World Child & Adolescent **Psychiatry** ISSUE 26, September 2024

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

World Psychiatric Association,
Child and Adolescent Psychiatry Section's
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Chair's column

Prof. Anthony Guerrero (Hawai'i)

Chair, Child and Adolescent Psychiatry Section, World Psychiatric Association

Dear Colleagues,

It is my sincere privilege and pleasure to introduce this edition of World Child and Adolescent Psychiatry (World CAP), the official newsletter and e-journal of the Child and Adolescent Psychiatry Section of the World Psychiatric Association. This is the first edition to be published under the new leadership of Dr. Flávio Dias Silva as the Section Secretary and Editor of World CAP, Dr. Vlatka Boričević Maršanić as the Section Co-Chair, and myself as the Section Chair. We are grateful for Dr. Tomoya Hirota's continued generous help as a Deputy Editor.

With the current state of world affairs, and the risk that youth face from various adversities such as armed conflict, poverty, food insecurity, disasters, and displacement, our work as child and adolescent psychiatrists is as important as ever. Given how thinly spread our specialty is throughout the globe, we must focus on not just local clinical services, but also on educating and collaborating with others, growing the workforce, shaping policies that affect availability of resources, and engaging in research and mutual learning that improves the wellbeing of all youth on the planet.

This edition of World CAP highlights the important work being done towards these goals and represents an important venue for "improving child and adolescent mental health by connecting global wisdom with everyday practice and advocacy." This edition highlights: programs that serve vulnerable youth and that can serve as models for other settings where resources are limited, creative treatment approaches that broaden youths' opportunities for improvement and that engage multiple disciplines in improving youth mental health, and innovations that prepare a global workforce of

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providers to care for youth with mental health needs. The editorial team invites you to absorb the wisdom contained in these articles, to consider connecting with the authors and other colleagues involved in the featured work, and to submit articles on topics that can stimulate further dialogue and knowledge advancement.

We also invite you to make sure you are an active member of the Child and Adolescent Psychiatry Section (https://www.wpanet.org/_files/ugd/842ec8_51fd0f0629184f059cc88f671893ede5.pdf) and if not, to formally join the Section (https://www.wpanet.org/join-a-wpa-section) . We would look forward to your participation in other activities of the Section, including quarterly member meetings via video-tele-conference, collaborations around presentation submissions and networking events at various international meetings, and collaborating in the planning of a Project ECHO® forum focused global challenges in child and adolescent mental health. Please note that the majority of our Section's materials, including all past World CAP issues, can be found at https://www.wpanet.org/child-adolescent-psychiatry.

Happy Readings!

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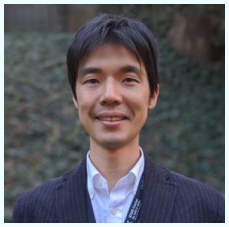
Editor's column

Flávio Dias Silva, MD, MSc (Brazil)

Tomoya Hirota, MD, (USA/Japan)



Dear colleagues, it is a joy to be able to organize the first edition of the WPACAP Journal under the responsibility of the new board of the Child and Adolescent Psychiatry Section of the WPA. This e-Journal has a long history and has mainly been an important vehicle for child and adolescent psychiatrists from all over the world to network with each other and with psychiatrists from other specialties and areas of expertise. Under the leadership of Prof Norbert Skokauskas for the past nine years, WPACAP has been an open space for communication on child and adolescent mental health issues within the WPA.

In this new edition, I am honored to take on the task of editing this e-Journal. And for this challenge, it has been essential to have the support of Section Chair Prof Anthony Guerrero, the Section Co-Chair Dr Vlatka Boričević Maršanić , but also the experience, generosity and commitment of Dr . Tomoya Hirota, Deputy Editor of the Journal for nearly a decade.

For this issue, we have initiated some changes - especially in the improvement of the e-Journal sections. As the table of contents shows, we have created or organized specific spaces for different types of publications. We still want to do a lot more - we have in mind a broader graphic revamp, and even an increase in interactivity between readers. But we believe that these will only be improvements. The essentials are already solidly built: a Journal that invites all child and adolescent psychiatrists to publicize their work and interests.

We hope you enjoy the e-Journal, and thank you for your trust!

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Invitation to submit

World Child & Adolescent Psychiatry is published by the Board of the Section of Child and Adolescent Psychiatry. It is a non-commercial, non-profit vehicle that welcomes articles from all members of the Section who wish to share their interests, news or scientific findings. To take part, simply express your interest to the editors and we will be happy to guide you. Our contact e-mails are available on the last page of the e-Journal. Get involved!

A World Child & Adolescent Psychiatry é publicada pela Direção da Secção de Psiquiatria da Infância e da Adolescência. Trata-se de um veículo não comercial e sem fins lucrativos que acolhe artigos de todos os membros da Secção que desejem partilhar os seus interesses, notícias ou descobertas científicas. Para participar, basta manifestar o seu interesse aos editores e teremos todo o prazer em o orientar. Os nossos e-mails de contacto estão disponíveis na última página da revista eletrônica. Participe!

World Child & Adolescent Psychiatry es una publicación del Consejo de la Sección de Psiquiatría del Niño y del Adolescente. Es un vehículo no comercial y sin ánimo de lucro que acoge artículos de todos los miembros de la Sección que deseen compartir sus intereses, noticias o descubrimientos científicos. Para participar, simplemente exprese su interés a los editores y estaremos encantados de orientarle. Nuestros correos electrónicos de contacto están disponibles en la última página del e-Journal. ¡Participe!

World Child & Adolescent Psychiatry est publié par le conseil d'administration de la section de psychiatrie de l'enfant et de l'adolescent. Il s'agit d'une publication non commerciale et à but non lucratif qui accueille les articles de tous les membres de la section qui souhaitent partager leurs intérêts, leurs nouvelles ou leurs découvertes scientifiques. Pour participer, il vous suffit d'exprimer votre intérêt auprès des éditeurs et nous nous ferons un plaisir de vous guider.
Nos adresses électroniques de contact sont disponibles en dernière page de l'e-Journal. Participez !

يرغبون الذين القسم أعضاء جميع من بالمقالات ترحب ربحية وغير تجارية غير وسيلة وهي .والمراهقين للأطفال النفسي الطب قسم مجلس قبل من والمراهقين للأطفال النفسي للطب العالمية المجلة نشر يتم
توجيهك وسيسعدنا للمحررين اهتمامك عن التعبير سوى عليك ما ،للمشاركة .العلمية نتائجهم أو أخبارهم أو اهتماماتهم مشاركة في.
شارك .الإلكترونية المجلة من الأخيرة الصفحة في الإلكتروني البريد عبر معنا التواصل يمكنكم!

World Child & Adolescent Psychiatryは、児童青年精神医学部門の理事会によって発行されています。本誌は非営利・非商業的な媒体であり、関心事やニュース、科学的知見を共有したいセクションの全メンバーからの記事を歓迎します。参加を希望される方は、編集部までご連絡ください。
連絡先のEメールは、電子ジャーナルの最終ページに掲載されています。参加する

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Honorary Chair's column

Prof Norbert Skokauskas (Norway)

In this section we will be inviting former chairs of the WPA Child and Adolescent Section to write freely about their views on our profession, our specialty, and the WPA itself.

In this edition, we have invited **Professor Norbert Skokauskas**, from Norway, who was the last chair of our Section and who since this year has taken on another important role in the WPA, that of Publications and Education Secretary, He kindly agreed to be interviewed by the new editors of the WPACAP Journal.

WPACAP: *Professor Skokauskas, you have been a great leader in the WPA and have served as Secretary and then Chair of the Child and Adolescent Psychiatry Section, and now as Secretary for Education and Scientific Publications at the WPA. Can you tell us a little about your experiences*

Prof. N. Skokauskas: First, thank you very much for inviting me to this interview. It is a pleasure to see the "World Child and Adolescent Psychiatry" journal, which we all started more than ten years ago, continue to grow and develop. For me it was an enormous honor and pleasure to serve as Secretary and then as Chair of the WPA Child an Adolescent Psychiatry Section. This section is one of the oldest at the WPA, and always has been one of the most active sections at the WPA. The World Psychiatric Association Child and Adolescent Psychiatry (WPA-CAP) section supports the overall mission and goals of the WPA, in working with its members and partners around the world to promote child and adolescent mental health and to encourage the highest possible standards of clinical practice and ethical behavior in child and adolescent psychiatry. Throughout the years, I have had the privilege of working with, teaching, learning from, and leading alongside exceptional colleagues. Prof. Bennett Leventhal (WPA CAP Chair 2011-2017) is widely recognized for his leadership and expertise in fostering career development and training programs as well as collaborative research

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networks that focus on everything from molecular genetics to community service and public health. Dr. Gordana Milavić (WPA CAP Co-Chair 2011-2017) was the Clinical Director of the Child and Adolescent Mental Health Service at South London and Maudsley NHS Foundation Trust, UK, and is now Chair, Association for Child and Adolescent Psychiatry (UK), and President of the Psychiatry Section, Royal Society of Medicine (UK). Prof. Anthony Guerrero (WPA CAP Co-Chair 2017-2023) is the Chair of the Department of Psychiatry at the University of Hawai'i at Mānoa's John A. Burns School of Medicine and current Chair of the WPA CAP section. Dr. Bruno Falissard (WPA CAP Co-Chair 2017-2020) is a child and adolescent psychiatrist and Professor of Biostatistics at Paris-Saclay University, France. From 2015 to 2019 Prof. Falissard was the President of the IACAPAP (International Association of Child and Adolescent Psychiatry and Allied Professions). Dr. Vlatka Boričević Maršanić (WPA CAP secretary 2017-2023) is a child and adolescent psychiatrist at Zagreba Child and Youth Protection Centre and current Co-Chair of the WPA CAP.

WPACAP: *Can you tell us a bit about the duties of the WPA Education and Publications Secretary?*

Prof. N. Skokauskas: The duties of the WPA Education and Publication Secretary are defined by the WPA Statutes and Laws. According to them, the Secretary for Education and Scientific Publications co-ordinates the educational activities of the Association and ensures the distribution of educational programmes of the WPA in co-operation with the Zonal Representatives and, as necessary, with the Secretaries for Scientific Sections, and for Scientific Meetings, the Executive Committee and the Member Societies. The Secretary for Education and Scientific Publications is also responsible for implementing the editorial policies of the WPA and maintains oversight of its publications.

WPACAP: *What are your greatest wishes regarding the WPA's education and publication activities, and what are the biggest challenges of your role?*

Prof. N. Skokauskas: With regards to overall vision for the WPA's education and scientific publication activities, I would kindly suggest to your readers to look at "The blueprint for advancing psychiatric education and scientific publications," published by me and the WPA standing committee on Education and Scientific publications: Gary Chaimowitz (Canada), Dina Elgabry (UAE), Andrea Fiorillo (Italy), Anusha Lachman (South Africa), Angeles Lopez Geist (Argentina), Paul Robertson (Australia), Hee Jeong Yoo (South Korea), and Bennett Leventhal (USA). The paper is published in the May 2024 issue of "World Psychiatry."

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More specifically, I would like to point out that, in June 2024, the WPA Education and Scientific Publications Committee launched an e-journal, "Psychiatry and Education." The primary objective of "Education and Psychiatry" is to provide a comprehensive global overview of psychiatry education and to thereby facilitate the exchange of innovative ideas and foster collaborative efforts aimed at enhancing learning outcomes.

In addition, the WPA Committee on Education and Scientific Publications will launch the Global Study on Psychiatric Training to explore the structure and quality of psychiatry teaching to medical students in multiple countries around the world and examine the integration of psychiatry within undergraduate medical curricula. More details will follow.

WPACAP: *In your opinion, what is the future for the WPA?*

Prof. N. Skokauskas: Building on the Association's foundational activities, the WPA Action Plan 2023-2026 aspires to enhance the mental and physical well-being of psychiatric patients, psychiatric staff, and the broader public. To accomplish this goal, the WPA Action Plan 2023-2026 prioritizes the following actions: implementation of evidence-based therapies, prevention and adoption of healthy lifestyles, research, and communication. The WPA Action Plan 2023-2026 seeks to uplift the mental health of the global community by making significant strides in psychiatry and public mental health in the upcoming years. The Plan underscores the importance of integrating mental well-being across all fields of society, including education, clean water and sanitation, affordable and clean energy, good work environments, and reduced inequalities.

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Research communications

Integrating Neuroscience and the Creative arts in children, adolescents and families across geographies.

Ramya Mohan, MBBS, FRCPsych (UK and India).*

*Medical and Creative Director, i MANAS International hub. Consultant Child and Adolescent Psychiatrist, Priory Healthcare and Harley Street. Medical Educator, KSS Deanery. Founding Executive Committee member, Association of Child and Adolescent Mental Health (ACAMH) International – India.


Dr Ramya Mohan (UK, India)

"Life isn't a support-system for Art. It's the other way around." (Stephen King)

Mental illness has now overtaken cardiovascular diseases as the most significant cause of morbidity globally (WHO). Mental health issues among children and adolescents have become a pressing global concern, with rising rates of anxiety, depression and other psychological disorders. Addressing these challenges requires innovative approaches that combine scientific understanding with practical interventions. Integrating neuroscience with the creative arts offers a promising avenue for enhancing young people's mental health and emotional well-being (1,8).

Neuroscience provides crucial insights into the brain's development and functioning, particularly in the developing brains of children and adolescents. Research shows that the brain's plasticity - the ability to change and adapt—plays a significant role in emotional regulation and resilience (2). Understanding how experiences shape the brain can inform interventions that promote mental health.

Creative arts therapies have been shown to offer significant benefits for mental health. For example, art therapy can help children to express emotions nonverbally, reducing symptoms of anxiety and depression (3). Music therapy has been found to improve mood and social interaction among adolescents (4). These therapies leverage the expressive and transformative power of the arts to support psychological well-being.

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Combining neuroscience with creative arts that involve using artistic activities to stimulate brain functions related to emotion, cognition, and social interaction has high potential. For example, visual stimuli aid self-guided emotional regulation (5). Programs like the "Healing Arts Program" at the University of Florida demonstrate how integrating these fields can improve mental health outcomes (6). In addition, recent studies incorporating the role of music and creative therapeutic techniques (CAPE - Creative Arts for Processing Emotions) in self-guided emotional regulation (1,8) showed significant promise. A further study by the authors evaluating the usefulness of this multidimensional approach found improved efficacy and sustenance (9). Such programs use the creative arts to engage neural pathways involved in emotional regulation and stress reduction.

The current challenging climate, particularly post-COVID-19 in the UK, has seen a gradual dwindling of resources available for patients and services overstretched in every sense. The NHS CAMHS services in the UK, for example, are under severe pressure from firefighting mental health crises and are struggling to offer much more. The recent Children's Mental Health review (2022-23) highlights long waiting lists, competing pressures for clinical services, and significant geographical variations in the availability of CAMHS services. This situation has led to poor engagement and efficacy, contributing to a vicious cycle. On the other hand, in densely-populated, large countries like India with high levels of need, multiple variables (socio-demographic, cultural, geographical, and economic) and patchy access to training /specialist healthcare, there is a different, complex set of needs that requires a larger scale, targeted, culturally sensitive and evidence-based approach. Furthermore, from our clinical experience at the grassroots level in Europe and Asia, it is evident that the dynamic and complementary interactions between healthcare, education, social care, the voluntary sector, and cultural structures vary greatly across geographies. Identifying a commonly applicable clinical management language to enable a holistic approach would be critical.

Many wellness-based apps and online services have tried to address this challenge and are available in the market in recent years. However, one size does not fit all. Cultural sensitivity is crucial when implementing creative arts programs in different regions to support mental health in culturally relevant ways (7). In this context, we have tried to set up a comprehensive mental health app-based, technology-supported hybrid platform accessible globally, based on the CAPE: Creative Arts for Processing Emotions approach (1,8,10). This program has streamlined and integrated learnings from cross-cultural initiatives and clinical experiences across India and Europe from the grassroots level - through community development projects, media-based engagement work, frontline clinical practice and clinical research. The aim is to make available an integrated, standardized, accessible, creativity-based and technology-friendly approach to

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cater to better mental health and emotional well-being for children, adolescents and families. The CAPEforHealth Program multicentric study is currently trialing this approach in the UK and India as an adjunct to traditional medication and/or direct therapy-based approaches. Preliminary results indicate significantly improved engagement and clinical efficacy, particularly in developmental disability/neurodiversity with/without comorbid mental illness in a clinical population from 8 to 18.

Integrating neuroscience and the creative arts offers a multifaceted approach to enhancing mental health and emotional well-being in children and adolescents (1,8,10). By understanding the brain's role in emotional regulation and leveraging the therapeutic potential of the creative arts, we can develop effective interventions that resonate across cultures and communities - to improve tailored health access, optimize engagement, enhance mental health and emotional well-being and promote sustenance of recovery (9,10). Future research should continue to explore these intersections, aiming to create holistic programs that address the diverse needs of young people globally.

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Clinical Practice News

Novel understandings of social withdrawal in youth: Introducing the concept of pathological and non-pathological hikikomori.

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Dr Takahiro Kato (Japan)

Hikikomori and Futoko in Japan

Ever since Japanese psychiatrist Dr. Tamaki Saito first described this condition in 1998, problematic social withdrawal behavior, called "hikikomori," in which people stay at home for six months or longer without going out to school or job, has been recognized as a significant mental health concern. [1].

The Japan's Ministry of Health, Labour and Welfare (MHLW) published guidelines for the evaluation and management of hikikomori in 2010, and the definition of hikikomori is as follows:

> ***"As a result of various factors, avoiding social participation (schooling including compulsory education, employment including part-time jobs and other interactions outside of the home), which in principle has continued under the condition of being house bound for a period of more than 6 months (this may include leaving the home while still avoiding interactions with others). In general, hikikomori is considered to be a non-psychotic phenomenon that is distinguishable from the withdrawal state based on the positive or negative symptoms of schizophrenia, but it should be noted that it is not unlikely that in fact it may include schizophrenia before definitive diagnosis."*** [2]

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Before that, pathological social withdrawal condition among teens had long been observed in Japan as school refusal, or truancy ("futoko" in Japanese) since the 1970s. Futoko (truancy) has been defined as a condition in which a pupil/student is absent from school for more than 30 days a year for reasons other than illness or financial reasons at home. According to a survey by the Ministry of Education, Culture, Sports, Science and Technology (MEXT), the number of children who are truant has been increasing for 10 consecutive years since 2013 and is estimated to exceed 290,000 in 2022 after the COVID-19 pandemic. The latest MEXT survey in 2022 has estimated that 3.17% (about 1 in 32) are not attending school; 1.7% (approximately 1 in 59) of primary schools students, 5.98% (approximately 1 in 17) of junior high school students.

Regarding hikikomori, a Cabinet Office survey released in 2016 estimated 540,000 people in the 15-39 age group in a hikikomori condition, and a survey reported in 2019 for the 40-64 age group estimated 610,000, suggesting that a total of 1.15 million people are in a condition of hikikomori in Japan. The latest Cabinet Office survey published in 2023 estimated 1,460,000 people to be hikikomori, an increase of more than 300,000 people in four years following the start of the COVID-19 pandemic in 2020.

Hikikomori as a global mental health issue

In 2011, we pioneeringly predicted the pandemic of hikikomori in the future [3], and we have revealed that actually hikikomori is now spreading all over the world [4, 5]. In 2013, I established the world's first hikikomori research clinic at Kyushu University Hospital (Fukuoka, Japan), and hundreds of persons who show hikikomori-like conditions have been evaluated, treated and also recruited for clinical research 6, 7. In the Hikikomori Research Lab at Kyushu University (Hiki-Lab@Q), we have revealed that hikikomori negatively impacts not only the affected individual's mental health, but also the wider educational system and workforce stability, and we are proposing that hikikomori is an urgent global issue in the administration of health, welfare and labor [3, 5, 6, 8]. Now, hikikomori is known to be comorbid with various mental disorders such as schizophrenia, depression, anxiety disorders, personality disorders, and autism spectrum disorder (ASD) [9-12]. Memorably, hikikomori has been newly listed in the section, 'Culture and Psychiatric Diagnosis' in the Diagnostic & Statistical Manual of Mental Disorders (DSM)-5-TR [13].

Here we introduce the latest diagnostic and assessment methods for hikikomori developed in my lab. These methods are expected to help in assessing hikikomori-like persons and futoko students in clinical practices.

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The latest definition of Hikikomori

Previous definitions of hikikomori were somehow vague, which resulted in confusion in clinical practice [2]. During my clinical interviews in the hikikomori clinic at Kyushu University Hospital, some young persons were denied being called "hikikomori" for the following reasons: "I am not avoiding society but just staying home," "Every night, I can go to convenience store," and/or "I have many online friends and enjoy gaming every night." On the other hand, most such persons have significant functional impairment or distress associated with hikikomori-like conditions. To overcome the confusion surrounding the definitions of hikikomori, we proposed a novel international diagnostic criterion of hikikomori in 2019/2020 just before the COVID-19 pandemic [see Kato et al. Psychiatry and Clinical Neurosciences 2019 & World Psychiatry 2020.[9, 14]]. The main definition is as follows:

> ***"Hikikomori is a form of pathological social withdrawal or social isolation whose essential feature is physical isolation in one's home. The person must meet the following criteria: 1. Marked social isolation in one's home. 2.Duration of continuous social isolation for at least 6 months. 3.Significant functional impairment or distress associated with the social isolation".***

Evaluation of pathological and non-pathological hikikomori during the post-COVID-19 era

On the other hand, due to the COVID-19 pandemic, our global society has faced the novel world where not outing is no longer considered pathological in itself, as a "new normal," and a new concept of "hikikomori" is warranted. With the widespread availability of online classes and work-from-home programs, there are even people who live happily, not morbidly, by not going out. According to the social needs, we have just proposed the novel concept of "non-pathological (or happy)" hikikomori [15]. If a person is in the condition of hikikomori and has no "significant functional impairment and distress associated with the social isolation," he/she should be regarded as "non-pathological" hikikomori. Herein I introduce the quick method of distinguishing between pathological and non-pathological hikikomori based on the 2019/2020 definition of hikikomori [14]. Just recently, we have developed a structured interview form and a self-rated screening form for diagnosing hikikomori, called HiDE (Hikikomori Diagnostic Evaluation) [16]. The HiDE can differentiate between pathological and non-pathological hikikomori [16]. A self-rated scale, called "HiDE-Screening Form (HiDE-S)," contains 15 questions, which can easily and quickly assess whether persons with hikikomori are "pathological" or "non-pathological" (Table 1) [16].

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Early intervention is especially important to prevent the progression from futoko to hikikomori; thus, the criterion of the "6 months" duration of hikikomori needs to be revised [14]. The HiDE-S can assess early stages of hikikomori and futoko (within 3 months from the onset) [16]. We have conducted an online survey among Japanese non-working adults and revealed that people who have become "pathological" hikikomori for "less than three months" showed an especially strong tendency toward gaming disorder compared to the other groups of hikikomori for more than three months [17]. In addition, this survey has shown that people with hikikomori who have a lower tendency of "avoiding social roles" tend to develop gaming disorder, and the most popular game among the participants was a "role-playing" game [17]. These outcomes suggest that loss of work and consequent hikikomori situations may cause loss of social roles, and that use of games, alternatively, during the early hikikomori period may be a self-help action by gaining alternative social roles through avatars in the virtual gaming world. This survey was conducted among Japanese adults, and further investigations should be conducted among young people also in other countries.

Conclusion

This report outlines the growing trend of hikikomori (social withdrawal) and futoko (truancy) based on the clinical and research activities at Kyushu University, Fukuoka, Japan. Due to the COIVD-19 pandemic, staying home by itself is no longer pathological. Therefore, in the era of the post-COVID-19 pandemic, it is necessary to distinguish between pathological and non-pathological hikikomori, and to take immediate action if the hikikomori condition is pathological. We herein introduce the updated diagnostic criteria of hikikomori and a simple questionnaire, HiDE-S, which are useful for this distinction. We hope that these tools will be used around the world to promote mental health services for young people.

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Table 1. Hikikomori Diagnostic Evaluation-Screening Form (HiDE-S) [16]

HiDE-S
(Version 1.1. July 2024)

These questions ask about your lifestyle. Please sel appropriate answer for each question below.

1. During the past one month, about how many days a week did you go ou such as to take out the trash or visit a convenience store?
□0 Four or more days/week □1 Two or three days/week □2 One day or l □3 None
2. Setting aside times when you went out briefly as in #1 above, during the month, about how many days a week did you go out for an hour or more, i going out for work, school, shopping, and so on?
□0 Four or more days/week □1 Two or three days/week □2 One day or l □3 None
3. If you answered "four or more days/week" for #2, please select "None" he answered anything else, about how long has it been that you have been g at that frequency?
□0 None □1 Less than three months □2 Between at least 3 months and le months
□3 6 months or more (Specify: _____)
4. During the past one month, how often do you feel you have gone out?
□0 Very often □1 Often □2 Somewhat often □3 Not often □4 Very seldom
5. Does the frequency of how often you have gone out in the past one mont you?
□0 No □1 Yes
6. Does the frequency of how often you have gone out in the past one mor you feel isolated or lonely?
□0 No □1 Yes
7. Has your family or people around you sought seemed to worry about the fr of how often you have gone out in the past one month?
□0 No □1 Yes
8. Has your family or people around you sought help because of the frequenc often you have gone out in the past one month?
□0 No □1 Yes
9. Has the frequency of how often you have gone out in the past one month c your work (schooling) or job search?
□0 No □1 Yes
10. Has the frequency of how often you have gone out in the past one month c your relationships with family members?
□0 No □1 Yes

[Notes] HiDE (including HiDE-I and HiDE-S) was originally produced by Takahiro A. Kato and his lab members in the Hikikomori-Research Lab at Kyushu University. HIDE is copyrighted by Takahiro A. Kato, the principal developer. Unauthorized commercial use, modifications or translation of HiDE is prohibited. If you wish to use HiDE for commercial purposes or to have HiDE translated, you must contact the principal developer: Takahiro A. Kato (kato.takahiro.015@m.kyushu-u.ac.jp/kato.takahiro.a@gmail.com). Officially translated versions of HiDE will be presented at the website of the Hikikomori-Research Lab (https://www.hikikomori-lab.com/en/).

[How to use the HiDE-S]

HiDE-S is a self-rated scale which contains 12 questions. Q1, Q2, and Q3 assess the degree of outings as "physical hikikomori" and its duration. First, Q1 asks about the frequency of outings for short periods of time. Q2 asks about the frequency of outings other than those in Q1. Even if a person goes out for short periods of time four or more days a week in Q1, if he/she goes out less than three days a week in Q2, he/she is evaluated as a "physical hikikomori." Depending on the frequency of outings in Q2, the respondent will be rated as "non hikikomori condition" if he/she goes out more than 4 days a week, as "mild" if he/she goes out 2-3 days a week, and as "moderate or more" if he/she goes out once a week or less. Q3 evaluates the duration of hikikomori: "pre-hikikomori" for 3 months to less than 6 months, and "hikikomori" for more than 6 months.

Q4 asks about subjective feelings about outings. This is an important item for providing supports and interventions, but it is not directly related to the diagnosis.

Seven questions from Q5 to Q11 assess "presence of distress and/or impairment." If any of the answers are "yes," the person is considered to have "pathological hikikomori." If the answer to any of the questions is "No," the person is considered to have "non-pathological hikikomori." In other words, even if a person meets the criteria for "physical hikikomori" in Q2, if he/she answers "No" to all of Q5 through Q11, he/she is evaluated as possibly having "non-pathological hikikomori."

Q12 assesses current social status. It is not uncommon for homeworkers and retirees to fall into the category of "physical hikikomori," but most of them are assumed to be "non-pathological hikikomori." In the unlikely event that a person falls into the category of "pathological hikikomori," some forms of supports and interventions are needed.

For a more rigorous assessment and diagnosis, a structured interview (HiDE-I) should be conducted.

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Child and Adolescent Mental Health around the World

Child and Adolescent Psychiatry Training in Indonesia: Current Situation and Challenges.

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Dr. Fransiska Kaligis

Abstract

There is a persistent discrepancy between the number of healthcare professionals and general population in Indonesia. While the population continues to rise, medical schools are limited and may require almost a decade to complete education. In addition to being a subspeciality, child & adolescent psychiatry is integrated, through modules, in psychiatric residency training and medical training and, through workshops, in Continuing Medical Education (CME). In residency training, the child and adolescent psychiatry module is 3-6 months.

Psychiatrists are expected to be able to perform child and adolescent psychiatric examinations, handle emergency cases and perform individual psychotherapy as well as family therapy. Medical students also undergo psychiatric rotations during their medical training, as general practitioners are expected to have the ability to screen and diagnose for conditions such as intellectual disability, ADHD and autism in accordance with the national standard. Socio-economic changes and an increase in social problems that influence children, such as the internet, violence and abuse, serve as challenges in this generation. In addition, service facilities for child and adolescent psychiatry and mental health are limited, and community stigma around mental health issues are still high. Nevertheless, opportunities can be found by encouraging psychiatrists to pursue child psychiatry training, fostering collaboration with other professions, empowering community care, focusing on preventive measures, and developing training workshops for healthcare professionals. Despite the low number of child and adolescent psychiatry subspecialists in Indonesia, challenges in

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shortage of resources can be minimized by improving community care and empowering allied professions, as promotion and prevention remain key to decreasing child and adolescent mental health problems.

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Introduction

Indonesia, a vast archipelago nation in Southeast Asia, comprises approximately 17,000 islands and is divided into 34 provinces. With a current population of 273 million, about 32.38% (88.4 million) are children and adolescents under 18 years old. **Table 1** provides a detailed breakdown of the population under 18 years old.[1]

Table 1. Population Under 18 Years Old

Age Group	Boys	Girls	Total
< 4 years old	11.303.486	10.790.940	22.094.426
5-9 years old	11.242.240	10.771.528	22.013.768
10-14 years old	11.356.245	10.732.428	22.088.673
15-19 years old	11.432.945	10.730.583	22.163.528

The number of psychiatrists in Indonesia is far from ideal. As of 2023, there are around 1,300 psychiatrists in Indonesia, equating to 0.5 per 100,000 population, with only about 60 of them being child psychiatrists (0.06 per 100,000 child population). About 68% of all psychiatrists are located in Java, whereas regions outside Java generally depend on community services. Most of the existing psychiatrists are concentrated in major urban areas, as depicted in Diagram 1 below.[2] This diagram underscores the vast discrepancy of mental health service availability around the archipelago.

Since 2014, mental health services have been included in Indonesia's Universal Health Coverage (UHC). However, mental health receives only 1% of the national health budget, which itself accounts for merely 3% of Indonesia's GDP. Consequently, there is a scarcity of healthcare workers trained to provide mental health services to Indonesian children and adolescents.[3]

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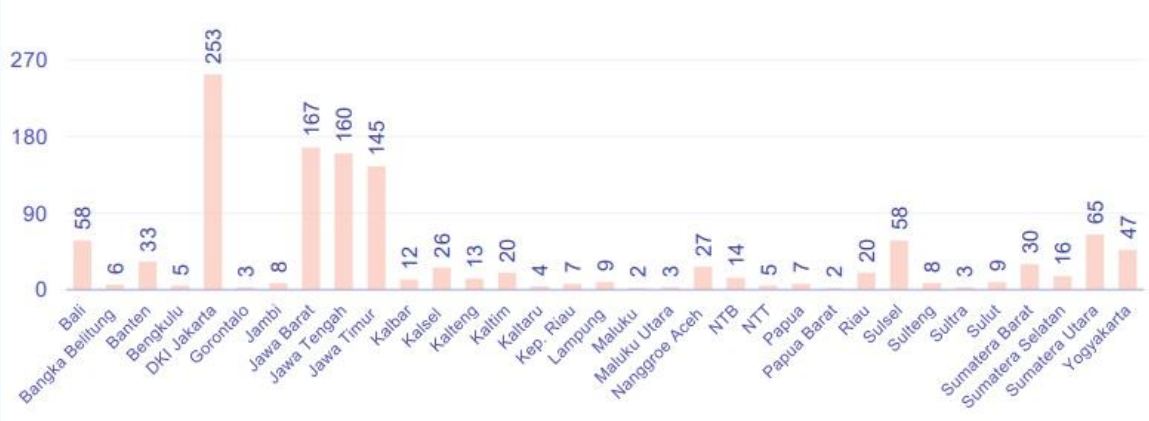

Diagram 1. Psychiatrist distribution in Indonesia (2022).

Lack of mental health service, especially for children and adolescents, contributes significantly for a high prevalence of mental health problems later in life. Among Indonesian adolescents, one in three experienced a mental health problem in the past 12 months, and one in twenty had a diagnosed mental disorder during the same period. The COVID-19 pandemic has exacerbated these issues, with 4.6% of adolescents reporting increased anxiety, depression, loneliness, or difficulty concentrating.[4]

The Pathway to Becoming a Child and Adolescent Psychiatrist in Indonesia

While there is an urgent and increasing need for psychiatrists, especially child and adolescent psychiatrists, the journey of becoming one is quite long. Obtaining a bachelor of medical sciences requires completing a four-year medical school program. Following this, individuals must undergo 1.5 to 2 years of clinical rotations to qualify as a medical doctor. To obtain a license to practice, they must participate in a one-year internship program. Those interested in further academic pursuits can enroll in a two-year program to earn a Master of Biomedical Sciences degree, and subsequently, an additional three years of study to achieve a Doctoral (PhD) degree. For professional advancement, especially in Child and Adolescent Psychiatry, medical practitioners can pursue a four-year residency to become a psychiatrist, and an additional two years of training to become a sub-specialist in child and adolescent psychiatry.

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Current Child and Adolescent Psychiatry Training and Education Programs in Indonesia

Currently, Indonesia has 92 faculties of medicine and nine centers offering Psychiatric Residency Programs, and the number is expected to increase to ten centers soon. Additionally, there are two centers providing Child and Adolescent Psychiatry subspecialty programs, located in Jakarta and Surabaya. The subspecialty program was initiated in 1976 by Indonesian psychiatrists who received their training in the USA and Canada. It is now recognized as a professional degree by both the Indonesian Ministry of Education and the Indonesian College of Psychiatry.[5]

The Child and Adolescent Psychiatry Subspecialty Program in Indonesia employs various training methods, including seminars, case presentations, clinical outpatient work, inpatient and community work, liaison consultations with other departments, e-learning, and journal clubs. The curriculum is specified in Table 2.[6]

Table 2. Curriculum of Child and Adolescent Psychiatry Subspecialty Program in Indonesia[6]

Semester	Topics
Semester 1	Aspect of ethics and professionalism Research methodology, statistics, evidence-based medicine Molecular biology and clinical practice Clinical pharmacology Developmental psychopathology Clinical skill of child and adolescent psychiatry Research literature review
Semester 2	Child psychiatry examination, forensic psychiatry interview Psychopharmacology and neurobiology Management of CAP disorders (neurodevelopmental, psychosis, mood disorder, anxiety disorder, elimination) Research proposal
Semester 3	Dynamic psychopathology Psychotherapy - CBT, play therapy Consultation liaison psychiatry in child and adolescent cases Management of CAP disorders (complex cases - feeding and eating problems, personality disorder in adolescence)
Semester 4	Family therapy Community psychiatry Infant psychiatry Elective module Management of multidisciplinary cases (eg. psychiatric problems in child/adolescent with chronic medical illnesses) Research thesis

The Child and Adolescent Psychiatry Module is also included and has become an integral component of the General Psychiatric Residency Training Program in Indonesia, conducted during the fifth and sixth semesters, with a duration of 3-6 months. This module aims to ensure that psychiatric residents become proficient in conducting child and

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adolescent psychiatric examinations, understanding developmental psychopathology and neurodevelopmental disorders, and managing child psychiatric emergencies.[7]

Medical students undergo a clinical rotation in psychiatry. For medical students, the curriculum requires them to diagnose, perform initial management for, and provide education for various conditions, including organic mental disorders, psychotic disorders, mood disorders, anxiety disorders, insomnia, and somatoform disorders. The psychiatry rotation, lasting 3-5 weeks, is a crucial part of their training. Regarding child and adolescent mental health issues, students as future general practitioners should be capable of recognizing signs and symptoms before referring patients to a psychiatrist, particularly for neurodevelopmental disorders such as intellectual disability, autism spectrum disorder, and attention deficit hyperactivity disorder (ADHD) and other psychiatric conditions that occur in childhood. To achieve these competencies, the program incorporates diverse learning methods, including lectures, case-based discussion, bedside teaching, and community education.[8]

Continuing Medical Education and Community Collaboration

Aside from the formal education program for medical students and psychiatry residents, education inchild and adolescent psychiatry is also accommodated in Continuing Medical Education (CME). CME for postgraduates in Indonesia is typically conducted through seminars and workshops. These sessions often focus on child and adolescent psychiatry and mental health and emphasize promotion, prevention, and early detection. Psychiatrists are encouraged to collaborate with other specialists and allied professionals to enhance community care.

The Indonesian Psychiatric Association develops training programs and workshops for psychiatrists, other specialist doctors, general practitioners, nurses, school personnel (including teachers and school counselors), and other professionals. These programs focus on the early detection and prevention of child mental health problems. Training for allied professions may include screening for mental health problems and psychosocial interventions, such as counseling or psychological first aid in the areas that are vulnerable to natural disasters.

Conclusion

Child and adolescent psychiatry is integrated into subspecialty training, psychiatric residency modules, and medical training programs. There are limited resources dedicated to child and adolescent psychiatry in Indonesia, an issue that can be addressed by enhancing community care and empowering allied professionals. Training in child and adolescent

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mental health for general psychiatrists, general practitioners, and other healthcare workers focuses on early detection and intervention. Subspecialists in Child and Adolescent Psychiatry are trained to manage complex cases in the referral hospitals and will also take on leadership roles, collaborating with general psychiatrists, general practitioners, and other allied professionals to provide good mental health practice for Indonesian children and adolescents.

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Decriminalization of suicide: the historical context and what needs to be done.

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According to the World Health Organization (WHO), each year, more than 700,000 people take their own lives. [1] Suicide rates have become alarmingly high in adolescents, with suicide being the fourth leading cause of death in 15-19 year olds. The number of deaths is similar in both males and females in this age group. About 88% of the adolescents who completed suicide were from low- and middle-income countries, where 90% of the world's adolescents reside. [2] The leading methods of suicide for the 15- to 19-year age group in 2013 were suffocation (43%), discharge of firearms (42%), poisoning (6%), and falling (3%). [3]

There are many environmental, psychological, and biological factors that correlate to suicide and suicide attempts. Childhood abuse, bullying, and suicides in the family and peers contribute to suicidal thoughts and behaviors among youth. Adolescents go through multiple changes in their life during their teenage years, making important decisions about education, living arrangements, finances, and peer groups. Inadequate support while navigating these challenges can lead to problems of low self-esteem and worthlessness, which lead to an increase in suicidal behavior. Studies have also suggested impairment in biological circuits, including the hippocampus and dorsolateral prefrontal cortex, in people who attempted suicide. A decrease in serotonin with its metabolite 5-hydroxyindoleacetic acid has been associated with an increase in suicidal risk in individuals. Moreover, individuals with a family history of suicide are at an increased risk of suicidal behavior due to the familial transmission of suicidal behavior. These factors highlight the fact that suicidal behaviors result from the interplay of biopsychosocial factors. [4,5]

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Current estimates suggest that every 40 seconds one individual dies by suicide somewhere in the world, but there is a high likelihood that these cases are an underrepresentation of the real cases due to the stigma associated with suicide.[6] Deaths due to suicide are often misclassified as an accident or another cause of death. Often, registering a suicide is a complex process involving judicial authorities. The stigma associated with suicide stems from its history of criminalization. In most of the mainstream religions, suicide is considered a sin, and this belief led to the incorporation of the religious doctrine into laws. In Christianity, suicide is considered a violation of the commandment, "You shall not murder," while in Islam, it is believed that our life belongs to God, and thus it is a sin to take one's own life. In Buddhism and some sects of Hinduism, suicide is believed to be the rebirth of life with endless suffering, while others believe it to be a triumph over death. [7,8]

In the 1960s, there was a shift from suicide being a sin against religion to a sin against the state when the British Common law delineated taking one's life as a crime against the state. The majority of the British Colonies upheld the British Common Law long after their independence. Most of the countries have decriminalized suicide and suicidal attempts and are making efforts to meet the UN Sustainable Development Goal of reducing the global suicide rate by one-third by 2030. However, still today, in at least 23 countries, suicide remains illegal. In many African countries, suicide attempts are still punishable, while in North Korea, family and relatives of suicide victims are punished as part of a collective punishment. [9, 10]

Even in countries where suicide has been decriminalized, the stigma associated with it still prevails, hindering the victims to come forward. In one such story, a suicide survivor from Pakistan, a country where penalization of attempted suicide was abolished in 2022, admitted to feeling guilty about committing suicide and stated, "What made it worse was the way the police dealt with it. They humiliated my dad just so they could get money out of him." What we need to understand is that penalizing suicide and suicide attempts can be counterproductive, as it can worsen stigma and shame and ultimately prevent people from seeking the mental health help that they need. [11]

Even though decriminalization is a step forward to meeting the aforementioned goals, there need to be effective strategies in place to help adolescents who come forward with attempted suicides. Without national strategies, adequate social support, and access to mental health facilities, the decriminalization of suicide would not be enough. However, it is a step in the right direction. Different countries have adopted varied suicide prevention strategies. Denmark, which had one of the highest levels of suicides, implemented means restriction and established suicide prevention clinics,

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emergency psychiatry teams, and a post-discharge outpatient program, and subsequently experienced a significant drop in the suicide rate from 38 to 11.4/100,000. The UK implemented similar strategies for improving mental health accessibility and continuity and also experienced a decrease in suicide rates. Moreover, suicide hotlines, school and college screenings, and education and outreach through social media can play a beneficial role in suicide prevention. [12]

Today, suicide is one of the leading causes of death worldwide. It is not only essential to pave the way for the decriminalization of suicide and suicide attempts but also to have effective strategies in place to prevent it. Suicide cannot be prevented by an isolated strategy; rather, suicide prevention requires a more collaborative approach with multiple stakeholders to identify individuals who can be at risk of suicide and ensure that they have adequate access to mental health facilities for prevention.

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Child and adolescent mental health: bridging the treatment gap – a model from a teaching general hospital in India.

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Photo: A view of the Child and Adolescent Guidance Clinic, Govt Medical College, Kottayam

A wide treatment gap, as high as more than 80% in child and adolescent mental health, exists in both the developed and the developing world (1) (2). Specialized infrastructural facilities and services for children and specialists trained in the sub-specialty of child mental health are scarce in low- and middle-income countries. Setting up multidisciplinary teams required for child and adolescent services in resource-limited settings is a real challenge. Alternative models, including resource sharing models, have been developed in low- and middle-income countries and have been found effective and sustainable (3).

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The Child and Adolescent Clinic (previously named the Child Guidance Clinic) of Government Medical College Kottayam in Kerala, the southernmost state of India, has been functioning in the public sector for the last 25 years and has catered to the mental health needs of youth in at least 5 revenue districts in Kerala, with a population of approximately six million. The services slowly evolved from the liaison work which was happening between the departments of pediatrics and psychiatry since the 1990s. In order to tackle the resource scarcity on both sides, a working strategy of psychiatrists, pediatricians and psychiatric social workers sitting together once a week was practiced. As this joint venture began to yield satisfying results, pediatricians and psychiatrists working in the periphery began to direct their child cases to this service. The residents in training from both specialties and the post-graduate nurse trainees also began to get associated with this weekly clinic.

Soon it became evident that the services are to be extended to the community, as the educational component could be imparted only with such a strategy. School-based parent training and teacher training became an important component of these services over the next decade. The mental health professionals working in this clinic are now collaborating with various school based mental health programs and parent groups.

The Early Intervention Clinic, led by pediatricians for early detection and multi-disciplinary management of autism and other neurodevelopmental disorders, and the Child and Adolescent Clinic, led by psychiatrists, are collaborating with each other, and a mutually complementary style of functioning is evolving. Networks with psychiatrists, other mental health professionals and pediatricians working in community are being developed, with the Child and Adolescent Clinic as the hub. An effective consultation – liaison model among specialists and governmental agencies like child welfare and protection, non-governmental organizations, and schools could be an answer for bridging the gap in child mental health care in India. Provisions in the Mental Health care Act 2017, which requires specialized establishments for the in-patient care of children with mental disorders, also offer opportunities for extending the services of the Child and Adolescent Clinic in the future. (4)

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Leaving no one behind: In pursuit of equitable access to mental healthcare for children in carceral settings in Plateau State, Nigeria.

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Dr Margaret Ojeahere

Access to healthcare is a fundamental right for every human regardless of age, race, gender, status, or background. Improving access to healthcare for vulnerable populations is critical to achieving health equity and the sustainable development goals. Unfortunately, equitable access to mental healthcare remains a challenge globally, with some regions of the world disproportionately affected than others. It has been established that mental health inequities are more profound in low- and-middle-income countries like Nigeria, compounded by the insufficient number of trained personnel to provide mental healthcare to underserved populations such as children. These disparities are further amplified among vulnerable populations such as children with mental health conditions.

Evidence shows that incarcerated children are likely to develop mental health conditions, such as depression, psychosis, anxiety disorders, and suicide before and during incarceration. Children in carceral settings face a double whammy despite prison systems being recognized as essential contributors to population health, as they remain largely excluded in health equity and mental health considerations. Unfortunately, this dilemma is exacerbated by the lack of sufficient evidence on the magnitude of this burden in sub-Saharan Africa. This evidence would be essential to inform policy changes and optimize interventions.

In the last quinquennium, Plateau state in Nigeria has experienced increased armed conflicts and kidnapping, with children and adolescents as victims. In some instances, they are recruited to perpetuate these criminal acts. Invariably, increasing numbers of children are incarcerated compared to previous years, and there is information that indicates that over tens of thousands of children are incarcerated in Africa each year. However, there is a dearth of data on this subject and none presently from Nigeria to the best of my knowledge.

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To address the inequities and discrimination associated with mental healthcare for incarcerated children in Nigeria, and backed with the ethos of the sustainable development goals of leaving no one behind, some staff of Jos University Teaching Hospital, Plateau State, Nigeria, comprising of myself as the lead, psychiatrist trainees, a psychologist, a social worker, and a vocational therapist, together with volunteers (some with lived experience), adopted feasible, acceptable, effective, and sustainable strategies to address some gaps associated with mental healthcare for incarcerated children in Nigeria.

Firstly, within our community, we carried out advocacy events aimed at reducing stigma and enlightening the public on the possible challenges faced by incarcerated children (and their caregivers) and possible causes for their incarceration. Secondly, we trained operational staff of correctional homes on using an adapted mhGAP Intervention guide (mhGAP-IG) to identify mental health conditions, to offer interventions for mild conditions, and to refer some moderate and severe conditions to appropriate facilities where child and adolescent mental health services are provided in Plateau State. In addition to collaborating with the staff, I also collaborate with various non-governmental organizations that aide in reintegration after incarceration and with legal organizations that offer pro bono services to help indigent or falsely accused children access justice.

My team and I are currently determining the prevalence of and factors associated with inequities in mental healthcare for children in Plateau state correctional homes and examining the perspectives of incarcerated children and stakeholders. Preliminary findings from our mixed study on 12- to 18-year old children and adolescents incarcerated from 2022 to April May 2024 suggest that over 60% of the youth have conduct disorders, approximately 5% have Intellectual developmental disorder, and 8% were falsely accused. Over 90% of them admitted having used at least one form of a psychoactive substance at one point in their life before being incarcerated. Reports from stakeholders suggest that several of them did not realise that childhood mental disorders can lead to criminal tendencies and incarceration. We are presently developing a position paper, among others, exploring alternatives to incarceration.

I am optimistic that findings from our study and from implementing task-shifting to improve mental healthcare access will provide evidence on existing inequities among incarcerated populations. This evidence will guide frameworks for subsequent research and policy development, and proffer strategies to strengthen health equity and mental healthcare for incarcerated children generally.

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Educational opportunities

ACAMH Learn Launching September 2024: a new, free-to-access, child and adolescent mental health and neurodevelopmental disorders video learning portal by The Association for Child and Adolescent Mental Health (ACAMH). *Dr Mark G. Lovell, from United Kingdom*.*

*Deputy Chair, Director of CPD and Training, Trustee, Association for Child and Adolescent Mental Health
Consultant Child and Adolescent Intellectual Disability Psychiatrist, Tees, Esk and Wear Valleys NHS Foundation Trust, UK


Dr Mark Lovell

Introduction

The Association for Child and Adolescent Mental Health (ACAMH) was founded in 1956* and is the largest child and adolescent mental health multidisciplinary evidence-base-into-practice educational charity in the UK. ACAMH's vision, *"Sharing best evidence, improving practice"* guides our mission to enhance mental health and wellbeing for ages 0-25 years. We achieve this mission by sharing evidence-based practices, promoting quality research, advocating multidisciplinary approaches, and providing cost-effective learning opportunities.

ACAMH is a membership body with a branch network throughout the UK and Ireland, and 3 other international affiliated ACAMHs have been created in Malta, India and Egypt with ACAMH's support. ACAMH also publishes 3 peer reviewed journals; *Journal of Child Psychology and Psychiatry* (Impact Factor 2023, 6.5), *Child and Adolescent Mental Health* (Impact Factor 2023, 6.8) and *JCPP Advances* (Impact Factor due 2025) as well as a portfolio of events, both online and in- person. These include international lectures honoring Jack Tizard, Emanuel Miller and Judy Dunn), master classes, branch or special interest groups, and the ACAMH Annual Awards event celebrating excellence in child and adolescent mental health research and clinical fields. See www.acamh.org for more detail and other resources, including clinical topic guides.

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The ACAMH is delighted to announce the launch of a new open access educational website, *ACAMH Learn*, focused on child and adolescent mental health and neurodevelopmental disorders and geared towards a variety of audiences.

Why has *ACAMH Learn* been created?

ACAMH Learn has been created to meet a global need for quality child and adolescent mental health and neurodevelopmental disorder education that is free to access.

The core aim of *ACAMH Learn* is to promote best practice in child and adolescent mental health and neurodevelopmental disorders through Continuing Professional Development/Continuing Medical Education (CPD/CME). Ongoing education ensures that the learner can effectively incorporate new methods and tools into practice. By continually improving skills and knowledge, the learner can grow professionally and provide high-quality, inclusive outcomes. *ACAMH Learn* achieves these goals by offering high-quality, accessible content that addresses a wide range of topics. These topics includes guidance and practical advice for managing mental health in various settings, from the therapy room to the classroom; information on diagnostic and therapeutic techniques; and updates on new research findings.

Open access is important, as it democratises knowledge and addresses global inequalities in access to learning. It acknowledges that there are training differences for professionals in different geographies and that access to evidence-based learning is not currently equitable. By allowing anyone to freely access and benefit from research findings, it accelerates scientific discovery, fosters innovation, and promotes equity by removing financial barriers. Particularly now, where we see training budget cuts, the significance of high-quality evidence-based free learning continues to grow.

The importance of learning anytime, anywhere, across desktop, tablet, and mobile devices, cannot be overstated. This flexibility ensures accessible learning for everyone, regardless of their location, schedule, and budget. Whether you are at home, commuting, or travelling, you can continue to learn seamlessly using digital-first designed bite-sized learning, without the constraints of traditional learning environments.

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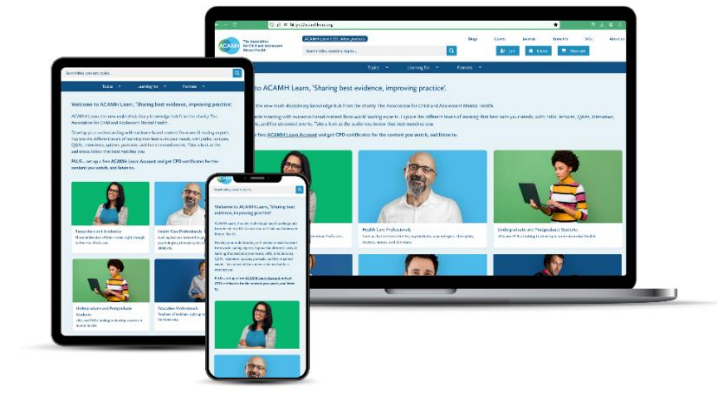
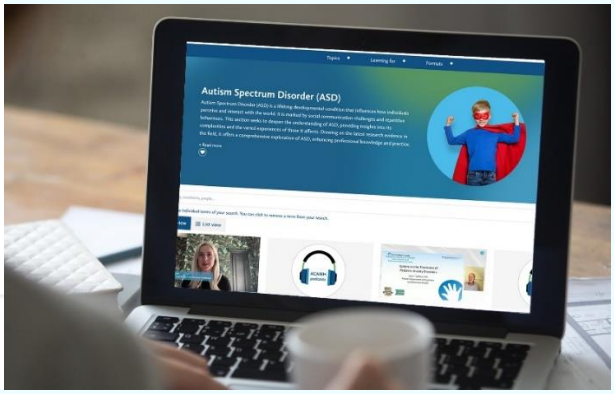
Evidence-based research is crucial, as it ensures decisions and practices are grounded in reliable, scientific data. This approach enhances accuracy, improves outcomes, reduces bias, and supports the development of best practice across various fields, from education to medicine. It fosters trust and accountability in findings.

The above fits within ACAMH's charitable remit, which is to improve practice through dissemination of evidence-based information. *ACAMH Learn* will enhance knowledge, improve professional practice, contribute to better quality of care and outcomes for young people and lead to the development of future research.





What will *ACAMH Learn* contain?

On launch it will contain 50 newly commissioned videos from topic experts and ACAMH's archive of about 250 pieces of audio or video learning content. Content will range from 2-minute myth busting videos to deep dives on clinical and research topics. After the launch, there will be a release of new video content on a weekly basis.

ACAMH Learn will feature commissioned and curated content for learning at 3 levels:

- **Introductory:** This level is aimed at parents, students, trainees and non-child and adolescent mental health professionals, e.g., teachers and social workers.
- **In Practice:** This level is aimed at clinicians that work in mental health services and will provide a basic clinical knowledge of common disorders or clinical/research topics.
- **In Depth:** This level is aimed at clinicians with greater levels of experience or expertise and at researchers and will focus on more advanced knowledge, practice and summaries of published research.

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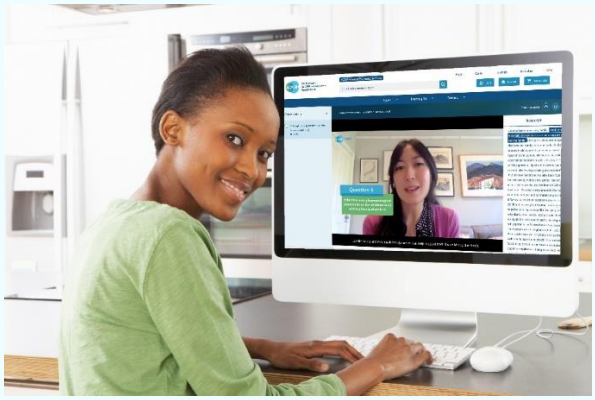
A professional audio-video production company has been commissioned in the production of invited videos, and *ACAMH Learn*'s platform has been designed using end-user feedback as part of the creative process to improve usability and to drive functionality.

The content will be initially created by invited speakers from around the world and trusted organizations, and their biographies will be linked to the talks so that a learner can be assured of a speaker's credentials. Uninvited submissions will also be considered by *ACAMH Learn*'s Content Producer (a Clinical Psychologist) to ensure that the quality of the video content is maintained before acceptance to the site.

Learning will be curated into learning paths, to cluster similar learning on a topic. *ACAMH Learn* will also have a bespoke search functionality to guide learners towards preferred content. The tagging process is overseen by a Professor of Child and Adolescent Psychology to ensure academic and clinical rigour in the search functionality. Each video will be transcribed to enable better search functionality and meet the needs of those that prefer written over spoken English. The videos will also be translated into different languages over time.

After watching a video, knowledge tests are available, so that viewers can check their learning, and a learning log is saved. The viewers can create a personalized library that remembers what content has been watched and listened to, and notes progress to ensure a smooth and continuous learning experience. This feature makes it easier to pick up and play content without losing track, thereby maintaining the momentum of learning. The viewer can also save favourite videos, forward video clips to others and download personal Continuing Professional Development (CPD) certificates for annual appraisal records and submission to professional accrediting bodies.



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Should you want to learn more, the videos will be linked to ACAMH's paid-for events, and there will also be links to relevant curated content.

ACAMH Learn Key points

- **Free learning** - anytime, anywhere, on desktop, tablet, and mobile.
- **Over 200+** world-class mental health experts, providing insights, and guidance.
- **300+ hours** of meticulously crafted videos and podcasts.
- **CPD (equivalent to CME) accreditation** - free certificates for watching videos and listening to podcasts.
- **Personalised library of content** that allows the viewer to pick up and play from where content was last viewed.
- **Transcripts** for all videos and podcasts
- **Knowledge tests** to assess learning
- **Weekly updates** - Every week at least one new piece of content will be released.

Future developments?

ACAMH Learn is currently exploring alternative language options, with the 1st development being a Spanish language version of the website. A variety of options are being considered e.g., Spanish language-first videos, translated transcripts, dubbing and use of Artificial Intelligence (AI).

A Research Dissemination Hub is being considered for the hosting of video summaries of any child, adolescent and young person research (age 0-25). This hub would allow global dissemination of the research beyond the peer reviewed journals. The initial focus has been on content from the *JCPP*, *CAMH* and *JCPP Advances* journals, which are published by the ACAMH. The intention is to expand to any research that has been published in a peer-reviewed journal.

Call for action:

1) Engage with free online learning from 16 September 2024 onwards.
2) Contribute videos of clinical topic talks and research summaries.
3) Disseminate *ACAMH Learn* to multidisciplinary and multiagency peers.

If you would like to be involved in contributing or disseminating *ACAMH Learn* please contact mark.lovell@nhs.net and guido@acamh.org .

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*The initial idea for the Association was conceived at the 1954 International Congress of Child Psychiatry and Allied Disciplines when Emanuel Miller, one of its delegates, was so impressed with the multi-disciplinary network, that he was inspired to replicate this in the UK. A network was created, which brought together the different types of professionals engaged in the field, who reported on research findings and presented clinical experiences. Created to meet the needs of members of the child guidance team, for which Emanuel Miller was so well known, the resulting Association for Child Psychology and Psychiatry adopted wider aims, including the fundamental study of the child and family, and eventually became the Association for Child and Adolescent Health (ACAMH) in 2005 to acknowledge the broader multidisciplinary membership base (ACAMH, 2006).

Declarations of Interest

The Author has no financial conflicts of interest directly related to *ACAMH Learn.*

ACAMH pays money to the Author's main employer for release of time.

The Author receives income from ACAMH for presenting and editing content separate from *ACAMH Learn*.

References

ACAMH (2006) The Association for Child and Adolescent Mental Health…celebrating 50 years of advancing the study of child and adolescent mental health. www.acamh.org/app/uploads/2018/11/50-anniversary-brochure.pdf

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Future meetings

In this section you will find upcoming events in the field of Child and Adolescent Psychiatry. Click on the image and you will be redirected to the event website.

And please, we would like to invite you to help us build this section by sharing events you know about. Click on the following link and send us the details of the events you would like to publicize here - https://forms.gle/FFe1M8qnkPubmwWU7

The 24th World Congress of Psychiatry 2024

American Academic of Child and Adolescent Psychiatry (AACAP) – Annual Meeting

The 21st International ESCAP Congress

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