Conclusions.— Many traditional services in the EE region continue to violate human rights of children. This unacceptable fact needs to be addressed in most serious way by all stakeholders.

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Psychological framework in paediatrics

Tu-S-311
Introduction: The psychologically orientated paediatrician/prenatal counseling – a pediatric cardiologist perspective
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Complex congenital heart disease (CHD) is not infrequently diagnosed on routine prenatal ultrasounds, and/or confirmed at dedicated centres. Such diagnoses lead to considerable stress of the affected parents which may be conceptualised as a “grief reaction”. Termination if such an option is available, is often proceeded with if there is an associated chromosomal or other malformation. Yet the parental decision process need be made in a setting of great emotional turmoil while trying to understand the abnormality, its consequences, and the need of surgical and other interventions with uncertain outcomes. Adding to the stress is a limited time frame — in Melbourne by 24 weeks if termination is contemplated.

Despite the considerable information requested, it is often poorly absorbed as the parents describe themselves as being in a state of “shock”. In addition information is sought not only on the immediate outcomes but those extending into childhood and adult life, with questions related to schooling, sports, higher education, employment, marriage and even pregnancy — a daunting task when such counselling occurs at 18 to 20 weeks gestation or earlier. That is made even more difficult when at times there may be an evolving cardiac lesion as the pregnancy progresses with a worsening prognosis. Recognising the psychological constructs has allowed counselling to proceed in a non-directive manner, usually in conjunction with an obstetrician ultrasonologist, describing the abnormality in simple terms, concentrating on the quality of life issues rather than on the detail of the abnormality. The information provided in multiple sessions allows the parents to assimilate this knowledge and to work through their grief. Additional material such as a CD-ROM, diagrams, literature etc. may also be made available for the parents to view in their own time. There is also a need for clinicians to become aware of their own reactions in diagnosing serious cardiac abnormality where despite multiple surgical and other interventions, a poor outcome may be forthcoming. Recognising ones own vulnerability and sharing painful experiences with others allows one to continue to work effectively in this difficult area.

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Tu-S-312
Engaging with neonatal death and bereavement – a neonatologist’s perspective
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Neonatal intensive care is a high-pressure environment, because of both workload and also the nature of the task. Death remains a frequent event and the spectre of disability hangs over many babies and management decisions, whether antenatally or postnatally. Managing such pressures with families with widely differing expectations of intensive care and diverse belief systems around the issues of death and disability is a complex task. Families are experiencing the worst time of their lives and emotions are raw. We are also ourselves challenged by death and disability. They can be seen as professional failures, a challenge to our vision of ourselves as healers or “fixers”. Our self-management affects our decision-making and communication with parents. We are also mortal. The management of death by neonatologists is materially affected by their own fears and concerns about their own death. Neonatologists’ views of the quality of life for disabled survivors also differ materially from those of parents or those of survivors of NICU. The ability to explore such issues with ourselves is an essential prerequisite for balanced counselling of families around perinatal palliative care decisions, decisions around the margins of viability and limitation of treatment in neonatal intensive care. This must also be recognised in the supports provided for our colleagues and ourselves.

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TOC : Approche thérapeutique intégrative

Tu-S-314
Données récentes sur le trouble obsessif compulsif chez l’enfant
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Introduction.— Plusieurs nouvelles données de recherche font ressortir les particularités du TOC chez l’enfant ; nous exposerons celles qui nous apparaissent les plus pertinentes pour la pratique clinique reliée à ce domaine. En deuxième partie, nous aborderons les aspects cliniques reliés au traitement psychothérapeutique individuel et familial.

En effet, une approche thérapeutique intégrée s’est montrée rapidement nécessaire dans le suivi thérapeutique d’enfants présentant un trouble anxieux de type obsessionnel-compulsif. Nous voulons illustrer ce travail par des cas cliniques et des réflexions théoriques. Traditionnellement, au Québec, une psychothérapie d’enfant est menée en parallèle avec des entretiens thérapeutiques pour les parents.

Nous travaillons au sein d’une clinique externe spécialisée de trouble anxieux faisant partie du département de psychiatrie d’un centre hospitalier universitaire pédiatrique (0–18 ans).

Objectifs de la présentation.— La première partie de la présentation portera sur les suites postopératoires de la littérature scientifique pédiopsychiatrique concernant le trouble obsessionnel-compulsif chez l’enfant. Les domaines abordés seront : la phénoméologie et les dernières recherches sur les présentations cliniques et les types de symptômes ; seront aussi abordées sous le même angle des recherches récentes, les questions des comorbidités psychiatriques, des facteurs étiologiques (génétique, neuro-imagerie, caractéristiques familiales), du devenir et des essais thérapeutiques (TCC et pharmacologie) novateurs.

La deuxième partie proposera :
– d’exposer un modèle thérapeutique d’approche intégrée (perspectives cognitivo-comportementale, développementale et systémique) pour comprendre et traiter un enfant (6–12 ans) qui présente une problématique obsessionnelle-compulsive ;
– de situer les caractéristiques psychologiques fréquemment rencontrées ;
– de faire ressortir la pertinence de renforcer la cohésion parentale et de favoriser les capacités de mentalisation chez les parents en rapport avec la problématique de l’accommodation.

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Bipolar disorders in adolescents (Coby study)

Tu-S-315a
Bipolar disorder type I in children and adolescents: Clinical characteristics at intake and 1-year follow-up
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The aim of this presentation is to describe clinical data from a naturalistic follow-up of children and adolescents with Bipolar Disorder (BD) type I which were admitted to our clinic (both inpatients and outpatients), and were followed for at least six to twelve months. All subjects were assessed using the KSADS, and met DSM-IV criteria for BD type I. Demographics, comorbidity, family history, past psychiatric history, functioning and number of past treatments and hospitalizations were assessed at intake. Information obtained after follow-up included number of hospitalizations, phenomenology, ADHD and anxiety comorbidity, number of mood episodes, psychotic symptoms, suicidality, substance use, treatment and functioning. Subjects were seen at least once or twice a month during follow-up. Intake and follow-up data will be discussed in the context of the background literature.

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Tu-S-315b
Follow-up study of a cohort of inpatients adolescents with bipolar disorder type I
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Follow-up study of a cohort of inpatients adolescents with bipolar disorder type I. Clinical particularities of acute mania in adolescents have been described in several studies but still little is known about adult outcome and diagnosis stability. In our 5-year follow-up study, we assessed diagnosis stability of adolescent-onset BD I and potential factors associated with diagnosis transition and quality of outcome respectively.

Method: Eighty subjects, aged 12 to 20 years, consecutively hospitalized for a manic or mixed episode between 1994 and 2003 were recruited. All patients were contacted in 2005–2006 for a follow-up assessment. Five refused, 20 were lost, 55 were assessed by direct and complete interviews (67%) or by phone and treating psychiatrist (33%).

Results: At follow-up, 35 patients had a diagnosis of BD, eight changed for schizo-affective disorder, 11 for schizophrenia. Mortality and morbidity were severe (one died, 91% had at least one relapse). All patients with a good psychosocial functioning at follow-up have a BD diagnosis.

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C.A.M.H. Service innovations in the developing world

Tu-S-316
Mental health gap action programme (mhGAP):
Development, implementation and contribution towards improved child and adolescent mental health services
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Despite international evidence documenting a high prevalence of disabling mental conditions among children worldwide, access to child mental health care is inadequate in most LAMIC. The World Health Organization Mental Health Gap Action Programme (mhGAP) aims to contribute to address this treatment gap by providing a step-wise framework for improving quality and access to mental health services, including child and adolescent mental health services. The mhGAP advocates for mainstreaming mental health promotion and care services within existing PHC and community-based interventions, by engaging a broad range of stakeholders and service providers and by strengthening human resources’ skills at various levels of the health and education systems. It adopts a life-cycle approach. Evidence-based guidelines for management of priority mental, neurological and substance abuse conditions and training materials are being adapted and pilot tested in several countries. Lessons learnt and preliminary findings from the evaluation of mhGAP implementation will be shared.

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Tu-S-317
Developing child mental health services in the developing world
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There is an urgent need to pay attention to the mental health of children in developing countries. Professionals confronted with this task face a number of challenges. Services have to be planned in a rational way, keeping in mind the needs of local populations. These needs will often exceed the available resources, and it will be necessary to set priorities. Feasible and cost-effective models of service delivery then have to be developed to meet these needs. Professor Rahman will discuss a framework within which mental health needs of children can be assessed, priorities established, and services organised. This is illustrated with examples of relevant activities undertaken in low-income developing countries over the last two decades.

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Tu-S-318
Innovations in a child mental health service in Uruguay
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Uruguay is a small country in the Southern Cone of Latin America, with 3,000,000 inhabitants, one million of them underage (below 18 years old), 97.5% of the children attend school. However, nearly 50% of the children are born below the poverty line.

In 2003, through the contribution made to ATLAS on mental health resources, requested by WMH, it appears that the country could not account for children’s mental health needs and had no knowledge about the prevalence of psychiatric pathology nor about the available resources. Moreover, there were no validated epidemiological scales in child mental health.

The first epidemiological study in children’s mental health was conducted in 2005–2007, showing a prevalence of pathology in 22% of the children and a strong relationship with SES. In 2008–2009, epidemiological studies were conducted in populations with very low incomes, confirming these findings. The discrepancy between needs and resources is historic, so strategies that point to a proper use of resources are generated. Specialized polyclinics are created to account for the prevalent pathologies: severe mood and behavior disorders, learning disorders and developmental disorders.

Under the concept of University Extension, there is collaboration with the establishment of local polyclinics that, in relation to the educational system, tend to decrease the impact of learning difficulties in child’s development.

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Tu-S-319
Child and adolescent mental health service innovations in Ibadan, Nigeria
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The prevalence of child mental disorders is about 20% in most parts of the world including Nigeria. The development of CAMH services at the University College Hospital, Ibadan, Nigeria commenced about a decade ago. To accommodate the growing need, a community outreach to the juvenile justice system, and a joint Paediatric Neurology/Child Psychiatry service were introduced. This study aims to describe the development of these services and to evaluate their impact on the short term psychosocial functioning of youth, as well as establish satisfaction with the services. Reports and activity logs around the development of the services were reviewed. The strengths and difficulties questionnaire (SDQ) and a semi-structured client satisfaction questionnaire were administered to youth and caregivers attending the services at baseline, and at three months follow-up.