN DUBAI

IACAPAP 2018 PRAGUE CALL FOR ABSTRACTS

CONTENTS

President's column

MENTAL HEALTH AND PSYCHIATRY

For a good partnership, let's get clear about what we mean by each

Because "psychiatry", for some, refers only to serious (and historically, untreatable) mental illness, those who want to speak positively of human development sometimes invoke "mental health". Sometimes "psychiatry" and "mental health" are used as if they refer to the same thing. Not so sure.

When talking about psychiatry, things are rather clear: psychiatry is the medical specialty that deals with mental disorders. Some of these disorders have been known throughout history; others have been recognized in modern times. For most, their course, as well as the names they are given, vary greatly with culture and context. Psychiatry, the medical specialty devoted to people with such disorders, has a long history, in which superstition, exclusion and control have been increasingly replaced by validated diagnoses and effective treatments and (hopefully) by humane care. To be sure, questions persist: along with the rest of medicine, do we care for patients or just treat the disease? What's the relationship between a person's (subjective) mental suffering and the (objective) symptoms and other troubles that others can see?

A larger question remained: would Psychiatry, like other branches of Medicine, embrace, not just the treatment of disease, but the promotion of health? How narrowly or broadly should Psychiatry define itself? That leads us to mental health.

Tracing the history of mental health is not so simple. For centuries, health meant absence of disease. But in 1937, Lerich redefined "health" in a simple and elegant way: health is "life, in the silence of the organs". At the end of World War II, WHO proposed a new approach that had considerable success: health is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity". For many, then "health" became "well-being". Perhaps this change reflected the wish for healing from societies plagued by years of conflict marked by extermination camps and the dropping of two atomic bombs. In any case, happiness became a priority, and the promotion of well-being was a positive impulse. Medicine of course had a role to play.

The next step came in 2001 when WHO defined mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". This definition was surprising. What was the difference between health and mental health? How did the term "mental" appear in the definition of health but be missing from the definition of mental health? In addition, how did mental health get linked to

variables like the productivity of our work?

As mental health embraces well-being, psychiatry does so as well. Indeed, with severe mental disorders, recovery from the disorder is a necessity to reach some states of well-being. But defining the boundaries is not so simple with disorders having mild or even moderate level of severity. In a recent study (HBSC 2014) including seven thousand adolescents, 11.4% of subjects declaring a satisfying level of well-being (Cantril scale) had symptoms compatible with depression. This apparent paradox comes in part from a loose definition of well-being. Many philosophers have tried to deal with it in the past but they succeeded only in underlining the heterogeneity of the concept (from pleasure to satisfaction). Moreover, child and adolescent psychiatrists will recognize this dilemma as they move between the worlds of psychiatry and medicine and the world of mental health. Should doctors prescribe medicines to youths to induce “a state of well-being” or to help them to “work productively” or to “make a contribution to their community”?

The links between mental health and psychiatry are therefore complex. Obviously, in the acute phase of a severe mental illness, physicians help restore mental health. But they actually do much more. Allowing someone to reconstitute himself as a thinking, autonomous subject in the midst of his own challenges (including a mental disorder) is much different from providing welfare or self-realization. Moreover, if a physician has a social legitimacy to relieve suffering, including by means of sometimes invasive therapeutics, he/she has none to decide the happiness of his/her fellow men.

There is, however, an in-between that challenges the tension between psychiatry and mental health, that of knowledge and prevention. Indeed most epidemiological studies in child and adolescent psychiatry are useful for public health professionals interested in youths’ mental health. This is, for example, the case of early parental interventions for families at risk: they decrease the incidence of mental disorders in the offspring; they also improve the mental health of those who are fortunate not to present full diagnoses. Concerning prevention, this is where we should focus our efforts. Prevention is a major challenge for our discipline for this century, and this is where child and adolescent psychiatry and mental health have to work together. Not a simple business…

Bruno Falissard, Marlène Monegat, Gordon Harper

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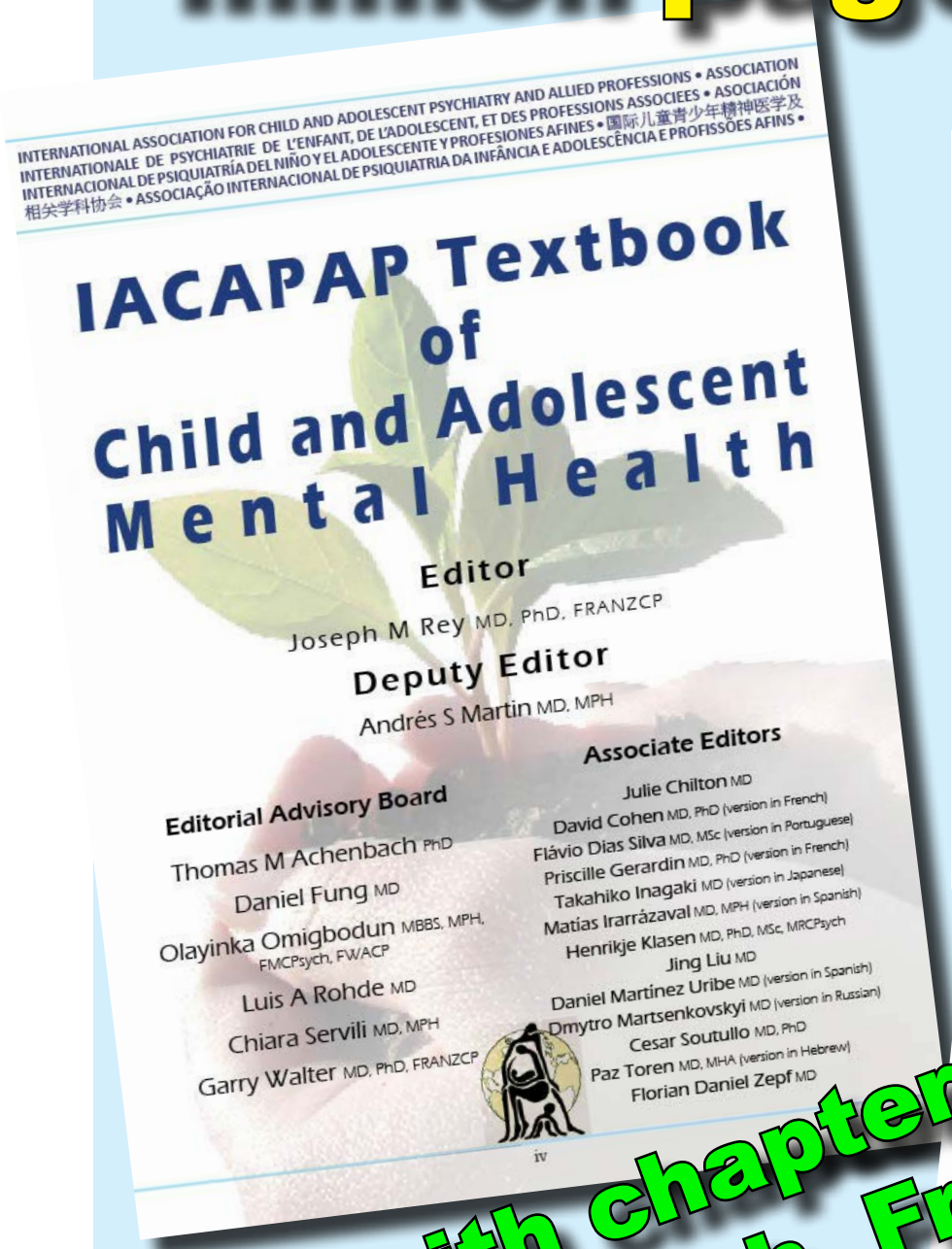

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PSYCHIATRY OF THE 21st CENTURY: ISSUES AND INNOVATIVE DECISIONS

THE UKRAINIAN ANNUAL SCIENTIFIC CONFERENCE 2017

Igor Martsenkovsky

This year's congress took place in Kiev, 27-29 April 2017 and was organized by the Association of Psychiatrists of Ukraine, the Ukrainian Research Institute of Social and Forensic Psychiatry and Drug Abuse, the charitable foundation Research Innovation in Medicine (RIMON) with support from the World Health Organization, the International Organization Global Initiative in Psychiatry, the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP), Section of Child and Adolescent Psychiatry of the World Psychiatric Association, the Council of Europe of the Pompidou Group, the German Association for Psychiatry, Psychotherapy and Psychosomatics, and Israel Trauma Coalition.

In its fifth iteration, this Annual conference has become the largest and most important event in the calendar for experts in the field of mental health in Ukraine. The conference provided an opportunity for researchers, scientists, postgraduate students, doctoral students, practicing psychiatrists, psychiatric trainees, healthcare managers, social workers, nurses, and psychologists to meet and share new information and experience. This meeting became a great opportunity for the mental health specialists to establish contacts and collaborations to improve the quality of care and to promote research.

This year the conference brought together 485 participants from all regions of Ukraine together with colleagues from 15 other countries. Apart from the Ukrainian speakers, there were lectures and oral presentations by experts from the United States, Germany, France, Great Britain, Norway, Poland, Netherlands, Turkey, Lithuania, Azerbaijan Republic, and Israel. The official conference languages were English and Ukrainian with simultaneous translation. All lectures and speeches are recorded on video and will be available on the website of URISFPDA and RIMON.

Within the framework of the conference, many issues related to the reform of the mental health system in Ukraine were discussed. A number of symposia were devoted to the international experience in the rehabilitation of PTSD, scientific research methods and management in child and adolescent psychiatry, mental health care in closed social care institutions, approaches to the

"Ukrainian mental health is going through turbulent times. The war in the East has affected many citizens, while the presence of large numbers of internally displaced persons has put an extra strain on the existing services. At the same time, the political challenges in the country have been strengthened by the drive to reform mental health care services. At this time, coming together to discuss all these issues is becoming even more important. The future of Ukrainian psychiatry is on the agenda".

treatment of patients with addiction in the penitentiary system, and prevention, diagnosis and treatment of comorbid disorders in psychiatry.

The opening ceremony started with the welcome speech of the President of the Ukrainian Psychiatric Association Dr. Semyon Gluzman (Ukraine). In his speech, he emphasized that "Ukrainian mental health is going through turbulent times. The war in the East has affected many citizens, while the presence of large numbers of internally displaced persons has put an extra strain on the existing services. At the same time, the political challenges in the country have been strengthened by the drive to reform mental health care services. At this time, coming together to discuss all these issues is becoming even more important. The future of Ukrainian Psychiatry is on the agenda".

President of the WPA, Professor Helen Herrman (Australia) emphasized the importance of promotion of Mental Health of women and girls in adversity because in resource-poor countries an adversity and political crises bring a range of problems that erode protections, increase social injustice and inequality and entail human rights violations. In her talk, she noted that there is a growing international consensus on the need for a range of mental health and social interventions integration with existing systems. Dr. Herrman stated that "The mental health and psychosocial response programs increasingly integrated into humanitarian assistance programs can be seen as an opportunity to model the introduction of mental health centrally and explicitly in the public heath framework of a country. Interventions should be carried out at several levels, and alongside help provided to those with mental illnesses. They also include social policies such as rebuilding housing and opening schools and activities closer to the person, such as livelihood support to women and girls". At the same time, there are still many challenges left like evaluation and refining programs and good practice after a disaster: monitoring the effects on mental health of events in non-health sectors; and monitoring the effects on broader health and function of activities designed primarily to promote mental health.

President of the International Association for Child Psychiatry and Allied Professions, Professor Bruno Falissard (France) believes that now is the time for child and adolescent mental health to be examined from more than just a scientific perspective. "At the moment, there is a temptation to focus on only neurobiological aspects of mental disorders and to treat them accordingly, but there is a risk in that — it can be easy to forget that a large part of child and adolescent mental health issues come from understanding

social adversity." Dr. Falissard told about IACAPAP educational projects and work that was done to ensure that psychiatrists and other mental health specialists from countries that were formed after the collapse of the USSR, including Ukraine, did not feel isolated.

The program also included plenary lectures by Professor Prof. Bruno Fallisard (Paris, France - Borderline personality disorders in children and adolescents), Prof Bennett L. Leventhal (San Francisco, USA - ADHD: disorder of lifespan), talk of Prof. Fusun Cuhadaroglu (Ankara, Turkey - Non-suicidal self-injurious behavior and suicide attempts among adolescents), Dr. Igor Martsenkovsky (Kyiv, Ukraine - Treatment of epilepsy in children with pervasive developmental disorders), Prof. Galina Pilyahina (Kyiv, Ukraine - Autodestructive manifestations of mental and behavioral disorders in adolescents), Dr. Inna Martsenkovska (Kyiv, Ukraine - Clinical polymorphism of affective disorders in children with autistic disorders), Dr. Volodymyr Kharytonov (Kyiv, Ukraine - Bumetanide treatment of autistic disorder in children), Olesya Vashchenko, Tatyana-Maryana Pavlenko (Kyiv, Ukraine - Health promotion and prevention in child and adolescent mental heath) and workshop by Dr. Dennis Ougrin (London, UK - Therapeutic Assessment for adolescents with self-harm).

Of particular interest was a symposium entitled: "Research activities of young scientists in the field of psychiatry". Professor Helen. Herrman (Australia), Bennett L. Leventhal (USA), Norbert Skokauskas (Norway) heard and analyzed research projects carried out by young scientists including Leyla Hasan-Zadeh (Azerbaijan Republic - Diagnosis and treatment of bipolar disorder in Azerbaijan: international standards and local traditions), Konstyantyn Dubovyk (Ukraine - Peculiarities of motor disorders in children with autism spectrum disorders), Dmytro Martsenkovskyi (Ukraine - Comparative A study of the long-term effects of trauma-focused therapy and fluoxetine therapy in children with PTSD and comorbid depression), Yuliya Yachnik (Ukraine - Mental health care of the adolescents under conditions of multifield hospital), Tatyana Ilnytska (Ukraine - The efficiency of Assistance in PTSD among the military persons).

This congress has been one of the most inspiring events for professionals in the sphere of mental health in Ukraine this year as demonstrated by the growing number of attendees, and the attention given to it by health managers and administrators.

IACAPAP 2018

23–27 JULY 2018, PRAGUE, CZECH REPUBLIC

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International Association
for Child and Adolescent Psychiatry
and Allied Professions

23rd WORLD CONGRESS OF THE INTERNATIONAL ASSOCIATION
FOR CHILD AND ADOLESCENT PSYCHIATRY AND ALLIED PROFESSIONS

Call for Abstracts

Prague, the city of spires, located in the Czech Republic is to host the IACAPAP 2018 Congress on 23–27 July 2018. With the congress theme focused on Understanding Diversity and Uniqueness, there will be many interesting topics to be discussed. The aim of the congress is to not only offer a one-of-a-kind opportunity to share views of cutting-edge findings and trends in the field. It will also emphasize the importance of comprehensive care of the mental health of children and adolescents as a main priority of modern society in the 21st century. Let the individual and unique join the common, typical and safe across society. This is undoubtedly how our fields can in at least some way contribute to an improved understanding among different cultures and societies of people living in different places.

Keynote Speakers

Louise Arseneault
King's College, United Kingdom

Boris Birmaher
University of Pittsburgh, USA

Jan Buitelaar
Radboud University, Netherlands

Gabrielle Carlson
Stony Brook University, USA

Valsamma Eapen
University of New South Wales, Australia

Bruno Falissard
Université Paris-Sud, France

Jörg M. Fegert
Universität Ulm, Germany

Ruth Feldman
Bar-Ilan University, Israel

Nathan Fox
University of Maryland, USA

Tomáš Hájek
Dalhousie University, Canada

Alexandra Harrison
University of Massachusetts, USA

Johannes Hebebrand
University of Duisburg-Essen, Germany

Michal Hrdlička
Charles University in Prague, Czech Republic

Miri Keren
Tel Aviv University, Israel

Kerim Munir
Harvard University, USA

Olayinka Omigdobun
University of Ibadan, Nigeria

Tomáš Paus
University of Toronto, Canada

Dainius Pūras
Vilnius University, Lithuania

Luis Rohde
Federal University of Rio Grande do Sul, Brazil

Chiara Servilli
World Health Organization, Switzerland

Anne Thorup
University of Copenhagen, Denmark

Rudolf Uher
Dalhousie University, Canada

Chris Wilkes
University of Calgary, Canada

Abstract Topics

Congress abstract submission is now open – abstract submissions are welcome to compose the congress program. The congress theme focuses on Understanding Diversity and Uniqueness with abstracts to be submitted in the following major areas and topics:

General Child and Adolescent Mental Health

- Adoption, Extra-Familiar Care
- Advocacy, Ethics, Human Rights, Rights of the Child, Policy
- Child Abuse, CAN, Bullying, Child Protection
- Children of Parents with Mental Disorders
- Culture and Transcultural Psychiatry
- Early Markers of Mental Disorders, Early Diagnostics and Interventions
- Education, Free Time Activities, Lifestyle of Children and Adolescents
- Economics, Resources, Funding in Child and Adolescent Mental Care
- Emotions, Emotion Regulation
- Epidemiology and Public Health in Child and Adolescent Psychiatry
- Fighting Stigma
- Forensic Psychiatry and the Role of the Legal System in Child Mental Health
- Gender and Gender Dysphoria
- Genetics and Epigenetics
- Immunology, Infectious Diseases and Child and Adolescent Mental Health
- Infant Mental Health
- Media and the Internet
- Mental Health Promotion and Education
- Neurology and Child and Adolescent Mental Health
- New Technologies in Diagnostics and Therapy
- Neuroimaging, EEG
- Parenting, Attachment
- Prematurity and Perinatal Complications
- Prevention
- Refugees, Migration and Mental Health Issues
- Resilience, Coping Mechanisms
- Sexuality and Sexology, LGBT Youth
- Traditional Medicine

Psychiatric Disorders and Co-Morbid Conditions

- ADHD
- Anxiety Disorders
- Attachment Disorders
- Autism Spectrum Disorders
- Catatonia
- Conduct and Oppositional Defiant Disorder
- Culture Bound Disorders
- Developmental Disorders
- Dissociative and Conversion Disorders
- Eating and Feeding Disorders
- Effects of Violence, Disasters, Civil Conflicts and Migration; Trauma Informed Care
- Emergencies
- Intellectual Disability, Borderline Intellectual Functioning
- Learning Disabilities
- Medically Unexplained Symptoms
- Mental Issues with Co-Morbid Medical Disorders
- Mood Disorders
- New Disorders – Still to be Classified
- Parent-Child Relational Problems
- Personality Disorders – Arbitrary and Empirical Age Threshold
- Psychiatric Classifications and Diagnostic Issues
- Psychosomatics, Dissociative Disorders
- Psychotic Disorders
- Self-Harm Behavior, Suicidality and its Prevention
- Sleep Impairment
- Substance-Related Issues and Disorders
- Tic Disorders
- Trauma Related Disorders

Principles of Treatment and Care

- Bridging the Gap Between Adolescent and Adult Mental Health Care
- Clinical High-Risk, Early Interventions
- Community Care, Day Programs
- Counseling
- Crisis Intervention
- ECT, Stimulation Methods
- e-Health Interventions
- Family Interventions
- Individualized/Genes Based Psychiatry
- Innovative Assessment and Intervention Programs
- Inpatient Care
- Integrative Medicine in Mental Health
- Liaison Psychiatry
- Pharmacotherapy
- Psychotherapy
- Safety of Treatments in Child and Adolescent Psychiatry
- School Mental Health Services
- Systems of Care
- Treatment Planning

Submissions

Each author may select what best suits him/her from a wide range of different presentation types, including:

Free Paper

15 m

Free papers are intended for the presentation of new research data or other scholarly work. Authors may choose from two commonly used types:

a. Oral paper (15 minutes incl. discussion) – multiple oral presentations will be scheduled in sessions with presentations on similar topics. If your paper is not selected for an oral presentation, you may be offered the option to present your work as a poster.
b. Poster presentation – posters will be on display for one day of the congress.

Research Symposium

90 m

A research symposium is a submission of a whole 90 minute session, where the chair submits one overall abstract describing the session and 4–5 abstracts of concrete presentations, which will form the session.

It should present new research data on related topics, with an overarching theme that is discussed by the chair. The new research should be described with reference to the relevant literature.

It is permissible but not required for the chair to give one of these presentations. Approximately one-quarter of the time should be devoted to questions and discussion.

Pre-Congress Course

Do you have an topic with potential interest for others to study but fear that it exceeds the time given for one session? You are welcome to suggest a half day or one day pre-congress course, which if accepted, would be held on the day before the congress for any interested delegates at an extra registration fee. A pre-congress course can be held on any topic related to the congress theme. When submitting the proposal, the overall description, the learning objectives, motivation for participants as well as the concrete topics to be discussed must be mentioned together with all participating speakers. All details are to be submitted by the course facilitator.

Workshop

75 m

A workshop is a submission of a whole 75 minute session. Workshops should be interactive and provide instruction in a set of clinical, research or educational skills. The information presented should be scholarly and evidence-based, with reference to the relevant literature. Workshops may be led by one or more presenters, who should all appear among the abstract authors. The workshop chair submits one overall abstract.

Academic Perspective

90 m

An academic perspective is a submission of a whole 90 minute session, where the chair submits one overall abstract describing the session and 2–3 abstracts of concrete contributions which will form the session. Academic perspectives generally do not present new research data, but provide complementary or opposing perspectives on a pertinent clinical, educational or advocacy issue that is introduced by the chair. The information presented should be scholarly and evidence based, with reference to the relevant literature. It is permissible but not required for the chair to give one of these presentations. Approximately one-quarter of the time should be devoted to questions and discussion.

Special Interest Study Group

75 m

A special interest study group is an opportunity for networking and discussion among attendees who share a particular practice setting or academic interest. The chair is expected to provide learning objectives for the session, introduce the topic and facilitate discussion. He/she should submit one abstract describing the 75 minute session.

Media Theatre

90 m

An open 90 minute discussion on a topic based on multimedia presentation (motion picture, documentary, video tape, music or other form of media relevant to child and adolescent mental health. The media theatre organizer is expected to suggest both the video and the theme to be discussed by his colleagues (submitted as authors) together with the public attending the session. The session should provide an opportunity for open discussions.

Full details of abstract submission together with the IACAPAP 2018 Call for Abstract Brochure are available online at www.iacapap2018.org

Adopt a Delegate

Key Features of the Program

1. Delegates from Lower and Middle Income Countries (LMIC) can be "adopted" by fellow colleagues or companies/sponsors.
2. The adoption of a delegate from a LMIC country (through sponsorship) will provide the delegate with the opportunity to attend the IACAPAP 2018 Congress.
3. Adopted delegates will have the opportunity to present details of their local situation at the congress, thereby creating awareness which in turn could induce assistance from their sponsors and high income country peers.

For the first time, an ambitious goal has been set for the IACAPAP 2018 Congress to collect and allocate funding to support participation of delegates coming from Lower and Middle Income Countries to be able to actively participate in the congress. The IACAPAP Local Organizing Committee trust to be able to raise sufficient funds to bring their colleagues to share the experience and initiate further collaboration.

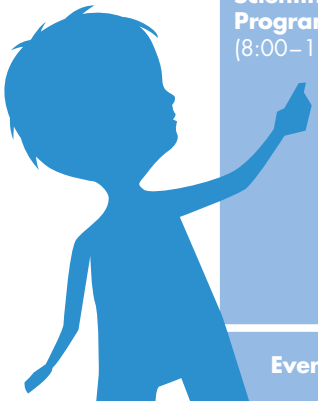
Application Conditions

- Applicants up to 35 years of age
- Be native/resident in the country in which he/she works
- Submit abstract online
- Submit supporting formal letter from the applicant's employer/national association representative or local government representative
- Submit applicant's personal letter of motivation to describe how the applicant's immediate child and adolescent mental health care or research or his/her country would benefit from his/her attendance to the congress
- Successful applicants will receive sponsorship for congress registration and four nights accommodation (arrangements to be made and paid by the delegate in advance and later reimbursement on-site upon the delegate's arrival to the congress)

Application and Selection Process

- Applications for the adopt a delegate program to be marked by an author during the abstract submission process
- Applicants' abstracts subject to equal evaluation with all submitted abstracts for the congress
- The highest ranked abstracts for the adopt a delegate program are to be considered by the committee allocated for the program
- Notification sent to applicants by 15 March 2018

Program Overview



IACAPAP 2018 CONGRESS	Monday 23 July 2018	Tuesday 24 July 2018	Wednesday 25 July 2018	Thursday 26 July 2018	Friday 27 July 2018
Scientific Program (8:00–18:00)	Pre-Congress Courses	Workshops / Parallel Sessions	Workshops / Parallel Sessions	Workshops / Parallel Sessions	Workshops / Parallel Sessions
		Plenary Lecture	Plenary Lecture	Plenary Lecture	Plenary Lecture
		Coffee Break	Coffee Break	Coffee Break	Coffee Break
		State of Art Lectures	State of Art Lectures	State of Art Lectures	State of Art Lectures
		Parallel Sessions	Parallel Sessions	Parallel Sessions	Parallel Sessions
		Lunch Break	Lunch Break	Lunch Break	Lunch Break
		Plenary Lecture	Plenary Lecture	Plenary Lecture	Plenary Lecture
		Parallel Sessions	Parallel Sessions	Parallel Sessions	Parallel Sessions
	Opening Ceremony	Coffee Break	Coffee Break	Coffee Break	Closing Ceremony
		Parallel Sessions	Parallel Sessions	Parallel Sessions	
Evening	Welcome Cocktail		Congress Dinner		

© CzechTourism.com / Dagmar Veselková

The capital city, Prague, is an enchanting and historical place

It has a rich history, unique architecture and a rich culture. With the congress venue, Prague Congress Centre conveniently located just 5 minutes from the city center, there will be plenty of time to explore the historical sights while strolling through the Old Town Square with the Astronomical Clock and across the Charles Bridge towards the Prague Castle for breathtaking views of the red roofs across the valley.

With frequent flights scheduled for the Vaclav Havel Airport in Prague, your vacation before or after the congress cannot be easier. Immerse yourself in culture while exploring the gothic churches and colorful baroque buildings throughout the day and enjoy the local cuisine before setting for an evening of classical music concert in Rudolfinum…

Not so much seeking after the culture and busy city life? With its beautiful cities, magnificent castles and fascinating history, there's plenty to be enjoyed on holiday to the Czech Republic outside the city of Prague. Book your time to spare for the enchanted country!

Important Dates

15 June 2017 Abstract Submission Open	**October 2017** Registration Open
31 December 2017 Abstract Submission Deadline	**February 2018** Notification of Abstract Acceptance
21 March 2018 Early Bird Registration Deadline	**21 March 2018** Registration Deadline for Presenting Authors
4 July 2018 Online Registration to Close	**23–27 July 2018** IACAPAP 2018 Congress

Sightseeing Tours

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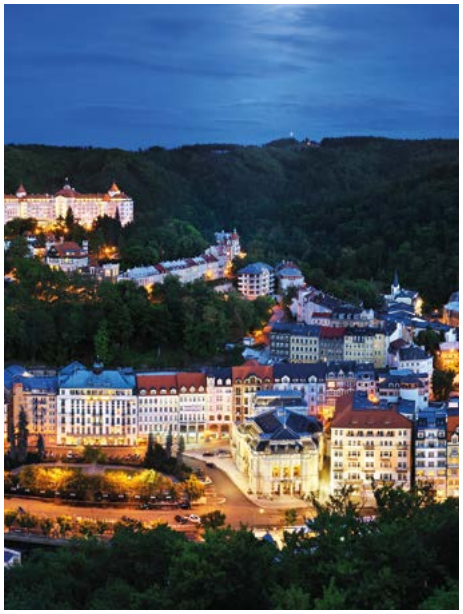
Karlovy Vary and Moser Factory

Probably the best-known spa town in the Czech Republic, with history dating back to the 14th century. Most famous for the healing powers of the local springs, Karlovy Vary also became famous thanks to the local manufacturing of world renowned Moser crystal, Carlsbad porcelain or the herb liqueur Becherovka. Visit the Moser factory and tour of the town center to see the most famous geyser Vřídlo (Sprudel) – gushing its mineral water to a height of almost 12 meters.



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Kutná Hora and Sedlec Ossuary

UNESCO world heritage site, a medieval silver mining center, was once the second richest city in the Kingdom of Bohemia. The tour of Kutná Hora will not only take you to St Barbara's Cathedral but also to many beautiful gothic, renaissance and baroque townhouses - you will also visit one of the most interesting burial grounds in the world: the Sedlec Ossuary. This chapel is decorated with more than 40 000 human bones, arranged into various decorations.

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Karlštejn

Karlštejn Castle is one of the most visited castles in the Czech Republic. Originally served to safeguard the imperial and royal treasure and the Crown jewels it served also as the archive of state documents. After climbing the hill, a tour of the interiors will acquaint you with not only the history of the castle, but also with the life of Charles IV and fine arts during his reign.

Český Krumlov

A medieval town in South Bohemia, retains its fairytale-like atmosphere to this day and is well-deserving of its inclusion on UNESCO's list of cultural heritage sites. Enjoy a stroll through the narrow, winding streets of the historical center, filled with Gothic, Renaissance and Baroque buildings from the times of the Rožmberk, Eggenberg and Schwarzenberg noble families. Visit the local castle, the second largest castle in the Czech Republic, filled with ancient furniture, artwork, tapestries and exquisitely adorned weapons.

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to receive all information on registration opening, congress program news, accommodation availability, sightseeing tips and much more.

A conversation with Savita Malhotra

2016 IACAPAP International Contribution Award

Dr. Savita Malhotra of India was awarded IACAPAP's International Contribution Award at the 2016 World Congress in Calgary, Canada. The award recognizes the accomplishments of a senior individual in the promotion of child and adolescent psychiatry in the developing world and is sponsored by the Korean Academy of Child and Adolescent Psychiatry. Dr. Hesham Hamoda IACAPAP's Vice President and Deputy Editor of the Bulletin interviewed Dr. Malhotra about her award.

First of all congratulations on your award and thank you for taking the time to share your experience in the Bulletin.

Thank you very much.

Tell us a little about your background and current position? What inspired you to choose child psychiatry?

I worked as consultant in general psychiatry in the Post Graduate Institute of Medical Education and Research (PGIMER) in the Indian city of Chandigarh for about 40 years, till the end of January 2016, when I retired as Dean of the Institute, Professor and Head, Department of Psychiatry and Drug Deaddiction and Treatment Center. I was in charge of child and adolescent psychiatry services for over 35 years. This is an academic department in a premier medical institute in my country and where all my work in child psychiatry was done. When I joined as consultant in PGIMER, I was given the responsibility for running the child guidance clinic—there were no other takers. I worked incessantly and very soon appreciated the potential and value of child psychiatry in mental health. My inspiration came from the work of Stella Chess and Alexander Thomas. I was so fascinated by their theory of temperament that I chose this as the topic for my PhD. I was fortunate to have been guided by them in my research. Over the years, they became friends, to the extent that I stayed in their house in New York during several of my travels. I also had the good fortune to meet Leon Eisenberg, Sir Michael Rutter and many other stalwarts in the world of child psychiatry. I admired and learned from them in my earlier years. In India child psychiatry has always been a part of general adult

In India we have one child psychiatrist per 5 million children and adolescents and we will never have enough providers.

psychiatry; only very recently has it been recognized as a separate discipline, but still remaining within adult psychiatry. There was no training in child psychiatry then. We had to get training overseas. I came to the US and the UK for my child and adolescent psychiatry training.

Such an inspiring journey. Tell us about your current and previous work and its impact.

I have worked in the areas of temperament and its relationship with psychopathology; stress and mental disorders in children; epidemiology; childhood onset schizophrenia; disintegrative disorders of childhood; and autism and pervasive developmental disorders. Most recently, I have been working in tele-psychiatry developing and implementing a system of automated diagnosis and treatment of mental disorders in children and adults, to be carried out by non-specialists in remote areas. In India we have one child psychiatrist per 5 million children and adolescents and we will never have enough providers. This could be one of the solutions to the access problem. I have also been engaged in supplementing and supporting training and research in child psychiatry in the South East Asia region.

How do you see child and adolescent mental health (CAMH) in India at this time and its future prospects?

CAMH in India has come of age. I have been part of the journey from CAMH being a minor, inconsequential area of psychiatry to being recognized as a specialty within psychiatry. There is now specialty training available in three centers in India including PGIMER, where I worked. Many students are now opting for research and training in child psychiatry. The Medical Council of India has mandated experience in child and adolescent psychiatry services as part of general psychiatry training, due to this all the medical colleges and institutes are opening child psychiatry services. There is tremendous need for these services, not only because we have about 500 million children and adolescents in the country but also because the rates of mental disorders are in range of 6-12%. Moreover, pediatricians have no training or exposure to child psychiatry in India. Pediatricians can be a potential resource if suitably trained.

CAMH in India has come of age. I have been part of the journey from it being a minor inconsequential area of psychiatry to being recognized as a specialty area within psychiatry.

What does this award mean to you?

I feel honored that my work has been recognized. It has been a difficult journey where I had to overcome much opposition and lack of support but, in the end, I have great satisfaction and a sense of achievement that all that hard work and pain was worthwhile. For me it has been a great moment to stand with many other stalwarts who received this award in the past.

If there is a decision in your career that you regret, what would that be?

In regards to my professional work I have no regrets. The only thing I can say is that I mostly focused on general psychiatry colleagues for the development and recognition of child psychiatry. I should have equally involved pediatricians in this endeavor. They need to be trained and involved in child psychiatry services.

What advice do you have for physicians who are at the beginning of their career in child and adolescent mental health?

CAMH is the most fascinating and most promising field of psychiatry, especially with current knowledge and research in the areas of cognitive neuroscience, neurodevelopmental underpinnings of social emotional behavior and so on. There is great potential for child psychiatry to lead in the understanding of psychopathology not only in childhood but also in adulthood. We are at the threshold of developing effective preventive strategies at all levels. Being a child and adolescent psychiatrist you can make a difference to not only a child's life but also to the entire family. Working with children is very gratifying.

Thank you very much for your time!

GLOBAL CONFERENCE IN DUBAI DISCUSSED COMPREHENSIVE AUTISM CARE SYSTEMS

Ammar Albanna, Sandra Willis & John Fayyad

Al Jalila Children's Specialty Hospital in Dubai hosted a three-day conference titled "Systems of Care for Autism Spectrum Disorder: A Global Perspective", in collaboration with the Eastern Mediterranean Association for Child and Adolescent Psychiatry and Allied Professionals (EMACAPAP) and the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP). During this unique conference, regional and international experts convened in order to share best practices, experiences and challenges with regards to setting up and implementing comprehensive systems of care for autism.

Autism spectrum disorder (ASD) is notably complex, and affects individuals who require multiple services that cut across different care systems including health, social, and education. Although existing systems of care in the region include effective and helpful elements, the lack of integration and fragmentation results in significant burden on individuals and families, including being subjected to ineffective or harmful treatments, inaccurate diagnoses, and therefore increased economic burden and suboptimal health and wellbeing outcomes. Hence, this conference was organized to think from a "systems of care" perspective in order to develop integrated services that optimize the use of resources and outcomes.

Pre Conference

Shortly prior to the conference, on March 20th and 21st, the Government of Dubai's Executive Council (TEC) organized an annual think-tank to accelerate the development of a system-level approach for autism and other developmental disorders, entitled "My Name is Ibrahim: Dubai Systems of Care for Autism", named after a young man with autism whose documentary was screened at the event. The multi-agency and stakeholder representation was tasked to develop a system of care for autism in Dubai that promotes optimal identification, intervention and inclusion of people with ASD within an integrated system of health, education

& social care, thereby leading to the development of coherent integrated policy and programmatic interventions. This was presented at the conference jointly with the TEC advisor and psychologist Dr. Sandra Willis, who also moderated the post-conference day.

Furthermore, a focus group with families of individuals with Autism was conducted at Al Jalila Children's Hospital on March 26th, during which approximately 50 families shared their thoughts regarding current autism services. The results were also summarized and presented at the conference.

The Conference:

The conference took place at the recently established Mohammed Bin Rashid University of Medicine and Health Sciences auditorium from March 30 to April 1, 2017. There were 25 presentations covering topics such as screening and awareness programs, comprehensive assessment standards, early intervention models, and other aspects of care from a "systems" perspective from different regional countries including the UAE (Dubai, and Abu Dhabi), Qatar, Saudi Arabia (Eastern region and Riyadh), Bahrain, Lebanon, Tunisia, Pakistan and Bangladesh, and international presentations from Australia and the USA. The conference was attended by more than 300 delegates and participants who actively engaged in discussions during the three days.

Opening remarks were presented by Mr. Khalid Al Shaikh Al Shamsi, CEO of Dubai Healthcare City Authority, and by Dr. Ammar Albanna, the conference chair, who is the Head of Child and Adolescence Mental Health Centre of Excellence at Al Jalila Children's Specialty Hospital, President of the Emirates Society for Child Mental Health, and a 2012 Donald Cohen Fellow of IACAPAP. Opening remarks were also given by the conference co-chairs Dr. John Fayyad, Secretary General of EMACAPAP, Dr. Hesham Hamoda, Vice President of IACAPAP, and Dr. Salmaan Keshavjee, Director, Harvard Medical School Center for Global Health Delivery Dubai - Harvard Medical School.

Keynote and invited speakers included global autism expert Professor Bennet Leventhal, Chair of Child Psychiatry at WPA, who gave a series of presentations including "Global Prevalence and Burden of ASD" and "Standards of Comprehensive Assessment in ASD." Dr. Kerim Munir from Boston Children's Hospital and IACAPAP Vice President, spoke on "Autism Spectrum Disorder: A Global Framework for Action", while Dr. Valsamma Eapen, Chair of Child Psychiatry at the University of New South Wales in Australia shared the Australia perspective on "Screening Versus Surveillance for ASD at the population level: A case for proportionate universalism," and "ASD in Australia - are we meeting best standards?" Dr. Myron Belfer from Boston Children's Hospital spoke on "Systems of Care: A Global Perspective." Experts from Harvard also included other IACAPAP leaders such as the

Treasurer of IACAPAP, Dr Gordon Harper, and IACAPAP's VP Dr Hesham Hamoda.

This meeting continued the tradition of EMACAPAP in promoting science and research in the Arab world. EMACAPAP, which was founded in the year 2000, is a regional organization of multi-disciplinary professionals specialized in the mental health care of children and adolescents. It aims to increase awareness about child mental health and to join together professionals concerned with the wellbeing of children and adolescents from Arab countries, to discuss issues pertinent to the region, improve training in childhood mental health and foster research. Psychiatrists, pediatricians, psychologists, educators, social workers and speech and language therapists from various Arab countries meet periodically around a topic of major importance to the mental health of children and adolescents in the region. Previous meetings have been organized in Alexandria, Egypt, Tunisia, Lebanon, and Kuwait around the topics of anxiety disorders, depression, autism, trauma, ADHD and infant mental health. During each of the EMACAPAP meetings, mentorship groups take place where junior professionals from various countries in the region bring research proposals for discussion with seniors from the region and with the international experts present at the meeting.

During the Dubai meeting, three research study groups were held for nine junior researchers who presented their work at the end of the conference. This was done to advance interest in researching this important area regionally that,in turn, opens the door for collaborative research and networking across the region.

A unique art exhibition was also held during the conference during which artists from the Emirates Society for Fine Arts presented paintings inspired by drawings of children with autism spectrum disorder from the Dubai Autism Centre.

Post Conference

Lastly, a full-day post-conference workshop was held at Al Jalila Children's in partnership with the Harvard Center for Global Health Delivery - Dubai, with participants including global and regional experts in addition to national stakeholders with regards to ASD services and policy makers to discuss a Dubai model of care for autism. The meeting was held on the World Autism Awareness Day, April 2nd, which also saw the creation of the "Dubai Declaration for Autism", announced in partnership with the Dubai Executive Council. The workshop was organized in partnership with The Executive Council of Dubai (TEC).

One of the most important outcomes of the conference was the publication of a comprehensive document on systems of care for autism spectrum disorder in the region, created by Al Jalila Children's Hospital in partnership with the Harvard Centre for Global Health Delivery.

This initiative by Al Jalila Children's, the first dedicated and specialized pediatric hospital in the UAE includes centers of excellence for child and adolescent mental health and neuroscience, is actively setting the standards for UAE and the region when it comes to child mental health.

The 9th Congress of The Asian Society for Child and Adolescent Psychiatry and Allied Professions (ASCAPAP) and 3rd National Congress of the Indonesian Association of Child and Adolescent Mental Health (IACAMH)

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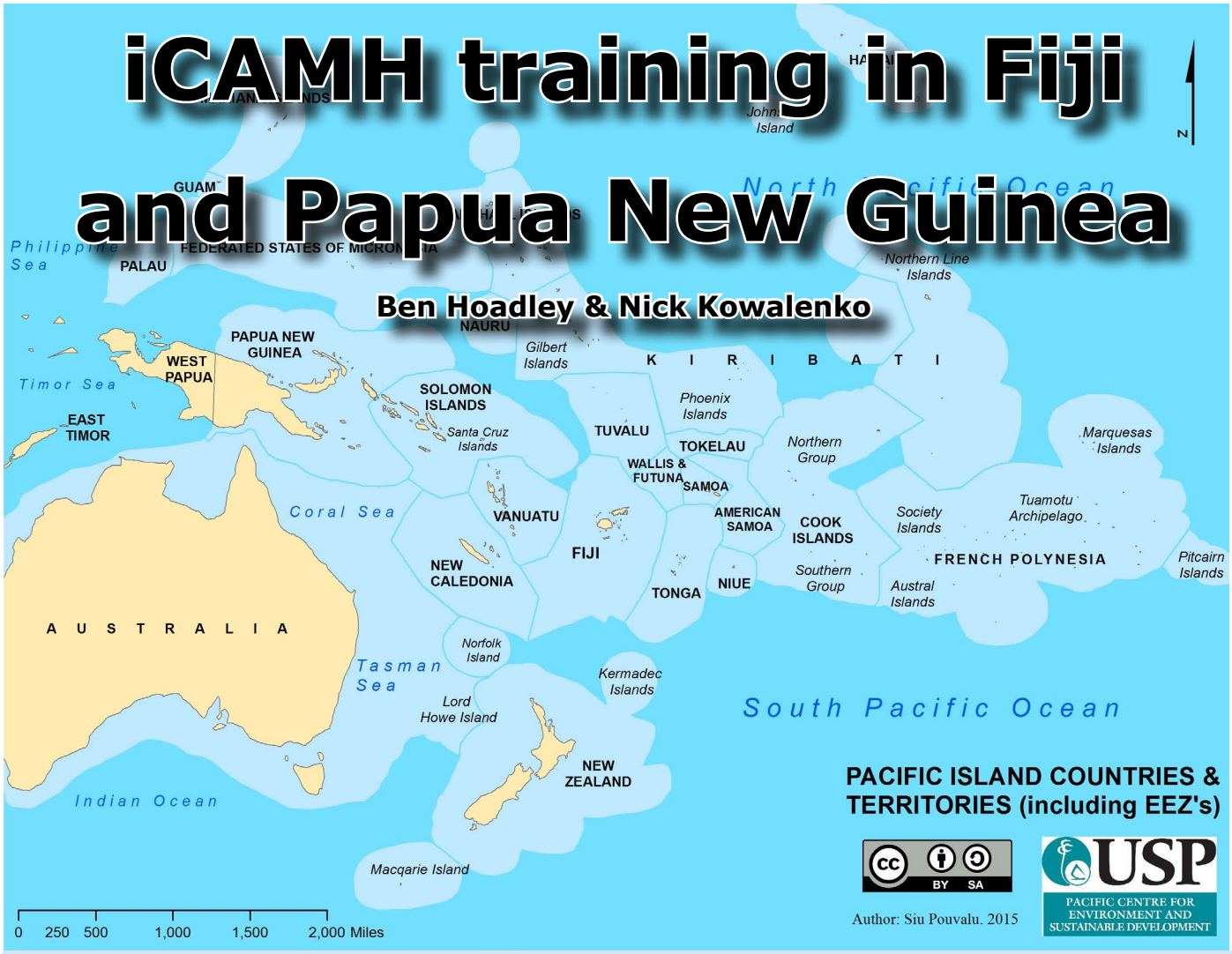
iCAMH training in Fiji and Papua New Guinea

Ben Hoadley & Nick Kowalenko

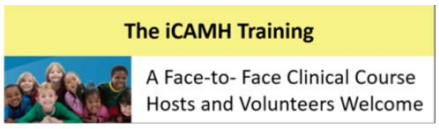


This is a summary of the iCAMH training conducted in Papua New Guinea and Fiji in October 2016 and March 2017 respectively. We were aware that iCAMH training had previously been conducted in Ethiopia and having read of the iCAMH experience in Sri Lanka, which was reported in the November 2016 IACAPAP Bulletin, we felt it might be important to reflect on this early experience of implementing iCAMH education in the Pacific context.

The iCAMH training was provided by Dr Nick Kowalenko, a child psychiatrist based in Sydney who is also the current IACAPAP Regional Coordinator (Oceania Region) and as a training experience by Dr Ben Hoadley, now a child psychiatrist also based in Sydney. The iCAMH training was conducted in partnership with the Papa New Guinea University in Port Moresby and with the Fiji Alliance for Mental Health (FAMH) in Suva, Fiji. In Papua New Guinea, Drs Florence Muga and Monica Hagali, and in Fiji Drs Odille Chang and Myrielle Allen, were key to the implementation of the course. Anne Rauch coordinated iCAMH training in Fiji.

These partnerships evolved out of a longer-term commitment to the Asia-Pacific region, as established by the Faculty of Child and Adolescent Psychiatry of the Royal Australian and New Zealand College of Psychiatrists. Relationships with Pacific clinicians had previously been established through academic ties and through *Pacifica Study Groups* held in Australasia and in the Pacific. These ties were strengthened as the 2015 RANZCP Faculty of Child and Adolescent Psychiatry Conference which was held in Port Villa, Vanuatu, in conjunction with the Pasifika Medical Association and Vanuatu Medical and Dental Association.

Papua New Guinea is a nation of significant cultural and linguistic diversity with a population in excess of 7 million, over half of which are under the age of 24, the majority living in non-urban regions. The nation has only one child and adolescent psychiatrist, Dr Hagali, who provides a weekly half-day clinic in Port Moresby.



If you want to know more about iCAMH training click on the image

Prior to the training in Papua New Guinea and Fiji, email-based discussions took place with Dr Henrekje Klasen, who developed the iCAMH program. We were also fortunate that Dr Kumudu Rathnayaka was able to provide us advice and insights from her experience; Dr Rathnayaka had provided the iCAMH training in Sri Lanka.

The iCAMH training

Papua New Guinea

The training took place in the facilities of the University of Papua New Guinea School of Medicine and Health Sciences, adjacent to Port Moresby General Hospital. The training was attended by eight participants inclusive of medical officers of psychiatric and paediatric backgrounds and nursing staff of the nearby psychiatric inpatient facility.

Drs Muga and Hagali provided formal introductions and opened the course after which we were given a tour of the campus and the local hospital facilities (including the emergency department and short-stay psychiatric facility). The training over the three subsequent days initially focused on assessment and formulation, development and neurodevelopmental disorders as well as psychiatric aspects of organic illness. The partnership with Papua New Guinea University provided the opportunity to present at the hospital grand rounds; a case involving a child with a cerebral tumour, seizure disorder, and complex psychosocial predicament was presented and the multidisciplinary audience (including medical students and specialist physicians from medical and surgical backgrounds) were invited to engage in discussion.

We also provided an introduction to attachment theory, considered the implications of trauma (from child abuse and neglect through to natural disaster and PTSD in young people) and discussed externalising and internalising disorders and suicide prevention. Lectures on ethics and practice (including prescribing for young people, with more detailed focus on psychotic illness) were provided in addition to the iCAMH syllabus and concluded the training.

On our final day, at the conclusion of the course, all attendees were asked to participate in clinical role-plays, similar to objective structured clinical examinations (OSCE), and to provide feedback. We were presented with traditional woven baskets to formalise the closing of the course.

Fiji

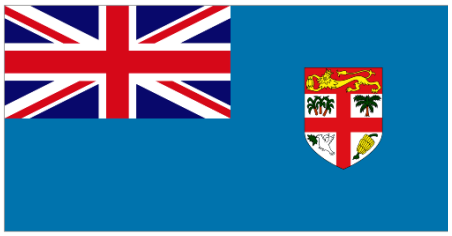
The training took place in the meeting room of Namosi House, the Ministry of Health headquarters in Suva. The training was attended by fifteen participants consisting primarily of medical officers and nursing staff from psychiatric and paediatric contexts. Two psychologists also took part in the training. Prior to the course, a basic text had been provided to participants in ebook (pdf) format. All but two participants had been able to access this reading.

Dr Allen opened the training with formal introductions and Anne Rauch emphasised the involvement and support of Fiji Alliance for Mental Health and spoke to the organisation's role in supporting mental health care in Fiji. The iCAMH training in Fiji was structured similarly to that in PNG though we were able to provide more space in the timetable for case-based and role-play style learning at the request of participants.

REFLECTIONS

Our experience in delivering iCAMH allowed us to develop some awareness of constraints in the

Papua New Guinea participants



Fiji has a population of approximately one million; though the largest two Islands account for the majority of the population, a significant group live permanently in regional and rural areas across an archipelago of several hundred islands. The only child and adolescent psychiatrist in Fiji, Dr Allen, is in an academic role and the one formal clinic operates a half day per month.

provision of child-oriented mental health services in these two Pacific nations. Though it was apparent that the barriers to such services included a paucity of experienced clinicians, the iCAMH participants stressed that the constraints also had roots in socio-political and environmental factors. For example, the distribution of the population across remote areas, distant from centralised mental health services which had been structured predominantly to provide inpatient care, posed a particular challenge to both groups of clinicians.

Despite these commonalities, the experiences of the clinicians in the two nations also diverged, in part a consequence of environmental differences. Clinicians spoke of personal and clinical encounters indicating the ever-present risk of violence in Port Moresby and of the impact of intergenerational trauma. We learnt of community approaches to child-rearing practice that differed markedly from our own experience in Australasia and which, as the participants' suggested, might have provided a buffer from the impact of trauma for some families.

The Fijian clinicians' experience had been coloured by the impact of Cyclone Winston, which had a devastating effect on the island nation in early 2016. Furthermore the Fijian population had, in recent years, incorporated legal reform concerning the corporal punishment of children. The impact of this change entered the discourse concerning school-based interventions and externalising disorders. In 2016, prior to our provision of iCAMH, we had fortuitously visited Koro Island, a small Island northeast of the most populated island (Viti Levu), which had been severely affected by cyclone Winston. On Koro, we met with teachers and community members and gained some initial insight into the impact of natural disaster on wellbeing and on the mental health of the communities we encountered. This experience perhaps allowed us to consider better the contextual challenges which Fiji faces post natural disaster.

We were able to be more flexible with the structure of the iCAMH course in Fiji and could respond more easily to participant preference for a more interactive approach to learning. The group in Fiji was also at an advantage as their workplace roles seemed to be covered for much of the week. Negotiating workplace cover was more challenging for the group in Papa New Guinea and practical barriers to providing such cover for all of the participants meant that not all members of this group were present at all times throughout the course.

The provision of iCAMH was also a training experience for Dr Hoadley, who was approaching formal qualification as a child and adolescent psychiatrist at the time.

Fiji participants

Top: Dr Kowalenko during one of the sessions. Riding waves in Papua New Guinea has a long history (photo Surfing Association of Papua New Guinea (SAPNG)/Andy Abel). Rugby is Fiji's national sport

Though the benefits of such a training experience cannot be fully summarised here, the opportunity to reconceptualise the role of child-oriented clinicians, and to consider child mental health in such different contexts and systems stand out as invaluable.

CONCLUSIONS AND FUTURE CONSIDERATIONS

The training was well received and the feedback was very positive. Comments from participants indicated that they felt the iCAMH course was important, participants valued the knowledge and experience of the presenters, and some considered that the skills they had developed might help them manage the presentations of children and young people in their specific contexts.

At the conclusion of iCAMH, participants expressed interest in accessing further mentorship, including case-based supervision, to supplement ongoing learning. Such mentorship has played a role in supporting psychiatrists elsewhere in the Pacific region (Vanuatu) and the trainers plan to explore the options by which they could provide such support. The significant burden of mental health problems, yet resource limitations of Pacific nations, suggests Australasian clinicians and educators may have an ongoing role in assisting with child and adolescent mental health workforce capacity building.

The iCAMH training therefore provides content which seems of value to Pacific clinicians across different settings. The training offers a framework which can provide for interactive case-based learning and for role-plays which may assist with skill development as well as gains in knowledge. The dramatically different social and environmental factors unique to Pacific nations are vital considerations for the translation of IACAPAP and Australasian content and styles of teaching. We will therefore look to evaluate the iCAMH training in the Pacific to-date using the course appraisal documents provided by Dr Klasen and the invaluable feedback from course participants.

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DR. MUIDEEN BAKARE

Confronting Sickle Cell Disease, Stigma and Poverty in Nigeria

Patricia Ibeziako

Dr. Muideen Owolabi Bakare is a leader in the field of neurodevelopmental disabilities in sub-Saharan Africa. A trained Psychiatrist practicing in Nigeria, he is the Chief Consultant Psychiatrist and Head of the Child and Adolescent Unit of the Federal Neuropsychiatric Hospital, Enugu State, Nigeria. He is also the Chairman of Childhood Neuropsychiatric Disorders Initiatives (CNDI), a non-profit organization committed to promoting the physical, social and mental well-being of children and adolescents in Nigeria and other parts of Africa. Dr Bakare has made an impact internationally as the Secretary of the World Psychiatric Association (WPA) Section on Intellectual Disability and a Member of the WHO Extended Peer-Review Group for the classification of Intellectual Developmental Disorders for ICD-11. He has spoken at numerous conferences including the International Meeting for Autism Research (IMFAR), WPA World Congress, and the IACAPAP congress. He was part of the Delphi Panelists that contributed to the rounds of Grand Challenges in Global Mental Health initiative.

As a Nigerian psychiatrist currently practicing in the United States, Muideen's story touches me for several reasons. My career as a pediatric consultation-liaison psychiatrist was influenced by watching the silent emotional toll of sickle cell disease on children at different stages of my life. Throughout my childhood, I had classmates with this illness who mysteriously disappeared from class and sometimes never returned. I did not understand what they were going through but I could feel their desolation and despair. This experience was most profound during my pediatrics rotation in medical school at the University of Ibadan, Nigeria, where I finally got to see the physical suffering that children with sickle cell disease had to endure, and yet, even in the hospital setting, their emotional suffering was rarely acknowledged, much less addressed. Muideen and I met as classmates during medical school and we became good friends during our internship. I was struck by his incredible determination and fortitude as an adult living with sickle cell disease and in awe of his ability to defy all odds and power through numerous challenges that the rest of us did not have to endure. Muideen has achieved what many in our home environment would have imagined unthinkable, and he continues to soar. Most recently he was inspired to write a memoir after listening to a keynote lecture on resilience given by Professor Myron Belfer at the 2016 IACAPAP conference in Canada. It is a compelling and very moving memoir that highlights the remarkable journey of this psychiatrist who truly exemplifies resilience.

Muideen, can you tell us a little about your upbringing?

I grew up in Ibadan, South-Western Nigeria, reputed as the largest city in West Africa. One could experience a mixture of educational advantages and modernity as well as stark illiteracy and poverty depending on where you lived, in an affluent area or in the inner city's deprived communities. I was the first child born to poor parents two years after the Nigerian civil war. When I was nine months old they learned I had sickle cell disease.

What challenges did you face living with sickle cell disease?

Growing up with sickle cell disease in an underprivileged community, where illiteracy and poverty are highly prevalent, exposed me to many stigmatizing experiences stemming from a lack of understanding of the causes and consequences of the illness. Like me, children with sickle cell disease in those communities are often referred to as "Abiku", which means "children with attachment to the spirit world". The belief is that such children are born into the world for a brief period and that they would soon die, reuniting with the spirit world without growing up into adulthood, thereby putting their parents in a permanent state of grief. Often, these parents are labeled as cursed for having such children and sacrifices with live animals are often performed to appease the spirit world, so as to keep these children living to a ripe old age.

I suffered frequently not only from vaso-occlusive crises—with the attendant excruciating bone pains that characterize the condition—but also from frequent hemolytic crises leading to anemia that necessitated repeated blood transfusions. I suffered a number of complications of sickle cell disease ranging from chronic leg ulcers to a stiff, immovable joint due to avascular necrosis of the head of the femur, which led to a permanent limping gait. Some people thought my limp resulted from a road traffic accident, others that it was a complication of childhood polio.

Knowledge and awareness of sickle cell disease was at the barest minimum when I was growing up and I was often bullied by other children. I coped by living in denial of having this illness to avoid being stigmatized, even when symptoms were so obvious to make a spot diagnosis.

Why did you decide to study medicine and what drew you to the field of psychiatry?

Frequent sickle cell disease-related crises made me pay repeated visits to the University College Hospital in Ibadan, where I came in contact with medical students, whom I began to admire. This admiration resulted in my dreaming of becoming a doctor. The dream grew with a desire to understand sickle cell disease, a condition that had brought me so much suffering and limitations, and to see if there was anything I could do to alleviate the suffering in myself and others with this illness. My dream of going through medical school was to unravel the mystery of this illness. So, my mind was set to become a physician, regardless of the enormous challenges of poverty, discouragement from medical practitioners, and the huge work load of medical school.

I finally made it. I became a medical practitioner but was rejected and prevented from specializing in hematology, the specialty of my dreams. I was

'I became a medical practitioner but was rejected and prevented from specializing in hematology, the specialty of my dreams. I was excluded on the grounds that the then head of department of hematology thought I would not be able to cope as a trainee in the postgraduate program because of suffering from sickle cell disease'

excluded on the grounds that the then head of department of hematology thought I would not be able to cope as a trainee in the postgraduate program because of suffering from sickle cell disease. This added to the rejection, discrimination and stigma I had experienced growing up, which made me think that I was inferior and undermined my self-esteem and self-worth.

I was devastated, but serendipity smiled on me when I found solace in the specialty of psychiatry and mental health, where I learnt a lot about the relationship between the mind and body. This knowledge helped me make sense of the psychological problems I experienced as a child. I had relentlessly sought acceptance and love, but they were nowhere to be found.

You have become very successful in spite of tremendous difficulties. We often hear about the challenges of living in a developing country but not enough about the strength of individuals who overcome these challenges. To what do you attribute your incredible resilience?

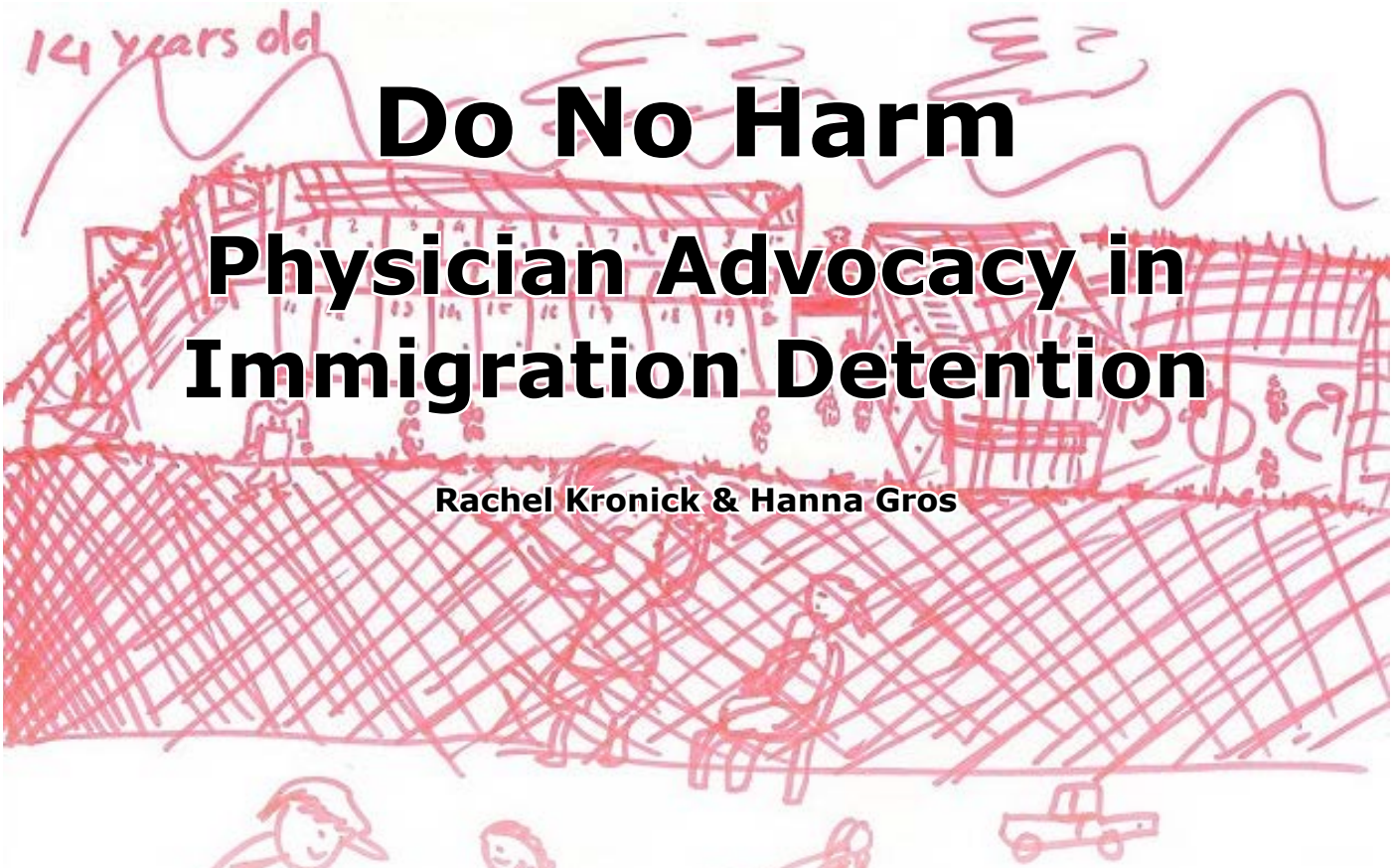
There are few things I dread more in this world than poverty. However, I believe a major thing that can sustain anyone in the face of adversity is having a goal to achieve. When you live for something and have a purpose, you are more likely to have hope and survive. My illness instilled a dream and sense of purpose in me and I derived motivation from having mentors to look up to, which I have written about in my memoir. I also read motivational books like the 'Amazing Results of Positive Thinking' by Norman Vincent Peale.

You are fairly young to have written a memoir. What motivated you to write one and what do you hope people will gain from reading it?

When I was growing up there weren't many adult role models living with sickle cell disease, let alone any who spoke out about their experiences. There was and still is much shame and stigma associated with this illness in Africa. I wanted to motivate children everywhere growing up with similar problems, so I documented my experience of growing up and living with sickle cell disease in Ibadan. I titled the memoir "Aro'môl'éegun"—this is the Yoruba name for sickle cell disease, literarily translated to mean "harbinger of bone pains". "Aro'môl'éegun" documents my struggles and successes from which I hope resilience and hope would be derived by anyone struggling with chronic illness or other challenges in life.

Your story is very powerful and inspiring. Where can one get a copy of your memoir?

The Memoir will soon be officially published. Anyone interested in getting an electronic copy can send me an email at mobakare2000@yahoo.com



Do No Harm

Physician Advocacy in Immigration Detention

Rachel Kronick & Hanna Gros

In February 2016, a 16-year-old Syrian boy, Mohammed*, arrived alone in Canada to seek asylum. Just a few months prior, in contrast to the growing xenophobic trends around the world, Canada proudly announced a welcoming policy towards Syrian refugees. Indeed, this welcoming policy was precisely the reason Mohammed's parents chose to send him across the ocean to seek asylum. However, Mohammed did not receive the greeting he expected: instead, Canada Border Services Agency officers arrested him and detained him in isolation for three weeks at the Toronto Immigration Holding Centre. Mohammed posed no danger and had no past criminality, but he endured confinement that constitutes torture under international law.

Over the past several years, Canada has detained hundreds of children for administrative purposes related to their immigration status. Detention facilities function as medium-security prisons, where children are held with their mothers and separated from their fathers. Children like Mohammed, who arrive unaccompanied by parents or legal guardians, may be held in segregation. Immigration detainees must follow strict rules and routines, and they are kept under constant surveillance by guards. Although they are not serving a sentence, immigration detainees experience many of the same conditions as those convicted of crimes – with an important distinction: there is no maximum length of time for immigration detention. Unlike those held under the criminal justice system, immigration detainees do not have a countdown to their date of release.

Immigration Detention is Harmful to Mental Health

The severe human rights violations that immigration detainees suffer manifest in pervasive mental health issues. Our studies at McGill University have illustrated that immigration detention has a profoundly detrimental impact on everyone who experiences it, but particularly children. Through our research, we observed children who were pervasively under-stimulated for weeks. They had no contact with children outside of detention, and access to education and recreation was severely limited. In a matter of weeks, healthy and bright children lost their appetite for food and their interest in play, they spent their days tearful and listless, and developed nightmares and separation anxiety. Our research suggests that children experience immigration detention as a significant post-migratory stress or even trauma. The impact of detention can continue even after release: we observed children who developed selective mutism, sleeping difficulties, behavioral disturbances, regression of milestones, and children who refused to leave their home due to a debilitating anxiety of being re-arrested. Immigration detention can be particularly harmful to families fleeing violence and persecution. For the families in our study, living in prison after arriving in a country they had hoped could offer them safety, was a constant reminder of their insecurity, and a trigger for traumatic re-experiencing.

Unfortunately, the practice of detaining children and families is not limited to Canada. Countries across the globe are increasingly resorting to punitive immigration detention systems to "protect borders." From the US to Australia and across Europe, children and their parents are being held in punishing and sometimes dangerous conditions because of their migration status. Mental health research around the world unequivocally confirms that immigration detention is severely harmful to children and their parents. In Australia, for example, child and family psychiatrist Dr. Sarah Mares and her colleagues have found extreme rates of distress and psychological disorder in detained children. In the US, Human Rights First reported on twenty-two detained mothers who went on hunger strike at the Berks Country Residential Center in

Pennsylvania in protest of the harm inflicted on their children. The report documented high rates of PTSD and anxiety that alarmingly resulted in a suicide attempt by one child who believed his death might facilitate his mother's release.

Immigration Detention needs Physician Advocacy

Physician advocacy in the realm of immigration detention is contributing to growing collaborative and inter-disciplinary research, intersecting health sciences and human rights. This research is providing an essential evidentiary foundation for informed policy proposals and powerful legal challenges. Last year, pediatricians, family physicians, psychiatrists—including the Canadian Academy of Child and Adolescent Psychiatrists—and allied health professionals, joined forces with lawyers and human rights advocates to publish a statement calling on the Canadian government to stop the detention of children. Physicians in the American Academy of Pediatrics have also repeatedly called on the US government to protect children from immigration detention, as did our United Kingdom colleagues in 2009.

According to the UNHCR, 50% of people forcibly displaced in 2015 worldwide were children under 18. While countries around the world are responding to the refugee crises with increasingly punitive and inhumane border control practices, child and adolescent psychiatrists have an important role to play in advocating for the protection of children's health and human rights. For our voices to be heard, we must build networks of international solidarity, and educate ourselves, each other, and the public, about the harms of immigration detention. Such initiatives are underway. In Canada, in June 2018, physicians, lawyers and advocates will gather in Montreal for a 2-day conference, to share knowledge, create collaborative research opportunities, and build global advocacy strategies.

As doctors we vow to do no harm. But when we cannot stop harm from within our own offices, we must advocate on a systemic level for policy changes that ensure children's rights, health and humanity are protected.

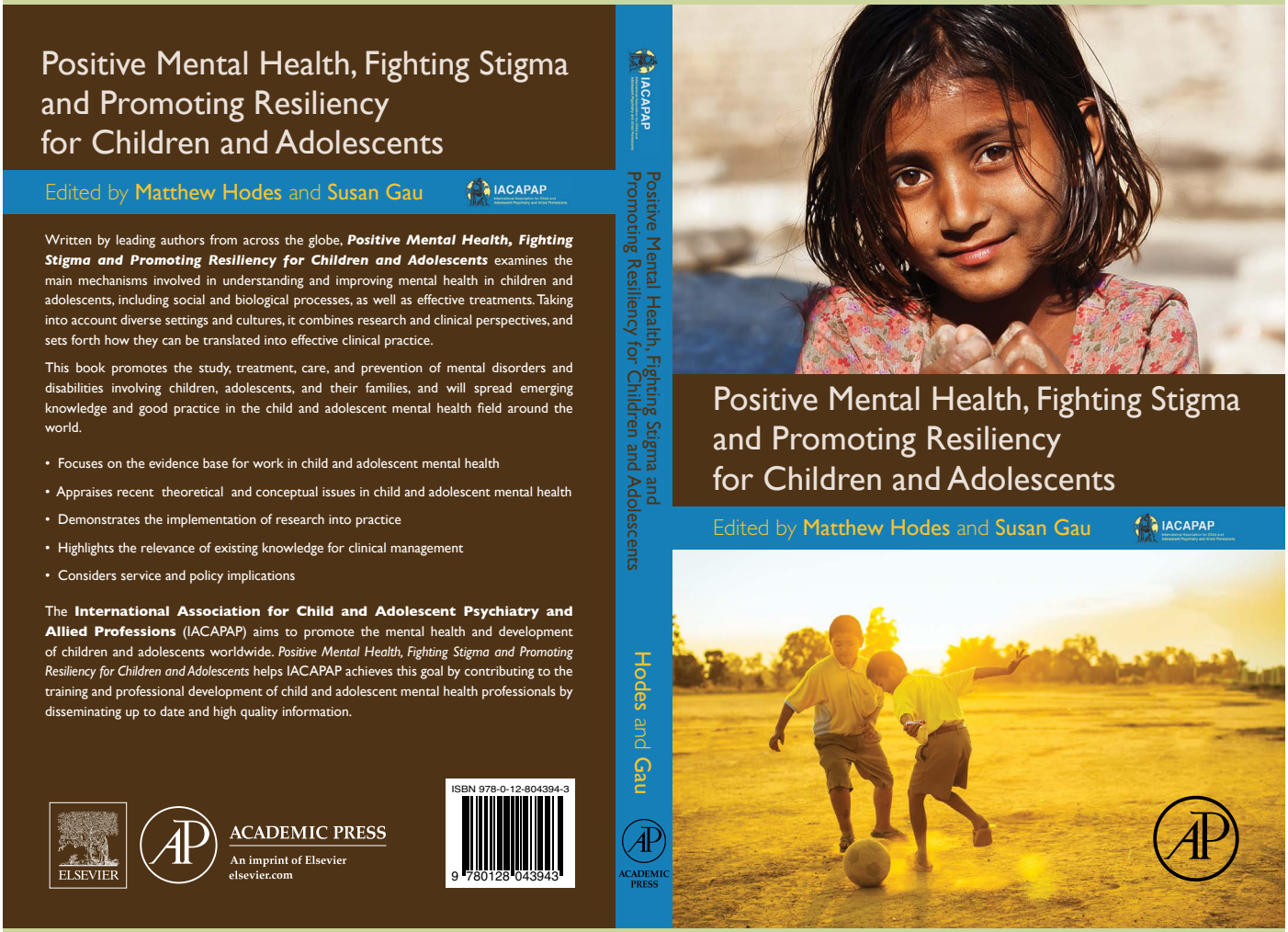
*The individual's name has been changed in order to protect his identity.

Countries across the globe are increasingly resorting to punitive immigration detention systems to "protect borders." From the US to Australia and across Europe, children and their parents are being held in punishing and sometimes dangerous conditions because of their migration status.

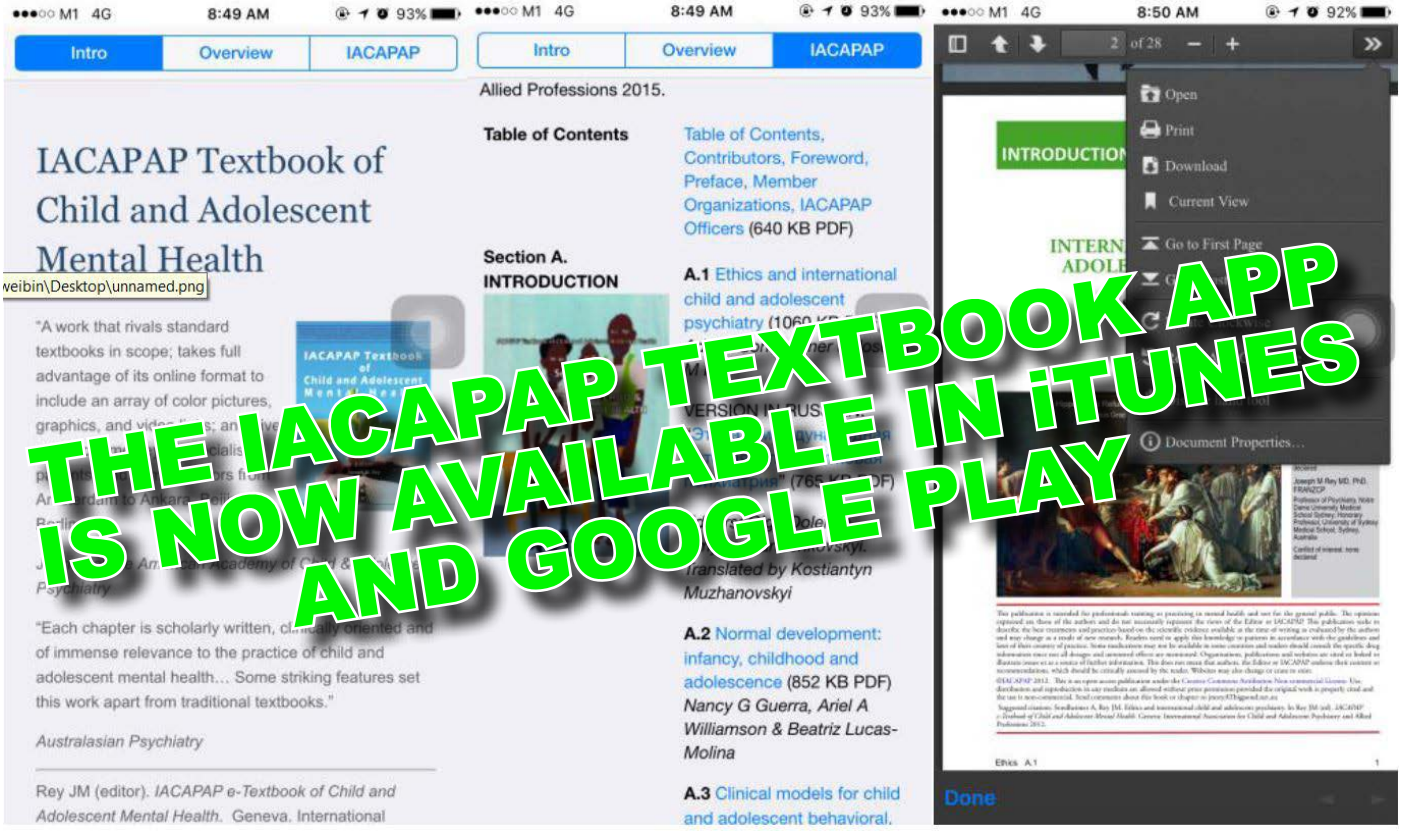
2016 IACAPAP CONGRESS MONOGRAPH

Positive Mental Health, Fighting Stigma and Promoting Resiliency for Children and Adolescents

AVAILABLE NOW



The 2016 IACAPAP Monograph entitled "Positive Mental Health, Fighting Stigma and Promoting Resiliency for Children and Adolescents" reflects the theme of the congress held in Calgary, Canada 18- 22 September 2016. The authors, selected from around the world, are experts in their field. They address conceptual issues including "What is positive mental health" (Professor Bruno Falissard, University of Paris-Sud) , and new classification systems in child psychiatry (Professor Elena Garralda, Imperial College London); risk and resiliency for disorders drawing on biological perspectives from genetics (Dr Miriam Peskin & Professor Gil Zalsman, Tel Aviv University & Columbia University) and also brain abnormalities (Professor Frank MacMaster et al, University of Calgary); psychosocial influences including adjustment of left behind children following parental migration (Professor Yi Zheng, Capital Medical University, Beijing), and promoting resilience in indigenous youth (Professor Laurence Kirmayer et al, McGill University). Service and treatment chapters address the promotion of mental health literacy in schools and reducing stigma (Professor Stan Kutcher et al, Dalhousie University), youth mental health services (Professor Patrick McGorry & Sherilyn Goldstone, Orygen, Australia), promoting parenting (Dr David Hawes & Dr Jennifer Allen, University of Sydney & University College London), resilience in autism spectrum disorder (Professor Peter Szatmari et al, University of Toronto), treatment of anorexia nervosa (Associate Professor Jennifer Derenne & Professor James Lock, Stanford University), psychopharmacology of depression and resilience (Assistant Professor Meredith Chapman et al, UT Southwestern Medical Centre, Dallas) , and helping very disturbed children in secure settings (Miriam Yurtbasi et al, Monash University).



The new IACAPAP eTextbook app gives instant access to the IACAPAP Textbook of Child and Adolescent Mental Health using smartphones, both iOS and Android-based. Install it and you will be able to access the wealth of information in the Textbook at the touch of a button. Thanks to Dr Melvyn Zhang and his technical team from Singapore for devising the app and to Dr Daniel Fung.

To install the app in your smartphone or tablet go to the iTunes (Apple devices) or Google Play (Android devices) store, search for "IACAPAP Text" and follow the prompts. Alternatively click on the following hyperlinks:

Apple: https://itunes.apple.com/us/app/iacapap-text/id1000560502?ls=1&mt=8

Android: https://play.google.com/store/apps/details?id=com.htbros.iacapapbook&hl=en

For the latest news about the Textbook and other relevant information go to https://www.facebook.com/IACAPAP-Textbook-of-Child-and-Adolescent-Mental-Health-249690448525378/

DEINSTITUTIONALIZATION OF PSYCHIATRIC CARE IN MOSCOW

Olga Rusakovskaya

According to WHO's European Mental Health Action Plan 2013-2020, mental health policies need to implement structural reform to establish accessible, safe and effective services that meet people's mental, physical and social needs. Mental health services must be oriented not only to treat the symptoms of mental disorders but also to build hope and create opportunities for them. Services must be provided and activities undertaken that empower individuals as well as communities to realize their potential, while protecting and promoting their human rights.

At the end of 2016 the Moscow's Department of Public Health published the results of a review of psychiatric services in Moscow. The main findings were:

- Distribution of resources between the psychiatric organizations of different boroughs was uneven. In some boroughs there were many more psychiatric beds in day clinics or day and night clinics, many more specialists and more financial resources than in others.
- Institutional care was prioritized over community-based mental health care. This resulted in more financial resources and a larger number of specialists in some boroughs.
- There was a lack of specialists such as psychologists, psychotherapists, and social workers in outpatient community-based mental health care.
- There was a lack of space for outpatient psychiatric clinics.
- Institutional care wasn't effective enough. Duration of hospitalization had become greater than expected according to clinical standards. About 10% of patients of day and night clinics had long term mental health problems and needed support in residential care home instead of treatment in day and night clinics. At least 10% of patients didn't need intensive treatment and could be treated in day or outpatient clinics.

Based on these findings a Concept for the Development of Moscow Psychiatric Services was elaborated. According to this plan the number of outpatient services would be doubled (from 20 to 40) in 2017. For this purpose, two additional buildings had already been assigned and thirty more would be allocated by the government for community based mental health care in different Moscow boroughs. The number of psychiatric beds in day and night clinics would be reduced significantly. One large psychiatric hospital (The Psychiatric Clinic #15) would be transformed into a residential care home for 600 patients. Two others psychiatric hospitals (#3 and #4) would be combined (the Psychiatric Clinic for Boundary Disorders to be amalgamated with the Clinic for Neurosis).

These issues were not so relevant for child and adolescent psychiatry, which already had focused on outpatient services for decades. To make psychiatric services for families more accessible, psychiatric consultation was organized not only in outpatient clinics but also in community-based health centers. There are five rehabilitation facilities in Moscow for children with intellectual or developmental disabilities, speech disturbances, and behavioral problems. Children typically stay for five days or as day-only patients.

Professor Georgij Kostjuk opening of new building for community based mental health care in Moscow.

In such centers children and adolescents receive treatment, psychological and family counseling, speech therapy, schooling and leisure activities during a period (from some weeks to a school term). During the last few years, centres of medical-psychological-social support for children, adolescents and their parents have been set up in every borough of Moscow.

Regretfully, these changes in psychiatric services for adults provoked discontent in parts of the professional community, relatives of psychiatric hospital patients, and citizens in general. Concerns that as a result of these changes people with acute psychosis would not receive appropriate medical care were voiced in the media. However, experience in the rest of the world and in some Russian regions—where deinstitutionalization of psychiatric service was implemented some years ago (Krasnoyarsk, for example)—suggest these fears are unfounded.

The real leader of the reorganization of psychiatric services in Moscow has been Kostjuk Georgij. He graduated from Military Medical Academy in 1988, specialized in psychiatry, worked in Kaliningrad as the Chief Psychiatrist of the Baltic fleet. He is Professor Head of Psychiatric Clinic #1 in Moscow, Chief Visiting Psychiatrist of Moscow. In my opinion, he succeeded in bringing together a team of specialists interested not only in treatment, but in psychosocial rehabilitation and in providing real support for patients and their families. I have observed that these professionals are successful in getting over the distrust and fear regarding the changes in the mental health services. They communicate with their patients in social media, visit them at home, social workers take them to museums and theatres… They show much enthusiasm, warmth and respect for their patients. I don't know how this will pan out in the future but I hope the reform will make psychiatric services in Moscow better.

The Turkish Association of Child and Adolescent Psychiatry organized the 27th Turkish Child and Adolescent Psychiatry Congress, which took place on 10-13th May, 2017, in Cesme, Turkey. A wide range of participants from Turkey and neighboring countries attended, most were residents and early career specialists. Many well known scientists, such as C. Correll, M. Ghaziuddin, P. Stallard, E. Leibenluft, C. Soutullo, Y. Kaminer and M. Pakyurek, presented and shared their research and clinical experiences in plenary sessions and workshops.

The theme of the congress, "Algorithms and Solutions", pointed to the need of finding solutions to the growing challenges faced by child and adolescent psychiatrists. The congress included 33 panels, 15 workshops, 11 keynote addresses, and 5 courses. English and Turkish were the official languages. Speakers' presentations were simultaneously translated in the main hall where all the plenary sessions and international presentations took place.

All keynote addresses were very well attended; these included among others "Prevention of Psychosis and Mania: Where do We Stand and Where do We Go?" by Christoph Correll; "Recent Advances in Autism Research" by Mohammed Ghaziuddin; "Irritability in DSM and RDOC" by Ellen Leibenluft; and "CBT in Schools: The Prevention of Anxiety and Low Mood in Children" by Paul Stallard. Among the workshops it is worth highlighting "Psychodynamic Psychotherapy with Difficult Adolescent Cases" given by Fusun Cuhadaroglu; "Child and Adolescent Psychiatry Training in USA, UK and Turkey" moderated by Aysen Baykara; and "New Systematic Classifications in Neuropsychopharmacology" moderated by Oguz Karamustafalioglu. One of the exciting courses was "Neuroimaging in Psychiatric Research" given by Ali Saffet Gonul. There were also sessions where colleagues from neighboring countries like Kosovo, Albania, Bosnia-Herzegova, presented their work.

94 oral and 207 poster papers were presented. The Turkish Association provided 36 scholarships to support registration and accommodation expenses of residents. Three posters were given the Professor Fahrettin Gokay Research Award: Z. Topal *et al* received the first prize by their study "Emotional and Cognitive Conflict Resolution in Adolescent Offspring of Parents Diagnosed with Recurrent Depressive Disorder and Bipolar Disorder and Matched Healthy Controls'; MO. Kutuk *et al* were awarded the second and third prizes for their studies "Psychopathology and Development of Offspring of

Mothers in Prison: Dingle Center Study From Turkey" and "No Association Between Polymorphisms of Vitamin D and Oxytocin Receptor Genes and Autistic Spectrum Disorder in a Sample of Turkish Children". There were also three project awards given by the Turkish Association for Child and Adolescent Psychiatry: "Effects of Psychoeducational Psychotherapy on Emotion Regulation, Functionality, Brain Connectivity and Prognosis in Children with DMDD and Bipolar Disorder" by NI Emiroglu; "Sociocognitive and Dysmorphological Features of Specific Learning Disability and High Intellectual Capacity" by S. Celenay *et al.*; and "Linguistic and Neurocognitive Evaluation of Reading Skills in Children with Dyslexia and Attention Deficit Hyperactivity Disorder" by Y. Tanir *et al*.

The Turkish Association also presented a plaque to Professor Ülkü Ülgür, a Turkish-American child psychiatrist who has the International Scholar Award established on his behalf by the American Academy for Child and Adolescent Psychiatry, for his contribution to the development of child and adolescent psychiatry in Turkey.

Cesme is a sea-side resort town on the Aegean coast of Turkey, 85 km West of Izmir. It lies on the extreme western tip of Turkey. The name of "Cesme", that means "fountain" in Persian, gets its name from the many Ottoman fountains scattered across the city. Cesme is the center of a holiday resort area that feature lovely beaches and spas. According to a New York Times 2016 report, Cesme was ranked 14th among 52 places to visit in the world.

The social program was as rich as the scientific one. Yeni Turku, a Turkish band, held a private concert for the participants at the ancient castle of Çeşme. Their musical style is harmony of traditional Turkish and modern musical instruments, including *kemenche*, *qanun*, *ney* and guitar. In addition, a one-day post-congress tour was organized to Chios, one of the Greek islands located close to the west of Çeşme. Getting to know colleagues from neighbouring countries, and sharing knowledge and experience with them was another important aspect of this meeting which we hope will continue in future congresses. The Turkish Association of Child and Adolescent Psychiatry expects to have more international participants in next year's congress.

Hakan Ogutlu, Fusun Cuhadaroglu

IACAPAP SURVEY OF CHILD AND ADOLESCENT MENTAL HEALTH POLICIES

Füsun Çuhadaroğlu MD

WHO data show that:

- Nearly 50% of the world's population is under the age of 18
- Globally, 10-20% of children and adolescents experience a mental disorder
- 50% of all mental illnesses have their onset by the age of 14 and 75% by the mid-20s
- Neuropsychiatric conditions are the leading cause of disability (including development, educational attainment, and potential to live fulfilling and productive lives) in young people in all regions
- Children with mental disorders face major challenges with:
  - Stigma
  - Isolation and discrimination
  - Lack of access to health care and education facilities
  - Violation of their human rights.
- Only a small fraction of global mental health resources are invested in child and adolescent mental health (CAMH) care across low and middle-income countries.

Child and adolescent mental health services face many challenges, especially in low and middle-income countries: barriers to care at every turn, lack of trained professionals, cost constraints that limit access to services, stigma, and lack of effective treatments. Key to these global difficulties is the absence of government policies. "*Atlas: Child and Adolescent Mental Health Resources*" (2005), a collaborative project of WHO, WPA and IACAPAP, was a first attempt to develop a database containing information about the current epidemiological situation and policies about CAMH in different parts of the world.

In 2016 we asked IACAPAP's member countries to complete a survey with the aim of determining:

- CAMH services capacities
- CAMH policies and policy programs
- The need for the development of national CAMH policies.

Having promised to share the results of the survey with members, I present below the data obtained. The survey was conducted online between October 2015 and July 2016 using Survey Monkey. Several reminders were sent before closing the survey. 22 out of 62 members responded (36%); 7 (32%) were from high income counties and 15 (68%) from middle and low income

SURVEY PARTICIPANTS

- Argentina
- Bangladesh
- Belgium
- Bulgaria
- Canada
- China
- Egypt
- The Eastern Mediterranean Association of Child and Adolescent Psychiatry and Allied Professionals
- Germany
- Greece
- Korea
- Singapore
- Slovenia
- South Africa
- Spain
- Taiwan
- Turkey
- United Arab Emirates
- United Kingdom

QUESTIONS ASKED

- Is there a mental health action plan (activities planned to meet the mental health and psychiatric needs of children and adolescents) developed either with or without the established policy program in your country?
- Do you have an officially established child and adolescent mental health policy program in your country? (A CAMH policy program is a written principles and ways to deal with mental health needs and problems of children, adolescents and families, accepted by the governmental bodies)
- What is the priority in the action plan in your country?
- What do you, as a CAMH professional, consider as the major ıssues to be gıven priority in the policy program and action plan in your country?
- Is the number of chıld and adolescent mental health professionals enough for providıng the services? If no, please indicate which professions are needed to be increased in number?
- Is there a formal training program for child and adolescent mental health professionals in your country? Please mark the ones whıch have.
- Is there an institution, like a board, for the qualification of training or services?
- Are there other professions (e.g. pediatrics) or NGO's involved in providing mental health services for children and adolescents? If yes, please indicate which ones.
- Is there coordination of services between child psychiatrists and other professions?
- What type of advocacy actions are being carried on in your country?
- What are the potential barriers (threats) for the development of a CAMH policy program or action plan that could exist in your country?
- What are the strengths of CAMH professionals/associations in your country to develop and promote such a policy program and action plan?
- What are the weaknesses of the CAMH professionals/ associations in your country to develop and promote such a policy program and action plan?
- In what ways do you think IACAPAP can support your association to promote the development of a CAMH policy program or action plan?
- Do you think that developing an action plan to increase awareness of CAMH and to develop a CAMH policy program can be effective in your country? IfYES, would you, or a representative from your country, be interested to join a group under the umbrella of IACAPAP to work on the issue?

ones. The low response rate limited statistical analysis to compare the results between high and lower income countries.

Results

- 36% of the countries that responded had no CAMH action plan
- 43% had no CAMH policy program
- Promotion of CAMH was a priority in the mental health action plan of 67% of the countries while treatment was 44% and advocacy was considered only in 11%
- 53% stated they needed financial resources as a priority
- 95% of the countries did not have the number of child and adolescent psychiatrists needed to carry on the services and about 50% lacked allied mental health professionals
- There were formal training programs for child and adolescent psychiatry in 65% and for allied professionals in around 16%
- 30% had no institution to accredit training and in 55% there were no specific qualifications required for services
- In 10% of the countries there was no coordination of child and adolescent psychiatry services and those of allied professions. In 45 % coordination was done by either government bodies or local authorities; NGOs played a role in 20%.
- In 20% of the countries there was no advocacy action at all for CAMH. 65% of advocacy actions were carried on by national NGOs. International NGOs were involved in 15% only.
- Major strengths listed referred mostly to characteristics of the professionals like good quality of training, multidisciplinary work, and vitality of national NGOs.
- Major weaknesses highlighted referred mostly to nonprofessional issues such as lack of financial and research resources, lack of awareness among politicians, and poor coordination.
- Members thought that lack of political will, training, and human

Füsun Çuhadaroğlu MD

Professor of Child & Adolescent Psychiatry, Hacettepe University Faculty of Medicine Ankara, Turkey & Secretary General of IACAPAP

resources, inappropriate use of financial resources, stigma and low mental health awareness were the main barriers in the development CAMH policy programs.

- Expectations of IACAPAP members referred mostly to internal and external support for advocacy, research and policy development training by providing professionals experienced in the development and negotiation of policy with politicians.
- All respondents expressed their wish to be involved in a collaborative work with IACAPAP to develop CAMH policy programs where needed.

Comments and suggestions

WHO reports show there is a worldwide absence of identifiable national child and adolescent mental health policies. Our Survey results also show that almost half of the countries (43%) lack CAMH policies. A striking fact is that policy- and decision-makers, health professionals, and the general public are not aware of the importance of CAMH and of the severity of mental health problems in this age group. One the most frequently mentioned point in the survey was the lack of awareness of politicians about CAMH policy. Respondents also stated that advocacy should have a higher priority than it currently had in their countries.

A positive aspect was that 65% of the counties reported that advocacy activities were mainly carried out by NGO's, assumed to be national associations. As Belfer (2008) stated policy development is not just politics, but needs continuously informed advocacy about the issue, and to communicate and educate politicians on an ongoing basis. Survey results show that our colleagues in various countries are aware of this fact and what they would expect from IACAPAP is support, advocacy, and to increase the awareness of politicians.

Especially in low and middle income countries, 53% of the members reported that lack of financial resources was a major issue. Not surprisingly, 95% of the countries, including high income ones, had fewer child and adolescent psychiatrists than needed to deliver services; about 50% lacked allied mental health professionals. Members viewed the lack of adequate human resources among the barriers for the development of policy programs.

Other weaknesses identified referred to lack of training and lack of experienced professionals to initiate programs. There were formal training programs for CAP in 65% of the respondent countries, and for allied professions around 16%. This point was also mentioned among the expectations from IACAPAP: "to provide training programs to increase the quality of services and research capacity and to provide standard guidelines". IACAPAP has been working to develop online training programs for CAMH professionals who have no access to formal programs and a MOOC has been developed as an online certificate program.

One of the points mentioned by most of the countries is the lack of coordination of the services. Obviously, development of child and adolescent mental health policy programs should include this issue.

The strengths of child psychiatrists worldwide are their commitment to professional development, to be able to work with professionals from multiple disciplines, and having national associations. IACAPAP may support the national associations to organize training programs, can be more active with advocacy issues, work to diminish stigma and, most importantly, to increase the public and, especially, politicians' awareness about the importance of CAMH issues. Many respondents would like IACAPAP to do more education on policy development, to provide successful examples and for experts to help them develop their own national policy program.

Some of the countries reported that they have established policy programs and were willing to share their experience. IACAPAP may assist by helping those members to form a team, a task force, which can work with national associations on CAMH policy development issues, have education and discussion sessions, and support them by providing expertise. Educating colleagues within the national associations will increase their strengths and may enrich their capacity when they are negotiating with politicians about policy. This group can also gather examples of policy programs and how they are implemented in various countries, and share these with others.

CHILD AND ADOLESCENT PSYCHIATRY AND MENTAL HEALTH

PUBLISHING IN CAPMH

FAQs

- **What are the aims and scope of *CAPMH*?**

Child and Adolescent Psychiatry and Mental Health is an open access, online journal that provides an international platform for rapid and comprehensive scientific communication on child and adolescent mental health across different cultural backgrounds. The journal is aimed at clinicians and researchers focused on improving the knowledge base for the diagnosis, prognosis and treatment of mental health conditions in children and adolescents. In addition, aspects which are still underrepresented in the traditional journals such as neurobiology and neuropsychology of psychiatric disorders in childhood and adolescence or international perspectives on child and adolescent psychiatry are considered as well.

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1. High visibility: open access policy allows maximum visibility of articles published (all articles are freely available on the journal website)
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All articles submitted undergo independent peer-reviewing (sometimes several rounds; depending on the authors' responsiveness). Independent reviewers are asked to return their report within 3 weeks. The average review time depends on the speediness of the authors' in revising their article according to the reviewers' comments. The final decision, acceptance or rejection, is made by the handling editor. The average acceptance rate is 65%. All articles are immediately published upon formal acceptance (only few formatting checks are necessary taking between 5 days and 3 weeks at most). The average time from initial submission to final publication is 19 weeks, much shorter than the average journal.

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CHILD AND ADOLESCENT PSYCHIATRY AND MENTAL HEALTH

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- American Academy of Child and Adolescent Psychiatry (AACAP)
Asociación Argentina de Psiquiatría Infantil y Profesiones Afines (AAPI)
- Asociacion Argentina de Psiquiatria Infantil y Profesiones Afines (AAPI)
- Asociación Argentina de Psiquiatría y Psicologia de la Infancia y la Adolescencia (ASAPPIA)
- Associação Brasileira de Neurologia e Psiquiatria Infantil e Profissões Afins (ABENEPI)
- Associação Portuguesa de Psiquiatria da Infância e da Adolescência (APPIA)
- Asociación de Psiquiatría y Psicopatológica de la Infancia y la Adolescencia, Uruguay (APPIA)
- Asociación Española de Psiquiatría del Niño y del Adolescente (AEPNYA)
- Association for Child and Adolescent Psychiatry and Allied Professions in Nigeria (ACAPAN)
- Asociación Mexicana de Psiquiatría Infantil AC (AMPI)
- Association for Child and Adolescent Mental Health, United Kingdom (ACAMH)
- Association for Child and Adolescent Psychiatry and Allied Professions of Serbia (DEAPS)
- Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA)
- Bangladesh Association For Child & Adolescent Mental Health (BACAMH)
- Bulgarian Association of Child and Adolescent Psychiatry and Allied Professions (BACAPAP)
- Canadian Academy of Child and Adolescent Psychiatry (CACAP)
- Child Mental Health Association of Egypt
- Chilean Society of Child and Adolescent Psychiatry and Neurology (SOPNIA)
- Chinese Association for Child Mental Health (CACMH)
- Chinese Society of Child and Adolescent Psychiatry (CSCAP)
- Croatian Society of Child and Adolescent Psychiatry (CROSIPAP)
- Czech Association of Child and Adolescent Psychiatry
- Danish Association for Child Psychiatry, Clinical Child Psychology and Allied Professions (BÖPS)
- Deutsche Gesellschaft für Kinder- und Jugendpsychiatrie, Psychosomatik und Psychotherapie
- Dutch Association of Psychiatry – Department of Child and Adolescent Psychiatry
- Egyptian Child and Adolescent Psychiatry Association (ECAPA)
- Emirates Society for Child Mental Health
- Estonian Child and Adolescent Psychiatry Section of the Estonian Psychiatric Association
- Faculty of Child and Adolescent Psychiatry of the Royal Australian and New Zealand College of Psychiatrists (RANZCP)
- Finnish Society for Child and Adolescent Psychiatry
- Flemish Association of Child and Adolescent Psychiatry
- Hellenic Society of Child and Adolescent Psychiatry (HSCAP)
- Hungarian Association for Paediatric Neurology and Child and Adolescent Psychiatry
- Icelandic Association for Child and Adolescent Psychiatry
- Indian Association for Child and Adolescent Mental Health
- Iranian Academy of Child and Adolescent Psychiatry (IACAP)
- Iraqi Association for Child Mental Health (IACMH)
- Israel Society of Child and Adolescent Psychiatry
- Japanese Society of Child and Adolescent Psychiatry
- Korean Academy of Child and Adolescent Psychiatry (KACAP)
- Kuwait Association for Child and Adolescent Mental Health (KACAMH)
- Latvian Association for Child and Adolescent Psychiatry (LACAP)
- Lithuanian Society of Child and Adolescent Psychiatry
- Malaysian Child and Adolescent Psychiatric Association (MYCAPS)
- Norwegian Association for Child and Adolescent Psychiatric Institutions
- Österreichische Gesellschaft für Kinder- und Jugendneuropsychiatrie
- Polish Psychiatric Association - Scientific Section for Child and Adolescent Psychiatry
- Romanian Society of Neurology and Psychiatry for Children and Adolescents (SNPCAR)
- Russian Association for Child Psychiatrists and Psychologists (ACPP)
- Section of Child and Adolescent Psychiatry of the College of Psychiatrists, Academy of Medicine, Singapore
- Section of Child Psychiatry of the Scientific Society of Neurologists, Psychiatrists and Narcologists of Ukraine
- Slovenian Association for Child and Adolescent Psychiatry
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- South African Association for Child and Adolescent Psychiatry and Allied Professions (SAACAPAP)
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- Swiss Society for Child and Adolescent Psychiatry and Psychotherapy (SSCAPP)
- Taiwanese Society of Child and Adolescent Psychiatry (TSCAP)
- Turkish Association of Child and Adolescent Mental Health

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IACAPAP OFFICERS

www.iacapap.org

President

Bruno Falissard MD, PhD
Professor of Public Health, Université Paris-Sud. Paris, France.
bruno.falissard@gmail.com

Secretary General

Füsun Çuhadaroğlu Çetin MD
Professor of Child and Adolescent Psychiatry, Hacettepe University School of Medicine, Ankara, Turkey.
fusuncuha@gmail.com

Treasurer

Gordon Harper MD
Associate Professor of Psychiatry, Harvard Medical School, Senior Child Psychiatrist, Massachusetts Department of Mental Health. 128 Crafts Road, Chestnut Hill, MA 02467, USA.
gordon_harper@hms.harvard.edu

Past President

Olayinka Omigbodun MBBS, MPH
Professor of Psychiatry, Centre for Child & Adolescent Mental Health (CCAMH), University of Ibadan; College of Medicine, University of Ibadan; University College Hospital. Ibadan, 200010, Nigeria.
Olayinka.omigbodun@gmail.com

Honorary Presidents

Myron L. Belfer MD, MPA (USA)
Myron_Belfer@hms.harvard.edu

Helmut Remschmidt MD, PhD (Germany)
remschm@med.uni-marburg.de

Per-Anders Rydelius MD, PhD (Sweden)
per-anders.rydelius@ki.se

Vice Presidents

Daniel Fung MD (Singapore)
daniel_fung@imh.com.sg

Susan Shur-Fen Gau MD, PhD (Taiwan)
gaushufe@ntu.edu.tw

Hesham Hamoda MD, MPH (USA)
Hesham.Hamoda@childrens.harvard.edu

Sigita Lesinskiene MD, PhD (Lithuania)
sigita.lesinskiene@mf.vu.lt

Kerim Munir MD (USA)
Kerim.Munir@childrens.harvard.edu

Christina Schwenck Dr Phil (Germany)
cschwenck@yahoo.de

Laura Viola MD, PhD (Uruguay)
viollaura@gmail.com

Chris Wilkes BSc, MB, ChB, MPhil (Canada)
chris.wilkes@albertahealthservices.ca

Yi Zheng MD (People's Republic of China)
yizheng@ccmu.edu.cn

Monograph Editor

Matthew Hodes MBBS, BSc, MSc, PhD, FRCPsych (UK)
m.hodes@imperial.ac.uk

Bulletin & eTextook Editor

Joseph M. Rey MD, PhD (Australia)
jmrey@bigpond.net.au

Donald F. Cohen Fellowship Program

Naoufel Gaddour MD (Tunisia)
naoufel.gaddour@gmail.com

Ayesha Mian. MD (Pakistan)
ayeshamian174@gmail.com

Helmut Remschmidt Research Seminar

Per-Anders Rydelius MD, PhD (Sweden)
per-anders.rydelius@ki.se

Petrus J de Vries MBChB, PhD(South Africa)
petrus.devries@uct.ac.za

Liaison with CAPMH Journal

Christian Kieling MD (Brazil)
ckieling@gmail.com

Andres Martin MD, MPH (USA)
andres.martin@yale.edu

Counsellors

Joaquin Fuentes MD (Spain)
fuentes.j@telefonica.net

Patrick Haemmerle MD, MPH (Switzerland)
haemmerlep@bluewin.ch

Bung Nyun Kim MD, PhD (South Korea)
kbn1@snu.ac.kr