Systematic reviews analysing the link between cannabis and psychotic disorders added evidence about the potential role of cannabis in the pathogenesis of schizophrenia. Moore et al. reviewed 35 studies on the relationship between cannabis use and the occurrence of psychotic or affective mental health outcomes, and found an increased risk of any psychotic outcome in individuals who had ever used cannabis [41]. Results were consistent with a dose-response effect, with greater risk in people who used cannabis more frequently. Preliminary studies [42] have reported an increasing use of novel psychoactive drugs, such as synthetic cannabinoids, especially among young people suffering from mental disorders. Synthetic cannabinoids may also exacerbate psychotic symptoms in vulnerable individuals [43], and

Journal of Psychopathology 2015;21:390-399

Psychopathology of addictions

Psychopathology of dual diagnosis: new trumpets and old uncertainties

G. Carrà[1], F. Bartoli[2], M. Clerici[2], N. el-Guebaly[3]

[1] Division of Psychiatry, University College London, London, UK; [2] Department of Medicine and Surgery, University of Milano Bicocca, Monza, Italy; [3] Division of Addiction, Department of Psychiatry, University of Calgary and Alberta Gambling Research Institute, Canada

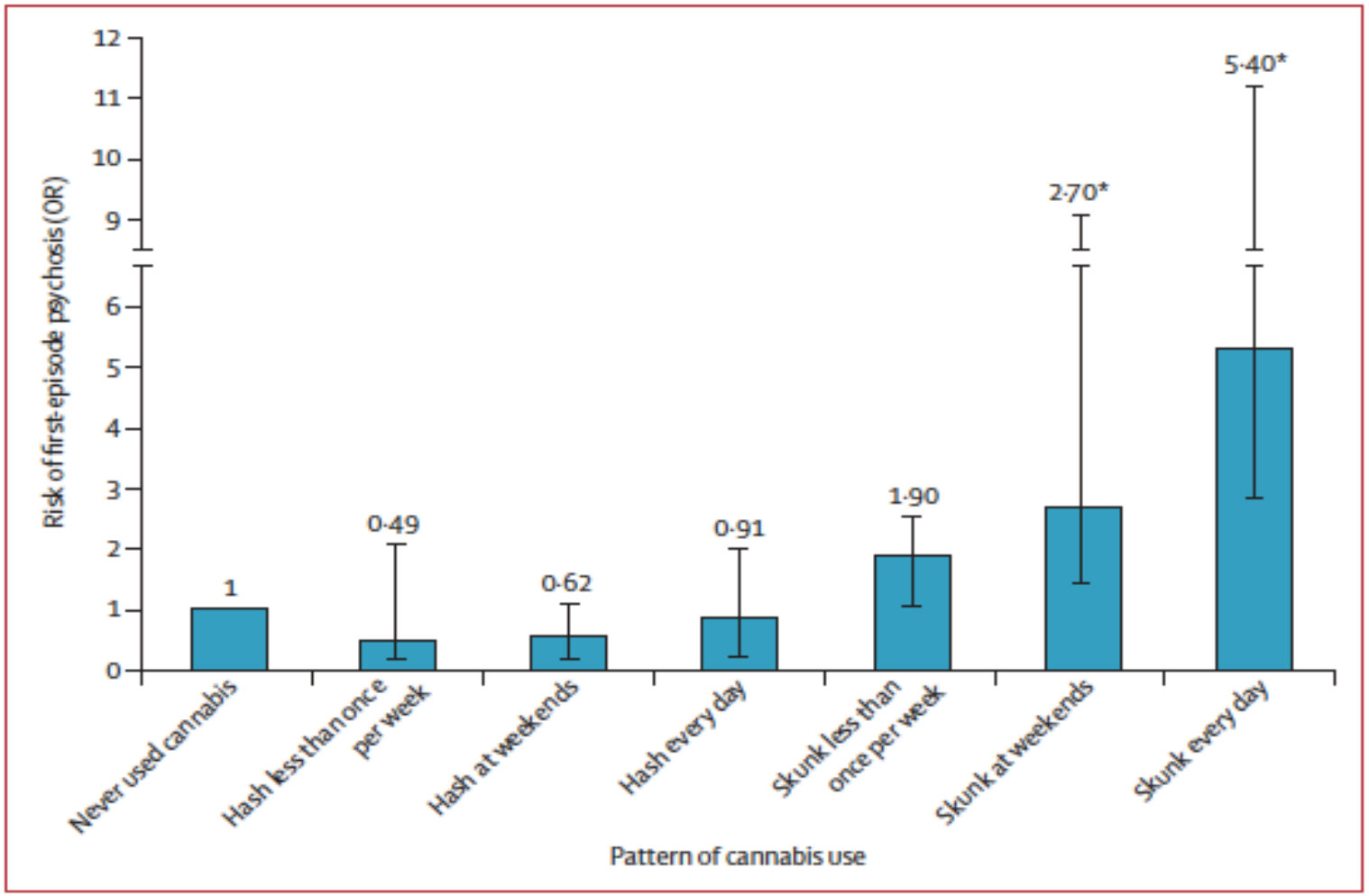
However, although the aetiological role of cannabinoids in chronic psychosis can be supported by some neurobiological models [46 47], cannabis seems to be neither a sufficient nor a necessary condition for the onset of chronic psychotic disorders, appearing as one of the several known and unknown factors that interact each other increasing the individual risk of psychosis [40 48]. The role of cannabis on psychosis may be a good example of the role of the gene/environment interaction in determining vulnerability in psychiatric disorders [48 49].

Proportion of patients in south London with first-episode psychosis attributable to use of high potency cannabis: a case-control study

Marta Di Forti, Arianna Marconi, Elena Carra, Sara Fraietta, Antonella Trotta, Matteo Bonomo, Francesca Bian
Jennifer O'Connor, Manuela Russo, Simona A Stilo, Tiago Reis Marques, Valeria Mondelli, Paola Dazzan, Carmir
Fiona Gaughran, Zerrin Atakan, Conrad Iyegbe, John Powell, Craig Morgan, Michael Lynskey, Robin M Murray

Lancet Psychiatry 2015
Published Online
February 18, 2015
http://dx.doi.org/10.1016/
S2215-0366(14)00117-5

OR adjusted for age, gender, ethnic origin, education, employment status, and tobacco use.

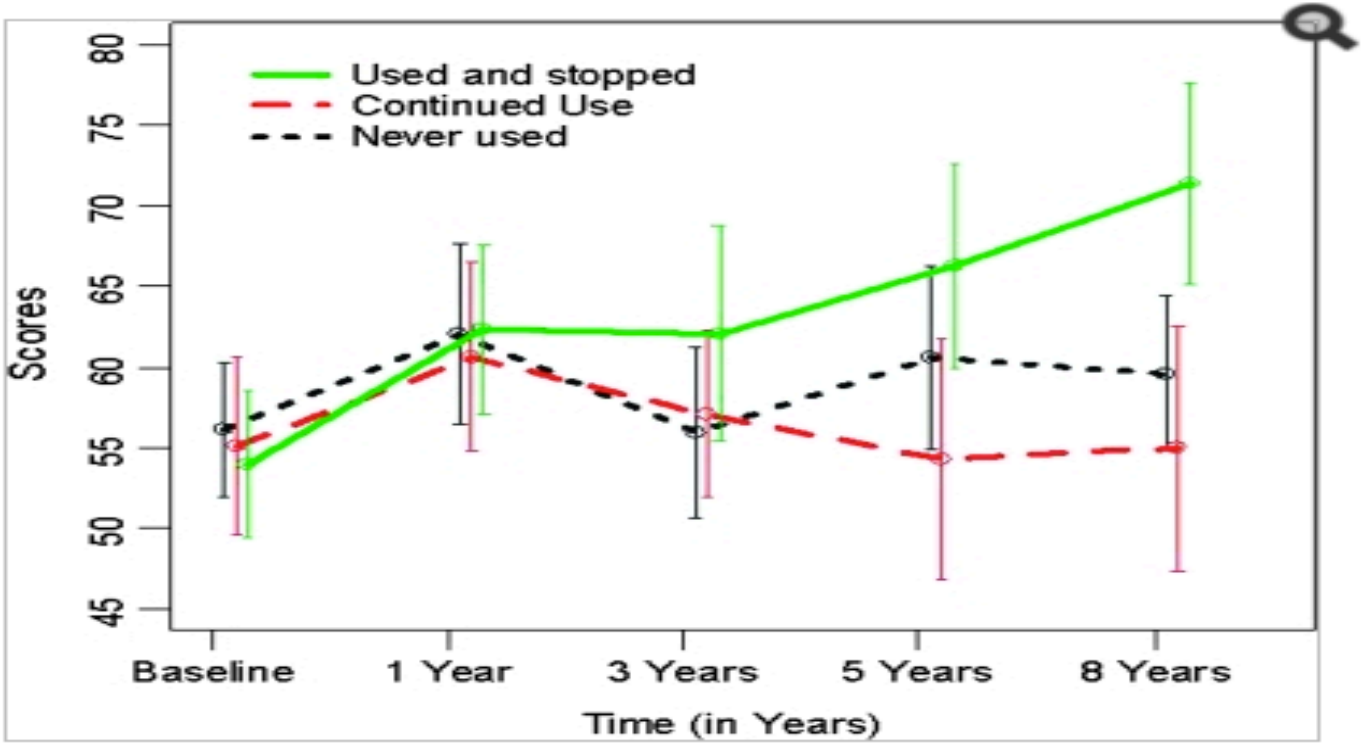


Schizophrenia Bulletin

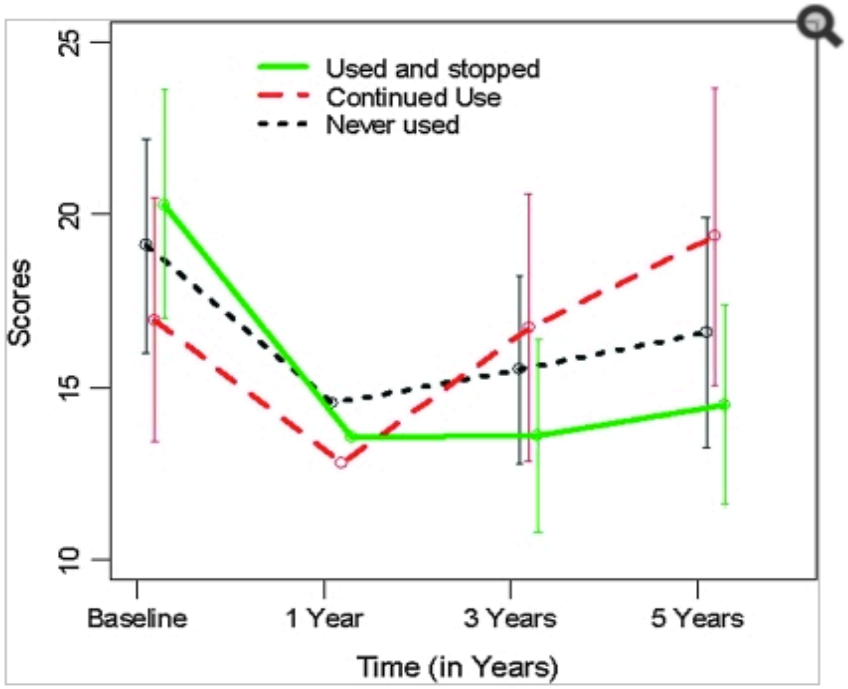
Schizophr Bull. 2011 May; 37(3): 631–639.
Published online 2009 Nov 13.
doi: 10.1093/schbul/sbp126
PMCID: PMC3080669

Cannabis and First-Episode Psychosis: Different Long-term Outcomes Depending on Continued or Discontinued Use

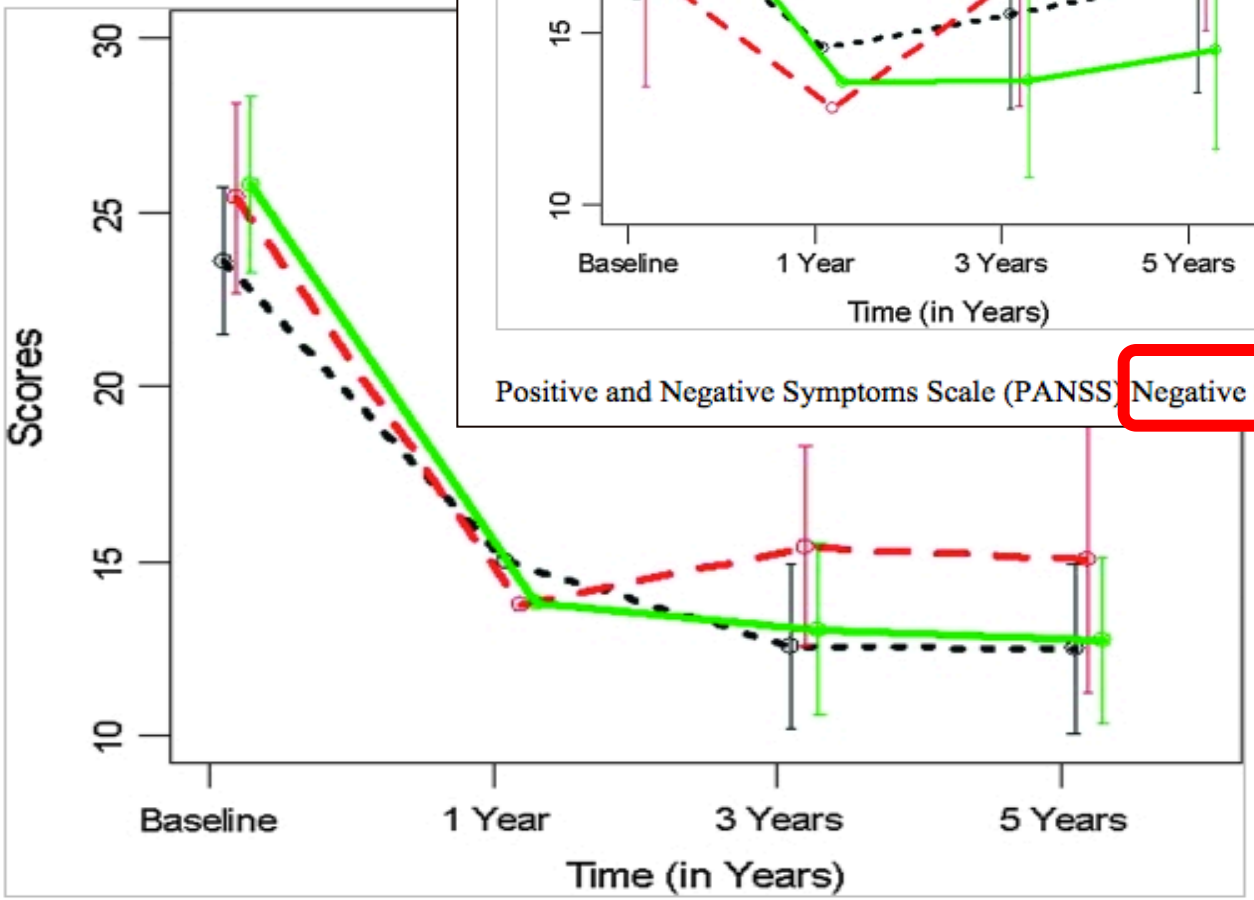
Ana González-Pinto,[1,2] Susana Alberich,[2] Sara Barbeito,[2] Miguel Gutierrez,[2] Patricia Vega,[2] Berta Ibáñez,[3] Mahmoud Karim Haidar,[2]



Global Assessment of Functioning (GAF) Outcome by Cannabis Use Group.



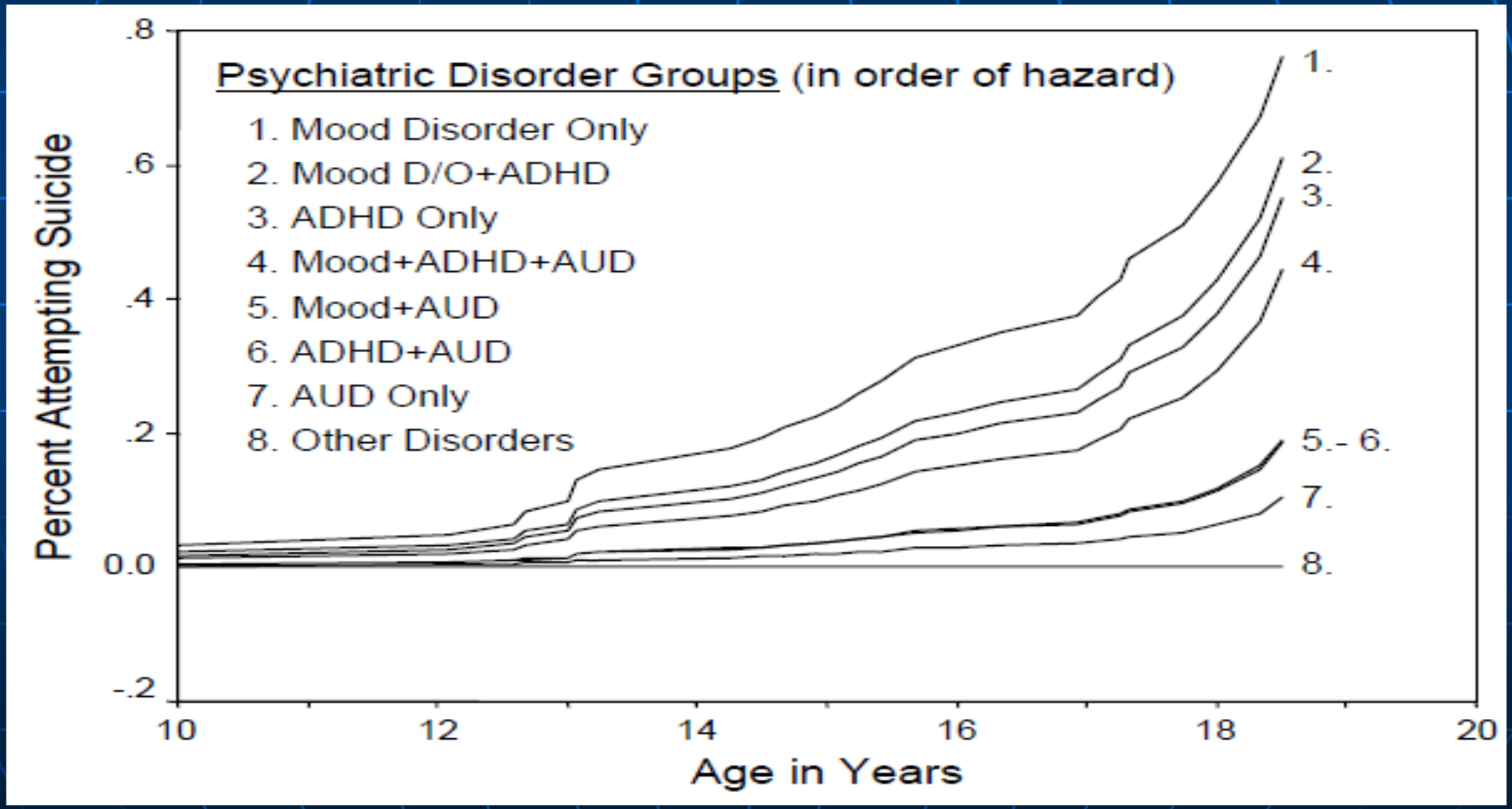
Positive and Negative Symptoms Scale (PANSS) Negative Symptoms Outcome by Cannabis Use Group



Positive and Negative Symptoms Scale (PANSS) Positive Symptoms Outcome by Cannabis Use Group.

Comorbidity and hazard curves for risk of first attempted suicide in male adolescents with drug related disorder

(Kelly et al, Drug Alcohol Depend. 2004)



Specific substance use and suicide attempts: data from 16 European countries

any 30-day cannabis use	**(OR 1.37**, 95%CI: 1.18-1.58)
30-day frequent alcohol use	(1.47, 1.32-1.63)
30-day regular tobacco use	(2.02, 1.84-2.21)
lifetime use of illegal drugs other than cannabis	(2.41, 2.14-2.70)
lifetime tranquillizer or sedative use	**(3.34, 3.00-3.71)**

The risk approximately doubled for every additional substance used

Kokkevi et al, Eur Child Adolesc Psychiatry. 2012

attempted suicide ratio

attempters with substance abuse disorders had **higher levels of lethality** than attempters without substance abuse

(Mc Manama O'Brien & Berzin Suicide Life Threat Behav. 2012

Articles

THE LANCET

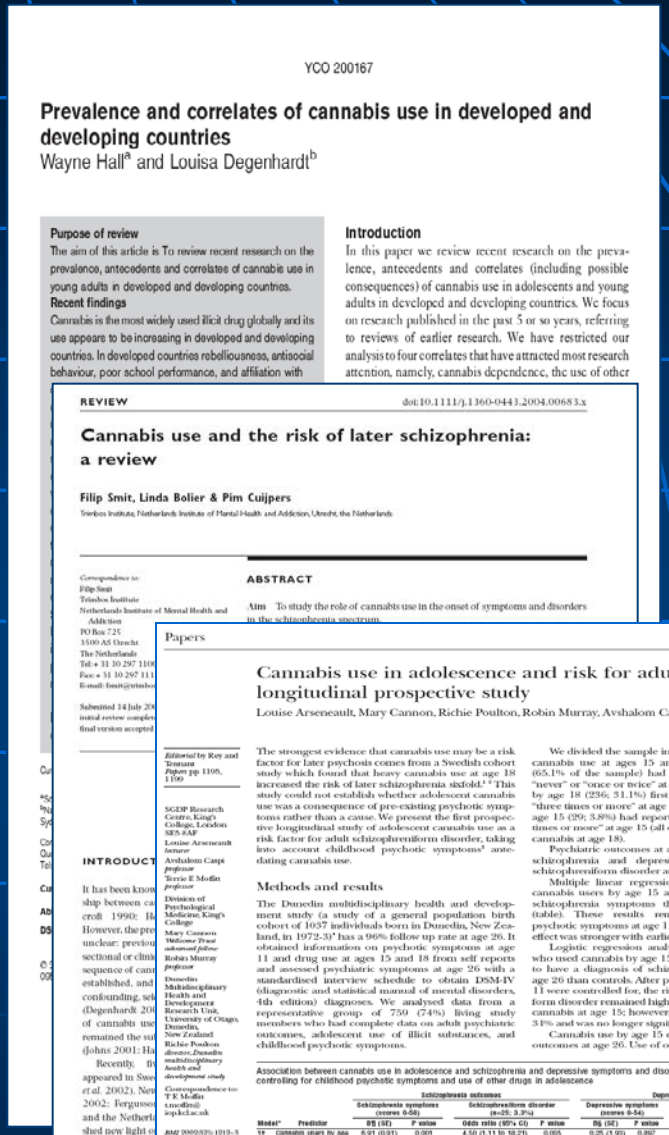
The natural history of self-harm from adolescence to young adulthood: a population-based cohort study

Paul Moran, Carolyn Coffey, Helena Romaniuk, Craig Olsson, Rohan Borschmann, John B Carlin, George C Patton

The early detection and treatment of common mental disorders during adolescence might constitute an important and unrecognised component of suicide prevention in young adults

...problemi aperti per i teen-agers che usano sostanze (Galanter, Kleber, 2006)

…per milioni di giovani che fanno uso di THC e di stimolanti, gli effetti cumulativi sullo sviluppo intellettivo e sulla personalità saranno dannosi proprio in relazione alle sfide della condizione adulta. Considerando il potenziale educativo e lavorativo di un giovane che manifesta una compromissione a livello della memoria, delle abilità di apprendimento o delle motivazioni, la perdita di risorse umane e i costi sociali conseguenti si riveleranno negli anni sempre più drammatici



YCO 200167

Prevalence and correlates of cannabis use in developed and developing countries

Wayne Hall[a] and Louisa Degenhardt[b]

Purpose of review

The aim of this article is To review recent research on the prevalence, antecedents and correlates of cannabis use in young adults in developed and developing countries.

Recent findings

Cannabis is the most widely used illicit drug globally and its use appears to be increasing in developed and developing countries. In developed countries rebelliousness, antisocial behaviour, poor school performance, and affiliation with

Introduction

In this paper we review recent research on the prevalence, antecedents and correlates (including possible consequences) of cannabis use in adolescents and young adults in developed and developing countries. We focus on research published in the past 5 or so years, referring to reviews of earlier research. We have restricted our analysis to four correlates that have attracted most research attention, namely, cannabis dependence, the use of other

REVIEW

doi:10.1111/j.1360-0443.2004.00683.x

Cannabis use and the risk of later schizophrenia: a review

Filip Smit, Linda Bolier & Pim Cuijpers

Trimbos Institute, Netherlands Institute of Mental Health and Addiction, Utrecht, the Netherlands

ABSTRACT

Aim To study the role of cannabis use in the onset of symptoms and disorders in the schizophrenia spectrum.

Papers

Cannabis use in adolescence and risk for adult psychosis: longitudinal prospective study

Louise Arseneault, Mary Cannon, Richie Poulton, Robin Murray, Avshalom Caspi, Terrie E Moffitt

The strongest evidence that cannabis use may be a risk factor for later psychosis comes from a Swedish cohort study which found that heavy cannabis use at age 18 increased the risk of later schizophrenia sixfold.[1,2] This study could not establish whether adolescent cannabis use was a consequence of pre-existing psychotic symptoms rather than a cause. We present the first prospective longitudinal study of adolescent cannabis use as a risk factor for adult schizophreniform disorder, taking into account childhood psychotic symptoms[3] antedating cannabis use.

Methods and results

The Dunedin multidisciplinary health and development study (a study of a general population birth cohort of 1037 individuals born in Dunedin, New Zealand, in 1972-3)[4] has a 96% follow up rate at age 26. It obtained information on psychotic symptoms at age 11 and drug use at ages 15 and 18 from self reports and assessed psychiatric symptoms at age 26 with a standardised interview schedule to obtain DSM-IV (diagnostic and statistical manual of mental disorders, 4th edition) diagnoses. We analysed data from a representative group of 759 (74%) living study members who had complete data on adult psychiatric outcomes, adolescent use of illicit substances, and childhood psychotic symptoms.

We divided the sample into three groups based on cannabis use at ages 15 and 18. The 494 controls (65.1% of the sample) had reported using cannabis "never" or "once or twice" at both ages; cannabis users by age 18 (236; 31.1%) first reported using cannabis "three times or more" at age 18; and cannabis users by age 15 (29; 3.8%) had reported using cannabis "three times or more" at age 15 (all of whom continued to use cannabis at age 18).

Psychiatric outcomes at age 26 were symptoms of schizophrenia and depression and diagnoses of schizophreniform disorder and depression.

Multiple linear regression analyses showed that cannabis users by age 15 and by age 18 had more schizophrenia symptoms than controls at age 26 (table). These results remained significant after psychotic symptoms at age 11 were controlled for. The effect was stronger with earlier use.

Logistic regression analyses showed that people who used cannabis by age 15 were four times as likely to have a diagnosis of schizophreniform disorder at age 26 than controls. After psychotic symptoms at age 11 were controlled for, the risk for adult schizophreniform disorder remained higher among those who used cannabis at age 15; however, this risk was reduced by 31% and was no longer significant.

Cannabis use by age 15 did not predict depressive outcomes at age 26. Use of other drugs in adolescence

Association between cannabis use in adolescence and schizophrenia and depressive symptoms and disorders at age 26 (n=759), controlling for childhood psychotic symptoms and use of other drugs in adolescence

		Schizophrenia outcomes				Depression outcomes			
		Schizophrenia symptoms (scores 0-58)		Schizophreniform disorder (n=25; 3.3%)		Depressive symptoms (scores 0-54)		Depressive disorder (n=118; 15.5%)	
Model*	Predictor	B§ (SE)	P value	Odds ratio (95% CI)	P value	B§ (SE)	P value	Odds ratio (95% CI)	P value
1†	Cannabis users by age 15	6.91 (0.91)	0.001	4.50 (1.11 to 18.21)	0.005	0.25 (1.93)	0.897	1.02 (0.34 to 3.04)	0.971
	Cannabis users by age 18	1.04 (0.40)	0.009	1.65 (0.65 to 4.18)	0.293	1.98 (0.84)	0.018	1.62 (1.06 to 2.49)	0.028
2‡	Weak psychotic symptoms at age 11	0.58 (0.53)	0.201	4.65 (1.84 to 11.78)	0.001	1.60 (1.13)	0.159	1.45 (0.82 to 2.56)	0.203
	Strong psychotic symptoms at age 11	5.16 (1.39)	0.001	15.97 (3.38 to 75.47)	0.001	−0.55 (2.96)	0.852	0.54 (0.07 to 4.25)	0.554
	Cannabis users by age 15	6.36 (0.91)	0.001	3.12 (0.73 to 13.29)	0.124	0.13 (1.94)	0.946	1.01 (0.24 to 3.02)	0.987
	Cannabis users by age 18	1.03 (0.39)	0.009	1.42 (0.54 to 3.74)	0.473	1.96 (0.84)	0.020	1.61 (1.05 to 2.47)	0.031
3§	Other drug users at age 15 to 18	−0.3 (0.66)	0.655	0.30 (0.05 to 1.62)	0.160	2.48 (1.45)	0.086	1.23 (0.55 to 2.32)	0.743
	Cannabis users by age 15	7.2 (1.07)	0.001	11.38 (1.84 to 70.45)	0.009	−1.75 (2.28)	0.438	0.93 (0.27 to 3.17)	0.905
	Cannabis users by age 18	1.1 (0.42)	0.008	1.95 (0.76 to 5.01)	0.167	1.55 (0.88)	0.079	1.59 (1.01 to 2.49)	0.043

*Model 1 includes the effects of adolescent cannabis use only; model 2 adds to model 1 controls for childhood psychotic symptoms; model 3 adds to model 1 controls for other drug use.
†Estimates for each step are given controlling for socioeconomic status and sex. The socioeconomic status of study members' families was coded into one of six categories based on educational level and income associated with occupations in New Zealand. The scale ranges from 1=unskilled labourer to 6=professional and reflects the average of the highest status of either parent across the seven assessments of the Dunedin study from birth through to age 15.
‡When study members were aged 11, five questions about psychotic symptoms were asked during the interview and were then scored by a psychiatrist (0=no; 1=yes, likely; 2=yes, definitely). Individuals reporting weak psychotic symptoms at age 11 (94 (12.4%) with score of 1) and those reporting strong symptoms (12 (1.6%) with score of ≥ 2) were compared with individuals who reported no symptoms at all (653 (86.0%)).
§Comparisons for other drug users at age 15 to 18 (76; 10.0%) were made with individuals who reported "never" using other drugs at ages 15 and 18 (681; 89.7%). Other drugs refer to substances such as glue, cocaine, and opiates.
¶Confidence intervals for regression coefficients (B) can be calculated using the standard error of the estimate, based on the formula: B±(1.96*SE).

1212

BMJ VOLUME 325 23 NOVEMBER 2002 bmj.com

Segnalibro

- **Difficoltà del trattamento e della prevenzione: un’agenda per riorganizzare gli interventi**

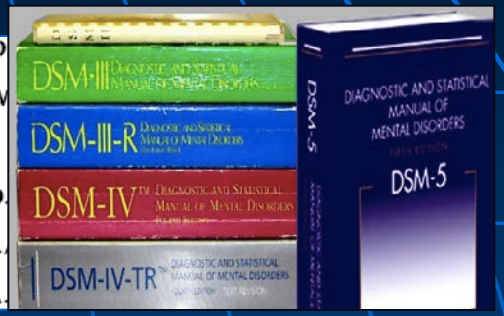
alcuni problemi “pratici” della diagnosi

(Am J Psychiatry 2006; 163:689–696)

Article

Diagnosis of Comorbid Psychiatric Disorders in Substance Users Assessed With the Psychiatric Research Interview for Substance and Mental Disorders for DSM-IV

Deborah Hasin, Ph.D
Sharon Samet, M.S.W
Edward Nunes, M.D.
Jakob Meydan, Psy.D.
Karen Matseoane, B.A.
Rachel Waxman, B.A.



- In qust’ambito, come in tutta la psichiatria il processo che conduce alla formulazione di una diagnosi è complicato da una sostanziale **assenza di marker biologici** (ad es., test)
- E’ ancora necessario un incremento delle conoscenze su segni e sintomi clinici e sindromi, per ottenere un più alto livello di ***reliability*** (Regier et al, 1994; Ross et al, 1995) e di ***validity*** diagnostica (Weiss et al, 1992; Kranzler et al, 1995)
- La diagnosi di disturbo mentale tra chi fa uso di sostanze è complicata dalla **somiglianza tra sintomi effetto di condizioni di intossicazione/astinenza da sostanze e sintomi di disturbi “primari”**

STABILITA' DEL DISTURBO, STABILITA' DELLA DIAGNOSI?

AD ESEMPIO, AD 1 ANNO DI FOLLOW-UP:

- 44.3% mantengono la diagnosi di DCS
- 40.2% mantengono la diagnosi di disturbo dell'umore/d'ansia attuale
- 66% mantengono la diagnosi di Asse II

Verheul, R. et al, (2000) Axis I and Axis II disorders in alcoholics and drug addicts: fact or artifact? J. Stud Alcohol 61, 101-110

THE AMERICAN JOURNAL OF PSYCHIATRY

Reviews and Overviews

Mechanisms of Psychiatric Illness

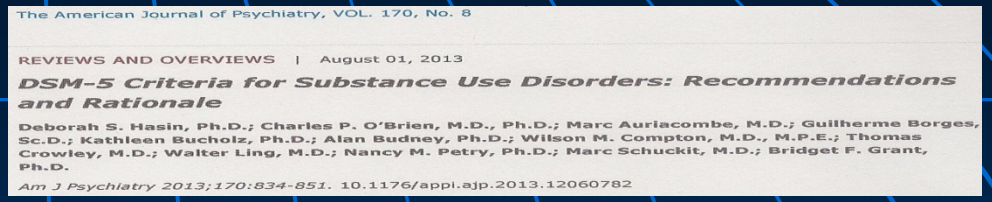
DSM-5 Criteria for Substance Use Disorders: Recommendations and Rationale

TABLE 1. DSM-5 Substance-Related Disorders Work Group[a]

Name	Degree(s)	Specialization	Country
Charles O'Brien (chair)[b]	M.D., Ph.D.	Addiction psychiatry	USA
Marc Auriacombe	M.D.	Addiction psychiatry	France
Guilherme Borges	Sc.D.	Epidemiology	Mexico
Kathleen Bucholz	Ph.D.	Epidemiology	USA
Alan Budney	Ph.D.	Substance use disorder treatment, marijuana	USA
Wilson Compton[b]	M.D., M.P.E	Epidemiology, addiction psychiatry	USA
Thomas Crowley[c]	M.D.	Psychiatry	USA
Bridget F. Grant[b]	Ph.D., Ph.D.	Epidemiology, biostatistics, survey research	USA
Deborah S. Hasin	Ph.D.	Epidemiology of substance use and psychiatric disorders	USA
Walter Ling	M.D.	Addiction psychiatry	USA
Nancy M. Petry	Ph.D.	Substance use and gambling treatment	USA
Marc Schuckit	M.D.	Genetics and comorbidity	USA

[a] In addition to the scientists listed here who were members during the entire duration of the process, a list of consultants and advisers who served on various subcommittees and contributed substantially to the discussion is contained in the official publication of DSM-5.
[b] Also a DSM-5 Task Force member.
[c] Co-chair, 2007–2011.

DSM-5 Criteria for Substance Use Disorders: Recommendations and Rationale



The American Journal of Psychiatry, VOL. 170, No. 8

REVIEWS AND OVERVIEWS | August 01, 2013

DSM-5 Criteria for Substance Use Disorders: Recommendations and Rationale

Deborah S. Hasin, Ph.D.; Charles P. O'Brien, M.D., Ph.D.; Marc Auriacombe, M.D.; Guilherme Borges, Sc.D.; Kathleen Bucholz, Ph.D.; Alan Budney, Ph.D.; Wilson M. Compton, M.D., M.P.E.; Thomas Crowley, M.D.; Walter Ling, M.D.; Nancy M. Petry, Ph.D.; Marc Schuckit, M.D.; Bridget F. Grant, Ph.D.

Am J Psychiatry 2013;170:834-851. 10.1176/appi.ajp.2013.12060782

...to retain the division into two main disorders (dependence and abuse)...!?

The work group recommendations for DSM-5 revisions included combining abuse and dependence criteria into **a single substance use disorder** based on consistent findings from over 200.000 study participants. The proposed changes overcome many problems, while further studies will be needed to address issues for which less data were available

Perché più criteri per la diagnosi?

Drug and Alcohol Dependence
Volume 96, Issues 1–2, 1 July 2008, Pages 187–191

Short communication

Diagnostic orphans for alcohol use disorders in a treatment-seeking psychiatric sample

Lara A. Ray[a], Robert Miranda Jr.[a], Iwona Chelminski[b], Diane Young[b], Mark Zimmerman[b]
[a] Center for Alcohol and Addiction Studies, Brown University, Providence, RI, USA
[b] Department of Psychiatry and Human Behavior, Brown Medical School, Providence, RI, USA

Un numero rilevante di soggetti, sulla base dei criteri DSM-IV, rimanevano privi di diagnosi, in quanto non soddisfacevano alcun criterio per l'abuso di sostanze e avevano non più di due criteri positivi per la dipendenza: i cosiddetti "*diagnostic orphans*"

Addiction

NEW AND REMAINING PROBLEMS WITH DSM-V

AMBROS UCHTENHAGEN

Issue

Article first published online: 8 APR 2011
DOI: 10.1111/j.1360-0443.2010.03328.x

Addiction
RESEARCH REPORT
doi:10.1111/j.1360-0443.2010.03340

An evaluation of the proposed DSM-5 alcohol use disorder criteria using Australian national data

Louise Mewton[1], Tim Slade[1], Orla McBride[2], Rachel Grove[1] & Maree Teesson[1]

National Drug and Alcohol Research Centre, University of New South Wales, Sydney, Australia[1] and Department of Psychology, Division of Population Hea Sciences, Royal College of Surgeons in Ireland, Dublin, Ireland[2]

Journal of Studies on Alcohol and Drugs
Formerly the Journal of Studies on Alcohol

The Five-Year Diagnostic Utility of "Diagnostic Orphans" for Alcohol Use Disorders in a National Sample of Young Adults*

THOMAS C. HARFORD, PH.D., HSIAO-YE YI, PH.D.,† AND BRIDGET F. GRANT, PH.D., PH.D.†

CSR, Incorporated, Alcohol Epidemiologic Data System, 2107 Wilson Boulevard, Suite 1000, Arlington, Virginia 22201

I "*diagnostic orphans*" - ad esempio, in relazione al disturbo da uso di alcol (2 criteri per dipendenza e nessun criterio per abuso) - hanno, in un follow-up a 5 anni, un rischio 3 volte maggiore di sviluppare una diagnosi di abuso e 4 volte maggiore di sviluppare dipendenza da alcol

Dal DSM-IV al DSM-5: alcuni confronti epidemiologici

Addictive Behaviors 41 (2015) 46–50

Contents lists available at ScienceDirect

Addictive Behaviors

From DSM-IV to DSM-5 alcohol use disorder: An overview of epidemiological data

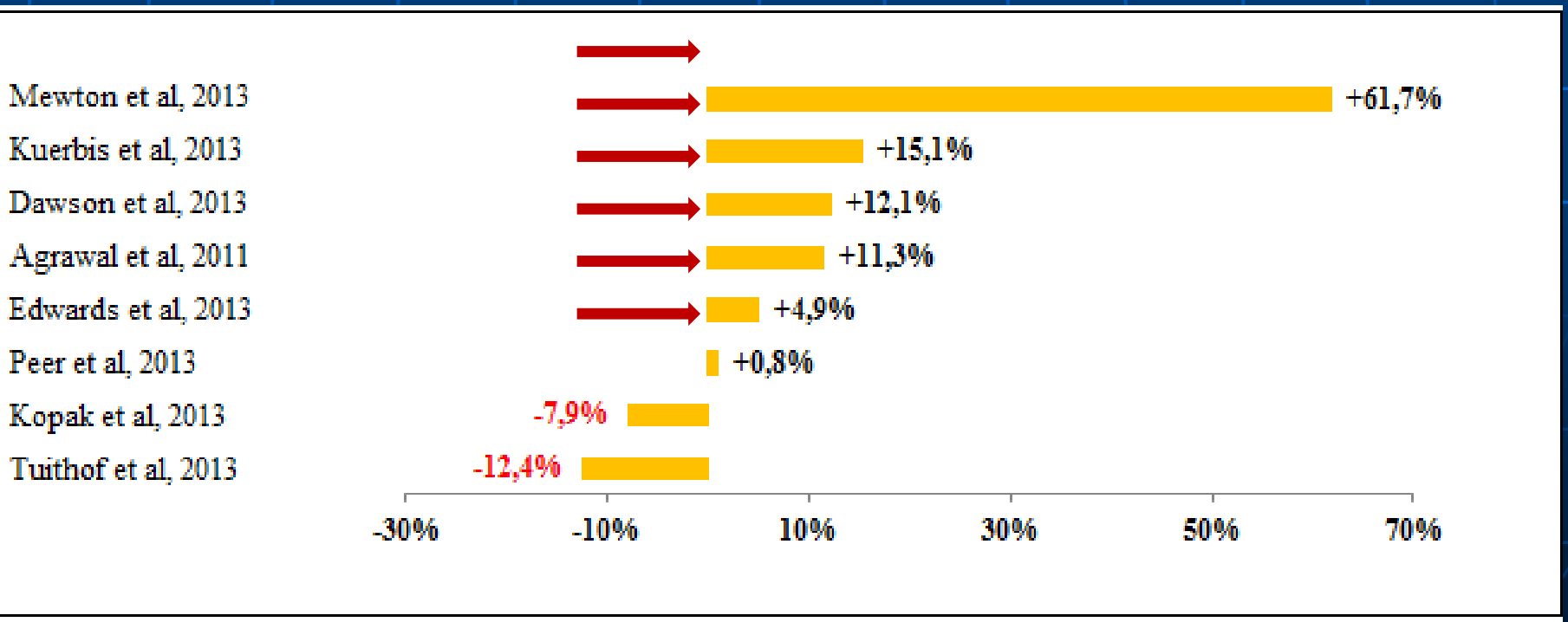
Francesco Bartoli [a], Giuseppe Carrà [b,*], Cristina Crocamo [a], Massimo Clerici [a]

[a] Department of Surgery and Translational Medicine, University of Milano Bicocca, Via Cadore 48, 20900 Monza, MB, Italy
[b] Division of Psychiatry, Faculty of Brain Sciences, University College London, Charles Bell House, 67–73 Riding House Street, London W1W7EJ, UK

HIGHLIGHTS

- We assessed the epidemiological impact of DSM-5 criteria for AUD.
- We reviewed available studies with data on both DSM-IV and DSM-5 AUD.
- DSM-5 may imply an increase in prevalence rates of AUD.

a) Alcohol use disorder: DSM-5 vs DSM-IV



Dal DSM-IV al DSM-5: alcuni confronti epidemiologici

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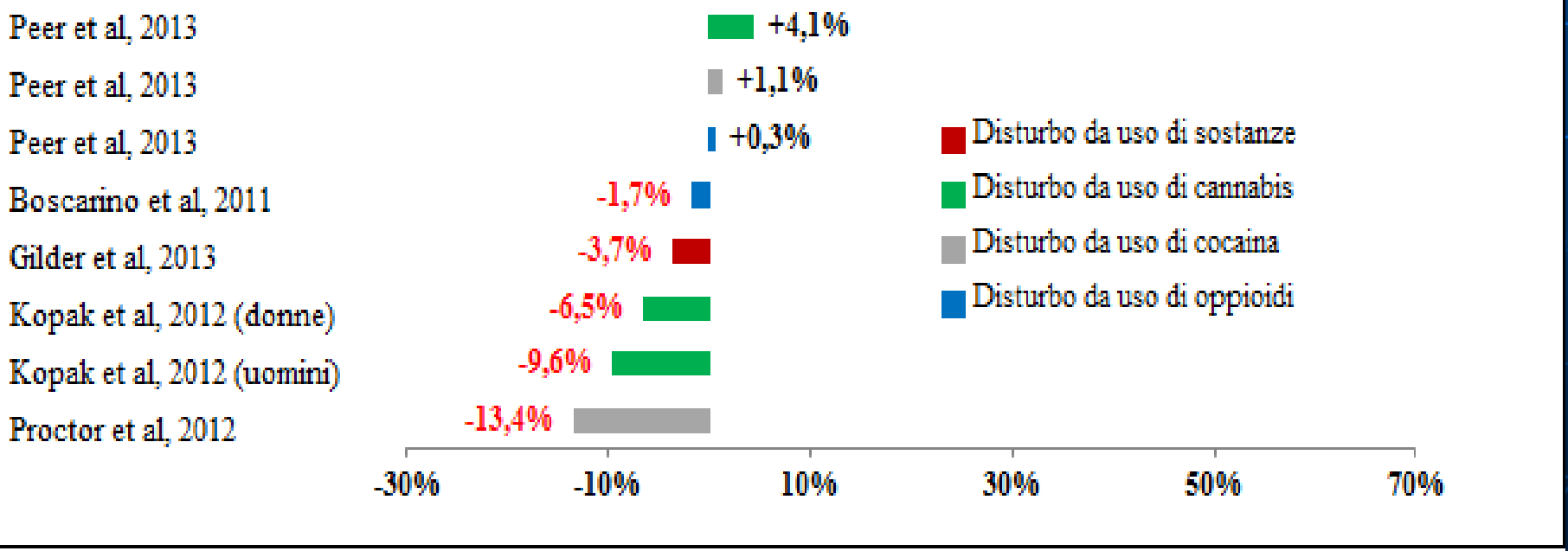
HIGHLIGHTS

- We assessed the epidemiological impact of DSM-5 criteria for AUD.
- We reviewed available studies with data on both DSM-IV and DSM-5 AUD.
- DSM-5 may imply an increase in prevalence rates of AUD.

b) Substance use disorder: DSM-5 vs DSM-IV



DIAGNOSTIC QUESTIONS
should any criteria be dropped/ added?

The legal problems criterion was excluded from DSM-5 diagnostic criteria because

- **very low prevalence**
- **poor discrimination power**
- **poor fit with other SUD criteria**

The craving criterion was found to have very high discrimination, indicating that it provides a high level of information regarding the underlying trait of interest..."

should any criteria be added?

Psychol Med. 2011 Mar;41(3):629-40. doi: 10.1017/S003329171000053X. Epub 2010 May 12.

Alcohol craving and the dimensionality of alcohol disorders.

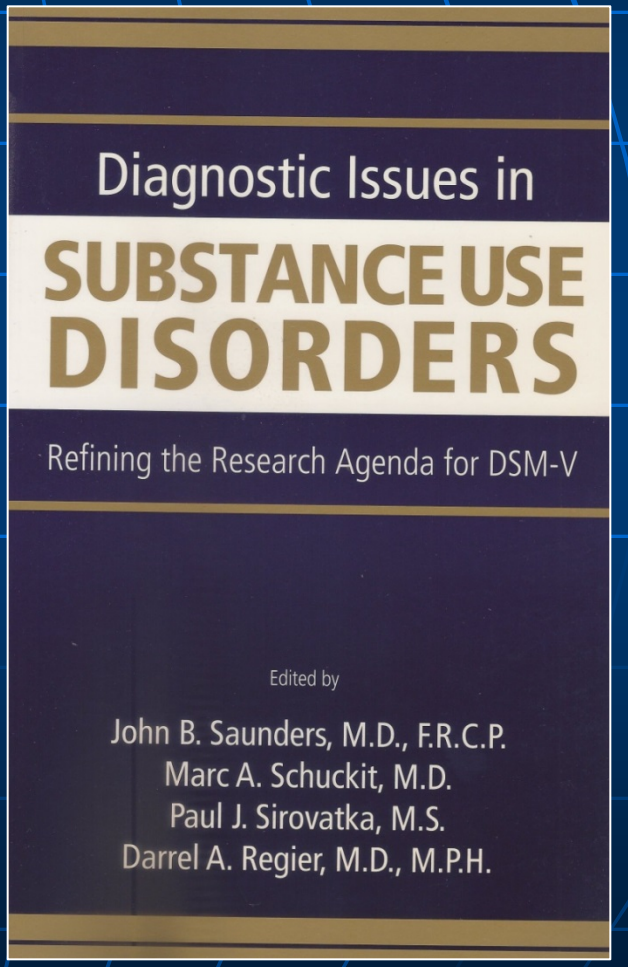
Keyes KM, Krueger RF, Grant BF, Hasin DS.

New York State Psychiatric Institute, New York, NY 10032, USA.

	With craving	Without craving	
	N=203	N=1799	
	% (SE)	% (SE)	OR1 (95% C.I.)*
Used treatment services for alcohol problems in the past year (%, SE)	31.2 (3.79)	10.2 (0.90)	3.25 (2.09–5.04)
Alcohol dependence prior to the past year (%, SE)	76.9 (3.46)	23.1 (3.52)	4.07 (2.42–6.84)
Meets criteria for alcohol abuse (%, SE)	86.8 (2.89)	56.2 (1.40)	5.63 (3.00–10.56)
Current depression diagnosis (%, SE)	41.0 (4.07)	16.9 (1.06)	3.93 (2.51–6.15)
Current drug abuse/dependence diagnosis (%, SE)	26.0 (3.51)	13.8 (0.97)	2.00 (1.33–3.01)

DSM-5 Criteria for Substance Use Disorders: Recommendations and Rationale

- eliminare la dicotomia abuso/dipendenza
- eliminare l'ambiguità terminologica tra dipendenza e addiction
- arrivare ad una diagnosi monodimensionale con criteri di gravità
- arrivare alla copertura dei cosiddetti "orfani diagnostici"
- eliminare I problemi legali come criterio
- aggiungere il craving come criterio
- aggiungere le sindromi astinenziali da cannabis e caffeine
- allineare i criteri per i disturbi da uso di nicotina con quelli delle altre sostanze
- ***spostare il gambling in questo capitolo***



From DSM-IV to DSM-5 criteria

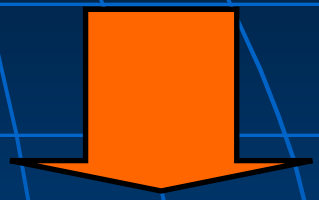
CRITERI DIAGNOSTICI DISTURBO DA USO DI SOSTANZE

- **Abuso**
  - Uso ripetuto in situazioni rischiose
  - Problematiche sociali / relazionali correlate all'uso
  - Incapacità ad adempiere ai principali compiti
  - ~~Problematiche legali~~
- **Dipendenza**
  - Astinenza
  - Tolleranza
  - Uso per periodi prolungati ed in quantità maggiori
  - Tentativi di ridurre o controllare l'uso
  - Grande quantità di tempo dedicato all'uso
  - Problematiche di natura fisica o psicologica
  - Interruzione di attività a causa dell'uso
  - **Craving**

From DSM-IV to DSM-5 criteria

CRITERI DIAGNOSTICI DISTURBO DA USO DI SOSTANZE

- Uso ripetuto in situazioni rischiose
- Problematiche sociali/relazionali correlate all'uso
- Incapacità ad adempiere ai principali compiti
- Astinenza
- Tolleranza
- Uso per periodi prolungati e in quantità maggiori
- Tentativi di ridurre o controllare l'uso
- Grande quantità di tempo dedicato all'uso
- Problematiche di natura fisica o psicologica
- Interruzione di attività a causa dell'uso
- **Craving**



- **2-3 criteri (disturbo lieve)**
- **4-5 criteri (disturbo moderato)**
- **6 o > criteri (disturbo grave)**

L'INTERVENTO SUL PAZIENTE "COMPLESSO" IN COMORBIDITA'

"CHI CONTINUA AD ASSUMERE SOSTANZE RAPPRESENTA UNA PIATTAFORMA PARTICOLARMENTE INSTABILE SULLA QUALE COSTRUIRE UNA FARMACOTERAPIA IL PIU' POSSIBILE OMEOSTATICA" (Gastfriend, 1997)

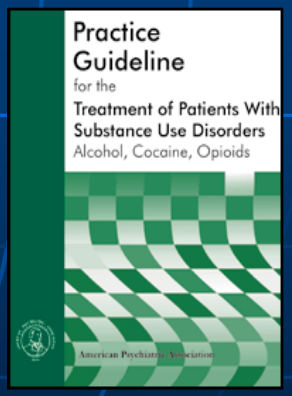
NONOSTANTE I RISCHI DI ERRORE DIAGNOSTICO O MISDIAGNOSI NON CI SI PUO' QUASI MAI PERMETTERE L'ATTESA DEL RAGGIUNGIMENTO DI UNA PIENA CONDIZIONE DI ASTINENZA

nella maggior parte dei casi, allora, il trattamento risponde alla necessità di intervenire su:

- **LE SEQUELE DELL'USO DI SOSTANZE**
- **EVENTUALI DISTURBI PSICHIATRICI NON CORRELATI ALL'USO**
- **UNA COMBINAZIONE DI ENTRAMBE LE CONDIZIONI**

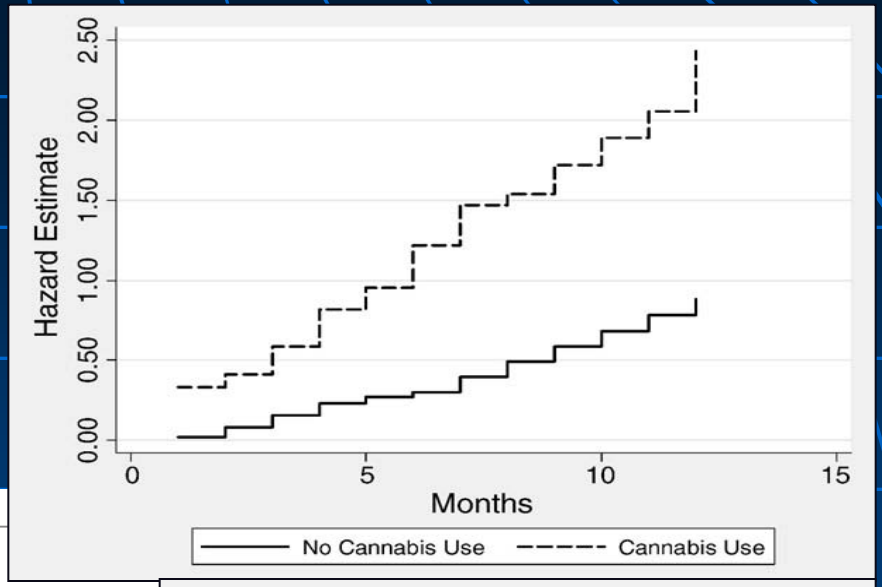
non sottovalutando, peraltro, la rilevanza del disturbo di personalità precocemente comorbile e le caratteristiche della sua espressività (cluster)

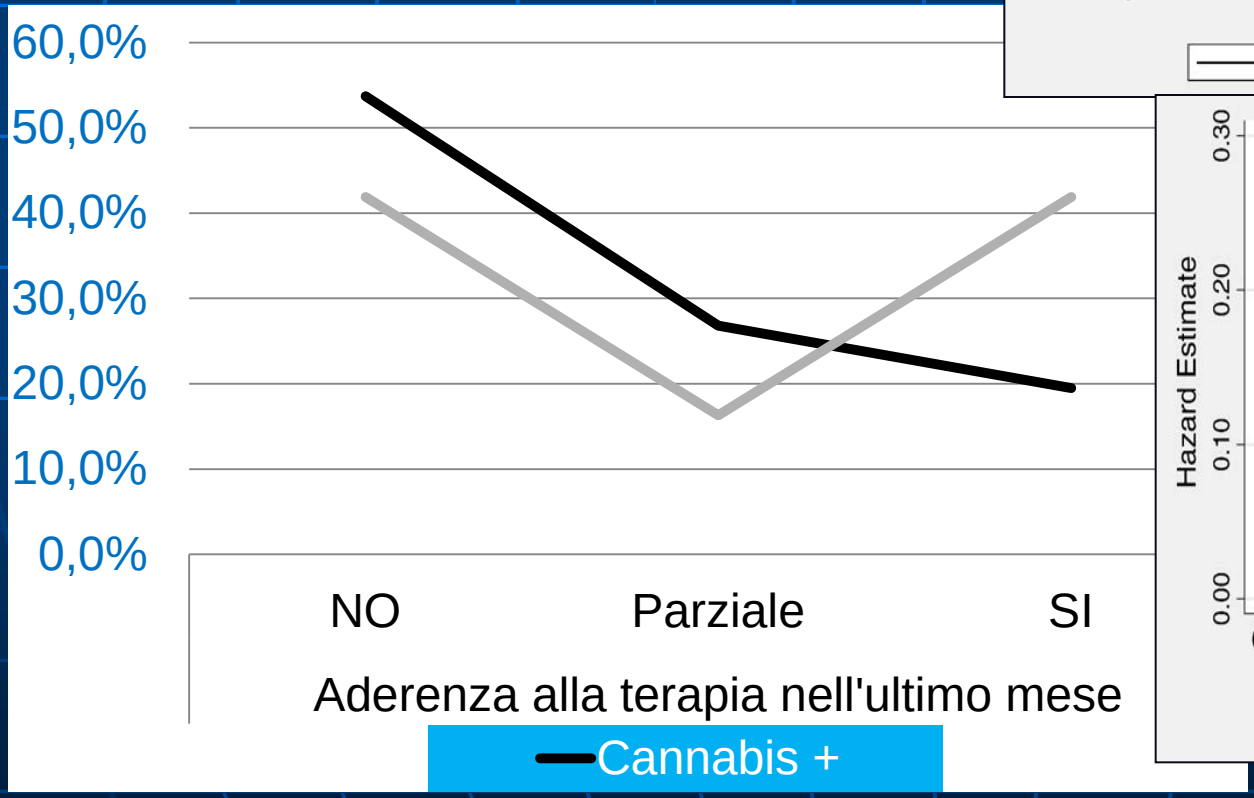
(Clark, McClanahan, 1998)

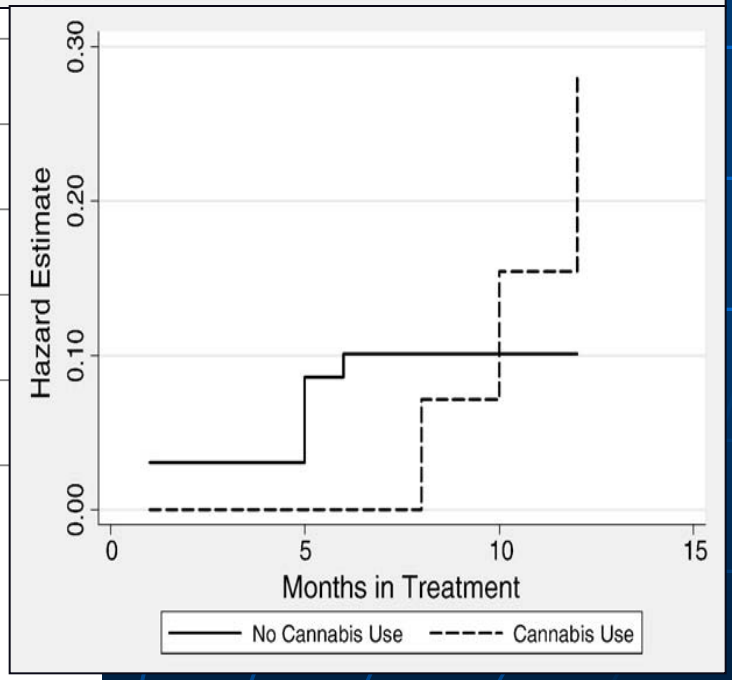


IL PROBLEMA DELLA COMPLIANCE. Fattori

* individuali
* ambientali
* correlati alla terapia







CANNABIS E COMPLIANCE (Rehman et al, 2007 Abdel-Baki et al, 2012)

SPECIAL ARTICLE

Management of persons with co-occurring severe mental illness and substance use disorder: program implications

Robert E. Drake, Kim T. Mueser, Mary F. Brunette

World Psychiatry
OFFICIAL JOURNAL OF THE WORLD PSYCHIATRIC ASSOCIATION (WPA)

- peer-oriented group interventions directed by a professional leader, despite heterogeneity of clinical models, are consistently effective in helping clients to reduce substance use and to improve other outcomes.
- contingency management also appears to be effective in reducing substance use and improving other outcomes, but has been less thoroughly studied and rarely used in routine programs.
- long-term residential interventions, again despite heterogeneity of models, are effective in reducing substance use and improving other outcomes for clients who have failed to respond to outpatient interventions and for those who are homeless.
- intensive case management, including assertive community treatment, consistently improves residential stability and community tenure, but does not consistently impact substance use.


SPECIAL ARTICLE

Management of persons with co-occurring severe mental illness and substance use disorder: program implications

ROBERT E. DRAKE, KIM T. MUESER, MARY F. BRUNETTE

Several promising interventions, including:

- **family psychoeducation**
- **intensive outpatient programs**
- **self-help programs** and
- **jail diversion and release programs**, have received minimal research attention but warrant further study

Journal of the American Academy of Child & Adolescent Psychiatry
Volume 54, Issue 2, February 2015, Pages 97–107.e2

Review

Therapeutic Interventions for Suicide Attempts and Self-Harm in Adolescents: Systematic Review and Meta-Analysis

Dennis Ougrin, MBBS, MRCPsych, PGDip(Oxon), PhD[a], Troy Tranah, BSc, MSc, PhD[b], Daniel Stahl, PhD[c], Paul Moran, MBBS, BSc, MSc, DLSHTM, MD, MRCPsych[c], Joan Rosenbaum Asarnow, PhD[d]

Accepted 23 October 2014, Available online 25 October 2014

- Nineteen RCTs including 2,176 youth were analyzed
- Therapeutic interventions (Tis) included psychological and social interventions
- The proportion of the adolescents who self-harmed over the follow-up period was lower in the intervention groups (28%) than in controls (33%) (test for overall effect $z = 2.31$; $p = .02$).
- TIs with the largest effect sizes were **dialectical behavior therapy** (DBT), **cognitive-behavioral therapy** (CBT), and **mentalization-based therapy** (MBT)

Prevention and Early Intervention

EDITORIAL

Investing in youth mental health is a best buy

Patrick D McGorry, Rosemary Purcell, Ian B Hickie and Anthony F Jorm

The logic and plan for achieving early intervention in youth mental health in Australia

"Mental illnesses are the chronic diseases of the young."[1]

Mental and substance use disorders are among the most important health issues facing Australians.[2,3] They are easily the key health issue for young people in their teenage years and early 20s and, if these disorders persist, the constraints, distress and disability they cause can last for decades. Epidemiological data indicate that 75% of people suffering from an adult-type psychiatric disorder have experienced its onset by 24 years of age,[4] with the onset for most of these disorders — notably mood, psychotic, personality, eating and substance use disorders — mainly falling into a relatively discrete time band from the early teens to the mid 20s, and reaching a peak in the early 20s.

Mental and substance use disorders in young people: high tide and rising?

In Australia, the prevalence of mental health problems among

with the ageing of the population. The Australian Tr *Intergenerational report* has pointed out that population age lead to decreasing workforce participation and increasing g ment expenditure on income support.[12] Increasing the pa tion of younger people is important to ameliorate these Mental disorders are an important factor in limiting econor social participation, and it has been argued that improving health can reduce unemployment and welfare dependency.

Mental health care systems are weakest where th need to be strongest

During the 1990s, federal, state and territory government progress in improving supports and services for people affe mental disorders, but the reform process has stalled recer the same time, expectations for better care were raised by i ing community awareness,[15-17] and by enhancements

SERVICE MODELS FOR THE FUTURE

The specialist youth mental health model: strengthening the weakest link in the public mental health system

Patrick D McGorry

Our health system needs to take the next step forward in removing the barriers between health professionals and young people. It needs to start listening to what we are saying and what we are asking for. To know what works best for us, the system has to become youth-friendly and youth-oriented. *(Vittoria Tonin, Platform youth participation program, ORYGEN Youth Health, 2007)*

Mental disorders account for around 50% of the total disease burden among young people aged 12–25 years in

ABSTRACT

- Despite mental disorders being the dominant health issue confronting young people, youth mental health is yet to be recognised as a discrete, unified program area; responsibility for young people's mental health is currently split across multiple levels of government.
- Public specialist mental health services have followed a paediatric–adult split in service delivery, mirroring general

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

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

Lancet 2007; 369: 1302–13
Published Online March 27, 2007
DOI:10.1016/S0140-6736(07)60368-7

See Comment page 1239
See Perspectives page 1251

This is the third in a Series of six papers about adolescent health

Department of Epidemiology and Public Health, London School of Hygiene and Tropical Medicine, London, UK (V Patel MRCPsych); Sangath

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.

Early Intervention IN PSYCHIATRY
First Impact Factor released in June 2010 and now listed in MEDLINE!

Early Intervention in Psychiatry 2013; **7:** 103–108
doi:10.1111/eip.12048

Editorial

Towards a new paradigm of care: the International Declaration on Youth Mental Health

INTRODUCTION

A recent and growing body of evidence on young people's mental health has pointed to the need for an international response to the increasing and concerning rates of mental ill-health among young

support from specialist mental health services. Specialist mental health services have traditionally followed a paediatric-adult split, with child and adolescent services offering intervention until the largely arbitrary ages of 16 or 18 years and adult services taking all young people 18 years and older.[1]

Cochrane Database Syst Rev. ; (6): CD004718. doi:10.1002/14651858.CD004718.pub3.

Early intervention for psychosis

Max Marshall[1] and **John Rathbone**[2]

[1]University of Manchester, The Lantern Centre, Preston., UK

[2]HEDS, ScHARR, The University of Sheffield, Sheffield, UK

Early intervention in psychosis has two elements that are distinct from standard care:

a)Early detection → **the identification of people thought likely to develop psychosis** (i.e. those who display prodromal symptoms, but have never been psychotic) **or who are already psychotic, but have not yet received adequate treatment**

b)Phase-specific treatments → **deliver treatments** (psychological, social or physical) **directed at preventing progression to psychosis** (in people with prodromal symptoms) **or at promoting recovery** (in people who have recently experienced their first episode of psychosis)

Early detection and phase-specific treatments may be provided as (1) supplements to standard psychiatric care, or (2) by specialised early intervention teams providing care exclusively to people who have prodromal symptoms or are in early stages of schizophrenia

Staging Model of Disease

Stage	Melanoma	Psychosis	Treatment
0	Increased risk / No Symptoms	Increased risk / No Sx	Treatment needs to be stage specific
1a	First skin changes	Mild / non-specific Sx /funct decline	
1b	Later skin changes	UHR – sub-threshold	
2	Diagnosis of melanoma	FEP – full threshold	
3a	Incomplete remission from first episode of care	Incomplete remission from first episode of care	
3b	Recurrence / Metastases	Recurrence or relapse stabilised with treatment but still residual symptoms	
3c	Treatment Resistance	Multiple relapses with clinical deterioration	
4	Terminal cancer	Severe, persistent or unremitting illness	

Schizophrenia Bulletin vol. 41 no. 6 pp. 1379–1386, 2015
doi:10.1093/schbul/sbv016

A Systematic Review of the Effect of Early Interventions for Psychosis on the Usage of Inpatient Services

Jason R. Randall[1,2], Sherri Vokey[3], Hal Loewen[3], Patricia J. Martens[1,2], Marni Brownell[1,2], Alan Katz[1,2], Nathan C. Nickel[1,2], Elaine Burland[2], and Dan Chateau*[,1,2]

This review suggests that these interventions do reduce the use of inpatient services. Results supported the occurrence of a positive effect for intervention for both outcome measures:

any hospitalization and bed-days usage

HOWEVER

(a)**There was significant heterogeneity of effect across the studies** due to a handful of **studies with unusually positive responses**

(b)**The improvements associated with these early intervention programs may not be specific to them.** Future research should attempt to examine which specific components of these early intervention programs are beneficial and which may be unnecessary

(c)**One area of concern for future research is whether the improvement afforded by these intervention programs can be maintained beyond the first few years.** Some research has suggested that the gains from early intervention fade after the patients leave the program

Cochrane Database Syst Rev. ; (6): CD004718. doi:10.1002/14651858.CD004718.pub3.

Early intervention for psychosis

Max Marshall[1] and **John Rathbone**[2]

[1]University of Manchester, The Lantern Centre, Preston., UK

[2]HEDS, ScHARR, The University of Sheffield, Sheffield, UK

Implications for practice

1. For people presenting with prodromal symptoms of psychosis

At the moment it is not clear whether treating people presenting with prodromal symptoms of schizophrenia provides benefits

2. For people in their first episode of psychosis

There is some support for specialised early intervention services but again further evidence is needed

Phase-specific treatments for people in their first episode of psychosis may help with employment and family therapy

Cochrane Database Syst Rev. ; (6): CD004718. doi:10.1002/14651858.CD004718.pub3.

Early intervention for psychosis

Max Marshall[1] and **John Rathbone**[2]

[1]University of Manchester, The Lantern Centre, Preston., UK

[2]HEDS, ScHARR, The University of Sheffield, Sheffield, UK

Implications for practice

3. For clinicians

Family intervention may be of value for people in their first episode of psychosis, as it may for people with longer established illnesses

It is important for clinicians to continue to keep up to date with this fast-expanding field

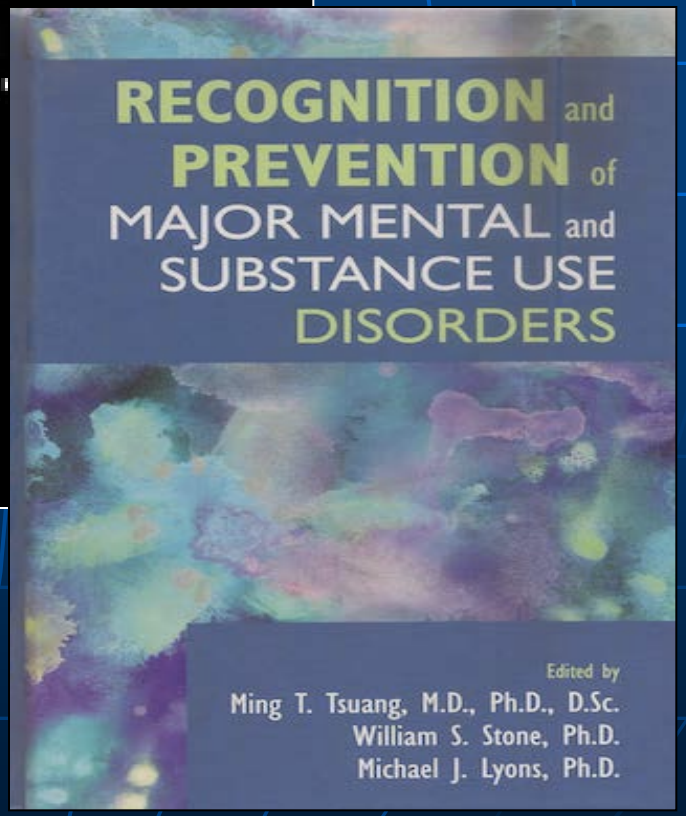
4. For policy makers

It is premature to implement wide-spread treatment programmes for people with prodromal symptoms

Such treatment programmes should only be implemented within the context of a well-designed randomised study

Io non soffro di disturbi mentali…

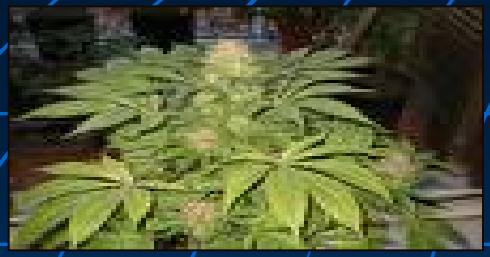
me li sto godendo tutti.



Prevention and Early Intervention

from Mrazek and Haggerty (1994)

interventions from universal prevention through long term care and rehabilitation



non solo cannabis: …la prevenzione è possibile?

- Le scuole dovrebbero essere l'ambiente cruciale in cui offrire interventi preventivi
- Tuttavia, nella stragrande maggioranza dei casi, il personale non è consapevole dei problemi degli studenti perché questi ultimi si rivolgono più facilmente ai loro pari per richieste di supporto ed aiuto
- È necessario che gli interventi preventivi siano EB perché possano essere efficaci. Target prioritario dell'intervento sono i fattori di rischio e di protezione

Joe & Bryant, 2007; Evans, 2005
Mann, 2005; Muehlenkamp 2009

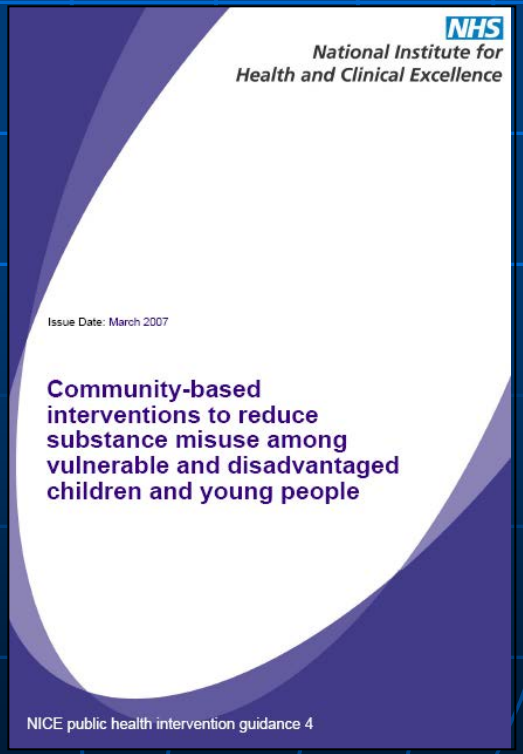
Linee guida e raccomandazioni

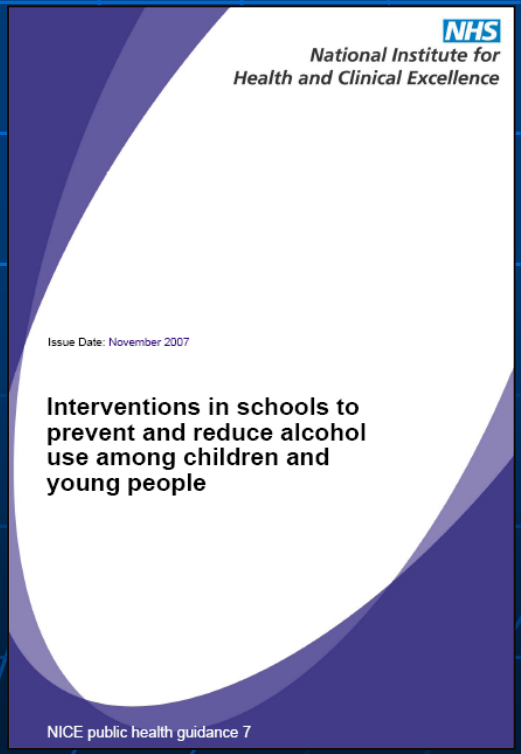
USA

National Institute of Drug Addiction - NIDA

UK

National Institute of Clinical Excellence - NICE



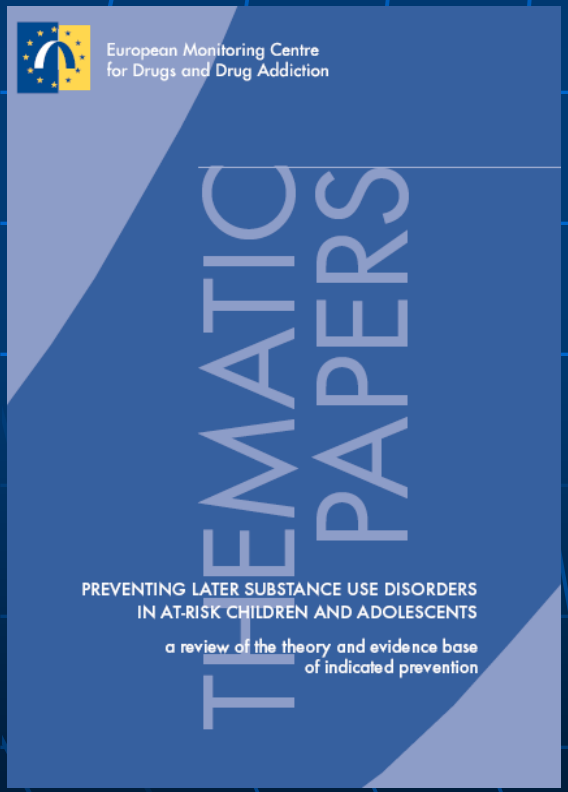


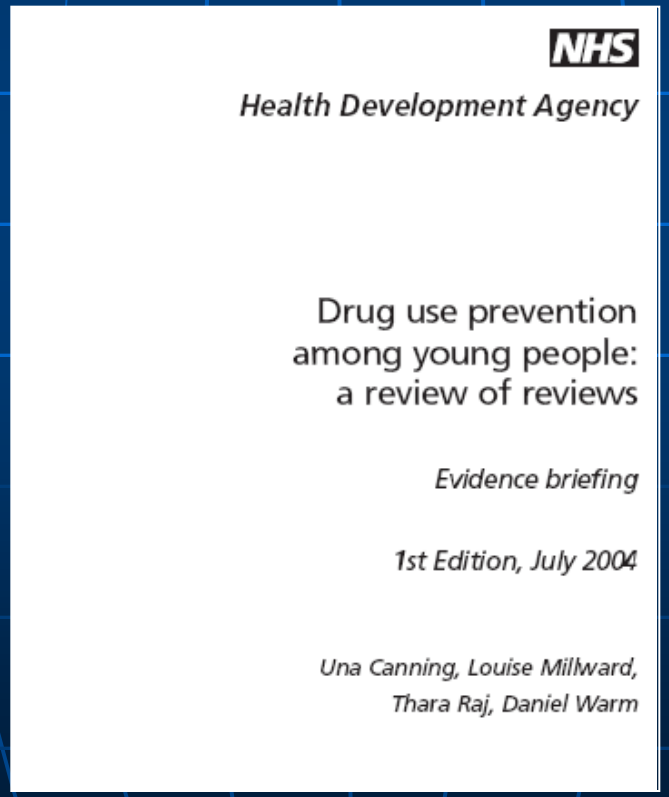
Revisioni/Valutazioni EBM

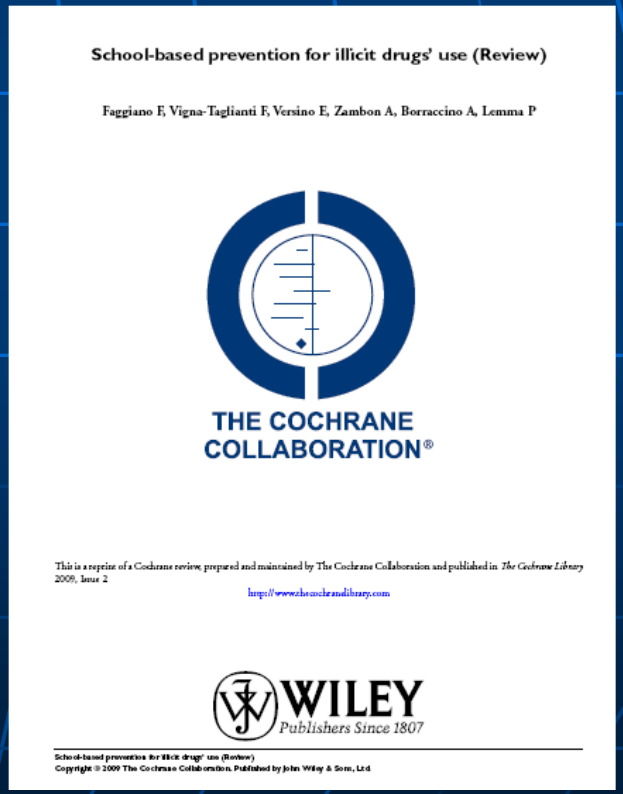
European Monitoring Centre for Drugs and Drug Addiction - EMCDDA

National Institute of Clinical Excellence - NICE

The Cochrane Collaboration







Programmi preventivi: NIDA

- **rinforzare i fattori protettivi** e invertire o **ridurre i fattori di rischio**
- indirizzarli a **tutte le forme di uso di sostanze**
- **modificarli** e **adattarli** per rispondere ai rischi specifici e alle caratteristiche dei destinatari (anche psicopatologiche…)
- **rivolgerli anche ai familiari**, per migliorare la coesione e le capacità relazionali familiari
  - monitoraggio e supervisione genitoriale
  - formazione e informazione per familiari
- attivarli nelle **scuole**
  - materne
  - elementari
  - medie e superiori

con **formazione degli insegnanti** su buone pratiche di gestione della classe, di risposta agli eventi e di coping alle problematiche

Interventi preventivi: NICE

	a chi si rivolge	da chi è svolta	cosa prevede
1	giovani a rischio	partnership locali tra soggetti strategici	sviluppo ed implementazione di strategie individualizzate e supportate da un modello che definisce il ruolo di agenzie locali, i criteri di invio, etc.
2	giovani a rischio	medici, SSN, autorità locali, settori vari	screening e valutazione dei soggetti a rischio supporto ed invio a servizi appropriati
3	giovani a rischio genitori e carers	medici, SSN, autorità locali, settori vari	supporto per genitori, carers e famiglie bisognose
4	bambini con DC "ad alto rischio" genitori e carers	medici con training in terapia comportamentale di gruppo	terapia comportamentale di gruppo per i bambini training di gruppo in parental skills per genitori e carers
5	giovani a rischio	medici con training in intervista motivazionale	interviste motivazionali

Interventi preventivi (NIDA, 2010; NICE, 2011)

OBIETTIVI DA IMPLEMENTARE

nelle scuole si può ritardare l'esordio dell'uso di sostanze o diminuirne il consumo, ma l'effetto si riduce nel tempo

METODOLOGIE PIU' INDICATE:

- quelle "solo" **informative** non sono risultate molto efficaci
- quelle **universali** sembrano più efficaci per adolescenti "a basso rischio"
- quelle **intensive** sembrano valide per adolescenti "ad alto rischio"
- quelle **interattive** - che utilizzano i pari - sono più efficaci di quelle non interattive; inoltre, chi eroga il programma tende ad avere un maggior beneficio

Prevention Programs

- Preventive programmes should be based on the **detection of risk factors associated with both suicide and substance abuse disorder** Evidence suggests that targeted suicide prevention programmes can be delivered which reduce the burden associated with substance abuse and suicide in youths
- **Programmes should combine different therapeutic strategies** such as peer-to-peer education, school-based programmes, psychotherapy and pharmacological treatment
- Although many suicide prevention programs have been developed and implemented, **few are evidence-based** in their effectiveness in decreasing suicide rates

Pompili et al, Eur Arch Psychiatry Clin Neurosci. 2012
Pirruccello J Psychosoc Nurs Ment Health Serv. 2010

Effective prevention programs

- **Evaluation:** suicide and drug abuse/dependence risk factors
- **Assessment:** psychiatric and substance use disorders
- **Treatment:** delivering **efficacious treatments** for children and adolescents would offer better possibilities to prevent suicides/addiction:

- Psychosocial treatments (limited evidences support their effectiveness) for **addiction**
- Various treatment modalities are useful in the treatment of **suicidal youths** (***cognitive behavioral therapy and specialized emergency room interventions***)

- **Effectiveness of SSRI:** studies are limited, but the evidences support their use as first-line antidepressant medication in youth depression

- For **high-risk youth**, providing **continuity of care is a challenge**, since they are often noncompliant and commonly drop out or terminate their treatment prematurely

Pelkonen &Marttunen. Paediatr Drugs.2003

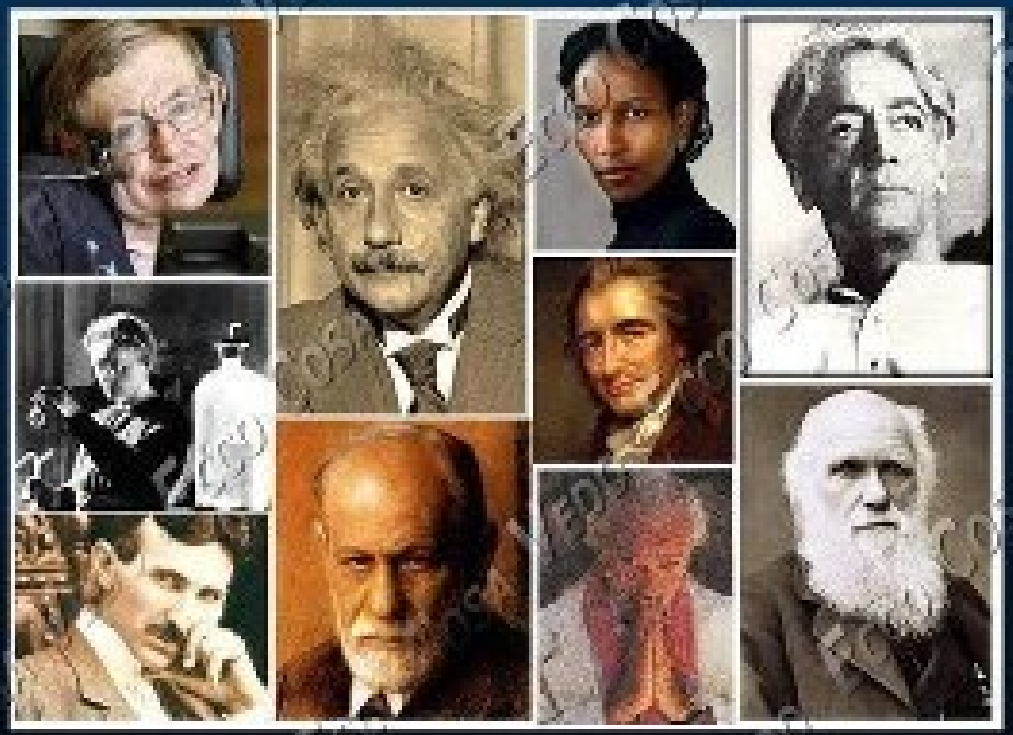
Psychosocial Treatments for People with Co-occurring Severe Mental Illnesses and Substance Use Disorders (Dual Diagnosis): A Review of Empirical Evidence

Jan Horsfall, PhD, Michelle Cleary, PhD, Glenn E. Hunt, PhD, and Garry Walter, MD, PhD

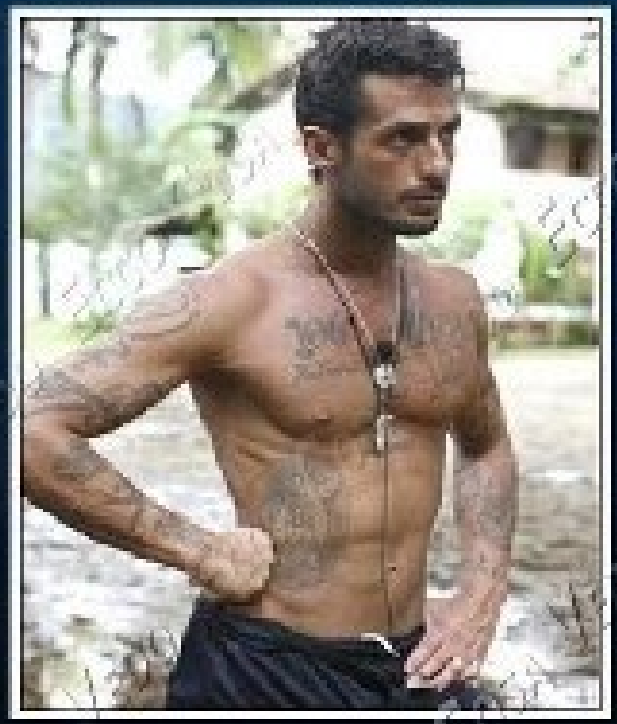
Harvard Review of Psychiatry

- Services should be integrated and well coordinated:
  - take a *team approach*
  - be *multidisciplinary*
  - have *specialist-trained personnel* (including 24-hour access)
  - include *a range of program* types
  - provide for long-term follow-up
- Interventions for substance reduction may need to be further developed and adapted for people with serious mental illnesses
- Further quality trials in this area will contribute to the growing body of data of effective interventions

A proposito di adolescenti…



SE NON RICONOSCETE LORO



MA RICONOSCETE LUI

C'È QUALCOSA CHE NON VA

CON LA VOSTRA ISTRUZIONE