

Giovanni de Girolamo

ETA' DI INSORGENZA DEI DISTURBI MENTALI: COSA SAPPIAMO? QUALI IMPLICAZIONI PER I SERVIZI?



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Centro Nazionale per lo Studio e la Cura
della Malattia di Alzheimer e Malattie Mentali

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

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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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Key words: Age of onset (AOO), early intervention, prevention, DUP, treatment delay.

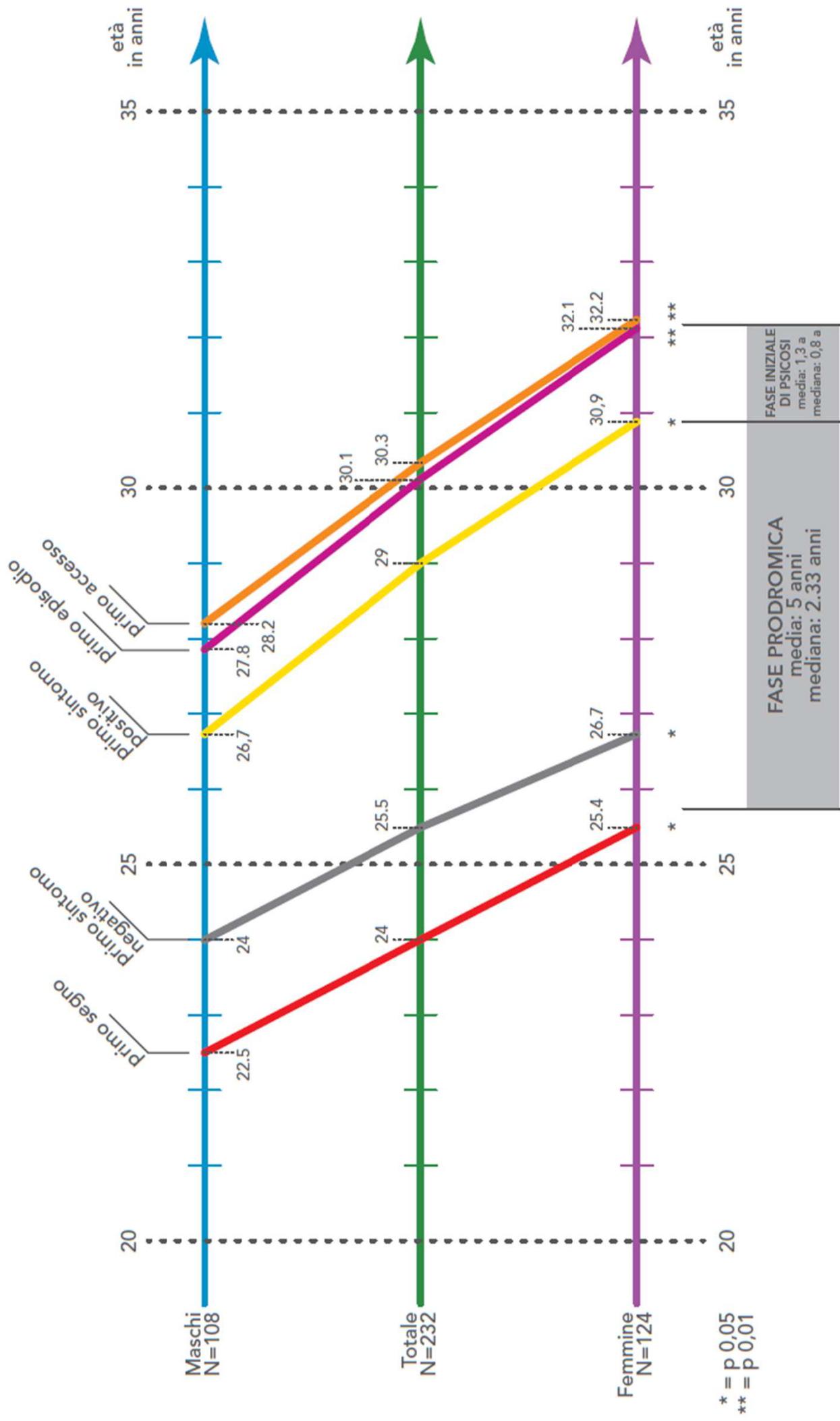
CHE COSA E' L'ETA' DI INSORGENZA?

Vi sono vari criteri, non univoci, per definire l'età di insorgenza di un disturbo:

- 1. Età in cui cominciano a manifestarsi i primi processi morfofunzionali patologici che condurranno alla malattia conclamata (es. alterazioni cellulari o recettoriali)**
- 2. Età in cui si manifestano i primi segni di malattia (es. disfunzioni cognitive)**
- 3. Età in cui si manifestano i primi sintomi di malattia (es. depressione dell'umore)**
- 4. Età del primo episodio franco di malattia (es. primo episodio psicotico)**
- 5. Età del primo contatto con un servizio sanitario, generale o specialistico**
- 6. Età del primo trattamento farmacologico**
- 7. Età del primo ricovero ospedaliero**

PERCHE' E' IMPORTANTE STUDIARE L'ETA' DI INSORGENZA?

1. Consente di studiare i **precursori** ed i **prodromi** di malattia
2. Consente di studiare il **rischio lifetime di malattia**, che è diverso dalla prevalenza lifetime in quanto in quest'ultima stima vengono incluse persone di età diverse, e che quindi hanno avuto una differente possibilità di ammalarsi
3. Consente di studiare **la comorbidità in senso diacronico** (disturbo primario, es. depressione → automedicazione con alcool o sostanze → disturbo secondario da abuso di alcool/sostanze)
4. Consente di **pianificare** la prevenzione primaria e secondaria, e gli interventi precoci



Valori medi dell'età di insorgenza del disturbo schizofrenico secondo 5 diverse definizioni di esordio (N=232).
 Adattata da Hafner, 1996.

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.

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	Males		Females		Total	
	Cause	Total DALYs (x1000) (%)	Cause	Total DALYs (x1000) (%)	Cause	Total DALYs (x1000) (%)
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%)

RESEARCH REPORT

Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative

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CONCLUSIONI WMH SURVEY INITIATIVE

- ✓ **Coerenza cross-nazionale nell'età di insorgenza dei disturbi d'ansia e dell'umore (età mediana: 15 anni per disturbi d'ansia, 26 anni per disturbi dell'umore).**
- ✓ **Fino a 12 anni d'età, la differenza tra M e F in termini di rischio di insorgenza di disturbi d'umore è bassa. Sia per i disturbi d'ansia e dell'umore in adolescenza la differenza tra F e M aumenta, con un rischio > per le femmine.**
- ✓ **Considerando i diversi disturbi d'ansia vi è un'eterogeneità nelle età di esordio: GAD, disturbo di panico e agorafobia hanno un esordio più tardivo rispetto a fobie specifiche.**

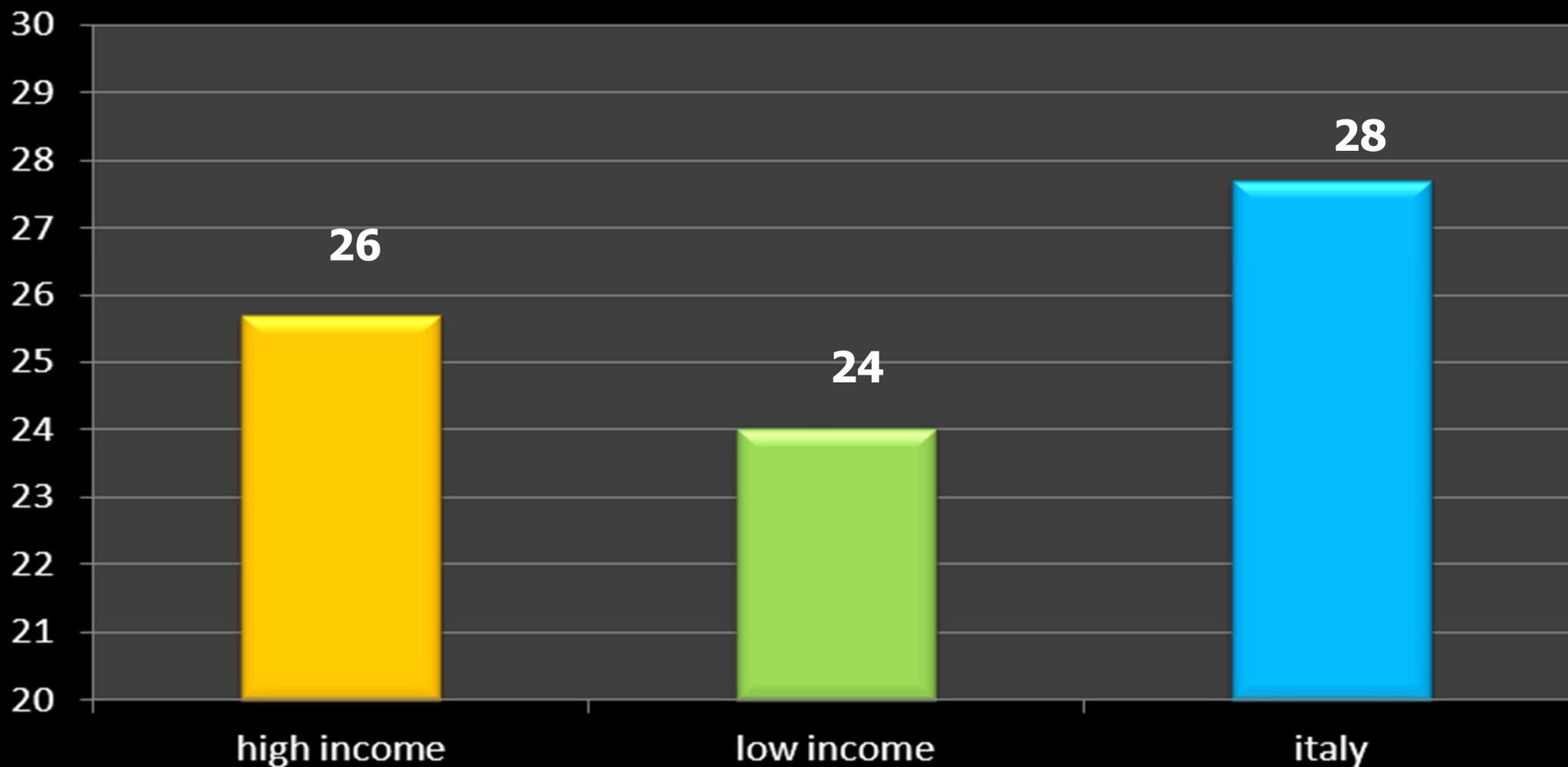
RESEARCH ARTICLE

Open Access

Cross-national epidemiology of DSM-IV major depressive episode

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Median age of onset of DSM-IV/CIDI major depressive episodes





Comparisons of perceived quality of life across clinical states in bipolar disorder: data from the first 2000 Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) participants

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Abstract

Background: Evidence indicates that quality of life is subnormal in patients with bipolar disorder and that it differs across mood states. However, the pattern of specific deficits has not been well studied, and the role of potential confounders has received no attention.

Method: We investigated the self-reported quality of life, Medical Outcomes Study 36-Item Short Form (SF-36), and Quality of Life-Enjoyment and Satisfaction (QLESQ) at baseline across the clinical states of the first 2000 participants enrolled in Systematic Treatment Enhancement Program for Bipolar Disorder.

Results: Bivariate analyses indicated significant differences across mood state, with depressive symptoms predicting lower SF-36 mental and physical scores and QLESQ overall score. However, adjustment for relevant clinical and demographic variables erased the difference in the SF-36 physical score. Notably, covariate adjustment removed the apparently “supranormal” SF-36 mental and QLESQ scores among those with mania/hypomania compared with those euthymic.

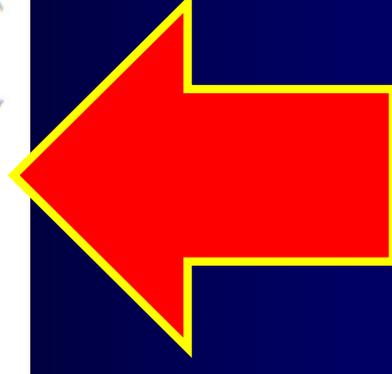
Conclusion: Depressive symptoms are a strong predictor of quality of life, yet covariate adjustment has an impact as well. Clinically, this indicates the need for addressing these factors if quality of life is to be maximized. Such factors should also be taken into account in future naturalistic and clinical trials research on quality of life in bipolar disorder.

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Clinical characteristics

Clinical state (frequency/%)

Depression	521 (26.1)
Mixed	173 (8.7)
Mania/hypomania	130 (6.5)
Continued symptomatic	186 (9.3)
Roughening	71 (3.6)
Recovered	388 (19.4)
Recovered	530 (26.5)
Age at onset (y) (mean [SD])	17.3 (8.7)



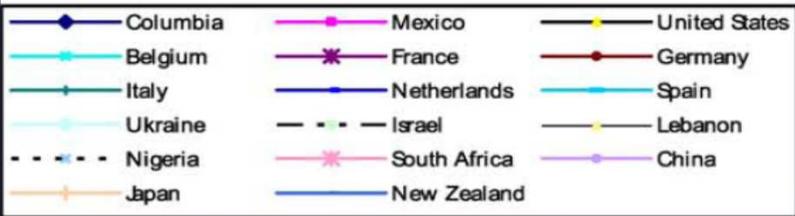
Toward a Global View of Alcohol, Tobacco, Cannabis, and Cocaine Use: Findings from the WHO World Mental Health Surveys

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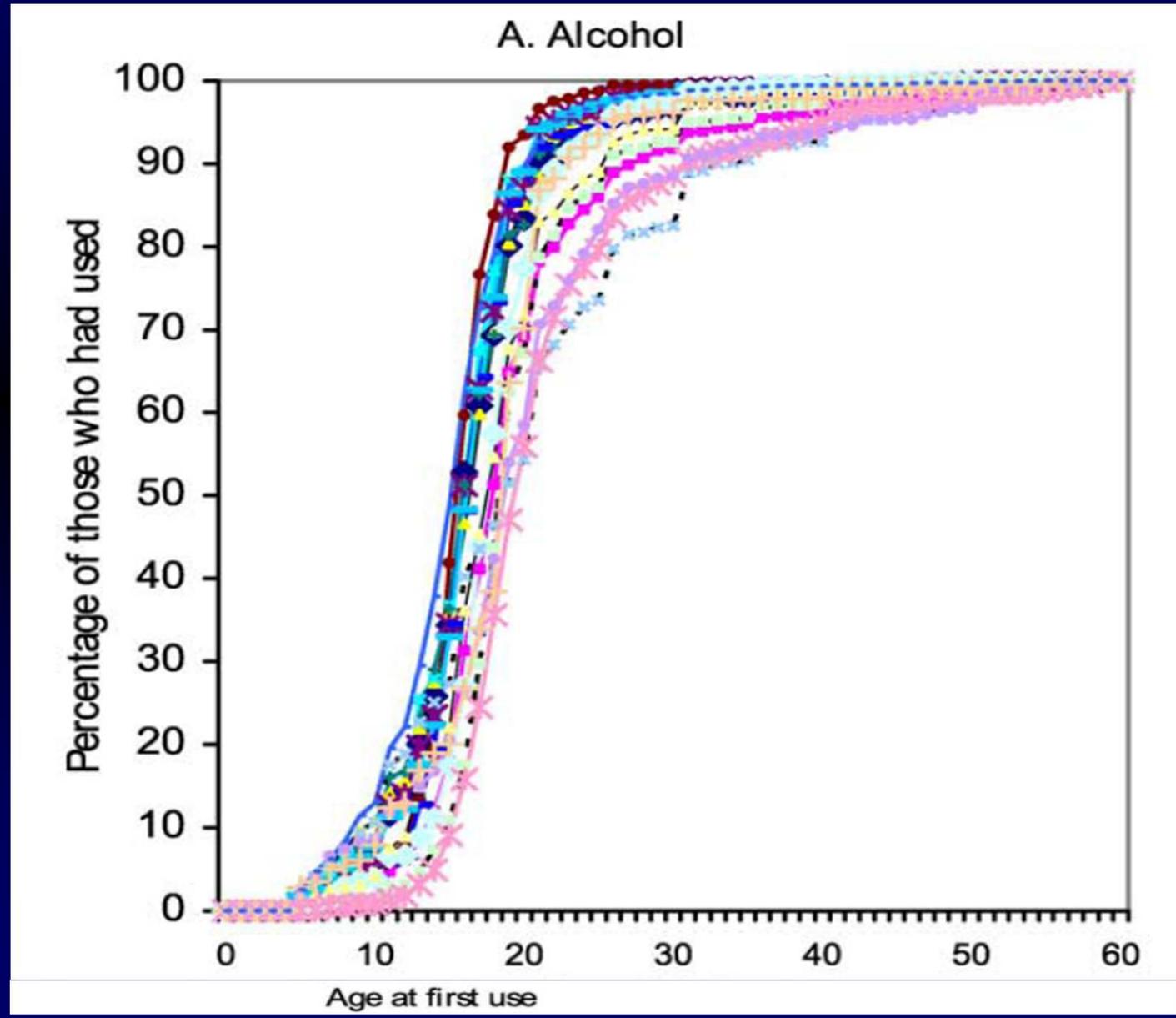
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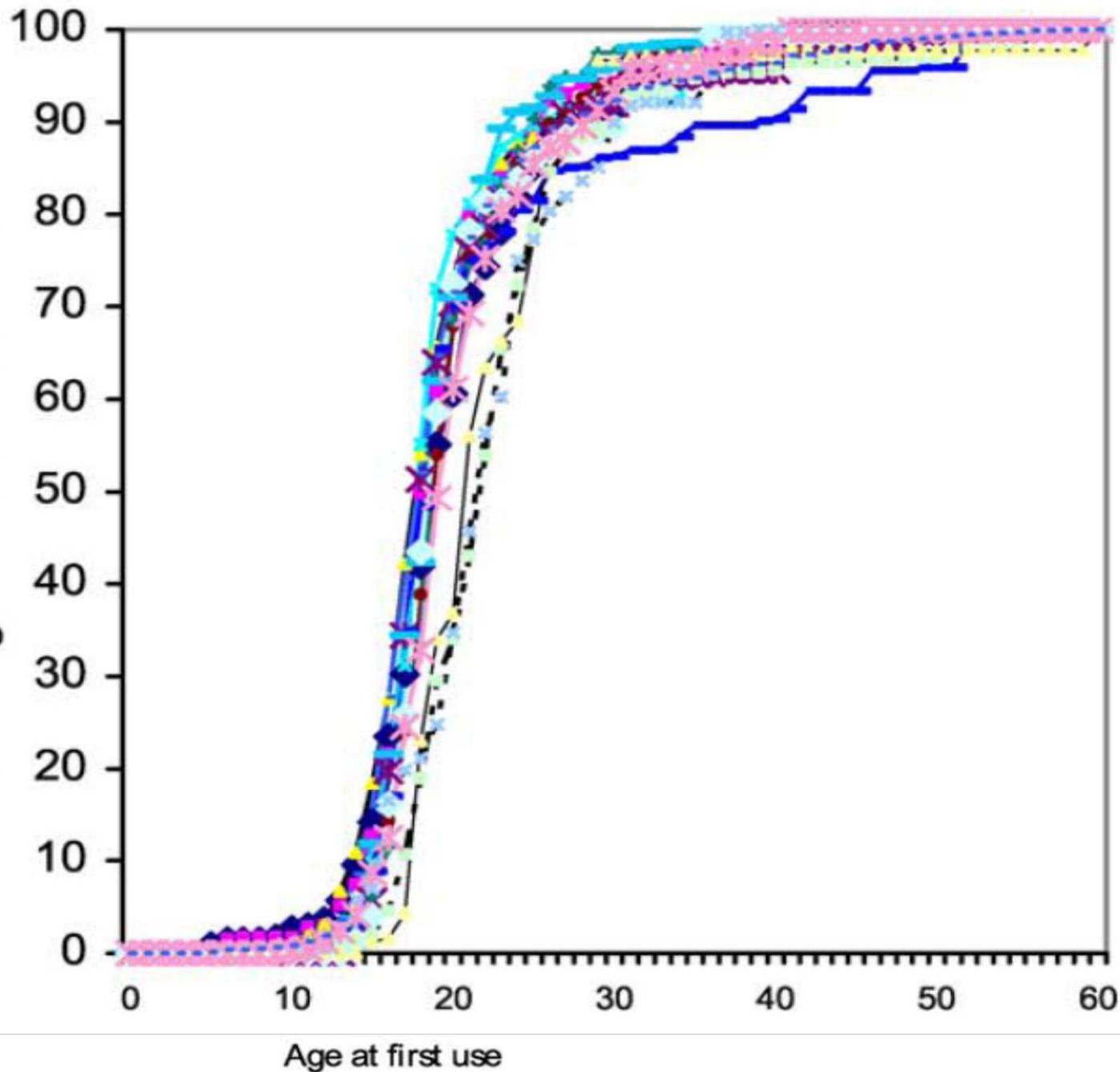
Age at first use



**ETA' MEDIANA:
16-19**

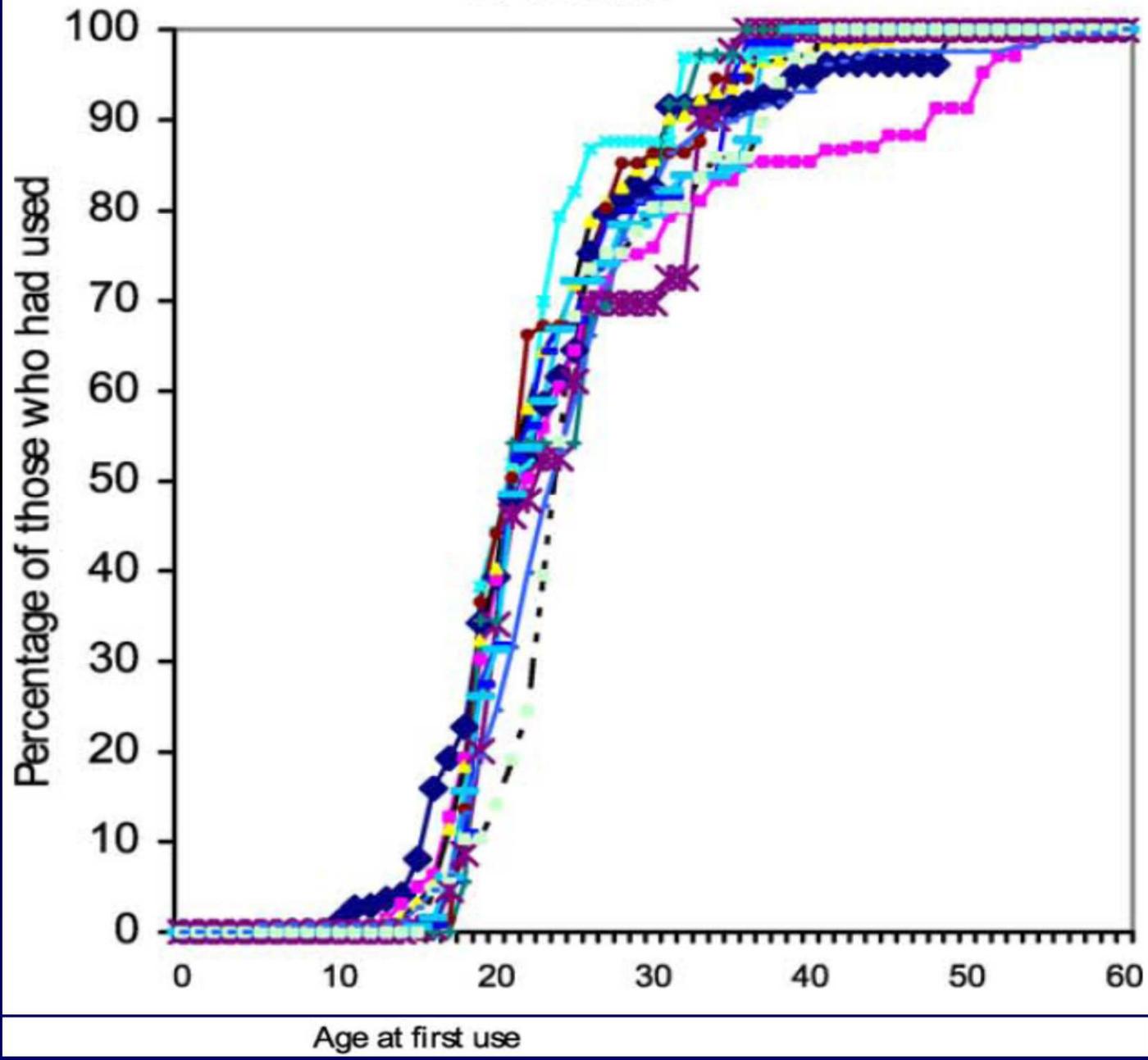


C. Cannabis



**ETA' MEDIANA:
18-19**

D. Cocaine



**ETA' MEDIANA:
21-24**

Age at first use

—◆— Columbia	—■— Mexico	—●— United States
—◆— Belgium	—*— France	—●— Germany
—◆— Italy	—◆— Netherlands	—◆— Spain
—◆— Ukraine	—◆— Israel	—◆— Lebanon
—◆— Nigeria	—◆— South Africa	—◆— China
—◆— Japan	—◆— New Zealand	

Systematic review and collaborative recalculation of 133693 incident cases of schizophrenia

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Background. This systematic review and collaborative recalculation was set up to recalculate schizophrenia incidence rates from previously published studies by age and sex.

Method. PubMed, EMBASE and PsycINFO databases were searched (January 1950 to December 2009) for schizophrenia incidence studies. Numerator and population data were extracted by age, sex and, if possible, study period. Original data were requested from the authors to calculate age- and sex-specific incidence rates. Incidence rate ratios (IRRs) with their 95% confidence intervals (CIs) were computed by age and sex from negative binomial regression models.

Results. Forty-three independent samples met inclusion criteria, yielding 133 693 incident cases of schizophrenia for analysis. Men had a 1.15-fold (95% CI 1.00–1.31) greater risk of schizophrenia than women. In men, incidence peaked at age 20–29 years (median rate 4.15/10 000 person-years, IRR 2.61, 95% CI 1.74–3.92). In women, incidence peaked at age 20–29 (median rate 1.71/10 000 person-years, IRR 2.34, 95% CI 1.66–3.28) and 30–39 years (median rate 1.24/10 000 person-years, IRR 2.25, 95% CI 1.55–3.28). This peak was followed by an age-incidence decline up to age 60 years that was stronger in men than in women ($\chi^2 = 57.90$, $p < 0.001$). The relative risk of schizophrenia was greater in men up to age 39 years and this reversed to a greater relative risk in women over the age groups 50–70 years. No evidence for a second incidence peak in middle-aged women was found.

Conclusions. Robust sex differences exist in the distribution of schizophrenia risk across the age span, suggesting differential susceptibility to schizophrenia for men and women at different stages of life.

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Key words: Age at onset, age–sex interaction, epidemiology, incidence, schizophrenia.



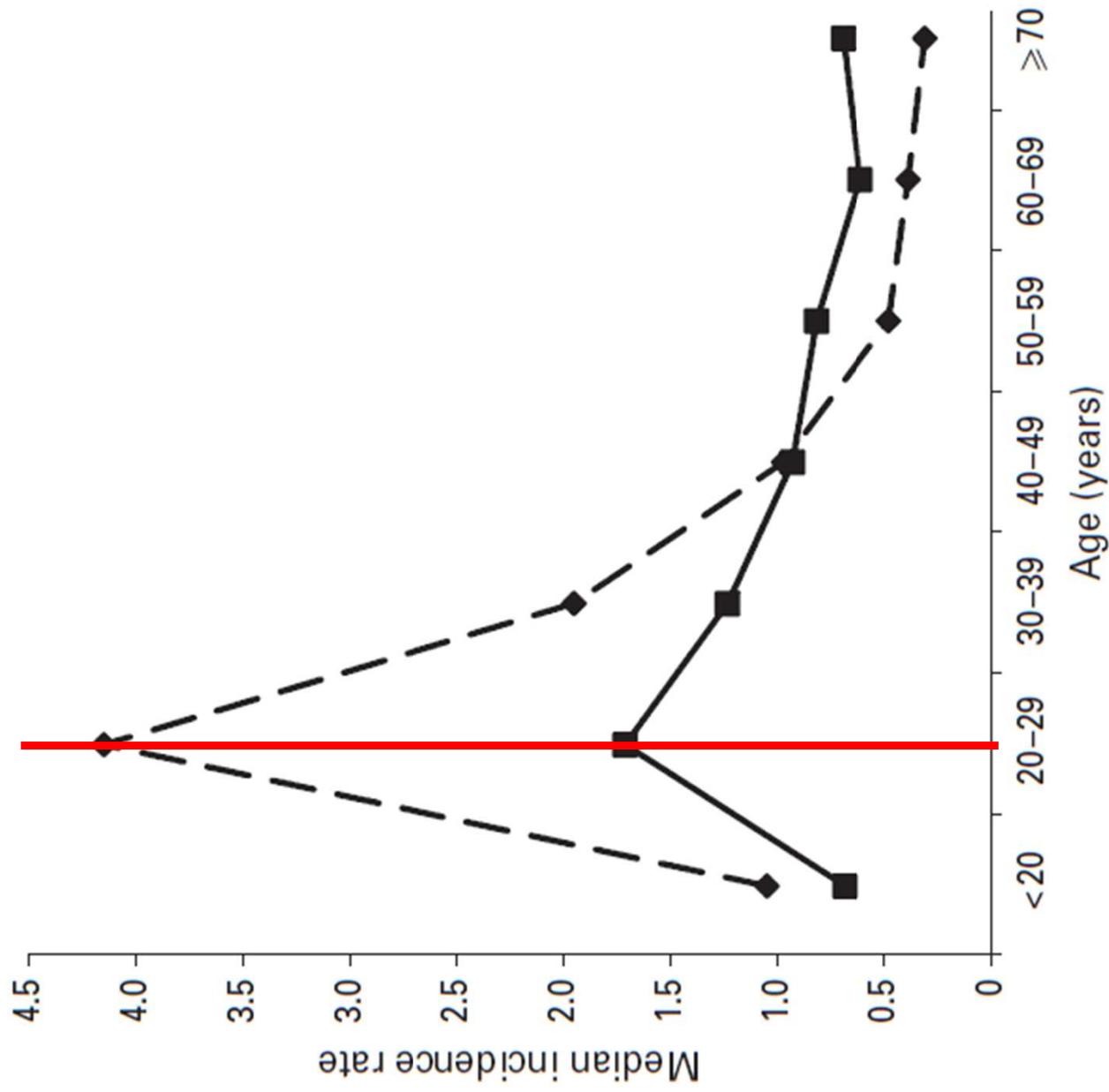


Fig. 1. Estimated age- and sex-specific median incidence rates (per 10 000 person-years): —■—, women; - - -◆- - -, men.

Età primo episodio psicotico in due studi italiani

- **Studio PICOS:**

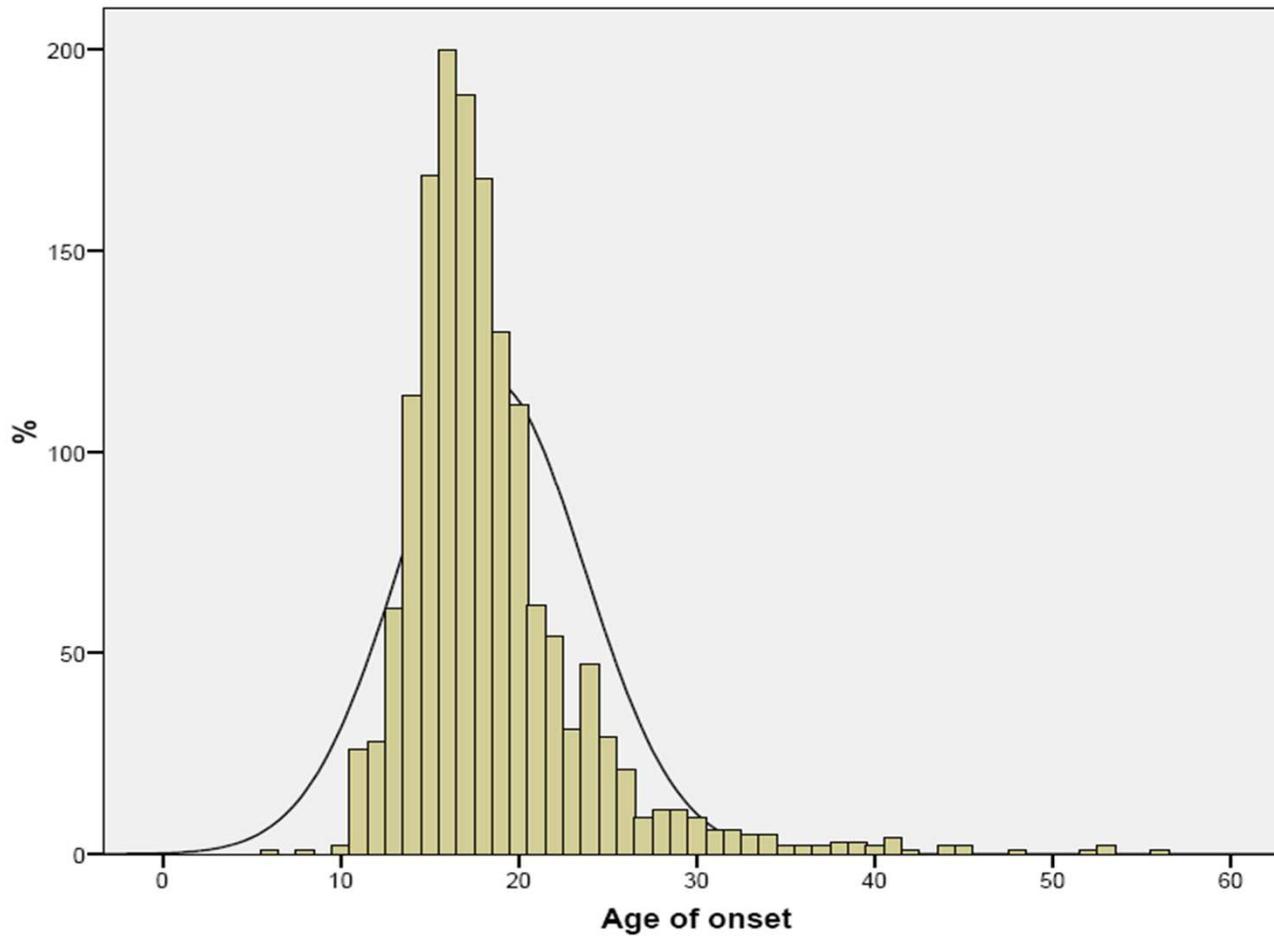
- **15-29 anni: 39%**

- **30-54 anni: 61%**

- **Studio GET-UP:**

- **gruppo sperimentale (N=272) età media: 29.3 (+9.8)**

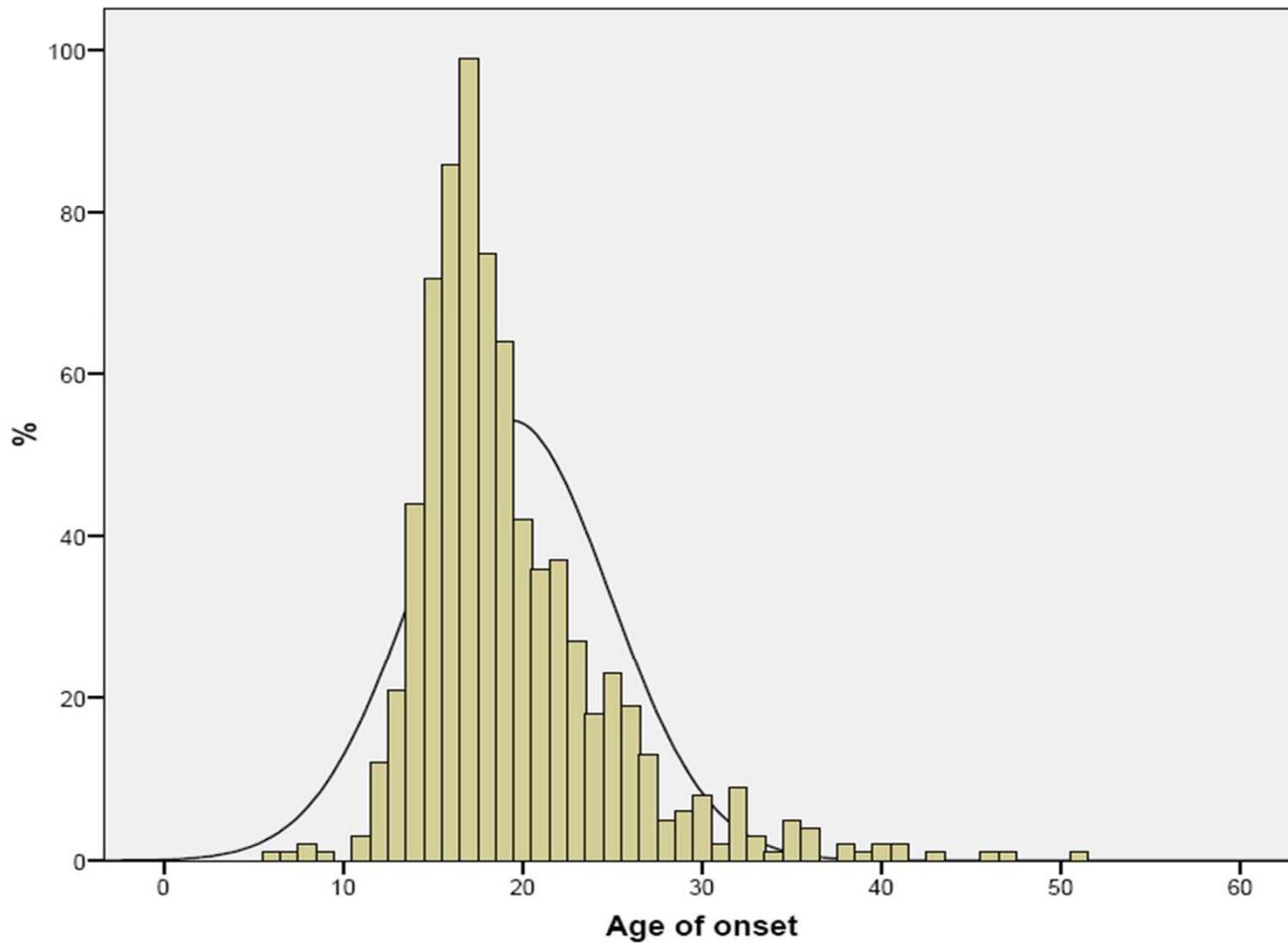
- **gruppo di controllo (N=172) età media: 31.5 (+9.2)**



ANORESSIA
Age Onset (AN):
mode 16 ys
mean 18.5 ys

Favaro et al, *J Clin Psychiatry*, 2009





BULIMIA

Age of Onset (BN)

mode 17 ys

mean 19.3 ys



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

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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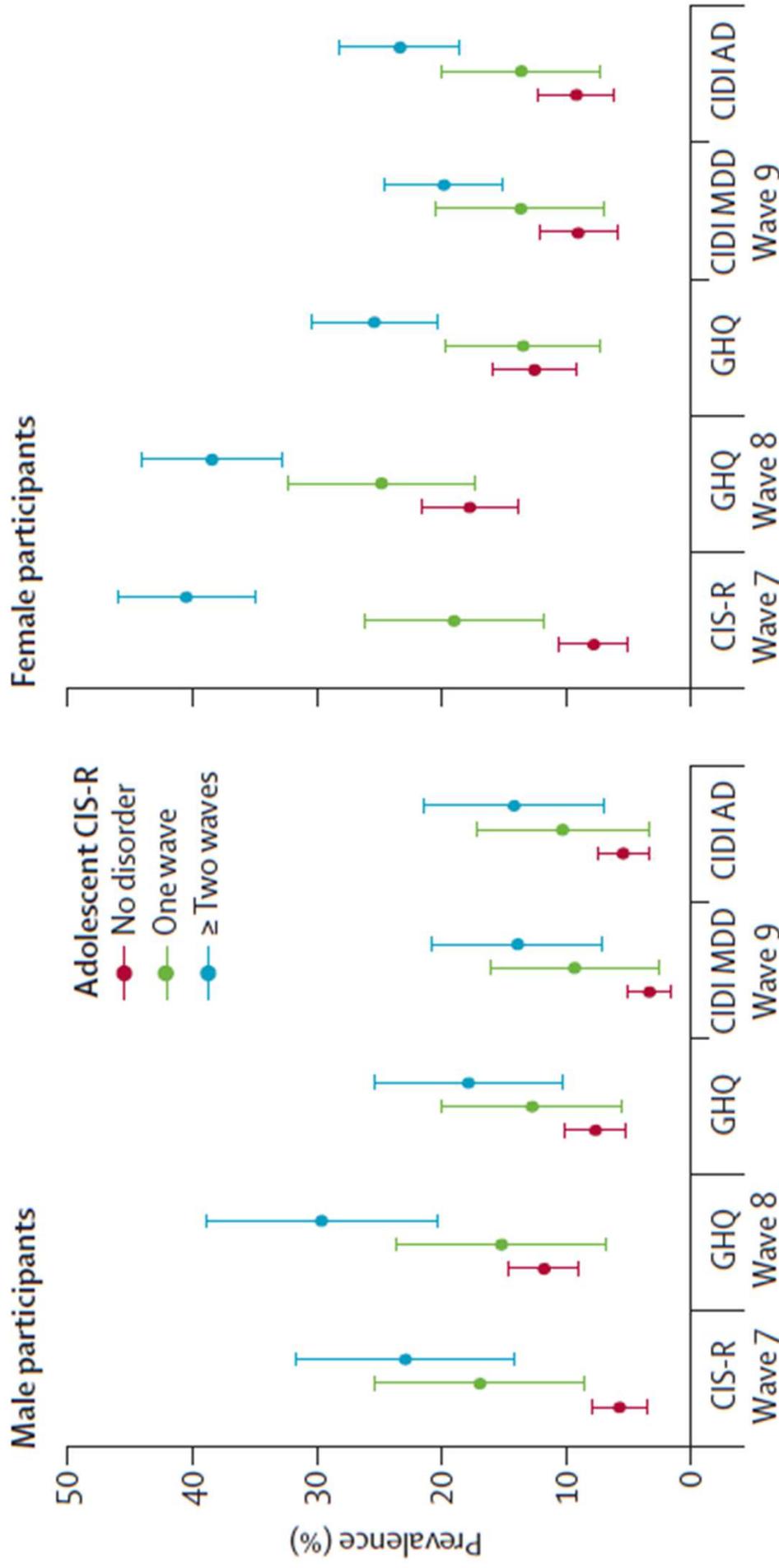


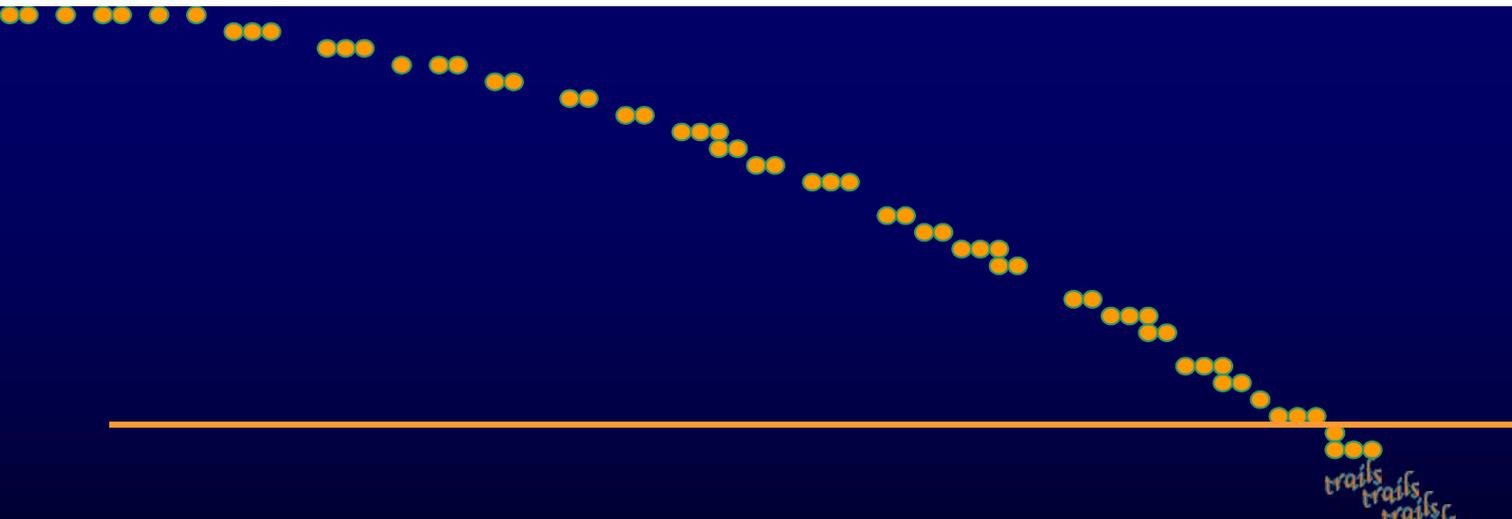
Figure 2: Estimated prevalence of mental disorders in young adulthood, by sex and persistence of mental disorders in adolescence (CIS-R ≥ 12)

Error bars are 95% CIs. CIS-R=Revised Clinical Interview Schedule. GHQ=General Health Questionnaire. CIDI MDD=Composite International Diagnostic Interview major depressive disorder. CIDI AD=Composite International Diagnostic Interview anxiety disorder.

Prognostic predictors of young adult disorder*

	Young adult mental disorder			
	1 wave		2+ waves	
2+ teen waves	1.5	0.9, 2.3	3.2	1.9, 5.4
Female	1.6	1.0, 2.4	2.1	1.3, 3.4
Parental separation	1.1	0.7, 1.7	1.6	1.0, 2.5
Antisocial behaviour	0.8	0.5, 1.2	1.2	0.8, 2
Risky alcohol	1	0.6, 1.6	0.5	0.2, 0.9
Daily tobacco	1	0.7, 1.7	0.8	0.5, 1.4
Weekly+ cannabis	1.3	0.7, 2.5	1.6	0.8, 3.1

* Multinomial logistic models



TRACKING ADOLESCENTS' INDIVIDUAL LIVES

SURVEY

A longitudinal multidisciplinary study of mental, behavioral & physical health, and social development from pre-puberty into adulthood.

An internationally competitive resource



Study design TRAILS in a nutshell

- Longitudinal: childhood into young adulthood
- Population (N=2,230) + high-risk cohort (N=600)
- Biennial assessments. Core funded until 2015
- Multiple informants, determinants and outcomes
- Psychological, social, medical & biological data
- Current Status: 2nd wave (96% response)

trails

Mental health in Dutch adolescents: a TRAILS report on prevalence, severity, age of onset, continuity and co-morbidity of DSM disorders

J. Ormel^{1*}, D. Raven¹, F. van Oort², C. A. Hartman¹, S. A. Reijneveld³, R. Veenstra⁴,
W. A. M. Vollebergh⁵, J. Buitelaar⁶, F. C. Verhulst² and A. J. Oldehinkel¹

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² *Department of Child and Adolescent Psychiatry and Psychology, Erasmus Medical Center, Rotterdam, The Netherlands*

³ *Department of Health Sciences, University of Groningen, University Medical Center Groningen, Groningen, The Netherlands*

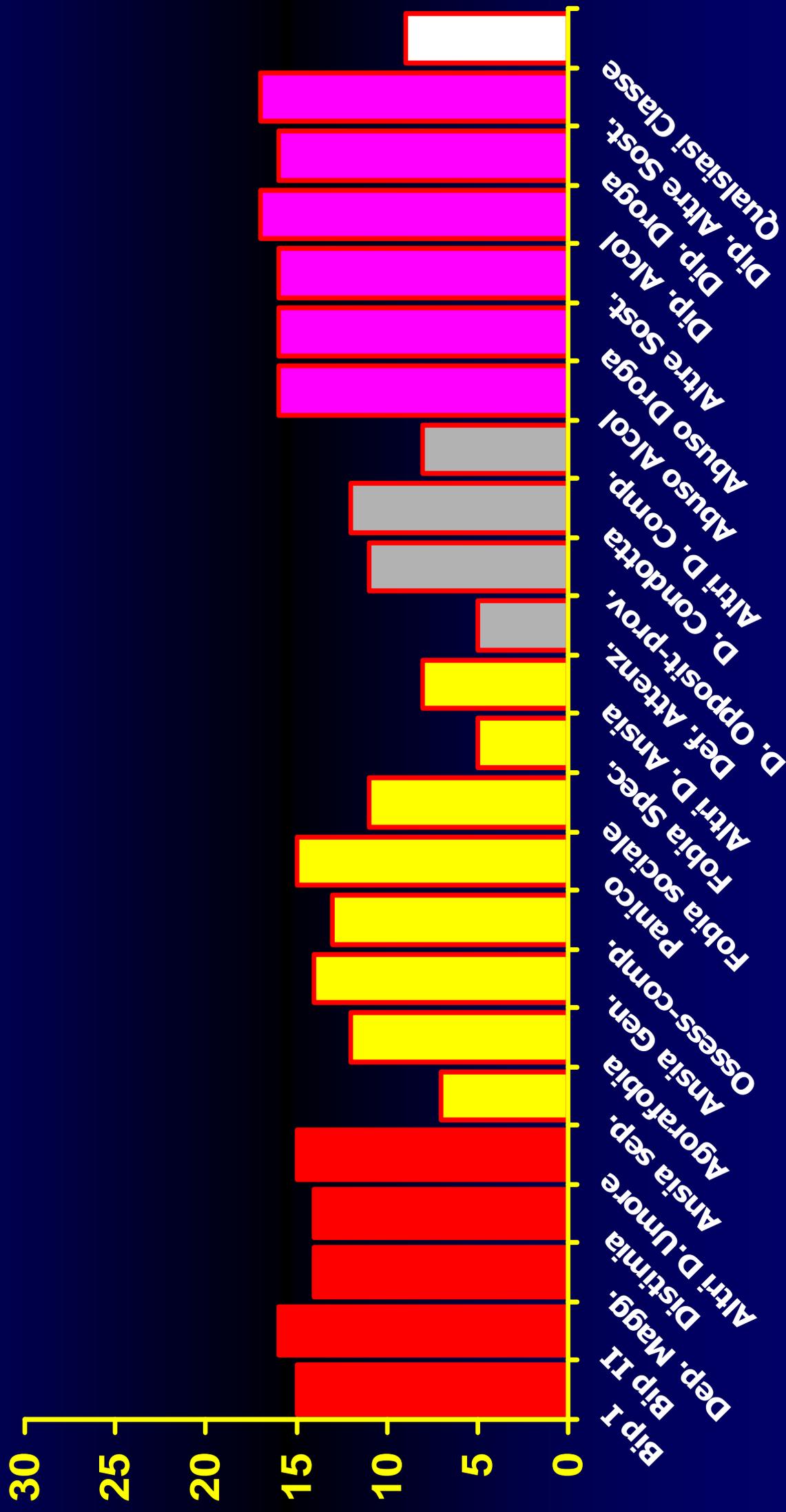
⁴ *Department of Sociology, University of Groningen, Groningen, The Netherlands*

⁵ *Department of Youth and Family, University of Utrecht, Utrecht, The Netherlands*

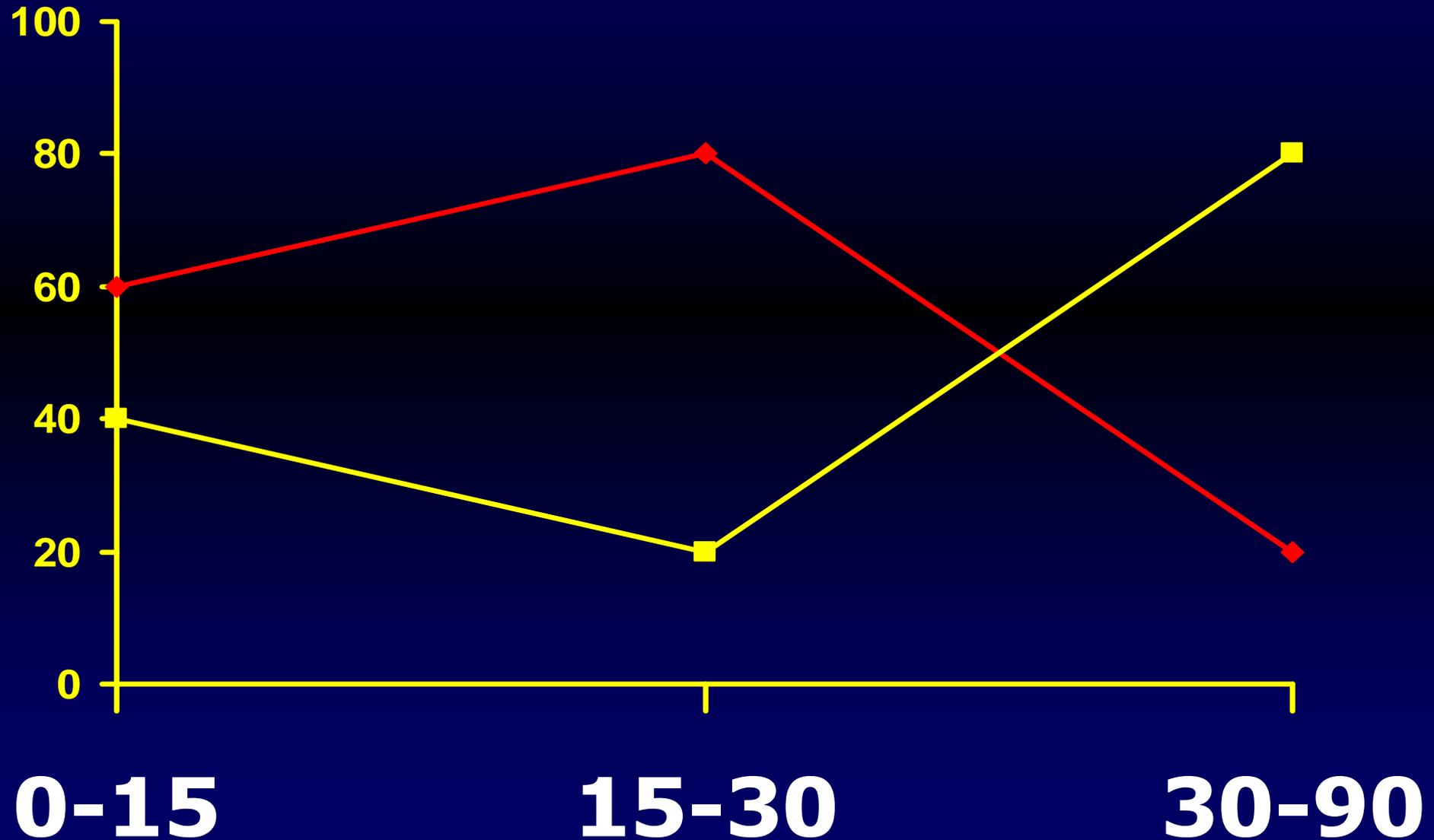
⁶ *Department of Psychiatry, Radboud University Nijmegen, Nijmegen, The Netherlands*

1.584 adolescenti valutati ad 11 ed a 19 anni

Età mediana di insorgenza (anni) dei disturbi mentali nello studio TRAILS



% dei disturbi mentali (linea rossa) e di quelli somatici (linea verde) in tre fasce di età

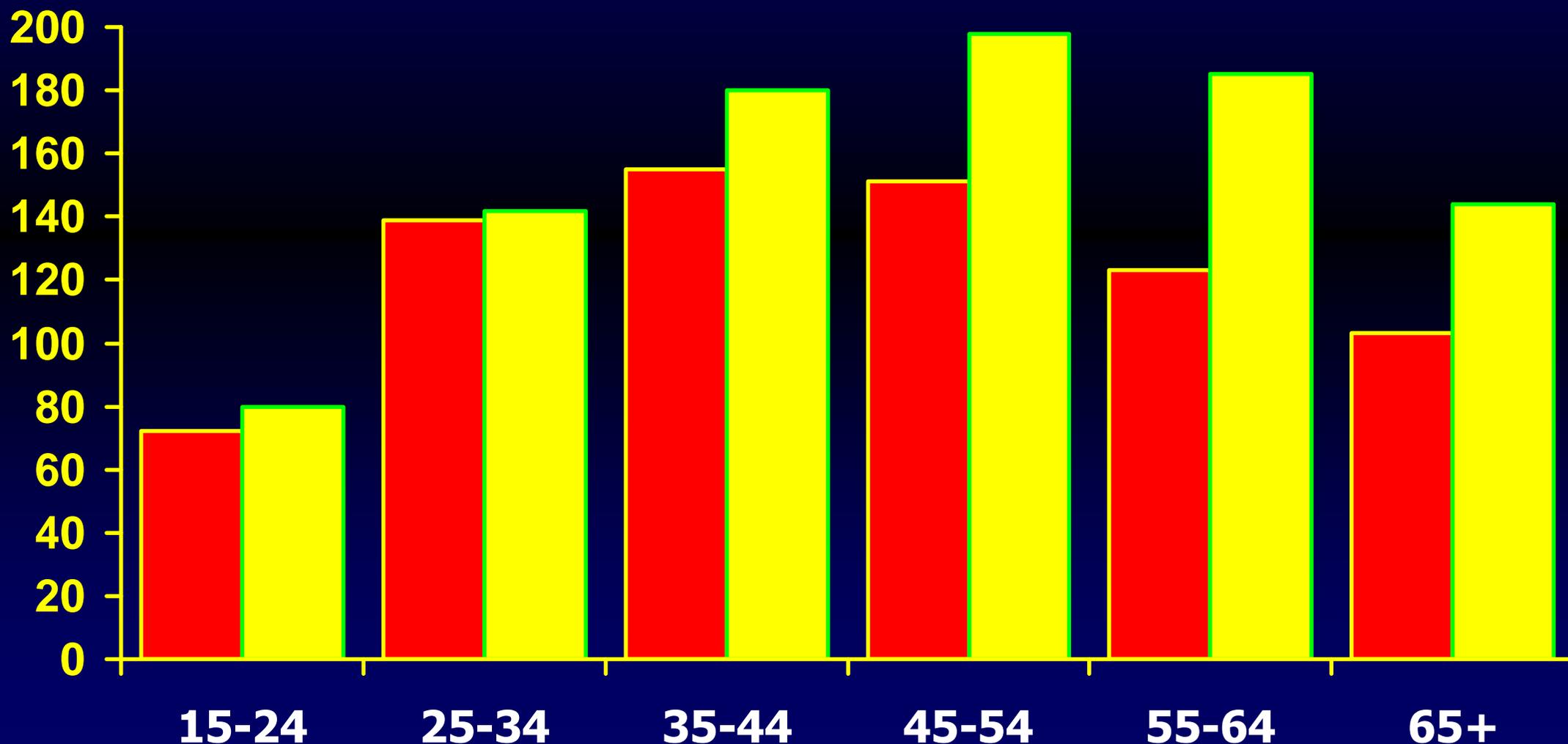


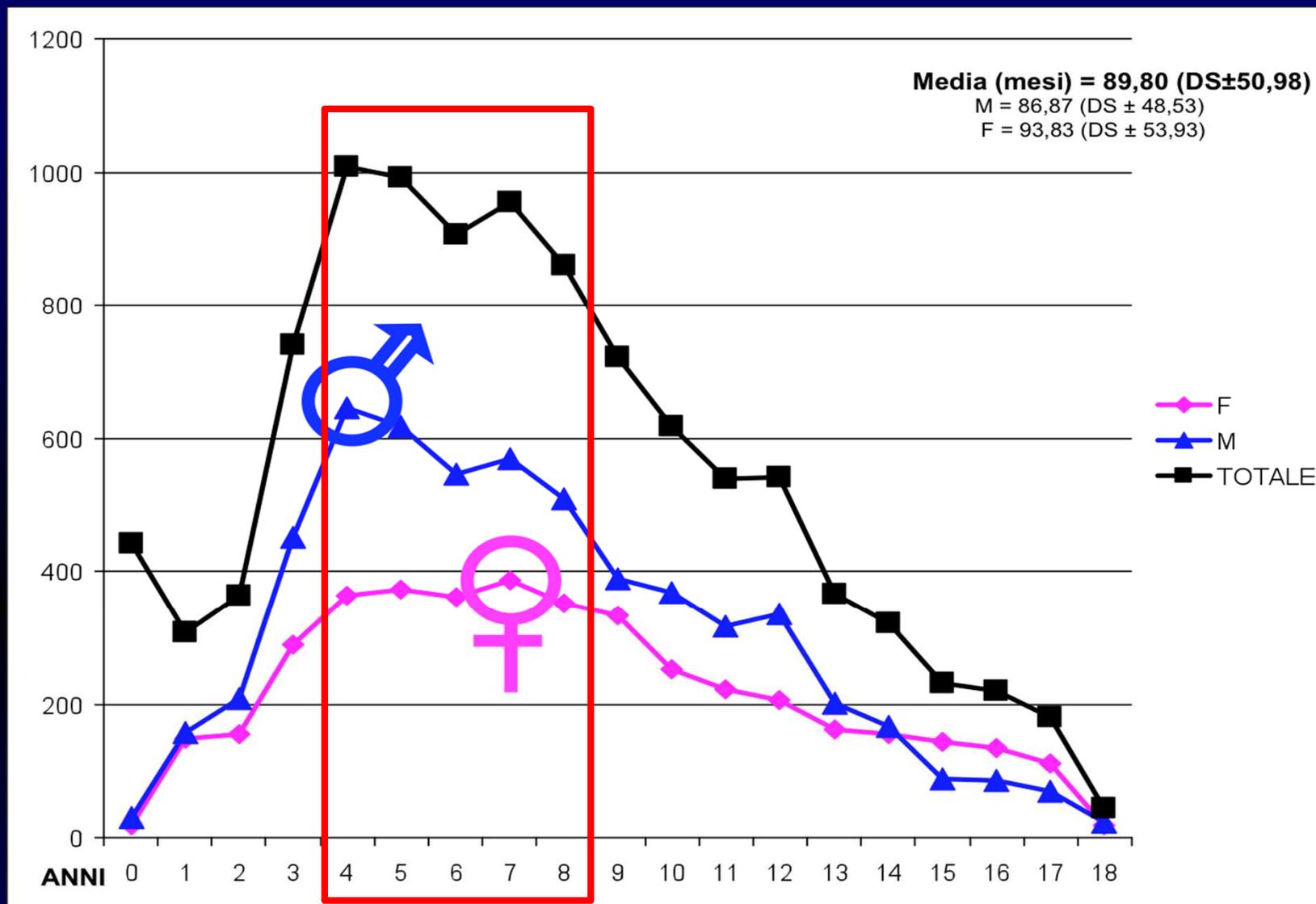
**Quale è l'età dei pazienti
in trattamento?**

**La situazione dei DSM,
UONPIA E SERT**

Prevalenza trattata in Lombardia per classi di età, anno 2005 (tassi X 10.000 persone)

Maschi Femmine





ETA' AL MOMENTO DEL CONTATTO
periodo di riferimento: 1994-2007
N=10.087

RESEARCH ARTICLE

Open Access

The characteristics and activities of child and adolescent mental health services in Italy: a regional survey

Laura Pedrini¹, Giovanni Colasurdo², Stefano Costa³, Michela Fabiani⁴, Linda Ferraresi⁵, Emilio Franzoni⁶, Francesca Masina⁷, Renato Moschen⁸, Vittoria Neviani⁹, Stefano Palazzi¹⁰, Roberto Parisi¹¹, Antonia Parmeggiani¹², Antonio Preti¹³, Cosimo Ricciutello¹⁴, Marco BL Rocchi¹⁵, Davide Sisti¹⁵, Antonella Squarcia¹⁶, Stefano Trebbi¹⁷, Donatella Turchetti¹⁸, Paola Visconti¹⁹, Andrea Tullini²⁰ and Giovanni de Girolamo^{1*}, for the PREMIA Group

Abstract

Background: To date, no studies have assessed in detail the characteristics, organisation, and functioning of Child and Adolescent Mental Health Services (CAMHS). This information gap represents a major limitation for researchers and clinicians because most mental disorders have their onset in childhood or adolescence, and effective interventions can therefore represent a major factor in avoiding chronicity. Interventions and mental health care are delivered by and through services, and not by individual, private clinicians, and drawbacks or limitations of services generally translate in inappropriateness and ineffectiveness of treatments and interventions: therefore information about services is essential to improve the quality of care and ultimately the course and outcome of mental disorders in childhood and adolescence.

The present paper reports the results of the first study aimed at providing detailed, updated and comprehensive data on CAMHS of a densely populated Italian region (over 4 million inhabitants) with a target population of 633,725 subjects aged 0-17 years.

Methods: Unit Chiefs of all the CAMHS filled in a structured 'Facility Form', with activity data referring to 2008 (data for inpatient facilities referred to 2009), which were then analysed in detail.

Results: Eleven CAMHS were operative, including 110 outpatient units, with a ratio of approximately 20 child psychiatrists and 23 psychologists per 100,000 inhabitants aged 0-17 years. All outpatient units were well equipped and organized and all granted free service access. In 2008, approximately 6% of the target population was in contact with outpatient CAMHS, showing substantial homogeneity across the eleven areas thereby. Most patients in contact in 2008 received a language disorder- or learning disability diagnosis (41%). First-ever contacts accounted for 30% of annual visits across all units. Hospital bed availability was 5 per 100,000 inhabitants aged 0-17 years.

Conclusion: The percentage of young people in contact with CAMHS for mental disorders is in line with those observed in previous epidemiological studies. The overall number of child psychiatrists per 100,000 inhabitants is one of the highest in Europe and it is comparable with the most well equipped areas in the US. This comparison should be interpreted with caution, however, because in Italy, child psychiatrists also treat neurological disorders. Critical areas requiring improvement are: the uneven utilisation of standardised assessment procedures and the limited availability of dedicated emergency services during non-office hours (e.g., nights and holidays).

Keywords: Child and Adolescent Mental Health Services (CAMHS), Process of care, Adolescence, Child Psychiatry

**Approx. 4.5
million
inhabitants
and 633,725
children 0-17**

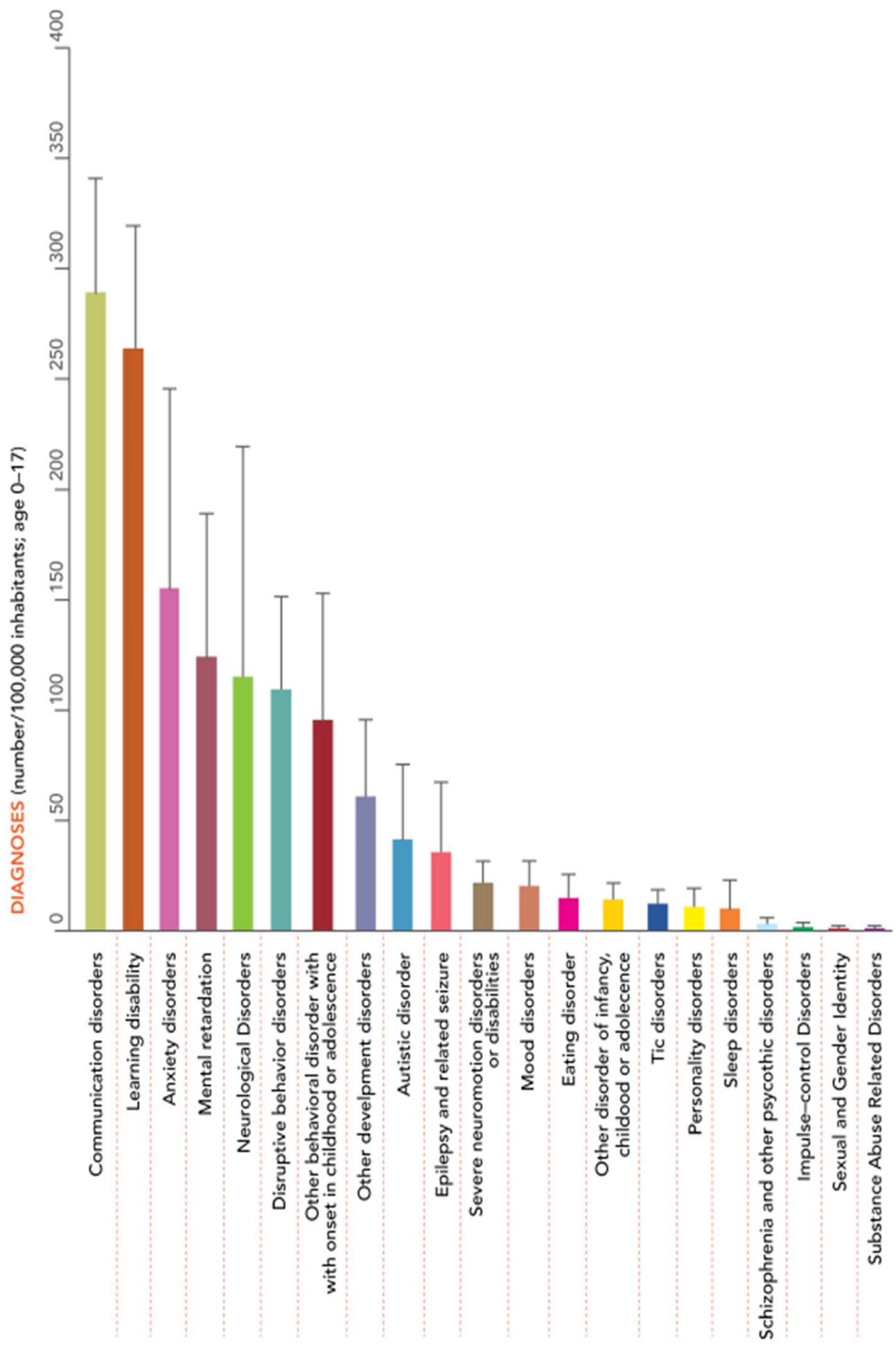


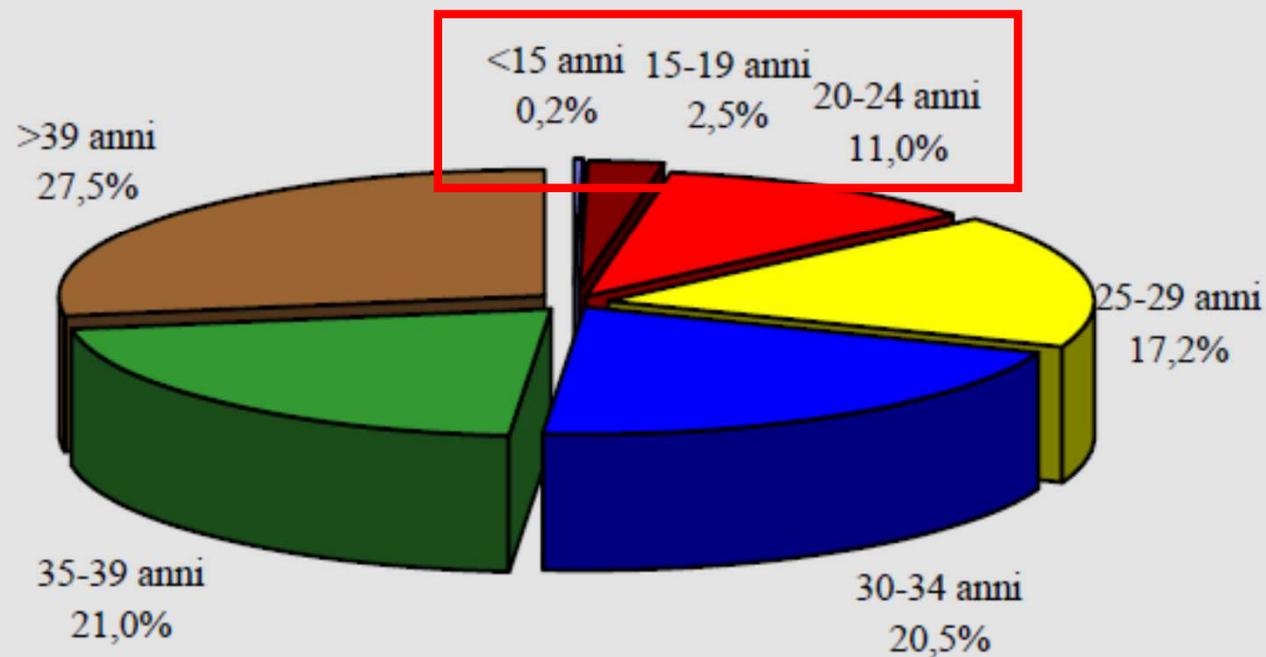
Figure 1 Distribution of all diagnoses in the target population (0-17 years). Data refer to number of patients in treatment per 100,000 inhabitants aged 0-17 years, with standard deviations.

TABELLE E GRAFICI

Graf.7 - UTENTI DISTRIBUITI PER FASCE DI ETA' - ANNO 2006

TOTALE UTENTI

< 24 anni: 13,7%



L'ESPERIENZA INGLESE: TRANSITION FROM CAMHS TO ADULT MENTAL HEALTH SERVICES (TRACK)

BJPsych

The British Journal of Psychiatry (2010)
197, 305–312. doi: 10.1192/bjp.bp.109.075135

Process, outcome and experience of transition from child to adult mental healthcare: multiperspective study

Swaran P. Singh, Moli Paul, Tamsin Ford, Tami Kramer, Tim Weaver, Susan McLaren, Kimberly Hovish, Zoebia Islam, Ruth Belling and Sarah White

Background

Many adolescents with mental health problems experience transition of care from child and adolescent mental health services (CAMHS) to adult mental health services (AMHS).

Aims

As part of the TRACK study we evaluated the process, outcomes and user and carer experience of transition from CAMHS to AMHS.

Method

We identified a cohort of service users crossing the CAMHS/AMHS boundary over 1 year across six mental health trusts in England. We tracked their journey to determine predictors of optimal transition and conducted qualitative interviews with a subsample of users, their carers and clinicians on how transition was experienced.

Results

Of 154 individuals who crossed the transition boundary in 1 year, 90 were actual referrals (i.e. they made a transition to AMHS), and 64 were potential referrals (i.e. were either

not referred to AMHS or not accepted by AMHS). Individuals with a history of severe mental illness, being on medication or having been admitted were more likely to make a transition than those with neurodevelopmental disorders, emotional/neurotic disorders and emerging personality disorder. Optimal transition, defined as adequate transition planning, good information transfer across teams, joint working between teams and continuity of care following transition, was experienced by less than 5% of those who made a transition. Following transition, most service users stayed engaged with AMHS and reported improvement in their mental health.

Conclusions

For the vast majority of service users, transition from CAMHS to AMHS is poorly planned, poorly executed and poorly experienced. The transition process accentuates pre-existing barriers between CAMHS and AMHS.

Declaration of interest

None.



**THEME [HEALTH.2013.3.1-1]
[Comparative Effectiveness Research (CER) in
health systems and health services interventions]**

Grant agreement for: Collaborative project

Annex I - "Description of Work"

Project acronym: MILESTONE

Project full title: " THE MILESTONE PROJECT: Managing the Link and Strengthening Transition from Child to Adult Mental Health Care "

Grant agreement no: 602442



LIST OF BENEFICIARIES

Project Number ¹	602442	Project Acronym ²	MILESTONE
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List of Beneficiaries

No	Name	Short name	Country	Project entry month ¹⁰	Project exit month
1	THE UNIVERSITY OF WARWICK	UoW	United Kingdom	1	60
2	PROVINCIA LOMBARDO VENETA ORDINE OSPEDALIERO DI SAN GIOVANNI DI DIO - FATEBENEFRAPELLI	IRCCS FBF	Italy	1	60
3	KING'S COLLEGE LONDON	KCL	United Kingdom	1	60
4	CENTRE HOSPITALIER UNIVERSITAIRE DE MONTPELLIER	CHRU	France	1	60
5	Stichting Yulius	Yulius	Netherlands	1	60
6	UNIVERSITAET ULM	UULM	Germany	1	60
7	KATHOLIEKE UNIVERSITEIT LEUVEN	KU Leuven	Belgium	1	60
8	UNIVERSITY COLLEGE DUBLIN, NATIONAL UNIVERSITY OF IRELAND, DUBLIN	NUID UCD	Ireland	1	60
9	Klinički bolnički centar Split	KBC Split	Croatia	1	60
10	HEALTHTRACKER LTD	HT	United Kingdom	1	60
11	ERASMUS UNIVERSITAIR MEDISCH CENTRUM ROTTERDAM	ErasmusMC	Netherlands	1	60
12	Concentris Research Management GmbH	concentris	Germany	1	60

WORK PACKAGE 3

**Longitudinal cohort study of transition of care from CAMHS to AMHS.
Responsabili: Yulius, ErasmusMC, UoW.**

- **Studio prospettico di coorte condotto in 8 Paesi Europei.**
- **Reclutamento di 1.000 utenti CAMHS N=50-150/paese/anno (30 per CAMHS/AMHS)**
- **4 fasi di valutazione multi-livello (utenti, caregiver/partner, clinici e ricercatori) per un arco di tempo di 3 anni**

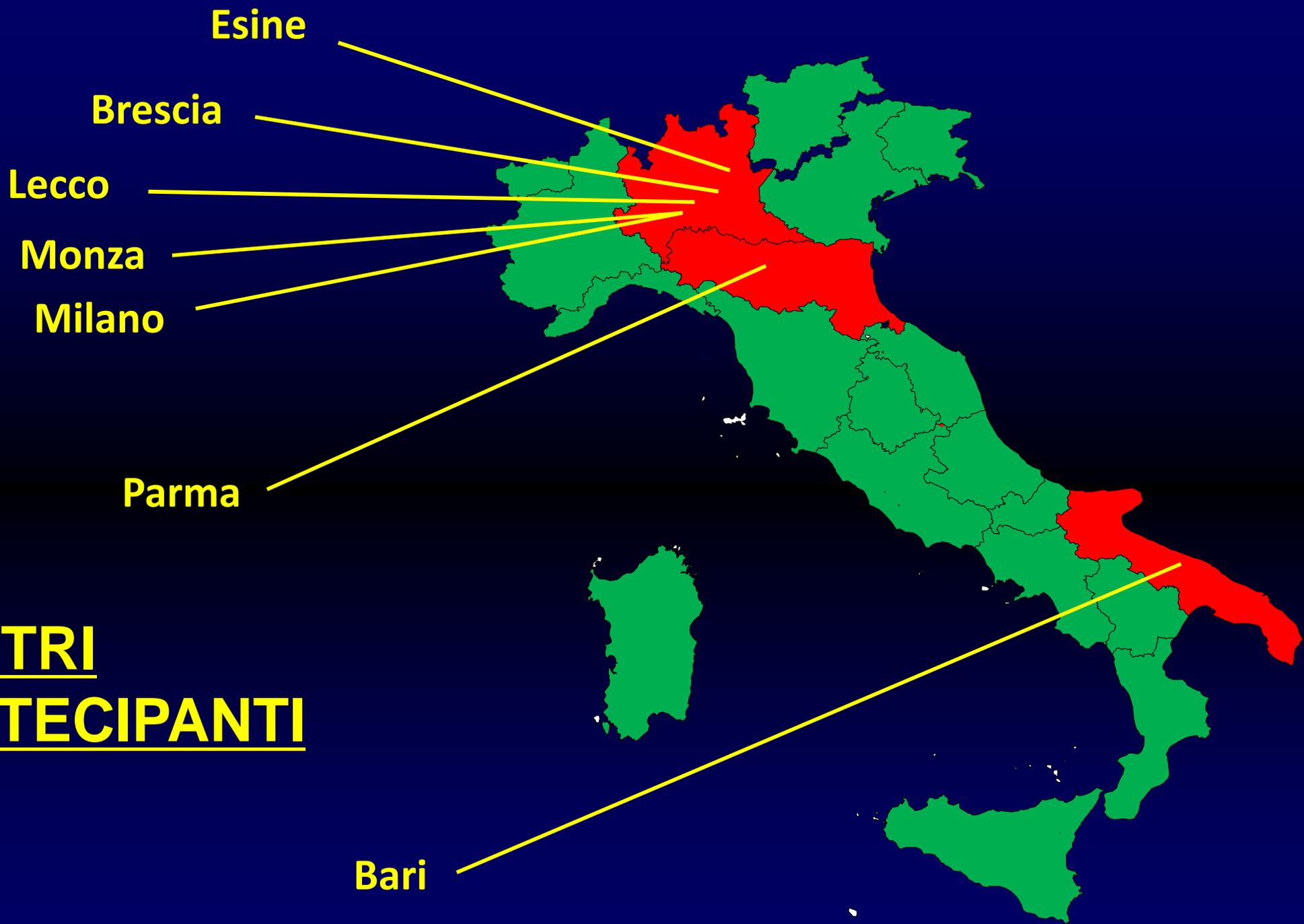
WORK PACKAGE 4

Cluster- randomised control trial of managed transition in improving outcomes for young people. Responsabile: UoW-MHWB

- 1. Randomizzare i CAMHS partecipanti nei gruppi di intervento o di controllo in rapporto 1: 4**
- 2. Realizzare l'intervento sperimentale (TRaM) ed il trattamento standard (TAU)**
- 3. Determinare l'efficacia di tale protocollo nel**
 - migliorare il processo di transizione ed i suoi esiti**
 - garantire un'appropriata dimissione**

PARTECIPAZIONE ITALIANA

- Reclutamento di **ALMENO 200** utenti adolescenti (**17 ANNI**) al momento della transizione
- Partecipazione allo studio prospettico di coorte
- Partecipazione al trial controllato e randomizzato (**1:4**)



CENTRI
PARTECIPANTI

CONCLUSIONI (I):

- **La divisione tra UONPIA, DSM e SERT non ha alcun senso: serve solo ad avere professionisti che trattano pz o troppo piccoli (UONPIA) o troppo anziani (DSM e SERT) e TRE direttori invece di UNO (magari competente)!**
- **Il servizio dovrebbe essere unico, senza soluzioni di continuità, con articolazioni diverse ed un unico Direttore**

CONCLUSIONI (II):

- **Il servizio dovrebbe disporre di tecniche di identificazione precoce rivolte ai giovani**
- **IL servizio dovrebbe formare agli interventi psicosociali di provata efficacia con queste popolazioni di pz**
- **Il servizio dovrebbe disporre di sedi user-friendly capaci di attirare i giovani**
- **Il servizio dovrebbe offrire soluzioni di counselling e di supporto scolastico e lavorativo**



IRCCS FATEBENEFRAELLI - BRESCIA (ITALY)



European Conference on
YOUTH MENTAL HEALTH:
 FROM CONTINUITY
 OF PSYCHOPATHOLOGY TO
 CONTINUITY OF CARE
 (STraMeHS)



"This conference arises from the project
**YOUTH MENTAL HEALTH:
 FROM CONTINUITY OF PSYCHOPATHOLOGY
 TO CONTINUITY OF CARE (STraMeHS)**
 which has received funding from
 the European Union,
 in the framework of the
 Public Health Programme."



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The Conference aims to achieve the wide geographical area of the 28 European countries.

Online registrations are free but subject to approval the Scientific Committee. Approved registrations will be confirmed by the Organizing Secretariat via email within 30 days.

The Conference is open to mental health, experts (clinicians and researchers), policy - makers, family and users associations.

Participants are welcome to submit proposals for oral presentations and posters. Abstracts (max 250 words, structured) must be sent not later than July 31st 2014.

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