Convegno ATS Brescia

NEUROPSICHIATRIA E DIPENDENZE

Dialoghi terapeutici tra gli attori della rete di ATS Brescia

Brescia, 16.11.2017

MINORI, SOSTANZE E DISTURBI PSICHIATRICI:
DATI EPIDEMIOLOGICI E QUADRI CLINICI

Massimo Clerici

DMC, Università degli studi di Milano Bicocca

massimo.clerici@unimib.it

UNIVERSITÀ DEGLI STUDI DI MILANO BICOCCA

SIP

SIP.Dip.
Società Italiana
Psichiatria delle Dipendenze
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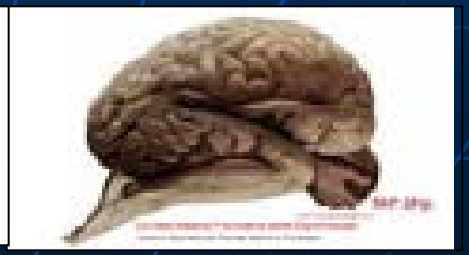
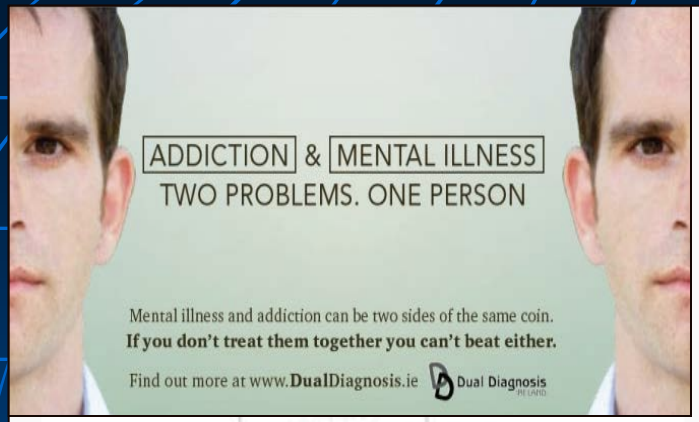


Segnalibro

- Introduzione: i “confini” del nostro lavoro oggi
- Psicopatologia, dipendenze e comorbilità: un problema di disturbi o di Servizi?
- La questione degli esordi tra sostanze e disturbi mentali
- Difficoltà del trattamento e della prevenzione: un’agenda per riorganizzare gli interventi

Segnalibro

- **Introduzione:**
  i “confini”del nostro lavoro oggi



FeDerSerD SINPIA

COMUNICATO STAMPA

"CARTA DEI SERVIZI DEI PAZIENTI CON DISTURBI PSICHIATRICI E DISTURBI DA USO DI SOSTANZE E ADDICTION"

Le principali Società Scientifiche dell'area della salute psichica dei cittadini: la Federazione Italiana degli operatori dei dipartimenti e dei servizi delle dipendenze – FeDerSerD -, la Società italiana di Psichiatria – SIP -, e la Società italiana di Neuropsichiatria dell'infanzia e dell'adolescenza – SINPIA -, hanno proposto una Carta dei Servizi per valorizzare la rete specialistica e integrata dei servizi a tutela dei malati e in applicazione dei LEA.

Centralità della persona, lotta allo stigma, specificità ed appropriatezza degli interventi, sono i cardini della Carta.

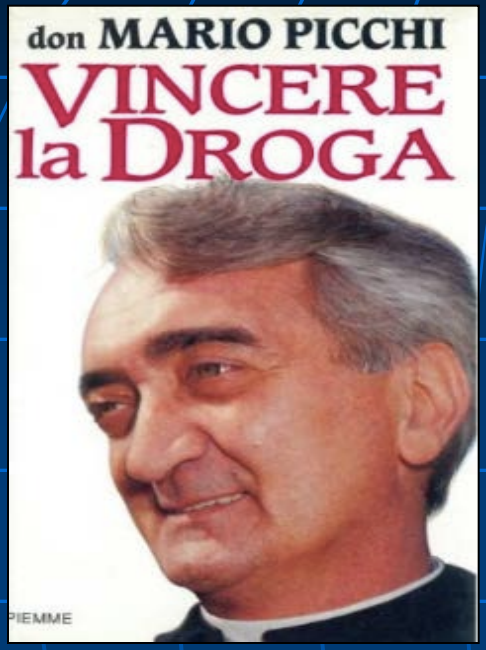
In una società che ci richiama tutti ad un maggiore impegno a tutela dei nostri giovani e dei malati per disturbi psichiatrici, da uso di sostanze e comportamenti di addiction, il mondo scientifico si propone con percorsi chiari, applicabili, unitari, a favore dei nostri cittadini.

Criteri diagnostici rigorosi e scientifici, superamento del concetto di doppia diagnosi, presa in carico integrata da parte dei servizi, privilegio alle azioni di approccio e diagnosi precoci, valorizzazione degli interventi di recovery, superamento di una visione frammentata e segmentata per competenze, formazione qualificata e comune: questi alcuni punti di azione comune ed integrata.

Un primo fondamentale atto che vedrà impegnati gli operatori e i professionisti nei territori e potrà avere sviluppo se le istituzioni centrali e regionali garantiranno assetti organizzativi e risorse adeguate.

Roma, 24 ottobre 2017

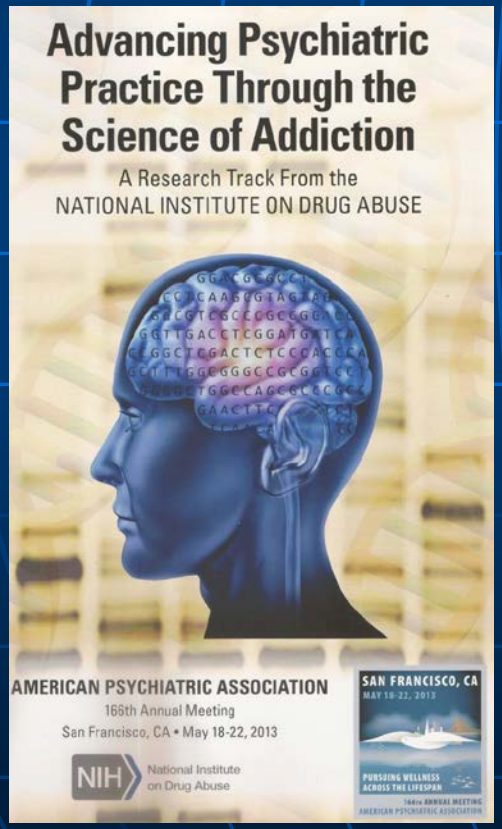
vizi, disturbi o normalità?



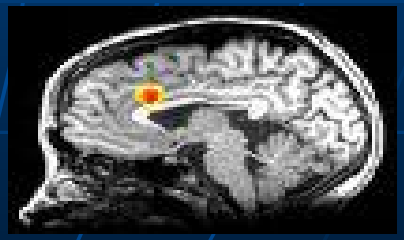
PER FORTUNA CHE IN FOTO NON SI NOTANO I DISTURBI MENTALI

NON SOFFRO DI DISTURBI MENTALI!!!! CI VADO D'ACCORDISSIMO!

World Health Organization

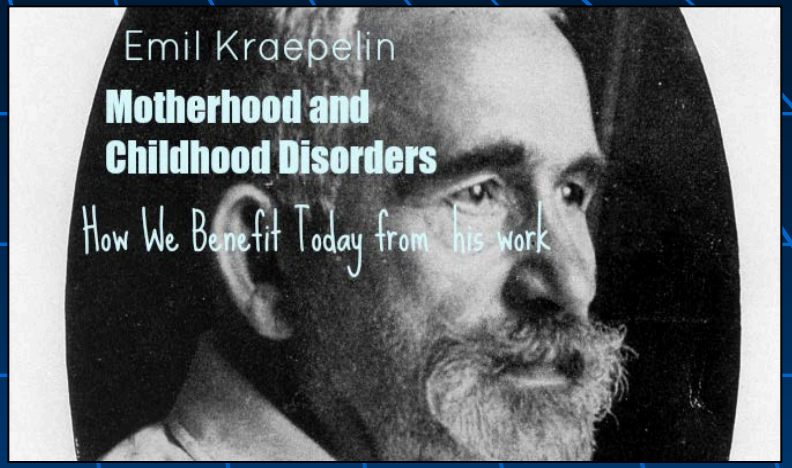


Abuso e Dipendenza da sostanze devono, inevitabilmente, essere considerati un disturbo del cervello, quanto ogni altro disturbo mentale



Organizzazione Mondiale della Sanità (WHO), 2004


NESSUNO
È DISABILE
ALLA FELICITÀ.


Emil Kraepelin
Motherhood and
Childhood Disorders
How We Benefit Today from his work


Fanculo il latte,
dammi una birra!

ADOLESCENZA E USO DI SOSTANZE

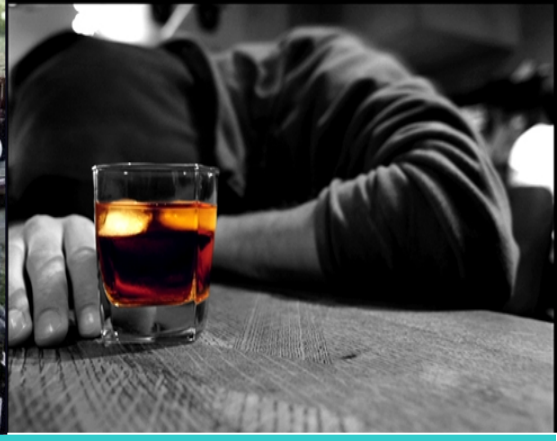
...dalle ultime relazioni annuali dell'Osservatorio europeo delle droghe e tossicodipendenze (oedt, www.emcdda.europa.eu) emerge come il consumo tra i giovani adulti (15-34 anni) oscilli dal 2,9% (Italia) al 6,2% (Regno Unito)

…i livelli più elevati di consumo per specifica sostanza (cannabis) tra i giovani adulti sono stati registrati in Repubblica Ceca (28,2%): tra gli altri, la prevalenza maggiore è stata segnalata in Italia (20,3%), Spagna (18,8%) e Francia (16,7%)

Ne deriva l'importanza di:

1) accrescere le conoscenze e la comprensione dei comportamenti a rischio, concentrandosi sui problemi di salute mentale che si manifestano precocemente e che aumentano il rischio di sviluppare disturbi correlati all'uso

2) sviluppare la rete di intervento e identificare modelli utili per le pratiche di prevenzione e trattamento, in particolare per bambini e adolescenti a rischio



European School Survey Project on Alcohol and Other Drugs
- ESPAD: studenti europei 15-16 anni

USO

▪ lifetime*	90%
▪ ultimo anno*	82%
• 1-5 volte	21%
• ≥ 40 volte	27%
▪ ultimo mese*	61%

* almeno una volta

INTOSSICAZIONE

▪ lifetime*	50%
▪ ultimo anno*	39%
▪ ultimo mese*	18%

EMCDDA
European Monitoring Centre for Drugs and Drug Addiction

ESPAD, 2015

Uso di sostanze nella popolazione giovanile

(ESPAD, 2015)

DROGHE (cannabis, amfetamine, cocaina, ecstasy, LSD, eroina)

- **uso lifetime*** **20%**

CANNABIS

- **uso ultimo anno*** **14%**

  ultimo mese* **7%**

ALCOL + FARMACI

- **uso lifetime*** **7% (F>M)**

TRANQUILLANTI E SEDATIVI

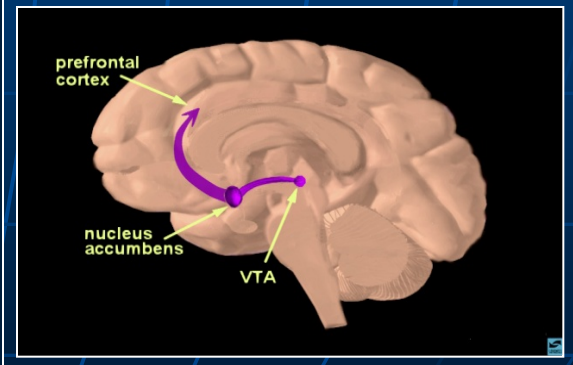
- **uso lifetime*** **7% (F>M)**

* almeno una volta

EMCDDA
European Monitoring Centre for Drugs and Drug Addiction

…le conseguenze… (Sussman et al, 2008)

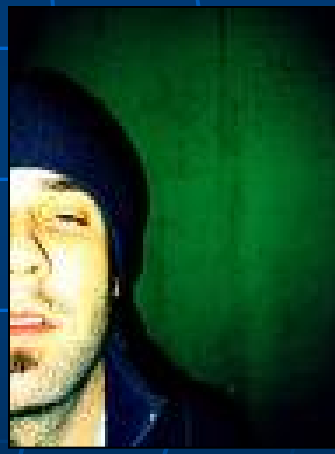
- conseguenze avverse immediate
  - furti, incidenti, overdose
  - impulsività, violenza
- conseguenze avverse, sul breve periodo, a livello di funzionamento psicosociale
- scarse performance scolastiche
- instabilità lavorativa
- gravidanze indesiderate
- malattie sessualmente trasmesse
- conseguenze avverse, sul medio e lungo periodo, a carico del SNC soprattutto disturbi mentali …



Priorità: …in trattamento o no?

la proporzione di giovani di età <15 anni in trattamento per uso di sostanze nella maggior parte dei paesi europei costituisce <1% degli utenti totali (rapporto M:F = 2.5). Le cause sono:

- uso "tendenzialmente" non problematico (ideologie degli operatori!!)
- uso di sostanze non documentato (approccio superficiale deglioperatori!!)
- uso di sostanze non rilevato (privacy, anonimato…) (famiglie, operatori!!)
- **resistenza degli operatori, scarsa disponibilità di Servizi specifici per giovani e, più in generale, difficoltà di accesso e scarsa compliance**



Compton, 2010

EMCDDA, 2013

sostanze, comorbilità, esordi, adolescenza a rischio … no grazie!

il peso della “doppia diagnosi” nella formazione, oggi…

200 Exhibitors presenting new technologies • 450 Scientific Program Sessions • 43 Courses • Earn up to 50 CMEs*

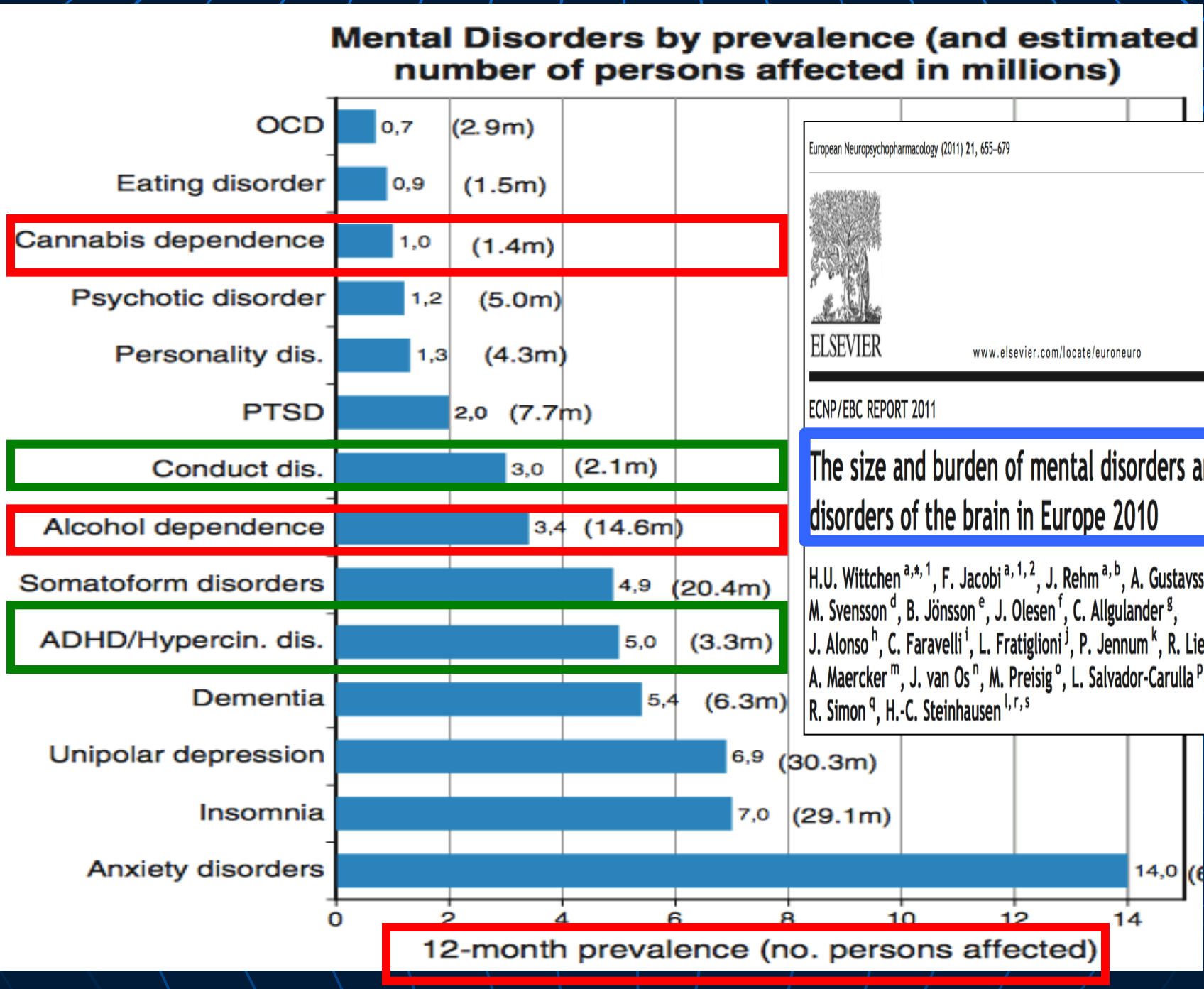
Choose CME programming hours from these subspecialties:

65 hours of Addiction Psychiatry
63 hours of Child & Adolescent Psychiatry
71.5 hours of Forensic Psychiatry
38 hours of Geriatric Psychiatry
106 hours of Psychosomatic Medicine

Other specialized tracks to customize your schedule include: Residents, Military, Integrated Care, and Ethics. Plus, visit the APP Bookstore, the Publisher's Book Fair, Media Workshops, Career Fair, International Pavilion and Mind Games contribute to your total Meeting experience.

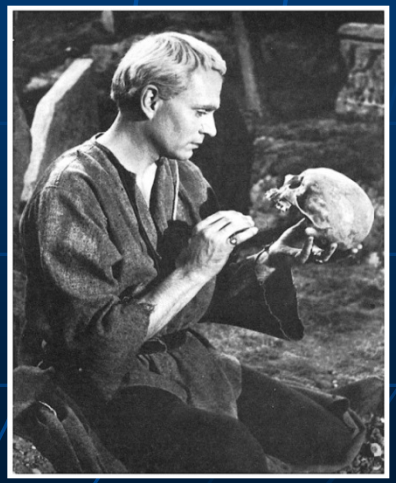
Segnalibro

- **Psicopatologia, dipendenze e comorbilità: un problema di disturbi o di Servizi?**


Mental Disorders by prevalence (and estimated number of persons affected in millions)
OCD 0,7 (2.9m)
Eating disorder 0,9 (1.5m)
Cannabis dependence 1,0 (1.4m)
Psychotic disorder 1,2 (5.0m)
Personality dis. 1,3 (4.3m)
PTSD 2,0 (7.7m)
Conduct dis. 3,0 (2.1m)
Alcohol dependence 3,4 (14.6m)
Somatoform disorders 4,9 (20.4m)
ADHD/Hypercin. dis. 5,0 (3.3m)
Dementia 5,4 (6.3m)
Unipolar depression 6,9 (30.3m)
Insomnia 7,0 (29.1m)
Anxiety disorders 14,0
0
2
4
6
8
10
12
14
12-month prevalence (no. persons affected)
European Neuropsychopharmacology (2011) 21, 655–679
ELSEVIER
www.elsevier.com/locate/euroneuro
ECNP/EBC REPORT 2011
The size and burden of mental disorders and other disorders of the brain in Europe 2010
H.U. Wittchen [a,*,1], F. Jacobi [a,1,2], J. Rehm [a,b], A. Gustavsson [c], M. Svensson [d], B. Jönsson [e], J. Olesen [f], C. Allgulander [g], J. Alonso [h], C. Faravelli [i], L. Fratiglioni [j], P. Jennum [k], R. Lieb [l], A. Maercker [m], J. van Os [n], M. Preisig [o], L. Salvador-Carulla [p], R. Simon [q], H.-C. Steinhausen [l,r,s]

…"dual diagnosis" concept is clinically inadequate but comorbidity is useful!

- **High rates of patients comorbid for ≥3 *lifetime disorders* (approximately 15%)**
- **Many patients have ≥3 *current diagnoses*, including other medical conditions**
- Therefore, popularization of "dual diagnosis" concept has led to:
  - Oversimplification
  - Need of increased recognition



Kessler et al. Arch Gen Psychiatry, 1994;51(1):8-19

DSM-5 Table of Contents

Section I: DSM-5 Basics

Section II: Diagnostic Criteria & Codes

Neurodevelopmental Disorders
Intellectual disabilities
Intellectual disability
Global Developmental Delay
Communication Disorders
Languag
Speech
Phonological)
Social (P
Disorder
Autism Spe
Attention-D
ADHD
Specific Lea
Motor disor
Develop
Stereoty
Tic Diso
Tourette
Persister
Disorder
Provisio
Other Neuroc
Other s
Disorder
Unspecif
Disorder

Schizophrenia Spectrum and Other Psychotic Disorders
Schizotypal (Personality) Disorder
Delusional Disorder

Unspecified Catatonia

Bipolar and Related Disorders
Bipolar I Disorder
Bipolar II Disorder
Cyclothymic Disorder
Substance/Medication-Induced Bipolar and Related
Bipolar and Related Disorder Due to Another Medical

IN FOCUS: Substance-Use & Addictive Disorders (DSM-5)

Substance-Use Disorder (Legal Problems – **OUT;** Cravings – **IN**)

- Alcohol Use Disorder
- Cannabis Use Disorder
- Hallucinogen Use Disorder (which has subsumed Phencyclidine [PCP])
- Inhalant Use Disorder
- Opioid Use Disorder
- Sedative/Hypnotic Use Disorder (changed from Sedative, Hypnotic or Anxiolytic Disorder)
- Stimulant Use Disorder (combining DSM-IV-TR's Cocaine and Amphetamine Abuse and Dependence)
- Tobacco Use Disorder
- Unknown Substance Use Disorder
- Gambling Disorder

- There are no Caffeine Use or Internet Use Disorders in the DSM-5.

Substance/Medication Induced Anxiety Disorder
Anxiety Disorder Due to Another Medical Cond.

Obsessive-Compulsive and Related Disorders

Acute Stress Disor
Adjustment Disor

Dissociative Dis
Dissociative Ident
Dissociative Amne
Depersonalization

Somati
Somatic
Illness A

nation Disorders
sis
resis

-Wake Disorders
nia Disorder
somnolence Disorder
lepsy

Breathing-Related Sleep Disorders
Obstructive Sleep Apnea Hypopnea
Central Sleep Apnea
Sleep-Related Hypoventilation
Circadian Rhythm Sleep- Wake Disorder

“Doppia Diagnosi”, “Doppie Diagnosi”, ...“non diagnosi”… “nuove diagnosi”… nella stragrande maggioranza dei casi, una… “clinica della confusione”

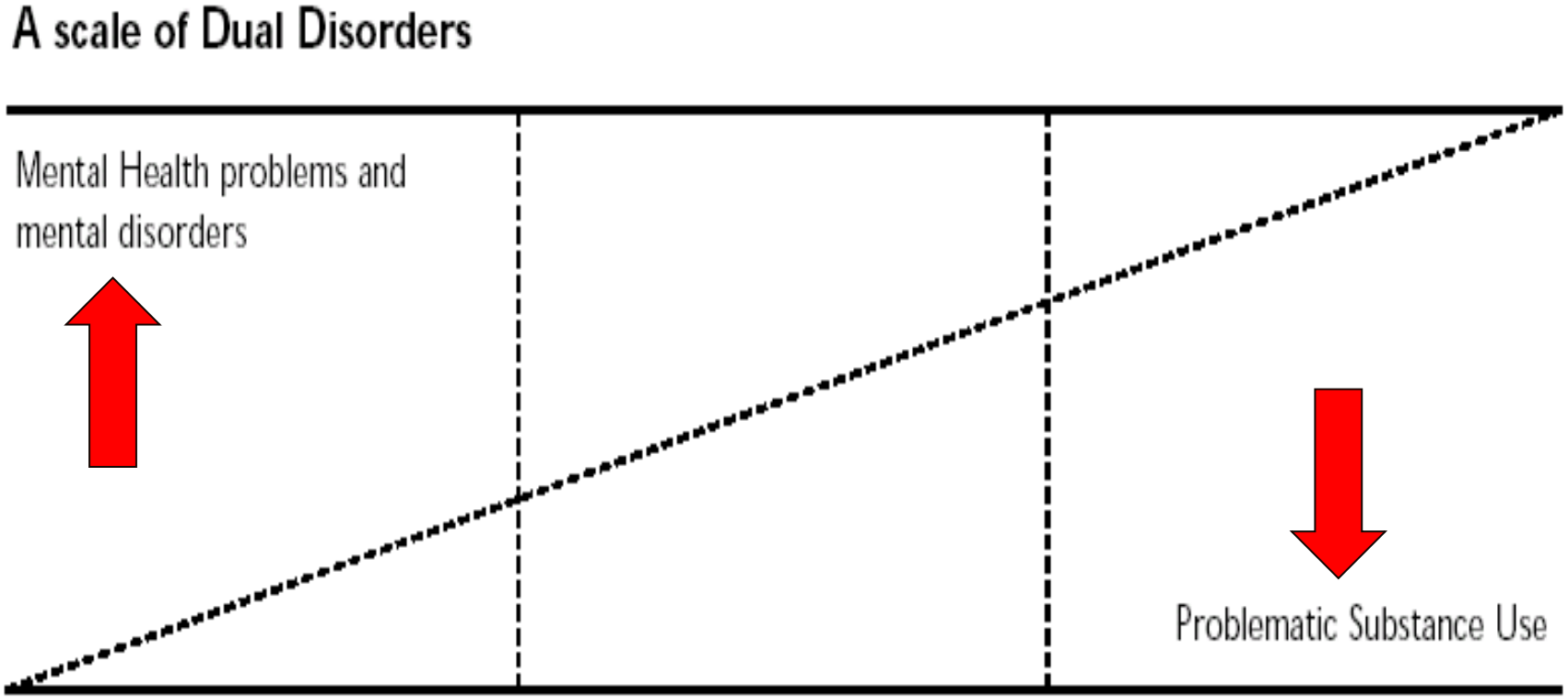
- **Quadri sovrapposti, quadri misti**
- **Stati misti, cicli rapidi, depressione agitata, mania disforica**
- **Decorsi rallentati**
- **Associazioni spurie o composite**
- **Patomorfosi eterogenea**
- **Effetti acuti di intossicazione o di astinenza e/o di cronicizzazione**
- **Influenza dei trattamenti sostitutivi, off-label o delle condizioni organiche comorbili**

La doppia diagnosi si configura come un potente disorganizzatore nosografico”

con alterazioni della processualità temporale dei disturbi mentali classicamente descritti (acuzie, cronicità, ciclicità, remissione, scompenso, ricaduta, recidiva)

Co-existent psychiatric and substance misuse disorders (Ries, 1993)

Comorbid mental/substance use disorders may occur concurrently/successively (at different times in a person's life)



Pergamon

Addictive Behaviors, Vol. 23, No. 6, pp. 717–734, 1998

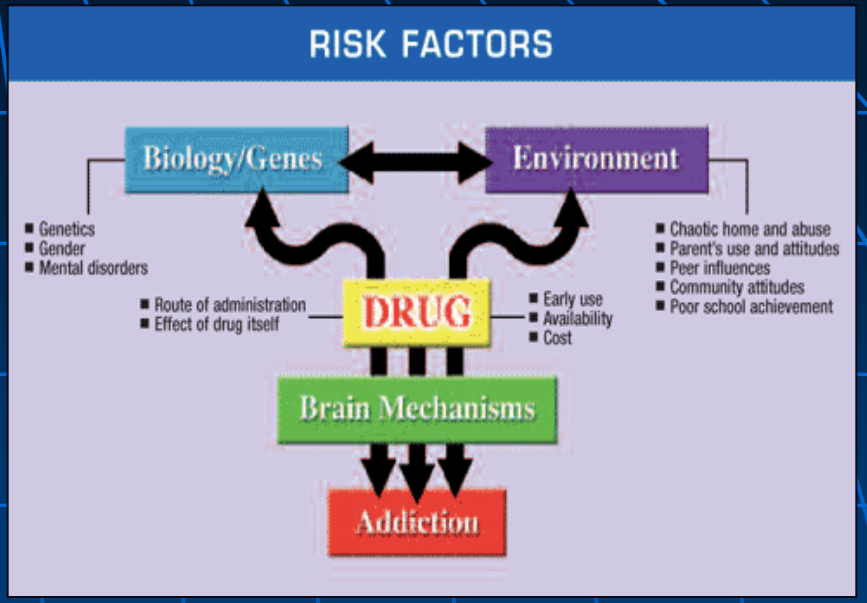
0306-4603/98 $19.00 + .00

PII S0306-4603(98)00073-2

I. Severe Mental Illness and Comorbidity: Alan S. Bellack, Chair

DUAL DIAGNOSIS: A REVIEW OF ETIOLOGICAL THEORIES

KIM T. MUESER,* ROBERT E. DRAKE,* and MICHAEL A. WALLACH†



Negli adolescenti e nei giovani adulti con DUS, la co-presenza di ADHD è frequente

Dipendenza da oppiacei

5-22%

Più di 2 sostanze

17-21%

Dipendenza da alcool

33-71%

Dipendenza da cocaina

10-35%

Dipendenza da nicotina

40-70%

Wilens & Dodson, 2004
Wilens, 2004

Attention-deficit Hyperactivity disorder (ADHD) as a Risk Factor

ODD/CD

Disturbi di Personalità
DP Antisociale

ADHD

ADDICTION

V. GENETICA

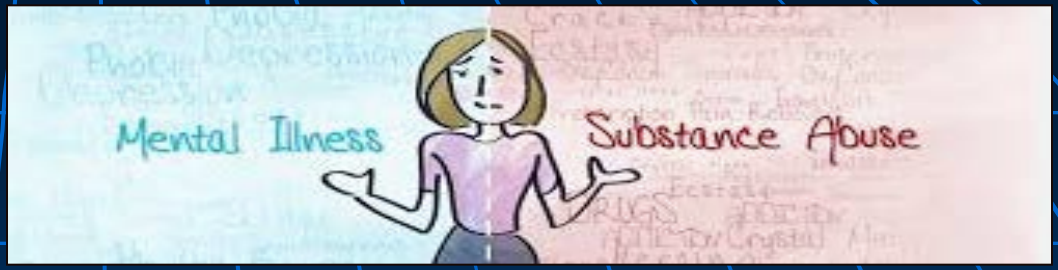
PRIORITA' TEMPORALE (Fayyad et al., 2007)

Co-occurring disorder	ADHD first % (s.e.)	Other disorder first % (s.e.)	Both in same year % (s.e.)	n[1]
Mood disorder	85.6 (2.5)	9.5 (2.4)	4.9 (1.3)	310
Anxiety disorder	49.6 (3.9)	41.2 (4.0)	9.2 (2.0)	312
Specific phobia	34.3 (5.3)	54.8 (5.1)	11.0 (2.8)	185
Any other anxiety disorder	68.5 (4.1)	19.7 (3.2)	11.8 (2.2)	244
Substance use disorder	99.0 (0.7)	0.5 (0.5)	0.4 (0.4)	145

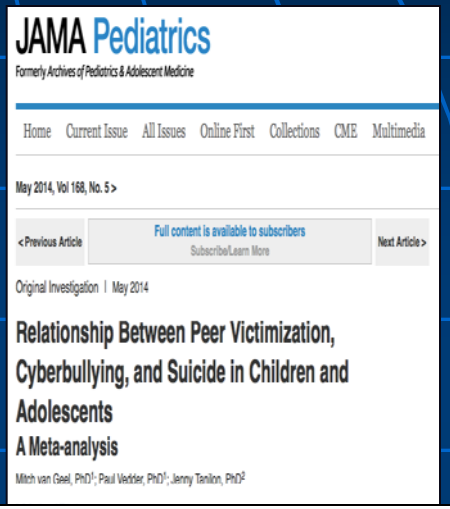
Quello che rimane ancora poco chiaro è se le correlazioni tra ADHD, CD, DUS e altri disturbi mentali siano di ordine causale – uno può determinare l'altro – o si spieghino solo per l'interscambio di sintomi o di fattori di rischio comuni (Skodol et al., 1999). L'uso di sostanze potrebbe non indurre - ma solo catalizzare - lo sviluppo di comportamenti che generano dipendenza come espressione di tratti o disturbi della personalità (Rounsaville et al., 1998)

I diversi disturbi osservati e descritti in uno spettro così variegato di comorbilità multiple potrebbero non essere affatto distinti, ma solo artefatti o varianti di una medesima, unica condizione/patologia sottostante (Robins, 1998; Fayyad et al, 2007)

Risk factors



- Family history of depression or other mental illness
- Family history of suicide
- History of depression or other mental illness
- History of previous suicide attempts
- Alcohol or drug abuse
- Incarceration/Homelessness
- Easy access to drugs
- Easy access to lethal methods
- Exposure to the suicidal behavior of others
- Stressfull life event or loss


JAMA Pediatrics

Formerly Archives of Pediatrics & Adolescent Medicine

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May 2014, Vol 168, No. 5 >

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Original Investigation | May 2014

Relationship Between Peer Victimization, Cyberbullying, and Suicide in Children and Adolescents

A Meta-analysis

Mitch van Geel, PhD[1]; Paul Vedder, PhD[1]; Jenny Tanilon, PhD[2]


PEDIATRICS

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Institution: WHPR INC, B.LUBMAN

Review Article

Bullying and Suicidal Ideation and Behaviors: A Meta-Analysis

Melissa K. Holt, PhD[a], Alana M. Vivolo-Kantor, MPH, CHES[b], Joshua R. Polanin, PhD[c], Kristin M. Holland, PhD[b], Sarah DeGue, PhD[b], Jennifer L. Matjasko, PhD[b], Misty Wolfe, MPH[b], and Gerald Reid, MA[a]

This Article

Published online January 5, 2015

(doi: 10.1542/peds.2014-1864)

» Abstract Free

Full Text (PDF)

Article Type

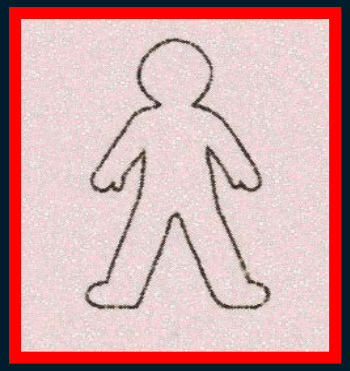
Review Article

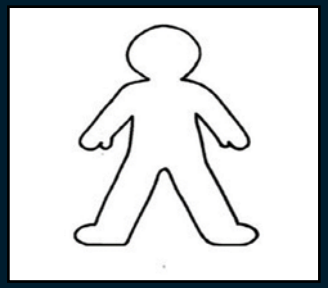
Services

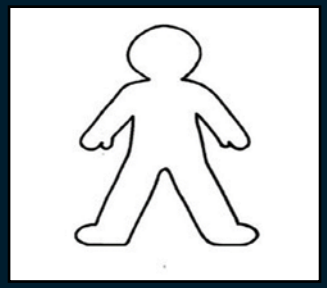
Why Youth? (Kessler et al. 2005)

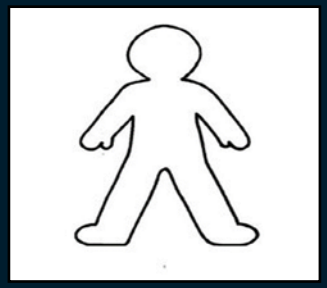
75% of mental illnesses occur before the age of 25 years

Approx 1 in 4 young people (16-24 yrs) will have experienced a mental health disorder in the previous 12 month period









A tale of two Systems: barriers to integrated Services for the dually diagnosed youth

- Most adolescents receive substance abuse treatment separately from medical and psychiatric Services, typically in community-based programs
- Differences across systems have perpetuated significant systemic **barriers to access for youth with co-occurring problems** reinforced by distinct funding mechanisms and different Service's opinions
- A limited % of clinicians and researchers focus on dually diagnosed youth
- Few (<30%) providers respond using formal assessment practices or diagnostic protocols (10%)

Libby and Riggs 2008; Hawkins, 2009; Lichtenstein et al., 2010

Segnalibro

- La questione degli esordi tra sostanze e disturbi mentali


Braxton is addicted
to methadone.


IMMENSO.ORG

THE JOURNAL OF CHILD PSYCHOLOGY AND PSYCHIATRY

ACAMH THE ASSOCIATION FOR CHILD AND ADOLESCENT MENTAL HEALTH

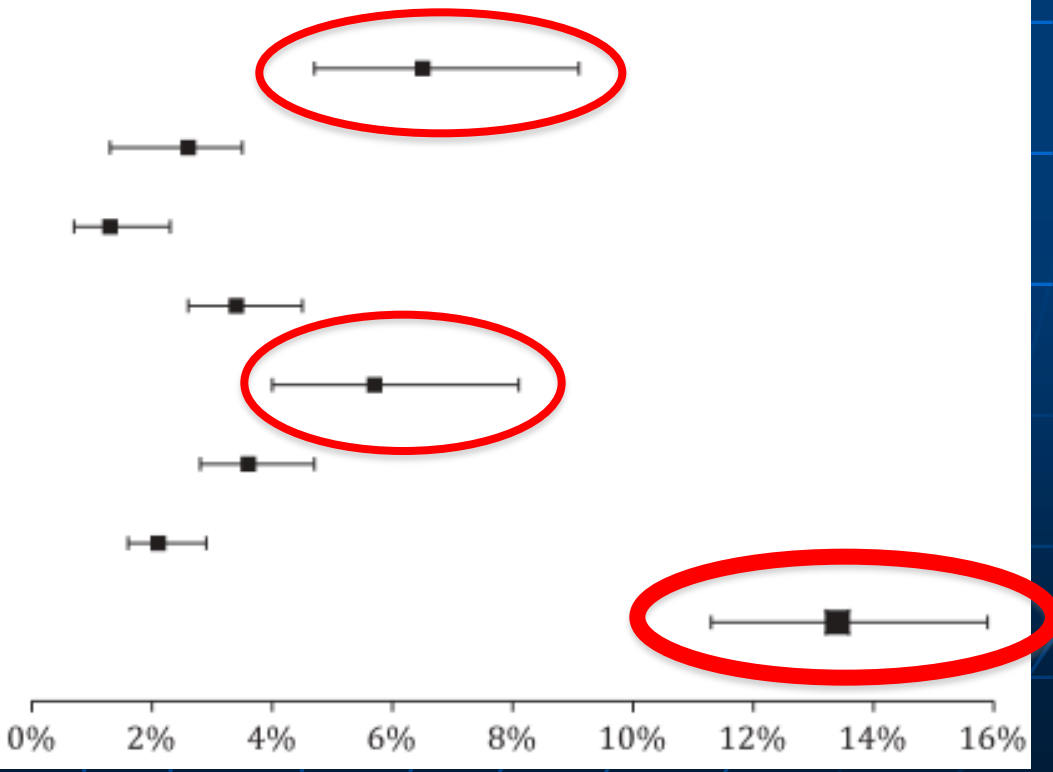
Journal of Child Psychology and Psychiatry 56:3 (2015), pp 345–365

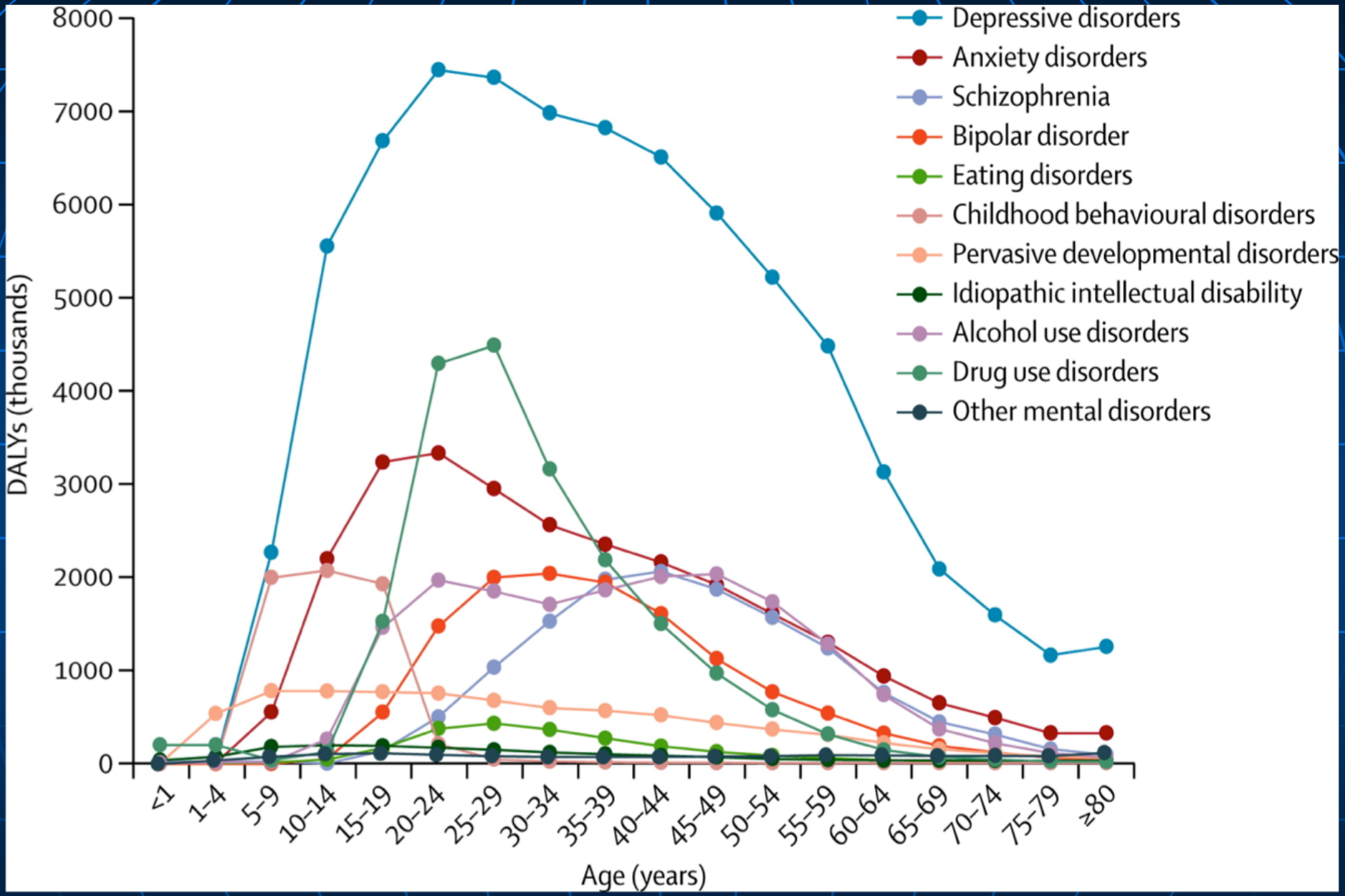
doi:10.1111/jcpp.12381

Annual Research Review: A meta-analysis of the worldwide prevalence of mental disorders in children and adolescents

Guilherme V. Polanczyk,[1,2,3] Giovanni A. Salum,[3,4] Luisa S. Sugaya,[1,2] Arthur Caye,[4] and Luis A. Rohde[3,4]

Outcome	N studies	Sample size
Any anxiety disorder	41	63130
Any depressive disorder	23	59492
MDD	22	68382
ADHD	33	77297
Any disruptive behavior disorder	19	38324
ODD	28	69799
CD	28	73679
Any mental disorder	41	87742





the burden of disease attributable to mental health and substance use disorders across the age span (Harris et al, 2005)

Gateway Drugs: How Does Addiction Start?

EXAMPLES OF GATEWAY DRUGS

- Marijuana
- Tobacco
- Alcohol
- Or prescription pills

Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide

NIDA

NATIONAL INSTITUTE ON DRUG ABUSE

Elementary and middle school students are becoming more involved with gateway drugs.

Gateway Drugs

- 1 in 4 teenagers smokes cigarettes.
- Every day, on average, 11,318 American youth try alcohol for the first time
- 7.2% of 14- to 15-year-olds report using marijuana in the past month. That's an average of 3 kids in every math class of 40 students. By the time these kids turn 16 and 17, that number will double.

Timeline of Drug Use

Most commonly reported order of drug usage

First drug used

Alcohol

Marijuana

Hallucinogens

Cocaine

Ecstasy

Adderall

Benzodiazepines

Opiates

Heroin

Methamphetamine

Tenth drug used

Heroin use is part of a larger substance abuse problem.

Nearly all people who used heroin also used at least 1 other drug.

Most used at least 3 other drugs.

Heroin is a highly addictive opioid drug with a high risk of overdose and **death** for users.

People who are addicted to...

ALCOHOL

are **2x**

MARIJUANA

are **3x**

COCAINE

are **15x**

Rx OPIOID PAINKILLERS

are **40x**

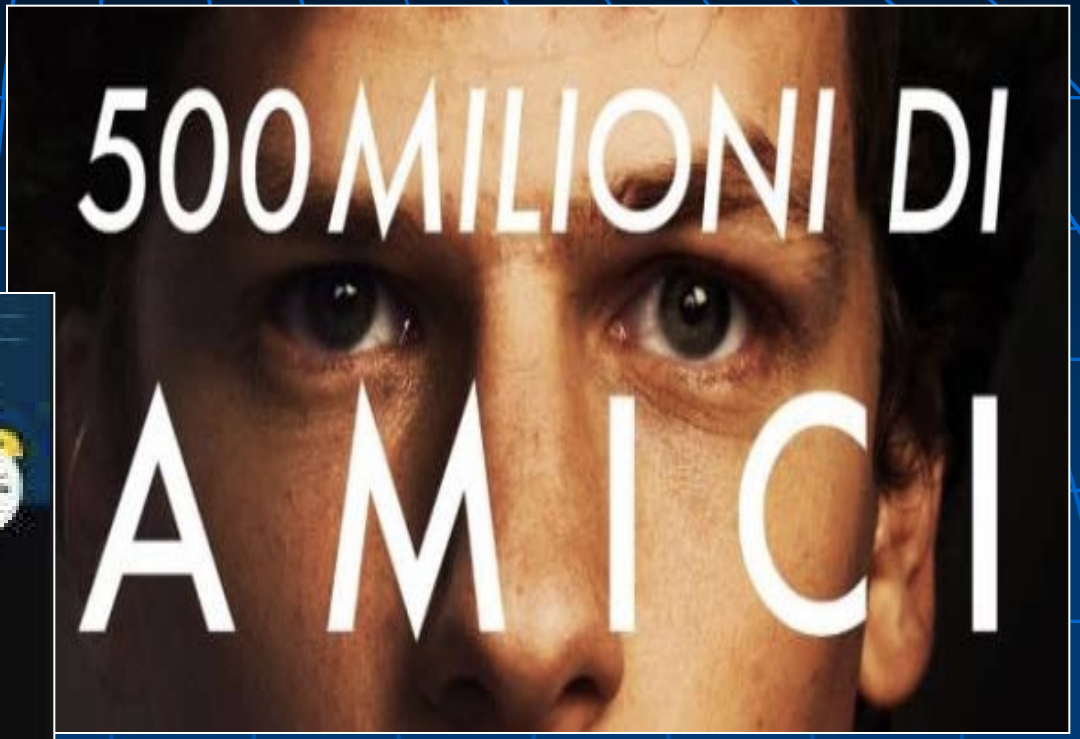
...more likely to be addicted to heroin.

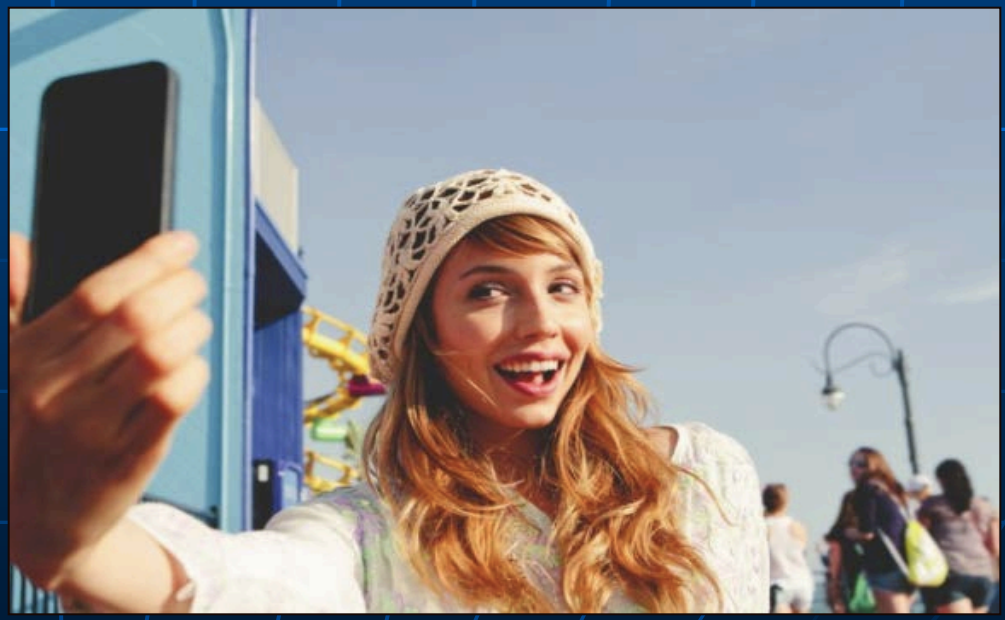
SOURCE: National Survey on Drug Use and Health (NSDUH), 2011-2013.

NIH
National Institute on Drug Abuse
The Science of Drug Abuse & Addiction

NIAAA
National Institute on Alcohol Abuse and Alcoholism

accelerazione tecnologica?






DO YOU KNOW
WHAT YOUR KIDS
ARE WATCHING
ON THE INTERNET
RIGHT NOW?
innocence
DANGER

Mental Health Gaps for Youth

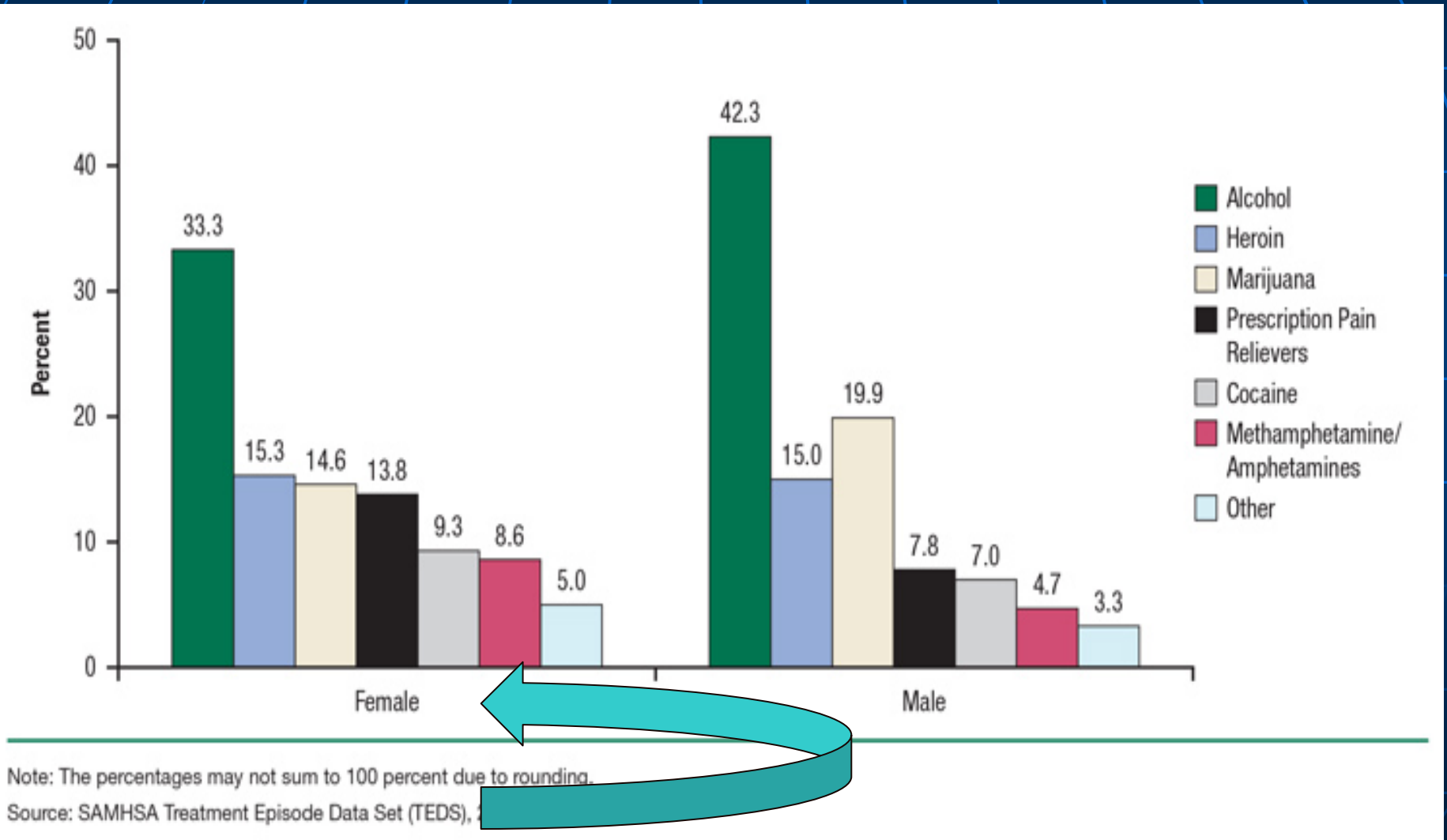
- 10-20% of youths in the U.S. meet diagnostic criteria for Mental Health (MH) disorders
- Up to 50% of youth in the Child Welfare System and 70% in the Jail System have a diagnosable MH disorder
- Only 20-30% of those in need receive specialized MH care
- Although youth comprise 25% of the population, only 1/9 of health care funding is directed to them
- A great number with disability

Substance Abuse and Mental Health Services Administration

SAMHSA

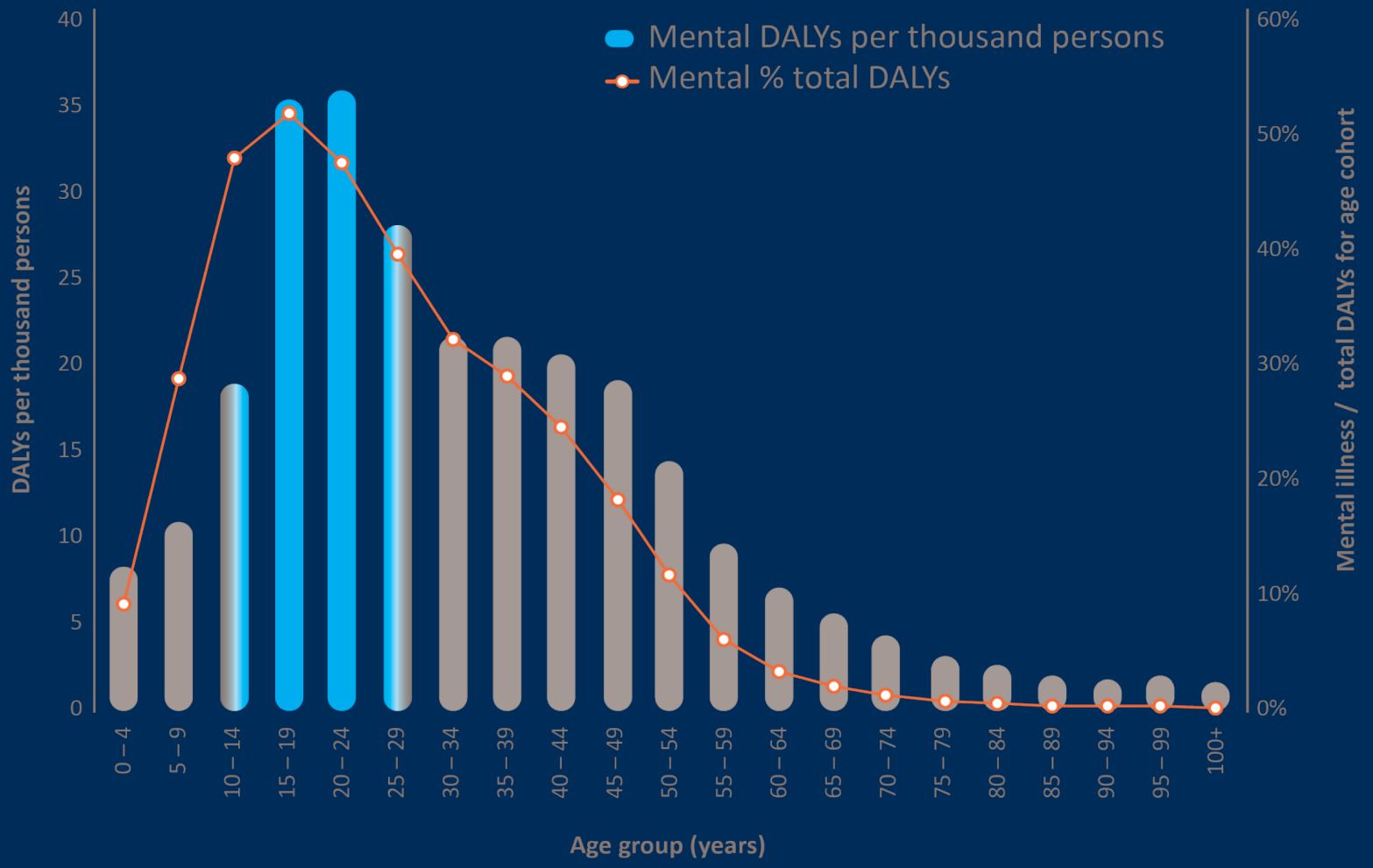
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Substance Abuse Treatment Admissions Aged 12 or Older, by Gender and Primary Substance of Abuse (2014)



Note: The percentages may not sum to 100 percent due to rounding.

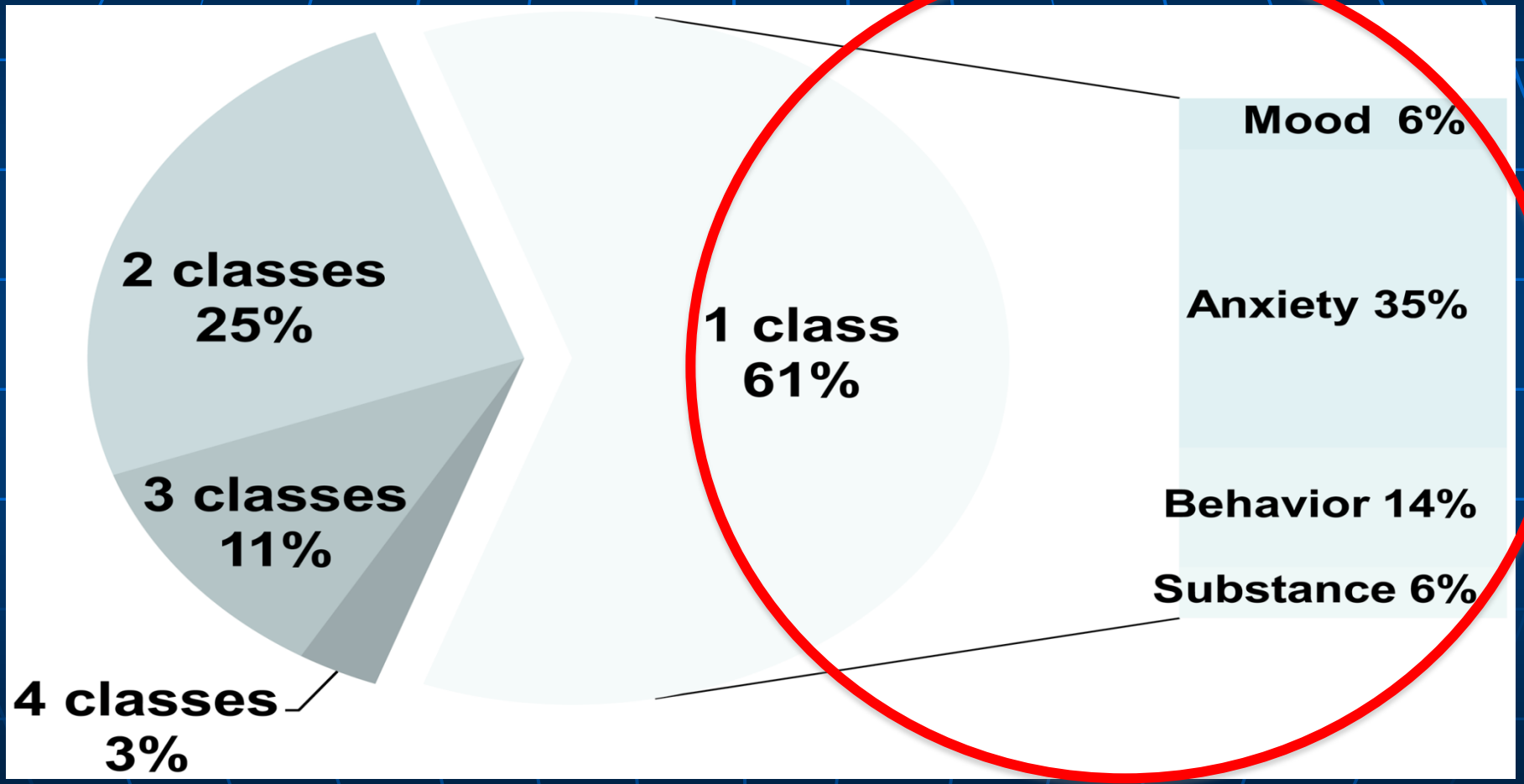
Source: SAMHSA Treatment Episode Data Set (TEDS),



Disability-Adjusted Life Year, Measure of lost years to illness (Kazak et a,l 2010)

J Am Acad Child Adolesc Psychiatry. 2010 October ; 49(10): 980–989. doi:10.1016/j.jaac.2010.05.017.

Lifetime Prevalence of Mental Disorders in US Adolescents: Results from the National Comorbidity Study-Adolescent Supplement (NCS-A)



Distribution of the Major Classes of DSM-IVTR Disorders Among Adolescents with at Least One Disorder

J Am Acad Child Adolesc Psychiatry. 2010 October ; 49(10): 980–989. doi:10.1016/j.jaac.2010.05.017.

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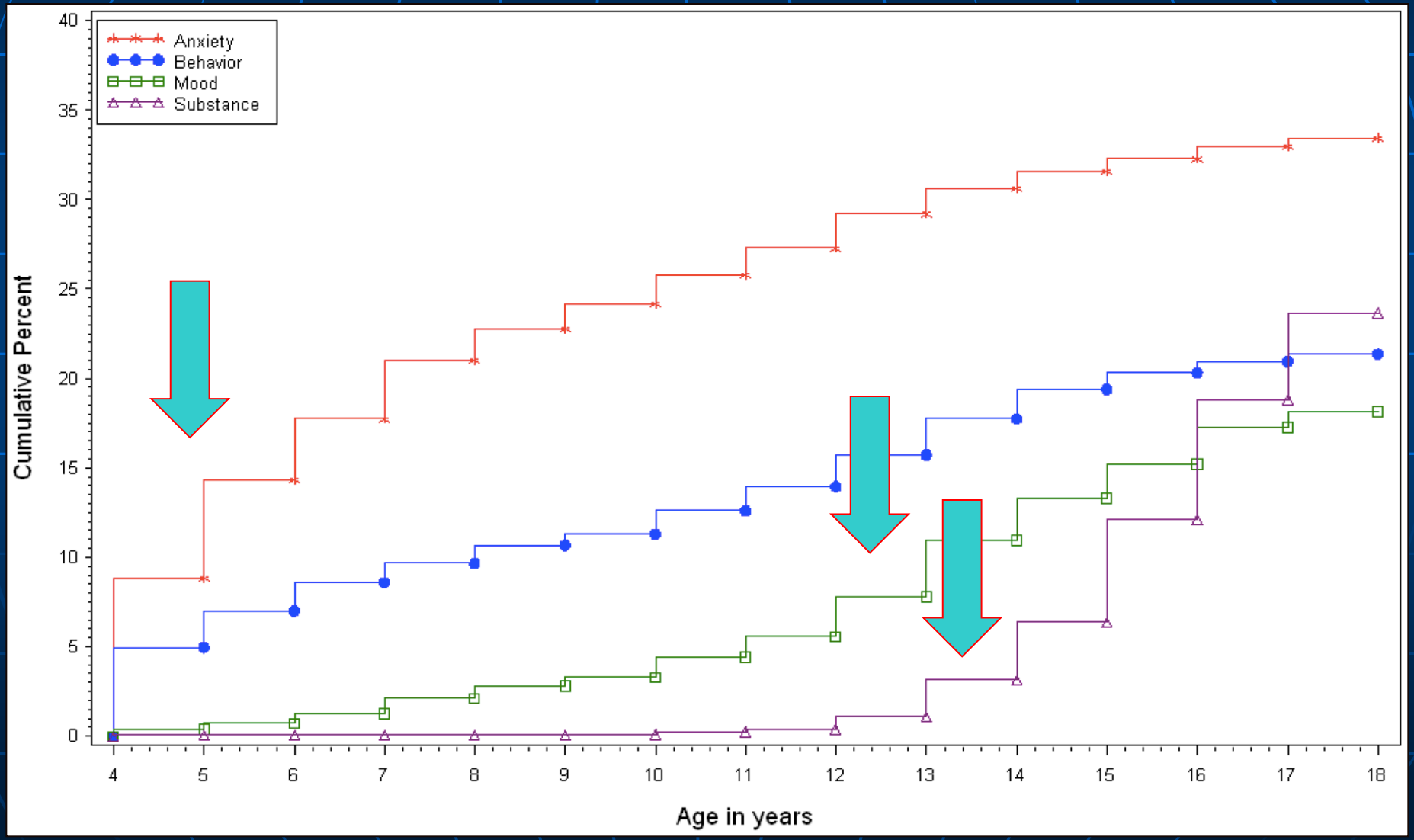


age at which Marijuana use is first initiated

Age

13 – 20 Years

Schizophrenia

Social Phobias

Panic Disorder

Bipolar Disorder

10 - 13 Years

Eating Disorders

Obsessive-Compulsive Disorders

5 – 10 Years

Anti-social Behavior

Conduct Disorder

Depression

Anxiety

Infancy to 5 Years

Attention Deficit Hyperactivity Disorder

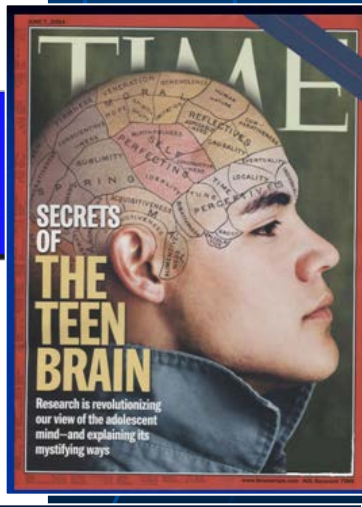
Autism

Age of Onset of Brain Disorders

Addiction

Drug Use

Brain Disorders



Developed from Time Magazine, January 20, 2003, p. 82

SAMHSA (2003) – Data from National Survey of Drug Use (2003)

J Am Acad Child Adolesc Psychiatry. 2010 October ; 49(10): 980–989. doi:10.1016/j.jaac.2010.05.017.

Lifetime Prevalence of Mental Disorders in US Adolescents: Results from the National Comorbidity Study-Adolescent Supplement (NCS-A)

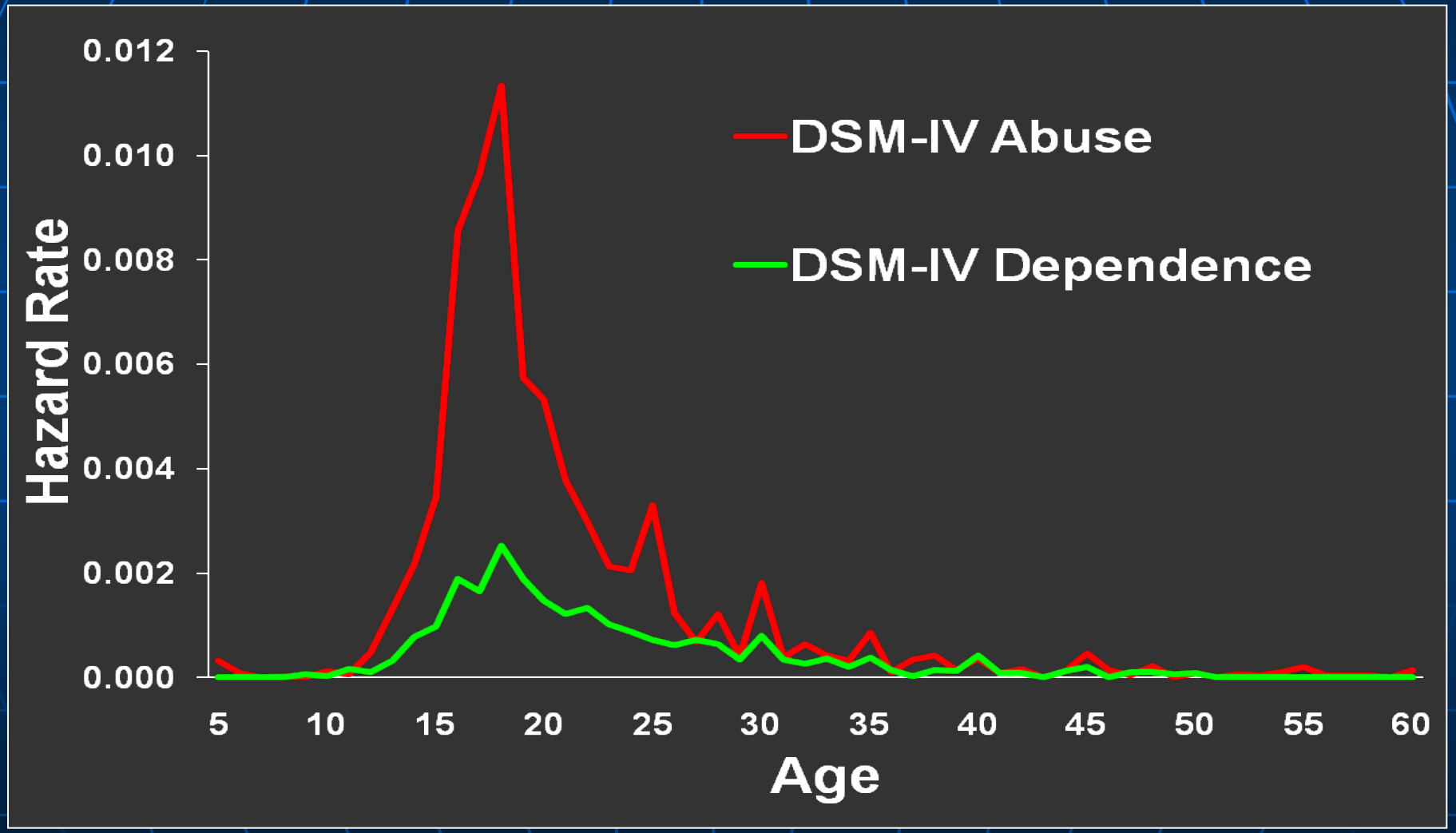
Mood disorders → **14.3%** (11.7% with MDD or dysthymia and 2.9% with BD). **Prevalence increase x2 from 13-14-year age group to 17-18-y.a.group**

Anxiety disorders → **31.9%** (8.3% for *severe cases*)

ADHD → **8.7%** (4.2%, *severe cases*)
Oppositional defiant disorder → **12.6%** (6.5%, *severe cases*)
Conduct disorder → **6.8%** (2.2%, *severe cases*)

Substance use disorders → **11.4%**
- **8.9%** with drug abuse/dependence
- **6.4%** with alcohol abuse/dependence

Addiction is a Developmental Disorder
Onset is During Adolescence



(Compton et al. 2007)

Why we can not further ignore SUD in adolescents (patients) with mental illness

(Compton, 2010)

Adolescents with mental illness are at greater risk for substance abuse because…

- drugs can trigger mental disorders in those that are vulnerable and can exacerbate their course
- overlapping genetic, environmental and epigenetic vulnerabilities between different disorders in adolescents (psychosis, mood d.)
- drugs contribute significantly to the morbidity and mortality of adolescents with mental illness
- there is an increased risk for earlier relapse, non admission to Services, treatment non-completion and poorer response

UNMET NEEDS OF ADOLESCENTS

RESEARCH REPORT

Reducing the treatment gap for mental disorders: a WPA survey

VIKRAM PATEL[1], MARIO MAJ[2], ALAN J. FLISHER[3], MARY J. DE SILVA[1], MIRJA KOSCHORKE[1], MARTIN PRINCE[4] AND WPA ZONAL AND MEMBER SOCIETY REPRESENTATIVES*

[1]London School of Hygiene and Tropical Medicine, London, UK; [2]Department of P
and Mental Health, University of Cape Town, Rondebosch 7700, Cape Town, South
* The WPA Zonal and Member Society Representatives are listed in the Appendix

nian Psychiatric Association), Mohammed R. Lafta (Iraqi Society of Psychiatrists), Mariano Bassi (Italian Psychiatric Association), Massimo Clerici (Italian Association for Research in Schizophrenia), Roger Gibson (Jamaica Psychiatric Association), Takuya Kojima (Japanese Society of Psychiatry

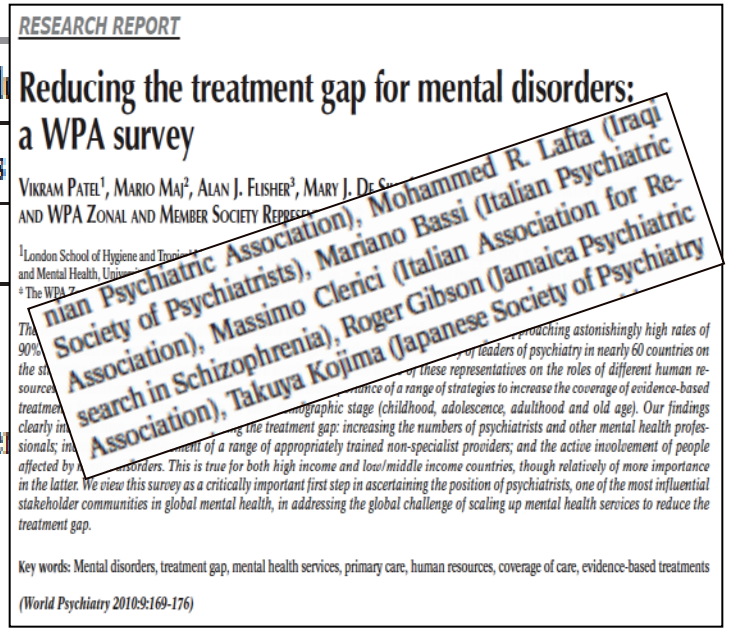
The treatment gap for people with mental disorders exceeds 50% in all countries of the world, approaching astonishingly high rates of 90% in the least resourced countries. We report the findings of the first systematic survey of leaders of psychiatry in nearly 60 countries on the strategies for reducing the treatment gap. We sought to elicit the views of these representatives on the roles of different human resources and health care settings in delivering care and on the importance of a range of strategies to increase the coverage of evidence-based treatments for priority mental disorders for each demographic stage (childhood, adolescence, adulthood and old age). Our findings clearly indicate three strategies for reducing the treatment gap: increasing the numbers of psychiatrists and other mental health professionals; increasing the involvement of a range of appropriately trained non-specialist providers; and the active involvement of people affected by mental disorders. This is true for both high income and low/middle income countries, though relatively of more importance in the latter. We view this survey as a critically important first step in ascertaining the position of psychiatrists, one of the most influential stakeholder communities in global mental health, in addressing the global challenge of scaling up mental health services to reduce the treatment gap.

Key words: Mental disorders, treatment gap, mental health services, primary care, human resources, coverage of care, evidence-based treatments

(World Psychiatry 2010:9:169-176)

Table 1 Mental disorders currently representing a major focus for health services and those regarded as needing greater attention (in order of importance)

Children		Adolescents		Adu
Current priority mental disorders				
HIC	LMIC	HIC	LMIC	HIC
- Conduct disorder - Hyperkinetic disorder - Anxiety disorders	- Mental retardation - Hyperkinetic disorder - Conduct disorder	- Depression - Anxiety disorders - Schizophrenia	- Schizophrenia - Substance abuse - Depression	- Schizophrenia - Depression - Bipolar disorder



RESEARCH REPORT

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Th… …touching astonishingly high rates of 90%… …of leaders of psychiatry in nearly 60 countries on the st… …of these representatives on the roles of different human resources… …dance of a range of strategies to increase the coverage of evidence-based treatment… …ographic stage (childhood, adolescence, adulthood and old age). Our findings clearly in… …g the treatment gap: increasing the numbers of psychiatrists and other mental health professionals; in… …ment of a range of appropriately trained non-specialist providers; and the active involvement of people affected by m… …isorders. This is true for both high income and low/middle income countries, though relatively of more importance in the latter. We view this survey as a critically important first step in ascertaining the position of psychiatrists, one of the most influential stakeholder communities in global mental health, in addressing the global challenge of scaling up mental health services to reduce the treatment gap.

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(World Psychiatry 2010;9:169-176)

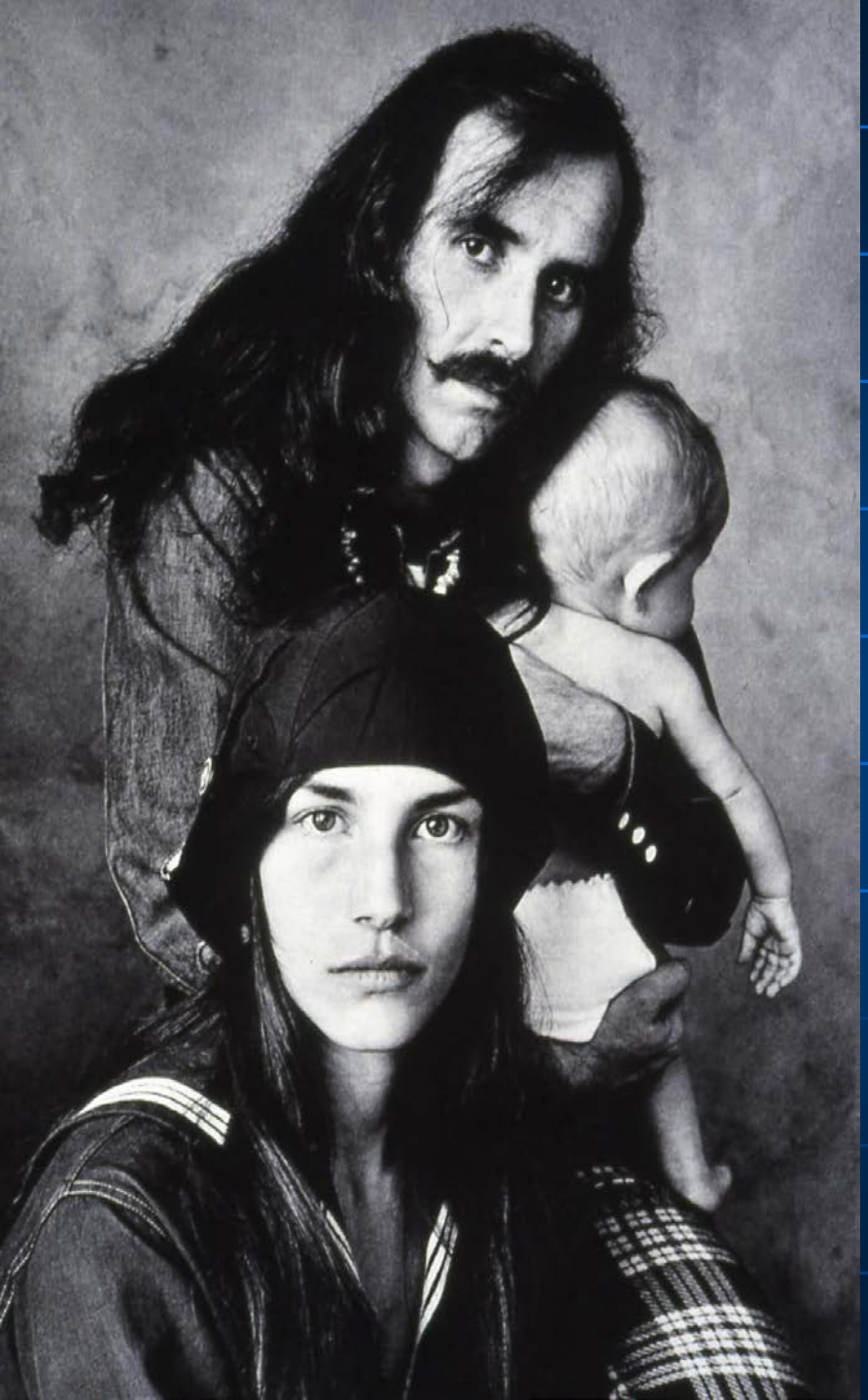
Disorders needing greater attention							
HIC	LMIC	HIC	LMIC	HIC	LMIC	HIC	LMIC
- Pervasive developmental disorders - Hyperkinetic disorder	- Hyperkinetic disorder - Anxiety disorders - Depression	- Substance abuse	- Depression - Substance abuse - Anxiety disorders	Personality disorders Substance abuse	- Depression - Anxiety disorders - Bipolar disorder	- Depression - Dementia	- Depression - Dementia

HIC – high-income countries; LMIC – low- and middle-income countries

Table 3 Importance of human resources for increasing coverage of care for priority disorders according to respondents

Human resource	Roles	Children				Adolescents				Adults		Adults and older people		Older people	
		Hyperkinetic disorder		Anxiety disorders		Depression		Substance abuse		Schizophrenia		Depression		Dementia	
		HIC	LMIC	HIC	LMIC	HIC	LMIC	HIC	LMIC	HIC	LMIC	HIC	LMIC	HIC	LMIC
Psychiatrist	Diagnosis	√√√	√√√	√√√	√√√	√√√	√√√	√√√	√√√	√√√	√√√	√√√	√√√	√√√	√√√
	Medication	√√√	√√√	√√√	√√√	√√√	√√√	√√√	√√√	√√√	√√√	√√√	√√√	√√√	√√√
	Psychosocial	√√	√√	√√√	√√	√√√	√√	√√√	√√	√√√	√√√	√√√	√√	√√√	√√
Other mental health specialist	Diagnosis	√√√	√√√	√√√	√√√	√√√	√√	√√	√√√	√	√√	-	√√	-	√√
	Medication	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Psychosocial	√√√	√√√	√√√	√√√	√√√	√√√	√√√	√√√	√√	√√√	√√√	√√√	√√√	√√
Primary care doctor	Diagnosis	√	√√	√√	√√	√√	√√	√√	√√√	-	√√	√√√	√√√	√√√	√√√
	Medication	√	√	√	√√	√√	√√	√√	√√	-	√	√√	√√	√√	√√
	Psychosocial	-	-	√	√	√	√	√	√√	-	√	√	√	-	√
Non-medical health worker	Diagnosis	-	-	-	-	-		-	√	-	-	-	-	-	-
	Medication	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Psychosocial	-	√	√	√√	√√	√√	√√	√√	√√	√√	√	√√√	√√	√√
Service users/family members	Diagnosis	-	-	-	√	-	√	√√	√√	-	√	-	√√	√	√
	Medication	-	-	-	-	-	√	-	√	-	√	-	√	-	-
	Psychosocial	√	√√	√√	√√	√√	√√	√√	√√	√√√	√√	√√	√√	√√	√√

HIC – high-income countries; LMIC – low- and middle-income countries; √√√ – extremely important; √√ – very important; √ – important



"SINDROME AMOTIVAZIONALE" vs PSICOSI DA HASHISH

…la generazione hippy…

da sempre sono descritti stadi dell'intossicazione cronica da cannabinoidi in cui le anomalie del comportamento e i disturbi psichici acquistano gravità progressiva: gli ultimi stadi hanno caratteristiche psicotiche

(Steinbrecheer, 1964; Stringaris, 1972)

Psychological Medicine (2012), **42**, 1857–1863. © Cambridge University Press 2012
doi:10.1017/S0033291711002960

ORIGINAL ARTICLE

Prevalence of psychotic symptoms in childhood and adolescence: a systematic review and meta-analysis of population-based studies

I. Kelleher[1*†], D. Connor[1†], M. C. Clarke[1], N. Devlin[1,2], M. Harley[1,2] and M. Cannon[1,3*]

Psychological Medicine, **42** (2012).

Letter to the Editor

All that shines is not psychosis: a cautionary note on the assessment of psychotic symptoms in childhood and adolescence

- **for the child population (9 to 12 years)**

→ 17%

- **for the adolescent population (13–18 years)**

→ 7.5% **OVERESTIMATION OF PSYCHOSIS RISK?**

A growing empirical literature indicates that the specificity of some of the psychotic-like experiences might be very limited and that they probably intercept a broad spectrum of sub-threshold psychopathology not necessarily forerunning psychosis, but also anxiety or affective disorders. It seems unrealistic that these prevalences in children equates to the lifetime prevalence of mental disorders in the general population!!