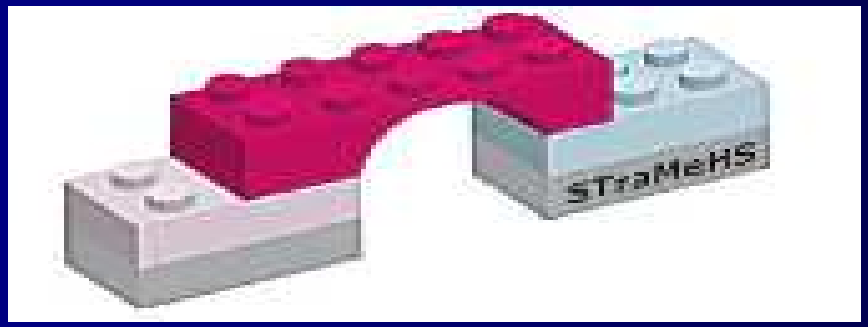
Giovanni de Girolamo

YOUTH MENTAL HEALTH: FROM CONTINUITY OF PSYCHOPATHOLOGY TO CONTINUITY OF CARE. AN INTRODUCTION

IRCCS
CENTRO SAN GIOVANNI DI DIO FATEBENEFRATELLI – BRESCIA
Centro Nazionale per lo Studio e la Cura
della Malattia di Alzheimer e Malattie Mentali



The United Nations define YOUTH as people aged between 15 and 24 years.

With a population of 1.8 billion, they comprise a quarter of the world's population.

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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See **Comment** page 2058

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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%)

Nature Reviews Neuroscience | AOP, published online 15 December 2008; doi:10.1038/nrn2513

PERSPECTIVES

OPINION

Why do many psychiatric disorders emerge during adolescence?

Tomáš Paus, Matcheri Keshavan and Jay N. Giedd

Abstract | The peak age of onset for many psychiatric disorders is adolescence, a time of remarkable physical and behavioural changes. The processes in the brain that underlie these behavioural changes have been the subject of recent investigations. What do we know about the maturation of the human brain during adolescence? Do structural changes in the cerebral cortex reflect synaptic pruning? Are increases in white-matter volume driven by myelination? Is the adolescent brain more or less sensitive to reward? Finding answers to these questions might enable us to further our understanding of mental health during adolescence.

Volumes of white matter show a rather clear linear increase throughout childhood and adolescence, with the maximum volumes often reached as late as the third decade of life[10]. It seems that the slope of the age-related increase is steeper in males than in females[7,11]. More recently, diffusion tensor imaging (DTI) has been used to assess white-matter changes in more detail in the human brain during childhood and adolescence. Overall, DTI studies reveal age-related decreases in the magnitude and increases in the directionality of water diffusion in a number of white-matter regions[12–14], many of which are identical to those revealed by structural MRI studies, such as those of the arcuate fasciculus. Such changes in DTI-derived measures may indicate ongoing maturation of axons and/or their myelin sheaths (see below).

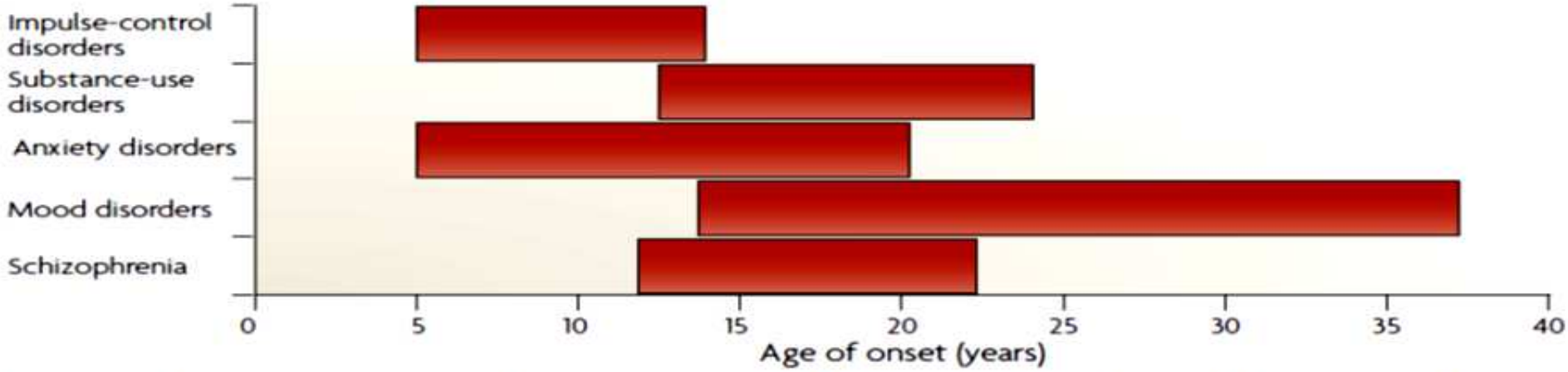

Figure 4 | **Ranges of onset age for common psychiatric disorders.** Recent data from the National Comorbidity Survey Replication study[50,112], a nationally representative epidemiological survey of

RESEARCH REPORT

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

RONALD C. KESSLER[1], MATTHIAS ANGERMEYER[2], JAMES C. ANTHONY[3], RON DE GRAAF[4], KOEN DEMYTTENAERE[5], ISABELLE GASQUET[6], GIOVANNI DE GIROLAMO[7], SEMYON GLUZMAN[8], OYE GUREJE[9], JOSEP MARIA HARO[10], NORITO KAWAKAMI[11], AIMEE KARAM[12], DAPHNA LEVINSON[13], MARIA ELENA MEDINA MORA[14], MARK A. OAKLEY BROWNE[15], JOSÉ POSADA-VILLA[16], DAN J. STEIN[17], CHEUK HIM ADLEY TSANG[18], SERGIO AGUILAR-GAXIOLA[19], JORDI ALONSO[20], SING LEE[21], STEVEN HEERINGA[22], BETH-ELLEN PENNELL[22], PATRICIA BERGLUND[22], MICHAEL J. GRUBER[1], MARIA PETUKHOVA[1], SOMNATH CHATTERJI[23], T. BEDIRHAN ÜSTÜN[23], FOR THE WHO WORLD MENTAL HEALTH SURVEY CONSORTIUM

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Age-of-onset percentiles,y

Bromet et al. BMC Medicine 2011, 9:90
http://www.biomedcentral.com/1741-7015/9/90

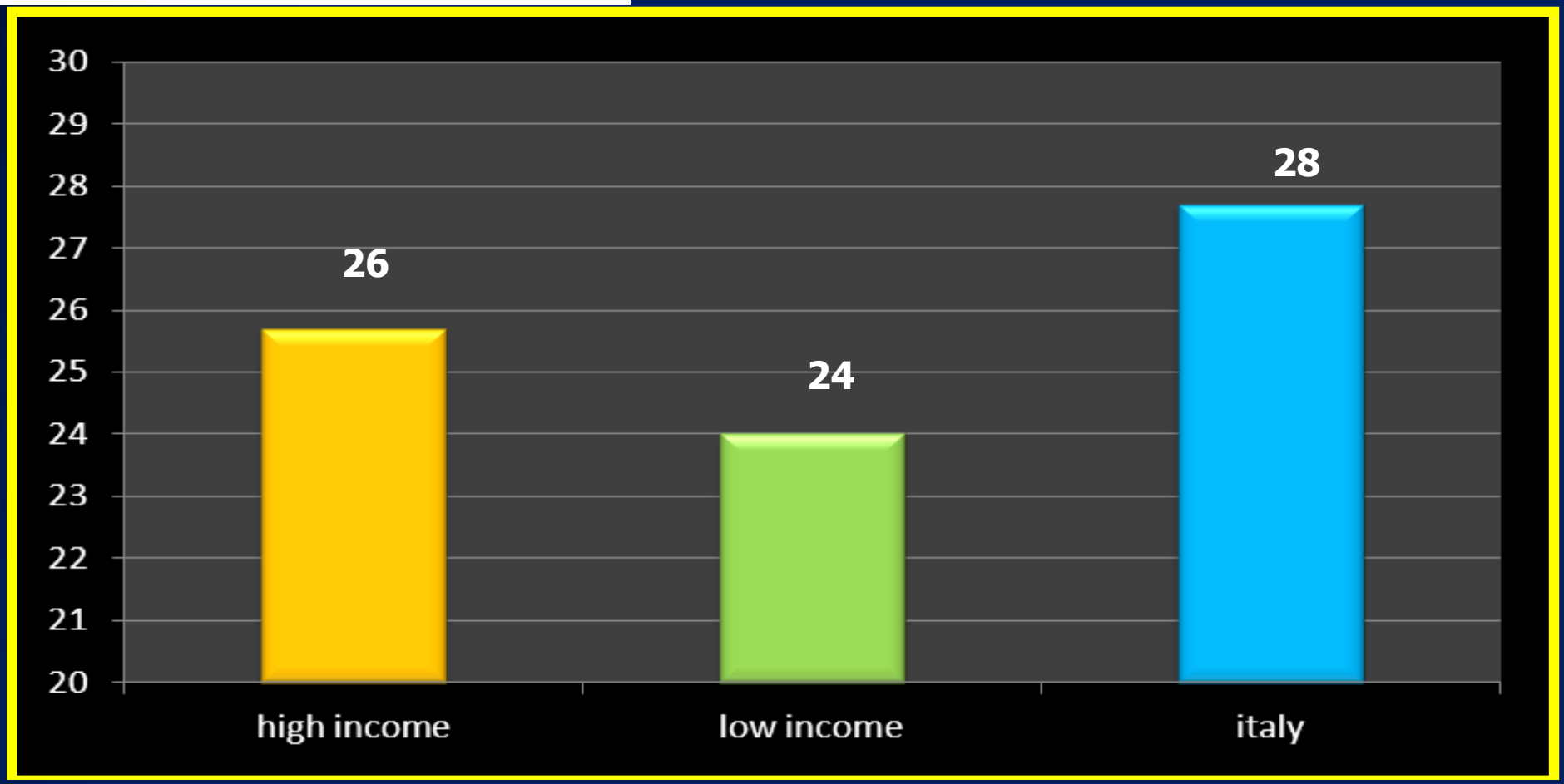
BMC Medicine

RESEARCH ARTICLE Open Access

Cross-national epidemiology of DSM-IV major depressive episode

Evelyn Bromet[1*], Laura Helena Andrade[2], Irving Hwang[3], Nancy A Sampson[3], Jordi Alonso[4], Giovanni de Girolamo[5], Ron de Graaf[6], Koen Demyttenaere[7], Chiyi Hu[8], Noboru Iwata[9], Aimee N Karam[10], Jagdish Kaur[11], Stanislav Kostyuchenko[12], Jean-Pierre Lépine[13], Daphna Levinson[14], Herbert Matschinger[15], Maria Elena Medina Mora[16], Mark Oakley Browne[17], Jose Posada-Villa[18], Maria Carmen Viana[19], David R Williams[20] and Ronald C Kessler[3]

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



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PLOS MEDICINE

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

Louisa Degenhardt[1*], Wai-Tat Chiu[2], Nancy Sampson[2], Ronald C. Kessler[2], James C. Anthony[3], Matthias Angermeyer[4], Ronny Bruffaerts[5], Giovanni de Girolamo[6], Oye Gureje[7], Yueqin Huang[8], Aimee Karam[9], Stanislav Kostyuchenko[10], Jean Pierre Lepine[11], Maria Elena Medina Mora[12], Yehuda Neumark[13], J. Hans Ormel[14], Alejandra Pinto-Meza[15], José Posada-Villa[16], Dan J. Stein[17], Tadashi Takeshima[18], J. Elisabeth Wells[19]

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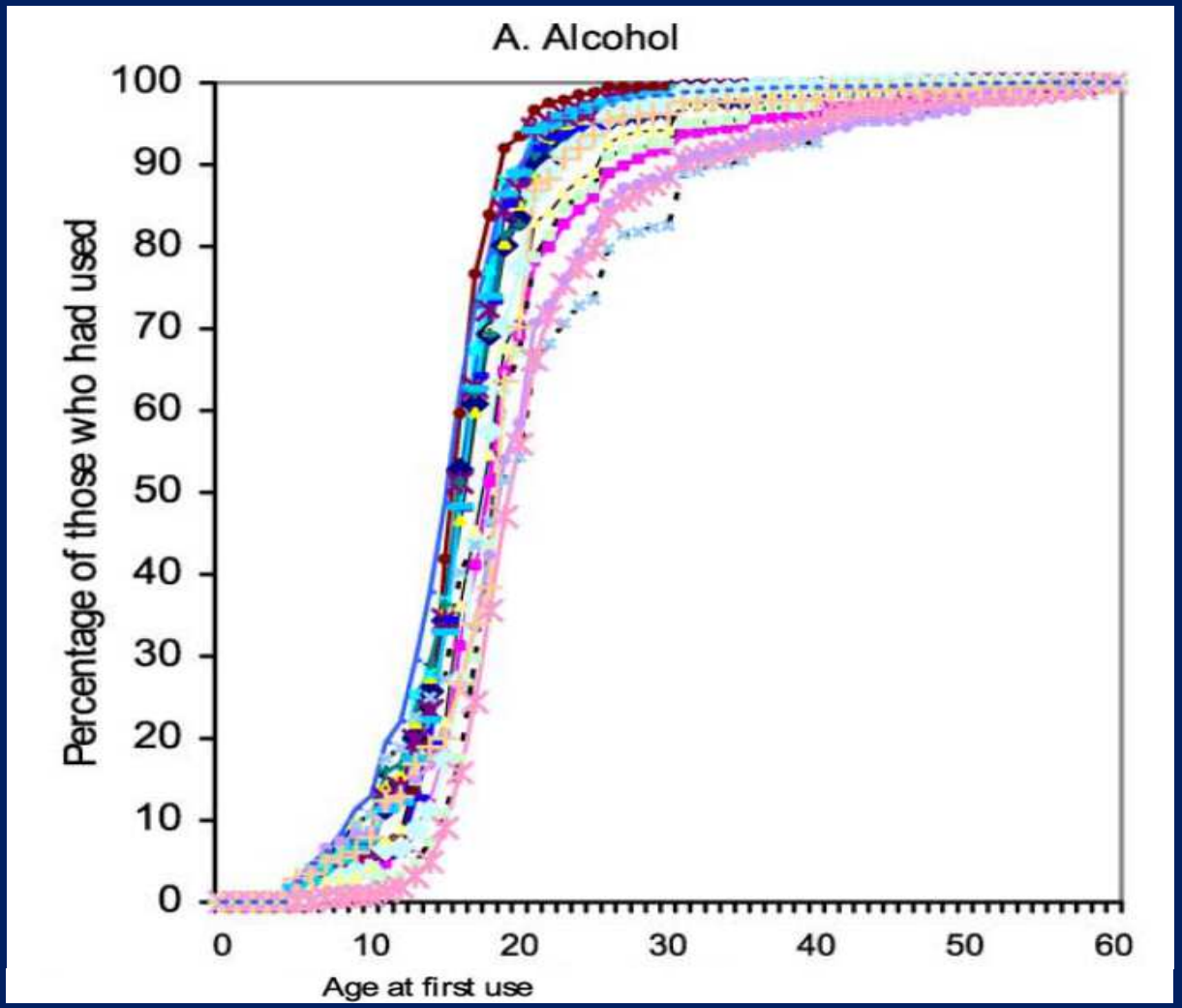
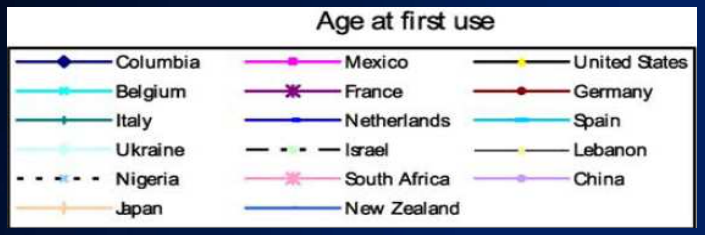
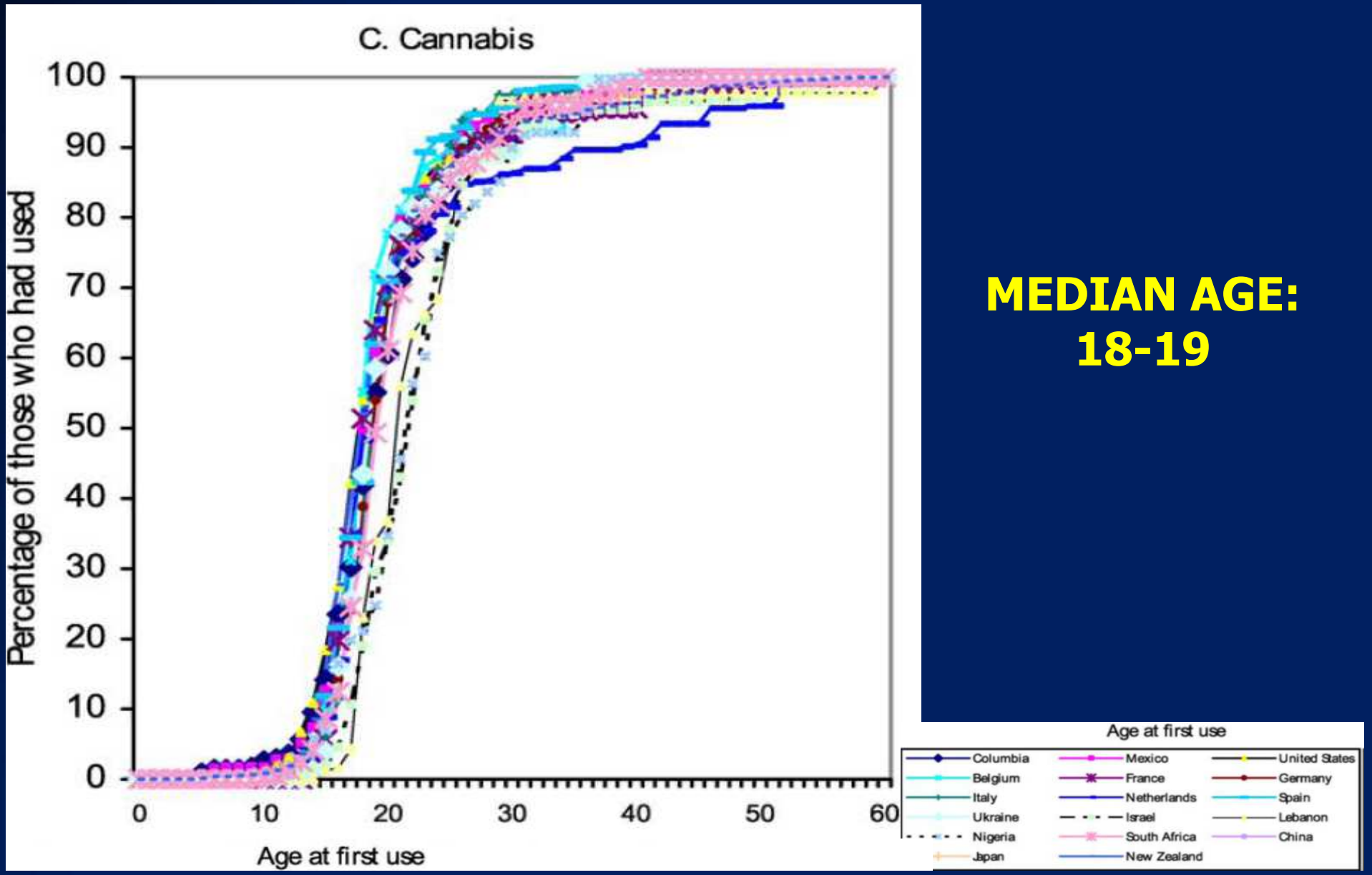
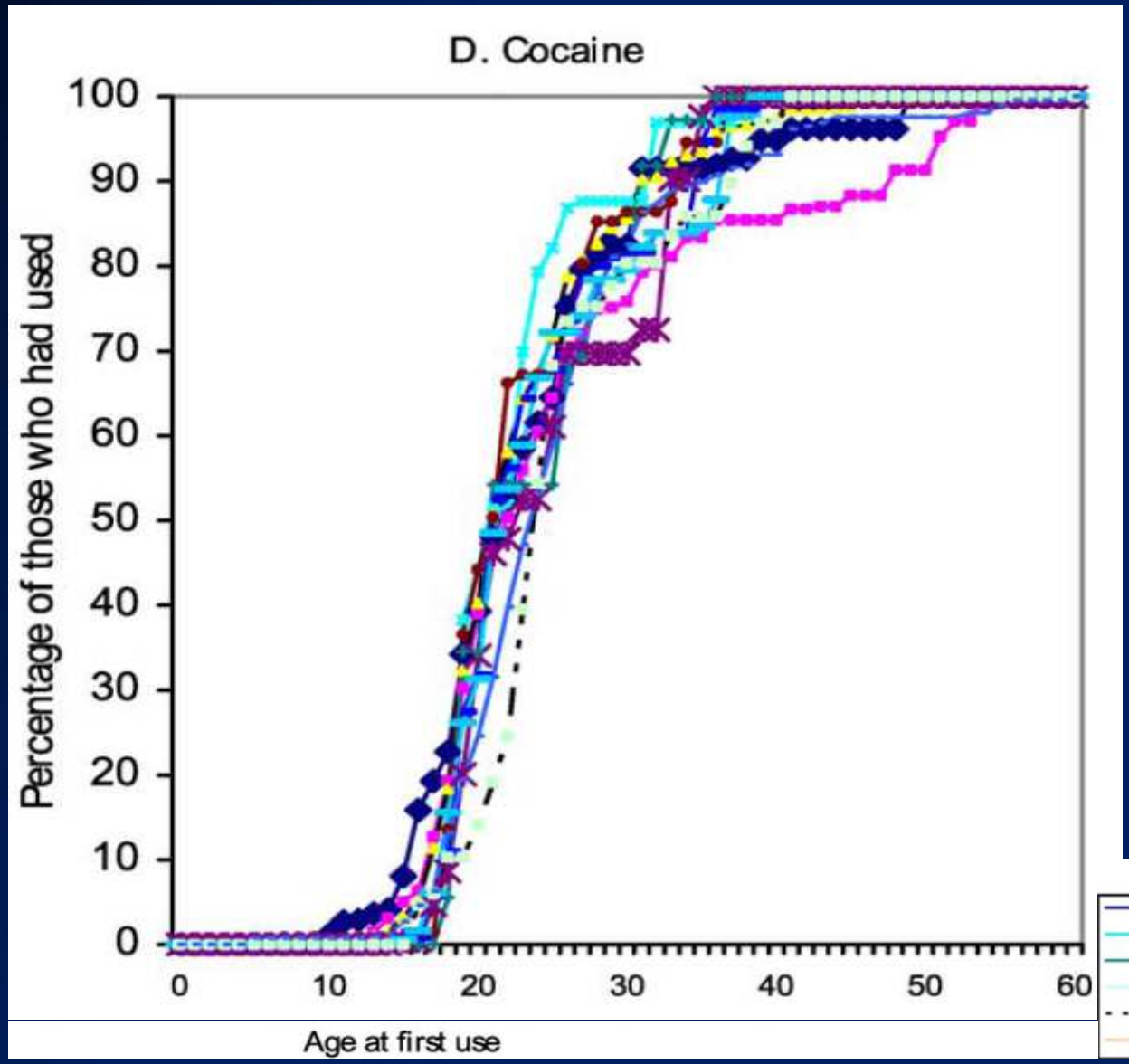
MEDIAN AGE: 16-19



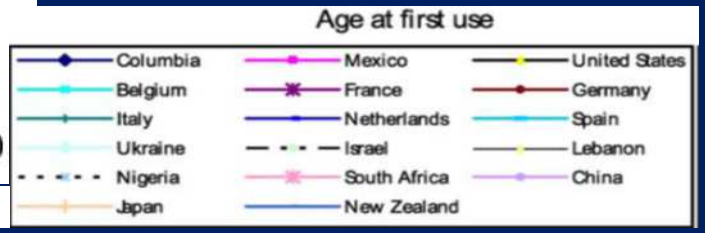




MEDIAN AGE:
18-19



MEDIAN AGE:
21-24



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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

Hongwei Zhang[a,*], Stephen R. Wisniewski[a], Mark S. Bauer[b], Gary S. Sachs[c], Michael E. Thase[d], for the STEP-BD Investigators

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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.

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)
Recovering	388 (19.4)
Recovered	530 (26.5)
Age at onset (y) (mean [SD])	17.3 (8.7)

Psychological Medicine, Page 1 of 8. © Cambridge University Press 2012
doi:10.1017/S0033291712002796

REVIEW ARTICLE

Systematic review and collaborative recalculation of 133 693 incident cases of schizophrenia

M. van der Werf[1], M. Hanssen[1,2], S. Köhler[1], M. Verkaaik[2], F. R. Verhey[1], RISE Investigators†, R. van Winkel[1], J. van Os[1,3]* and J. Allardyce[1]

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[3] *Department of Psychosis Studies, Institute of Psychiatry, King's College London, King's Health Partners, London, UK*

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.

Received 28 October 2011; Revised 27 October 2012; Accepted 6 November 2012

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

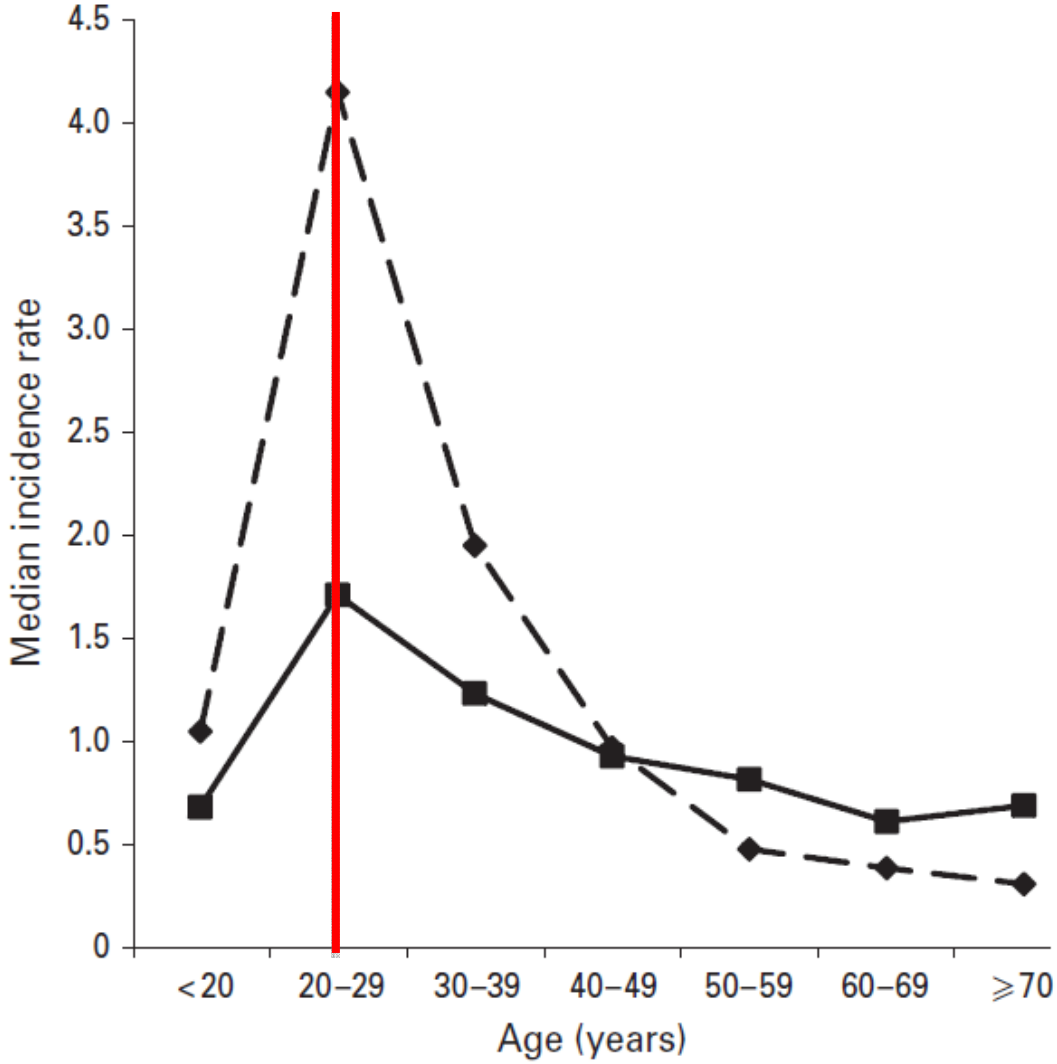
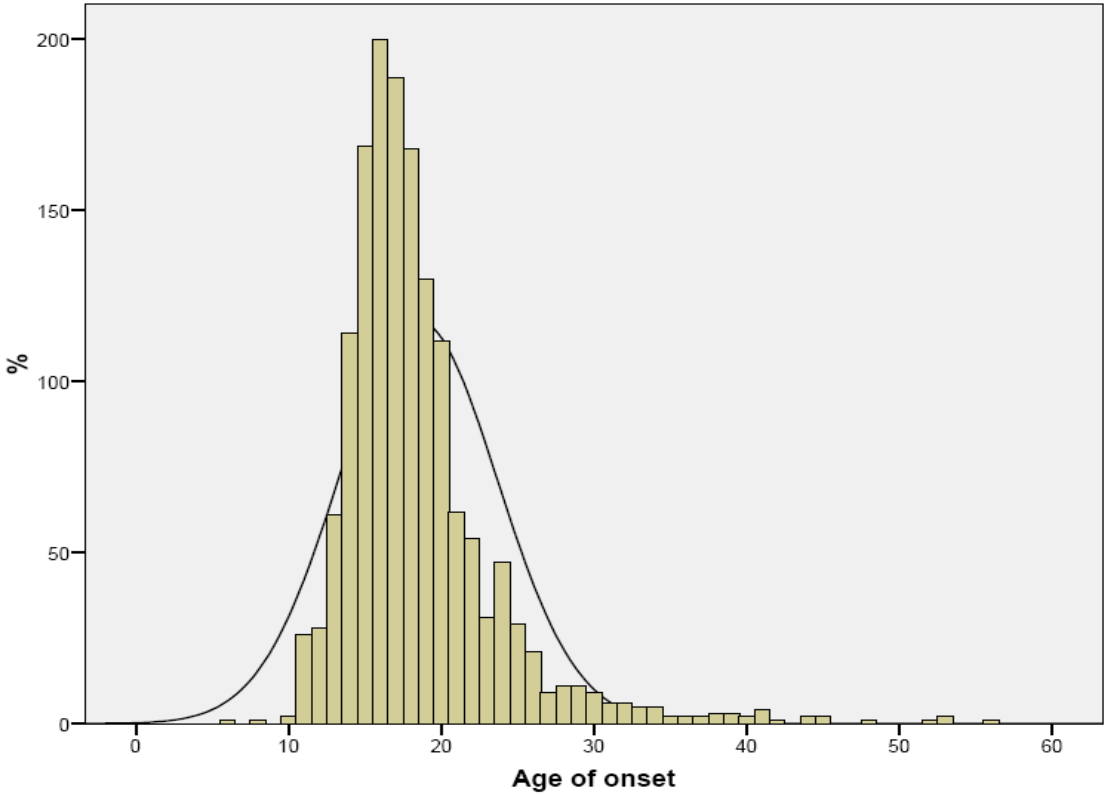


Fig. 1. Estimated age- and sex-specific median incidence rates (per 10 000 person-years): —■—, women; – –◆– –, men.



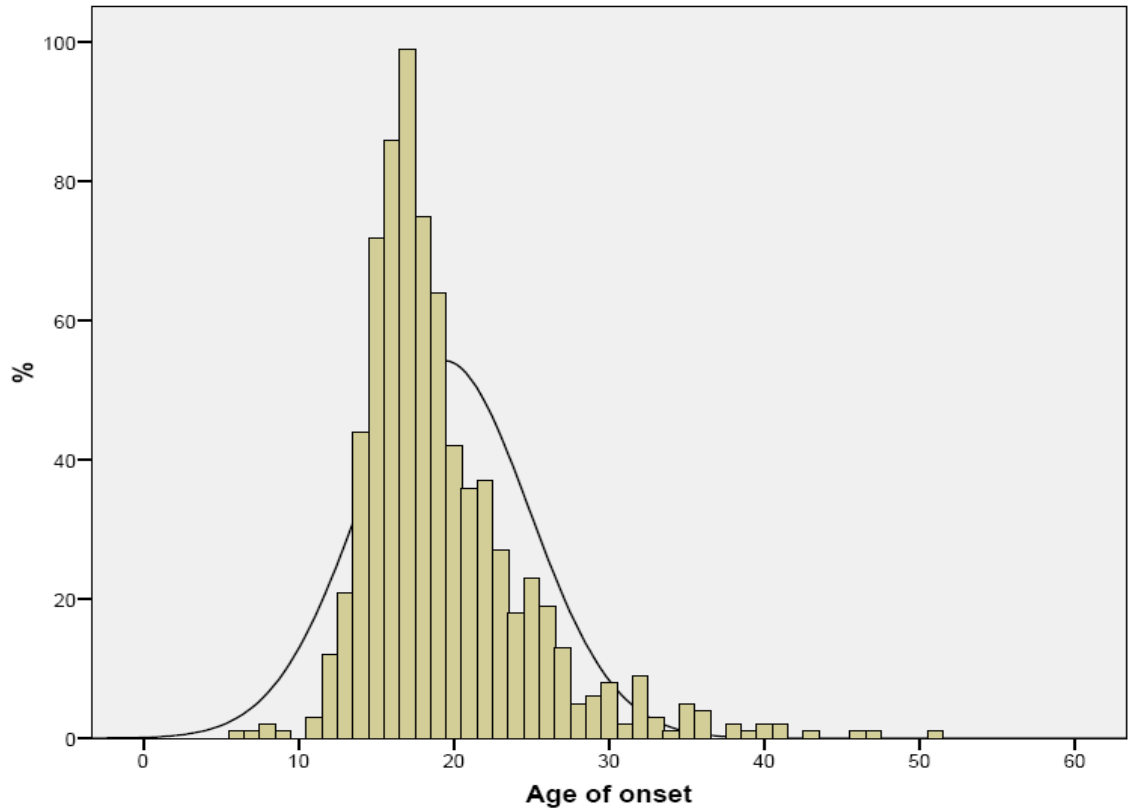
Favaro et al, *J Clin Psychiatry*, 2009

ANOREXIA

Age of 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

Psychological Medicine, Page 1 of 16. © Cambridge University Press 2014
doi:10.1017/S0033291714001469

ORIGINAL ARTICLE

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. Raven[1], F. van Oort[2], C. A. Hartman[1], S. A. Reijneveld[3], R. Veenstra[4], W. A. M. Vollebergh[5], J. Buitelaar[6], F. C. Verhulst[2] and A. J. Oldehinkel[1]

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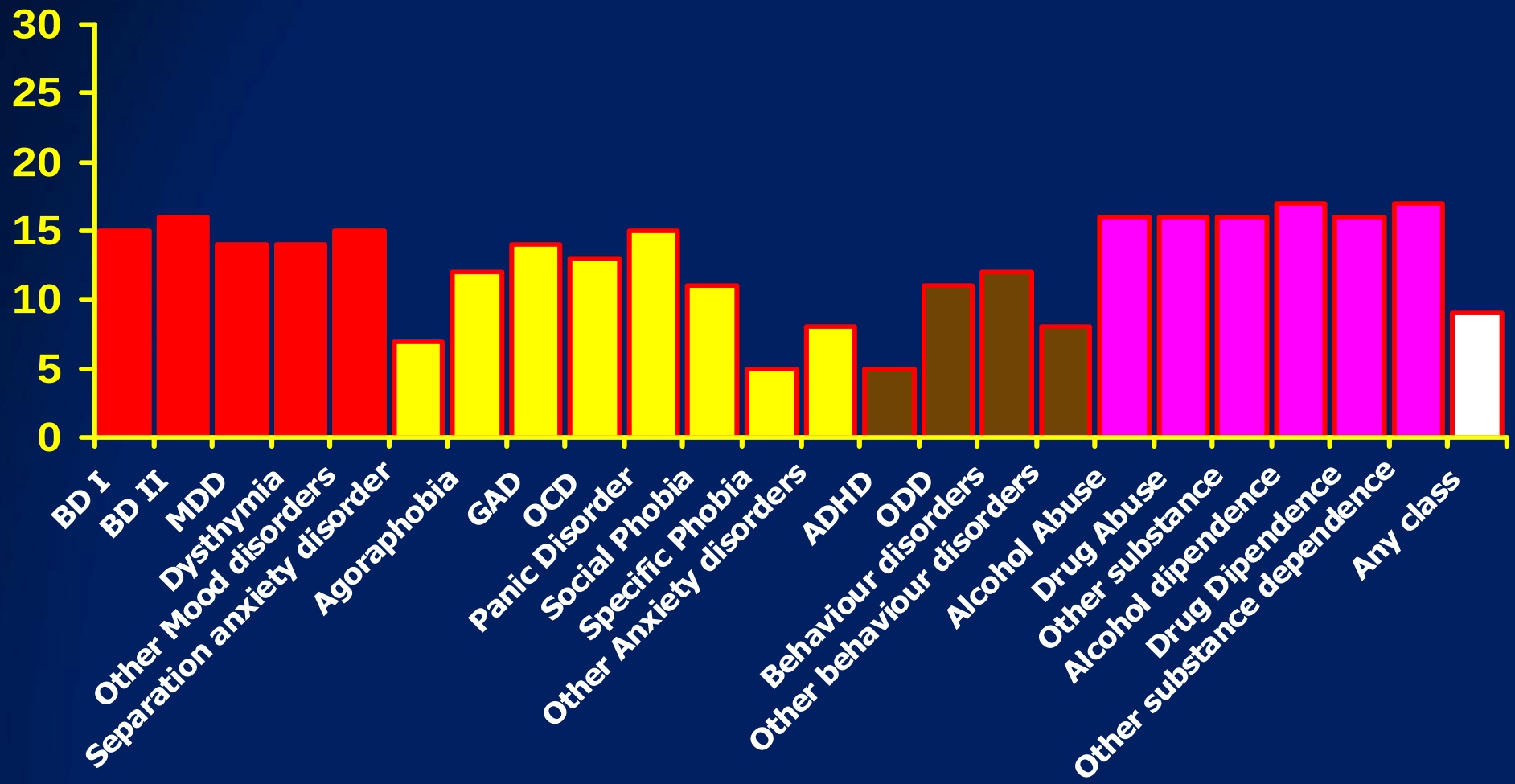
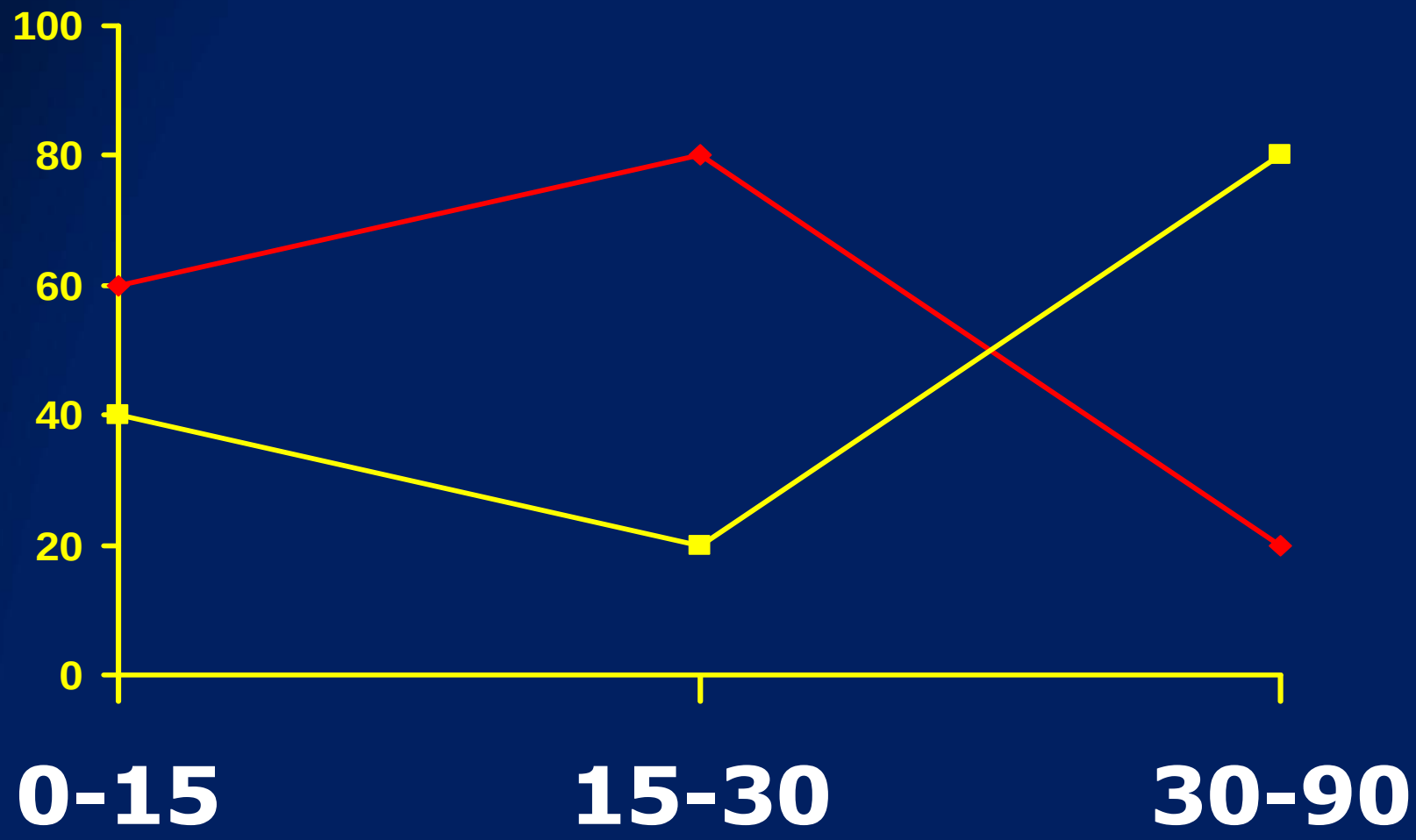
[6] *Department of Psychiatry, Radboud University Nijmegen, Nijmegen, The Netherlands*

1,584 adolescents assessed at 11 and 19 years

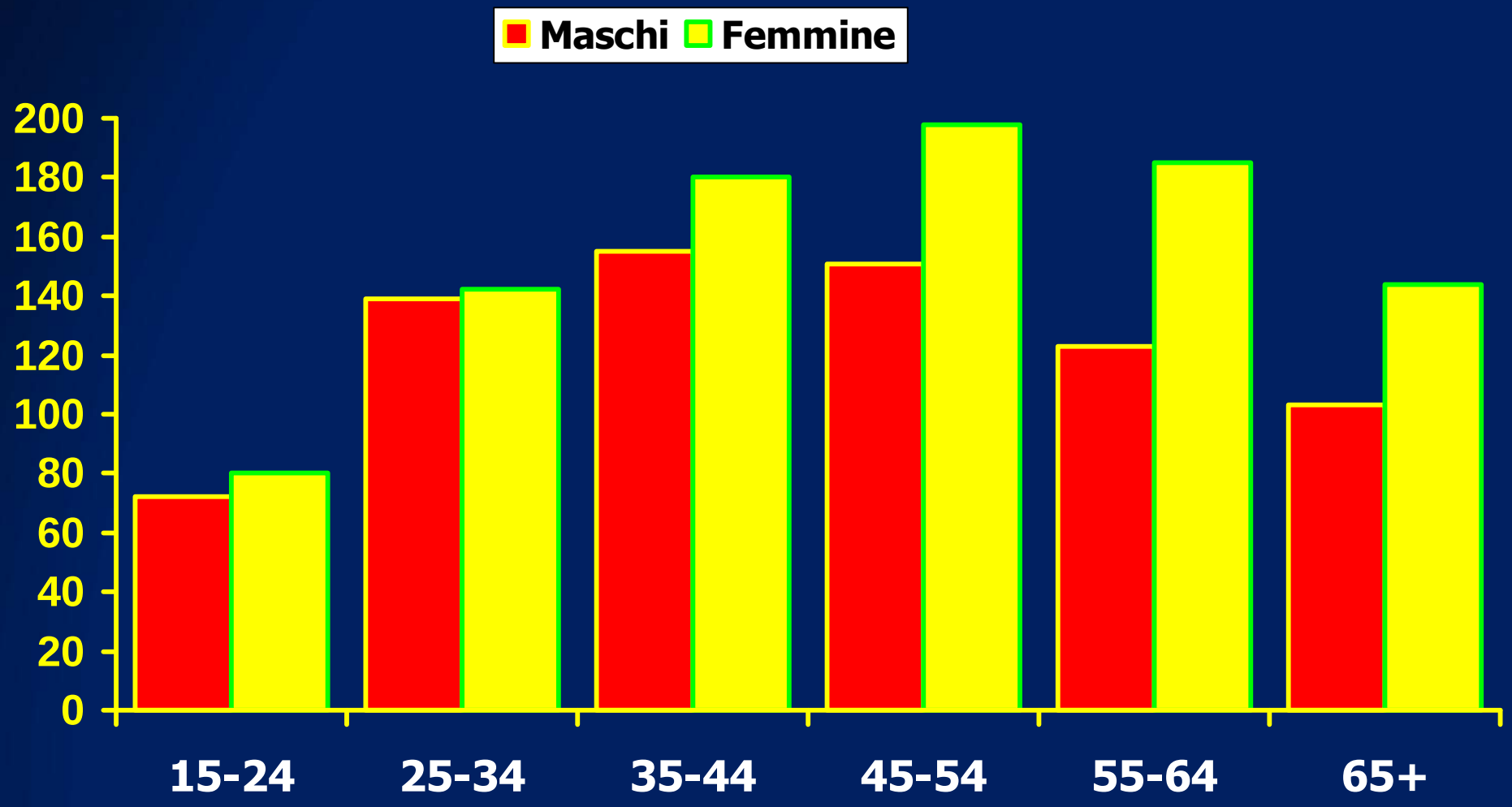
Median AOO (years) of mental disorders in the TRAILS study

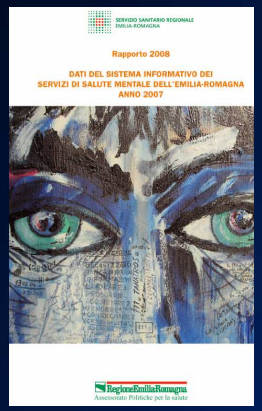


% of mental disorders (red line) and physical disorders (yellow line) in three age groups

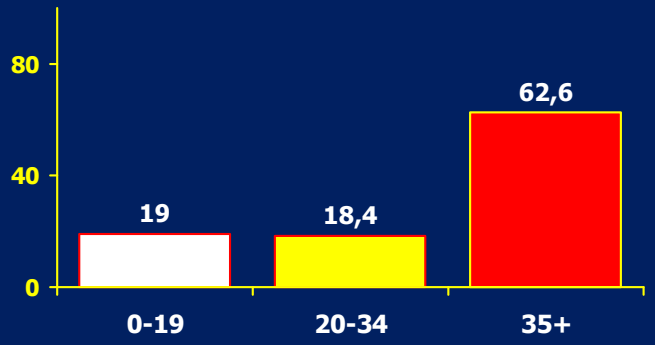


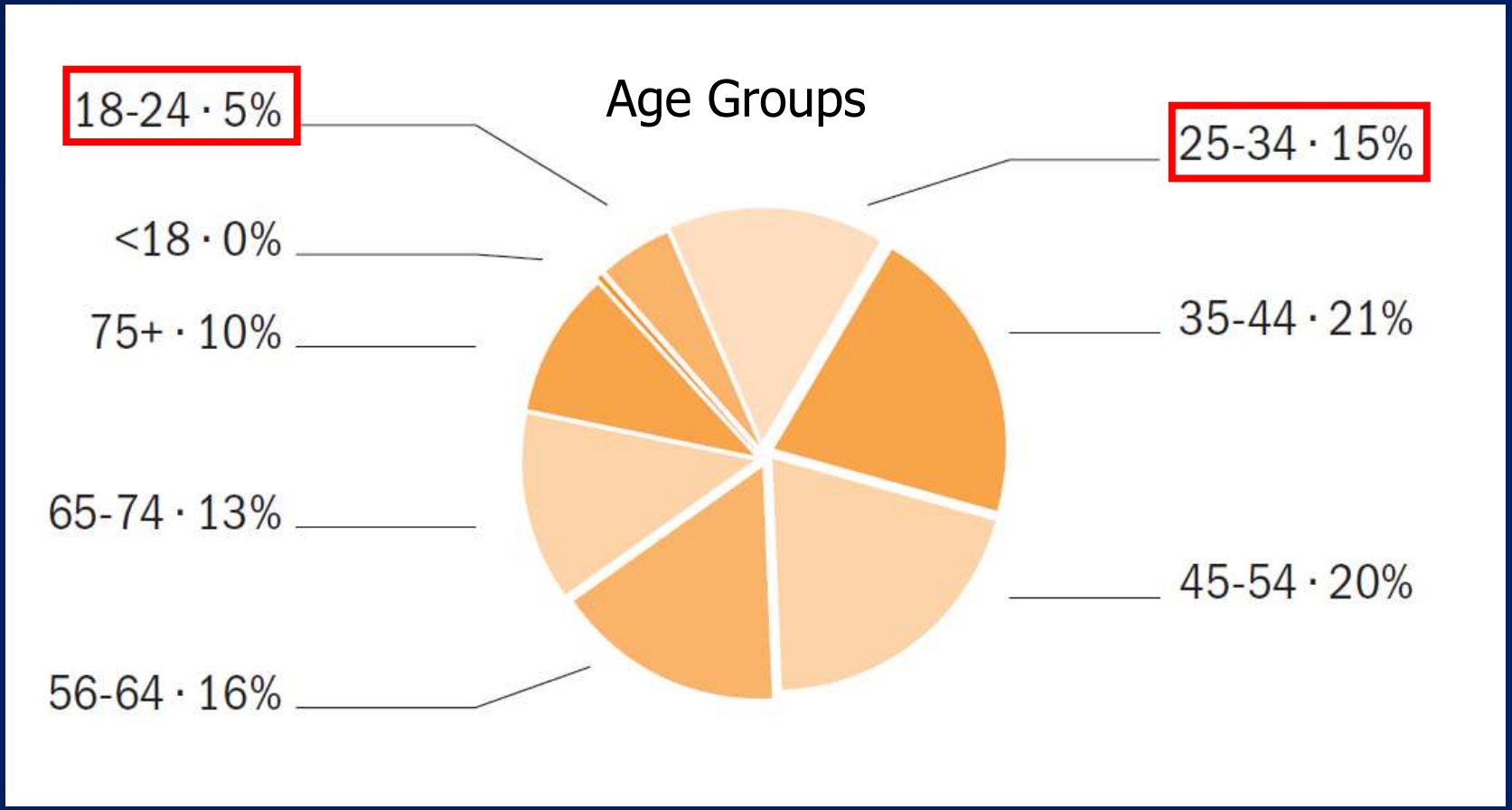
TREATED PREVALENCE IN LOMBARDY (8 MILLION INHAB.) YEAR 2005 (rates per 10,000 popn)

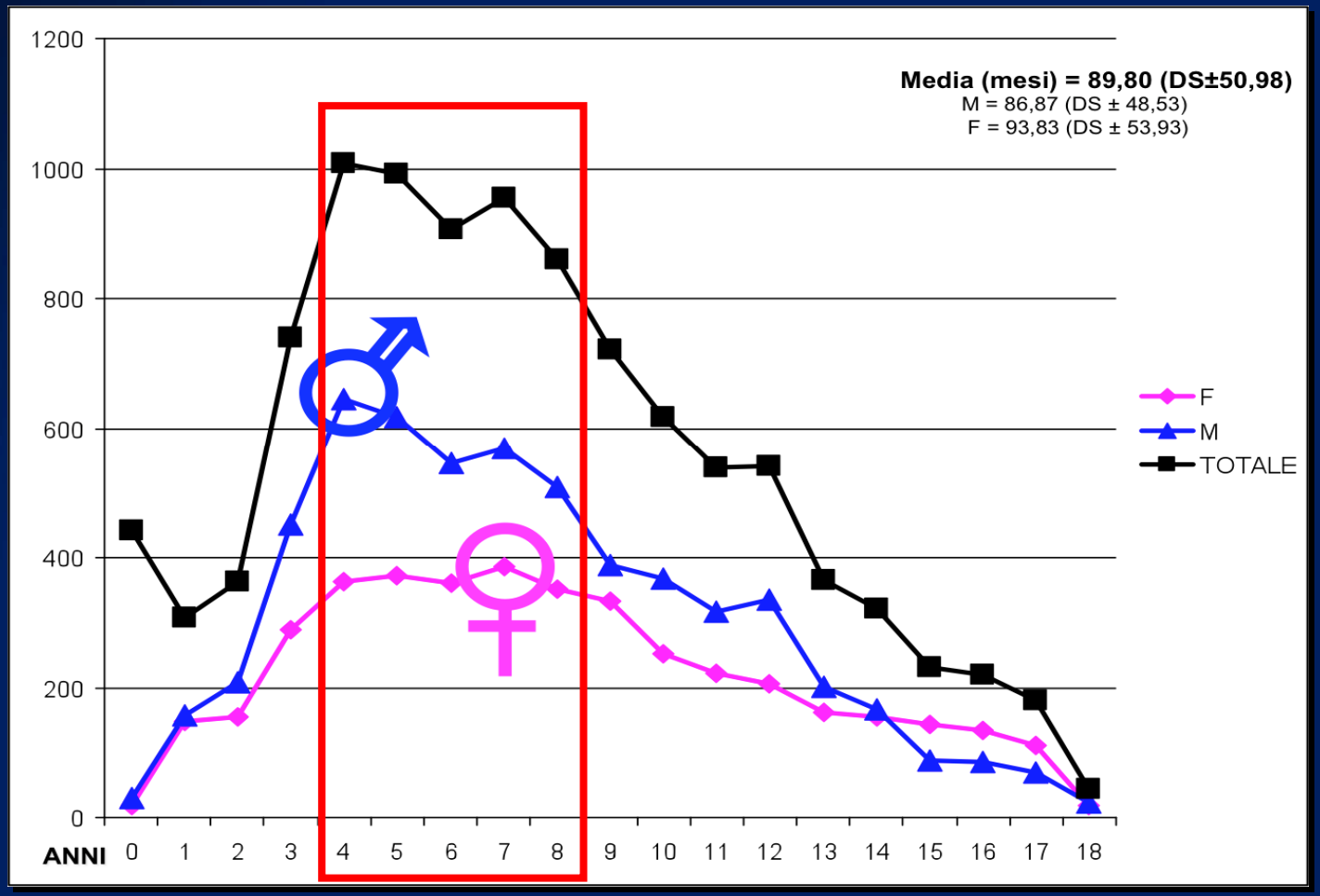




% OF PATIENTS IN TREATMENT AT MENTAL HEALTH SERVICES IN A LARGE ITALIAN REGION BY AGE GROUPS

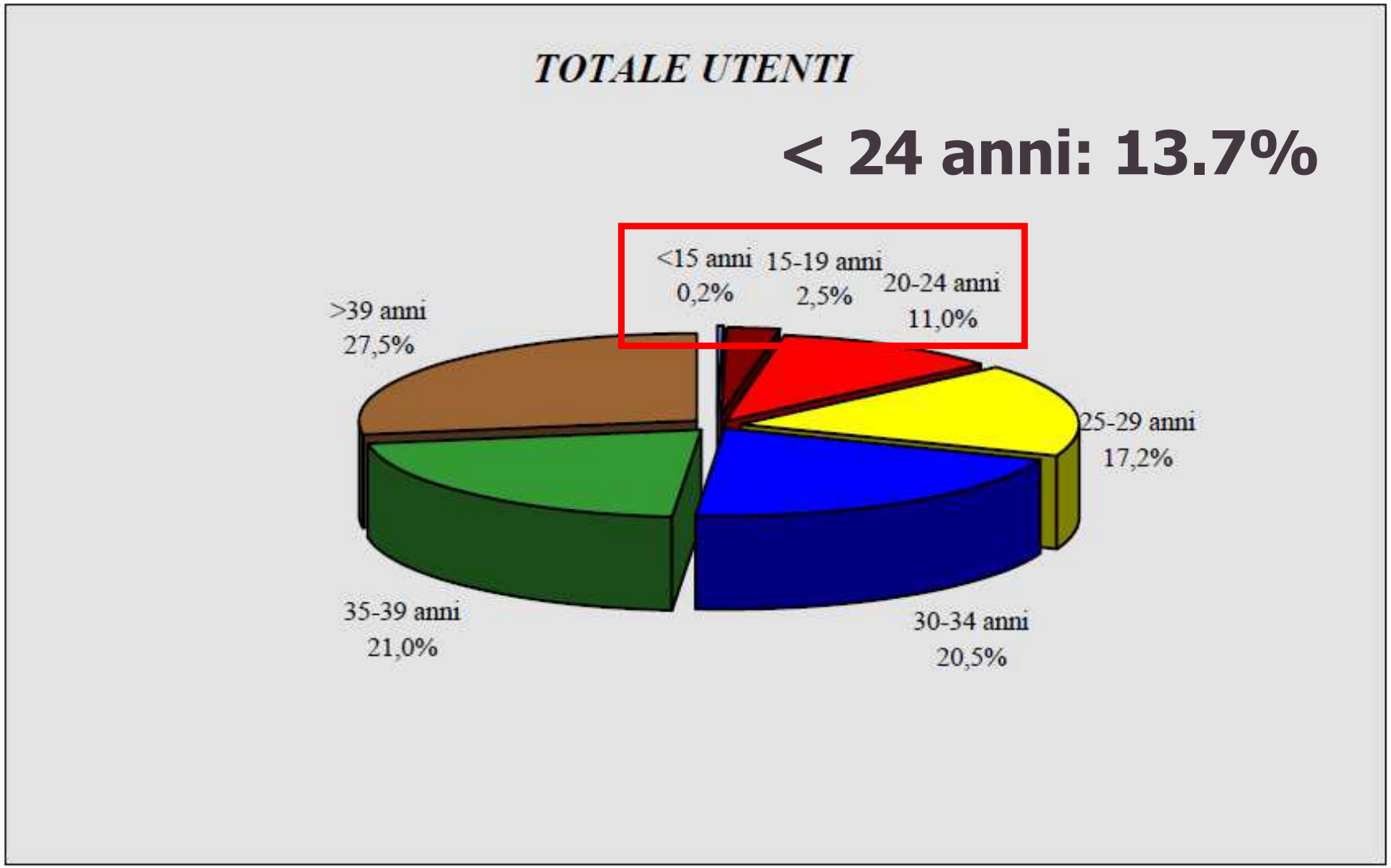






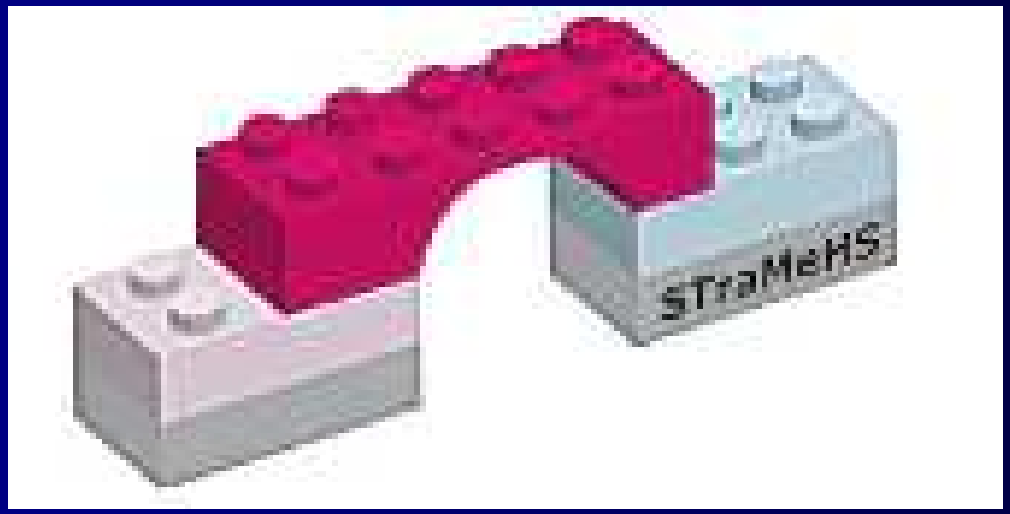
PTS TREATED IN A LARGE ITALIAN CAMHS, YEARS 1994-2007 N=10,087

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



Transition from CAMHS to AMHS: the European context

- Very little research (Exceptions UK, Ireland, France)
- Little information on process, outcomes and experience of transition in various healthcare contexts
  - E.g. Do transition policies exist?
- CAMHS-AMHS interface problematic everywhere?
- Recent systematic review suggests transitional care problematic across the world (Paul et al, 2014)
- Transitions boundaries vary: 16-21 years
- Public/private provision
- Huge divergence in quality of care



Discontinuity between service streams is in the age range with the peak incidence of new-onset disorders. The mental health system is weakest where it should be strongest.

McGorry et al., 2014

The MILESTONE Project: Managing the Link and Strengthening Transition from Child to Adult Mental Health Care

MILESTONE

Goals of the MILESTONE

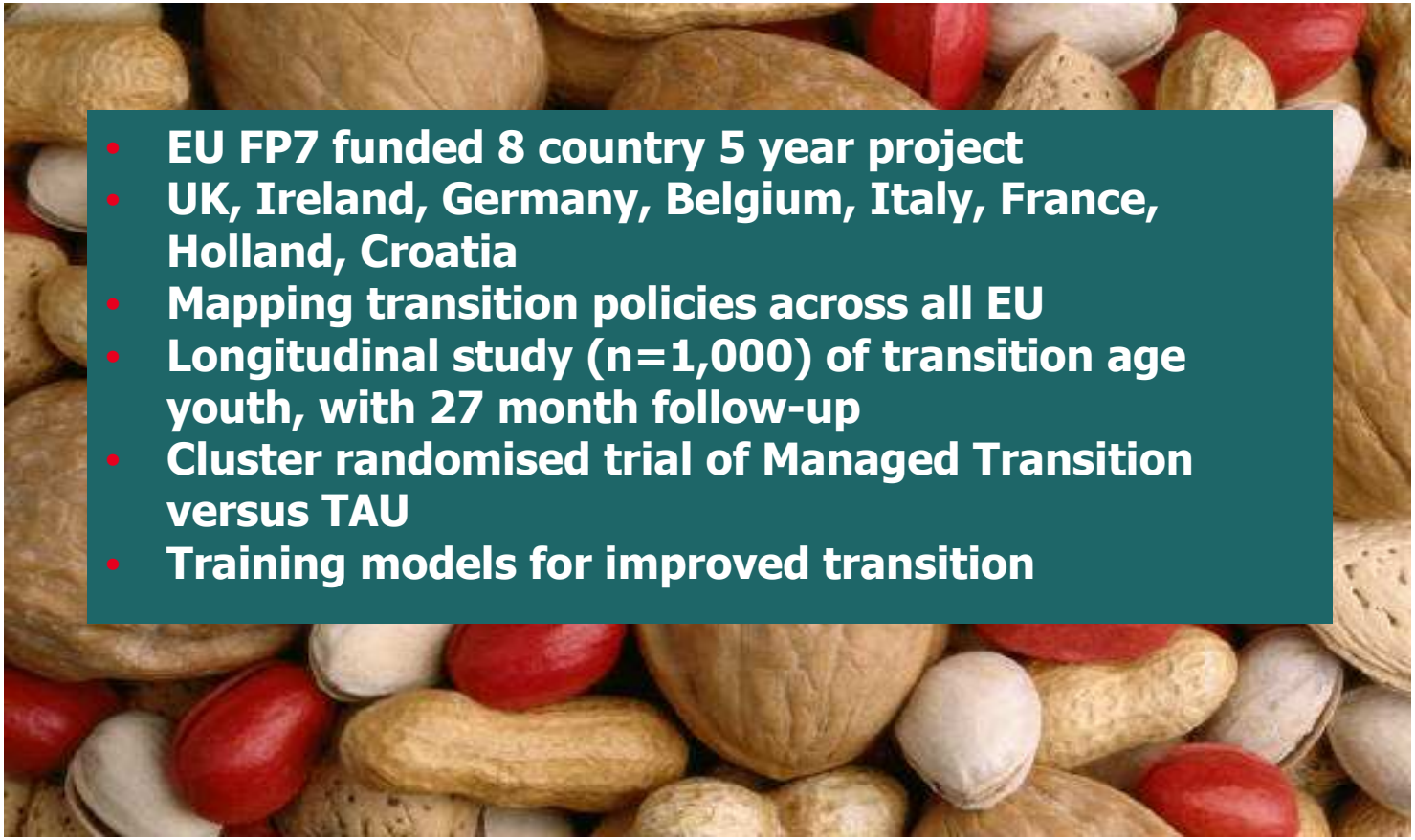
1) To systematically collect evidence and determine care gaps in current mental health services across healthcare systems in Europe.

2) To robustly evaluate an innovative transitional care intervention and develop a sustainable and standardised best-practice-model, with guidelines on transition.

MILESTONE

This project has received funding from the European Union's Seventh Framework Programme for research, technological development and demonstration under grant agreement no 602442

MILESTONE in a nutshell



- EU FP7 funded 8 country 5 year project
- UK, Ireland, Germany, Belgium, Italy, France, Holland, Croatia
- Mapping transition policies across all EU
- Longitudinal study (n=1,000) of transition age youth, with 27 month follow-up
- Cluster randomised trial of Managed Transition versus TAU
- Training models for improved transition

MILESTONE

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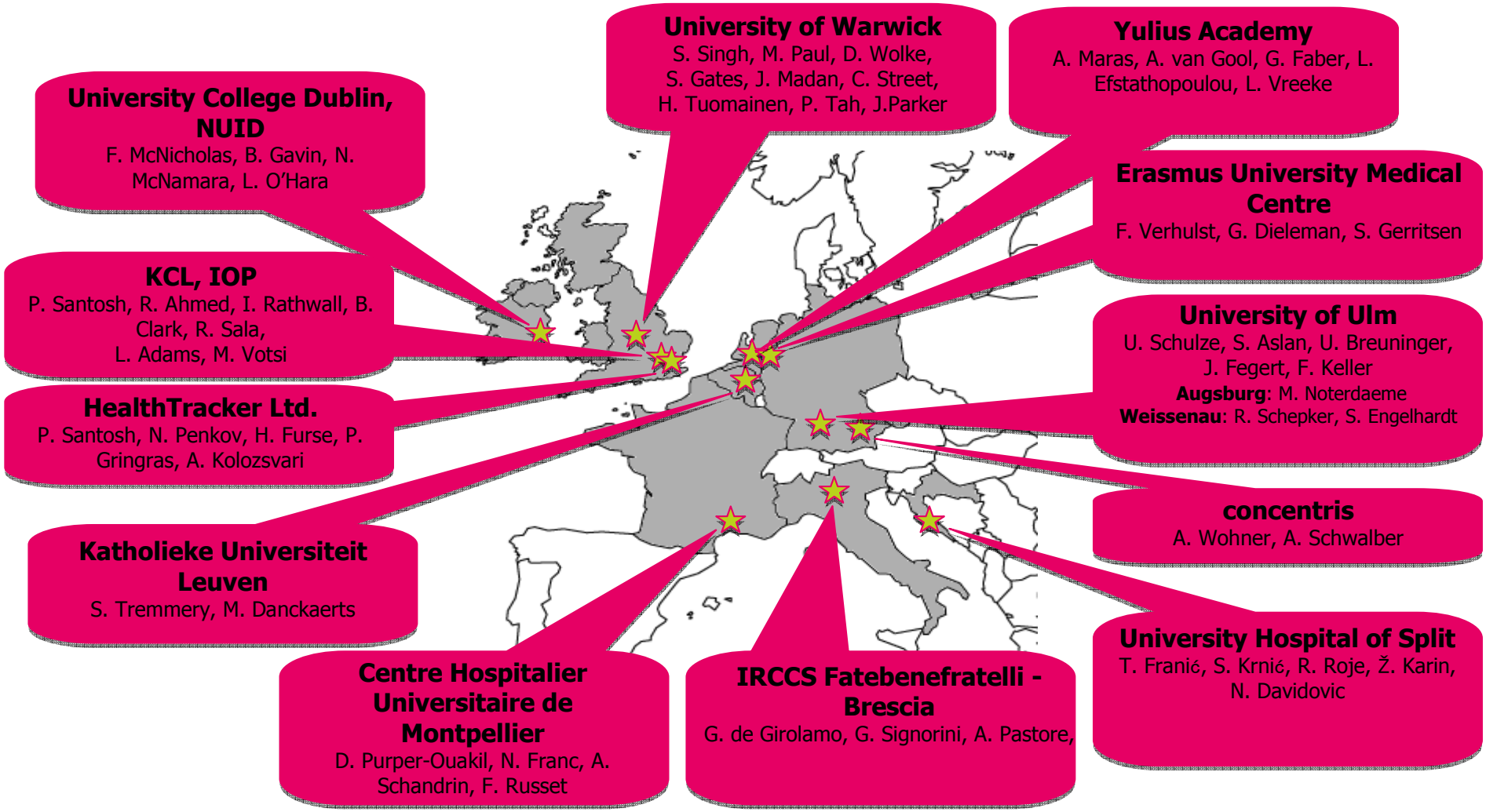
MILESTONE partners



MILESTONE

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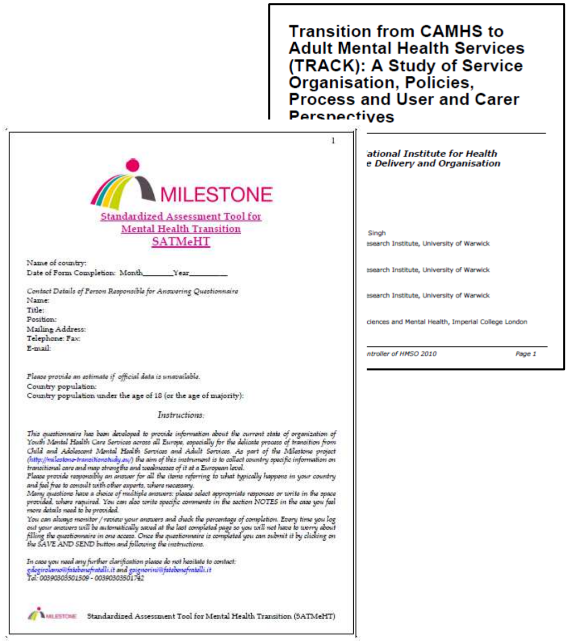
European CAMHS Mapping Questionnaire (ECM-Q)

Standardized Assessment Tool for Mental Health Transition (SATMeHT)



Online survey

MILESTONE
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PRELIMINARY RESULTS

ECM-Q Activity Data

(14 countries replied)

***How many patients have been treated in all CAMHS operating in your country in the latest year available*?**

8 COUNTRIES

Average of 120,619 per country (DS=135,605)

Range: 659-432,000

In the latest year how many of them were females and how many males?

Males: 60%

Females: 40%

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PRELIMINARY RESULTS: 6 COUNTRIES

DSM-V DIAGNOSTIC CATEGORIES IN THE NATIONAL CASEMIX

✓ **Neurodevelopmental disorders**	**66%**
✓ **Schizophrenia spectrum and other psychotic disorders**	**0.6%**
✓ **Bipolar and related disorders**	**1 %**
✓ **Depressive disorders**	**7%**
✓ **Anxiety disorders**	**13%**
✓ **OCD**	**1%**
✓ **Feeding and Eating disorders**	**2%**
✓ **Elimination disorders**	**8%**
✓ **Substance-related and addictive disorders**	**0.5%**
✓ **Other mental disorder**	**1%**

MILESTONE

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PRELIMINARY RESULTS

ECM-Q Activity Data

In the latest year available how many first-ever cases (total N) have been recorded in all CAMHS active at national level?

Average of 61,233 per country (SD=68,098)
Range: 1,330-213,447

MILESTONE

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PRELIMINARY RESULTS

SATMeHT

(13 completed questionnaires)

What is the likely percentage of patients under 30 years of age who access AMHS with prior contact with CAMHS in their history?

33% Range: 10-70%

Do you have a written policy or guidelines at a national or regional level for managing the interface between CAMHS and adult services?

2/13 COUNTRIES REPLIED "YES"

What sorts of difficulties are children or young people, who need transitional care and have mental disorders, most frequently personally experiencing?

Lack of connection between CAMHS and AMHS	10/13
Lack of specific competencies in AMHS	10/13
Full AMHS caseload	6/13
Eligibility differences	6/13
Lack of specific destination	5/13
System culture differences	4/13
Territoriality	4/13
Ignorance of other systems	3/13

MILESTONE

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