I disturbi psichici del bambino e dell'adolescente:

dai pregiudizi alle evidenze scientifiche

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Breve Overview

1. **I disturbi psichiatrici in adolescenza**

2. **UOC Neuropsichiatria Infantile Bambino Gesù: protocolli di valutazione**

3. **Modelli d' intervento**

1. I disturbi psichiatrici in adolescenza

- Secondo **l'Organizzazione mondiale della Sanità**, il **7-10%** di tutti i bambini e adolescenti è esposto al rischio di una malattia psichiatrica

- Il **75%** dei disturbi mentali si manifesta in maniera sintomatologicamente evidente entro i **25 anni** (Patel, Fisher et al., 2007)

- Il **picco d'incidenza** delle patologie psichiatriche si ha tra i **12** ed i **35** anni (Patel, Fisher et al., 2007)

Figure 4 | **Ranges of onset age for common psychiatric disorders.** Recent data from the N

"Roughly half of all lifetime mental disorders in most studies start by the mid-teens and three quarters by the mid-20s. Later onsets are mostly secondary conditions. Severe disorders are typically preceded by less severe disorders that are seldom brought to clinical attention"

Kessler et al, Current Opinion Psychiatry, 2007

The Lancet; Apr 14-Apr 20, 2007; 369, 9569; ProQuest Psychology Journals
pg. 1302

Mental health of young people: a global public-health challenge

Vikram Patel, Alan J Flisher, Sarah Hetrick, Patrick McGorry

Mental disorders account for a large proportion of the disease burden in young people in all societies. Most mental disorders begin during youth (12–24 years of age), although they are often first detected later in life. Poor mental health is strongly related to other health and development concerns in young people, notably lower educational achievements, substance abuse, violence, and poor reproductive and sexual health. The effectiveness of some interventions for some mental disorders in this age-group have been established, although more research is urgently needed to improve the range of affordable and feasible interventions, since most mental-health needs in young people are unmet, even in high-income countries. Key challenges to addressing mental-health needs include the shortage of mental-health professionals, the fairly low capacity and motivation of non-specialist health workers to provide quality mental-health services to young people, and the stigma associated with mental disorder. We propose a population-based, youth focused model, explicitly integrating mental health with other youth health and welfare expertise. Addressing young people's mental-health needs is crucial if they are to fulfil their potential and contribute fully to the development of their communities.

Il 50% delle malattie mentali gravi degli adulti ha origine a partire dai 14 anni di età.

Health-system responses

Treatments for mental disorders in young people have improved substantially during the past two decades with safer and more effective drugs, more practical forms of psychosocial interventions, and reforms in service-delivery models. Several meta-analyses[96–98] have shown support for individual, group, and family psychotherapies, particularly those with a behavioural or cognitive-behavioural orientation, for a range of mental health and behavioural disorders. In terms of evidence for specific interventions for specific disorders, some encouraging developments have taken place in early intervention in psychotic disorders in young people, in terms of early detection, phase-specific treatment, and health-services reform.[99–104]

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	Risk factors	Protective factors
Biological		
	Exposure to toxins (eg, tobacco, alcohol) in pregnancy Genetic tendency to psychiatric disorder Head trauma Hypoxia at birth and other birth complications HIV infection Malnutrition Substance abuse Other illnesses	Age-appropriate physical development Good physical health Good intellectual functioning
Psychological		
	Learning disorders Maladaptive personality traits Sexual, physical, emotional abuse and neglect Difficult temperament	Ability to learn from experiences Good self-esteem High level of problem-solving ability Social skills
Social		
Family	Inconsistent care-giving Family conflict Poor family discipline Poor family management Death of a family member	Family attachment Opportunities for positive involvement in family Rewards for involvement in family
School	Academic failure Failure of schools to provide appropriate environment to support attendance and learning Inadequate or inappropriate provision of education Bullying	Opportunities for involvement in school life Positive reinforcement from academic achievement Identity with school or need for educational attainment
Community	Transitions (eg, urbanisation) Community disorganisation Discrimination and marginalisation Exposure to violence	Connectedness to community Opportunities for leisure Positive cultural experiences Positive role models Rewards for community involvement Connection with community organisations

Table 2: Selected risk and protective factors for mental health of children and adolescents, by domain[38]

Lifetime Prevalence and Age-of-Onset Distributions of *DSM-IV* Disorders in the National Comorbidity Survey Replication

Ronald C. Kessler, PhD; Patricia Berglund, MBA; Olga Demler, MA, MS; Robert Jin, MA; Kathleen R. Merikangas, PhD; Ellen E. Walters, MS

Context: Little is known about lifetime prevalence or age of onset of *DSM-IV* disorders.

Objective: To estimate lifetime prevalence and age-of-onset distributions of *DSM-IV* disorders in the recently completed National Comorbidity Survey Replication.

Design and Setting: Nationally representative face-to-face household survey conducted between February 2001 and April 2003 using the fully structured World Health Organization World Mental Health Survey version of the Composite International Diagnostic Interview.

Participants: Nine thousand two hundred eighty-two English-speaking respondents aged 18 years and older.

Main Outcome Measures: Lifetime *DSM-IV* anxiety, mood, impulse-control, and substance use disorders.

Results: Lifetime prevalence estimates are as follows: anxiety disorders, 28.8%; mood disorders, 20.8%; impulse-control disorders, 24.8%; substance use disorders, 14.6%; any disorder, 46.4%. Median age of onset is much earlier for anxiety (11 years) and impulse-control (11 years) disorders than for substance use (20 years) and mood (30 years) disorders. Half of all lifetime cases start by age 14 years and three fourths by age 24 years. Later onsets are mostly of comorbid conditions, with estimated lifetime risk of any disorder at age 75 years (50.8%) only slightly higher than observed lifetime prevalence (46.4%). Lifetime prevalence estimates are higher in recent cohorts than in earlier cohorts and have fairly stable intercohort differences across the life course that vary in substantively plausible ways among sociodemographic subgroups.

Conclusions: About half of Americans will meet the criteria for a *DSM-IV* disorder sometime in their life, with first onset usually in childhood or adolescence. Interventions aimed at prevention or early treatment need to focus on youth.

Arch Gen Psychiatry. 2005;62:593-602

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Table 3. Ages at Selected Percentiles on the Standardized Age-of-Onset Distributions of *DSM-IV*/WMH-CIDI Disorders, With Projected Lifetime Risk at Age 75 Years

	Projected Lifetime Risk at Age 75 y, % (SE)	Age at Selected Age-of-Onset Percentiles, y							
		5	10	25	50	75	90	95	99
Anxiety Disorders									
Panic disorder	6.0 (0.3)	6	10	16	24	40	51	56	63
Agoraphobia without panic	1.6 (0.2)	6	7	13	20	33	48	51	54
Specific phobia	13.2 (0.4)	4	5	5	7	12	23	41	64
Social phobia	12.6 (0.4)	5	6	8	13	15	23	34	52
Generalized anxiety disorder	8.3 (0.4)	8	13	20	31	47	58	66	75
Posttraumatic stress disorder*	8.7 (0.6)	6	9	15	23	39	53	61	71
Obsessive-compulsive disorder†	1.9 (0.3)	10	11	14	19	30	48	54	54
Separation anxiety disorder‡	5.2 (0.4)	5	5	6	7	10	13	14	17
Any anxiety disorder§	31.5 (1.1)	5	5	6	11	21	41	51	65
Mood Disorders									
Major depressive disorder	23.2 (0.6)	12	14	19	32	44	56	64	73
Dysthymia	3.4 (0.3)	7	11	17	31	43	51	57	73
Bipolar I-II disorders	5.1 (0.3)	11	13	17	25	42	50	57	65
Any mood disorder	28.0 (0.8)	11	13	18	30	43	54	63	73
Impulse-Control Disorders									
Oppositional-defiant disorder‡	8.5 (0.7)	5	6	8	13	14	16	17	18
Conduct disorder‡	9.5 (0.8)	6	7	10	13	15	17	17	18
Attention-deficit/hyperactivity disorder‡	8.1 (0.6)	5	6	7	7	8	11	11	16
Intermittent explosive disorder	5.4 (0.3)	6	8	11	15	20	26	37	46
Any impulse-control disorder‡	25.4 (1.1)	5	6	7	11	15	18	23	36
Substance Use Disorders									
Alcohol abuse*	15.1 (0.7)	15	16	18	21	29	39	44	54
Alcohol dependence*	6.5 (0.4)	16	17	19	23	31	41	50	56
Drug abuse*	8.5 (0.4)	15	16	17	19	23	29	36	46
Drug dependence*	3.4 (0.3)	15	16	18	21	28	36	41	49
Any substance use disorder§	16.3 (0.6)	15	16	18	20	27	37	41	54
Any Disorder									
Any disorder§	50.8 (1.2)	5	5	7	14	24	42	51	64

Abbreviation: WMH-CIDI, World Mental Health Survey version of the Composite International Diagnostic Interview.

Lancet 2011; 377: 2093–102

Global burden of disease in young people aged 10–24 years: a systematic analysis

Fiona M Gore, Paul J N Bloem, George C Patton, Jane Ferguson, Véronique Joseph, Carolyn Coffey, Susan M Sawyer, Colin D Mathers

Summary

Background Young people aged 10–24 years represent 27% of the world's population. Although important health problems and risk factors for disease in later life emerge in these years, the contribution to the global burden of disease is unknown. We describe the global burden of disease arising in young people and the contribution of risk factors to that burden.

Methods We used data from WHO's 2004 Global Burden of Disease study. Cause-specific disability-adjusted life-years (DALYs) for young people aged 10–24 years were estimated by WHO region on the basis of available data for incidence, prevalence, severity, and mortality. WHO member states were classified into low-income, middle-income, and high-income countries, and into WHO regions. We estimated DALYs attributable to specific global health risk factors using the comparative risk assessment method. DALYs were divided into years of life lost because of premature mortality (YLLs) and years lost because of disability (YLDs), and are presented for regions by sex and by 5-year age groups.

Findings The total number of incident DALYs in those aged 10–24 years was about 236 million, representing 15·5% of total DALYs for all age groups. Africa had the highest rate of DALYs for this age group, which was 2·5 times greater than in high-income countries (208 *vs* 82 DALYs per 1000 population). Across regions, DALY rates were 12% higher in girls than in boys between 15 and 19 years (137 *vs* 153). Worldwide, the three main causes of YLDs for 10–24-year-olds were neuropsychiatric disorders (45%), unintentional injuries (12%), and infectious and parasitic diseases (10%). The main risk factors for incident DALYs in 10–24-year-olds were alcohol (7% of DALYs), unsafe sex (4%), iron deficiency (3%), lack of contraception (2%), and illicit drug use (2%).

Interpretation The health of young people has been largely neglected in global public health because this age group is perceived as healthy. However, opportunities for prevention of disease and injury in this age group are not fully exploited. The findings from this study suggest that adolescent health would benefit from increased public health attention.

Lancet 2011; 377: 2093–102

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	Males		Females		Total	
	Cause	Total DALYs (100 000s) (%)	Cause	Total DALYs (100 000s) (%)	Cause	Total DALYs (100 000s) (%)
10–24 years						
1	Road traffic accidents	93 (7·8%)	Unipolar depressive disorders	115 (9·8%)	Unipolar depressive disorders	193 (8·2%)
2	Unipolar depressive disorders	78 (6·6%)	Schizophrenia	46 (4·0%)	Road traffic accidents	127 (5·4%)
3	Violence	69 (5·8%)	Bipolar disorder	44 (3·7%)	Schizophrenia	96 (4·1%)
4	Alcohol use	62 (5·3%)	Abortion	43 (3·7%)	Bipolar disorder	88 (3·8%)
5	Schizophrenia	50 (4·2%)	HIV/AIDS	38 (3·2%)	Violence	81 (3·5%)
6	Bipolar disorder	45 (3·8%)	Road traffic accidents	34 (2·9%)	Alcohol use	71 (3·0%)
7	Self-inflicted injuries	35 (3·0%)	Self-inflicted injuries	32 (2·7%)	HIV/AIDS	70 (3·0%)
8	HIV/AIDS	32 (2·7%)	Maternal sepsis	32 (2·7%)	Self-inflicted injuries	67 (2·8%)
9	Tuberculosis	32 (2·7%)	Lower respiratory infections	30 (2·6%)	Tuberculosis	60 (2·6%)
10	Asthma	32 (2·7%)	Panic disorder	30 (2·6%)	Lower respiratory infections	60 (2·6%)

10–14 years						
1	Road traffic accidents	15 (6·0%)	Lower respiratory infections	15 (6·3%)	Unipolar depressive disorders	28 (5·7%)
2	Unipolar depressive disorders	14 (5·4%)	Unipolar depressive disorders	14 (6·1%)	Lower respiratory infections	28 (5·6%)
3	Lower respiratory infections	13 (4·9%)	Asthma	12 (5·1%)	Road traffic accidents	26 (5·2%)
4	Asthma	10 (4·1%)	Migraine	11 (4·8%)	Asthma	23 (4·6%)
5	Drownings	10 (3·8%)	Road traffic accidents	10 (4·2%)	Refractive errors	19 (3·8%)
6	Refractive errors	10 (3·7%)	Refractive errors	9 (3·8%)	Iron-deficiency anaemia	17 (3·4%)
7	Falls	9 (3·4%)	Iron-deficiency anaemia	8 (3·5%)	Falls	16 (3·2%)
8	Iron-deficiency anaemia	9 (3·4%)	Falls	7 (2·9%)	Migraine	16 (3·2%)
9	Schizophrenia	6 (2·5%)	Diarrhoeal diseases	6 (2·7%)	Drownings	14 (2·9%)
10	Lymphatic filariasis	6 (2·5%)	Fires	6 (2·5%)	Diarrhoeal diseases	12 (2·4%)
15–19 years						
1	Unipolar depressive disorders	34 (8·0%)	Unipolar depressive disorders	53 (11·7%)	Unipolar depressive disorders	86 (9·9%)
2	Road traffic accidents	33 (7·8%)	Schizophrenia	23 (5·2%)	Schizophrenia	46 (5·3%)
3	Alcohol use	30 (7·2%)	Bipolar disorder	22 (4·9%)	Road traffic accidents	46 (5·3%)
4	Schizophrenia	23 (5·4%)	Abortion	17 (3·8%)	Bipolar disorder	44 (5·1%)
5	Bipolar disorder	23 (5·3%)	Panic disorder	16 (3·5%)	Alcohol use	34 (4·0%)
6	Violence	21 (5·1%)	Maternal sepsis	14 (3·1%)	Violence	26 (3·0%)
7	Drug misuse	11 (2·7%)	Self-inflicted injuries	13 (3·0%)	Self-inflicted injuries	24 (2·8%)
8	Asthma	11 (2·6%)	Road traffic accidents	13 (2·9%)	Panic disorder	23 (2·7%)
9	Self-inflicted injuries	11 (2·6%)	Chlamydia	10 (2·3%)	Asthma	18 (2·0%)
10	Drownings	10 (2·5%)	Iron-deficiency anaemia	9 (2·1%)	HIV/AIDS	17 (2·0%)
20–24 years						
1	Road traffic accidents	44 (8·7%)	Unipolar depressive disorders	48 (9·9%)	Unipolar depressive disorders	79 (7·9%)
2	Violence	41 (8·1%)	HIV/AIDS	24 (5·0%)	Road traffic accidents	56 (5·6%)
3	Unipolar depressive	31 (6·0%)	Abortion	24 (4·9%)	Violence	47 (4·7%)
4	Alcohol use	28 (5·6%)	Schizophrenia	21 (4·4%)	HIV/AIDS	44 (4·4%)
5	Self-inflicted injuries	21 (4·0%)	Bipolar disorder	20 (4·1%)	Schizophrenia	42 (4·2%)
6	Schizophrenia	21 (4·0%)	Maternal sepsis	18 (3·7%)	Bipolar disorder	40 (4·1%)
7	Bipolar disorder	20 (4·0%)	Tuberculosis	15 (3·2%)	Tuberculosis	35 (3·5%)
8	HIV/AIDS	20 (3·9%)	Self-inflicted injuries	14 (2·9%)	Self-inflicted injuries	35 (3·5%)
9	Tuberculosis	20 (3·9%)	Panic disorder	14 (2·9%)	Alcohol use	32 (3·2%)
10	War	14 (2·7%)	Road traffic accidents	11 (2·3%)	Abortion	24 (2·4%)

The prognosis of common mental disorders in adolescents: a 14-year prospective cohort study

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George C Patton, Carolyn Coffey, Helena Romaniuk, Andrew Mackinnon, John B Carlin, Louisa Degenhardt, Craig A Olsson, Paul Moran

Summary

Background Most adults with common mental disorders report their first symptoms before 24 years of age. Although adolescent anxiety and depression are frequent, little clarity exists about which syndromes persist into adulthood or resolve before then. In this report, we aim to describe the patterns and predictors of persistence into adulthood.

Methods We recruited a stratified, random sample of 1943 adolescents from 44 secondary schools across the state of Victoria, Australia. Between August, 1992, and January, 2008, we assessed common mental disorder at five points in adolescence and three in young adulthood, commencing at a mean age of 15·5 years and ending at a mean age of 29·1 years. Adolescent disorders were defined on the Revised Clinical Interview Schedule (CIS-R) at five adolescent measurement points, with a primary cutoff score of 12 or higher representing a level at which a family doctor would be concerned. Secondary analyses addressed more severe disorders at a cutoff of 18 or higher.

Findings 236 of 821 (29%; 95% CI 25–32) male participants and 498 of 929 (54%; 51–57) female participants reported high symptoms on the CIS-R (≥12) at least once during adolescence. Almost 60% (434/734) went on to report a further episode as a young adult. However, for adolescents with one episode of less than 6 months duration, just over half had no further common mental health disorder as a young adult. Longer duration of mental health disorders in adolescence was the strongest predictor of clear-cut young adult disorder (odds ratio [OR] for persistent young adult disorder *vs* none 3·16, 95% CI 1·86–5·37). Girls (2·12, 1·29–3·48) and adolescents with a background of parental separation or divorce (1·62, 1·03–2·53) also had a greater likelihood of having ongoing disorder into young adulthood than did those without such a background. Rates of adolescent onset disorder dropped sharply by the late 20s (0·57, 0·45–0·73), suggesting a further resolution for many patients whose symptoms had persisted into the early 20s.

Interpretation Episodes of adolescent mental disorder often precede mental disorders in young adults. However, many such disorders, especially when brief in duration, are limited to the teenage years, with further symptom remission common in the late 20s. The resolution of many adolescent disorders gives reason for optimism that interventions that shorten the duration of episodes could prevent much morbidity later in life.

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Adolescenti	
Campione totale:	1943
Età (intervallo)	14.9 - 17.4
Prevalenza disturbi ansioso-depressivi	**41,5%**

Il 60% riceve una diagnosi di disturbo psichiatrico nella fascia d'età 21-29 (giovani adulti)

Original Investigation

National Trends in the Mental Health Care of Children, Adolescents, and Adults by Office-Based Physicians

JAMA Psychiatry. 2014;71(1):81-90. doi:10.1001/jamapsychiatry.2013.3074
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Mark Olfson, MD, MPH; Carlos Blanco, MD, PhD; Shuai Wang, PhD; Gonzalo Laje, MD, MHSc; Christoph U. Correll, MD

OBJECTIVE To assess national trends and patterns in the mental health care of children, adolescents, and adults in office-based medical practice.

DESIGN, SETTING, AND PARTICIPANTS Outpatient visits to physicians in office-based practice from the 1995-2010 National Ambulatory Medical Care Surveys (N = 446 542). Trends (1995-2010) in visits with mental health care indicators are first compared between youths (<21 years) and adults (≥21 years) and then between children (0-13 years) and adolescents (14-20 years). Background and clinical characteristics of recent visits (2007-2010) resulting in a mental disorder diagnosis are also compared among children, adolescents, and adults.

MAIN OUTCOMES AND MEASURES Visits resulting in mental disorder diagnoses, prescription of psychotropic medications, provision of psychotherapy, or psychiatrist care.

RESULTS Between 1995-1998 and 2007-2010, visits resulting in mental disorder diagnoses per 100 population increased significantly faster for youths (from 7.78 to 15.30 visits) than for adults (from 23.23 to 28.48 visits) (interaction: $P < .001$). Psychiatrist visits also increased significantly faster for youths (from 2.86 to 5.71 visits) than for adults (from 10.22 to 10.87 visits) (interaction: $P < .001$). Psychotropic medication visits increased at comparable rates for youths (from 8.35 to 17.12 visits) and adults (from 30.76 to 65.90 visits) (interaction: $P = .13$). While psychotherapy visits increased from 2.25 to 3.17 per 100 population for youths, they decreased from 8.37 to 6.36 for adults (interaction: $P < .001$). In 2007-2010, 27.4% of child visits, 47.9% of adolescent visits, and 36.6% of adult visits resulting in a mental disorder diagnosis were to a psychiatrist.

CONCLUSIONS AND RELEVANCE Compared with adult mental health care, the mental health care of young people has increased more rapidly and has coincided with increased psychotropic medication use. A great majority of mental health care in office-based medical practice to children, adolescents, and adults is provided by nonpsychiatrist physicians calling for increased consultation and communication between specialties.

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Table 1. Trends in Office-Based Visits Resulting in Mental Disorder Diagnoses, Psychotropic Medications, Psychotherapy, and Psychiatric Care for Young People and Adults in the United States, 1995-2010[a]

Characteristic	No. of Visits per 100 Population (95% CI)				OR (95% CI)	*P* Value for Interaction
	1995-1998	1999-2002	2003-2006	2007-2010		
Any mental disorder diagnosis						
Youths	7.78 (6.51-9.06)	12.38 (10.05-14.72)	15.37 (12.50-18.24)	15.30 (12.09-18.51)	1.90 (1.55-2.33)	<.001
Adults	23.23 (20.62-25.84)	24.61 (21.10-28.12)	27.27 (23.13-31.40)	28.48 (23.95-33.01)	1.07 (0.94-1.21)	
Any psychotropic medication						
Youths	8.35 (7.11-9.58)	11.96 (9.75-14.17)	14.49 (11.80-17.18)	17.12 (13.59-20.66)	2.08 (1.70-2.54)	.13
Adults	30.76 (27.24-34.28)	38.07 (32.42-43.72)	49.29 (41.30-57.28)	65.90 (54.57-77.22)	2.45 (2.21-2.72)	
Psychotherapy						
Youths	2.25 (1.65-2.84)	3.47 (2.43-4.51)	4.21 (3.10-5.33)	3.17 (2.23-4.12)	1.24 (0.87-1.77)	<.001
Adults	8.37 (7.25-9.48)	7.95 (6.57-9.32)	7.71 (6.51-8.90)	6.36 (5.15-7.57)	0.57 (0.44-0.75)	
Visit to psychiatrist						
Youths	2.86 (2.11-3.60)	5.69 (4.14-7.23)	6.53 (4.92-8.14)	5.71 (4.01-7.41)	1.70 (1.19-2.43)	<.001
Adults	10.22 (8.59-11.85)	10.20 (8.60-11.81)	10.88 (9.04-12.72)	10.87 (8.95-12.78)	0.85 (0.66-1.09)	

Abbreviation: OR, odds ratio.

[a] Data are from the National Ambulatory Medical Care Survey. Youth are younger than 21 years of age, and adults are 21 years of age or older.

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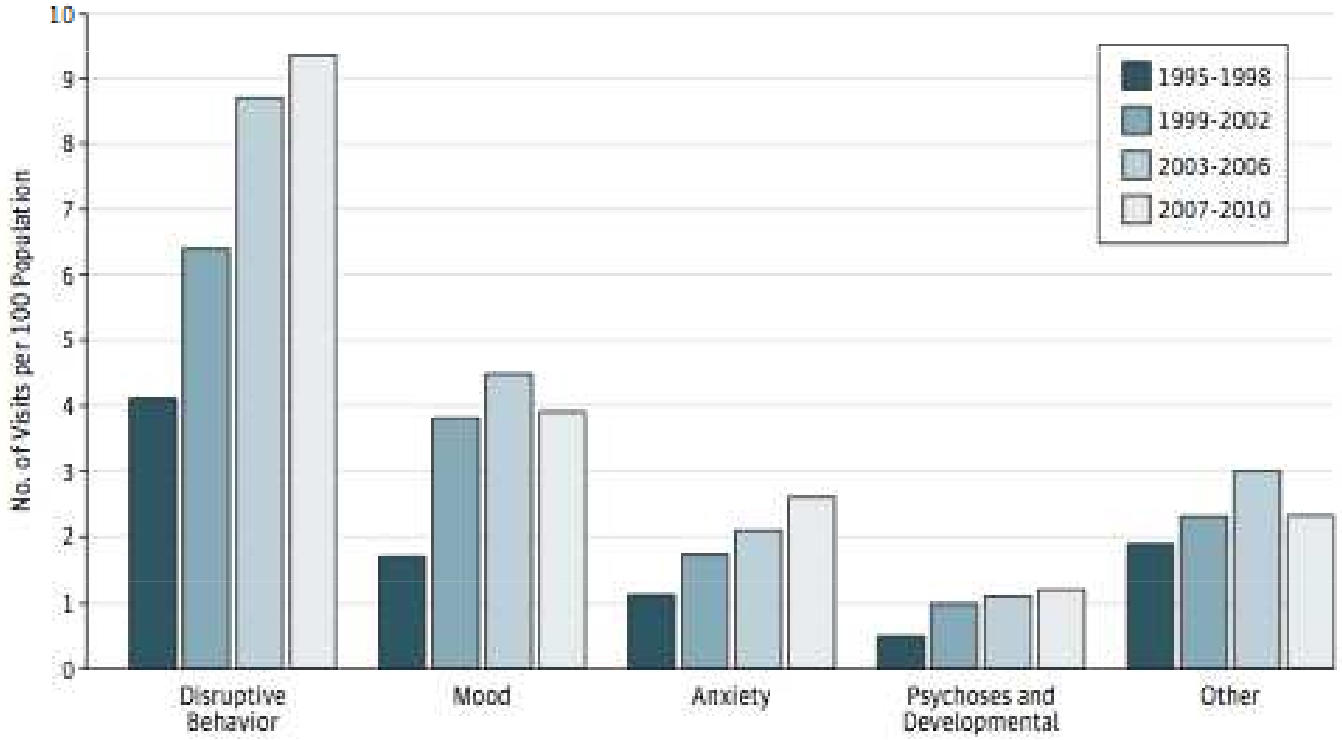
Figure 1. Trends in Office-Based Medical Visits by Young People With Mental Disorder Diagnoses, 1995-2010



Analysis was limited to young people (≤20 years). The odds ratios (ORs) and 95% CIs for the study period are for disruptive behavior disorders (OR 2.31 [95% CI, 1.78-2.99]), mood disorders (OR, 1.92 [95% CI, 1.40-2.64]), anxiety disorders (OR, 2.72 [95% CI, 1.71-4.32]), psychoses and developmental disorders (OR, 2.27 [95% CI, 1.44-3.59]), and other mental disorders (OR, 1.17 [95% CI, 0.87-1.57]). Data are from the National Ambulatory Medical Care Survey.

Table 2. Demographic and Clinical Characteristics of Children, Adolescents, and Adults Who Made Office-Based Physician Visits Resulting in a Mental Disorder Diagnosis, 2007-2010[a]

Characteristic	% of Visits Resulting in Mental Disorder Diagnosis			χ^2 Statistic	*P* Value	Group Differences
	1. Children (n = 1166)	2. Adolescents (n = 892)	3. Adults (n = 9264)			
Sex						
Male	69.02	55.93	37.62	27.81	<.001	1 > 2 > 3
Female	30.98	44.07	62.38			1 < 2 < 3
Race/ethnicity						
Non-Hispanic white[b]	71.77	82.13	84.53	5.66	<.002	1 < 2, 1 < 3
Non-Hispanic black	12.86	9.10	7.83			1 > 3
Hispanic	15.36	8.77	7.63			1 > 2, 1 > 3
Primary source of payment						
Private insurance	50.78	57.34	56.91	16.00	<.001	1 < 2, 1 < 3
Medicare	1.36	1.81	16.33			1 < 3, 2 < 3
Medicaid	37.30	23.12	10.29			1 > 2 > 3
Self-pay/other	10.55	17.73	16.47			1 < 2, 1 < 3
Mental disorders						
Disruptive behavior disorders	72.42	44.76	6.40	36.49	<.001	1 > 2 > 3
Mood disorders	11.68	44.68	53.63	40.51	<.001	1 < 2 < 3
Depression	5.85	29.46	42.37	37.96	<.001	1 < 2 < 3
Bipolar disorder	2.44	9.53	10.07	29.78	<.001	1 < 2, 1 < 3
Anxiety disorders	11.56	23.95	29.79	24.66	<.001	1 < 2 < 3
Psychoses/developmental disorders	8.80	6.36	11.22	7.02	<.001	2 < 3
Other mental disorders	16.12	14.22	18.66	2.95	.052	2 < 3
Comorbid mental disorders	19.18	30.46	17.75	11.06	<.001	1 < 2, 3 < 2
Psychotropic medications						
Any	64.52	71.43	71.21	4.29	.01	1 < 2, 1 < 3
ADHD medications[c]	55.76	36.70	7.69	30.40	<.001	1 > 2 > 3
Antipsychotics	11.06	18.30	15.04	6.32	.002	1 < 2, 1 < 3
Antidepressants	10.26	32.30	46.43	40.92	<.001	1 < 2 < 3
Anxiolytics	2.21	8.95	34.09	43.40	<.001	1 < 2 < 3
Mood stabilizers	4.29	9.85	8.24	10.83	<.001	1 < 2, 1 < 3
Medical specialty						
Psychiatrist	27.42	47.89	36.26	13.47	<.001	1 < 3 < 2
Adult psychiatry	23.84	43.74	35.39	15.12	<.001	1 < 3 < 2
Child psychiatry	3.58	4.14	0.87	2.05	.13	1 > 3, 2 > 3
Nonpsychiatrist physicians	72.58	52.11	63.74	13.47	<.001	2 < 3 < 1
Pediatrics	53.28	23.22	0.51	41.65	<.001	1 > 2 > 3
Family medicine/general practice	14.41	23.11	32.16	17.60	<.001	1 < 2 < 3
Internal medicine	0.54	2.09	19.50	33.13	<.001	1 < 3, 2 < 3
Other specialties	4.35	3.69	11.56	15.31	<.001	1 < 3, 2 < 3
Psychotherapy	14.28	26.92	20.89	10.91	<.001	1 < 3 < 2
Duration of visit, mean (SE), min	24.82 (0.76)	26.71 (0.95)	24.75 (0.45)	2.80[d]	.07	1 < 2, 3 < 2

Abbreviation: ADHD, attention-deficit/hyperactivity disorder.

[a] Data are from the National Ambulatory Medical Care Survey. Children range in age from 0 to 13 years, and adolescents range in age from 14 to 20 years.

[b] Includes whites, native Hawaiians or other Pacific Islanders, American Indians, and Alaskan natives.

[c] Include stimulants, atomoxetine hydrochloride, guanfacine hydrochloride, and clonidine hydrochloride.

[d] *F* statistic.

Prevalence and correlates of mental disorders among adolescents in Italy: the PrISMA study

Eur Child Adolesc Psychiatry (2009)
18:217–226 DOI 10.1007/s00787-008-0720-x

Frigerio A. et al.

Abstract *Background* While in the last 5 years several studies have been conducted in Italy on the prevalence of mental disorders in adults, to date no epidemiological study has been targeted on mental disorders in adolescents. *Method* A two-phase study was conducted on 3,418 participants using the child behavior checklist/6–18 (CBCL) and the development and well-being assessment (DAWBA), a structured interview with verbatim reports reviewed by clinicians. *Results* The prevalence of CBCL caseness and DSM-IV disorders was 9.8% (CI 8.8–10.8%) and 8.2% (CI 4.2–12.3%), respectively. DSM-IV Emotional disorders were more frequently observed (6.5% CI 2.2–10.8%) than externalizing disorders (1.2% CI 0.2–2.3%). In girls, prevalence estimates increased significantly with age; furthermore, living with a single parent, low level of maternal education, and low family income were associated with a higher likelihood of suffering from emotional or behavioral problems. *Conclusions* Approximately one in ten adolescents has psychological problems. Teachers and clinicians should focus on boys and girls living with a single parent and/or in disadvantaged socio-economic conditions.

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ORIGINAL CONTRIBUTION

Prevalence and correlates of mental disorders among adolescents in Italy: the PrISMA study

Table 1 Prevalence of behavioral problems and mental disorders by individual and family characteristics

	Phase 1 *N* (%)	CBCL caseness (unweighted data %)	OR (95% CI)	Phase 2 *N* (%)	ANY DSM-IV diagnosis (weighted data)	OR (95% CI)	Emotional disorders (weighted data)	Externalizing disorders (weighted data)
Total	3,418	9.8 (8.8–10.8)		631	8.2 (4.2–12.3)		6.5 (2.2–10.8)	1.2 (0.2–2.3)
Individual characteristics								
Gender								
Boys	1,695 (49.6)	10 (8.6–11.6)	1.05 (0.83–1.31)	290 (46.0)	8.1 (4.2–12.1)	1	5.9 (2.7–9.1)	1.4 (0–3.3)
Girls	1,723 (50.4)	9.6 (8.3–11.1)	1	341 (54.0)	8.3 (3.7–13)	1.01 (0.71–1.44)	7.1 (1.6–12.6)	1.1 (0–2.6)
Age								
10–11 years	1,048 (30.7)	6.5 (5.1–8.1)	1	180 (28.6)	2.4 (0–6.2)	1	1.8 (0–5.2)	0.3 (0–0.7)
12 years	1,186 (34.7)	11.1 (9.4–13)	**1.80 (1.33–2.45)**	209 (33.1)	8.4 (0–18.1)	3.64 (0.73–18.05)	7.3 (0–15.6)	1.3 (0–3.5)
13 years	1,026 (30)	11.2 (9.3–13.3)	**1.82 (1.33–2.49)**	203 (32.2)	13.0 (9.5–16.5)	**6.05 (1.57–23.22)**	10.9 (7.0–14.8)	0.8 (0–2.2)
14 years	158 (4.6)	13.3 (8.4–19.6)	**2.21 (1.31–3.72)**	39 (6.2)	16.5 (8.1–24.8)	**7.95 (2.33–27.09)**	5.8 (0–17.2)	10.7 (6.4–14.9)
Type of school								
Private	913 (26.7)	10.6 (8.7–12.8)	1.13 (0.88–1.45)	168 (26.6)	5.5 (0–10.4)	1.79 (0.65–4.96)	3.8 (1.1–6.5)	1.5 (0–4.0)
Public	2,505 (73.3)	9.5 (8.4–10.7)	1	463 (73.4)	9.4 (4.4–14.4)	1	7.6 (1.3–14.0)	1.1 (0.2–20.8)
Repeated classes								
No	3,275 (95.9)	9.3 (8.3–10.3)	1	587 (93.0)	7.7 (3.0–12.4)	1	6.1 (0.9–11.3)	1.1 (0.2–20.8)
Yes	141 (4.1)	22.7 (16.1–30.5)	**2.87 (1.90–4.33)**	44 (7.0)	20 (11.5–28.4)	**2.99 (1.01–8.87)**	15.3 (4.9–26.6)	3.7 (0–10.0)
Family characteristics								
Two parents	2,855 (84.1)	8.7 (7.6–9.7)	1	504 (80.1)	7.4 (3.7–11.1)	1	6.3 (3–9.5)	1.1 (0.2–20.1)
Single parent	538 (15.9)	16.4 (13.3–19.7)	**2.06 (1.59–2.69)**	125 (19.9)	13.6 (7.1–20.2)	**1.97 (1.32–2.93)**	8.4 (0–21.0)	2.1 (0–5.0)
Biological parents								
No	162 (4.8)	13.6 (8.7–19.8)	1.46 (0.92–2.33)	28 (4.4)	25.5 (0–87.5)	4.11 (0.18–92.21)	21.4 (0–78.6)	1.4 (0–5.2)
Yes	3,232 (95.2)	9.7 (9.7–10.7)	1	602 (95.6)	7.7 (4.7–10.7)	1	6.0 (2.9–9.2)	1.2 (0.3–2.2)
Mother education								
<10 years	1,112 (32.7)	13.8 (11.8–15.9)	**1.84 (1.47–2.32)**	228 (36.2)	13.2 (0–26.8)	2.50 (0.49–12.76)	9.4 (0–25.2)	2.6 (0.5–4.5)
10 years or above	2,286 (67.3)	8 (6.9–9.1)	1	402 (63.8)	5.7 (1.6–9.9)		5.1 (1.4–8.7)	0.6 (0–1.3)
Father education								
<10 years	1,161 (34.2)	12.8 (11.0–14.9)	**1.62 (1.29–2.06)**	238 (37.8)	13.0 (7.5–18.7)	**2.46 (1.29–4.68)**	9.2 (2.0–16.3)	2.6 (0–5.2)
10 years or above	2,237 (65.8)	8.3 (7.2–9.5)	1	392 (62.2)	5.8 (1.7–9.8)	1	5.2 (1.9–8.5)	0.6 (0–1.3)
SES								
Low	411 (12.9)	18 (14.4–22.1)	**2.94 (2.12–4.10)**	88 (14.7)	16.0 (0–32.1)	3.78 (0.26–53.73)	5.6 (0–11.9)	6.5 (0–14.9)
Medium	1,486 (46.5)	10.2 (8.7–11.8)	**1.52 (1.15–1.99)**	288 (48.1)	10.0 (6.1–13.9)	2.21 (0.59–8.27)	9.4 (6.1–12.7)	0.5 (0.2–1.2)
High	1,297 (40.6)	6.9 (5.6–8.5)	1	223 (37.2)	4.8 (0–12.5)	1	4.0 (0–10.6)	0.9 (0–2.1)
Income								
<10,000 euro	218 (7.7)	19.7 (14.6–25.6)	**2.90 (1.78–4.72)**	50 (9.6)	11.2 (0–22.6)	**1.88 (1.08–3.29)**	3.4 (0–8.5)	1.6 (0–4.0)
10,000–15,000 euro	402 (14.2)	14.4 (11.1–18.2)	**1.99 (1.27–3.12)**	82 (15.7)	10.9 (3.8–18.0)	1.75 (0.71–4.29)	9.7 (2.7–16.7)	0.8 (0–3.1)
15,000–31,000 euro	849 (30.0)	9.7 (7.7–11.8)	1.26 (0.83–1.92)	151 (28.9)	10.9 (0–24.6)	1.83 (0.26–12.83)	10.1 (0–23.5)	1.0 (0–2.6)
31,000–70,000 euro	938 (33.2)	7.2 (5.7–9.1)	0.92 (0.60–1.42)	167 (32)	4.1 (0–12.8)	0.64 (0.05–0.25)	3.6 (0–10.9)	0.5 (0–1.9)
>70,000 euro	422 (14.9)	7.8 (5.4–10.8)	1	72 (13.8)	6.3 (1.2–11.3)	1	5.6 (0–11.2)	0.6 (0–1.6)

Figures in boldface reflect statistically significant differences

2. UOC di Neuropsichiatria IRCCS Bambino Gesù:

Protocolli di valutazione

UOC di Neuropsichiatria IRCCS Bambino Gesù

Reparto di degenza (2013: 323 dimissioni)

- 8 posti letto (due dedicati ad adolescenti con sospetto esordiopsicotico)
- Ricoveri ordinari, programmati, in urgenza da Pronto soccorso

Finalità

- Approfondimento diagnostico
- Gestione degli stati di acuzie

Modalità d'accesso

- Pronto Soccorso
- Programmato

UOC di Neuropsichiatria IRCCS Bambino Gesù

Day Hospital

- 10 equipes plurispecialistiche:
  - Psicosi e UHR
  - Disturbi dell'Umore
  - Ansia e DOC
  - Anoressia e DCA
  - ADHD e DOP
  - Dislessia
  - Disturbi del Linguaggio
  - Autismo
  - Disabilità Intellettiva
  - Abuso

Lun-Sab 8-14 e 14-20

Finalità

- Approfondimento diagnostico
- Interventi terapeutici e follow-up

Modalità d'accesso

- Si accede tramite prenotazione in seguito a visita ambulatoriale

UOC di Neuropsichiatria IRCCS Bambino Gesù

Ambulatorio

- Neuropsicologico (4 vv/settimana)
- Neuropsichiatrico (7 vv/settimana)

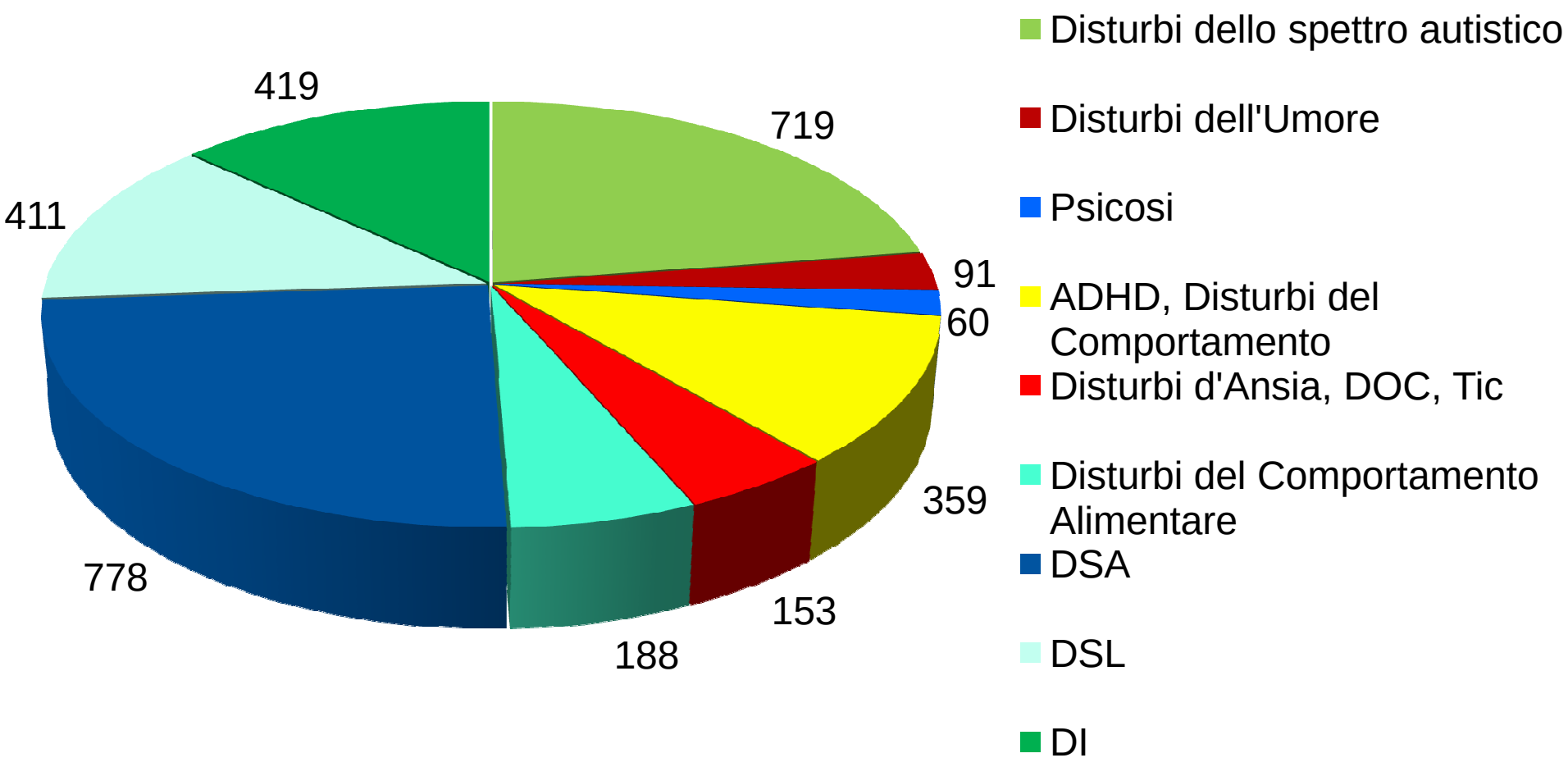
Finalità

- Prima visita, inquadramento diagnostico
- Follow-up in corso di trattamento

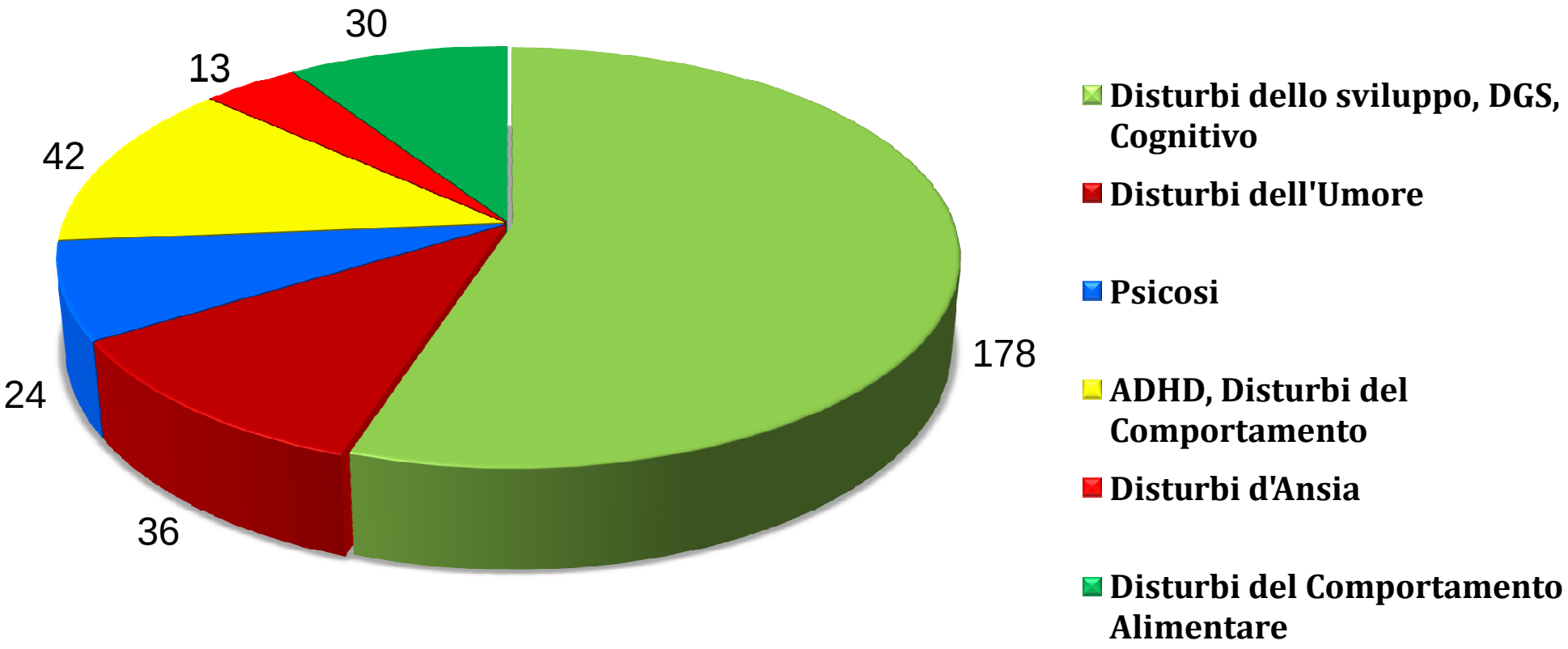
Modalità d'accesso

- Si accede tramite prenotazione

DH: Casistica totale 2013, N=3562



Reparto: Casistica totale 2013, N=323 (<13aa)



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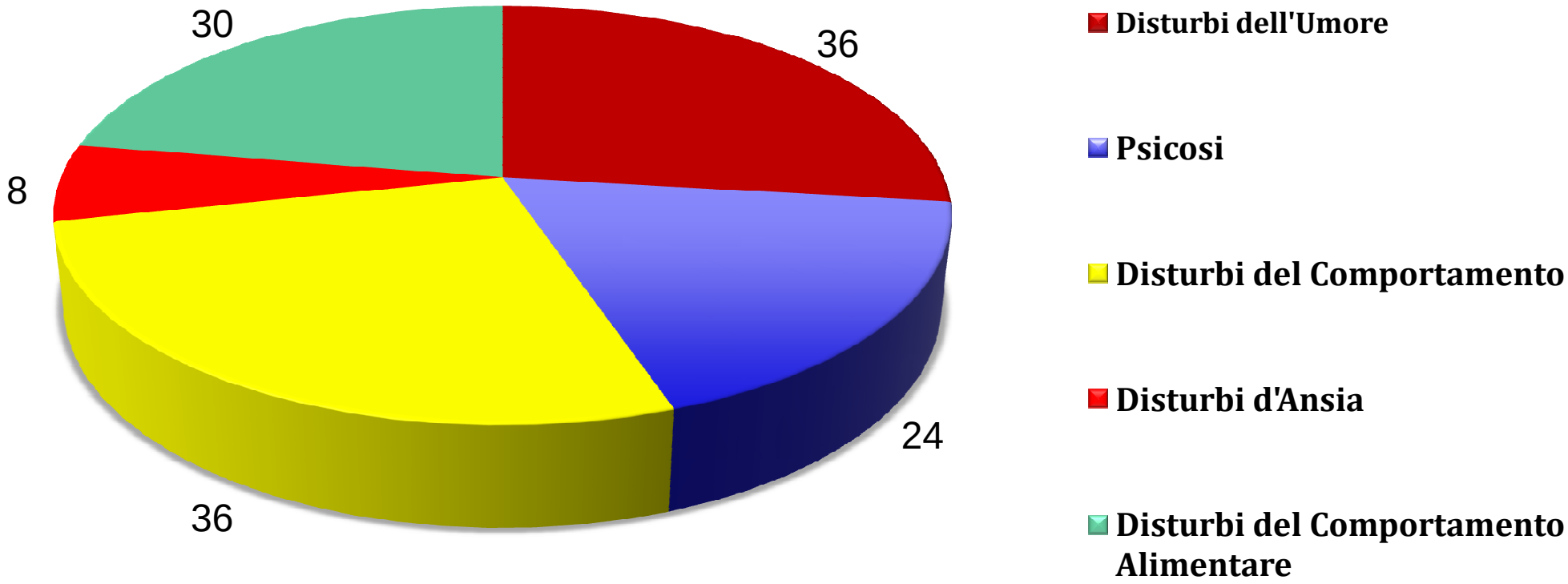

3. Modelli d' intervento: modalità di presa in carico e setting d'intervento

Epidemiology and Psychiatric Sciences (2012), **21**, 47–57.
doi:10.1017/S2045796011000746

SPECIAL ARTICLE

Age of onset of mental disorders and use of mental health services: needs, opportunities and obstacles

G. de Girolamo[1*], J. Dagani[1], R. Purcell[2], A. Cocchi[3] and P. D. McGorry[2]

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[2] *Department of Psychiatry, Orygen Youth Health Research Centre, Centre for Youth Mental Health, University of Melbourne, Australia*
[3] *A.O. Ospedale Niguarda Ca' Granda, Programma 2000, Via Livigno, 3, 20128 Milan, Italy*

Purpose of review. In this review, we provide an update of recent studies on the age of onset (AOO) of the major mental disorders, with a special focus on the availability and use of services providing prevention and early intervention.

Recent findings. The studies reviewed here confirm previous reports on the AOO of the major mental disorders. Although the behaviour disorders and specific anxiety disorders emerge during childhood, most of the high-prevalence disorders (mood, anxiety and substance use) emerge during adolescence and early adulthood, as do the psychotic disorders. Early AOO has been shown to be associated with a longer duration of untreated illness, and poorer clinical and functional outcomes.

Summary. Although the onset of most mental disorders usually occurs during the first three decades of life, effective treatment is typically not initiated until a number of years later. There is increasing evidence that intervention during the early stages of disorder may help reduce the severity and/or the persistence of the initial or primary disorder, and prevent secondary disorders. However, additional research is needed on effective interventions in early-stage cases, as well as on the long-term effects of early intervention, and for an appropriate service design for those with emerging mental disorders. This will mean not only the strengthening and re-engineering of existing systems, but is also crucial the construction of new streams of care for young people in transition to adulthood.

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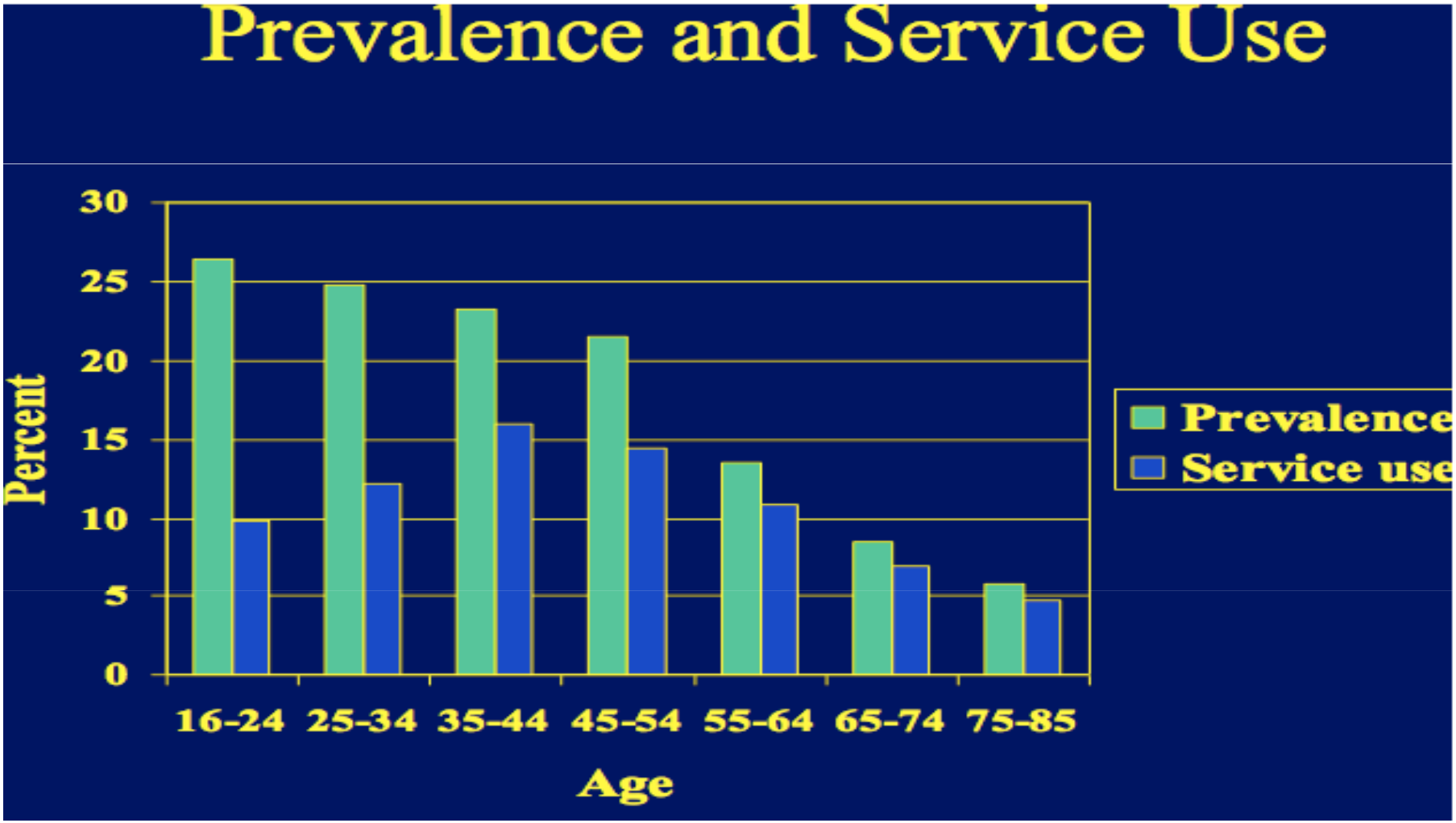
services are *qualitatively* appropriate. At the same time, however, the fact that over 80% of participants with significant mental health problems had not yet consulted mental health services suggests that referral is *quantitatively* inadequate. This latter finding is

Modelli di intervento



YOUTHspace

Public Mental Health Programme

Reducing treatment delay:
Reducing stigma, improving awareness, improving access

www.wheres-your-head-at.com

CLAHRC project:
reducing treatment delay in psychosis

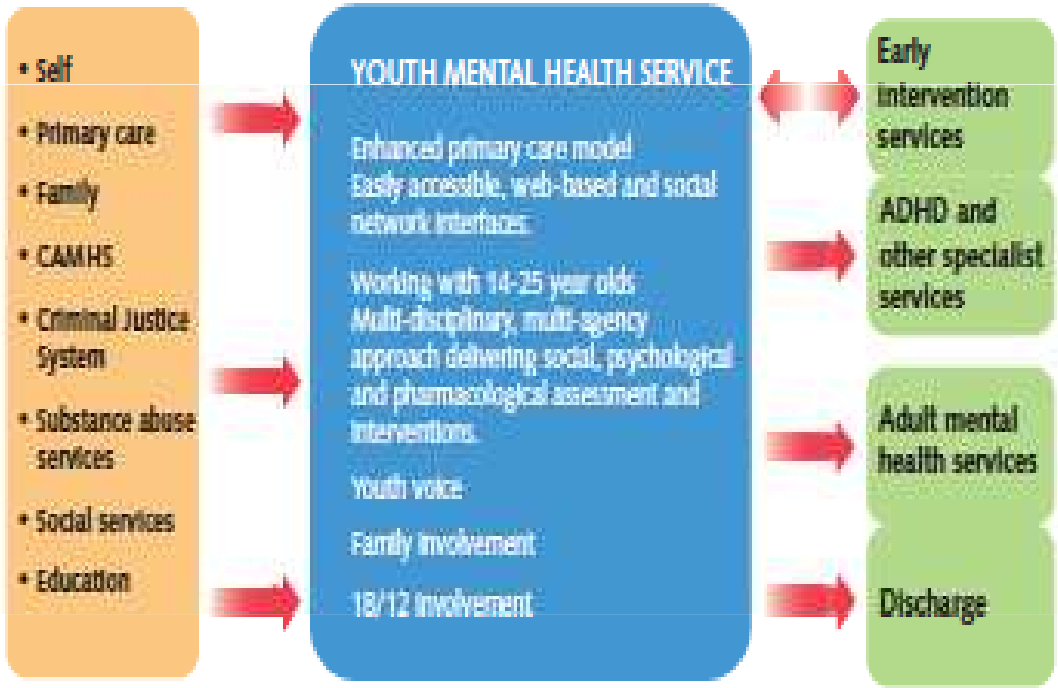
At risk groups

- Looked after kids
- Teenage mothers
- Asylum seekers
- UHR help seekers

Increasing resilience:
School-based interventions

Prospettive e Soluzioni

Figure 4: A youth mental health service



YouthSpace

Building on the model of its pioneering early intervention in psychosis service, Birmingham and Solihull Mental Health Trust has developed a youth mental health programme, in collaboration with the third sector and city council, to deliver a population-based public health intervention across the city.

YouthSpace is a multi-agency partnership including Fairbridge, Future Health and Social Care, Connexions and Unity FM radio, among others. Its vision is to encourage all young people in Birmingham to become members and to learn and be at ease with the language of mental health and well-being, to identify problems early, thus preventing longer-term difficulties.

The programme links with a number of streams of evidence-based interventions to prevent or reduce the impact of mental health problems on young people into their mid-twenties. These streams include psychosis, eating disorders, attention deficit/hyperactivity disorder (ADHD), depression and self-harm and emerging personality disorder.

The early detection team (ED:IT) undertakes specialised screening of 'at risk' groups, including young people leaving local authority care and those showing signs of school disengagement or who are in trouble with the police. School-based work includes mental health awareness and building resilience.

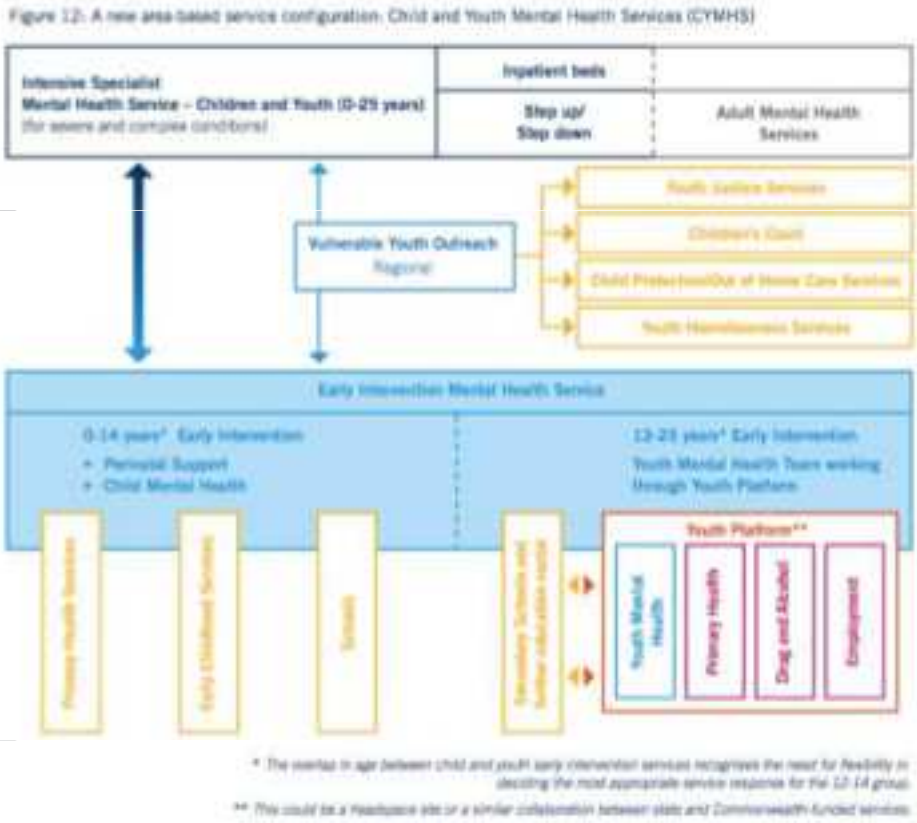
The YouthSpace youth board has developed a website, a cinema advert and a bus stop poster to encourage young people to seek help.

Of particular importance is the collaboration with CAMHS in providing early intervention in psychosis for young people from the age of 14, and a specialist team that manages the process of transition to adult services.

The programme links with the Collaborations for Leadership in Applied Health Research and Care pathways project, which is working with key 'pathway players' (for example, mosques, gurudwaras, Hindu temples, black churches and primary care services) to overcome stigma and other obstacles to accessing services and support.

www.wheres-your-head-at.com

Prospettive e Soluzioni (II)



Prospettive e Soluzioni (III)

headspace: Australia's National Youth Mental Health Foundation — where young minds come first

Patrick D McGorry, Chris Tanti, Ryan Stokes, Ian B Hickie, Kate Carnell, Lyndel K Littlefield and John Moran

- *headspace*, Australia's national youth mental health initiative, was created in 2006 in response to the recognition that the existing health system needed to be much more accessible and effective for young people with mental and substance use disorders.
- With funding of more than $54 million from the Australian Government, a carefully constructed and selected system of 30 "communities of youth services", or integrated service hubs and networks, across the nation is being established, supported by programs for community awareness, workforce training and evidence-based resource material.
- *headspace* aims to improve access, and service cohesion and quality, and ultimately health and social outcomes, for young people aged 12–25 years experiencing mental illness and related substance use problems.
- Within the Council of Australian Governments framework, this will require synergistic planning with, and co-investment on behalf of, state and territory governments, as well as the support and involvement of local communities and the wider Australian society.

MJA 2007; 187: 568–570

Buonasera Dottor Vicari

Grazie per avermi lasciato la sua mail e accettato la mia richiesta di avere qualche informazione di aiuto. In breve le racconto che ho un figlio di 16 anni dichiarato ADHD all'età di 11 e da allora ha l'insegnante di sostegno a scuola. Viviamo in … dove purtroppo l'ADHD è poco conosciuto da medici, scuole, istituzioni, ecc. insomma un "deserto" in materia. Con lui è stato un lungo calvario da quando aveva un anno. Il problema attuale è che lui da più di 18 mesi non accetta più farmaci (prendeva per andare a scuola il ritalin LA - acq in svizzera - e poi il Risperidal alla sera quando ha iniziato a essere violento.) Non accetta più di essere seguito da nessun medico e dalla neuropsichiatra. Purtroppo negli ultimi due anni è diventato fortemente aggressivo, prepotente e provocatorio. La nostra famiglia è distrutta in quanto lui ormai ci minaccia (spesso spacca i mobili o le porte di casa) chiede continuamente denaro e a scuola è veramente un disastro e sarà bocciato. Circa tre mesi fa è stato fermato dai carabinieri perché in possesso di 0,3 gr di marijuana e da allora aspettiamo esito analisi e provvedimento del tribunale dei minori. Purtroppo ho saputo che queste cose si protraggono nel tempo e si può arrivare anche ad attesa di un anno. La dottoressa che lo seguiva mi consiglia di attivare i servizi sociali per far fronte a questo problema e a "tutelarmi", ma non so se sia la cosa giusta. A lei chiedo, cosa possiamo fare noi genitori con un figlio che non accetta nessun aiuto???

Mi creda la mia vita di mamma è un inferno e mi sento terribilmente impotente e sbagliata perché non sono riuscita a fare nulla nonostante, mi creda, i mille sacrifici. Pensi che dall'età di due anni e mezzo che lo porto da psicologi, logopedisti, neuropsichiatri, ecc. ma non è servito a nulla. Tra un mese quando lui si renderà conto di essere bocciato (perché purtroppo lui pensa di farcela) arriverà a casa e sarà completamente "fuori" e mi spaccherà qualcosa se non peggio. Poi mi abbandonerà la scuola e allora???? Cosa mi rimane da fare? Lui non vuole mai parlare del suo problema, per lui non esiste, pensi che la storia della segnalazione ai tribunale dei minori non lo ha toccato per nulla, il fatto di essere stato portato in caserma non lo ha spaventato, non lo ha fatto riflettere, insomma sembra che tutto passi su di lui come nulla.

A lei, che conosce così bene questi ragazzi chiedo un aiuto su cosa posso fare come mamma e come genitori.

Grazie dell'attenzione che vorrà dedicarmi e la saluto cordialmente.

Conclusioni

Per i disturbi psichiatrici in adolescenza:

- ✧ necessità di interventi precoci
- ✧ necessità di interventi “fase del disturbo-specifici”
- ✧ utilità di approcci terapeutici “integrati”

www.specchioriflesso.net

Stefano Vicari vive e lavora a Roma città che adora e dove è nato nel 1959. Dirige l'Unità Operativa Complessa di Neuropsichiatria Infantile dell'Ospedale Pediatrico Bambino Gesù. Ha svolto periodi di ricerca all'estero ed è responsabile di progetti di ricerca nazionali e internazionali. È autore di libri per medici, psicologi e terapisti in italiano e in inglese e di oltre cento pubblicazioni scientifiche su riviste di settore. Questo è il suo primo libro di racconti. La Rai ne ha tratto una serie dal titolo *Disordini*, interpretata dallo stesso autore.

In copertina: foto © Matthieu Spohn/Corbis
Grafica Studio Baroni
www.tealibri.it

Carlo venuto da Marte
La storia sbagliata di Anna
Fabrizio, il fuoco e tutto il resto
Paolo che accarezzava il pavimento
Giulio e il ciliegio
Il vento di Lucia
L'insalata sotto il cuscino

Volti, nomi e storie
per raccontare una realtà di cui si parla troppo poco:
la sofferenza psichica degli adolescenti.
Per conoscere, per capire,
per sapere cosa si può e si deve fare

euro 13,00

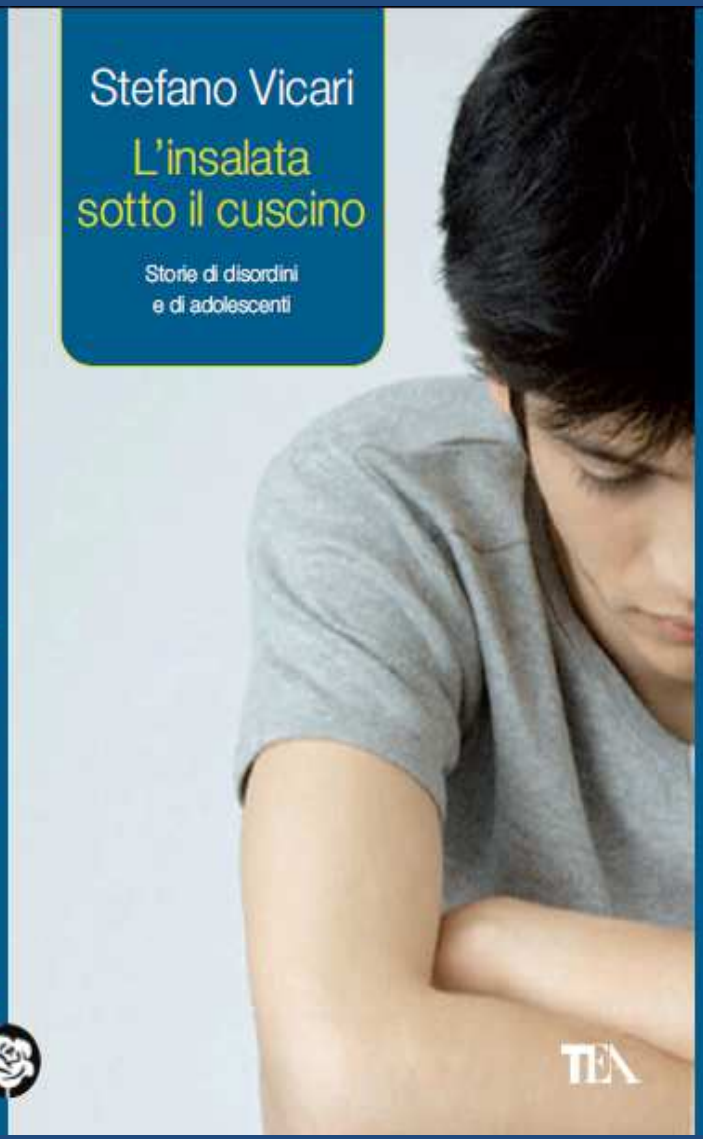
Stefano Vicari L'insalata sotto il cuscino

2014

Stefano Vicari

L'insalata sotto il cuscino

Storie di disordini e di adolescenti



TEA

«Sette racconti, sette storie di anoressia, depressione, schizofrenia, ansia, ossessioni, compulsioni... I protagonisti dei racconti, però, non sono gli stessi disturbi né, tantomeno, adulti delusi e logorati da una vita stressante e piena di amarezza. I protagonisti dei nostri racconti sono ragazzi, adolescenti poco più che bambini, che nonostante la giovane età si misurano con disturbi spesso invalidanti. Qualcuno potrebbe ritenere che il fenomeno riguardi una esigua minoranza. Purtroppo non è così.»
Forte di estese ricerche scientifiche e di una lunga esperienza «sul campo», Stefano Vicari, neuropsichiatra infantile, ha deciso di raccontare una realtà tanto dolorosa quanto poco conosciuta: la malattia mentale negli adolescenti. Dalle sue pagine emergono così storie individuali, volti e nomi di ragazze e ragazzi, e dei loro genitori, che soffrono, che lottano, che percorrono con coraggio la strada verso la guarigione. Storie drammatiche e toccanti, e anche cariche di speranza, che aiutano in concreto e senza terrorismi a superare i pregiudizi e ad affrontare con piena consapevolezza la realtà.

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I disturbi psichici del bambino e dell'adolescente:

dai pregiudizi alle evidenze scientifiche

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Bambino Gesù
OSPEDALE PEDIATRICO

Corso Residenziale di Alta Specializzazione per Professionisti della Salute Mentale in Età Evolutiva

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