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Case study: Sucessful of treatment in a severe self-mutilation case

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Self-mutilation behavior (SMB) is defined as all behaviors involving deliberate infliction of direct physical harm to one's own body without any intent to die. This case report describes the successful treatment of severe SMB in a 23-year-old woman, with multiple comorbidities. The patient was admitted to the multiple impulse-control disorder outpatient unit for treatment of SMB. This patient was submitted to the SCID-I/P, SCID-II/P, Y-BOCS, DY-BOCS, and Functional Assessment of Self-Mutilation (FASM) for diagnosis of SMB as well as comorbidities. The most frequently SMB presented was skin cutting which was associated with relief of intolerable affects. Others comorbidities presented by her were Obsessive-Compulsive Disorder(OCD), Social phobia, Bulimia, and Depression Disorder(DD) with high levels of anxiety. The patient was submitted to an interdisciplinary treatment. Treatment included cognitive-behavior therapy(CBT), nutritional orientation, and psychopharmacology which begun with venlafaxine (150mg/d) followed by fluoxetine(80mg/day), and carbamazepine(400mg/day), without success. After ten months of treatment the patient was stabilized in terms of DD, bulimic behaviors, and anxiety. OCD symptoms were mild, and SMB became rare. At this time the patient was taking ziprazidone(160mg/day), sertraline(200mg/day), and topiramate(100mg/day). These medications were maintained as well as CBT, with emphasis in social skill, and problem-solving techniques. After three more months of treatment she had stopped cutting herself and the OCD symptoms disappeared.

Conclusion: the collection of treatment modalities implemented by multidisciplinary team may serve as a guide to treat severe SMB. In addition, the association of drugs with different site of action, but all for impulse control, may contribute for the efficacy observed here.

P0254

Intervention plans - design individual action plans for each child

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Children bearing the same characteristics because of a particular syndrome can be more or less similar, but their individual profiles determine program of intervention. A single, clearly defined treatment model for a reduction of symptoms that children exhibit does not exist.

The most effective intervention method is based on designing individual action plan for each child, and therefore, it is necessary to promptly establish a correct assessment. Instead of lumping all children with a ''same diagnosis'' into one category, a multidimensional view is needed of child's individual characteristics.

Attention should also be paid to aspects of child's emotional behavior, social functioning and family relationships.

Diagnostic techniques used should help determine individual specificities of strong and weak traits in each child. To achieve this goal, studying child's profile, processing of sensory information, and analyzing motorics, verbal and cognitive skills, as well as observing social interaction is needed. Information gathered helps us understand a child's functional abilities and design a therapeutical program for each one.

An adequate treatment program should be based on a child's abilities and should also be able to detect spots where the abilities are insufficient in order to develop a compensatory strategy for overcoming difficulties. The goal of these treatments is utilizing a child's potential to the fullest.

Keywords: childern, interventio, action plan

P0255

Attempted suicide in bereaved individuals: The experience of a consultation-liaison psychiatric unit

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Introduction: Bereaved individuals are at high risk for suicidal behavior, a fact well-known since antiquity as indicated by the Greek myth of Aegeas, who in his grief jumped into the sea in the mistaken belief that his son, Theseus, had been slain.

Methods: We report the experience of our recently established Consultation-Liaison Psychiatric Unit in the management of bereaved patients who attempted suicide.

Results: Between December 2006 and August 2007 we accepted 36 requests for consultation with patients who had attempted suicide. Five patients (13.8%) reported the loss through death of a beloved one 3 to 22 months prior to the attempt. The most common reasons for attempted suicide were hopelessness, loneliness and meaninglessness of life, which they attributed to the bereavement. All patients had suicidal ideation for weeks or months prior to the attempt and two patients had revealed it to a close person. Only one patient had been assessed by a psychiatrist. Patients as well as their relatives reported that they considered these feelings as part of the normal grief process, even if they were prolonged or overwhelming. Two patients denied any further psychiatric intervention, one dropped out after one month's follow-up and two patients display a good outcome after a period of more than 4 months' follow-up.

Conclusion: When assessing patients in the Consultation-Liaison context, consultants should bear in mind the impact of bereavement, especially in cultures where complicated grief is easily misconstrued as a normal process than as a condition which merits psychiatric evaluation and care.

P0256

Gender identity disorders at women with organic mental disorders

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Aims: revealing of pathogenetic mechanisms of gender dysphoria at women with organic mental disorders.

Object of research: 49 women with organic mental disorders (F06, F07 in ICD-10) and sexual development disorders (F52, F64, F65, F66 in ICD-10): the basic group with gender dysphoria (28 examinees), the group of comparison without gender dysphoria (21 examinees). Middle age in the basic group was 24,9 years, in group of comparison - 22,6 years.

Methods: sexological (including the scale of gender identity disorders developed by Vvedenskij G.E., Medinskij E.V., 2006), statistical (cluster and correlation analysis).

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Results: in the basic group physical's "I" disorder at the stage of sex self-consciousness (preference of external attributes of the opposite sex, negative perception of own corporal shape) have appeared are connected as among themselves, and with physical's "I" disorder on the following, sexual role stage (negative perception of the physiological displays one's anatomic sex) that has led to disorder at the stage of psychosexual orientations (choice of the opposite sex social and gender role). Infringements of development mental "I" on gender-role stage (preference of interests and hobbies more peculiar to the opposite sex in our culture and elements of musculan behaviour) have appeared are caused by infringements mental "I" at a stage of sexual consciousness (preference of game activity in the group of opposite sex) in the group of comparison.

Conclusions: pathogenesis of gender dysphoria at women with organic mental disorders connected with physical's "I" disorder at the stages of sex self-consciousness and sexual role.

P0257

My efforts and actions in making my treatment for mentall illness safer for me

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Patient safety of mentally ill can be endangered everywhere: in hospital, community, at home/family. There are lots of problems surrounding the mentally ill patient's safety during the treatment: Lower quality of medical services because of mental patients stigma& discrimination, Lack of compliance in therapeutic process which causes unsafe situations (refusal of medication, wrong medication or dose), Medical mistakes in treatment related to the fact that mental patients physical illness is often disregarded and neglected, Low awareness about side effects of psychiatric medication, Patients with severe/chronic mental illness can be easily misused or manipulated.

The authors are showing the story of a mentally ill patient and problems with patient safety in his medical treatment, around the issues of Patients engagement, Openness/ Honesty/Disclosure, Partnerships, Networking with various organizations and especially with the NGOs for human rights of mentally ill and at the end the action of the World Alliance for Patient Safety Workstands.

Authors are describing several activities conducted: Raising awareness about patient safety in mental field, Partnership of all key players (experts, professionals, families, patients), Education of patient advocates and patient for patient safety champions, Dissemination of good practice and solutions to prevent medical errors and improve patients safety, Learning from experience of mental patients (patient is an expert of his own experience, he is in a center of health care system and should be seen as a compass, conscience, teacher, catalyst and witness), Changing of European mental health policy to cover care of both physical and mental health.

P0258

Examining parental agreement and compliance with recommendations made by a mental health telephone triage service

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Objective: To date, the Calgary Health Region Child and Adolescent Mental Health Program (CAMHP) has triaged 23,883 referrals of which 14,034 have been enrolled and 9,849 have been referred at the time of triage to usually non-affiliated community-based programs or to the primary care referral source with recommendations. This paper reports on the results of a survey of those not accepted directly to CAMHP services in order to examine whether or not the recommendations made to the families seeking services were perceived as being appropriate.

Design and Methods: A survey was developed and a list of those who had been declined service and given recommendations to seek service in the community was generated and these were contacted based on random selection.

Results: Highlights include that a rating of 3.5/10 with respect to being satisfied with the service received on a scale of 1-10, with one being the best and ten being the worst. Additionally, when asked if AMH matched an appropriate mental health service to meet their child's needs, respondents replied Yes (56/69), No (11/69), Don't Remember (1/69), or Did not utilize the service (1/69).

Conclusions: The vast majority of clients surveyed were satisfied and felt that the recommendations made by AMH were appropriate. Implications for Practice or Policy AMH services appear to be appropriately aware of and linked with community serves to the extent that clients report a high level of contextual endorsement of the recommendations that are made.

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P0259

The place of the Western Canada waitlist project in regional child and adolescent mental health program services

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The Place of the Western Canada Waitlist Project in Regional Child and Adolescent Mental Health Program Services.

In this presentation is described the history of the Western Canada Waitlist Project (WCWL) and its implementation within the Child and Adolescent Mental Health Program. Highlighted is how the Western Canada Waitlist Project fits into regional clinical and accountability processes. Our results confirm that the Western Canada Waitlist Project Children's Mental Health component is a useful, economic instrument. For example, 11,067 Children's Mental Health Priority Criteria Score (CMH-PCS) forms have been completed since the beginning of the project in 2002. Not only have the WCWL data been used clinically to place clients within the continuum of care and develop priority and safety flags, the WCWL data have also been used to predict and model clinical outcomes. The current paper highlights the degree to which the WCWL-CMH-PCS, gathered at the time of screening and triage, prior to admission, predicts clinical outcomes at the time of discharge. Described is the way in which we plan to use this information to flag on admission, for the purpose of additional intervention, children who are at risk of poor clinical outcomes.

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