

**YOUTH MENTAL HEALTH: FROM CONTINUITY OF PSYCHOPATHOLOGY
TO CONTINUITY OF CARE (STraMeHS).**

AN EUROPEAN CONFERENCE, VENICE, 16-18 DECEMBER 2014

1. HEALTH AND ILL-HEALTH AMONG YOUNG PEOPLE

Young people aged 10–24 years represent 27% of the world's population. Important health issues and risk factors for disease occurrence in later life emerge in those years, and their contribution to the global incidence of disease is relevant. Using data from WHO's 2004 Global Burden of Disease study, Gore et al. (2011) calculated cause-specific disability-adjusted life-years (DALYs) for young people aged 10–24 years on the basis of available estimates for incidence, prevalence, severity, and mortality. They estimated DALYs attributable to specific global health risk factors using the comparative risk assessment method, and they divided DALYs into years of life lost because of premature mortality (YLLs) and years lost because of disability (YLDs). 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. The eight main causes of DALYs in this age group were all psychiatric and behavioural in nature: unipolar depressive disorders (8.2%); road traffic accidents (5.4%); schizophrenia (4.1%); bipolar disorder (3.8%); violence (3.5%); alcohol use (3.0%); HIV/AIDS (3.0%); and self-inflicted injuries (2.8%). In high-income countries neuropsychiatric disorders were the main cause of burden in those aged 15–24 years (50 DALYs per 1,000 males and 52 DALYs per 1,000 females).

This data show that, although this age group has generally been perceived as healthy, young people suffer from a relevant neuropsychiatric morbidity as well (de Girolamo et al., 2012; . Many large-scale prospective epidemiological studies, carried out in Europe, confirm this situation with regard to the psychological ill-health of adolescents and young people (Odelhinkel et al., 2011, Wasserman et al., 2010, Ford et al., 2003); moreover, cross-sectional studies have shown that the exposure to risk-factors in childhood and adolescence increases the probability of developing mental health disorders in adulthood (Scott et al, 2011; Bruffaerts et al., 2010; Kessler et al., 2007, 2010).

Moreover, temporal trends in incidence rates of mental disorders among adolescents and young people are a highly debated area. There is evidence of increased rates of substance abuse (Degenhardt et al., 2013) and suicide (Patel, 2012) over the last decades; on the contrary, more controversial is the case of depression, since some authors have stated that rates of depression did not increase in the last 30 years (Costello et al., 2006). Rates of schizophrenia have not decreased, and there has been an increase of substance-induced psychosis over time (Kirkbirde et al., 2009). These data again highlight the need for improved mental health care in these 'transition to adult years'.

2. THE CONTINUITY OF PSYCHOPATHOLOGY

Many studies have shown a high degree and type (i.e. homotypic and heterotypic) of continuity of psychopathology from childhood to middle adulthood (Rutter et al., 2006, Costello et al., 2003; Kim-Cohen et al., 2003), and underscore the need to study psychopathology through a developmental perspective.

However, there are important reasons for positive resolution expectations, as shown by a recent, landmark study by Patton et al. (2014) in which they evaluated patterns and predictors of persistence of problems into adulthood in a stratified, random sample of 1,943 adolescents followed up in the state of Victoria (Australia). Between 1992 and 2008, they assessed common mental disorders 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. At the end of that long follow-up, 29% male participants and 54% female participants reported high symptoms on the CIS-R (≥ 12) at least once during adolescence, and almost 60% 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 and adolescents with a background of parental separation or divorce also had a greater likelihood of having ongoing disorder into young adulthood than did those without such a background. Rates of adolescence onset disorder dropped sharply by the late 20s, suggesting a further resolution for many patients whose symptoms had persisted into the early 20s. The authors' interpretation is that episodes of adolescent mental disorder often precede mental disorders in young adults, but at the same time, many such

disorders, especially when brief in duration, are limited to the teenage years, with further symptom remission being a common evolution in the late 20s.

The resolution of many adolescent disorders gives reason for optimism, suggesting that interventions which shorten the duration of episodes could prevent much morbidity later in life. This study also underscores the need for an intensive investigation of the course of disorders during the developmental phase, and a close scrutiny of factors protecting against persistence of disorders.

3. IS CONTINUITY OF CARE IN PLACE?

If many mental disorders continue across different developmental stages, do mental health services guarantee continuity of care? In general only a few young people (less than one in six) with mental disorders access services or receive appropriate care (Kataoka et al., 2002; Offord et al., 1989). The current service configuration of distinct Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS) is a barrier to providing continuity of care, but barriers to transition are not restricted to age boundaries alone. Research findings indicate conceptual, clinical, and ideological differences between CAMHS and AMHS in relation to thresholds regarding acceptance criterion, professional differences and service structures/configurations which were found to be an impediment to continuity of care for young people, especially those who make a transition from one system of care to another (Singh, 2009). For these reasons, current service configuration of CAMHS and AMHS has been described as the “weakest link in a system where it should be most robust” (McGorry, 2007).

The TRACK study in the UK was the first systematic attempt to study the policy, process, outcome and experience of transition from CAMHS to AMHS. The findings were alarming: almost half the young people fell through the care gap between services, and those that managed transition received very poor transitional care. Across a wide range of CAMHS and AMHS providers, transition was poorly planned, executed and experienced (Singh et al., 2010).

As no meeting in Europe, to date, has discussed these specific problems and the strategies needed to achieve effective transitional care, an European conference on the issue of youth mental health and transition has been funded by the DG SANCO of the European Commission through the Consumers Health And Food Executive Agency

(CHAFFEA). The Conference on YOUTH MENTAL HEALTH: FROM CONTINUITY OF PSYCHOPATHOLOGY TO CONTINUITY OF CARE (STraMeHS) will be held in Venice on December 16-18, 2014.

The Conference aims at raising awareness and improving mental health providers, policy makers, decision makers and health administrators' knowledge about youth mental health and factors affecting this area. In addition, a second important objective is to identify and promote the development of integrated models of care and functioning of CAMHS and AMHS, with a specific focus on strategies and procedures on how to foster appropriate and timely transition from CAMHS to AMHS. A third aim is to promote the implementation of quality assurance programmes aimed at improving outcomes, quality of life, and overall health status of young patients needing transitional care.

4. A FORUM FOR A DISCUSSION

Thanks to the active participation of a large number of experts in child and adolescent and adult psychiatry, pediatricians, mental health workers, policy makers and representatives of users and of their families from all 28 European countries, as well as of a selected number of experts and stakeholders from extra-European countries, the Conference will help to map current services and transitional policies across EU, develop and propose transition-specific outcome measures and promote the discussion on innovative transitional care models.

Target participants will be the members of Europe's foremost professional associations and patient and caregiver associations working in the mental health field, as well as key policy makers and administrators. The topic of the STraMeHS Conference focuses on one of the five priorities selected by the "The European Pact for Mental Health and Well-Being" (EU High-Level Conference, Brussels 2008): this policy document underlined that mental health in youth is a key factor for societal growth and cohesion. The conference is also in line with the objectives of the Second Programme of Community Action in the Field of Health in generating and disseminating health information and knowledge.

This event has a great potential for positively impacting policy, services and research-related areas, opening the way for a substantial reorganization of CAMHS and AMHS across EU and strengthening the weak link between CAMHS and adult care. This

international initiative will expand health research system linkages for multidisciplinary and cross-sectoral research, addressing the needs for innovative models of transition in pediatric care or social services, which often face very similar problems, paving the way for efficient transition management policies without increasing expenses, possibly safeguarding the efforts made in the CAMHS.

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