

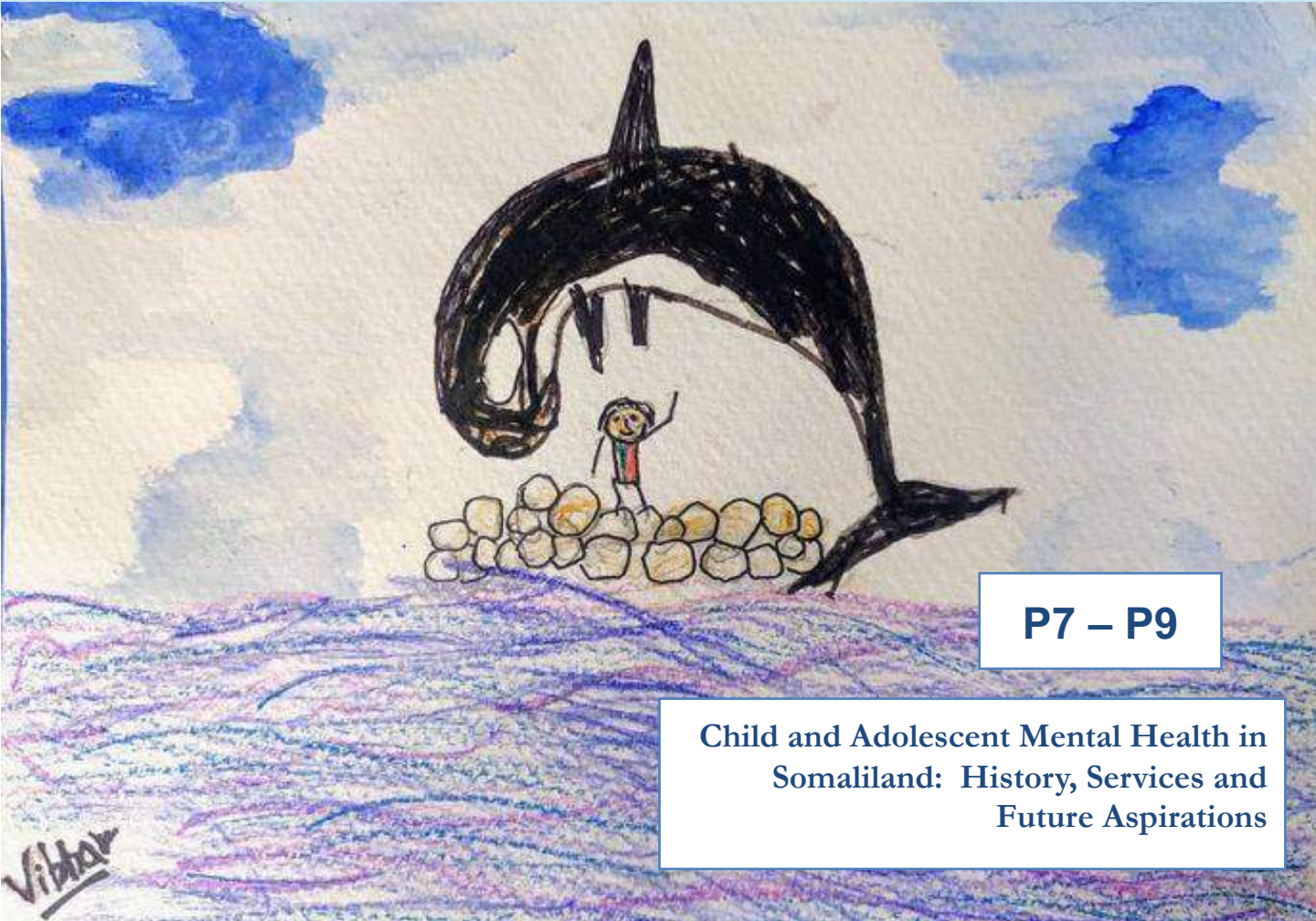


# IACAPAP

International Association for Child and Adolescent Psychiatry and Allied Professions



Jun 2021 | Issue #62



**P7 – P9**

**Child and Adolescent Mental Health in Somaliland: History, Services and Future Aspirations**

*By Vibhav, India age category: <6Y, I wish to have a friend like Willy!*

An International Collaboration between the Divisions of Child and Adolescent Psychiatry in Lithuania and Canada on Cannabis

**P10**

The World's First ACGMEI accredited Child and Adolescent Psychiatry Fellowship

**P14**

The Impact of Patient Suicide on Child and Adolescent Mental Health Professionals

**P18**

# CONTENTS

## Editor

Hesham Hamoda (Boston, USA)

## Deputy Editor

Maite Ferrin (London, UK)

## Correspondents

Andrea Abadi (Buenos Aires, Argentina)  
Birke Anbesse Hurrissa (Addis Ababa, Ethiopia)  
Tolu Bella-Awusah (Ibadan, Nigeria)  
Füsün Çuhadaroğlu Çetin (Ankara, Turkey)  
Francisco Rafael de la Peña Olvera (Mexico DF, Mexico)  
Daniel Fung (Singapore, Singapore)  
Naoufel Gaddour (Monastir, Tunisia)  
Jing Liu (Beijing, China)  
Sigita Lesinskiene (Vilnius, Lithuania)  
Manju Mehta (New Delhi, India)  
Dmytro Martsenkovskiy (Kiev, Ukraine)  
Monique Mocheru (Nairobi, Kenya)  
Cecilia Montiel (Maracaibo, Venezuela)  
Yoshiro Ono (Wakayama, Japan)  
Thiago Gatti Pianca (Porto Alegre, Brazil)  
Veit Roessner (Dresden, Germany)  
Anne-Catherine Rolland (Reims, France)  
Norbert Skokauskas (Dublin, Ireland)  
Sifat E Syed (Bangladesh)  
Olga Rusakovskaya (Moscow, Russia)  
Dejan Stevanovic (Belgrade, Serbia)  
Laura Viola (Montevideo, Uruguay)  
Chris Wilkes (Calgary, Canada)  
Azucena Díez-Suárez (Pamplona, Spain)  
Cecilia Hernández-González (Cádiz, Spain)

## Former Editors

Myron Belfer 1994  
Cynthia R. Pfeffer 1995  
Cynthia R. Pfeffer & Jocelyn Yosse Hattab 1996-2004  
Andrés Martín 2005-2007  
Joseph M. Rey 2008-2018

IACAPAP President's Message

P3

Child and Adolescent Mental Health in Somaliland: History, Services and Future Aspirations

P7

An International Collaboration between the Divisions of Child and Adolescent Psychiatry in Lithuania and Canada on Cannabis

P10

The World's First ACGMEI accredited Child and Adolescent Psychiatry Fellowship

P14

Sun Life Chair in Adolescent Mental Health, Dalhousie University, Faculty of Medicine

P17

The Impact of Patient Suicide on Child and Adolescent Mental Health Professionals

P18

IACAPAP One Minute Video: Tell Your Story!

P21

25<sup>th</sup> World Congress of the International Association for Child and Adolescent Psychiatry and Allied Professions

P22

IACAPAP Bulletin Advertising Opportunities

P23

# IACAPAP President's Message – Jun 2021

## The Mental Health of Children: Whose Business is it?

*By: Dr Daniel Fung, IACAPAP President, CEO, Institute of Mental Health Singapore, Adjunct Associate Professor, Lee Kong Chian Medical School, Nanyang Technological University*

It has been about a year and a half since the pandemic started back at the end of 2019. We have had to contend with changes and once in a life-time experiences. We have had to deal with what is described as a new normal, that of social distancing, use of masks and regular handwashing along with restrictions of travel and other interactions we are so accustomed to. If adults are affected by this, and there is a lot of evidence of this in many industries, including healthcare workers, we must realise the impact all this has on the young. The youth have taken to this poorly. Clinical services have become inundated with young people who cannot cope with school closure and the lack of social interactions. The isolation alone has resulted in more emotional meltdowns and seeking of services. Although much has pivoted onto telehealth, this comes with its own limitations. Populations' and professionals' lack of familiarity with the technology and its use, along with inadequate guidelines and legal frameworks, have all resulted in an uneven development in fully leveraging on this new way of service provision. All this has in fact also changed the way mental health services for the young should be organised and what the business of child and adolescent mental health is looking like.



**IACAPAP President  
Dr Daniel Fung**

IACAPAP has had severe disruption to its business model because it was dependent on regular face to face meetings to sustain both the financial and emotional links it had with its members. The world congress moved from being a 4-year event to a 2 year one to sustain some of these efforts alongside the mentoring clinical leadership and research programmes for early career specialists. I started out in my tenure as President with a goal of looking deeper into the business side of IACAPAP. This was not something that I intentionally planned to do early in my career. Trained in science and having curiosity about how cognitions and emotions affect behaviour,



I was largely unprepared for running a business. Yet in my second year as an associate consultant (which in Singapore terms means a qualified and independent psychiatrist), I was asked to attend a course on business management skills. I wondered why it was necessary and internally, I raged at the mere thought of making psychiatric practice a business. Surely, we as professionals had no business to dabble in such matters. We have, after all accountants and business managers to look after this in the hospital, to make sure that the books balance. We were responsible for the best possible care that we can provide for our patients, who were extremely ill, and required intensive care. It was patient safety and quality that made sense to me. Twenty years on from then, I am convinced that mental health professionals must have an intimate understanding on the business of mental healthcare. Why do I say that?

First traditional healthcare services by their very nature are intensive and limited resources. They require physical infrastructure to operate from and, in mental health, a highly trained workforce (whose training is lengthy and expensive) to provide intensive time and therefore costly services. Such services are often funded by governments. In countries with less resources, it is left to market forces and patients who are unable to pay for these will be excluded. This is worse in mental health because most mental illnesses are chronic diseases and tend to have high burden which means significant disability and inability of patients and families to pay for services. This can result in social drift which means such families drift into poverty levels which in turn may add on

to the social causation of some mental illnesses. This may not necessarily affect children since it is the parents who must pay for services but children in families who are in the lower social economic status may be deprived of services as a result, particularly in lower income countries.

Costs of quality healthcare has become prohibitive. As we develop the evidence base for efficacious treatments, there is little effort to try and manage the costs of such treatments. This is most evident in cancer treatments but is creeping across the entire healthcare system including mental health.

One of the reasons why there is a disparity in the distribution of mental health professionals is the result of such professionals migrating to areas (including crossing countries) where remuneration is higher leaving lower- and middle-income regions desperately short of the human resources needed to provide mental health services.

Aspirations of professionals are changing and the altruistic demands of working in resource depleted areas have driven many away from government funded public healthcare to more lucrative fee for service private businesses targeting wealthy clients who can pay. This vicious cycle makes it even less attractive for newly trained specialists to take on the challenges of working in such trying circumstances.

These three reasons of scarce resources, high cost and the absence of rewarding work is not sustainable in the long run. It will result in treatment gaps, a bankrupt system with disenfranchised

workers. This is the reason why the business of mental health services should be a high priority on every mental healthcare worker's mind.

Let's start by describing what is a business and how do we run a good business?

The legal definition of a business is “any activity or enterprise entered into for profit”. This provides two arms to the concept; one arm is about activity or enterprise, which means it could range from a singleton psychiatrist operating from a clinic to an entire hospital service providing mental healthcare and; the other arm is about making profit. A simple concept of profit is of course about financial gain. Essentially businesses are driven by financial gain. The question most people ask is more about when such an outcome occurs. In the short term, businesses are seen as successful if they can find a product that fits and meets the demand of the market, generate strong revenue and market share growth. This will lead to profitability and healthy balance sheets in the medium to long term which is a supposed mark of success. But what sets businesses apart? What exactly is a good business and what are the important long-term goals? The real goal of a good business is one that is able to develop a plan that is strategic, provide a team of people the opportunity to specifically execute that plan and to make sure that it is spread and sustained. The financial gain should not be seen as an outcome for individuals but broader, for the greater good of the community and country. In fact, one way of conceptualising profit is to consider the concept of value, which is essentially

the quality of a service over the cost. The value that a healthcare business creates is key to having what one can consider a successful business.



The mechanics of a good business emphasises having a good plan that is implemented by a good leadership with a good culture, with good understanding of strengths and risks of the business and creating a good work environment with social awareness, providing good customer service.

With this understanding in mind, good mental healthcare must start by making good business sense. Treatments must not only be evidence based but cost effective so that we can maximise the benefits for the entire community. Better still, the model should focus on long term and upstream work of promoting good mental health and preventing mental illness. For children, this may mean that our services will need to consider the social determinants of childhood mental illness and even as we are experts in diagnosing and treating such illnesses, we should consider how we can work across other sectors like education and social services to improve mental health literacy and prevent the causes of mental illness. To do this well, there must be a business model that can

sustain it. Such a model is likely to involve some aspect of what we call capitation or in our layman parlance, a subscription model not unlike how we buy insurance. All governments should have a budget for health but instead of spending it on illness alone, they should spare some into mental health promotion and mental illness prevention.

In the same light, IACAPAP is also moving towards a sustainable business model in which our membership fees and fundraising will form the basis of how we focus on our 2 main missions

1) Advocate for the promotion of the mental health and development of children and adolescents through policy, practice and research

2) Promote the study, treatment, care and prevention of mental and emotional disorders and disabilities in the young

So, whose business is it? IACAPAP should see ourselves being responsible for both the mental health of children and the mental disorders that some children suffer from. We can only do this well if we operate from a fiscally responsible business perspective. IACAPAP is not in the business of making money but we are in the business of making a difference, for the next generation.

-----

## YOU CAN MAKE A DIFFERENCE!

IACAPAP is a non-profit organisation that supports global sharing of knowledge in child and mental health. Your generous donation will help us continue bringing you exciting news and updates from around the world.

[Click here to Donate](#)





# Child and Adolescent Mental Health in Somaliland: History, Services and Future Aspirations

By: *Jibril I.M Handuleh<sup>1,2</sup>, MD MPH*

<sup>1</sup>*Psychiatry resident, Saint Paul's Hospital Millennium Medical college, Addis Ababa, Ethiopia*

<sup>2</sup>*Lecturer, School of Public Health and Psychiatry, Amoud University, Borama, Somaliland*

Somaliland is a de facto state in the horn of Africa. It declared its unilateral independence from the rest of Somalia in 1991. Despite the chaos, the political and security instability in Somalia, Somaliland has been stable for over three decades. During the early phases of the civil war most of the health professionals left the country and got resettled in the global north. It left the country with severe shortage of skilled health workers including mental health professionals.

Medical education was nonexistent in Somaliland for decades. By the year 2000, a global health partnership between Somaliland and King's College London led to establishing two medical schools in Somaliland. Also a nursing school named Edna Adan school was founded by a retired World Health Organization veteran from the country [1].

Psychiatry education at the undergraduate level also

started with visiting faculty under the UK-Somaliland collaboration mainly from the Maudsley Hospital in London in 2007. Since then, psychiatry education in medical schools became part of the mainstream education. In the first decade, the UK faculty led the teachings [2]. Final mental health exams for medical schools have both written and clinical parts, the later in the form of Objective Structured Clinical Examinations (OSCEs).

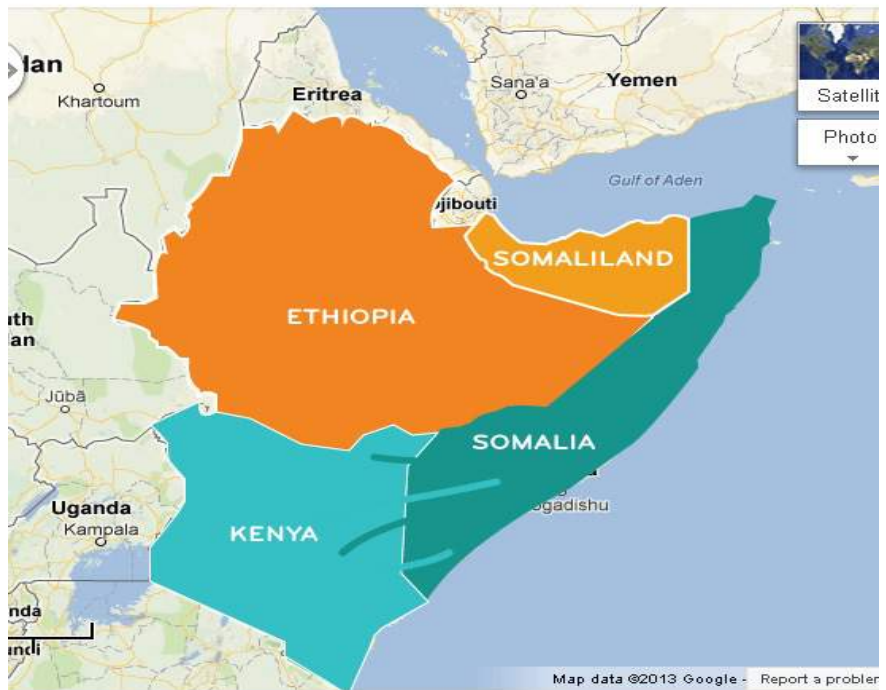


Figure 1 Somaliland Map

In addition to psychiatric education, the UK partnership in collaboration with Tropical Health and Educational Trust (THET) assisted setting up a mental health representative position which supported interns to have teaching and examiner roles under supervision of British psychiatrists. Within one year of the training, a mental health representative won a mental health services grant from THET for beginning mental health services from scratch at his home town of Borama in Somaliland [3]. We chose Borama as it was home to Amoud University, and it had active community engagement, strong international collaborations and academic resources compared to other towns in Somaliland.

A grant from THET funded Borama's first mental health service from scratch for 2 years. This helped set up outpatient, inpatient and community mental health services [4].



**Figure 2 Borama Hospital Mental Health Department**

The faculty at the Maudsley were diverse so we added school mental health outreach and a forensic psychiatry service. In the grant, we had the first opportunity to advocate and engage with the public on the issue of child and adolescent mental health in Somaliland [5].

Child and adolescent mental health was central to the larger public engagement efforts. Before embarking on child and adolescent mental health services, we did community awareness and promotion meetings. Elderly people, religious leaders and women associations were the groups that we selected to advocate and promote public mental health aspects of child and adolescent mental health in Somaliland.

Teachers and parents also joined a consultative meeting with the mental health unit at Borama Hospital. The association of school teachers in Borama had also requested a mental health service for the teachers and students alike. They pointed out that the mental health trauma of wars in Somaliland decades ago affected the mental health of parents. They knew that students, parents and teachers were suffering from mental health problems.

We chose to integrate CAP into our outpatient service and deliver school based mental health services in Borama. Since late 2011, Borama has had a child and adolescent mental health service as a part of its general psychiatry OPD services. At the same time, schools and the psychiatry department collaborated to serve the population of students and teachers with mental health disorders.



School principals communicated directly with the department to arrange both for emergency and outpatient mental health services.

Inpatient services for children and adolescents are not available in Somaliland. Outpatient care has been working well and a single seclusion room at the pediatric ward is the one bed available for inpatient emergencies. A dedicated team of a child and adolescent psychiatrist and a general adult psychiatrist from the UK supervised, mentored and observed colleagues that work in the service.

First, the whole team were general practitioners as Somaliland did not have a psychiatrist and the author who is a psychiatry trainee outside Somaliland with strong interest and aspiration to become a child and adolescent psychiatrist, offers telepsychiatry service to the Borama mental health unit over the weekends. Secondly, commitment to go for fellowship training in CAP and make international connections is there for us to develop our CAP capabilities.

In the future, there are plans for Somaliland to start its psychiatry residency program and psychiatry nursing program to address the mental health human resource. Current residents training in neighboring countries like Kenya and Ethiopia will return and contribute to the development of psychiatry and CAP in particular. At the same time, we shall be seeking partners in mental health education, research and service development.

Particular areas of focus will include school mental health, migration health

and mental health effects of climate change, urbanization and substance use in Somaliland. Research collaboration regionally and globally will be appropriate for the country to build its mental health services in both child and adolescent and women's mental health.

#### References

1. Leather, A., Ismail, E.A., Ali, R., Abdi, Y.A., Abby, M.H., Gulaid, S.A., Walhad, S.A., Guleid, S., Ervine, I.M., Lowe-Lauri, M. and Parker, M., 2006. Working together to rebuild health care in post-conflict Somaliland. *The Lancet*, 368(9541), pp.1119-1125.
2. Sheriff, R.S., Bass, N., Hughes, P., Ade-Odunlade, P., Ismail, A., Whitwell, S. and Jenkins, R., 2013. Use of interactive teaching techniques to introduce mental health training to medical schools in a resource-poor setting. *African journal of psychiatry*, 16(4), pp.256-263
3. Handuleh, J., 2012. Experiences of a junior doctor establishing mental health services in Somaliland. *Intervention*, 10(3), pp.274-8.
4. Handuleh, J., 2013. Transforming a Dumping Site into a Psychiatric Inpatient Unit in Somalia. *American Journal of Psychiatry*, 170(11), pp.1248-1248.
5. Handuleh, J., Whitwell, S. and Fekadu, D., 2013. Report: School mental health project in Somalia. *Arab Journal of Psychiatry*, 24(1), pp.46-51.

-----

# An International Collaboration between the Divisions of Child and Adolescent Psychiatry in Lithuania and Canada on Cannabis

*By: Prof Chris Wilkes, Division head of Child Psychiatry, Dept. Psychiatry, University of CALGARY Canada; Dr Sigita Lesinskiene, Vilnius University, Lithuania.*

The Lithuanian Society of Child and Adolescent Psychiatry and allied professionals from the clinics of Psychiatry in both universities in Lithuania (Vilnius University and Lithuanian University of Health Sciences) organized a conference on June 3rd, 2021 entitled “Consequences of psychoactive substance use and the treatment needs for children and adolescents”. This topic is salient and timely in Lithuania; as the government is planning the legalization of the use of small doses of cannabis. Consequently, in order to protect healthy development and plan services in child and adolescent Psychiatry it is imperative to learn from other countries such as Canada, that have gone through the legalization of Cannabis recently.

Dr Sigita Lesinskiene, a Past Vice President of IACAPAP has extensive experience in international collaboration on advocacy and education and invited Prof. Chris Wilkes, also a former Vice President of IACAPAP, from the University of Calgary to give an update on Canada’s experience with Cannabis 3yrs post legalization. In 2018, at the IACAPAP Congress in Prague, Prof. Chris Wilkes gave a lecture on the challenges facing Canada with the new 2018 legalization of Cannabis use. In light of the COVID pandemic restrictions Dr Lesinskiene and Prof Wilkes thought this would be an ideal opportunity to organize a virtual update on the Canadian experience.

Dr Lesinskiene was aware that the



Calgary, Canada

Lithuanian Society of CAP needed to discuss this sensitive issue of legalization of Cannabis, so they wrote letters to the Ministry of Health and other governmental bodies advocating for more coordinated service integration to support youth with these dependence issues because of the associated co-morbidities.



Dr Sigita Lesinskiene

Dr Lesinskiene and colleagues emphasized that opportunities for staged, continuous treatment for youth with addictions in Lithuania are significantly lower than for adults. In Lithuania minors intoxicated with alcohol and psychoactive substances are often treated in intensive care units at children's hospitals. After the stabilization of a life-threatening condition, they are discharged to homes or care. However, relapse is common and when mental and behavioral deterioration occurs, they are often placed for 2-3 weeks at inpatient treatment units at the child and adolescent psychiatric hospitals. Nevertheless, treatment is often short, and outpatient care is fragmented and insufficient. Thus, the goal of the conference with an international speaker was to share experiences that can facilitate, strengthen interventions and avoid creating systems that obstruct the

timely delivery of addiction services for minors.



Prof. Chris Wilkes

Prof Wilkes during his presentation emphasized that the legalization of cannabis in Canada has polarized the medical profession because social and political policy is now dictating the medical usage of Cannabis for a variety of conditions, including psychiatric disorders. Currently there is no level 1 evidence, double blind control trials, that cannabis is indicated for the primary treatment of any psychiatric disorder. To the contrary, we have evidence that early use is associated with later addiction and the development of psychosis in vulnerable youth as well as worsening of anxiety and depression in some youth. A [UNICEF study](#) in 2013 revealed that the prevalence of use over a year for Canadian teens was around 28%, the highest of 29 countries. A [study by the WHO](#) in 2016 revealed a prevalence rate over the last 30 days was 13% for 15 year olds but overall, 20% prevalence for 16- 24 years of age. The [Ontario CAMH 2012 study](#) of teens in grade 7 to grade 12 was around 20%. It is estimated that 37% of high school students in grade 12 in Ontario are using Cannabis. A [Deloitte survey](#) in 2016 estimated that an additional 17% of the





Vilnius, Lithuania

population will try Cannabis if it is legalized. The availability of cannabis in our society at present is a direct result of the aggressive marketing by some companies and complicit involvement by some well-meaning but misinformed medical doctors about the selective role of medical cannabis. In fact, the deloitte survey reveals that this is going to be big business representing a \$22.6 Billion market potential in Canada. This should not overshadow the importance of avoiding its use among vulnerable groups such as children, adolescents, pregnant women, and those with severe and persistent psychiatric illness.

Prof Wilkes emphasized that there is no doubt that cannabis has been used for thousands of years around the world for the treatment of pain and the induction of euphoria as a welcome relief from the painful demands of life. However, the medical role of cannabis is quite specific and includes pain relief, especially in certain cases of arthritis, multiple sclerosis and as an adjunct to treating chemotherapy induced nausea. Additionally, the decreased opioid death

rate in some states that have legalized cannabis speaks to the role of harm reduction strategies for opioid addiction using legalized cannabis. Now the legalization of cannabis has promoted welcomed research evaluation of cannabis use in medicine, especially of the differential roles of Tetrahydrocannabinol (THC) and Cannabidiol (CBD) in conditions such as intractable epilepsy and anxiety, but we are still waiting for that data.

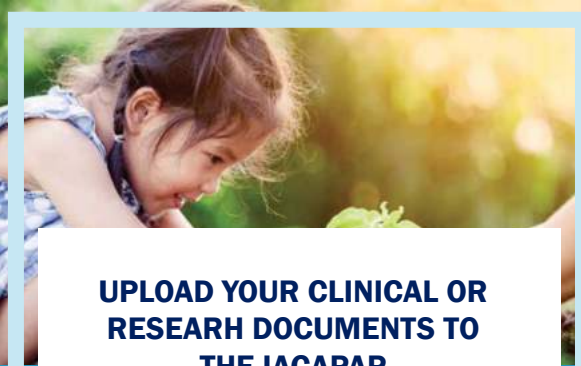
Although the decriminalization and increased availability of medical cannabis is good for some Canadians, this is not a benign substance, and it needs to be strictly regulated. The brain does not have alcohol receptors, but it does have cannabinoid receptors which are intimately involved in the brain and immune system. Cannabis plays an important role in our stress regulation and reward systems. Early use risks impairing our neuro-development, neural plasticity and therefore our ability to learn. Legalization of cannabis without careful regulation risks increasing its availability for the most vulnerable

populations in our communities, homes, schools, work, and other public places. The social, medical, and legal systems need to work carefully together for the benefit of all Canadians.

Prof Chris Wilkes emphasized that overall, in Canada there has only been a 2% increase in Cannabis use since legalization. Canada like other countries has been impacted by the COVID pandemic and the increasing use of Alcohol, Opioids, Crystal meth and other psychedelics when people are in lock down. However, services in Calgary have evolved over time to a more trauma informed and neuro-developmentally sensitive approach to addictions. Heavily influenced by the adverse child events literature and the work of the Harvard Child Development centre that promotes an eco-bio-developmental perspective. This work clearly show that trauma gets under your skin, an ACE score of 4 or more can double the risk of cardiac disease and Lung cancer and is associated with a 700% increased risk of becoming alcoholic. All this knowledge has led to cross ministerial collaboration with Child Welfare Systems, Justice, Education, health and Non-Government organizations to ensure a spectrum of services available for children and youth with addictions. Services are now looking at these patients differently, with the question of what has happened to you and how can we help, rather than the traditional approach of what is wrong with you and using a more punitive approach. However most public addiction services only involve a short term residential placement with outpatient follow up and are associated with frequent relapses; whereas some


private organizations in Calgary have a 2 year treatment program with better results. Clearly when it comes to the legalization or decriminalization of drugs in our society, we still have a lot more work to do and child and adolescent mental health professional have an important role to play in these discussions.

-----



**UPLOAD YOUR CLINICAL OR RESEARCH DOCUMENTS TO THE IACAPAP ARXIV!**

For more information please visit <http://arxiv-iacapap.org>



**IACAPAP**  
International Association for Child and Adolescent Psychiatry and Allied Professions

# The World's First ACGMEI accredited Child and Adolescent Psychiatry Fellowship

*By: Finza Latif, MD, DFAACAP, Sidra Medicine Qatar; Durre Shahwar, MBBS, MRCPsych, Sidra Medicine Qatar; Muhammad W. Azeem, MD, DFAACAP, DFAPA, Sidra Medicine Qatar.*



**From left to right: Dr. Mohamed Albreiki (child psychiatry fellow), Dr. Muhammad Ather (Outpatient Child Psychiatry Lead), Dr. Finza Latif (Program Training Director), Dr. Durre Shahwar (Associate Program Training Director), Professor Muhammad Waqar Azeem (Chair, Department of Psychiatry), Dr. Ahsan Nazeer (Division Chief, Child and Adolescent Psychiatry), Marcel Ramos (Program Training Coordinator)**

[Sidra Medicine](#) is an academic women and children's hospital in the state of Qatar, affiliated with [Weill Cornell Medical School-Qatar](#). The Psychiatry Department serves women and children with mental health difficulties in Emergency, Inpatient and Outpatient

settings. The Department has a multicultural faculty of psychiatrists and psychologists with multiple areas of expertise. Patient volumes have grown through the years due to community and school advocacy. The Department cared for >10,000 patients in 2020. The



hospital and the Department values education and aims to provide the highest standards of training to future child and adolescent psychiatrists, psychologists, pediatric specialty trainees and medical students.

The Department started the journey of developing a child and adolescent psychiatry fellowship training program in 2018. In order to ensure that the training program met the highest quality standards, it was modeled to meet the requirements of the Accreditation Council for Graduate Medical Education-International (ACGME-I). The ACGME is the main accreditor of graduate medical education programs in the United States while the ACGME-I extends this accreditation model internationally. The Advanced Specialty Training Program in Child and Adolescent Psychiatry at Sidra received accreditation by ACGMEI in

2019 for 3 positions per year for a 2 year training period.

The main strength of an ACGME-I program is a shift from the 'apprenticeship' or time based teaching model to a competency based model, ensuring specific standards for teaching, learning and professional practice. Fellows are required to meet 6 core competencies (Fig1) in order to graduate.

*Program Development:*

The educational program includes a core didactic curriculum and core clinical rotations. Clinical rotations are organized for each year using a block schedule (Fig 2). Fellows also receive protected time to complete scholarly activities including conference presentations, posters and original research.

## ACGME-I CORE COMPETENCIES <sup>a</sup>

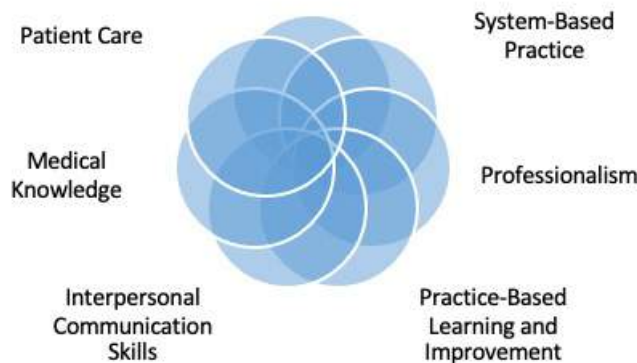


Fig 1

Block/4 weeks	BLOCKS												
	1	2	3	4	5	6	7	8	9	10	11	12	
Rotations/ Experience	Inpatient				Consult-Liaison				Emergency Dept.				
Outpatient	20%												

Fig 2: Sample Rotation Block Schedule Year 1

A wide range of elective clinical rotations are offered in the second year of training in order to enhance knowledge and expertise in overlapping pediatric specialties for example, pediatric neurology, developmental pediatrics and Adolescent medicine. School based rotations in regular and special education schools in the region are offered to enhance assessment and management skills in school settings. Quality of each rotation is ensured by having clear goals and measurable objectives. The fellow's progress is measured using 360 milestone evaluations that cover the six core

competencies.

Multidisciplinary feedback is valued, which includes feedback from supervisors, nursing, and patients. Teaching faculty also receive training in conducting milestone evaluations in order to ensure consistency.

Our mission, in alignment with the ACGME\_I is improving access to care and the overall health outcomes of patients and families in the region by training quality child and adolescent psychiatrists.

**CHECK OUT IACAPAP'S COVID-19 RESOURCES ON THE WEBSITE!**

<https://iacapap.org/resources-for-covid-19/>



## Sun Life Chair in Adolescent Mental Health, Dalhousie University, Faculty of Medicine

The Department of Psychiatry, Dalhousie University and the IWK Health Centre, are accepting applications for the Sun Life Chair in Adolescent Mental Health.

The successful applicant will lead the development of a clinical research program which will further develop innovative evidence-based interventions in adolescent mental health and mental illness. It is expected the Chair will work collaboratively with other research groups, regionally, nationally, and internationally as well as within Dalhousie University and the IWK Health Centre. The Dalhousie University Department of Psychiatry is home to six academic research chairs. The IWK Mental Health and Addictions Program provides a full range of mental health and psychiatric treatments for children and adolescents up until their 19th birthday, with 50,000 visits per year provided by over 450 inter-professional staff and 17 child and adolescent psychiatrists.

We wish to attract a talented and energetic leader (MD and/or PhD) with an excellent, established record of research accomplishments related to adolescent mental health. The successful applicant will demonstrate the ability to develop and direct an internationally recognized research program in mental illness/mental health, emphasizing the potential for translation and application to clinical practice. Applicants shall be collaborative and committed to the development of a strategy for adolescent mental health research, clinical practices and community outreach in the region and beyond. A demonstrated ability to attract external funding and sustain a strong research program is essential.

The Chair position provides a blend of salary, research funding and infrastructure support and the incumbent will be expected to compete successfully in regional, national and international funding competitions to further enhance the productivity of their research program. The ability to fulfill roles as a leader, mentor, collaborator and facilitator is an important asset. Evidence of outstanding collaborative, interdisciplinary research achievements, both nationally and internationally are valued attributes.

The Chair reports to the IWK Chief of Psychiatry and Head of the Department of Psychiatry. Working closely with the Faculty of Medicine Associate Dean of Research, the IWK Health Centre, and mental health researchers and clinicians, the Chair will:

- Develop and lead a clinical research program in adolescent mental health with input from the Department of Psychiatry (Faculty of Medicine) and Head, Division of Child and Adolescent Psychiatry; the IWK Mental Health and Addictions Program and VP Research, IWK Health Centre and the Chair, Advisory Board of the Sun Life Chair in Adolescent Mental Health.
- Conduct their own externally funded research into aspects of adolescent mental health that are in keeping with strategic plan/goals of Department of Psychiatry, Dalhousie Faculty of Medicine and IWK Mental Health and Addictions Program.
- If they are a clinician/physician, participate in clinical activities consistent with the research programs with clinical reporting relationships within the IWK Health Centre, and the expectation of 30 per cent clinical and 70 per cent research time allocation.
- In conjunction with other leaders in research, develop a training program directed toward producing independent researchers in adolescent mental health.

The successful candidate will be appointed to a five-year limited term appointment as the Sun Life Chair in Adolescent Mental Health, which is renewable subject to a successful review prior to the end of the first term. The incumbent will be granted a Career Stream academic appointment (i.e. Continuing Appointment or Tenure Stream, depending on qualifications) at the rank of associate or full professor (commensurate with experience) in the Department of Psychiatry at Dalhousie University.

Review of applications will begin May 21, 2021 and continue until position is filled. To apply, please submit your curriculum vitae, a two-page description of your research program and future research direction, and the names and contact information of three referees (two of whom must be from academic backgrounds) who may be contacted for references if required. All applications are to be submitted via PeopleAdmin: <https://dal.peopleadmin.ca/postings/5537>

All qualified candidates are encouraged to apply; however, Canadians and permanent residents will be given priority. Dalhousie University is committed to fostering a collegial culture grounded in diversity and inclusiveness. The university encourages applications from Indigenous persons, persons with a disability, racially visible persons, women, persons of a minority sexual orientation and/or gender identity, and all candidates who would contribute to the diversity of our community. For more information, please visit <https://www.dal.ca/hiringfordiversity>



# The Impact of Patient Suicide on Child and Adolescent Mental Health Professionals

*By: Zheala Qayyum, MD MMSc*

*Boston Children's Hospital and Harvard Medical School*

The death of a patient by suicide comes with a jarring suddenness for which no clinical professional can fully prepare. The odds of enduring such an experience are growing. Having taken care of many young patients for several years in acute care settings and emergency rooms, it is still a shock to hear about the adolescent I cared for over multiple hospitalizations for suicide attempts, dying of completed suicide, or the young person I saw for anxiety and depression in the context of difficult peer relationships, taking their own life after yet another peer rejection.

Suicide in adolescents and young adults is increasing, which means that mental health clinicians who provide care and support for these youth are at greater risk of such a loss. And this is indeed a loss, that brings with it not only shock, grief, and sadness, but a lot of shame, guilt, and self-doubt. It feels like a blow to a clinician's sense of competence and confidence. Those who lose a patient start second guessing their clinical decisions, become tentative and anxious, especially around documentation of risk assessment.

The suicide of a child or adolescent is made more complicated by the added layer of grief over a life largely un-lived, potential unmet. It also magnifies a sense of helplessness feeding the

perception that treatment failed this young person so early on in his or her life.

Though a patient's suicide has been described as an occupational hazard for all who work in mental health, the training of mental health professionals offers little guidance on what to do in the event of a patient suicide. Often mental health professionals and particularly trainees in the field, find themselves with no support or guidance in such instances. Sometimes cultural factors inhibit open discussions about the reality of suicide. Often societal stigma about death from mental illness limits discussion. But so, too, does the shame and guilt experienced by the individual practitioner's and the profession's largely unspoken expectation of a wall of silence.

There is a societal expectation that clinicians should be able to predict and prevent all suicide, that even one suicide is one too many. However, if the bar is set at zero suicides, any that happen feel like failure. That somehow the clinicians failed in their duty or responsibility towards this patient, or it's something they did or didn't do that contributed towards this outcome. It is true that in many instances suicide is preventable. The risk factors for suicide, however, are complex. They range from

serious mental health issues and lack of access to treatment to ongoing psychosocial stressors such as family turmoil, loss of relationships, academic issues, isolation and, especially in adolescents – impulsivity.

Most clinicians must endure the loss and grief of a young patient's suicide alone. They may also experience familial grief and at times, anger, directed towards them. These are but two reasons the support from peers and their institutional clinical team is so important. It can help minimize the immense burden of responsibility clinicians feel.

Consider the parallel world of physical illness. Typically, chronic medical illnesses and terminal illnesses warrant open discussions with the patient and the family about what to expect, the

course of treatment and the prognosis of the disease. Yet such discussions often are more muted in the case of psychiatric illness. Suicide is rarely discussed as a possible outcome of the natural progression of mental illness. Hence the death of a patient by suicide is experienced differently than death due to medical illness. And yet terminal illness in psychiatry, though hard to fathom, does exist. It is even harder to fathom in the case of children and adolescents, for whom we constantly holding out hope. And so, the most dire outcomes are pushed from family treatment discussions.

It is incumbent on us as mental health professionals to support our peers and seek support ourselves to minimize the shame, guilt and isolation that accompany the suicide of young patients.

## One Teenager Killed Himself. Six More Followed.

Beneath a rise in suicides nationwide is the vexing phenomenon of deaths clustering in the same town, at the same school, on the same block

**Teen suicides are increasing at an alarming pace, outstripping all other age groups, a new report says**

**Parents of teens who died by suicide hope speaking up will prevent more deaths**

**Their teen killed himself. Now they want to save others struggling during the pandemic.**

Media Reports on Suicide 1

## Attempted suicide rates among Victorian teenagers soar by 184 per cent in past six months, Kids Helpline reveals

A disturbing pattern of behaviour is emerging in Victorian teens amid the pandemic, sparking concerns of a mental health crisis.

### Tennessee teen's suicide highlights dangers of anti-LGBTQ bullying

Channing Smith's death by suicide after being cyberbullied highlights the decade-old movement to stop bullying online, where it flourishes.

## MOST TEEN DEATHS IN SA DUE TO SUICIDE – SADAG

It's Teen Suicide Prevention Week, which is meant to highlight the plight of teenagers taking their own lives in South Africa.

## About 7% of UK children have attempted suicide by age of 17 - study

Covid crisis will worsen mental health of young people, say experts concerned at rise in self-harming

## Suicide remains leading cause of death for S. Korean teens, youths

### Media Reports on Suicide 2

Death is part of what we experience when we are treating people. This death has to be owned by the system as a whole and the blame not placed on certain individuals, because the reasons why we can and can't hospitalize at-risk patients, how long we can keep them safe, how we can best support the youth in the community and help build resilience are all far bigger than the few people who are directly providing care for the patient. It is important to remember that, so that mental health clinicians don't have to grieve alone.

#### References:

Al-Mateen CS, Jones K, Linker J, O'Keefe D, Cimolai V. Clinician Response to a Child Who Completes

Suicide. *Child Adolesc Psychiatr Clin N Am.* 2018;27(4):621-635.

Qayyum Z, AhnAllen CG, Van Schalkwyk GI, Luff D. "You Really Never Forget It!" Psychiatry Trainee Supervision Needs and Supervisor Experiences Following the Suicide of a Patient. *Acad Psychiatry.* 2021;45(3):279-287.

doi:10.1007/s40596-020-01394-8

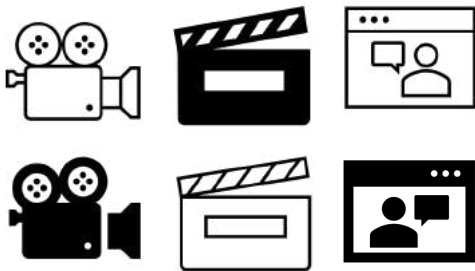
Gulfi A, Dransart DAC, Heeb JL, Gutjahr E. The impact of patient suicide on the professional reactions and practices of mental health caregivers and social workers. *Crisis.* 2010;31(4):202-10

-----



# IACAPAP One Minute Video: Tell Your Story!

*By: Jane Chang on behalf of the IACAPAP Communications Committee*



## Aim:

This project welcomes all professionals in the field of child and adolescent mental health all over the world to record short videos on one of the topics below. The intent is to share our stories and inspire future generations of CAMH professionals.

- ✓ Why did you choose child and adolescent mental health?
- ✓ What is one of the most memorable moments in your career?
- ✓ What advice would you give to those who are interested in a career in child and adolescent mental health?

❖ You are more than welcome to choose more than one of the topics.

## Who:

Professionals in the field of child and adolescent mental health

### ❖ Filming tips/rules:

1. If you are using a smartphone, film in a landscape/horizontal format.
2. If you are inside, use natural light from windows to light your face. This is true for cloudy days as well as sunny ones.
3. Try to avoid filming in front of a background that is brighter than your face.

4. Avoid filming in areas with excessive background noise, like near a busy street.
5. Please leave a few seconds of “dead space” on the beginning and end of your clip. This can just be a simple smile at the camera. This allows the editor to cut the clip off without seeing you reach to turn off your camera.
6. Your video can be in any language. If it’s in anything other than English, English subtitles are required.
7. Plagiarism of any sort is neither encouraged nor accepted
8. The content of your video(s) should NOT contain any of the following; Any video containing Any OF THE FOLLOWING will be disqualified:
  - ✗ Offensive or foul language
  - ✗ Violence
  - ✗ Child abuse
  - ✗ Drug and/or Alcohol usage
  - ✗ Defamatory content
  - ✗ Cruelty to Animals
  - ✗ Politically sensitive topics, material or comment
  - ✗ Sexual innuendos or nudity

❖ The submission for the one-minute videos will begin on July 1st and end on the **31st of July, 2021 (EST 23:59pm)**.

❖ After the committee has reviewed the videos, we will compile the videos and exhibit them on IACAPAP social media (twitter, FB, IG...)

❖ Please upload your 1-minute videos to the following drop box

<https://www.dropbox.com/scl/fi/2a4vgzlmjft2e210p074/IACAPAP-Video-Final.docx?dl=0&rlkey=w6blcr40h112vr583s4pkI913>

25<sup>th</sup>

World Congress of the International Association for Child and Adolescent Psychiatry and Allied Professions

CHILD AND ADOLESCENT MENTAL HEALTH:

**SHAPING THE FUTURE**

19-25 MARCH 2022

DUBAI, UNITED ARAB EMIRATES

[CLICK HERE FOR MORE INFORMATION!](#)



REGISTER NOW

[WWW.IACAPAP2022.COM](http://WWW.IACAPAP2022.COM)

## How to Become an IACAPAP Member

For more information of IACAPAP Membership, please visit <https://iacapap.org/membership/>

To become a member, contact the [Secretary-General](#) to get an application form.

# ADVERTISING OPPORTUNITIES!

Approximate circulation: 4,000

Distributed to the entire IACAPAP membership!!

Deadline	15 Sep 2021 (Graphics are due upon purchase of ad space)
Full Page	USD 2,000 (full colour)
½ Page	USD 1,500 (full colour)
¼ Page	USD 900 (full colour)

## Print Ad Specifications

Full page 8.5”w x 11”h

1/2 page 7.25”w x 5”h

1/4 page 3.5”w x 5”h

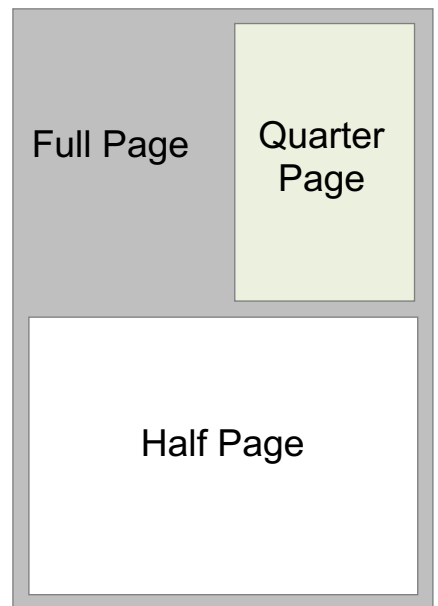
**Conditions** Advertising space is limited, and ads will be accepted on a first-come, first-served basis. The IACAPAP has the right to refuse or approve all ads. No ads will run until payment has been received. A late payment charge is assessed on unpaid balances. The late payment fee is 1.5% of the unpaid balance for each month after the due date of the invoice.

**Please note:** Commissions for advertising agencies are not included.


**Cancellation Policy:** Cancellations are not accepted. No refunds will be issued.

IACAPAP reserves the right to decline, amend, withdraw or otherwise deal with all advertisements submitted at the organization’s discretion and without explanation.

For enquiries, please email [info@iacapap.org](mailto:info@iacapap.org)







Want to share important events, programs or activities from your country with a wide international audience?

## **SUBMIT AN ARTICLE TO THE IACAPAP BULLETIN!**

For more information please contact:

Hesham Hamoda

[hesham.hamoda@childrens.harvard.edu](mailto:hesham.hamoda@childrens.harvard.edu)

Maite Ferrin

[maiteferrin@yahoo.es](mailto:maiteferrin@yahoo.es)



# IACAPAP

International Association for Child and  
Adolescent Psychiatry and Allied Professions

# IACAPAP Member Organisations

## Full Members

American Academy of Child and Adolescent Psychiatry (AACAP)

Asociacion Argentina de Psiquiatria Infantil y Profesionales Afines (AAPI)

Asociacion de Psiquiatria y Psicopatologia de la Infancia y la Adolescencia (APPIA)

Asociación Española de Psiquiatría del Niño y del Adolescente AEPNYA | (Spanish Society of Child and Adolescent Psychiatry) (AEPNYA)

Associação Brasileira de Neurologia, Psiquiatria Infantil e Profissionais Afins (ABENEPI)

Asociacion Mexicana de Psiquiatria Infantil A.C. (AMPI)

Association for Child and Adolescent Mental Health (ACAMH)

Association for Child and Adolescent Psychiatry and Allied Professions in Nigeria (ACAPAN)

Association for Child and Adolescent Psychiatry and Allied Professions of Serbia (DEAPS)

Association for child and adolescent psychiatry in Bosnia and Herzegovina

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 (CAPAP)

Child and Adolescent Psychiatry Section of Estonian Psychiatric Association

Child Mental Health Association in Egypt

Chilean Society of Child and Adolescent Psychiatry and Neurology (SOPNIA)

Chinese Society of Child and Adolescent Psychiatry (CSCAP)

Croatian Society of Child and Adolescent Psychiatry (CROSIPAP)

Danish Association for Child Psychiatry, Clinical Child Psychology and Allied Professions (BÖPS)

Egyptian Child and Adolescent Psychiatry Association (ECAPA)

Emirates Society for Child Mental Health

Faculty of Child and Adolescent Psychiatry of The Royal Australian and New Zealand College of Psychiatrists (RANZCP)

Finnish Society for Child and Adolescent Psychiatry (LPSY)

Flemish Association of Child and Adolescent Psychiatry (VVK)

French-Speaking Child and Adolescent Psychiatry Belgian Society (SBPEA)

German Society of Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy (DGKJP)

Hungarian Association of Child Neurology, Neurosurgery, Child and Adolescent Psychiatry (HACAPAP)

Icelandic Association for Child and Adolescent Psychiatry

Indian Association for Child and Adolescent Mental Health (IACAM)

Iranian Association of Child and Adolescent Psychiatry (IACAP)

Italian Society of Child and Adolescent NeuroPsychiatry (SINPIA)

Korean Academy of Child and Adolescent Psychiatry (KACAP)

Kuwait Association for Child and Adolescent Mental Health (KACAMH)

Latvian Association of Child Psychiatrists (LACP)

Lithuanian Society of Child and Adolescent Psychiatry

Malaysian Child and Adolescent Psychiatry Association (MYCAPS)

Netherlands Psychiatric Association - Department of Child and Adolescent Psychiatry (NnVP)

Norsk Forening For Barn- Og Unges Psykiske Helse, N-BUP | The Norwegian Association for Child and Adolescent Mental Health (N-BUP)

Österreichische Gesellschaft für Kinder- und Jugendneuropsychiatrie, Psychosomatik und Psychotherapie (ÖGKJP) | ASCAP – AUSTRIAN SOCIETY OF CHILD AND ADOLESCENT PSYCHIATRY, PSYCHOSOMATICS AND PSYCHOTHERAPY (ÖGKJP)

Philippines Society for Child and Adolescent Psychiatry (PSCAP)

Polish Psychiatric Association - Child and Youth Psychiatry Section

Portuguese Assoc. of Child and Adolescent Psychiatry (APPIA)

Posikiater per Femije dhe Adoloshent (KCAHAMHA)

Romanian Association of Child and Adolescent Psychiatry and Allied Professions (RACAPAP)

Romanian Society of Neurology and Psychiatry for Child and Adolescent (SNPCAR)

Russian Association for Child Psychiatrists and Psychologists (ACPP)

Section of Child and Adolescent Psychiatry, College of Psychiatrists, Academy of Medicine, Singapore (SCAP)

Section of Child and Adolescent Psychiatry in Slovak Psychiatric Association

Section on Child Psychiatry of the Scientific Society of Neurologists, Psychiatrists and Narcologists of Ukraine

Sekce dětské a dorostové psychiatrie Psychiatrické společnosti ČLS JEP | Section for Child and Adolescent Psychiatry of Psychiatric Association CZMA (Czech Medical Association)

# IACAPAP Member Organisations

## Full Members Continued...

Slovenian Association for Child and Adolescent Psychiatry (ZOMP)

Sociedad Espanola de Psiquiatria y Psicoterapia del Nino y del Adolescente (SEPYRNA)

Sociedad Uruguaya de Psiquiatria de la Infancia y la Adolescencia (SUPIA)

Société Tunisienne de psychiatrie de l'enfant et de l'adolescent (STPEA)

Sri Lanka College of Child and Adolescent Psychiatrists (SLCCAP)

Svenska Föreningen för Barn-och Ungdomspsykiatri. |The Swedish CAP association (SFBUP)

Swiss Society for Child and Adolescent Psychiatry and Psychotherapy (SSCAPP)

The Hellenic Society of Child and Adolescent Psychiatry (HSCAP)

The Hong Kong College of Psychiatrist

The Israel Child and Adolescent Psychiatric Association

The Japanese Society of Child and Adolescent Psychiatry (JSCAP)

The South African Association for Child and Adolescent Psychiatry and Allied Professions (SAACAPAP)

The Taiwanese Society of Child and Adolescent Psychiatry (TSCAP)

Turkish Association of Child and Adolescent Psychiatry (TACAP)

## Affiliated Members

African Association Child & Adolescent Mental Health (AACAMH)

Asian Society for Child and Adolescent Psychiatry and Allied Professions (ASCAPAP)

Asociacion Mexicana para la Practica, Investigacion y Ensenanza del Psicoanalisis, AC (AMPIEP)

ASSOCIATION EUROPÉENNE DE PSYCHOPATHOLOGIE DE L'ENFANT ET DE L'ADOLESCENT (AEPEA)

Eastern Mediterranean Association Of Child and Adolescent Psychiatry & Allied Professions (EMACAPAP)

European Federation for Psychiatric Trainees (EFPT)

European Society for Child and Adolescent Psychiatry (ESCAP)

Federación Latinoamericana de Psiquiatria de la Infancia, Adolescencia, Familia y Profesiones Afines (FLAPIA)

First Step Together Association for special education (FISTA)

Pakistan Psychiatric Society (PPS)



# IACAPAP Officers

[www.iacapap.org](http://www.iacapap.org)

## BUREAU

### President

#### Daniel Fung Shuen Sheng MD

CEO, Institute of Mental Health  
Singapore

Adjunct Associate Professor  
Lee Kong Chian School of Medicine,  
Nanyang Technological University  
Yong Loo Lin Medical School and  
DUKE NUS Medical School, National  
University of Singapore  
[daniel\\_fung@imh.com.sg](mailto:daniel_fung@imh.com.sg)

### Secretary General

#### Christina Schwenck PhD

Professor for Special Needs  
Educational and Clinical Child and  
Adolescent Psychology  
Justus-Liebig-University Gießen  
Germany  
[christina.schwenck@psychol.unigies-sen.de](mailto:christina.schwenck@psychol.unigies-sen.de)

### Treasurer

#### Petrus J de Vries MD

Sue Struengmann Professor of  
Child & Adolescent Psychiatry  
Division of Child & Adolescent  
Psychiatry  
Department of Psychiatry and  
Mental Health  
University of Cape Town  
South Africa  
[petrus.devries@uct.ac.za](mailto:petrus.devries@uct.ac.za)

### Past President

#### Bruno Falissard MD, PhD

Professor of Public Health,  
Université Paris-Sud. Paris, France.  
[bruno.falissard@gmail.com](mailto:bruno.falissard@gmail.com)

Connect with us!



### Vice Presidents

#### Andres Martin MD, MPH (USA)

[andres.martin@yale.edu](mailto:andres.martin@yale.edu)

#### Bung-Nyun Kim MD, PhD (South Korea)

[kbn1@snu.ac.kr](mailto:kbn1@snu.ac.kr)

#### Flora de la Barra MD (Chile)

[torbarra@gmail.com](mailto:torbarra@gmail.com)

#### Hesham Hamoda MD, MPH (USA)

[hesham.hamoda@childrens.harvard.edu](mailto:hesham.hamoda@childrens.harvard.edu)

#### Kajja Puura MD (Finland)

[Kajja.Puura@tuni.fi](mailto:Kajja.Puura@tuni.fi)

#### Maite Ferrin MD, PhD (Spain)

[maiteferrin@yahoo.es](mailto:maiteferrin@yahoo.es)

#### Michal Goetz MD (Czech Republic)

[michal.goetz@fmotol.cuni.cz](mailto:michal.goetz@fmotol.cuni.cz)

#### Nicholas Mark Kowalenko MD

(Australia)

[Nicholas.Kowalenko@health.nsw.gov.au](mailto:Nicholas.Kowalenko@health.nsw.gov.au)

#### Tolulope Bella-Awusah MD

(Nigeria)

[bellatt2002@yahoo.com](mailto:bellatt2002@yahoo.com)

### Honorary Presidents

#### Helmut Remschmidt MD, PhD

(Germany)

[remschm@med.uni-marburg.de](mailto:remschm@med.uni-marburg.de)

#### Myron L. Belfer MD, MPA (USA)

[Myron\\_Belfer@hms.harvard.edu](mailto:Myron_Belfer@hms.harvard.edu)

#### Per-Anders Rydelius MD, PhD

(Sweden)

[per-anders.rydelius@ki.se](mailto:per-anders.rydelius@ki.se)

### Monograph Editor

#### Matthew Hodes MBBS, BSc, MSc, PhD, FRCPsych (UK)

[m.hodes@imperial.ac.uk](mailto:m.hodes@imperial.ac.uk)

### Monograph Co-Editor

#### Petrus J de Vries MD (South Africa)

[petrus.devries@uct.ac.za](mailto:petrus.devries@uct.ac.za)

### Bulletin Editor

#### Hesham Hamoda MD, MPH (USA)

[hesham.hamoda@childrens.harvard.edu](mailto:hesham.hamoda@childrens.harvard.edu)

### Bulletin Deputy Editor

#### Maite Ferrin MD, PhD (Spain)

[maiteferrin@yahoo.es](mailto:maiteferrin@yahoo.es)

### e-Textbook Editors

#### Andres Martin MD, MPH (USA)

[andres.martin@yale.edu](mailto:andres.martin@yale.edu)

#### Joseph M. Rey MD, PhD (Australia)

[jmrey@bigpond.net.au](mailto:jmrey@bigpond.net.au)

### Helmut Remschmidt Research Seminars Coordinators

#### Per-Anders Rydelius MD, PhD

(Sweden)

[per-anders.rydelius@ki.se](mailto:per-anders.rydelius@ki.se)

#### Petrus J de Vries MD (South Africa)

[petrus.devries@uct.ac.za](mailto:petrus.devries@uct.ac.za)

### Donald J. Cohen Fellowship Program Coordinators

#### Ayesha Mian MD (Pakistan)

[ayeshamian174@gmail.com](mailto:ayeshamian174@gmail.com)

#### Naoufel Gaddour MD (Tunisia)

[naoufel.gaddour@gmail.com](mailto:naoufel.gaddour@gmail.com)

### Presidential Fellows for Global Education

#### Julie Chilton (USA)

[Julie.chilton@yale.edu](mailto:Julie.chilton@yale.edu)

### Presidential Fellows for Global Fundraising

#### Liu Jing (China)

[lijuch@163.com](mailto:lijuch@163.com)

### IACAPAP Councilors

#### Füsün Cetin Çuhadaroglu (Turkey)

[fusuncuha@gmail.com](mailto:fusuncuha@gmail.com)

#### Gordon Harper MD (USA)

[Gordon\\_harper@hms.harvard.edu](mailto:Gordon_harper@hms.harvard.edu)

#### Yi Zheng (China)

[doctorzy@yahoo.com](mailto:doctorzy@yahoo.com)