I was privileged to attend AACAP's 66th Annual Meeting this year in Chicago in no small part due to the generous travel award of CAPSGW. One session in particular resonated with me due to what I feel is the most fundamental challenge of our field: With so few providers, how do we reach the most kids who need us? AACAP estimates that there are only 8,300 child psychiatrists but over 15 million youth in need of psychiatric care. The session was an International Clinical Perspectives titled "A Global Mental Health Perspective of School-Based Mental Health Interventions for Youth in Limited-Resource Settings." It examined the challenge of reaching those in need in areas with significantly limited resources. It showcased four speakers discussing their efforts to impact the mental health gap in often perilously underserved regions. Additionally, it exhibited the work of two local members Drs. Anna Ordoñez and Michael Morse.

First up was Dr. Cardozo presenting a trial which was geared toward building resilience in at-risk 6th graders in Colombia. The goal here was to help protect against development of or reduce the severity of mental illness by targeting the entire student population. After a literature review this team selected a CBT intervention (FRIENDS) which was previously used in Australia and Mexico. The program had been effective in over 20 other trials and was recommended by the World Health Organization (WHO). It consisted of 10 weekly session including 2 booster sessions and 2 parent sessions. It was an admirable concept given its relatively small time investment (14 weeks) per cohort. Unfortunately, it failed to demonstrate clinically significant results. Several difficulties were identified and related to similar themes in the other speakers' presentations. One difficulty was establishing appropriate parameters and identifying accurate ways measure a complicated concept like resiliency. Another difficulty was establishing enough buy-in from parents (impacting parent group attendance), teachers/administration, and the children. Finally, several difficulties emerged by nature of being in a resource limited setting such as financial delays, funding shortages, and missing supplies.

The second and third speakers discussed WHO interventions both produced and in production and looked at countries in and around the Middle East (termed the Eastern Mediterranean Region). The first highlighted program was an implementation of a WHO intervention in Lahore, Pakistan. The speaker described a significant dearth of child psychiatrists (I believe only 7!) in the entire country. Given so few providers, the goal was to use schools as the "frontline" and essentially train teachers. The WHO model consisted of three 6-hour face-to-face sessions. Their primary outcome was looking at teachers' mental health literacy (via a self-administered questionnaire). They managed to get 220 teachers to participate. Questionnaire results were significantly positive at both the time of initial completion and 3 months later. Additionally, teachers reported increased confidence in helping students with mental health issues and improvement in the overall school environment. Unfortunately, the secondary outcomes regarding emotional and behavioral difficulties were not statistically significant, although positive trends were observed. This was again measured at 3-month intervals. Overall, 18 hours of training led to robust results. There may have been more significant results in student outcome if longer intervals were allowed. Although again, similar challenges were noted in this study as in the first intervention discussed. Also, although 18 hours in the grand scheme may not seem a significant investment, it may present a significant burden for busy teachers.

The next speaker discussed how the WHO is using technology to further develop more teacher training manuals. Translating the manuals to an online format would hopefully yield several advantages beyond the current format. Teachers could move at their own pace, may be more easily engaged through the use of voice actors to bring vignettes to life, and scalability would be significantly improved. Of particular interest was the development of a chat-bot called SHINE-BOT which was a program that teachers could access in real time. The goal was to help with particular questions and situations and provide guidance on appropriate management strategies.

The final speaker, Dr. Morse, discussed a program geared towards schools in Palestine. The children in Palestine face similar issues of insufficient access as there are no child psychiatrists in the country currently. The program discussed by this speaker was significantly more comprehensive. It included training of teachers by a psychotherapist prior to school and the formation of a permanent student support committee. This committee met weekly with the therapist who stayed with the school for a full year. At committee meetings, specific children having difficulties were discussed and methods to address those issues were reviewed (including bringing in parents to help). In this way, this program utilized primary prevention as well as more targeted interventions. Although the most comprehensive, there seemed to be fewer issues with teacher buy-in. However there were scalability concerns since it required significant time from both schools and a therapist. Additionally, measures used to show improvement were subjective (teachers rating scales of 1-10 in terms of difficulty).

Overall the talk provided great insights into the different strategies being attempted to tackle the mental health gap in significantly resource-limited populations. It was a pleasure to hear from such passionate colleagues who evoked hope despite daunting circumstances.

Written by Jacob Swartz, MD