World Child & Adolescent Psychiatry

ISSUE 28, August 2025

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

Warm greetings to everyone!

It is once again 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 (WPA-CAP). I want to give special kudos and gratitude to Editor, Dr. Flávio D. Silva (Brazil), and Deputy Editor, Dr. Tomoya Hirota (Japan-USA), for their diligent work on this edition. This current issue features excellent work done in mental health literacy, digital psychiatry, and models of care delivery in diverse settings and with a focus on reaching significantly underserved populations throughout the world.

With all the world's challenges, our work is as important and urgent as ever. Our strength lies in the commitment and expertise of our members, and in our ability to network globally in the pursuit of improved mental health for children and adolescents everywhere.

At this time, we eagerly anticipate the forthcoming **25th WPA World Congress of Psychiatry**, themed "The Role of Psychiatry in the Changing World," in Prague, Czech Republic, October 5-8, 2025. We wish all WPA-CAP members presenting and attending success and safe travels, and we look forward to hearing summaries and reflections related to the meeting.

World CAP continues to serve as an important venue for "improving child and adolescent mental health by connecting global wisdom with everyday practice and advocacy," and the editorial team invites you to connect with the authors and

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other colleagues involved in the featured work, and to submit articles on topics that can stimulate further dialogue and knowledge advancement. World CAP also serves as an important publication for keeping WPA-CAP members and other global colleagues informed about WPA-CAP activities.

On Tuesday, April 29th, 2025, WPA-CAP, together with the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP), the World Association for Infant Mental Health (WAIMH), and the International Society for Adolescent Psychiatry and Psychology (ISAPP), participated in the 2025s WICAMHD first ever hybrid in-person and online symposium, themed: "Bridging Worlds: Mental Health support for Displaced Children and Families," and strategically held in partnership with the Turkish Association of Child and Adolescent Psychiatry (TACAP)'s 34th National Congress of Child and Adolescent Mental Health and Illnesses in Kuşadası, Turkey. Please be sure to check out recordings of the symposium (as well as other excellent videos) at the YouTube site of the IACAPAP: https://www.youtube.com/channel/UCA8P0GbkpcM2Zkfvk3vJrag

WPA-CAP, through interested volunteer representatives of our organization, continues to support important educational outreaches in the specialty, including The Global Child and Adolescent Psychiatry Curriculum Project, led by the IACAPAP and the Child Mind Institute (CMI); and an integrated care webinar, spearheaded by Drs. Steven Sust and Sammi Wong, focused on medical/pre-medical students who may be involved in student-coordinated clinics.

And most recently, members of the WPA-CAP section have supported the project, Creation and Validation of a Global Mental Health Literacy Scale for Adolescents (GMHL-A) project, spearheaded by Professor Shuyan Liu from Charité-Universitätsmedizin Berlin, Germany and Professor Norman Sartorius.

We 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 also welcome 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 involvement in projects such as those described above. We also invite you to review our Section's materials, including all past World CAP issues, which can be found at https://www.wpanet.org/child-adolescent-psychiatry.

Happy Readings!

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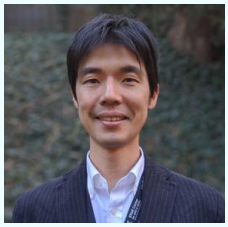
Editor's column

Flávio Dias Silva, MD, MSc (Brazil)

Tomoya Hirota, MD, (USA/Japan)



Dear colleagues,

It is a pleasure to greet you again and announce another edition of World CAP. This issue showcases a diverse collection of innovative approaches to improving child and adolescent mental health across continents, cultures, and care settings. Furthermore, it is increasingly clear that our e-Journal has strengthened its position as a tool for communicating innovations in the field of Child and Adolescent Psychiatry, addressing topics such as artificial intelligence, but also others such as the integration of our specialty with primary care and diverse sectors of healthcare systems.

We open with a groundbreaking comic book intervention aimed at improving mental health literacy among adolescents in Africa—an initiative that creatively reduces stigma while promoting wellbeing in low- and middle-income countries. A complementary perspective is offered through the development of an integrated, AI-enabled, gamified platform designed to personalize mental health literacy and support early identification and care navigation.

From Aotearoa New Zealand, Hinemoa et al. present Te Ara Arororeretini, a Māori-led primary care model that brings culturally grounded ADHD assessment and treatment to Northland communities. Their work reflects the urgency of culturally responsive solutions amidst national service gaps.

We also spotlight five U.S.-based mental health care models—from outpatient and in-home care to primary care-based and community clinic initiatives—that prioritize accessibility, equity, and adaptability in response to the youth mental health crisis. Similarly rooted in community need, the CEZAM Youth Center in Belgrade, Serbia, emerged after the 2023 mass shootings, offering urgently needed, youth-focused support through counseling, wellness, and education.

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Additional features include a public education initiative using video content to raise awareness about the risks of adolescent cannabis use, and a meeting report from the Congress of the Association for Child and Adolescent Psychiatry and Allied Professions of Serbia.

Finally, we are increasingly seeking to expand the dissemination of events in the field of child and adolescent psychiatry - highlighting calls not only for the upcoming WPA World Congress, but also for the upcoming congresses of the American, Canadian, European, and Asian academies/associations, as well as partner associations such as IACAPAP (International Association of Child and Adolescent Psychiatry and Allied Professions) and WAIMH (World Association on Infant Mental Health).

Together, these contributions underscore a shared global commitment to reimagining mental health care for young people through culturally relevant, accessible, and innovative strategies that inspire hope and action.

We continue to encourage the use of World CAP as a tool to bring psychiatrists from around the globe closer together, and above all, to ensure that this is reflected in better care for young people worldwide. We would therefore like to take this opportunity to thank our colleagues who submitted their very interesting papers on this issue and reiterate our invitation to all readers to promote World CAP among their peers, helping us to continue to open the doors of the Section to psychiatrists from all corners of the world.

Happy readings!

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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

World Child & Adolescent Psychiatry世界兒童與青少年精神病學》是由兒童與青少年精神病學分部理事會出版。這是一份非營利、非商業性的刊物，歡迎所有希望分享其興趣、新聞和科學發現的分會會員提供文章。如果您想參與，請聯絡編輯室。
聯絡電子郵件可在電子期刊的最後一頁找到。參與其中！

World Child & Adolescent Psychiatry diterbitkan oleh Dewan Bagian Psikiatri Anak dan Remaja. Jurnal ini bersifat non-komersial dan nirlaba yang menerima artikel dari semua anggota Seksi yang ingin berbagi minat, berita, atau temuan ilmiah. Untuk ikut serta, cukup ungkapkan minat Anda kepada para editor dan kami akan dengan senang hati memandu Anda. E-mail kontak kami tersedia di halaman terakhir e-Journal. Bergabunglah!

विश्व बाल एवं किशोर मनोचिकित्सा को बाल एवं किशोर मनोचिकित्सा अनुभाग के बोर्ड द्वारा प्रकाशित किया जाता है। यह एक गैर-वाणिज्यिक, गैर-लाभकारी माध्यम है जो अनुभाग के सभी सदस्यों के लेखों का स्वागत करता है जो अपनी रुचि, समाचार या वैज्ञानिक खोजों को साझा करना चाहते हैं। भाग लेने के लिए, बस संपादकों को अपनी रुचि व्यक्त करें और हमें आपका मार्गदर्शन करने में खुशी होगी। हमारे संपर्क ईमेल ई-जर्नल के अंतिम पृष्ठ पर उपलब्ध हैं। शामिल हों!

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Research communications

Mental Health Literacy in Sub-Saharan Africa: Empowering Adolescents Amid Growing Challenges.

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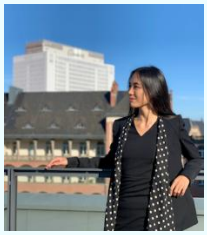

Dr Shuyan Liu

"

Introduction

Mental Health Literacy (MHL) is an increasingly researched concept that shows great promise as a low-cost, non-pharmacological intervention target to improve public mental health (1). Mental health care access remains limited in many low-resource settings, and populations face a growing number of risk factors for mental illnesses. It is critical to explore alternative, effective, and scalable approaches to improve mental health and protect against mental illnesses — and increasing MHL in the general population has the potential to address this need.

Jorm et al. (1997) originally defined MHL as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" [2]. Jorm later refined this definition [3], the focus remained exclusively on mental illness. A more comprehensive conceptualization was proposed by Kutcher et al. (2016), who expanded the definition of MHL to include: "understanding how to obtain and maintain positive mental health; understanding mental disorders and their treatments; decreasing stigma related to mental disorders; and enhancing help-seeking efficacy" [4]. This definition extends beyond knowledge of mental health and mental illness to also include stigma reduction and help-seeking behavior—components we regard as essential for advancing global mental health.

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A particularly vulnerable group worthy of attention are adolescents and youth, as over 60% of mental illnesses are estimated to begin before the age of 25 [5]. MHL is a crucial determinant of health behavior in this age group, influencing their ability to care for their mental health, recognize problems, know how to respond, seek appropriate help, and adhere to treatment. At a societal level, MHL also influences broader outcomes through factors such stigma, social exclusion, and access to work opportunities. Considering that adolescents and youth are critical periods for acquiring health-related knowledge, developing coping strategies, and fostering social cohesion, it is imperative to focus attention on improving MHL in this population.

In view of these theoretical considerations, it is important to examine the practical work conducted on MHL and evaluate whether it represents a suitable target for interventions aimed at young people. Several interventions have been developed to increase MHL, which have shown promise [1]. School-based interventions are among the most common; however, one systematic review found only moderate evidence of their effectiveness in reducing stigma, while another found no strong evidence for help-seeking behaviors [6][7]. Two main challenges remain – 1) Such interventions have not been widely implemented, despite the evidence of their effectiveness and 2) most research to date comes from high-income countries, with limited evidence from low- and middle-income countries (LMICs).

Evidence on MHL in Africa is particularly scarce [8], despite the region's high burden of mental illnesses [9] and numerous risk factors including poverty, low educational attainment, violence, and traumatic experiences. This lack of data on the state of MHL, its determinants, and effective interventions represents a critical gap, which our research aims to address within the Africa Research, Implementation Science, and Education (ARISE) network.

Our work

We aimed to improve mental health among adolescents and youth in Africa by addressing the research gap in MHL and developing evidence-based, contextually relevant interventions. To this end, we integrated a MHL component into the Research Network for the Design and Evaluation of Adolescent Health Interventions and Policies in Sub-Saharan Africa (DASH) cohort study. This study, funded by the German Federal Ministry of Research, Technology, and Space (BMFTR), was conducted across communities in seven countries: Burkina Faso, Ethiopia, Ghana, Nigeria, South Africa, Tanzania, and Uganda. In each country, we recruited a sample of 2,000 adolescents and young adults aged 10 to 24 years, with equal representation from the age groups 10–14, 15–19, and 20–24 years. To measure MHL we used an adapted version of the Universal Mental Health Literacy Scale for Adolescents (UMHL-A) [10], which originally consists of 17 items that

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we reduced to 10 items. The remaining 10 items covered each of the four domains of Kutcher's conceptualization of MHL – knowledge about mental health, knowledge about mental illnesses, stigma, and help-seeking. In addition, we embedded a randomized clinical trial (RCT) within the DASH study to test the effectiveness of a short comic book or flyer intervention in improving the MHL among young people [11].

Research goals

Our first goal is to provide evidence on the current state of MHL in the study communities. This includes cross-country comparison as well as deeper insights based on socioeconomic and demographic characteristics. Furthermore, a dimension-specific analysis will offer insights into which aspects of MHL may require targeted intervention. It will provide valuable information for policy decisions aimed at addressing the issue.

Our second goal is to identify risk and protective factors associated with MHL and assess its associations with mental health outcomes, such as symptoms of depression and anxiety. This analysis will help identify modifiable variables that can serve as intervention targets.

Our final goal is to test the effectiveness of a comic book or flyer intervention on MHL. The comic book intervention (Intervention 1) consists of two pages from the "Let's Talk About It", which is a 28-page Graphic Guide to Mental Health that was originally co-created by the Cartoon Studies Lab for the Ohio State Department of Health (USA), specifically designed for middle and high school students (https://www.cartoonstudies.org/css-studio/cartooningprojects/mentalhealth/). The two pages specifically highlight the two most prevalent mental disorders in this population: Anxiety and Depression [11]. The flyer intervention is designed to resemble the commonly used health information material in public health initiatives, and it contains text identical to that of the comic book. However, where text within illustrations could be confusing without accompanying visuals, we adjusted the wording slightly to maintain clarity [11]. This kind of research is particularly important in light of the WHO recommendation emphasizing the need to enhance mental health awareness and understanding [12], especially in resource-constrained settings. Our comic book intervention can serve as an especially engaging educational tool for younger adolescents, while the flyer may prove more effective for older youth. To our best knowledge, this is the first RCT testing a comic book intervention to improve MHL in LMICs.

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Conclusion

MHL is a crucial component in addressing today's global mental health challenges. Substantial gaps remain in our understanding of its prevalence, determinants, and the most cost-effective strategies to improve it, particularly in LMICs. Through our research, we aim to generate evidence that can inform future studies, guide the development of targeted interventions, and support policy initiatives to strengthen global mental health systems.

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Integrating Artificial Intelligence into School-Based Mental Health Approaches and Interventions.

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Dr Yifeng Wei

Introduction

Research indicates that, by the ages of 12-25, approximately 75% of individuals who develop mental disorders have already begun to show symptoms [1-2]. Mental disorders account for about 13% of the global burden of illness among children and adolescents [3-5]. When left untreated, these conditions may hinder developmental opportunities for youth, impair daily functions, and lead to increased morbidity and reduced life expectancy [6]. Additionally, untreated mental disorders are associated with a higher risk of developing chronic physical health conditions later in life [7-9]. Despite this, current systems often fail to identify and support young people early. This underscores the urgent need for early intervention strategies that foster positive mental health outcomes during childhood and adolescence, making schools a critical setting for such early interventions.

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Currently, an estimated 70 to 80% of children and adolescents do not receive the mental health care they need [10-11]. This may be due to multiple factors, including lack of knowledge about mental disorders and their treatments, stigma, limited mental health care access, and other socio-economic/cultural barriers [12]. Mental health literacy (MHL) programs have shown that improving knowledge and reducing stigma can empower young people to recognize mental health problems in themselves and others and seek help earlier [13]. MHL includes four interrelated domains: understanding how to obtain and maintain good mental health; understanding mental disorders and their treatments; decreasing stigma against mental illness; and enhancing help-seeking efficacy [14]. These domains serve as foundational tenets of mental health promotion, prevention, early identification, intervention, and ongoing care [14]. MHL stresses the need to equip individuals and communities with the knowledge, attitudes, and competencies they need to improve their mental health, better manage their illnesses, and advocate for better mental health care [15]. It further emphasizes the development of lifelong skills for people to better obtain, maintain, and sustain positive mental health. In this sense, the definition of MHL extends from a limited illness perspective to a holistic approach [14]. The World Health Organization (WHO) recognizes health literacy – including MHL – as a critical determinant of health, noting that it is "a stronger predictor of an individual's health status than income, employment status, education level, and racial or ethnic group," with the potential to reduce health inequities and improve both health systems and policy development [15-16].

Schools have been the primary entities hosting the MHL program, given their broad reach and daily contact with young people. Although these school-based traditional MHL programs have shown great potential; they often face scalability challenges and have shown mixed results in sustaining behavior change over time [13]. In contrast, digital mental health interventions, such as online cognitive-behavioral therapy modules, have demonstrated efficacy in reducing depression and anxiety symptoms among children and adolescents. These tools are particularly effective when complemented by human support or coaching, which enhances engagement and outcomes [17]. This suggests that a blended model—integrating digital tools with traditional MH interventions – holds significant promise.

However, existing initiative rarely integrates the full continuum of mental health promotion, prevention, early identification, and intervention into a cohesive, digitally enhanced strategy. Moreover, few programs have incorporated artificial intelligence (AI) or addressed the importance of cultural relevance, representing both a critical gap and an opportunity. While AI has been explored experimentally for mental health risk detection – such as analyzing social

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media posts or speech patterns to identify signs of distress – and for virtual counseling, these innovations remain fragmented and are seldom rigorously evaluated in child and adolescent populations.

We propose a transformative model that is proactive, integrated, and AI-enhanced. It replaces fragmented services with a continuum of support, accessible 24/7 through scalable digital tools. In this model, MHL will be delivered through an AI-personalized, gamified platform co-designed with youth and available in multiple languages. Early identification will be enabled by continuous, AI-based screening that uses behavioral and linguistic cues to flag emerging concerns before they escalate. Children and adolescents will have immediate access to therapeutic AI conversational agents and moderated peer support while awaiting or complementing human care. System navigation will be simplified through an AI assistant that provides real-time, personalized recommendations for appropriate services.

No large-scale initiatives have yet combined AI, interdisciplinary expertise, and community engagement to reimagine child and adolescent mental health support systems. We seek to fill that gap by uniting these elements into a single framework.

An integrated AI-enabled model for child and adolescent mental health

This model comprises four interlinked components corresponding to the multi-tiered framework: (1) Mental health literacy & promotion, (2) Early identification, (3) Early support and intervention, and (4) System navigation. Each component involves the development of AI-enhanced tools, co-creation with community partners – including children, adolescents, and culturally diverse communities – and pilot implementation and evaluation. Together, these elements aim to establish an integrated ecosystem of mental health support.

Building on existing evidence-based MHL curriculum [13], the student learning experience and outcomes may be enhanced by AI tutors and conversational agents powered by large language models. These systems, fine-tuned for child- and adolescent-friendly communication, can engage students in interactive learning modules, quizzes, and scenario-based dialogues. For example, a student could ask the AI tutors questions about stress or depression and receive accurate, age-appropriate answers. The AI will personalize content to the user's context and learning pace based on user preference alignment and conversational history/style – e.g., providing simpler explanations to younger users or culturally relevant examples for Indigenous adolescents through engaging youth, Indigenous elders and knowledge keepers in the co-design of the materials.

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To evaluate the effectiveness of this AI-enhanced MHL platform, a cluster randomized trial may be applied to compare the intervention schools (using the AI literacy platform) vs. control schools (holding standard health curriculum), measuring improvements in mental health knowledge, stigma, help-seeking intentions and behaviors, resilience, and wellbeing among students with validated psychometric instruments. The implementation of this approach is expected to improve MHL among children and adolescents. Specifically, students who engage with the AI-enhanced platform are anticipated to demonstrate improved knowledge, appropriate recognition of signs of common mental health problems or disorders, reduced stigma, and enhanced help-seeking intentions and behaviors. Based on existing literature [13], we project at least a 20% improvement in post-intervention scores on standardized measures of mental health knowledge and attitudes compared to baseline. Furthermore, we expect a corresponding increase in actual help-seeking behaviors among students exposed to the intervention, relative to those in control groups.

Aligned with the first component (mental health literacy and promotion), the second component focuses on developing AI tools for the early detection of emerging mental health issues. AI-powered screening applications (apps) can be used regularly (e.g., weekly) by children and adolescents in school and/or primary care settings to report their mood, stress, and other well-being indicators. These tools may employ natural language processing (NLP) to analyze free-text responses or journal entries by children and adolescents, detecting linguistic markers of anxiety, depression, or suicidal ideation (using algorithms trained on validated clinical datasets). It will also incorporate self-report questionnaires (e.g., weekly) and passive data (with consent), such as sleep or activity patterns from smartphones or wearables, to build individual behavioral baselines and detect early indicators of stress, anxiety, or depression and flag significant deviations.

Importantly, all AI-generated risk alerts will be subject to human oversight. Any positive flags will prompt review by a school counsellor or healthcare provider, with established emergency protocols activated in cases of high-risk concern. At the population level, machine learning will be applied to identify at-risk profiles (e.g., combining with risk factors such as experiences of bullying or academic stress) to inform upstream interventions. All data collection, storage and analysis should strictly follow privacy regulations and ethical guidelines – data should be encrypted and stored securely, and algorithms should be audited for bias. Evaluation of this component will include sensitivity and specificity of AI detection (compared to clinical assessments), user engagement rates, and the number of children and adolescents identified and referred to support earlier than they would have without the tool. A successful outcome will demonstrate

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the system's ability to detect early signs of mental health concerns that typically go unnoticed – enabling timely and effective intervention and support.

The third component addresses the gap between recognizing a mental health need and receiving appropriate care – a period often characterized by long wait times or limited-service accessibility. During this window, AI-augmented intervention tools can often offer timely, evidence-based support to children and adolescents, either as first-line resources or as adjuncts while they await or receive professional care. A central tool could be a therapeutic AI conversational agent, delivering interventions such as cognitive behavioral therapy (CBT) and other brief and structured interventions. Building on promising advancements in digital mental health, the conversational agent – accessible via a mobile app – would guide users through exercises for managing symptoms of anxiety, depression, or trauma (e.g., grounding strategies for panic or problem-solving techniques for stress). The content will be developed by clinical and school psychologists and culturally adapted, for example, with Indigenous elders and/or knowledge keepers advising on how traditional healing practices or cultural metaphors can be incorporated. This curated content will enable the AI tool to engage in natural, empathetic conversations and tailor its prompts based on the user's input and progress. For instance, if a user expresses feelings of hopelessness, the intervention tool can detect this using sentiment analysis and activate a safety protocol – encouraging the user to reach out to a crisis service or, with consent, notifying a human counsellor. Another potential tool is a virtual peer support platform where AI facilitates moderated peer support groups. AI can help match users with peer groups that share similar experiences and provide discussion topics or resources, while human facilitators ensure safety.

To evaluate the effectiveness of the third component, a randomized controlled trial will be conducted. Children and adolescents screening for positive mild-to-moderate anxiety/depression will be randomly assigned to either receive immediate access to the AI-augmented intervention or the standard waitlist care. Outcomes such as symptom improvement, self-efficacy, and time to recovery will be compared to those of a control group. User satisfaction and engagement metrics (e.g., drop-off rates) will also be assessed to refine engagement strategies.

The final component focuses on empowering children, adolescents, and families, as well as service providers (e.g., in education, mental health, child welfare, juvenile justice, and primary and tertiary care), to navigate the often complex landscape of mental health services – and on generating knowledge to influence policy. Central to this component is the development of an AI-powered navigation assistant that functions as a digital case manager, guiding users to the

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appropriate resources based on their needs. For example, the system could help determine whether a young person could benefit from a school counsellor, a specialized clinic, a cultural healing program, or an e-mental health service and provide tailored, step-by-step guidance on how to access those services.

This assistant will draw on a comprehensive, regularly updated database of provincial and community-based mental health services, developed in collaboration with health authorities and community organizations. Using natural language processing, users could ask, for instance, "I'm feeling very anxious, and I live in a remote town – what help can I get?" The assistant would respond with personalized options such as immediate self-help tools, nearby telehealth resources, and information about Indigenous adolescent programs, tailored to account for eligibility, location, and preferences. Additionally, the system will help service providers, such as school psychologists or family doctors, through dedicated dashboards that track a young person's engagement from the first 3 components' tools. It can flag when a higher level of care might be required, thereby streamlining referral pathways and improving continuity of care.

This final component requires close partnership with health systems and policymakers to ensure effective integration into existing infrastructures. A key research element will be a mixed-methods evaluation of implementation to study how AI-enhanced navigation framework can be integrated into schools, primary care, and community services. This evaluation will also explore barriers and facilitators to adoption, such as training needs, ethical considerations, and cost-effectiveness.

As a result of the implementation of the AI-enabled mental health model, it is expected that children and adolescents should report reduced symptoms of anxiety and depression measured by validated scales such as General Anxiety Disorder (GAD) – 7, Patient Health Questionnaire (PHQ) – 9 [18-19]; improved resilience and coping skills, measured by scales like the Child and Youth Resilience Measure (CYRM) [20]; and alleviated stress, measured by the Perceived Stress Scale [21]. Children and adolescents engaged with CBT AI conversational agent for at least 8 weeks are expected to have a greater reduction in depressive symptoms compared to a control group. An effect size of $d \geq 0.5$ based on prior digital CTB studies in youth is suggested as the target outcome [17]. Reductions in crisis events over time are also expected; for example, fewer emergency visits or suicide risk incidents among populations using this the system, as compared to baseline or control communities. These population-level changes may take a long time to fully materialize, but interim data (e.g., year-over-year comparisons in pilot communities) should show a downward trend.

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Risk mitigation

Developing AI that effectively engages children and adolescents while accurately detecting mental health signals presents significant challenges. This can be mitigated by leveraging existing validated models where possible, for example, using proven NLP models for sentiment and then customizing and by conducting extensive user testing. Strong partnerships with AI institutions and access to skilled AI talent are essential to troubleshoot technical challenges and explore alternative solutions when needed. In addition, the project's multi-tool design provides built-in flexibility. For instance, if one component – such as predictive analytics—generates too many false positives, human oversight will be in place to adjust thresholds or integrate additional data sources to enhance performance and accuracy.

Discussion

The impact of integrating AI into child and adolescent mental health interventions can be life-changing. By receiving support earlier and more effectively, children and adolescents are more likely to experience improved mental health during their formative years, laying the foundation for better educational outcomes, healthier relationships, and greater productivity in adulthood. Early intervention can also prevent the onset or escalation of serious mental illness, reducing the risk of long-term negative consequences such as school dropout, unemployment, or chronic health issues. In concrete terms, a teenager who, through the proposed AI tools, recognizes their depression early and gets help may avoid hospitalization or suicide attempts that might have occurred without intervention. Each such case has a profound impact on life.

Beyond immediate benefits, this approach also fosters long-term mental health literacy and self-management skills, helping young people build resilience and effective coping strategies. In doing so, it contributes to a generation better equipped to navigate mental health challenges throughout life. Importantly, the participatory nature of this model ensures that adolescents are not just passive recipients of care, but active contributors to the development and refinement of the tools. This inclusion promotes a sense of identity, agency, and trust in research – empowering young people and enhancing the overall impact of the intervention.

This model can potentially reduce the burden on specialized mental health services, alternative education placements, child welfare, and the justice system by catching problems earlier and handling mild-to-moderate cases in the community (or via self-help with AI support). If research shows reduced emergency visits or shorter waitlists as

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hypothesized, this can translate to significant cost savings and efficiency gains. For instance, diverting even a fraction of adolescents from emergency departments to earlier care pathways could save the healthcare system substantial resources, as the average cost of an emergency room visit or inpatient stay is high, whereas digital interventions are relatively low-cost once developed. Furthermore, the data and insights gained can help health system planners to proactively allocate resources. By integrating with the current health and education systems, this AI-enabled model positions itself to be adopted and sustained in different contexts.

In summary, the potential promise of this model is a future in which every young person has access to timely, culturally appropriate, and effective mental health support, largely enabled by intelligent systems that augment the reach of human caregivers.

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Child and Adolescent Mental Health around the World

He hāpai ō: Those who provide sustenance and support. *Te Ara Arorereti*ni: Pathway for ADHD assessment and treatment in primary care. Child and adolescent psychiatry in primary care, Te Hiku Hauora, Muriwhenua, Aotearoa NZ. *Dr Hinemoa Elder*, Materoa Blair**, from New Zealand.*

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Materoa Blair

Te Hiku Hauora
Maori Healthcare provider

Kupu whakataki. Introduction

Aotearoa (New Zealand in Māori) is in a child and adolescent mental health crisis. There are estimated to be less than 50 child and adolescent psychiatrists in the country, representing 1/100,000, when a suggested optimal number to meet the communities' needs should be at least 4/100,000. Recently 90% of child and adolescent mental health services were cut in one area because of workforce shortages of child and adolescent psychiatrists. Child and adolescent mental health needs among Māori, the indigenous peoples of Aotearoa, are recognized to be much higher than among non-Māori.

For the last year the authors have been working 0.6 FTE (Full Time Equivalent) in a primary health care organization, Te Hiku Hauora, which is located in Te Hiku o te Ika, the Tail of the Fish, the Far North Aotearoa, New Zealand and has two clinics in Kaitāia and Cooper's Beach, with around 12,000 people registered with our GP services. Readers may be familiar with the shape of the top of Aotearoa, New Zealand which resembles the tail of a stingray, hence the name Te Hiku o te Ika; the word 'hiku' indicating tail and 'ika' indicating fish. Māori are a significant proportion of the population, approximately 40% of the total 23,000 people living in the area, and 53% of our GP registered patients are Māori. This

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is an area of Aotearoa where approximately 40% of adults of working age are employed and the average annual income is estimated at around NZ$60,000, which is two thirds the national annual average income of approximately NZ$90,000. The living wage is estimated to be $27.80 per hour, while the average hourly rate in Kaitāia, the main town, is NZ$25.66.

In this article we report on the establishment of secondary mental health-level assessment and treatment of ADHD across the lifespan, from within our primary care organization, since March 2025.

People with untreated ADHD live with well recognized negative consequences, including premature death and increased substance use. Recent research following more than 150,000 people found that those who received biological treatment for their ADHD had an associated significantly lower all-cause mortality, particularly for death due to unnatural causes. Discussions with whānau (extended families) and with services in our area revealed extremely long waiting times for our tamariki mokopuna (children and grandchildren) to be assessed and provided with treatment options for possible ADHD. In Child and Adolescent Mental Health Services (CAMHS), for those over the age of 13 and in Pediatric Outpatient Clinics for those who are younger, whānau are waiting up to 12 months, with a wait time of at least 6 months being a common experience. For our pakeke, adults, Te Whatu Ora does not provide any such assessment. This means that people must seek such assessments in private, costing up to NZ$8000, putting this well outside the reach of most of our whānau.

Recent research in Aotearoa, reviewing more than 400,000 health records, has shown that tamariki Māori are more likely to be identified as having ADHD concerns in B4 School Checks, than non-Māori (2.8% vs 1.6%). Of grave concern, researchers found significant inequity in provision of biological treatment, this was most evident in the so called, "most deprived quintile" and outside of major urban areas. (1).

Having a child and adolescent psychiatrist and nurse working together has proved to be an effective model. This has enabled provision of the whole process in a convenient location, well-known and trusted by whānau (extended families'), in-clinic support and education to GPs, outreach workshops for schools and school communities, and liaison with CAMHS and pediatric services to best meet whānau needs. These activities occur in a timely manner and often in closer proximity than secondary services, with use of online meetings where this is preferred. Both the specialist and nurse are Māori, have whakapapa (kinship ties) and make other contributions of service to the community and are well

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known in the area. These factors likely reduce barriers to seeking support and discussing what this pathway entails, in a culturally safe and responsive way.

Our approach at Te Hiku Hauora represents implementation of the best practice guidelines and standards for assessing, diagnosing and treating ADHD. We have drawn on documents developed from discussions with representatives from professional clinical workforce and people with lived experience, and we have incorporated the principles from evidence-based guidelines, including guidelines from the Australian ADHD Professional Association (AADPA, 2022) and the UK National Institute for Health and Clinical Excellence (NICE, 2018). We continue to liaise with colleagues on national committees for best practice guidelines of assessment and treatment of ADHD. Our work has been presented at the Royal Australia and NZ College of Psychiatrists Faculty of Child and Adolescent Psychiatry retreat in Tūrangi, in March 2025 and we were invited to discuss our work with representative from the Ministry of Health in June 2025.

Ngā pou o te kaupapa: the key aspects of our work

Table 1 lists the core general principles that guide our Te Ara Aroreretini, ADHD pathway. The name signifies that this is a path for those with a sense of focus which flows in many directions. Here we present our approach with young people, recognizing we also provide a life-span pathway. Assessment of adult ADHD is not funded in Aotearoa NZ by taxpayer-funded mental health services and must be sought in private practice, which costs thousands of dollars, putting this outside the reach of most of our whānau.

Ētahi o ngā hua. Results.

Feedback from whānau, extended and from teachers and schools has been very positive, citing the reduction in wait times to see a specialist, the frequent and readily accessible means of contact, the family education provided, the collaborative and respectful approach, and the highly visible benefits on individual youths' well-being. Some comments from whānau included:

"*The Te Ara Aroreretini ADHD Pathway Programme, has demonstrated significant benefits for my whānau navigating the ADHD assessment and management process. Prior to the programme's implementation, we were faced with extensive waiting lists, sometimes up to five months, to see a specialist in the Far North. The new pathway has streamlined this process and offered crucial support, leading to remarkable improvements in my son's wellbeing and engagement with his learning at kura*."

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"A key strength of the programme has been its commitment to clear and consistent communication, evident since the beginning of March 2025. This has been a contrast to previous experiences, with regular phone calls and emails ensuring families are well-informed at every stage. The programme also prioritises flexibility, offering online hui (meetings)."

"This eliminates the need for time-consuming and often difficult trips into Kaitaia from my home in Pukenui, making the process more accessible for my whānau. Meeting Dr. Hinemoa and Matty online fostered a sense of whakawhanaungatanga (relationship building), which has been highly valued. Furthermore, timely reminders of meetings contribute to the smooth running of appointments."

"The programme goes beyond just assessment and medication; it actively educating my whānau and I about ADHD."

"This collaborative approach empowers Māori parents to better understand and manage their child's ADHD."

"The Te Ara Arororeretini programme boasts a quick turnaround time from initial assessment to the commencement of medication. In one instance, my son was able to begin medication on a Friday, just prior to starting school on the following Monday, after only two weeks from the programme's start. This rapid intervention has had a transformative impact."

"The most impactful benefits of the programme are evident in the profound positive changes observed in my son. He previously hated school and resisted attending, now actively wants to be at school. This shift is reflected in his school attendance for this term being above 90%. The programme has also fostered improved self-regulation and engagement."

"… Te Ara Arororeretini ADHD Pathway Programme offers a comprehensive and compassionate Māori approach to ADHD support. By prioritising clear communication, accessibility, whānau education, and intervention, it has significantly improved our lives not just for my son but for our whānau too. We are very happy!"

"E te rangatīra a Tākuta Hinemoa, Me pēhea rā te tuku mihi ki a koe? Tē taea aku kupu te whakaatu atu i ō mātou whakawhetai me ō mātou kare a roto ki a koe. He taonga tō mātou tama. I rere mai koe ki tō mātou ao whai rautaki ai tautoko ai anō nei he anahera koe. E kore te puna aroha e waimemeha noa mōu."

"All I can say is thank you, thank you for establishing access for my son (and I) to have screening and a diagnosis. Thank you for validating my son's feelings/emotions/frustrations/tears and fears (and our whanau also). Thank you for maintaining the mana of our whanau. Thank you for providing a service and opportunity to further our knowledge therefore enabling us to include strategies to uplift our boy. Thank you for the opportunity to have medication that has allowed our boy to use his superpowers for good.

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Tamariki mokopuna (grandchildren) seen in the last 3 months

7 tamariki mokopuna were assessed, all are Māori, 6 are from local iwi (tribe), one from iwi from outside of the rohe (area). 3 identify as tama (male) and 4 as kōtiro (female), they are between the ages of 7 and 12 years. All those assessed have been found to have ADHD. They had no other diagnoses identified. 6 of the 7 are currently taking medicine for their ADHD with positive effect. 6 of tamariki mokopuna are registered with our GP service. 2 of these tamariki came to our pathway referred by parents with a diagnosis of ADHD.

Kupu whakatepe. Conclusions.

Te Ara Aroreretini the ADHD pathway has proved to be a successful process in addressing the long wait times for our tamariki mokopuna and ensuring culturally safe and responsive processes that recognize the specific needs and culture of the area.

Our assessments are thorough, so where a diagnosis of ADHD is identified, this is robust. We continue to communicate with our community that in the context of accurately identifying ADHD, biological treatment can be effective and can reduce the well documented longer-term risks of untreated ADHD for our young people such as reducing the risks of substance abuse and premature death.

We have also found that when tamariki are not in school we have struggled to find other adults to provide data about tamariki in a different setting, a requirement of the diagnosis.

We also recognize that there are also considerable negative views towards the diagnosis of ADHD and biological treatment, as well as other conditions that impact on tamariki mokopuna mental wellbeing in our community. We respect these views, particularly in terms of our Māori world view, which is rightly skeptical about any such potential for labelling of our whānau with a Pākehā (Non-Māori) concept. We also recognize that the feedback we receive may be positively biased. We are committed to working to ensure our whānau have access to the right information in the right ways for them, in order to make informed decisions about their oranga, their health and wellbeing.

One of the key elements we have identified is having a psychiatrist, who is certified in child and adolescent psychiatry, and who is Māori with local iwi affiliations is important for the success of establishing and maintaining this pathway.

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Access to child and adolescent psychiatrists in primary care has been shown to be of benefit and be well received by whānau (2). We recommend other primary care organizations consider this approach. It is likely that having psychiatrists working part-time in primary care could be a partial solution to the workforce crisis in mental health services with the lack of availability of psychiatrists worldwide. This approach is also likely to add to the job satisfaction, bringing these specialists into more direct contact with the community aspects of the lives of tamariki mokopuna and whānau.

Overall, our goal is to ensure that our community has a greater and growing sense of informed choice about this condition that we call Te Aroreretini, also known as ADHD. Our whānau must have access to treatment options, where treatment is clearly indicated, and they must be fully involved in all steps along that journey. This approach supports our whānau to fully participate and enjoy success in their learning, in their opportunities, in their relationships and all aspects of their daily lives to fully express who they are, as the descendants of the magnificent ancestors that they are.

Box 1: Core general principles that guide our Te Ara Aroreretini, ADHD pathway

- We are a Māori organization in a community with a high percentage of Māori. Therefore, our responsiveness to Māori and cultural considerations are of paramount importance.
- Our Te Ara Aroreretini pathway acknowledges He Whakaputanga (1835) and Te Tiriti o Waitangi (1840), fundamental documents that determine the historical role of Māori as First Nations peoples in our country and our relationship with the British Crown, as critical in recognizing mana whenua and mana moana in Muriwhenua.
- Our whānau are at the heart of our assessment.
- This process proceeds with cultural safety and competency, honouring Te Ao Māori, Māori worldviews as well as opportunities for other cultural considerations.
- We bring a focus on equity, critical reflection, and cultural competency skills to our collaborative assessment, treatment and follow up.

Whakataukī, or proverbs are very important in our culture and in the way we interact with the whānau we work with. E ai ki te kōrero, it is said, "Ko te amorangi ki mua ko te hāpai ō ki muri", the leader, in this case our whānau, our extended families, show the way and we, the hāpai ō are there to provide the appropriate support. This is a well-known whakataukī, gifted to us by our kaumātua, our elders, which continues to guide our work.

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Ngā mihi matihere ki ngā tamariki mokopuna me ōna whānau, nā koutou tēnei ara i tautoko. We sincerely thank the young people and their extended families who are part of our collective community pathway programme.

Box 2: Te Ara Aroreretini, ADHD treatment and management

- Comprehensive assessment – provides options according to whānau requests regarding the offering of karakia (prayer), mihimihi (greetings) and whakawhanaungatanga (acknowledgement of connections), in order to establish mutually respectful, trusting relationships. Within this context the face-to-face meeting and so called "clinical interview" is the primary diagnostic tool. This covers various domains including:
  - the iwi (tribal) connections of whānau, their histories and traits
  - history of features of concern relating to ADHD
  - a mental health history, including assessment for differential co-occurring diagnoses longitudinally
  - medical history and a physical health assessment
  - developmental and family history
  - psychosocial assessment – including cultural, social, educational, employment and demographic information
  - a risk assessment and current mental state examination.
- Clear consideration of differential diagnoses and alternative explanations of presenting symptoms.
- We recognise that although we use the Conners™ validated rating scales to support the assessment, the scores are not the sole basis for a diagnosis of ADHD
- Symptoms of ADHD must be pervasive, across both time and settings:
  - collateral evidence of symptoms in childhood by 12 years of age
  - evidence of significant impairment across multiple settings.
- Diagnosis is completed by appropriately qualified and trained healthcare professionals who are:
  - appropriately registered
  - adequately trained in diagnostic assessment
  - experienced with conducting culturally safe clinical interviews, administering and interpreting standardised rating scales, and assessment of functional impairment
  - Experienced in ADHD diagnostic assessment or undergoing ADHD-specific supervision with an experienced clinician.
- Diagnosis is made with explicit reference to DSM criteria in the process and reporting of diagnoses.
- Access to multimodal treatment and support.
- Pharmacological and non-pharmacological approaches for different treatment symptom targets – pharmacological for core symptom reduction and non-pharmacological for improved functioning and wellbeing.
  - The specific non-pharmacological interventions offered vary by age group and developmental stage.
  - There is discussion of, and interventions to assist with sleep, eating habits, and physical activity, as indicated.
  - Access to cultural supports for whānau, these include activities such as waka ama provided by an Iwi NGO.
  - Access to psychological supports for whānau, these are available via school for some tamariki mokopuna, and in the community for others
- Evidence-based treatment that is tailored to whānau needs.
- Whānau-centred treatment and developmentally appropriate supported decision making is central to our approach.
- We actively involve multiple generations; the tamariki mokopuna, mātua, parents, pakeke, adults and whānau, and tailor the approach and information provided to their needs and preferences.

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Meeting the needs of children's mental health: Five clinical models in the United States.

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Introduction

Our digital native young people are not flourishing, according to a 2023 global study [1]. The COVID-19 pandemic has left behind a critical children's mental health crisis in the U.S. and around the world [2]. Even though they have far more

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access to resources and information at their fingertips than prior generations, young people are increasingly more isolated, lonely, and unhappy. Screens are feeding them wide ranges of issues to worry about from climate, economy and politics to a culture of immediacy and the fear of missing out, and offering innumerable virtual silos to escape from harsh realities. Without moderation, this leads to a spiraling quality of life, physical and mental health. In the U.S., one in five children struggles with mental illness, and suicide is the second leading cause of death among the age group 10–24-year-olds [3].

In the past several decades, our field has expanded psychiatric care beyond the traditional hospital model and the community-based programs [4]. There is growing attention on enhancing access to services and equity through innovative mental health service models [5]. This article introduces five widely practiced models of care in the U.S. to bridge the gap between conventional care in psychiatry. The goal here is to spark discussion, reflection, mutual learning, and collaboration among our global child and adolescent psychiatry colleagues to improve, implement, and disseminate models of care that can better respond to the mental health needs of children and families in the U.S. and around the globe.

1. Intensive Outpatient Program

Intensive Outpatient Program (IOP) is an intermediate hub of mental health care to bridge among psychiatric emergency, inpatient, and ambulatory services. Typically, IOP provides 6-8 weeks of group therapy, weekly medication management, and case management. Child and adolescent psychiatrists are leaders at IOP, with the role of guiding medication treatment and coordinating with other clinicians who run the group therapy and crisis management within the mental health system. Some IOPs operate during after-school hours to accommodate youth's adaptation to school and community after hospital discharge. IOP's goal is to reduce the use of higher levels of care while increasing the use of lower levels. Positive outcomes have been shown in adolescents who completed IOP with significant improvements in depression, suicidal ideation, and behaviors [6]. Since the COVID-19 pandemic, the tele-IOP has been developed, which has both shown to be equally effective as in-person treatment and more effective in youth among marginalized groups [7]. However, in adult IOP, the protection from re-hospitalization is limited to a certain number of days of care [8]. Other programs, such as Partial Hospitalization and Extended Day Treatment, are adapted similarly to IOP's model and have also shown evidence of positive outcomes [9,10].

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2. In-home treatment program

Intensive In-home Child and Adolescent Psychiatric Service (IICAP) was developed at Yale Child Study Center in 1995 [11]. It is a multi-systemic home-based intervention that engages various mental health providers, family, school, and community systems to prevent relapse of hospitalization in youth struggling with mental illness and significant trauma and psychosocial adversity [11,12]. Typically, IICAP is suitable for children and adolescents living with a stable family who show a strong commitment to participating in home-based treatment.

IICAP includes psychiatric assessment, individual psychotherapy for children and adults, family therapy, couples counseling, parent guidance, behavioral management, crisis intervention, and medication management for 5 hours per week across 6 months. Teams also provide 24/7 psychiatric crisis management. The treatment team includes a clinical social worker and mental health counselor who are under direct supervision by a child and adolescent psychiatrist [13]. The in-home modality scaffolds a "village" of various providers and families together and has similar clinical outcomes to inpatient treatment [14]. A long-term study showed that in-home treatment has considerably equal functional outcomes with inpatient care immediately after discharge, 1-2 years post-discharge, and up to 4.3 years post-discharge [15]. Parents also felt more competent to manage their children's mental health when treatment took place in the home environment compared with inpatient care.

3. Collaborative Care model

The Collaborative Care model (CoCM) is a comprehensive, integrated care model that started at the University of Washington due to a need to increase accessibility to mental health services. CoCMs emphasize providing psychiatric consultations within primary care settings, and many studies, such as the IMPACT trial [16], have proven their success. In this model, a child and adolescent psychiatrist works with a Behavioral Health Care Coordinator (BHC), reviews the patient registry (database that tracks patients' engagement and symptom improvement), and makes recommendations to share with the Primary Care Physician (PCP). BHC proactively follows up with the PCP and the child and adolescent psychiatrist while providing care management services, which include conducting brief psychosocial interventions and maintaining the registry. CoCMs have been associated with a 20% reduction in psychiatric readmissions and improved care coordination before and after ED visits [17]. However, CoCMs are not feasible for smaller practices due to implementation costs and complex coordination needs. On a global level, CoCMs have demonstrated success in

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managing common mental disorders such as depression, anxiety, PTSD, and substance use disorders across various settings, including low- and middle-income countries (LMICs) and high-income countries (HICs) [18].

4. Child Psychiatry Access Program

Child Psychiatry Access Program (CPAP) is a consultation model where the child and adolescent psychiatrist provides informal mental health consultations (real-time responses) via email, secure messages, or phone to PCPs regarding medications or psychiatric diagnoses. The child and adolescent psychiatrist would then bill the payer (insurer) directly for professional-to-professional service on behalf of the patient by utilizing interprofessional digital service codes. Because child and adolescent psychiatrists bill directly, they do not have to rely on billing by or reimbursement from a PCP. An example of this consultation model is the Health Resources and Services Administration (HRSA) funded "child psychiatry access programs (CPAP)" or "pediatric mental health care access programs."

The first CPAP model was established in Massachusetts in 2004, driven by concerns about the increasing prescription rates of psychotropic medications for children. CPAPs have proved to be cost-effective as they reduce the burden on specialized mental health services, as pediatricians are more able to handle cases, which lowers healthcare costs. In Massachusetts, the Massachusetts CPAP increased the percentage of primary care clinicians who felt able to meet psychiatric needs from 8% to 63% [19]. Compared to CoCMs, there is increased feasibility and lower investment costs for CPAPs, and similar models have been implemented in Canada and Australia [20].

5. Community-based clinics

Certified community-based mental health clinics (CCBHC) are non-profit organizations that provide rapid and accessible mental health and substance use services within a local community regardless of the patients' ability to pay, insurance status, or background. These clinics are designed to meet certain communities' specific needs and offer nine types of services, emphasizing 24/7 crisis care, evidence-based practices, and care coordination with other local institutions such as hospitals, law enforcement, and schools [21]. CAPs diagnose a wide range of mental, emotional, and behavioral disorders in concurrence with substance use. They also work within a multidisciplinary team that includes therapists, nurses, and PCPs.

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However, many of these clinics are chronically underfunded and understaffed, leading to larger caseloads for clinicians, resulting in increased burnout and longer wait times for patients. Clinics often lack the physical space, materials, and administrative support needed to provide comprehensive care, which can impact the quality of service. Today, there are more than 500 certified community-based mental health clinics, with at least one in almost every state. This model has also expanded to the District of Columbia and Puerto Rico [21].

Local and global strategies

The five models of care presented here aim to respond to the needs of children and adolescents in the complex, fragmented, multi-payer, and highly privatized healthcare system of the U.S., where rich and advanced resources coexist with stark healthcare disparities in access and outcomes [22]. Given the increasing diversity of the U.S. population and the growing visible mental health needs of countries across the world, including low and middle-income nations, the Western-centric child and adolescent mental health science and systems of care need to adapt to and learn from diverse and global contexts to meet local and worldwide needs [23]. Psychological, social, structural, and cross-cultural factors should be considered critical in local and global adaptation efforts. [24].

While these models could inform adoptions or inspire other strategies in diverse and global contexts, the U.S. and other countries would also benefit from consideration and local adaptation of strategies from low-resource settings, such as task-shifting and sharing with healthcare and lay professionals, and from the developments and growing reach of communication and internet technologies [25]. Child and adolescent psychiatrists should seek further collaborations and partnerships within the healthcare sector and with non-healthcare professionals and organizations, especially in community settings through schools, churches, grassroots nonprofits, and refugee camps [25], and further leverage remote communications and apps to reach faraway colleagues and patients.

Final thoughts

The field of child and adolescent psychiatry has been rapidly evolving, and so are the needs of children's mental health. We need to promote, implement, and disseminate innovative models of care that can meet the children's mental health demands with quality, cost-efficiency, and equity. The models discussed here are a work in progress in the U.S., subject to mutual learning and improvement with systems in other countries. Here, we invite colleagues around the world to

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engage in discussions to cross-pollinate our scientific knowledge and systems of care in order to meet the moment of the global crisis and opportunity in child and adolescent mental health.

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Youth Center – CEZAM (Centar za mlade) – Community Mental Health Care.

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** CEZAM Team - www.cezam.rs - Instagram profile #cezam.bgd

Prof Dr Milica P. Milovancevic

In response to the tragic events of mass shootings of May 2023 in Serbia, the Serbian government launched an ambitious initiative to enhance the country's capacity for psychosocial support. Initially, the project focused on delivering psychosocial support services for individuals and groups affected by traumatic events, offering capacity-building training programs for improving post-traumatic youth support in mental health specialists, teachers, and public

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administration professionals, as well as assessing the degree of traumatization in the affected school communities. In working with traumatized youth, specialists recognized a pressing need for durational preventive work in the communities. What began as a trauma response, grew into an expert-led proactive initiative to improve youth mental health in the long term. Just over six months into the project's existence, the work on building a mental health hub for young people in Belgrade began. In March 2024, after consultations with experts, decision-makers and youth representatives, the CEZAM Youth Centre was born. This article introduces the CEZAM model, its key components, results and lessons learned so far in over one year of existence with hopes that it will inspire preventive community-based initiatives elsewhere.

At the core of the CEZAM model is its free 1-1 psychosocial support service, that operates both in person and online, through videocall. Young people aged 10 to 30 years old can book their session online in less than a minute, through the cezam.rs website. Without the need for medical insurance, referral from a GP, teacher or parent, complex forms or assessments, CEZAM is committed to maximizing accessibility and minimizing stigma associated with asking for mental health support. Whilst the convenience of the booking process leads to no-shows (10%), we believe it is a small cost to pay for the service response we receive. Each young person is entitled to five sessions that they can use at their own pace. Each week, our 32 specialists offer 110 sessions. In the first year of existence, over 3100 counselling sessions were realized, over 65% with females, and over 65% with the 20-25 age group.

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Whilst intervention lies at the core of the CEZAM model, it is also coupled with various free-of-charge preventive programs - wellness and educational activities, directed towards improving life skills, inviting curiosity, inspiring confidence, overcoming loneliness and evading risky behaviors. Through non-formal educational and creative workshops, discussions, lectures, courses, debates, etc. CEZAM supports young people in preparing for the future, encouraging their development, independence and resilience to life's many challenges. So far, over 2000 young people have benefited from CEZAM's preventive program, with over 40 educational and 80 wellness activities realized. Some of our most loved wellness activities include art therapy, knitting, illustration and DIY (Do it Yourself) sessions, as well as board games and film nights. So far, our educational program has offered financial literacy and communication workshops, debate and film school, as well as learning skills activities for different age groups.

Because we know that parental support is vital for youth mental health, CEZAM also offers expert-led bimonthly psychoeducational panels and Q&A sessions. The CEZAM parental program helps parents, caregivers and teachers understand and support children with best practices, as well as presents opportunities for tailored advice. Up until now, the CEZAM parental program has hosted over 1000 participants in over 25 events, covering topics such as internet addiction, divorce and crisis navigation, depression and sexual development.

In order to improve community outreach, reduce stigma and improve mental health awareness among the youth, CEZAM launched a community volunteer network. Following a selection process of over 200 candidates, 35 young people aged 16-25 were selected for the The CEZAM Community Youth Volunteers Training Programme. The program equips young people with the knowledge and skills to recognize mental health challenges in their peers, provide

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accurate information, and help them reach adequate support. Building on the trust and openness of peer-to-peer relationships, the program empowers youth volunteers to enhance the timeliness of psychosocial intervention, build a culture of awareness and reduce stigma surrounding mental health in their schools, clubs and the wider community. So far, over 1200 hours of volunteer work, including advocacy and promotion, organizational support and communication efforts have helped us reach those in need.

Finally, CEZAM strongly relies on communication to appeal to its target audience. Investing significant efforts in crafting a relatable and approachable online and offline presence, CEZAM uses a cheerful and bright aesthetic, familiar faces and informal language, to break the negative association with hospital environments and offers a pleasant and even likeable image of mental health and related services. CEZAM social media accounts bring mental health to over half a million users per month, contributing to nationwide mental health destigmatisation.

After an intense first year, CEZAM has demonstrated that a community-based, youth-centered mental-health hub can move the conversation in Serbia from crisis response to long-term prevention. By combining free, easily booked 1-to-1 counselling with a rich menu of wellness, educational, parental support and volunteer programs, CEZAM has formed an integrated model that lowers traditional barriers to care, meets young people where they are, and builds a culture in which seeking help is normal, timely and stigma-free. Looking ahead, CEZAM's priorities include expanding its reach among underserved groups, particularly high school students, young men, and marginalized youth, while refining the quality of its existing programs. Plans are also underway to pilot similar hubs in other cities, using CEZAM Belgrade as a reference point for scalable, community-based mental health services. With a growing base of data, partnerships, and trained professionals, CEZAM is positioning itself as a practical and adaptable model for preventive youth mental health support, one that responds to real needs, works across sectors, and can be replicated in diverse local contexts.

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Educational opportunities

Cannabis psychoeducation video. *Dr Robin Cowperthwaite, from USA.*

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Dr Robin Cowperthwaite

Dr Cowperthwaite, a recent member of the WPA CAP Section, kindly contributed with the current World CAP issue sharing a recent work of the Oklahoma Psychiatric Physicians Association (OPPA), a video about risks of Marijuana use by youth. The video is available on Youtube (https://youtu.be/KjaPFlxro1s?si=ZGT5Up27mla0Y_M4) and can be a very useful tool for education about substance use. The video is also easily accessed by clicking in the image below. Thanks to Dr Cowpethwaite and other authors - Dr. Tessa Manning ,Dr. Grace Thetford-Harvey, all from University of Oklahoma, and Mrs. Cris Cotter, Mrs. Renee Mixon, Executive Directors of OPPA.

(2025, March15) *Navigating the Haze: Understanding the risks of Marijuana use in teens* [Video]. YouTube.

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Meeting reports

Report – 7th DEAPS Congress (Šabac, Serbia, May 29 – June 1, 2025). Congress of The Association for Child and Adolescent Psychiatry and Allied Professions of Serbia.

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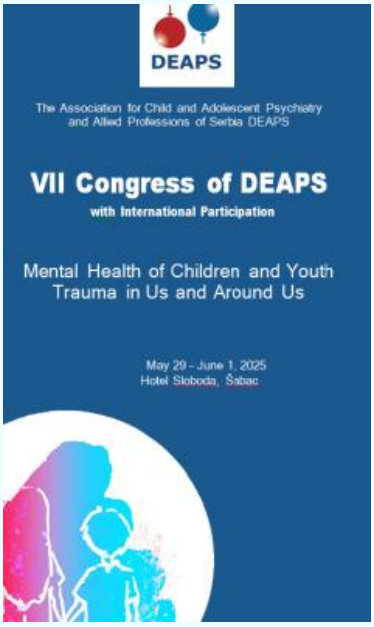

Serbia community had recently experienced a series of traumatic events that deeply impacted society, particularly children and young people. In response to these challenges, the theme of the congress was "Mental Health of Children and Adolescents – Trauma Within and Around Us." This three-day congress brought together leading professionals in the field, as well as others interested in the topics of trauma and mental health among children and youth. The goal was to enhance knowledge and skills related to trauma, ultimately contributing to better protection and preservation of the mental health of young people. The Congress brought together 180 participants in vibrant discussions, knowledge sharing, and future-oriented dialogue. Around 40 lectures were held, covering topics ranging from scientific to system-level approaches, along with poster sessions, case reports, and workshops. The program featured several international speakers, recognized as leading experts in the field of childhood and adolescent trauma - Dennis Ougrin, Berit Kieselbach, Lise Eilin Stene, Andrea Danese, Gordana Milavić and others.

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From experienced professionals to early career specialists, the Congress in Šabac served as a vital platform for addressing trauma in children and adolescents from diverse perspectives. In addition to its rich thematic framework, the Congress featured a diverse program of lectures, symposia, workshops, poster sessions, and expert meetings. Some of the key sessions included:

- The Pre-Congress Workshop, with the theme "Recognizing and Responding to Violence Against Children: Evidence-Based Strategies for Health Professionals," was led by Berit Kieselbach from the World Health Organization and provided us with practical guidance for frontline healthcare workers.
- Among the symposia, Children and Youth – Perpetrators and Victims of Criminal Offenses explored topics such as conduct disorders, systemic responses, evidence-based programs, and emergency shelters for abused children.
- The opening day also featured a Plenary Lecture on the Prevalence of Mental Disorders in Children and Adolescents in Serbia, highlighting recent national data.
- A particularly impactful segment was the UNICEF Symposium on the Youth Minimum Service Package (YMSP), covering topics like telehealth, psychosocial support, and experiences from both trainers and educators.
- The Symposium on Systemic Response to the May Tragedies in Serbia addressed trauma in youth, coordinated institutional reactions, the role of media, and the psychological support offered to both survivors and helpers.

Other plenary sessions included presentations on Providing Psychosocial Care to Youth After Mass Trauma and Health Sector Response to Violence Against Children.

A wide array of clinical and theoretical issues was addressed in the Symposium on Selected Topics in Child and Adolescent Psychiatry, including child forensic psychiatry, school violence, and the impact of adverse childhood experiences. Trauma-focused sessions were especially well attended, such as the Symposium on Trauma and Psychotherapy, with lectures on complex PTSD, group therapy, and supporting parents of traumatized children. Another session, Trauma in Early Childhood, emphasized the neurobiological effects of early stress and the importance of parenting practices.

In the session The Face and the Inside of Trauma, experts discussed multifaceted trauma presentations, support models, and how to care for the caregivers themselves.

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The Innovation & Regional Updates Sessions highlighted regional strategic developments, including the Strategic Framework for Advancing Child and Adolescent Mental Health in North Macedonia (2024–2030) and contributions from ACAMH on evidence-based practices.

A Round Table Discussion tackled legal and institutional challenges in the field of child forensic psychiatry, while the Panel Session on Local ''PORI Teams'' (Family Oriented Early Intervention) offered insight into community-based, intersectoral support mechanisms.

The final day featured two Plenary Lectures: Childhood Adversity and Psychopathology – Bridging Population Science and Clinical Practice and Therapeutic Assessment for Young People with Self-Harm, providing cutting-edge insights into mental health diagnostics and intervention.

The scientific program also included case presentations and a poster session, where 24 posters were displayed. The Congress brought together 180 participants in vibrant discussions, knowledge sharing, and future-oriented dialogue. Around 40 lectures were held, covering topics ranging from scientific to system-level approaches, along with poster sessions, case reports, and workshops. From experienced experts to early career professionals, the Congress in Šabac served as a vital platform for addressing trauma in children and adolescents from diverse perspectives.

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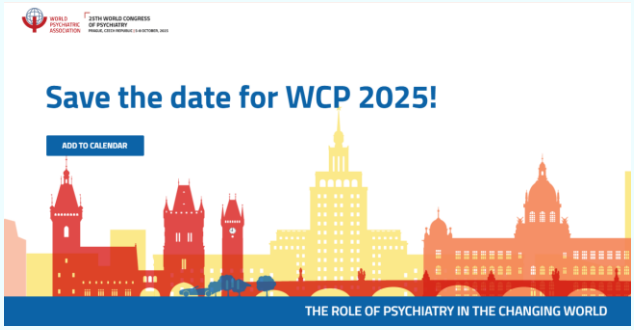
Future meetings

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

Still in 2025



The 25th World Congress of Psychiatry 2024

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

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2026

The 12th Congress of the Asian Society for Child and Adolescent Psychiatry and Allied Professions

The 27th World Congress of the International Association for Child and Adolescent Psychiatry and Allied Professions

Canadian Academy of Child and Adolescent Psychiatry (AACAP) – Annual Meeting

The 19th World Association on Infant Mental Health World Congress

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