Giovanni de Girolamo

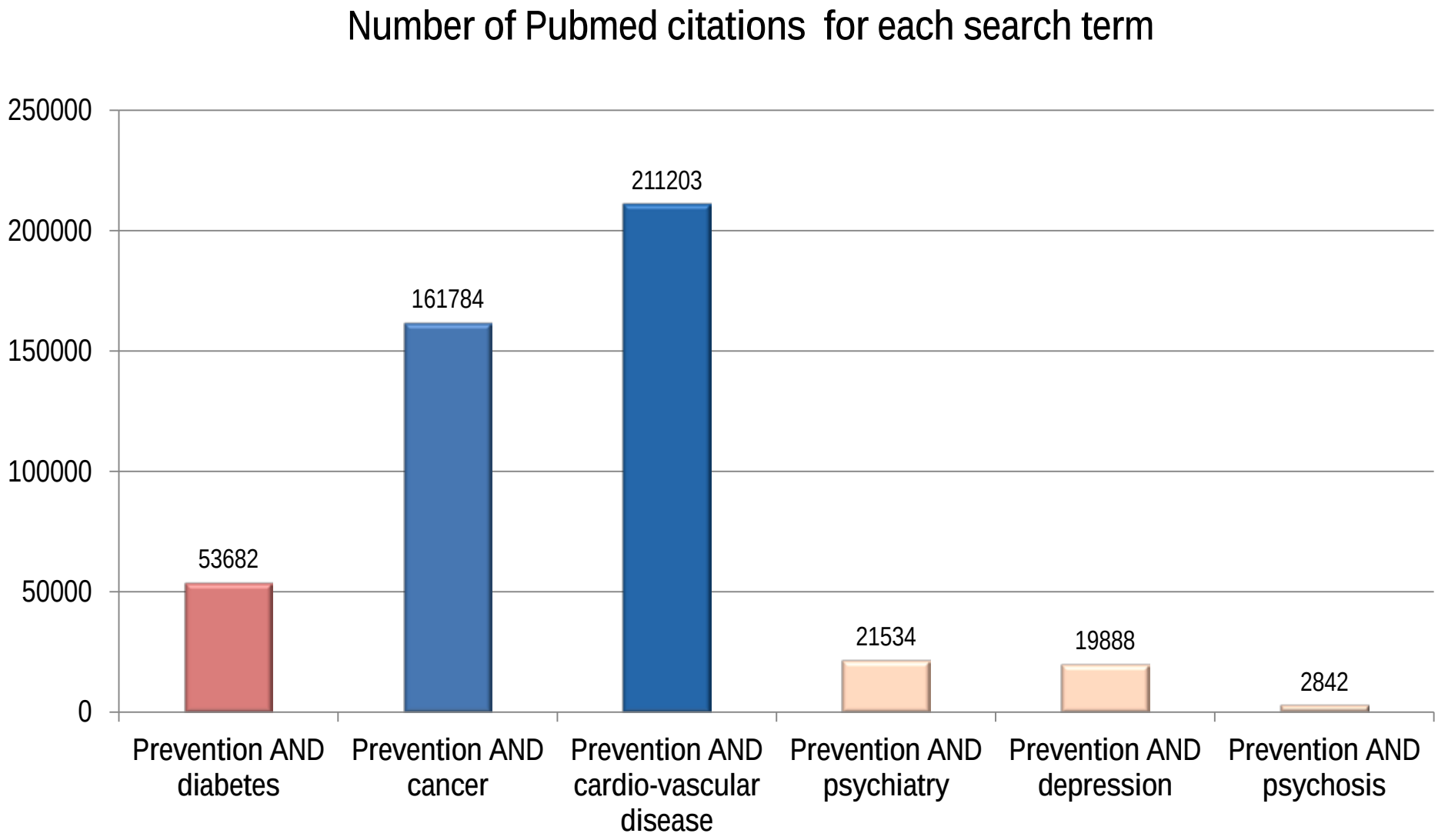
LA PREVENZIONE IN SALUTE MENTALE: SOSTENERE ED AIUTARE I FIGLI DI PERSONE CON DISTURBI MENTALI GRAVI

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

What is prevention?

Whole population through public health policy	Whole population: selected groups and healthy individuals	Selected individuals, high risk patients	Patients
PRIMORDIAL PREVENTION Establish or maintain conditions to minimize hazards to health	**PRIMARY PREVENTION** Prevent disease well before it develops. Reduce risk factors	**SECONDARY PREVENTION** Early detection of disease (screening and intervention for pre-diabetes)	**TERTIARY PREVENTION** Treat established disease to prevent deterioration
Advocacy for social change to make physical activity easier	Primary care advice as part of routine consultation	e.g. primary care risk factor reduction for those at risk of chronic disease, falls, injury	e.g. exercise advice as part of cardiac rehabilitation

Prevention in psychiatry: A neglected topic?



Eur Child Adolesc Psychiatry
DOI 10.1007/s00787-013-0434-6

EDITORIAL

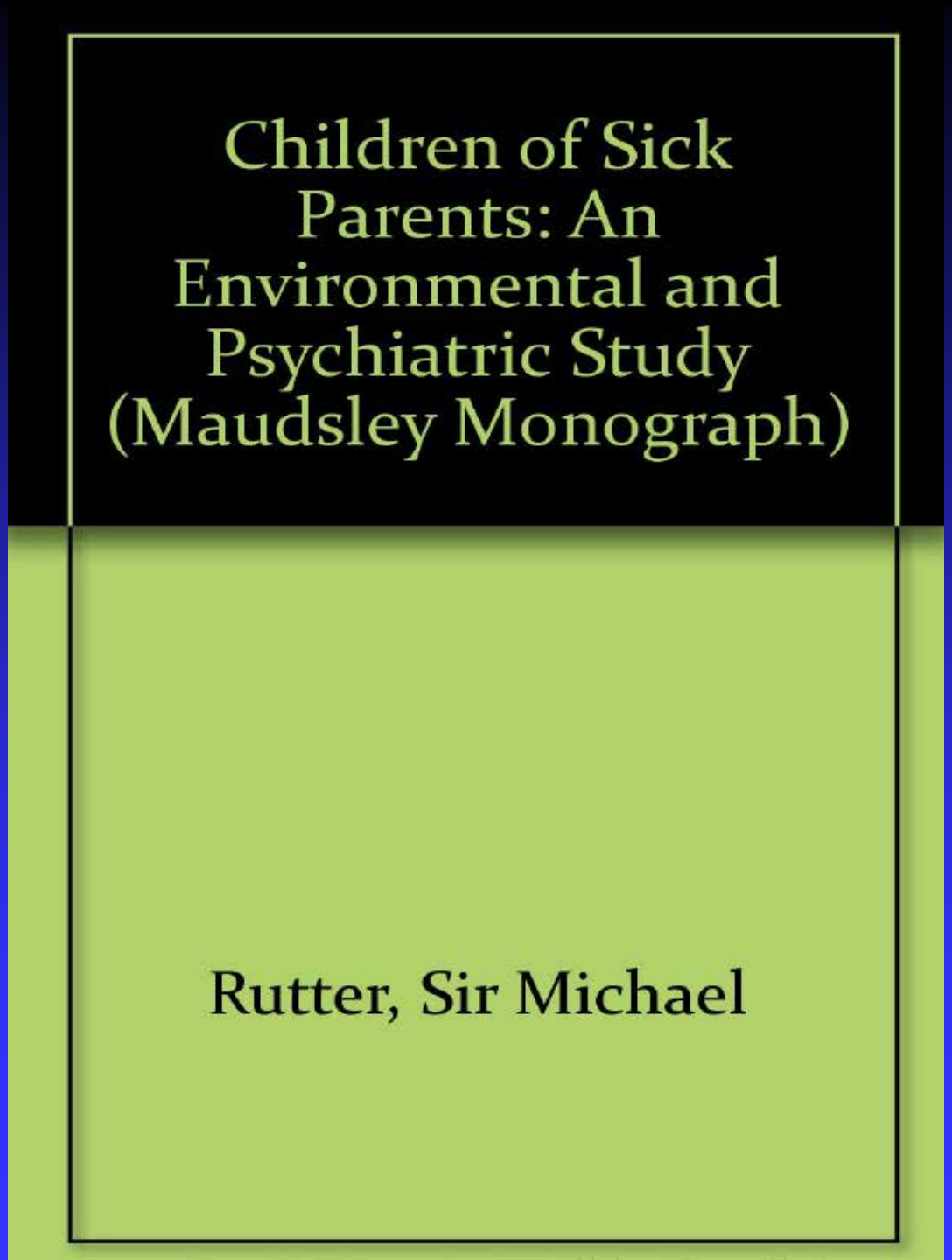
Why psychogeriatrics starts right after adolescence

Mara Parellada

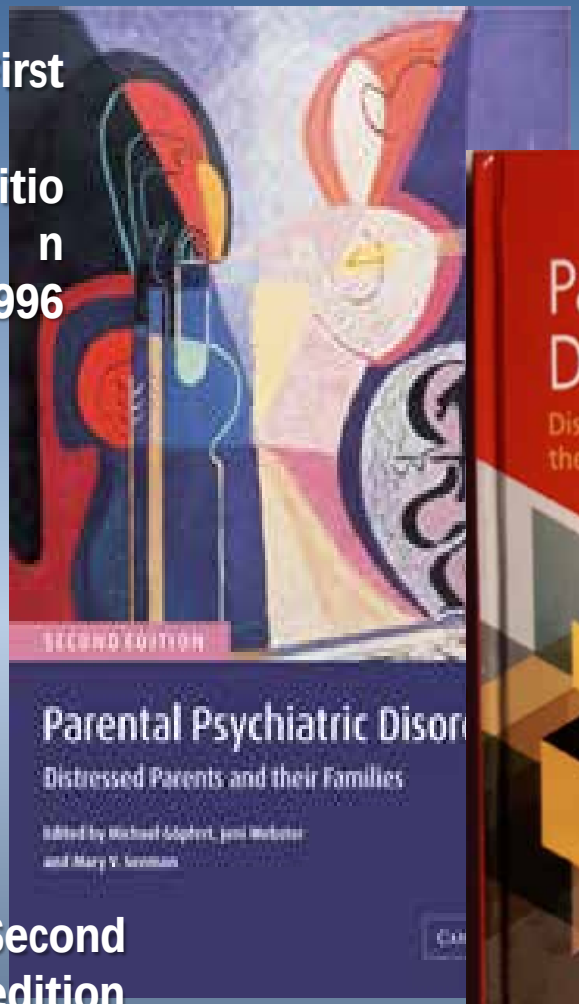
The borders between pediatric and adult medical specialties are always somewhat artificial, and based on spurious considerations, such as usually attaining the age of majority, i.e., 18 years; however, the borders between so-called child and adolescent (C&A) psychiatry and adult

females at 11.8 years [2]. The visual, auditory, and limbic cortices, which myelinate early, show a more linear pattern of aging than the frontal and parietal neocortices, which continue myelination into adulthood. Except for the posterior temporal regions, which have a more protracted

1966

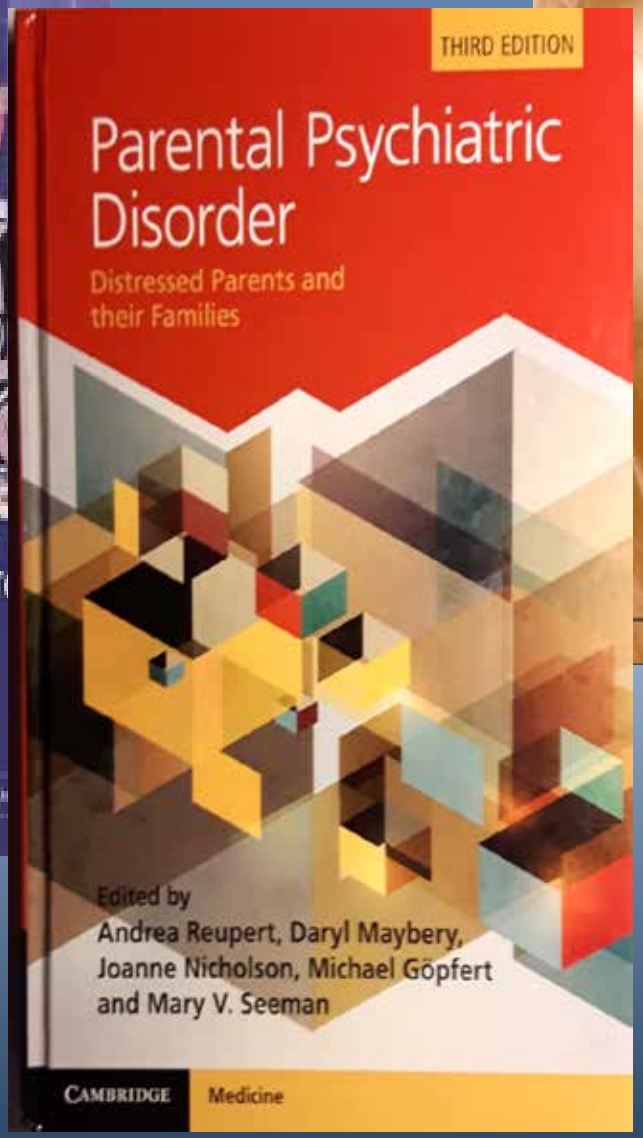

Children of Sick Parents: An Environmental and Psychiatric Study (Maudsley Monograph)
Rutter, Sir Michael

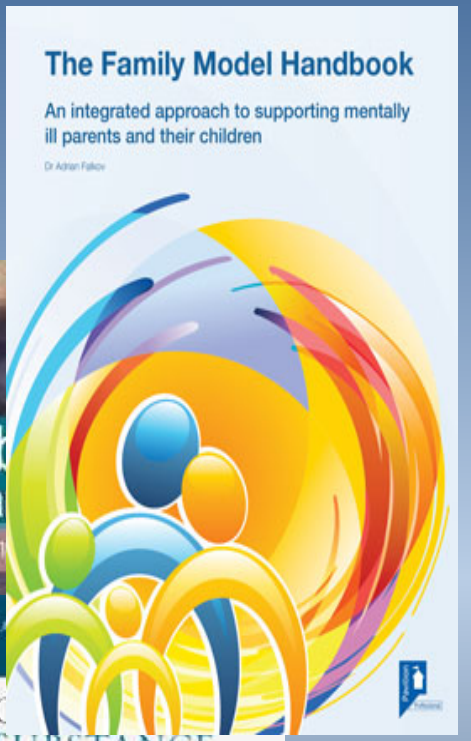
First edition 1996



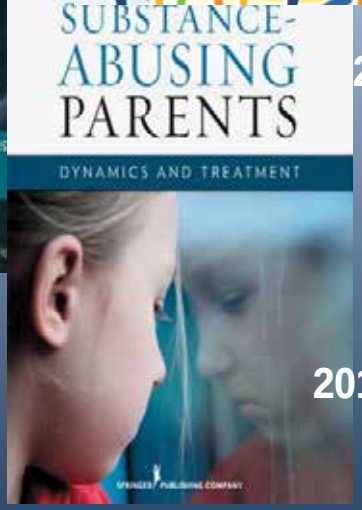
Second edition 2004

Third and most recent edition 2015





2013



2011

- **67% of women, and 75% of men, living with severe & persistent mental illness in the community, are parents** (Nicholson, J., et al. (2004) In CMHS, Mental Health, United States, 2002. Manderscheid, & Henderson,SAMHSA.)

- **Only 20% to 30% of them are raising their children (because most have lost custody).**

- **A 2-year study in England in 2007 found that almost 17,000 children care for a mentally ill parent, with little or no help from the state** (Aldridge & Sharpe, Loughborough Univ. 5/2007)

What is the impact of parental mental illness on children ? What problems do they experience ?

Research outcomes show higher risk of:

Parenting & family impact

- Poorer parental care
- Attachment problems
- Child abuse and neglect
- Family conflict & divorce
- Violence between parents

Vulnerability and Resilience

- Difficult temperament
- High stress reactivity
- Negative affectivity
- Less emotional resilience
- Negative self-concept
- Poor social competence

Subjective experiences

- Not informed, no communication about parents' illness
- Ashamed and feeling guilty
- Parentification & responsibility, "no childhood" and becoming
- 'Young carers".

Physical impact

- Birth complications
- HPA-axis, cortisol reactivity
- Weakened immune system
- Poorer infant growth
- Chronic diseases

Psychiatric outcomes

- Early behavioral problems
- Depressed and anxious
- Psychiatric disorders
- Substance abuse
- Suicidal behavior

Social

- Lower family income
- Stigma & social isolation
- Avoid disclosure, help seeking
- School Problems & Bullying
- Lower academic achievement

REVIEW

Offspring of Parents with Schizophrenia: A Systematic Review of Developmental Features Across Childhood

Mohajer Abbass Hameed, PhD and Andrew James Lewis, PhD

Abstract: A significant body of longitudinal research has followed the offspring of parents with schizophrenia. This article presents a systematic review of 46 separate papers presenting the results of 18 longitudinal studies that have followed children who are at familial high risk of developing psychotic disorders. The studies suggest that these children do show distinct developmental patterns characterized by higher rates of obstetric complication, neurodevelopmental features such as motor and cognitive deficits, and distinctive social behavior. This review summarizes those findings according to child developmental stages. Twelve of the studies followed offspring into adulthood and examined psychiatric diagnoses. From 15% to 40% of children at familial high risk developed psychotic disorders in adulthood. Many also received other psychiatric diagnoses such as mood or anxiety disorders. This combination of results suggests that offspring of parents with schizophrenia are at high risk not just for schizophrenia but, more broadly, for poor developmental and general mental health outcomes. The clinical implications of the findings are discussed, as are new prognostic strategies and potential programs for selective prevention.

Keywords: child development, children of parents with schizophrenia, familial high risk, genetic risk, schizophrenia

Maternal mental health and risk of child protection involvement: mental health diagnoses associated with increased risk

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Published Online First 16 July 2015

ABSTRACT

Background Previous research shows that maternal mental illness is an important risk factor for child maltreatment. This study aims to quantify the relationship between maternal mental health and risk of child maltreatment according to the different types of mental health diagnoses.

Methods The study used a retrospective cohort of children born in Western Australia between 1990 and 2005, with deidentified linked data from routine health and child protection collections.

Results Nearly 1 in 10 children (9.2%) of mothers with a prior mental health contact had a maltreatment allegation. Alternatively, almost half the children with a maltreatment allegation had a mother with a mental health contact. After adjusting for other risk factors, a history of mental health contacts was associated with a more than doubled risk of allegations (HR=2.64, 95% CI 2.50 to 2.80). Overall, all mental health diagnostic groups were associated with an increased risk of allegations. The greatest risk was found for maternal intellectual disability, followed by disorders of childhood and psychological development, personality disorders, substance-related disorders, and organic disorders. Maltreatment allegations were substantiated at a slightly higher rate than for the general population.

Conclusions Our study shows that maternal mental health is an important factor in child protection involvement. The level of risk varies across diagnostic groups. It is important that mothers with mental health issues are offered appropriate support and services. Adult mental health services should also be aware and discuss the impact of maternal mental health on the family and children's safety and well-being.

childbirth, was diagnosed with a mental health disorder, and this rate has increased over time (76/1000 births in 1990 to 131/1000 births in 2005).[2] Within this context, it is important to understand the relationship between mental health problems and child protection contact, including the age at which children of parents with mental health problems are vulnerable to involvement by child protection services.

Despite recognition that parental mental illness is an important risk factor for maltreatment,[4] few studies have quantified the relationship between parental mental health and child protection involvement.[3] Among substantiated maltreatment cases, Jeffreys *et al*,[5] found 51% of family assessments indicated the primary caregiver had a mental/emotional health problem. However, not all families had an assessment, and these were not conducted by mental health professionals. By contrast, a Canadian study found only 19.7% of child protection cases noted maternal mental health issues, which were associated with doubled risk of substantiations.[6] Park *et al*,[7] using linked administrative data, found increased rates of service provision and out-of-home care among Medicaid-eligible mothers with psychiatric diagnoses.

Perinatal mental health problems (those occurring during pregnancy or after childbirth) have received particular attention as women are at increased risk for mental health problems during this time.[8] Increased contact with health services during the perinatal period provides opportunities for early intervention. Within Australia, there has been funding from 2008 to 2013 to increase screening and treatment for depression via the

74,888 children (18.6%) with mothers with a mental health contact.

Across the entire birth cohort, 14,317 children had a maltreatment allegation.

Almost half (48.1%) the children with an allegation had mothers with a mental health contact.

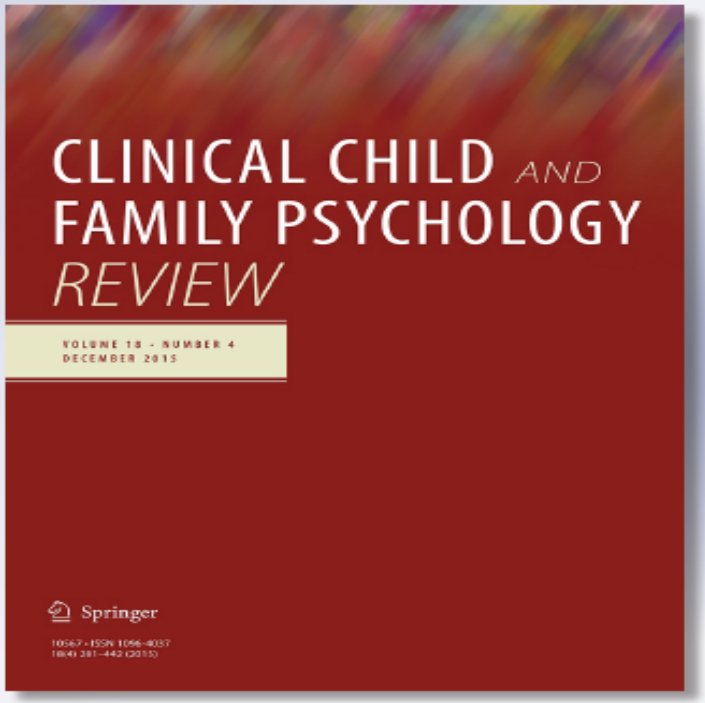
The Impact of Various Parental Mental Disorders on Children's Diagnoses: A Systematic Review

Floor van Santvoort, Clemens M. H. Hosman, Jan M. A. M. Janssens, Karin T. M. van Doesum, Andrea Reupert & Linda M. A. van Loon

Clinical Child and Family Psychology Review

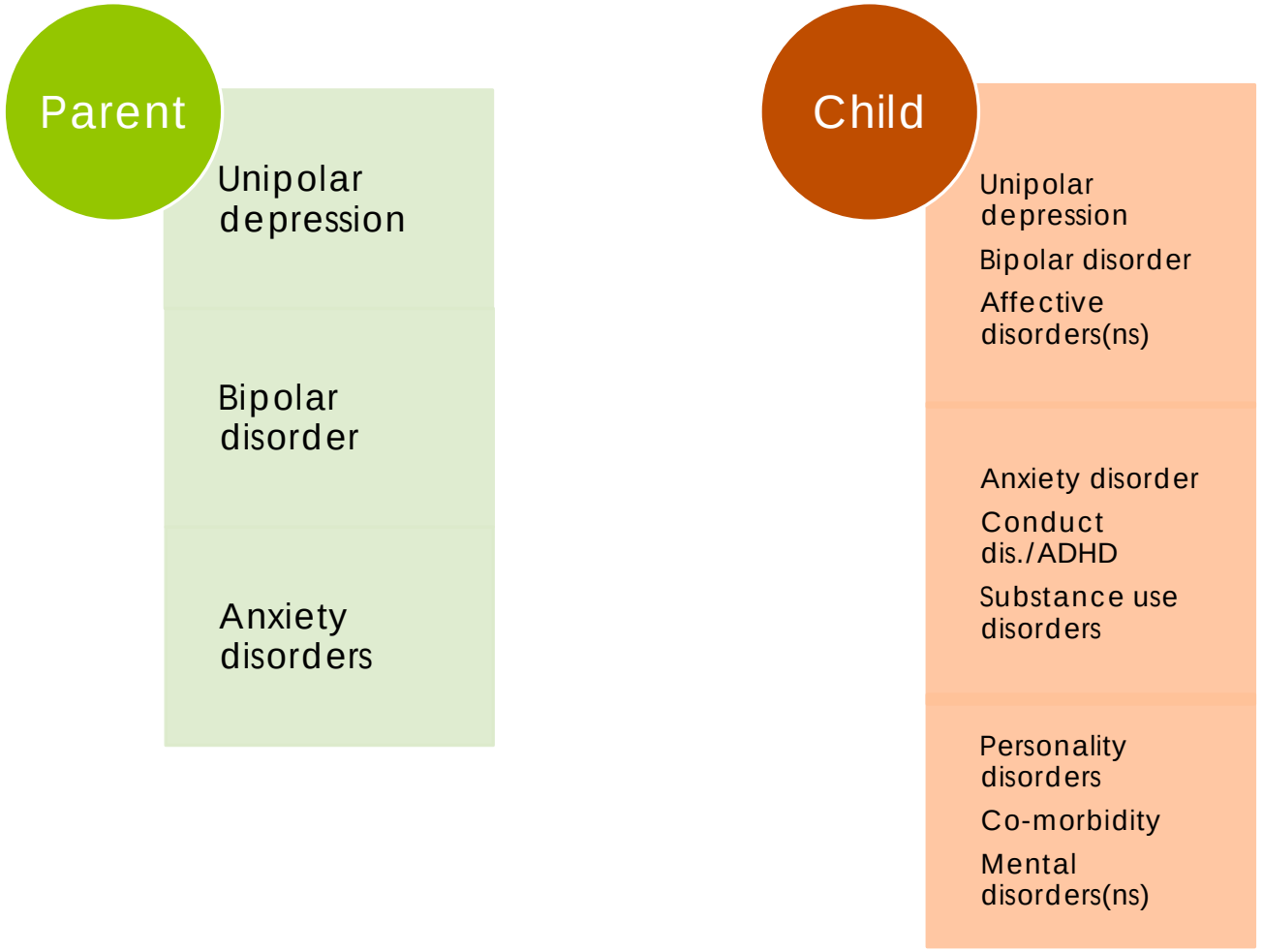
ISSN 1096-4037
Volume 18
Number 4

Clin Child Fam Psychol Rev (2015)
18:281-299
DOI 10.1007/s10567-015-0191-9



Springer

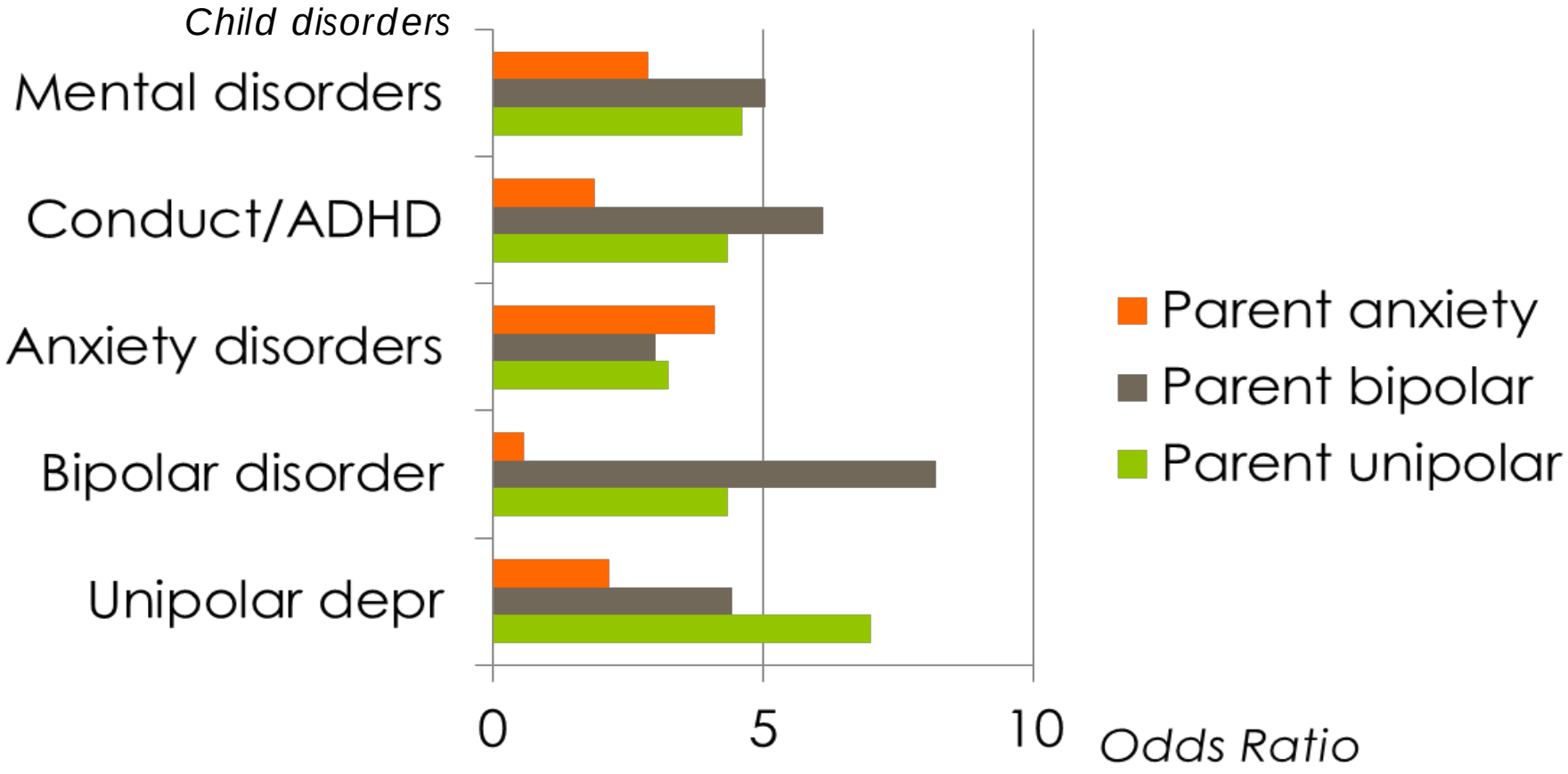
Parent and child disorders



Inclusion criteria

- Control group (diagnostic interview/ instrument)
- Parent disorder, child disorder
- Parent disorder present before child disorder (> 1 year, before birth, chronic)
- > 40 Children (0-21 years)
- Papers up to 01-04-2011

What is the strength of the relationships between child and parent mental disorders?



The Danish High Risk and Resilience Study VIA 7

by Thorup, Jepsen, Mors, Plessen and Nordentoft

Flowchart, register based parental diagnoses

N = 522
Children aged 7 years

N = 202
Children with parents diagnosed with schizophrenia

N = 200
Controls

N = 120
Children with parents diagnosed with bipolar disorder

N= 7
6 children with 2 parents diagnosed with schizophrenia
1 child with one parent with schizophrenia and one with biplolar disorder

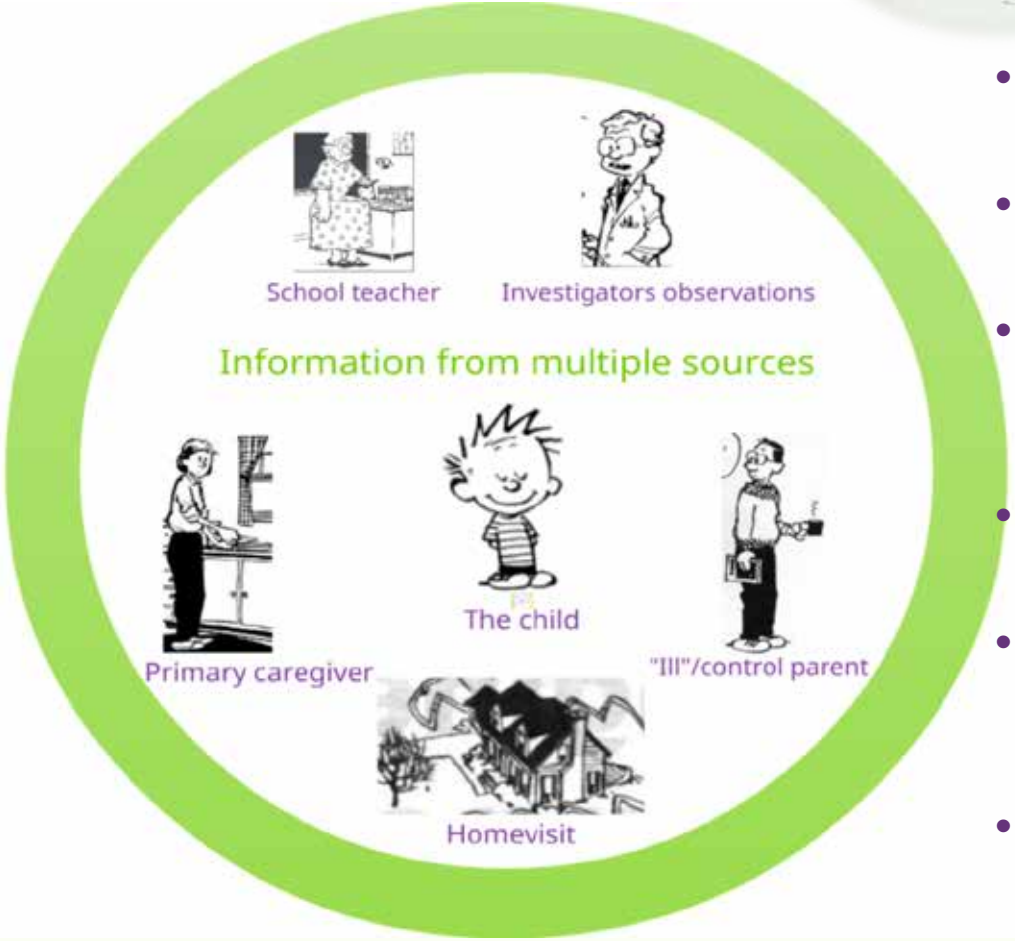
N = 195
Children with 1 parent diagnosed with schizophrenia

N = 1
Child with 2 parents diagnosed with bipolar disorder

N = 119
Children with 1 parent diagnosed with bipolar disorder

VIA 7

Methods

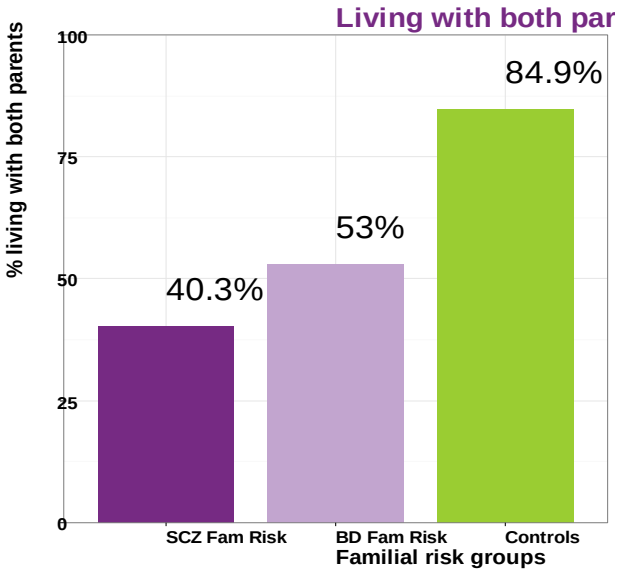


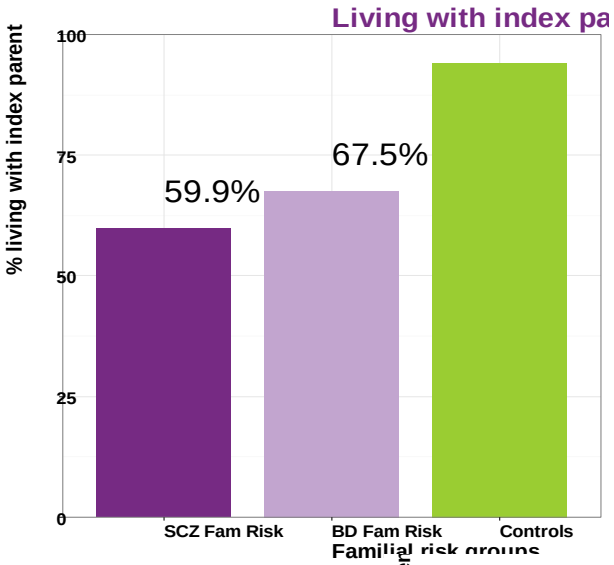
- **12 hours testing pr child and 6 hours pr parent**
- **Children manage to go through the comprehensive battery**
- **Many HR children show** *subthreshold psychiatric symptoms or signs of developmental delays*
- **Parent-child interaction can be problematic**
- **Many high-risk families are worried about their children and motivated for early interventions**
- **Variation! Some high-risk families do well!**

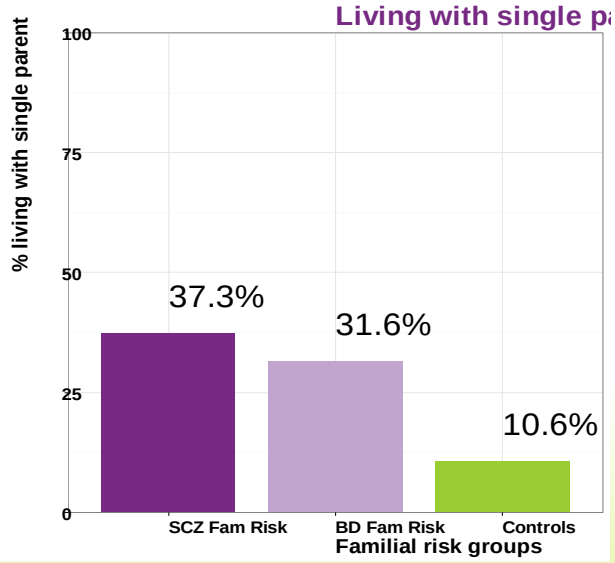
Living conditions for the child, percent, N=517

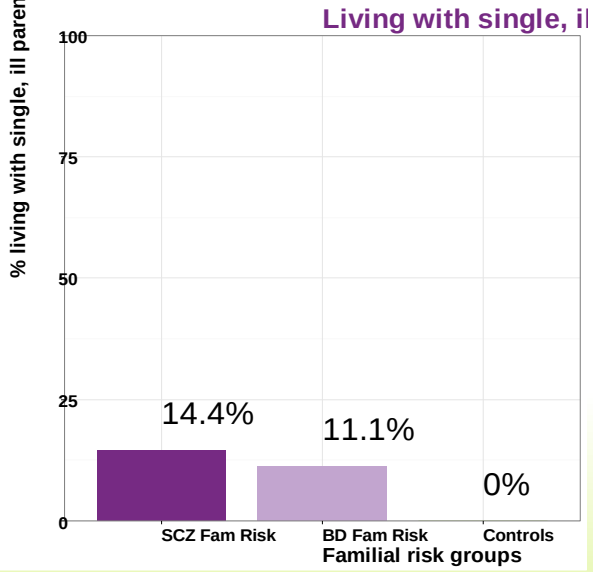
Anamnestic interview with caregiver

p<0.01 (Anova)





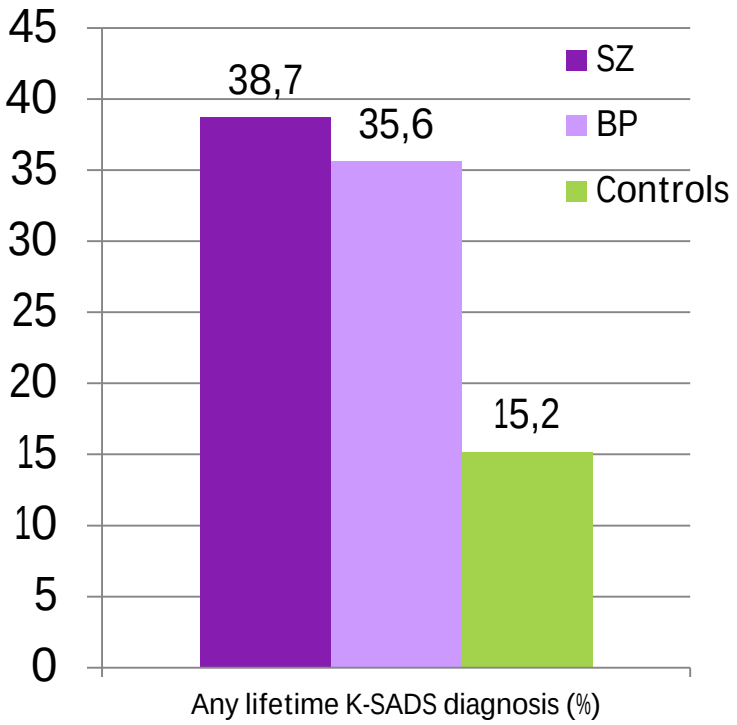


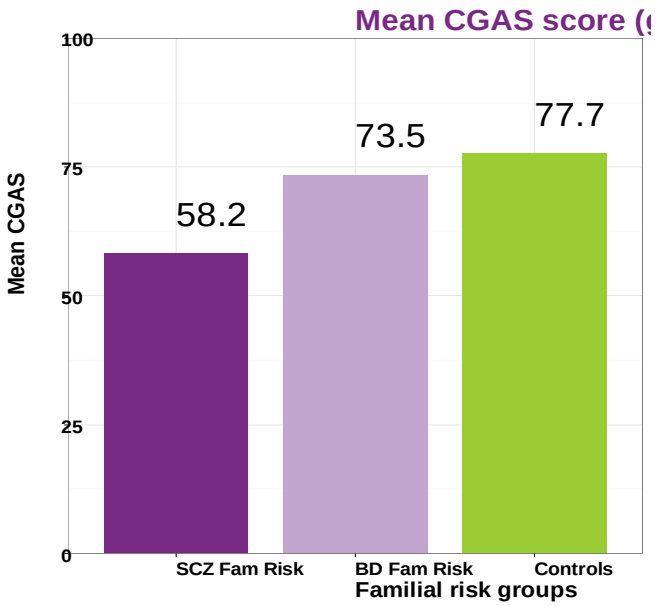


Psychopathology, K-sads, children (N= 514)

semistructured interview with caregiver and child (unpublished results)

Percentage, any life time mental illness diagnosis





	Sz high risk % (OR)	BD High Risk % (OR)	Controls % (OR)
Anxiety	11.1 % (2.6)*	11.9 % (2.8)*	4.6 % (1)
ADHD	20.6 % (3.5)*	8.5 % (1.2)	7.1 % (1)
Stress/adjustment disorder	5.5 % (3.8)	8.5 % (6.0)*	1.5 % (1)

*= significant

Impairments of motor function among children with a familial risk of schizophrenia or bipolar disorder at 7 years old in Denmark: an observational cohort study

Birgitte Klee Burton, Anne A E Thorup, Jens Richardt Jepsen, Gry Poulsen, Ditte Ellersgaard, Katrine S Spang, Camilla Jerlang Christiani, Nicoline Hemager, Ditte Gantriis, Aja Greve, Ole Mors, Merete Nordentoft, Kerstin Jessica Plessen

Summary

Background Owing to the genetic overlap between schizophrenia and bipolar disorder, we aimed to assess domain-specific motor aberrations and disorder specificity among 7-year-old children with a familial risk of schizophrenia or bipolar disorder by comparing children in familial risk groups with each other and with children not in these risk groups.

Methods In the Danish High Risk and Resilience Study, we established a cohort of 7-year-old children with no, one, or two parents with schizophrenia or bipolar disorder in Denmark between Jan 1, 2013, and Jan 31, 2016. We matched children of parents diagnosed with schizophrenia to children of parents without schizophrenia on the basis of their home address, age, and sex. Even though we did not match children of parents with bipolar disorder directly to controls because of resource constraints, we only recruited children into the three groups who did not differ in terms of age, sex, and urbanicity. We investigated motor function in children using the Movement Assessment Battery for Children–Second Edition. Motor function raters were masked to participants' clinical risk status during assessments. We assessed the effects of familial risk group in a mixed-model analysis with repeated measures with an unstructured variance component matrix.

Findings We studied 514 children (198 [39%] children of parents with schizophrenia, 119 [23%] of parents with bipolar disorder, and 197 [38%] of parents without schizophrenia or bipolar disorder). Children of parents with schizophrenia showed impaired motor performance compared with those of parents without in the subdomains of manual dexterity (mean difference −1·42 [95% CI −2·08 to −0·77]; p<0·0001) and balance (−1·38 [−2·03 to −0·72]; p<0·0001), but not of aiming and catching (−0·39 [−0·97 to 0·19]; p=0·18). Children of parents with bipolar disorder did not show any significant difference in motor performance to children of parents without in the subdomains of manual dexterity (−0·69 [−1·44 to 0·07]; p=0·08), balance (−0·68 [−1·44 to 0·08]; p=0·08), and aiming and catching (−0·36 [−1·03 to 0·31]; p=0·29). Comparison of familial risk groups of mental disorders revealed no significant differences in the subdomains of manual dexterity (−0·74 [−1·49 to 0·02]; p=0·06), balance (−0·70 [−1·46 to 0·06]; p=0·07), or aiming and catching (−0·03 [−0·70 to 0·63]; p=0·92).

Interpretation Motor abnormalities in children with a familial risk of schizophrenia are specific at 7 years of age with respect to fine motor function and balance, but non-specific with respect to familial risk of bipolar disorder. Clinicians should be aware of motor symptoms and refer children with definite motor problems (below the fifth percentile) to a child physiotherapist.

Funding Mental Health Services of the Capital Region of Denmark, Aarhus University, and the Lundbeck Foundation Initiative for Integrative Psychiatric Research.

Lancet Psychiatry 2017

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See Online/Comment http://dx.doi.org/10.1016/S2215-0366(17)30106-2

Child and Adolescent Mental Health Centre, Mental Health Services Capital Region, Research Unit, Copenhagen University Hospital, Copenhagen, Denmark (B K Burton MD, Anne A E Thorup PhD, J R Jepsen PhD, K S Spang MD, Prof K J Plessen PhD); **Mental Health Centre Copenhagen, Copenhagen University Hospital, Mental Health Services Capital Region, Hellerup, Denmark** (G Poulsen PhD, D Ellersgaard MD, C J Christiani MSc, N Hemager MSc, Prof M Nordentoft DMSc); **Department of Clinical Medicine, Faculty of Health and Medical Sciences** (B K Burton, A A E Thorup, D Ellersgaard, K S Spang, C J Christiani, N Hemager, Prof M Nordentoft, Prof K J Plessen), **and Department of Public Health, Section of Biostatistics** (G Poulsen), **University of Copenhagen, Copenhagen, Denmark; Centre for Neuropsychiatric Schizophrenia Research, and Centre for Clinical Intervention and Neuropsychiatric Schizophrenia Research, Copenhagen University Hospital, Psychiatric Hospital Centre Glostrup, Glostrup, Denmark** (J R Jepsen); **Psychosis Research Unit, Aarhus University Hospital, Risskov, Aarhus, Denmark** (D Gantriis MSc, A Greve MSc, Prof O Mors PhD); **and The Lundbeck Foundation Initiative for Integrative**

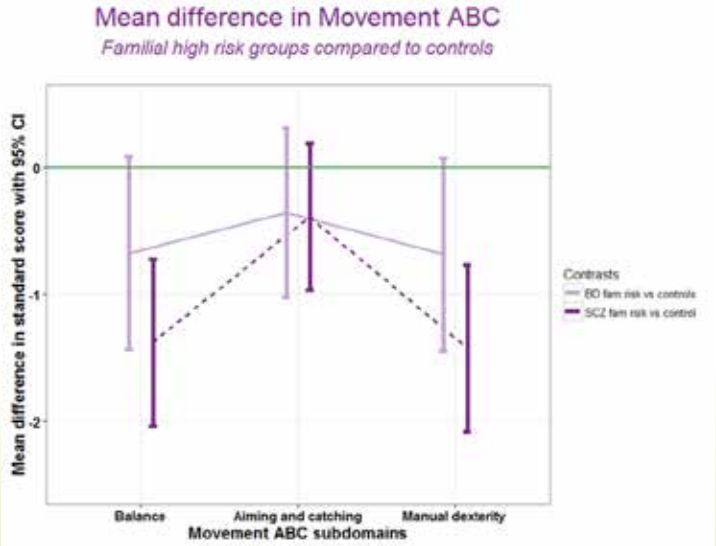
Introduction

Severe mental disorders in adults might originate from neurodevelopmental disturbances, with different deviations presenting in childhood.[1,2] Motor impairments are seen in individuals with schizophrenia either well before the disorder manifests[3–6] or at diagnosis.[7] Similarly, numerous studies of individuals with a familial risk of schizophrenia support the existence of motor deficits, particularly impaired coordination during development.[8] Most of the previous studies of individuals at high familial risk, however, included children of parents with schizophrenia across a broad age range and so puberty and developmental stages might have influenced the findings.[9–11]

Schizophrenia shares common characteristics and genetic liability (ie, shares some of the same genes) with bipolar disorder,[12] but the two disorders present with different behavioural characteristics and symptoms. One of these differences might be motor performance, which has not been examined in depth in individuals with bipolar disorder[13] or their first-degree relatives.[14] In a prospective study[6] derived from a birth cohort, individuals developing mania before the age of 26 years displayed better general motor performance during childhood than did healthy participants. One study[14] reported impairment of fine motor speed coordination in 28 offspring of parents with bipolar disorder. Slightly

Neurocognition and motor functioning

- In **18 out of 23 neuro cognitive measures**, children with familial risk for *schizophrenia* performed significantly poorer than both children with familial risk for bipolar disorder and controls.
- There were no significant differences between children with familial risk for bipolar disorder and controls, although the bipolar high risk children score ‘in between’ the controls and the schizophrenia high risk children
- Children born to parents with *schizophrenia* also showed significantly poorer motor functioning in domains of manual dexterity (fine motor skills) aiming and catching and balance (Lancet Psychiatry Klee Burton et al April 2017)



Conclusion, VIA 7, so far

- Children born to parents with schizophrenia and to a minor extent bipolar disorder suffer from **developmental difficulties and subthreshold problems** early in life -this time found in a *representative sample of 522 children all at the same age (seven years).*
- Results concerning **neurocognition, social functioning and motor function** were marked, but especially findings regarding the **home environment, the early life factors and social status of the families** were striking.

Schizophrenia Bulletin vol. 43 no. 1 pp. 205–213, 2017
doi:10.1093/schbul/sbw042
Advance Access publication April 30, 2016

Academic Performance in Children of Mothers With Schizophrenia and Other Severe Mental Illness, and Risk for Subsequent Development of Psychosis: A Population-Based Study

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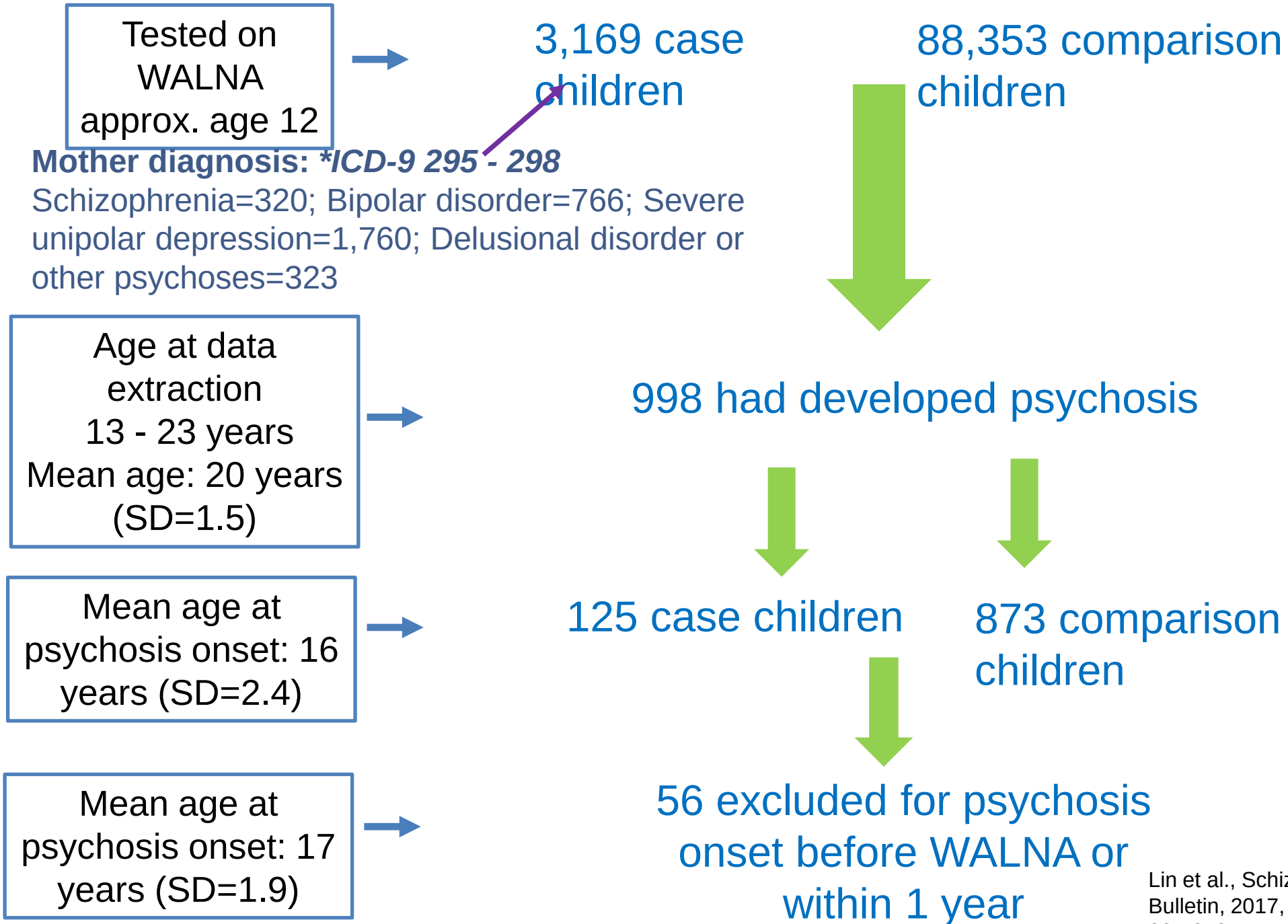
Slides courtesy of Dr Ashleigh Lin

Aim 1

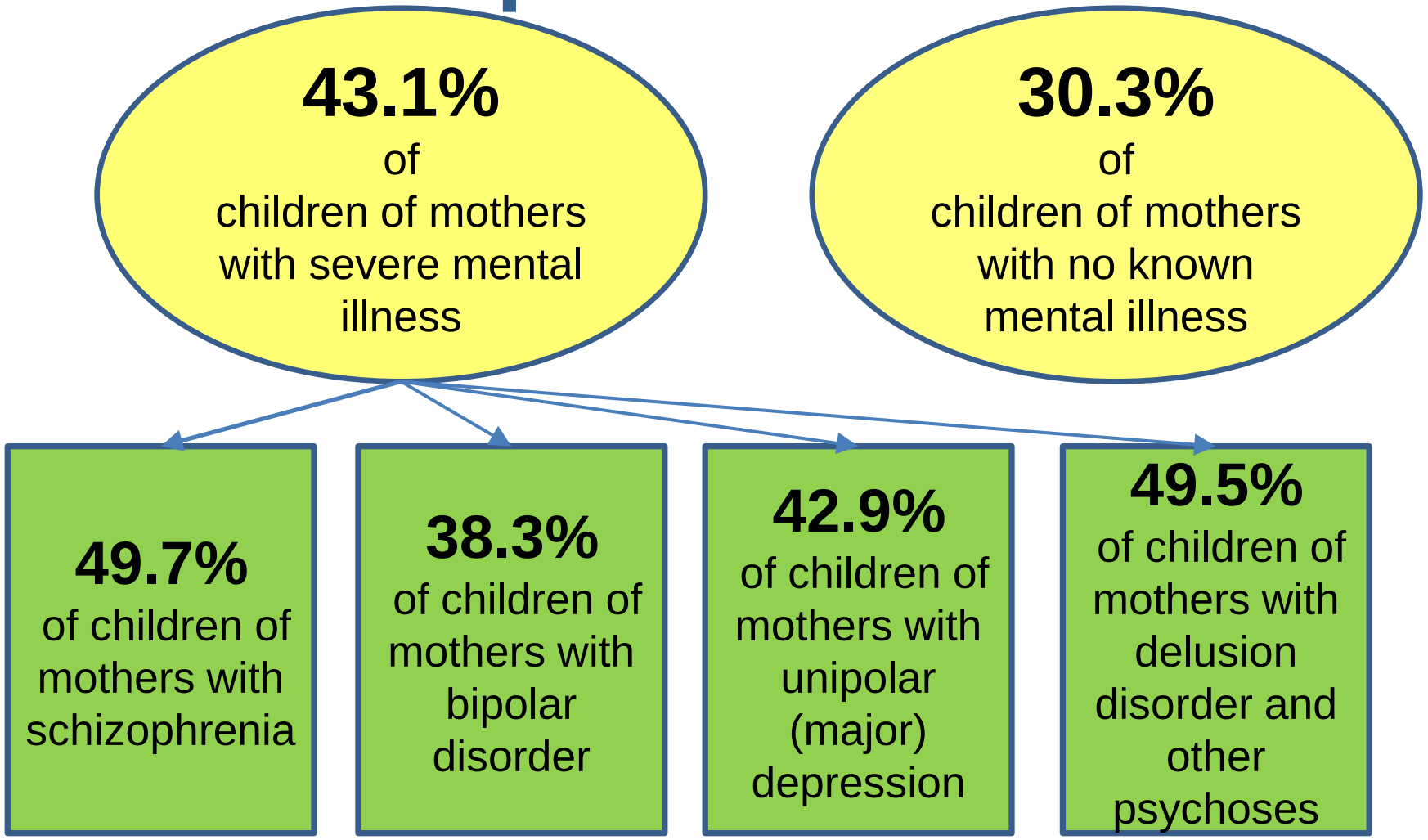
To investigate academic performance at age 12 of children with a mother diagnosed with schizophrenia, relative to the performance of children of mothers with other severe mental illness and of mothers with no known mental illness

Lin et al., Schizophrenia Bulletin, 2017, 43(1), 205-213.



Lin et al., Schizophrenia Bulletin, 2017, 43(1), 205-213

Below-benchmark academic performance



Lin et al., Schizophrenia Bulletin, 2017, 43(1), 205-213

	Numeracy	Spelling	Reading	Writing
Mother with any severe mental illness	**1.19 (1.08, 1.32)**	**1.26 (1.15, 1.38)**	1.08 (0.97, 1.21)	**1.22 (1.09, 1.37)**
Mother with no known mental illness	Reference	Reference	Reference	Reference

Notes. Fully adjusted model. Odds ratios are shown with 95% confidence intervals (CI) for the OR for any academic domain. Robust standard error was used to account for clustering of children within mothers.

Lin et al., Schizophrenia Bulletin, 2017, 43(1), 205-213.

Mother with…	Any domain	Numeracy	Spelling	Reading	Writing
Schizophrenia	**1.38 (1.07, 1.79)**	1.25 (0.94, 1.66)	**1.45 (1.10, 1.91)**	1.16 (0.85, 1.58)	1.11 (0.80, 1.55)
Bipolar disorder	**1.20 (1.02, 1.41)**	1.17 (0.95, 1.42)	1.10 (0.90, 1.33)	1.00 (0.79, 1.27)	0.93 (0.73, 1.18)
Unipolar (major) depression	**1.36 (1.22, 1.52)**	**1.22 (1.07, 1.39)**	**1.30 (1.15, 1.46)**	1.13 (0.97, 1.31)	**1.40 (1.21, 1.62)**
Delusional disorder or other psychosis	**1.41 (1.10, 1.81)**	1.06 (0.78, 1.45)	1.23 (0.93, 1.64)	0.99 (0.71, 1.37)	1.13 (0.80, 1.60)
No known mental illness	Reference	Reference	Reference	Reference	Reference

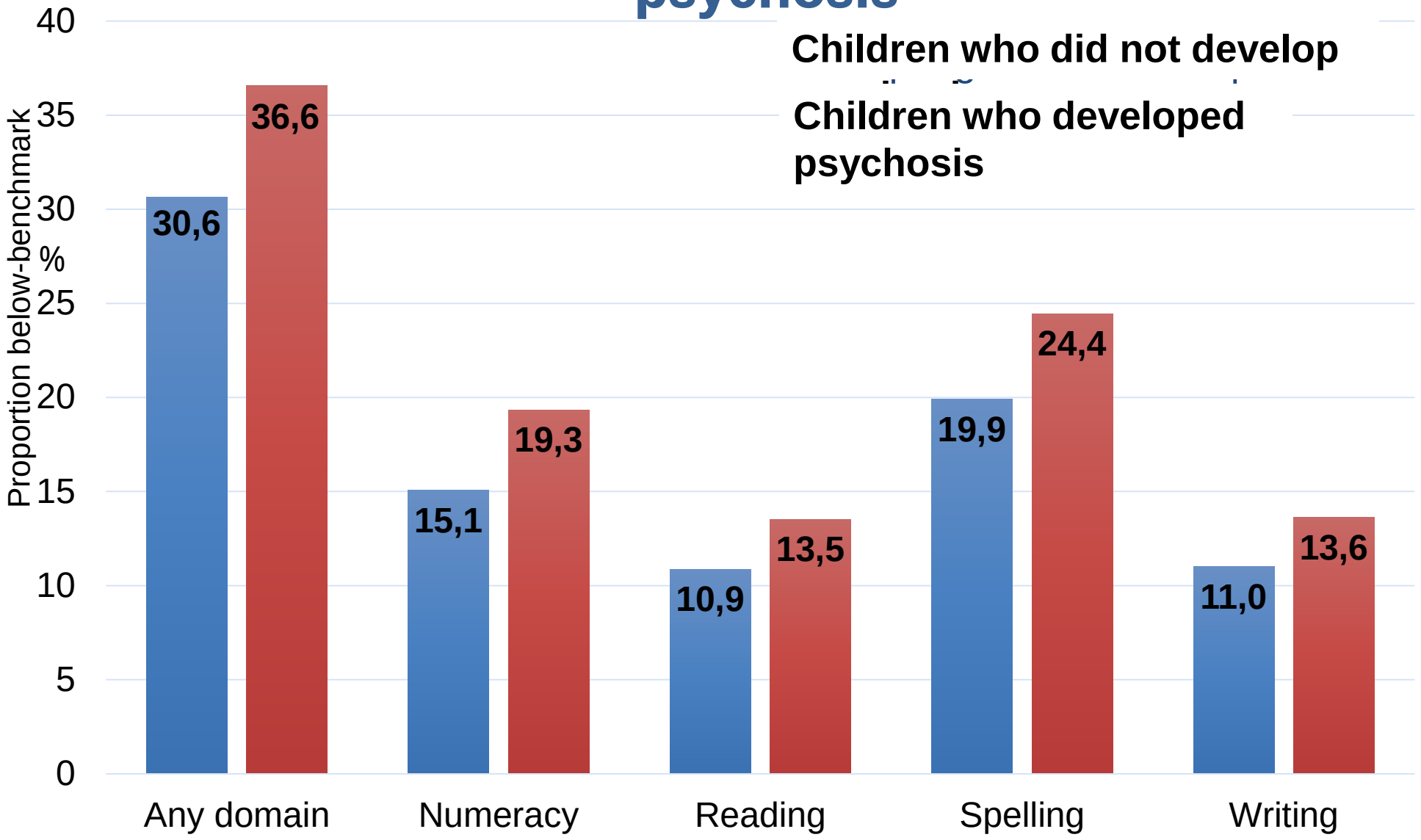
Lin et al., Schizophrenia Bulletin, 2017, 43(1), 205-213.

Aim 2

To clarify the association between academic performance at age 12 and the subsequent development of psychotic disorder

Lin et al., Schizophrenia Bulletin, 2017, 43(1), 205-213.

Academic performance and the development of psychosis



Lin et al., Schizophrenia Bulletin, 2017, 43(1), 205-213

Not all children in families with parental mental illness are at high risk

Focus preventive interventions at children and families who are <u>at high risk:</u>

especially where risk factors accumulate

Assess their risk and strengths profile!

Children and Families with High Risk

- **Very young children (prenatal > 5 yrs)**
- **Highly distressed pregnant mothers**
- **Chronic or multiple parental mental disorders**
- **Both parents have a mental disorder**
- **High conflict families; abuse & neglect**
- **Families with parental suicide**
- **Families living in poverty**
- **Refugee or war families**
- **Accumulation of risk factors ('cumulative risk')**

“Its the number of risk and protective factors that counts”

Increase number of protective factors, reduce number risk factors

Epad Study (UK)

Early Prediction of Adolescent Depression

Collishaw et al. 2016. *Lancet Psychiatry*

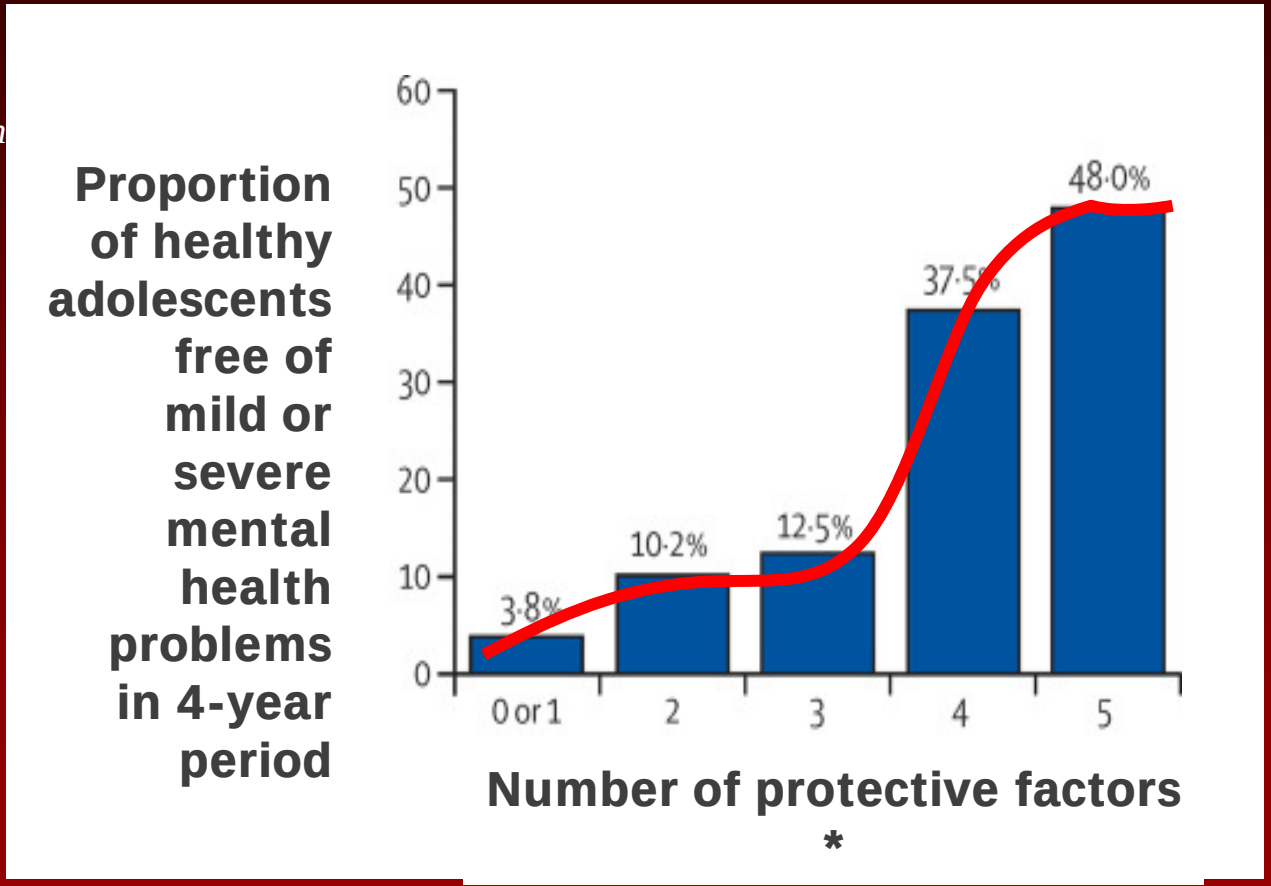
Adolescent offspring of parents with recurrent depression

N=262

Prospective study: 4 years

3 assessments

Age at start: 9 – 17 yrs



* parental positive emotion, co-parent support, good quality-social relationships, self-efficacy, frequent exercise

“Its the number of risk and protective factors that counts”

Increase the number of protective factors, reduce the number of risk factors

Pittsburgh Girls Study

Van der Molen et al. 2012
J. of Abnormal Child Psychology

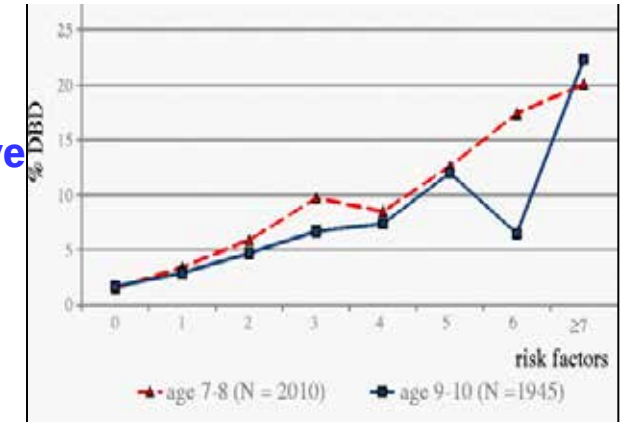
Longitudinal study

N = 2,034 (7 – 12 yrs)

Risk of Child Disruptive Behaviour

Number of maternal risk factors

Percentage child disruptive behavior

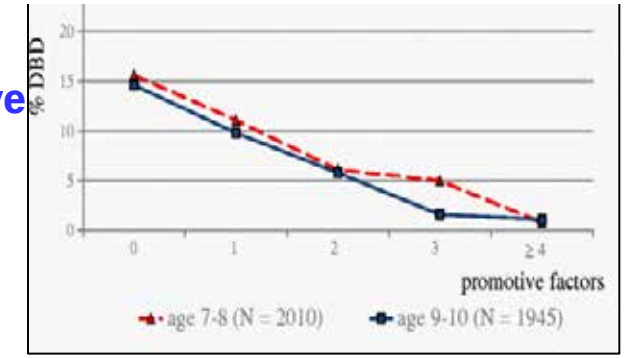


Maternal risk factors:

psychopathology, single mother, prenatal substance use, poor neighborhood, poor parenting

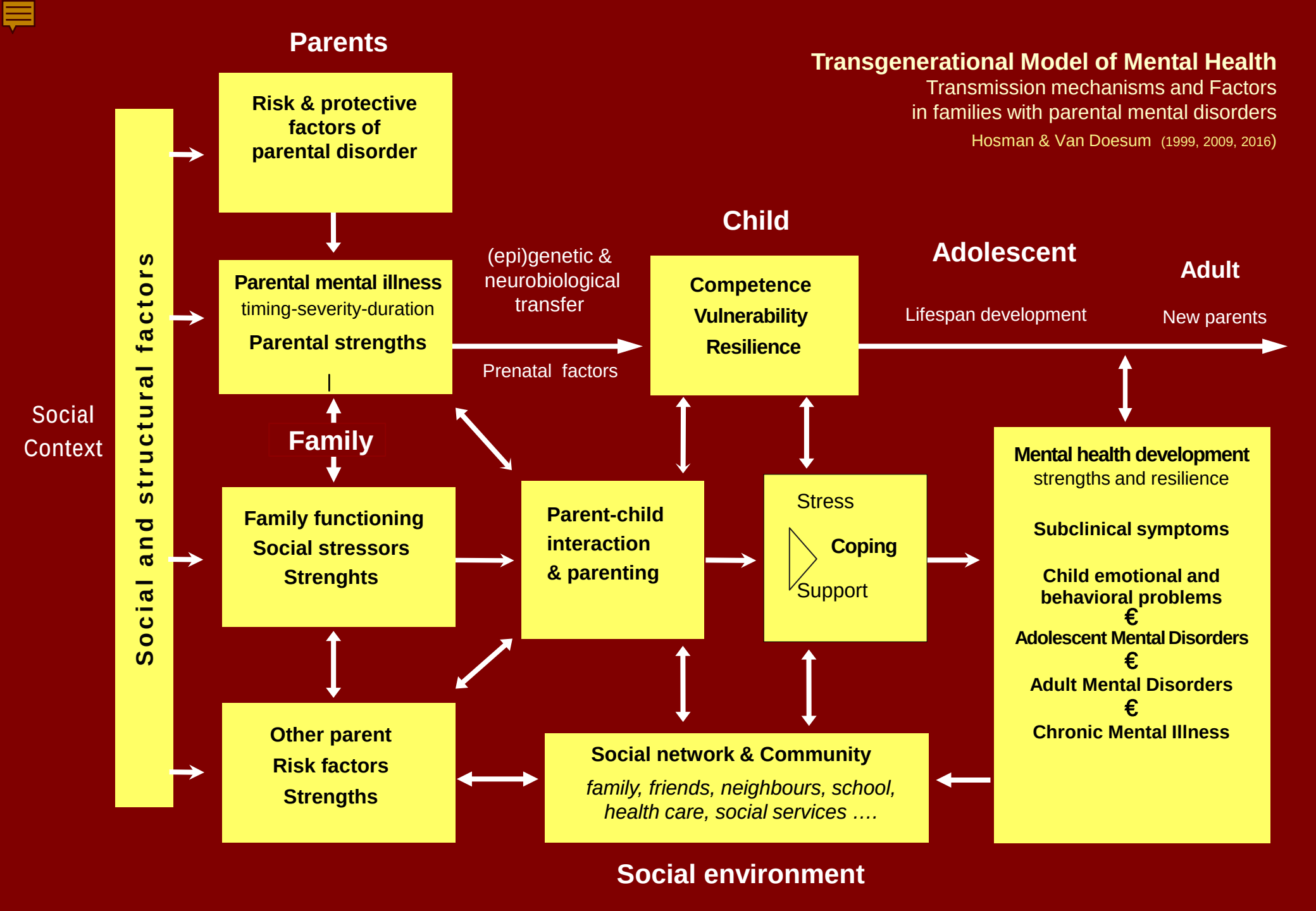
Number maternal promotive factors

Percentage child disruptive behavior



Maternal promotive factors:

low depression maternal warmth consistant discipline


Parents
Transgenerational Model of Mental Health
Transmission mechanisms and Factors
in families with parental mental disorders
Hosman & Van Doesum (1999, 2009, 2016)
Risk & protective factors of parental disorder
Child
Adolescent
Adult
Parental mental illness
timing-severity-duration
Parental strengths
(epi)genetic & neurobiological transfer
Prenatal factors
Competence
Vulnerability
Resilience
Lifespan development
New parents
Social and structural factors
Social Context
Family
Family functioning
Social stressors
Strenghts
Parent-child interaction & parenting
Stress
Coping
Support
Mental health development
strengths and resilience
Subclinical symptoms
Child emotional and behavioral problems
€
Adolescent Mental Disorders
€
Adult Mental Disorders
€
Chronic Mental Illness
Other parent
Risk factors
Strengths
Social network & Community
family, friends, neighbours, school, health care, social services ….
Social environment

REVIEW

Do preventive interventions for children of mentally ill parents work? Results of a systematic review and meta-analysis

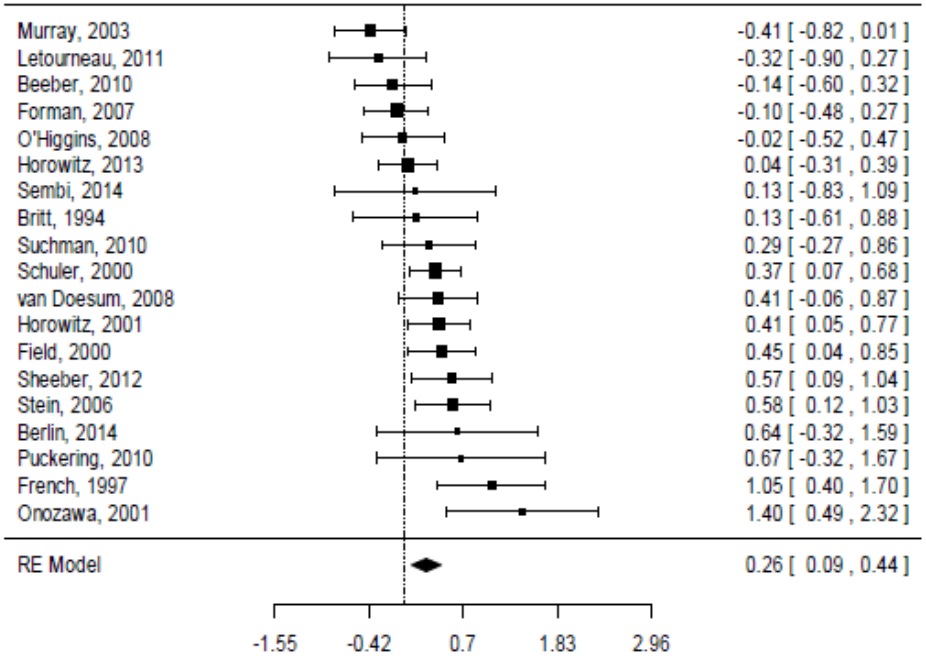
Martina Thanhäuser[a], *Gunnar Lemmer*[b], *Giovanni de Girolamo*[c], *and Hanna Christiansen*[a]

Purpose of review
The transgenerational transmission of mental disorders is one of the most significant causes of psychiatric morbidity. Several risk factors for children of parents with mental illness (COPMI) have been identified in numerous studies and meta-analyses.

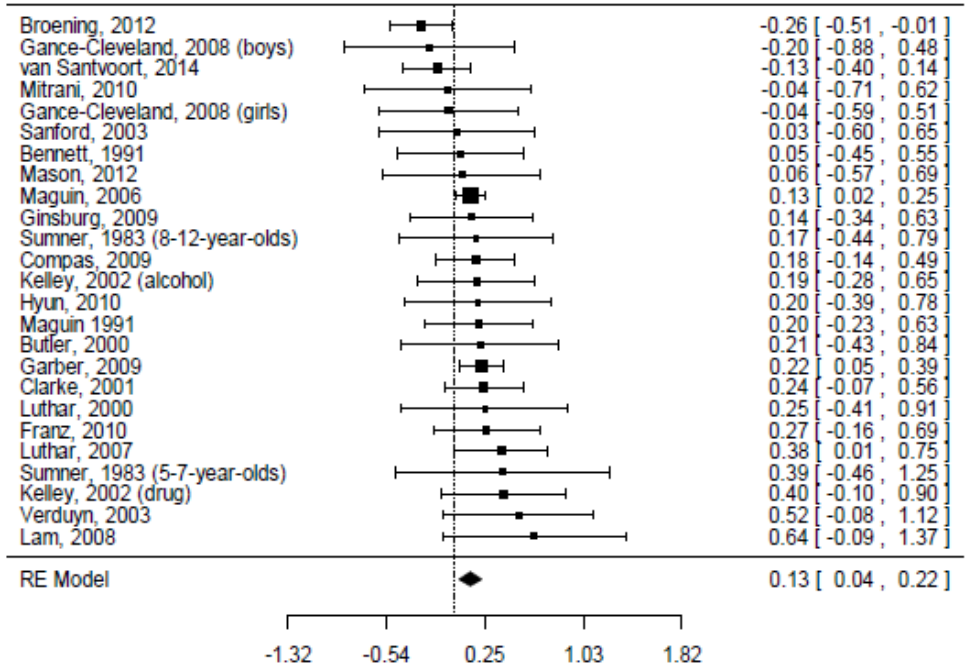
Recent findings
Many interventions have been developed for this high-risk group, but data about their efficacy are heterogeneous.

Summary
The current meta-analysis reports on 95 articles including 50 independent samples from randomized controlled trials quantifying effects of preventive interventions for COPMI. Random effect models resulted in small, though significant Effect Sizes(ES) for programs enhancing the mother-infant interaction (ES = .26) as well as mother's (ES = .33) and children's (ES = .31) behavior that proved to be stable over 12-month follow-up with expect to the infants' behavior. Interventions for children/adolescents resulted in significant small effects for global psychopathology (effect size = 0.14), as well as internalizing symptoms (effect size = 0.17), and increased significantly over time, with externalizing symptoms reaching significance in the follow-up assessments as well (effect size = 0.17). Interventions addressing parents and children jointly produced overall larger effects. Higher study quality was associated with smaller effects. There is a dearth of high quality studies that effectively reduce the high risk of COPMI for the development of mental disorders.

Keywords
children, intervention, mentally ill parents, meta-analysis, prevention



Forest plot Random Effects model (REM) for the total effect of mother-child interactions at post-test



Forest plot Random Effects Model (REM) for the total effect of child psychopathology at post-test

To conclude

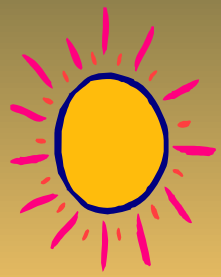
Supporting these children and families is urgently needed
We have knowledge and tools to make a change

Reflect on what you could contribute to prevent transgenerational transmission of mental illness and improve their mental health

At home sit together with your colleagues and discuss what you could do together to improve support for these families

Talk with primary health care, local organizations and policy-makers have you could create much better collective impact

Make a local plan for improving the conditions to make it happen



…. and Talk with the Children

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28.	EUROPEAN FEDERATION OF ASSOCIATIONS OF FAMILIES OF PEOPLE WITH MENTAL ILLNESS (EUFAMI)	Aagje IEVEN	Secretary General, Bruxelles, Belgium

IRCCS
Centro San Giovanni di Dio
Fatebenefratelli, Brescia

VENERDÌ 9 GIUGNO 2017

PREVENZIONE IN SALUTE MENTALE: AIUTARE I FIGLI DI PERSONE CON DISTURBI MENTALI GRAVI

Centro Paolo VI
Via Gezio Calini, 30 25121 Brescia

MODALITÀ ORGANIZZATIVE

La partecipazione al convegno ha un costo (volto a coprire parte delle spese organizzative) di € 50,00 che dovranno essere versati entro il giorno 1 Maggio 2017.
Essendo i posti limitati, si prega di inviare la pre-iscrizione tramite sito internet **www.irccs-fatebenefratelli.it**
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Centro Paolo VI - Via Gezio Calini, 30 25121 Brescia.

Concessi 3,5 crediti ECM per tutte le professioni sanitarie.

MODALITÀ DI PAGAMENTO

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Banca Monte dei Paschi di Siena - Via Corsica, 202
IBAN: IT55N0103011209000010130050
Oppure direttamente all'Ufficio Formazione.

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Chiara Barattieri, Chiara Buizza, Valentina Candini, Fabiana Faustini, Sara Raimondi, Giulia Signorini. Unità di Psichiatria Epidemiologica e Valutativa, IRCCS Fatebenefratelli, Brescia.

PROGRAMMA VENERDÌ 9 GIUGNO

Ore 8.30 - 9.00 **Registrazione dei partecipanti**

Ore 9.00 - 9.15 **Saluto delle autorità**

Chairmen: Giovanni de Girolamo & Giambattista Tura

Ore 9.20 - 9.45
Giovanni de Girolamo
Introduzione al problema dei Children Of Parents with Mental Illness (COPMI)

Ore 9.45 - 10.30
Darryl Maybery (Australia). **Discussant: Fabrizio Starace**
L'orizzonte epidemiologico: l'ampiezza del problema

Ore 10.30 - 11.15
Andrea Reupert (Australia). **Discussant: Elisa Fazzi**
Modelli di trasmissione intergenerazionale dei disturbi mentali

Ore 11:15 - 11.45
Pausa

Ore 11.45 - 12.30
Darryl Maybery.
Discussants: Stefano Barlati & Antonio Vita
Fattori di rischio e fattori protettivi: il ruolo dei geni e dell'ambiente

Ore 12.30 - 13.00
Il punto di vista degli interessati: testimonianze di figli e genitori

Ore 13.00 - 14.15
Lunch

Chairmen: Alberto Ghilardi & Maria Nobile

Ore 14.15 - 15.00
Andrea Reupert. Discussant: Alberto Zanobio
Come aiutare i figli: modelli di prevenzione e di intervento

Ore 15.00 - 15.45
Darryl Maybery.
Discussant: Francesco Maria Saviotti
Come aiutare i genitori: modelli di prevenzione e di intervento

Ore 15.45 - 16.15
Pausa

Ore 16.15 - 17.15
Tavola rotonda: Problematiche etiche, forensi ed assistenziali
Laura D'Urbino, Luciano Eusebi

OBIETTIVI E STRUTTURA DEL CONVEGNO

Uno dei più potenti fattori di rischio per il disagio psichico in età giovanile è rappresentato dall'avere una genitore (o entrambi i genitori) affetti da un disturbo mentale grave (tematica nota come *'Children Of Parents with Mental Illness'*, COPMI). Tale situazione infatti comporta l'esposizione del soggetto in età adolescenziale o giovanile ad un duplice rischio: da un lato la vulnerabilità ascrivibile alla dimostrata familiarità dei disturbi mentali gravi, con fattori di rischio di natura neurobiologica; dall'altro l'esposizione a stressor prolungati ed intensi, di natura ambientale, ascrivibili alla presenza di un genitore (o di entrambi i genitori) sofferente (-i) di un disturbo mentale. Questa duplice condizione di rischio è all'origine di una probabilità talvolta elevata di sviluppare lo stesso disturbo del genitore (cosiddetta "specificità transgenerazionale") o un altro disturbo mentale.

Interventi preventivi mirati possono ridurre del 40% il rischio di sviluppare un disturbo mentale in questa popolazione giovanile. Nonostante le evidenze di efficacia dei pochi programmi di prevenzione realizzati in altri paesi, questa tematica è rimasta a tutt'oggi quasi totalmente negletta in Italia.

L'IRCCS Fatebenefratelli di Brescia sta sviluppando una serie di iniziative a livello europeo sul tema dei COPMI. Il convegno si propone innanzitutto di fornire una panoramica scientificamente rigorosa delle conoscenze in quest'area, di presentare gli attuali modelli di trattamento disponibili e discutere la loro efficacia; i due relatori australiani sono tra i pionieri a livello internazionale in questo settore, ed hanno creato un ampio network di clinici e ricercatori impegnati sul tema dei COPMI (vedi schede biografiche). L'auspicio è che tali conoscenze possano essere trasferite nel contesto assistenziale italiano, migliorare la presa in carico di genitori affetti da disturbi mentali gravi e attuare programmi di prevenzione della salute mentale dei loro figli.