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 K-SADS, 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 schizoaffective 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 lifecycle 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 credited 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.