Adolescents with mental disorders: an experience of Multiprofessional approach

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Summary. This work aims to present an example of multiprofessional intervention with psychiatric adolescents and their families, throughout the description of a Daily Service for Psychiatric Adolescents and a survey of the cases treated during the last two years. Specifically, the study aims to analyze the psychopathological manifestations of a sample of 67 adolescents who were addressed to the semi-residential service for adolescent psychopathologies at the Neuropsychiatric Unit for Children and Adolescents of the local public health services in Padua (Italy) in the last two years. The study sample consists of 48 males (71.6%) and 19 females (28.4%), aged between 13 and 19 years. The patients' functioning and psychopathology were assessed using the Achenbach Youth Self Report 11-18, which was completed at the beginning of the semi-residential treatment.

Key words: psychopathology, adolescence, semi-residential service, mutiprofessional intervention, parental intervention.

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Introduction and background

In adolescence individuals may develop early signs of even severe psychopathological disorders, often with atypical symptoms that are not easy to recognize if the criteria for the diagnosis and classification of such

conditions are those used with adult patients. The efficacy of a multimodal, multidisciplinary approach to the treatment of psychopathologies in developmental age has been acknowledged internationally (Bond, Drake, Mueser, et al. 2001). Both research and clinical practice results show that such approach is more appropriate than single-profession, single-modality treatments (Gatta, Dal Zotto, Nequino, Del Col, et al 2010).

In the case of adolescents with moderate-to-severe psychopathologies manifested mainly in their behaviors, the adolescents' environment is always involved and the therapies attempted must necessarily be of multi-professional type. In the majority of cases, intervention is organized in the form of treatments at intermediate level, i.e. semi-residential or residential centers; this type of intervention is an indispensable alternative to hospitalization for this age group, because otherwise the extreme shortage of specialist structures would often mean admitting these adolescents either to pediatric clinics or to adult psychiatric wards. Choosing such an intermediate structure involves evaluating numerous variables, however, including the patient's conditions, the diagnostic hypothesis, the family's cooperation (in the sense of both its social setting and its educational level), as well as the availability of territorial resources. Assessing an adolescent's family and social environment is fundamental when programming a treatment that allows the individual to remain more or less extensively in his/her habitual environment. This work aims to present an example of multiprofessional intervention with psychiatric adolescents and their families.

The Semi-residential Adolescent Psychopathology Service

The study involved patients attending the Daily Service for Adolescents at the Neuropsychiatric Unit for Children and Adolescents in Padua. The main purposes of this service are the care and rehabilitation of adolescents with severe psychopathological disorders (mood disorders, psychotic disorders, antisocial behavior and personality disorders), particularly optimizing their welfare and providing intervention for these young patients through an integrated clinical and pedagogical approach. Various professional figures cooperate on the therapeutic project and this multi-professional team includes a child and adolescent neuropsychiatrist, a psychologist and three educators. Adolescents attending the center undergo an initial diagnostic process, leading to a psychiatric diagnosis formulated according to the ICD 10 (World Health Organization, 1992) and the therapeutic project involves attending a day centre.

The centre receives adolescents (males and females from 12 to 18 years of age) with various types of psychiatric and behavioral disorder of moderate to severe degree: it has a capacity to treat approximately 25 patients in all and can simultaneously accommodate up to six adolescents, with the ratio of one operator to every two patients.

The adolescents attend from Monday to Friday from 09.00 to 17.00. Access to the structure is based on individual projects prepared by the team, which establishes the number of weekly visits and their duration. The educators can also implement tailored and/or home-based interventions in situations where an adolescent suffers from significant social isolation, and in acute cases requiring temporary hospital stays, acting as companions and providing support while the patient is in hospital. Patients can also be received in emergency situations (moments of acute crisis, or when a "buffer intervention" is needed while a patient is waiting to join a residential community). These latter interventions do not follow the normal enrolment protocol.

The general goals of the service are:

- to optimize the patient care and education measures for adolescents in situations of particular mental illness and at particularly crucial times;
- to support the families in their educational role;
- to construct an integrated clinical and pedagogical project with the various services on different levels and with different institutional roles;
- to improve the social involvement of adolescent in their living environment.

The multidisciplinary team

The multidisciplinary team consists of: a developmental neuropsychiatrist responsible for the service, a psychologist-psychotherapist, two educators, a social worker, a coordinator, and an administrative assistant. There are also trainee psychologists, trainees on the degree course for professional educators at the Faculties of Education Sciences and Psychology, and physicians training in developmental neuropsychiatry.

The team holds the following meetings:

- a weekly meeting to coordinate their clinical-pedagogical work and program the educational activities;
- a weekly team meeting to discuss the cases;

- periodical meetings with social-sanitary operators and clinicians to report on the cases being treated in the semi-residential setting to discuss the clinical issues, assess the adolescent's progress, and recommend new patients for the treatment;
- a monthly supervisory team meeting with an outside psychiatrist-psychotherapist.

Protocol for enrolling new patients at the semi-residential center

The phase for assessing and enrolling an adolescent at the semi-residential center for adolescent psychopathologies is completed according to the following protocol.

Phase 1. The case is presented to the team operating at the semi-residential service for adolescent psychopathologies by the psychologist or neuropsychiatrist proposing their enrolment at the Neuropsychiatric Unit for Children and Adolescents and a file is prepared for the patient being recommended.

*Phase 2.*The case is discussed and, where applicable, a preliminary period of observation and assessment of the adolescent is decided.

Phase 3. A meeting is held with the patient and family to formalize the proposal to start with a preliminary period for the adolescent to get to know the semi-residential service. In addition to patients and their parents, this meeting is also attended by the clinician referring them and an educator.

*Phase 4.*The observation period starts, normally involving four meetings according to the following schedule:

- the first meeting is for introductions, observations and free activity (playing, computer, exploring spaces);
- the second meeting is when an observation file is completed (a semistructured interview) by a "third party" educator, i.e. an educator who has had the least to do with the adolescent so far, in order to guarantee the utmost neutrality in the administering the assessment tool. Then activities are proposed in small groups to see how the adolescent functions in group situations;
- at the third meeting activities are proposed on the basis of the adolescent's interests emerging from the previous interview;
- the fourth and last meeting is where, in addition to the activities already begun at the third meeting, there is also space for a conversation and exchange of ideas with the adolescent, to provide feedback relating to the previous meetings, the adolescent's mode

of participation and greater or lesser willingness to enroll at the semi-residential center.

Phase 5. The reference educator completes an initial observation file on the trend of the four meetings.

Phase 6. The team assesses the observation period within two weeks after its completion and decides whether to recommend that the adolescent continue with the semi-residential experience or terminate it.

*Phase 7.*The patient and family are informed about the child's progress so far and there is an exchange of ideas relating to the adolescent's and the family's experiences and motivations. If all concerned agree to the semi-residential program, this decision is shared and signed jointly by the family and by the physician referring the case to the team, and these parties agree on a first integrated, tailored therapeutic and educational project, and an initial schedule for the adolescent's attendance at the center.

The path for taking the patient into care

1. Formulation of the tailored educational project and schedule of attendance at the semi-residential center.

This phase is completed by the working team and the object is to prepare a first project in the light of the findings during the preliminary observation period. A record is made of patients' and their families' demographic details, the motives for enrolment on the program, the internal and external activities conducted, the established goals, the general and specific objectives of the course of therapy, a description of the integrated intervention designed for each adolescent of and the timing for assessing their progress and the project.

Access is always formulated on the basis of a tailored individual project and the adolescent's weekly attendance is constantly monitored. Punctuality and adherence to the agreed frequency of attendance is an important tool for assessing the adolescents' and their families' compliance with the agreed educational project, as well as being a necessary premise for implementing the semi-residential program. For each patient, a schedule is agreed with the family, the specialist and the adolescent concerned, starting from a minimum of two attendances a week (lasting four hours each).

2. Periodical clinical interviews and progress monitoring

For each patient, there are periodical clinical meetings with their own doctors to monitor their psycho-developmental trends and personal response to the therapy. The parental couple is also followed up with

regular meetings with a clinician (neuropsychiatrist or psychologist), possibly with the support of an educator.

This action on the families needs to be supported and empowered to help parents establish a different image of their child from the one they knew before, and make sense of the changes taking place in the child during the period in semi-residential care, as well as providing input on how the parents themselves need to respond to the child on a daily basis. A course of psychotherapy proper for both the adolescents and their parents is often recommended and implemented.

3. Completion of a file for recording changes and reviewing the therapy

After the first six months of attendance at the semi-residential centre, the educational project is reviewed, and the goals and/or operating methods are expanded and/or diversified, based on a first structured assessment of the adolescent's progress that involves completion and checklist of specific indicators relating to the various areas of intervention (relational, social, autonomy).

4. Ongoing assessment

The ongoing assessment of the adolescent's progress is based on various methods:

- periodic team discussions;
- periodic meetings with reference clinicians;
- periodic meetings with family;
- periodic meetings with teachers;
- periodic assessment of files completed by the reference educator;
- observation/assessment charts recorded before and after laboratory activities;
- the periodic administration of standardized tests (such as YSR 11-18) at the baseline, when the patient is taken into care and subsequently every six months.

This assessment and constant monitoring procedure enables the ongoing adjustment of the objectives of the integrated individual projects, which is normally done every 3-6 months. The tests can also be used as a tool for pre-and post-assessment of the effects of the intervention at the start and end of a specific laboratory activity to evaluate it efficacy.

5. Discharge

The end of the course of therapeutic intervention can be decided by various factors. In the most favorable of outcomes, the project may be concluded because the preset goals have been achieved and the adolescents have regained their social contacts and schooling experience, and the course of therapy undertaken can be consolidated.

Attendance at the centre may also be interrupted due to poor compliance on the part of the adolescent and/or the family (with repeated and unjustified failures to attend appointments at the semi-residential centre or meetings with clinicians, or inadequate cooperation). The program may also be stopped by the need to include the patient in a residential community. In each case, the conclusion of the project is confirmed during the course of a final meeting attended by all the parties involved (the adolescent, the family, the reference educator, the psychologist and the neuropsychiatrist).

Pedagogical activities

The object of the pedagogical activities is to support the adolescents in the course of their development by means of a relationship with the figure of the educator, who serves as an "auxiliary ego" and consequently as a supportive companion. This is achieved by providing a space, which takes practical shape in the rooms at the semi-residential centre, and by designing a project that involves customized objectives and timings.

In experiences of research applied to different educational settings, various functions have been identified on which the educator's action is concentrated.

The general educational goals of the educational process providing the starting point of an individual educational project tailored to each patient include:

- helping the adolescents to gain awareness of their own sentiments, impulses and behavior;
- helping them to test their abilities in a protected setting and to raise their self-esteem;
- helping them to realistically assess their living environment.

The activities in which the psycho-educational process takes shape are designed to achieve the individual objectives of each adolescent's project and rely on fundamental tools, such as providing a setting as a framework in which to enable to the experience of meeting, using the operator's capacity for empathy to create a relationship that can help the adolescent to let their emotional experiences resound inside themselves and thereby increasingly gain control over them, promoting organized behavior patterns, abilities and motivations that can pave the way to satisfactory social relations and an adequate performance in the completion of tasks and the achievement of goals. During their attendance at the center, the

adolescents conduct activities designed to develop their personal interests, acquire skills and reinforce their self-esteem. Outings, the preparation of a newspaper, painting, watching films, playing, writing, and dramatizations are activities conducted at the center, individually and in small groups, in the constant presence of the educators. There are also structured laboratories involving pet therapy, horse therapy, art therapy and naturalistic experiences at teaching farms organized in cooperation with other associations, as well as participation in therapeutic winter and summer holiday camps. For many young people, these activities are the only opportunities they have to put themselves to the test away from their usual living environments, to measure themselves against an adventure outside the home, and thereby testing their capacity to manage on their own, to experiment with detachment from the family, to live in groups and share the group's behavioral rules.

Finally, courses are also organized to support the adolescents' formal education in cooperation with their schools. This involves formulating tailored teaching programs and the presence of teachers at the semi-residential centre.

Working with adolescents means to work with their parents too; actually, our experience suggests that parents' involvement in their children's treatment is mediated by an alliance with them. In particular, a previous study suggested that working with parents benefits the young patients, responding both to the parent's need to report their children's difficulties and to the discomfort expressed by the children (Gatta, Ramaglioni, Lai, et al., 2009; Gatta, Dal Zotto, Nequinio, et al 2010).

When the parents of psychiatric adolescents are involved in the treatment, we consider the relationship between parents and children within a global caring approach, which becomes like a sort of working alliance, where also the cooperation between patient and clinician and the ability to work purposefully in the counselling situation become of fundamental importance. We have one meeting of 60 minutes with parents every two months to focus on the clinical monitoring of the adolescent. By clinical monitoring, we mean: a) assessing how the patient's symptoms evolve over time; b) taking into consideration the problems mentioned by parents in their dealing with the adolescent's behavior; c) evaluating the psycho-educational goals within the therapeutic project that could be brought up to date.

Clinical study

Aim

The aim of this study was to describe the psychopathological manifestations of a sample of 67 adolescents who were referred to the semi-residential service for adolescent psychopathologies at the Neuropsychiatric Unit for Children and Adolescents of the local public health services in Padua (Italy) in the last two years.

Sample

The study sample consisted of 48 males (71.6%) and 19 females (28.4%), aged between 13 and 19 years when they began to attend the semi-residential service, divided into three age groups, i.e. 13-14 (46.3%), 15-16 (41.8%) and 18-19 (11.9%); 29.9% of the sample were attending lower secondary school, 34.3% were at higher secondary school, and 35.8% had abandoned school.

Materials and methods

The patients' psychopathology was assessed using the Achenbach Youth Self Report 11-18, which was completed at the beginning of the semi-residential treatment.

It is one of the most commonly used scales for rating juvenile behavior and it is used internationally in the clinical setting and in research. It is in the form of a questionnaire completed by adolescents, and it has been translated and validated for Italians too (Frigerio et al., 2006; Ivanova et al., 2007). The questionnaire yields two profiles: one for competences (activities, social functioning, school performance) and one for behavioral and emotional problems, which can be assessed as "normal", "borderline" or "clinical" on 8 specific syndrome scales. The syndrome scales relating to the various psychopathological pictures are: anxiety/depression, withdrawal, somatization, social problems, thought-related problems, attention problems, aggressive and role-breaking behavior. The problems are grouped into: internalizing problems (anxiety, depression and withdrawal, somatization); externalizing problems (aggressive and role-breaking behavior); and other problems (social problems, thought-related problems, attention problems). The scores obtained by our patients in the

Achenbach Youth Self Report (YSR 11-18) at the baseline assessment were grouped into three clusters, i.e. cluster 1 ("normal") comprises scores in the range of 50 to 64; cluster 2 ("borderline") scores from 65 to 69; and cluster 3 ("pathological") scores from 70 to 100, as recommended in the manual (Achenbach & Rescorla, 2000, 2001).

Statistics

The statistical analysis was conducted using the following variables: gender, age, cultural level of the families of origin, formal education, situation of the parental couple, psychiatric diagnosis (ICD 10), reason for requesting to join the program, attendance at the semi-residential centre, period of stay at the semi-residential centre, type of intervention.

The data collected were input in a database and subsequently processed using the SSPS statistical software, rel. 14; a value of $p \leq 0.05$ was considered significant. After completing the frequency analysis, the chi square test was used as a statistical model (calculating the exact value of p) to analyze the gender-related differences in relation to all the above-listed variables.

Results and discussion

Socio-demographic characteristics of the sample

As mentioned it above, the sample consisted of 48 males (71.6%) and 19 females (28.4%).

Their age at the time of enrolment on the semi-residential program was distributed in the 13-14 year-old (46.3%) and 15-16 year-old (41.8%) age groups, while 11.9% of the adolescents were between 17 and 19 years old. Males and females were equally distributed in the three age groups ($\chi 2 = 1.20$, df = 2, pexact = n.s.).

As far as schooling was concerned, 29.9% of the patients were attending lower middle school, 34.3% were at higher middle school and 35.8% had abandoned school: leaving school of this last group was mainly due both to academic difficulties and to major behavioral issues or symptoms of mental illness and isolation that interfered significantly with school attendance. According to the ISTAT survey of 2008, the national

rate of adolescents abandoning their education in the first year of high school was 11.1% (ISTAT, 2008).

The drop-out phenomenon in our sample was clearly connected to these adolescents' psychiatric disease and it is also important as a prognostic indicator when considered in terms of the adolescent's psycho-educational growth.

There were no statistically significant differences between males and females as concerned with their school education (÷2 = .17, df = 2, pexact = n.s.).

The cultural level of the family of origin, judging from the formal education received by each of the parents (lower middle school, high school, university), was mainly medium-to-low: it was low for 32.8% of the sample, medium for 53.7%, and high for only 13.4%. This finding confirms, on the one hand, the trend of previously published studies on the inverse relationship between mental disorders in general and the families' socio-cultural level (Chandra et al., 1993; Flouri et al., 2010; WHO 2004), on the other, it goes to show that the intervention implemented is readily accessible to all, not discriminating between families in economic or cultural terms.

No significant differences emerged between males and females for this variable ($\chi 2 = .30$, df=2, pexact = n.s.).

In 76.1% of the cases, the families consisted of an intact parental couple, while in 23.9% the family was single-parent. No statistically significant differences emerged between males and females for this factor ($\chi 2 = 12$, df=1, pexact = n.s.).

Main psychopathological signs in our sample of adolescents and their diagnosis

For 40.3% of our patients, the reason for referral to our service was for behavioral problems, 23.9% had affective-relational and family problems, 19.4% had schooling problems, and 16.4% suffered from social isolation. The reason for requesting the service varied according to the gender of the sample considered ($\chi 2 = 8.82$, df=3, pexact= .03): male patients were more likely to ask for therapeutic intervention for behavioral problems (43.8% of the males vs 31.6% of the females), problems at school (20.8% of the males vs 15.8% of the females) or social isolation (20.8% of the males vs 5.3% of the females), while females were more likely to need to deal with affective-relational problems (14.6% of the males vs 47.4% of the females).

The sample consisted of adolescents who had been attributed a diagnosis according to the ICD 10 of psychotic disorders in 25.4% of cases, personality disorders in 34.3% (20.9% of them as a single diagnosis, 13.4% with comorbidities), behavioral disorders in 11.9%, phobias, stress-related and somatoform disorders in 10.4%, mental retardation in 9.0% and affective syndromes in 9.0% (Table 1).

TABLE 1
ICD 10 diagnoses

Diagnosis	%	(fq)
Psychotic disorders (F20-29)	25.4	(17)
Personality disorders (F60-69)	20.9	(14)
Two comorbid diagnoses (F60-69+ F30-48)	13.4	(09)
Behavioral and emotional disorders (F90-F98)	11.9	(08)
Phobias, stress-related and somatoform disorders (F40-48)	10.4	(07)
Affective disorders (F30-39)	9.0	(06)
Mental retardation, psychological development disorders (F70-89)	9.0	(06)
Total	100.0	(67)

No statistically significant differences emerged between males and females in relation to the diagnosis ICD 10 ($\chi 2 = 9.72$, df=6, pexact= n.s.).

These data do not confirm the literature on psychopathology in developmental age, in which gender variables are reportedly highly significant; for instance, psychosis, somatization, depression and eating disorders all have a different, gender-related prevalence and incidence (Costello et al., 2006; Frigerio et al., 2009; Kessler & Wang, 2008).

It is well known that problems of aggressive behavior, mental retardation and psychosis are more frequent in males, while eating disorders and internalizing disorders are more common among females.

Table 2 shows the percentage of scores obtained at the time of the initial YSR assessment in the three clusters (normal, borderline and pathological) on the eight syndromes scales. Three questionnaires were not considered because they were incomplete. It is worth noting that half the patients were “borderline” or “pathological” on the subscales for anxious-depressive disorders, social problems, and attention disorders. The same applied to the subscales for social withdrawal.

TABLE 2
YSR 11-18 Pretest Percentages and frequencies (for 64 subjects)

YSR syndromes scales	50-64 (normal)		65-69 (borderline)		70-100 (pathological)	
	%	(fq)	%	(fq)	%	(fq)
Social withdrawal	50.0	(32)	20.3	(13)	29.7	(19)
Somatization	79.7	(51)	15.6	(10)	4.7	(03)
Anxious-depressive disorders	37.5	(24)	26.6	(17)	35.9	(23)
Social problems	39.1	(25)	25.0	(16)	35.9	(23)
Thought-related disorders	73.4	(47)	18.8	(12)	7.8	(05)
Attention disorders	48.4	(31)	29.7	(19)	21.9	(14)
Delinquent behavior	84.4	(54)	10.9	(07)	4.7	(03)
Aggressive behavior	68.8	(44)	14.1	(09)	17.2	(11)

As concerns the gender-related differences (Table 3), there were no statistically significant differences except for the scales for somatization, anxious-depressive disorders and social problems, where the differences by gender tended towards significance.

In particular, there was a larger proportion of females with somatization and social problems among the "borderline" patients, and the girls prevailed for anxious-depressive disorders and social problems among the "pathological" cases.

Characteristics of the therapeutic project

The main goals of the educational-therapeutic project tailored to each patient were to help them achieve autonomy and improve their self-esteem (41.8% of cases) and socialization (29.9% of cases). Support for the family was identified as one of the priorities in 19.4% of cases, support in the adolescents' schooling in 9.0%. No statistically significant differences emerged between males and females for this variable ($\chi 2 = .22$, df=3, pexact=n.s.).

The majority of the adolescents attended the semi-residential centre for a period of time that exceeded three months; 50.7% of them attended for more than nine months (Table 4).

TABLE 3
YSR 11-18 Comparison between males and females in the three clusters of scores: *normal*, *borderline* and *pathological* (64 subjects)

YSR syndrome scales	50-64 (normal)				65-69 (borderline)				70-100 (pathological)				χ^2	df	p_{exact}
	Male		Female		Male		Female		Male		Female				
	%	(fq)	%	(fq)	%	(fq)	%	(fq)	%	(fq)	%	(fq)			
Social withdrawal	52.2	(24)	44.4	(8)	21.7	(10)	16.7	(3)	26.1	(12)	38.9	(7)	1.03	2	n.s.
Somatization	87.0	(40)	61.1	(11)	8.7	(4)	33.3	(6)	4.3	(2)	5.6	(1)	6.20	2	.06*
Anxious-depressive disorders	45.7	(21)	16.7	(3)	26.1	(12)	27.8	(5)	28.3	(13)	55.6	(10)	5.59	2	.07*
Social problems	47.8	(22)	16.7	(3)	21.7	(10)	33.3	(6)	30.4	(14)	50.0	(9)	5.29	2	.08*
Thought-related disorders	78.3	(36)	61.1	(11)	17.4	(8)	22.2	(4)	4.3	(2)	16.7	(3)	3.19	2	n.s.
Attention disorders	54.3	(25)	33.3	(6)	23.9	(11)	44.4	(8)	21.7	(10)	22.2	(4)	3.02	2	n.s.
Delinquent behavior	80.4	(37)	94.4	(17)	13.0	(6)	5.6	(1)	6.5	(3)	0	(0)	2.14	2	n.s.
Aggressive behavior	71.7	(33)	61.1	(11)	10.9	(5)	22.2	(4)	17.4	(8)	16.7	(3)	1.40	2	n.s.

Note. To enable their comparison, the percentages of males and females for each syndrome scale were calculated out of the total of the respective subsamples.

TABLE 4
Period of attendance at the semi-residential centre

Attendance at the semi-residential centre	%	(fq)
< 3 months	14.9	(10)
3-9 months	34.3	(23)
> 9 months	50.7	(34)
Total	100.0	(67)

No statistically significant differences emerged between males and females concerning the duration of the treatment ($\chi 2 = 2.15$, df=2, pexact = n.s.).

Approximately half the adolescents (49.3%) came to the semi-residential centre for 5-15 hours a week, 28.4% of them for less than 5 hours a week and 22.4% for more than 15 hours a week.

Their attendance at the semi-residential centre varied significantly as a function of gender in the sample considered ($\chi 2 = 11.88$, df=2, pexact= .002): most of the females attended the centre for less than 5 hours a week (47.4% of the females vs 20.8% of the males), or for more than 15 hours a week (36.8% of the females vs 16.7 of the males), while the majority of the males attended the centre for between 5 and 15 hours a week (62.5% of the males vs 15.8% of the females).

In 23.9% of the cases considered, there was an unscheduled interruption of the therapeutic project, within three months of joining the semi-residential centre in 14.9% of them; the difference between males and females was not significant ($\chi 2 = .09$, df=1, pexact =n.s.).

The type of therapeutic intervention for the majority of cases was of the integrated type (73.1%) with no differences between the genders ($\chi 2 = 1.34$, df=1, pexact =n.s.) (Table 5).

TABLE 5
Type of intervention

Type of intervention	%	(fq)
Mainly educational one	25.4	(17)
Multi-professional integrated	74.6	(50)
Total	100.0	(67)

In particular, the different psycho-educational therapy proposals are summarized in Table 6, where it is clear that in 41.8% of the cases a multi-professional integrated intervention (educational, psychological and pharmacological) was used, while an integrated educational and psychological intervention was applied in 28.4%, and a mainly educational-pedagogical type of intervention in 24.5%.

TABLE 6
Integration of the intervention

Integration of the intervention	%	(fq)
Educational	25.4	(17)
Educational and psychological	28.4	(19)
Educational and pharmacological	4.5	(3)
Educational, psychological and pharmacological	41.8	(28)
Total	100.0	(67)

No statistically significant differences emerged between males and females for the integration of the intervention ($\chi 2 = 2.63$, df=3, pexact =n.s.).

Going into more detail on the therapeutic project, as concerned the educator-adolescent-group relationship, there was a prevalence of individual interventions (65.7%) over group interventions (34.3%), with no significant differences between males and females ($\chi 2 = 2.07$, df=1, pexact =n.s.).

This can be explained in relation to the global usage of the service, characterized by cases of even severe psychiatric illness, for whom a dual relationship may be easier for the individual to tolerate and less risky from the point of view of any break down.

Discussion and Conclusions

This study aimed to give a picture of a multiprofessional approach to the adolescent's psychopathology. Where a semi-residential solution is available, the common qualifying elements are that the treatment must be temporary, not exclusive, oriented towards the patients' return to their communities and a switch to other solutions suited to their stage of development, in coordination with an integrated system of services. This

type of intervention demands a great commitment in terms of integrating the educational, rehabilitative and therapeutic aspects of the treatment: on the one hand because of 'heavy' psychopathological diagnosis (in the end, nearly half of our cases have diagnosis such as personality disorders, behavior disorders and comorbidity's ones); on the other hand because of the treatments' aims: helping patients' to remain in the social setting where they belong and thus stimulating the capabilities that they can subsequently use in their living environment, in their family group, in the places where they live, identifying the more socializing elements instead of the more severely impaired (in this sense the main type of intervention is an integrated one and the main goals of the intervention are about autonomy and socialization). In our experience the work done with the parents also has a fundamental part to play. Actually, unlike the diagnostic and therapeutic intervention with adults, daily clinical practice with adolescents who have psychological and behavioural disorders often demands parallel spaces for parents. This is based on the assumption that family characteristics strongly predict mental health in the developmental phase, making it increasingly necessary to use appropriate tools for investigating and supporting the role of parental figures in parallel with treatment for youths. Then, it is essential to identify a family's dysfunctional and functional characteristics in order to offer early and right interventions and to make parents act as a bridge to create access to the patient, to sustain him/her to go on with the therapy and to guarantee that the treatments are acceptable at family level.

Note

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