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Mental Health Analysis Profiles (MhAPs): Italy

Alessia Forti

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MENTAL HEALTH ANALYSIS PROFILES (MhAPs)
Italy

Alessia Forti

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ABSTRACT

As part of a wider project on mental health in OECD countries, a series of descriptive profiles have been prepared, intended to provide descriptive, easily comprehensible, highly informative accounts of the mental health systems of OECD countries. These profiles, entitled 'Mental Health Analysis Profiles' (MHAPs), will be able to inform discussion and reflection and provide an introduction to and a synthesised account of mental health in a given country. Each MHAP follows the same template, and whilst the MHAPs are stand-alone profiles, loose cross-country comparison using the MHAPs is possible and encouraged.

The recent history of mental health in Italy has been one of de-institutionalisation. The significant overhaul undertaken with regards to mental health over the last years is an example of this process: as it moved away from the century-long tradition of restrictive mental health asylums (*manicomi*) from the late 1970s with the recent process of closures of judicial psychiatric hospitals (*Ospedali Psichiatrici Giudiziari* – OPG), Italy progressively managed to integrate mental health services within community-based facilities. Focus was no longer on security and on isolating citizens suffering from mental disorders, but rather on patients' needs and moving towards social integration and rehabilitation.

RÉSUMÉ

Lancée dans le cadre d'un projet plus vaste consacré à la santé mentale dans les pays de l'OCDE, la série de profils « Santé mentale : profils d'analyse » (*Mental Health Analysis Profiles* - MHAP) vise à décrire de manière simple et détaillée les systèmes de santé mentale des pays de l'OCDE. Ces profils, qui étayeront les examens et les réflexions qui seront menés, feront le point sur la situation d'un pays donné dans le domaine de la santé mentale. Les profils MHAP sont indépendants les uns des autres mais suivent le même modèle : il est donc possible, et recommandé, de les utiliser pour procéder à des comparaisons entre pays.

L'histoire récente de la santé mentale en Italie a été marquée par la désinstitutionalisation, comme en témoignent les réformes importantes entreprises au cours des dernières années : en abandonnant peu à peu le placement traditionnel en hôpital psychiatrique (*manicomi*) à partir de la fin des années 1970 et en procédant depuis peu à la fermeture des hôpitaux psychiatriques judiciaires (*Ospedali Psichiatrici Giudiziari* - OPG), l'Italie est parvenue progressivement à intégrer des services de santé mentale dans les services de proximité. La priorité n'est plus accordée à la sécurité et à l'isolement des patients souffrant de troubles mentaux, mais plutôt aux besoins des patients, à leur insertion sociale et à leur réadaptation.

LIST OF ACRONYMS

AGENAS: National Agency for Regional Healthcare (*Agenzia per i Servizi Sanitari Regionali*)
AIFA: Italian Pharmaceutical Agency (*Agenzia Italiana del Farmaco*)
ASL: Local Health Authority (*Azienda Sanitaria Locale*)
CCM: National Centre for Prevention and Control of Diseases (*Centro Nazionale per la Prevenzione e il Controllo delle Malattie*)
CMHCs: Community Mental Health Centre (*Centro di Salute Mentale*)
CSP: South Verona community psychiatric service
CTOs: Compulsory Treatment Orders (*Trattamento Sanitario Obbligatorio*)
GHPU: General Hospital Psychiatric Unit (*Servizi Psichiatrici di Diagnosi Cura*)
ISFOL: Institute for the Development of Vocational Training (*Istituto per lo sviluppo della formazione professionale dei lavoratori*)
ISS: National Institute of Health (*Istituto Superiore di Sanità* ISS)
ISTAT: National Institute of Statistics (*Istituto Nazionale di Statistica*)
LEAs: Essential Levels of Assistance (*Livelli Essenziali di Assistenza*)
MEF: Ministry of the Economy and Finance (*Ministero dell'Economia e delle Finanze*)
MH: Ministry of Health (*Ministro della Salute*)
MSA: Ministry of Social Affairs (*Ministero del Lavoro e delle Poliche Sociali*)
NHC: National Health Council (*Consiglio Superiore di Sanità*)
NHS: National Health Service (*Servizio Sanitario Nazionale*)
OPG: Judiciary Psychiatric Hospital (*Ospedale Psichiatrico Giudiziario*)
RF: Residential facility (*Struttura residenziale)*.
SIEP: The Italian Society of Psychiatric Epidemiology *(Società Italiana di Epidemiologia Psichiatrica*)
SIS: Health Information System *(Sistema Informativo Sanitario*)
SISM: Mental Health Information System (*Sistema Informativo Salute Mentale*)
UNASAM: Italian National Union of Associations for Mental Health (*Unione Nazionale delle Associazioni per la Salute Mentale*)

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INTRODUCTION

1. This report is part of a series of descriptive profiles – Mental Health Analysis Profiles (MHAPs), produced by the OECD to give key insights into the mental health systems of select OECD countries. Following a set framework, these profiles give a detailed introduction to the history, mental health needs, and organisation and payment of care in select mental health systems. Countries have been selected so as to give an overview of different ways of approaching mental health care system organisation across the OECD, as well as to highlight examples of particularly innovative practice.

2. Having been one of the first countries to embark on the process of de-institutionalisation, Italy remains a world leader and a great innovator in care for mental disorders**.** Replacing psychiatric asylums with community-based services started in the 1960s and 1970s with the antipsychiatry movement led by Franco Basaglia, and was formalised with the adoption of Law 180 in 1978, and consolidated in 1999 with the actual closure of all mental hospitals in Italy. The Ministry of Health is committed to continuing to reducing the use of inpatient psychiatric treatment, and to shortening the length of stay in Residential Facilities, as part of the on-going de-institutionalisation process.

3. The federal organisation of Italy's health system, and mental health system, also makes Italy a particularly interesting example. The Federal system gives regions significant autonomy to organise, finance, deliver and monitor mental health services independently of central government, and to identify priorities in the mental health sector outside of a standardised national approach. As a consequence of this system, significant differences exist across regions in terms of the quality and quantity of mental health services, with examples of striking innovation and successful care delivery found alongside much less successful practices.

4. This report is designed to describe how mental health care is provided across the Italian population, from service provision for children and young people to available mental health care for older people. Attention is also paid to any groups in the population who may have difficulties accessing appropriate mental health care, for example minority ethnic groups. The report begins with a short history of the evolution of the Italian mental health system alongside a summary of the mental health characteristics of the population. The report goes on to describe the design of the Italian mental health system, recent mental health policy and legislation and a detailed examination of the mental health services and financing in the country. Examples of national, regional and local mental health initiatives and group-specific programmes are also explored.

1. MENTAL HEALTH HISTORY, LEGISLATION AND HUMAN RIGHTS

1.1. History and development of the mental health system

5. Stemming back to well before the unification of Italy in 1861, the mental health system was fragmented into numerous mental health facilities and lacked unified regulation. Despite the contribution of the Italian physician Vincenzo Chiarugi (1759-1820), who drew up the regulations of the S. Bonifacio Hospital in Florence (1789) (Burti, 2001), the first steps towards a more regulated mental health system occurred only at the beginning of the 20th century. As a result of the increasing number of people suffering from some kind of mental disorder and seeking admission to mental hospitals, in 1901 a committee of provincial councillors headed by Professor Belmondo was appointed by the provincial deputation of Venice in order to inspect the region's mental health facilities. At the time of the inspection, there was still no legislation regulating and unifying the variety of mental health facilities in the territory. Provincial asylums, charitable institutions, hospital wards devoted to mental health and private asylums constituted the spectrum of mental health services offered by localities, although substantial differences existed across the regions. Management responsibilities differed significantly across asylums, with cases where physician directors were given full health and administrative powers and other cases where they retained no major responsibilities over expenses and financing. Common to all services were shortages of medical and nursing staff, insufficient food provisions for inpatients, a lack of adequate hygienic conditions, the use of brutal means of restraint and overcrowded facilities due to increasing inpatient admissions coupled with decreasing discharge rates. The evaluation report that followed the inspection triggered questioning within provincial councils, with substantial changes being promptly introduced: the harshest means of restraint were abolished, health care personnel were replaced and some of the serving asylum directors were relieved of duty (Babini, 2009).

6. This restructuring process culminated in the adoption in 1904 of a mental health bill by the Government, then headed by Prime Minister Giolitti. The Law 36 of 1904 ("Provisions on Public and Private Mental Hospitals") was the first mental health law in Italy aiming to regulate the development and management of mental health facilities. The law gave psychiatrists full authority over the management and administration of mental health services, including disciplinary and enforcement responsibilities. Nevertheless, Law 36 was mainly centred on social control measures rather than on patients' health needs. Being labelled a danger to themselves and others, patients were committed against their will by physicians and police magistrates. These compulsory admissions could be ruled as permanent by a court of justice, and led to the loss of civil and political rights (Lo Scalzo *et al.,* 2009). In 1880, Enrico Morselli, an illustrious Italian psychiatrist, had already highlighted the tricky nature of the mental health asylum institution, which stems from its dual purpose of healing mentally disordered people whilst protecting society from potential harm. Only with the adoption of Law 180 in 1978 and the progressive closure of mental health hospitals in Italy did mental health treatment and social security embark on two clearly distinct paths. The conditions that led to the development, approval and implementation of Law 180 have to be sought in the years between 1904 and 1978.

7. In most European countries, the period between the First and Second World Wars saw the development of somatic therapies mainly used for the treatment of schizophrenic patients, namely shock therapies, *e.g.* insulin shock (Sakel in Austria 1933), cardiazolic shock (1935), psychosurgery (Moniz in Portugal; Fiamberti in Italy, 1935), acetylcholine shock (1937) and finally electroshock (Cerletti in Italy, 1938) (Babini, 2009). In the aftermath of the two world wars, these therapies became a valid and

inexpensive means of control over mentally disordered patients. The development of the first psychiatric drugs from 1951 onwards in Italy and in other Western countries significantly transformed the approach to patients' mental health care and the way mental hospitals were managed. On the one hand, the use of psychotropic pharmaceuticals substantially changed the relationship between patients and nurses, whose tasks passed from control, restraint and coercion to assistance and education. On the other hand, this dramatically transformed the relationship between patients and psychiatrists, allowing medical staff to adopt forms of therapy, including psychotherapy, other than shock therapies and restraint measures.

8. Running in parallel with the development of psychotropic drugs was the revision of mental health legislation in most Western countries. *e.g.* Portugal (1945), Norway (1949), Sweden (1949), England (1948-1959), United States (1951), France (1953-1954) and Germany (1952). In Italy, even though many proposals for the renovation of mental health legislation were introduced, ultimately they were never adopted by the Parliament.

9. However, in 1962 the Ministry of Health published "The Annals of Public Health" (*Annali della Sanità Pubblica*), a report devoted entirely to a description of Italy's mental health system. The outcomes of the investigation revealed serious deficiencies within the provision of mental health services across the country: a complete absence of any type of mental health facility in some regions; major differences in terms of provision from region to region, with northern Italy being significantly more equipped than the south; shortages in psychiatric bed provision; and insufficient availability of medical and nurse mental health staff (Babini, 2009).

10. As it became increasingly apparent that Law 36 was anachronistic, some initial experiments with mental health institutions were conducted in the 1960s. The state mental hospital of Gorizia (Friuli-Venezia-Giulia) headed by Franco Basaglia, a psychiatrist with a phenomenological orientation, was the first example of the progressive de-institutionalisation process that later unfolded in other mental health asylums across Italy. Psychiatric wards were progressively opened, allowing patients more freedom to circulate both in the hospital and the municipality; excessively restrictive measures were abandoned (Burti, 2001); contact between physicians and patients was encouraged and strengthened; several activity clubs, an internal journal named "Il Picchio", as well as domestic "committees" integrating patients in the management process of the asylum were established; medical uniforms were abolished. For the first time in the history of mental health in Italy, even patients suffering from the most serious disorders were entrusted with responsibilities within the hospital (Basaglia, 1968). In addition, the Gorizia mental health institution implemented a vast programme of discharge. Far from being an isolated event, the Gorizia pilot trial served as an example for the development of similar experiments in democratisation and de-institutionalisation across state mental health hospitals in Italy, *e.g.* Perugia (1965), Parma (1965), Cividale del Friuli (1968) and Nocera Superiore (1969) (Babini, 2009). Overall the Gorizia experiment contributed to eradicating the belief that mentally disordered individuals were dangerous for the society and led to replacing old-fashioned custodial care with alternative community care (Transella, 1986).

11. In 1968, the Minister of Health, Luigi Mariotti, after comparing mental health asylums to concentration camps ("*Manicomi come lager*") (Babini, 2009), approved the law excerpt n. 431 (otherwise called the Mariotti Law), which made some substantial changes to the 1904 Law. Law excerpt 431 allowed for voluntary hospitalisation in mental health hospitals that did not entail the loss of political and civil rights; it eliminated the inscription of mentally disordered people onto criminal records (as established by the Rocco Code under the Government of Mussolini), a formal stigma preventing mentally disordered individuals for accessing public jobs once released from the asylum.

12. The years following the adoption of law 431 in 1968 saw the growth of the anti-psychiatry movement, a political and cultural movement some of whose major exponents included, amongst others, Michel Foucault in France, R.D. Laing in Scotland, Thomas Szasz in Hungary and Franco Basaglia in

Italy. Mistrusting the attribution of mental illness to its biological components, the anti-psychiatry movement claimed that the origin of mental disorders had to be sought in political, family, social and relational roots, and subsequently criticised the the use of contention to deal with mental health disordered individuals (Bersani, 2009). Concretely, the movement aimed at creating two-way streets between the mental health system and the broader community, establishing social cooperatives by joining forces with other citizens' groups, and working toward community inclusion on a person-by-person basis (Davidson *et al.,* 2010). Designed like this, the process involves all its subjects as active participants, transforms the power relationship existing between the patient (and citizen) and the institution, and creates mental health services that completely replace detention in mental hospitals by deconstructing them and reconverting the material and human resources found in them (De Leonardis *et al.,* 1986). In the wake of the Gorizia experiment and with the impetus of the anti-psychiatry protest, other mental health asylums started following the Gorizia example. One of the most representative instances of the anti-psychiatry movement was the mental hospital of San Giovanni, based in Trieste and headed by Franco Basaglia (see Box 1).

Box 1. San Giovanni psychiatric hospital in Trieste

The San Giovanni psychiatric hospital was built in 1908 in Trieste. In Italy at that time, the San Giovanni psychiatric hospital was considered an exemplary model of mental health asylum, but from the 1930s security measures were introduced. In 1971, the then president of the provincial administration, the left-wing Christian Democrat Michele Zanetti appointed Franco Basaglia director of the San Giovanni asylum, with the idea of renovating psychiatric care, requalifying the medical and nurse personnel and raising funds for the psychiatric hospital. As director of the San Giovanni hospital, which at that time hosted approximately 1200 inpatients, 90% of whom were mandatory, Basaglia started a process of criticism of the mental health institution (Dell'Acqua, 2010).

As soon as Basaglia became the director of the asylum, the Mariotti Law was implemented in the hospital, with the aim of increasing and strengthening the medical personnel. Basaglia preferred to train young physicians rather than hiring psychiatrists already active in other mental health asylums. Together with nurses and future psychiatrists, a large number of volunteers, including students and workers, were also integrated into the asylum's community life. Volunteers actively participated in the hospital's decision-making process, contributed to organising activities for inpatients and followed patients on an individual basis. Even patients suffering from severe mental health disorders were entrusted with responsibilities within the hospital. It was a patient who used to swallow every type of metallic object, provoking serious injuries to his person, to whom Basaglia gave managing responsibilities over the coffee bar within the hospital; and a group of women were allowed to conduct autonomous lives in the apartment that was previously used by the asylum's director (Basaglia, 1968).

As in the Gorizia experiment, constraint measures were abolished, the use of electroshock was suppressed, the barriers enclosing the wards were removed and the hospital doors and gates opened. In 1972, a programme of financial subsidies was launched. Grants were assigned to former patients who were unemployed in order to avoid renewed hospitalisation and to escape the vicious cycle binding poverty with seclusion. At the beginning of 1973, Art. 4 of the Mariotti law was implemented within the hospital, according to which voluntary admissions allowed a patient (the "host") to be hospitalised without losing civil and political rights.

Running in parallel to this vast range of democratisation and de-institutionalisation was the idea that further initiatives should be undertaken in order to look beyond the asylum walls and towards the community, by putting in contact "sane" people living in the city with "mentally ill" patients living in the hospital. A group of patients started to increasingly participate in parties and activities within the city of Trieste. On February 1973, a blue-painted horse of paper-machè and wood, called "Marco Cavallo", together with a long procession of patients, physicians, nurses and health workers, paraded the streets of Trieste. The wooden horse was built by the patients in the course of a painting/sculpture/theatre/writing workshop within the hospital, and the name "Marco Cavallo" was adopted in honour of the horse that for years had been transporting the patient's linen from the hospital to the laundry. "Marco Cavallo" became the symbol of the process of liberation of inpatients, bringing the mentally disordered people into the social life of Trieste.

In September 1973, the United Workers Cooperative (*Cooperativa dei Lavoratori Uniti*), composed of San Giovanni inpatients, was legally recognised. The members of the Cooperative were given a paid contract for the cleaning and maintenance of the hospital, putting an end to the use of occupational therapy within the hospital.

Following these developments at the San Giovanni hospital, in October 1973 the WHO declared Trieste a "pilot zone" for psychiatry (Babini, 2009). The de-institutionalisation process culminated with the opening of the first community-based mental health centres in areas surrounding the San Giovanni hospital in 1975-1976, actually shifting the axis of mental health care from the hospital to the community (Dell'Acqua, 2010). Following the inception of Law 180 in 1978, the hospital of Trieste was closed in 1980. The San Giovanni mental health hospital of Trieste was the first hospital that has been closed in Italy, paving the way for the de-institutionalisation of mental patients and the establishment of an alternative model of community-based services, performing all the functions and providing all the services that were previously provided by asylums (Russo & Carelli, 2009).

"[...] *the important thing is that we have shown that the impossible becomes possible. Ten, fifteen, twenty years ago, it was unthinkable that an asylum could be dismantled. Asylums could become closed, and more closed than before – I do not know – but, at any account, we have shown that the mad can be assisted in another way, and this evidence is basic"* (Basaglia, 1979).

13. In 1978, Law 180 (also called Law Basaglia) was approved, with the mental hospital of Trieste being the first asylum to be closed in Italy. Law 180 in fact forbade new admissions to mental health institutes and the construction of new mental hospitals. Law 180 aimed at progressively closing existing mental hospitals, thus operating a translation from old mental health facilities, isolated from other health departments, to new fully integrated psychiatric services. Prevention, care and rehabilitation represented an important new feature of the 1978 law, in place of the aforementioned restrictive social control measures, with the new mental health facilities being in charge of the full array of mental health care, *i.e.* providing appropriate care to patients through community-based services, outpatient interventions and/or exceptional and temporary compulsory admissions (Lo Scalzo, 2009). Law 180 represented undisputed progress towards de-institutionalisation in Italy and abroad, and led to the progressive closure of mental health hospitals, the recognition of civil rights for people suffering from some kind of mental disorder, the transformation of the century-long relationship between psychiatry and justice, and the establishment of a variety of community-based mental health facilities within the territory. The inception of the de-institutionalisation of mental health in Italy also coincided with the creation of the National Health Service (NHS) (*Servizio Sanitario Nazionale* - SSN) in 1978.

14. This transition from old-style mental hospitals to new community-based facilities was, however, a slow process, with the 1978 law failing to design a precise framework and timeline for this transition and with all mental health hospitals being eventually closed only in 1999 (WHO, 2011) (for further information on the closure of mental hospitals, see Box 2).

Box 2. The process of closure of mental hospitals

There are currently no mental hospitals in Italy, as all of them have progressively been replaced by the Departments of Mental Health (DMHs) (*Dipartimento di Salute Mentale* –DSM) and a set of mental health services and facilities including Community Mental Health Centres (CMHCs)**, the** General Hospital Psychiatric Units (GHPU), semi-residential facilities and residential facilities (Ministry of Health, 2011c; Ministry of Health, 2011d).

Before the de-institutionalisation process brought about by Law 180, in 1978 there were 76 mental hospitals in Italy with a total of 78 538 mental health residents (De Girolamo *et al.,* 2007a). Law 180 enforced the compulsory closure of all existing mental hospitals and the discharge of all patients committed to asylums. Further legislation established the Department of Mental Health as the community-based service in charge of mental health care in each Local Health Authority (ASL), and thus devolved care for mental illness to ASLs. This was, however, a slow and difficult process, as precise guidelines for the transition from asylums to community-based facilities were not provided in Law 180. The financial law 724 of 1994 established a deadline for the final closure of all former mental health hospitals (December 31st 1996). A committee for monitoring the progressive closure of mental hospitals was appointed, but the process was nonetheless gradual and slow. Other financial laws in 1996 (Law 662) and 1997 (Law 449) reaffirmed the necessity of the planned closure of mental hospitals, a task that was eventually postponed until 1998 and finally completed in 1999 (Lo Scalzo *et al.,* 2009).

15. A set of two mental health national plans implemented in 1994 and 1998 further specified guidelines for service organisation, personnel training and transitional supervision (Ministry of Health, 1994; Ministry of Health, 2008a). A number of initiatives for monitoring the process were also promoted by the Ministry of Health and offered support to the regions to complete the transition.

16. The first Targeted Mental Health Care Plan (*Progetto Obiettivo per la Tutela della Salute Mentale* 1994-1996) (Ministry of Health, 1994) was implemented in the mid-1990s and created the Department of Mental Health (DMH), a network of mental health services responsible for mental health interventions and planning in each Local Health Authority. Guidelines on training personnel were defined and the final closure of old mental institutions was planned, but completed only in 1999.

17. A second national plan for mental health was then adopted for the period 1998-2000 in order to further define guidelines for residential facilities, which were to provide services for the last patients still committed in the old mental institutions, and for health interventions, social integration and rehabilitation. In this respect, the Targeted Mental Health Care Plan 1998-2000 (*Progetto Obiettivo Tutela Salute Mentale 1998-2000*) (Ministry of Health, 1998a) focused mainly on providing for better integration of existing mental health services (Burti, 2001) and for quality of care. The Targeted Mental Health Care Plan 1998-2000 aims at designing coverage for people affected by severe mental disorders and thus unable to live autonomously or exercise fully their citizenship rights. This population constitutes the core of priority health interventions that must be undertaken with the full cooperation and collaboration of mental health services, families and associations. The goals of the Targeted Mental Health Care Plan 1998-2000 were:

- To promote mental health in throughout the life cycle, even in the heart of medical prevention programmes and health education programmes;
- To prevent mental disorders at primary and secondary levels, with particular focus on high-risk sub-populations through the early mapping of difficult situations (especially among young people) and therapeutic-preventive interventions;
- To prevent mental disorders in public health, *i.e.* effectively decreasing disabling consequences via the reconstruction of personal, relational and social interconnections for people with severe mental disorders (with a focus on rehabilitation through work). This reconstructive mission takes place through resource activation;
- To maintain mental health and quality of life within the family nucleus to acceptable levels, improving the global functioning of family nuclei with serious relational issues, reducing the figures on suicide and attempted suicide in high-risk populations (*i.e.* specific mental pathologies or age-groups, like adolescents and seniors);
- To achieve better integration of mental health services with other services (universities, local administrations, non-profit organisations, etc.) and encourage participation of non-public actors (user and family associations);
- To promote better and more comprehensive information for patients and families, along with evidence-based medicine, standards for the certification of services and quality assurance;
- To evaluate the efficacy and effectiveness of interventions;
- To reorganise the delivery system of mental health services for children and adolescents.

18. Strategies to attain these goals aimed at specifying the organisation of the mental health services, since prior legislation had failed to do so. The Targeted Mental Health Care Plan 1998-2000 set out the characteristics of the Departments of Mental Health (DMHs) (*Dipartimento Salute Mentale* – DSM) that resulted from the first national plan for mental health for the period 1994-1998. In particular, the 1998-2000 Targeted Mental Health Care Plan stated that each of the then 196 Local Health Authorities in Italy should have its own Department of Mental Health, with coverage of a population of at most 150 000 inhabitants. There should be one Director for each DMH, in charge of managing the human and financial resources allocated to the module, organising a Monitoring and Evaluation System, and contributing to the promotion of quality assurance and the provision of ongoing personnel training. There should be an average ratio of one Department of Mental Health professional for every 1 500 inhabitants. Moreover, the Targeted Mental Health Care Plan 1998-2000 specified the functions of each mental health service provided by the Department of Mental Health (Ministry of Health, 1998a) (for further information on mental health services provided by DMHs, see section 4.1.).

19. A new policy document, the National Strategic Plan for Mental Health (*Linee di indirizzo nazionali per la salute mentale*) (Ministry of Health, 2008a), was issued in March 2008, with the approval of the Standing Conference on the Relations between the State, the Regions and the Autonomous Provinces (hereafter the Standing Conference between State and Regions) (*Conferenza Stato/Regioni*). This document updated the priorities and underlined the critical areas where intervention was required, especially concerning the Departments of Mental Health and the necessity to homogenise their services across the territory. Local and regional collaboration are also pointed out as key elements for improving equity of access to mental health services and overall quality, with the Departments of Mental Health being responsible for organising consultation roundtables (*tavolo di concertazione locale*) on priority objectives. The Local Health Authorities also were required to be equipped with their own Local Plan for Mental Health (*Piano di Azione Locale per la Salute Mentale*) obtained through consultation with all local actors. However, at the moment only a few regions have formally included the 2008 National Strategic Plan for Mental Health into their regional planning.

20. The last national mental health strategy was released in January 2013 – the Italian Mental Health Action Plan (IMHAP) (*Linee di Azioni Nazionale per la Salute Mentale*) (Ministry of Health, 2013) (see section 6.2 for further information).

21. Although the core of mental health strategies are settled within national mental health plans, every two years a National Health Plan (*Piano Sanitario Nazionale*) is released by the Ministry of Health with a special section devoted to mental health as a priority area – as did, for example, the National Health Plan 2006-2008 (Ministry of Health, 2006). The plan individuated the weaknesses of the mental health system in Italy and identified the priority areas for joint focus by the Government and regions. Overall staff shortages and the need to manage deficiencies in the Departments of Mental Health (DMHs) resulted in an inability to provide adequate services for individuals with mental illness; the general population is unaware of the meaning of mental illness; there is little knowledge about the existence of mental health facilities and how they work; and there is a general lack of early intervention in severe mental health cases. The overall goals of the 2006 National Health Plan were:

- Reducing stigma;
- Actuating early intervention programmes for the treatment of schizophrenia;
- Guaranteeing therapeutic continuity between mental health services for children, adolescents, adults and older people;
- Establishing recovery and reintegration programmes for mentally disordered offenders;

- Developing a National Mental Health Information System.

22. The last release of the National Health Plan covered the period 2011-2013 (*Piano Sanitario Nazionale 2011-2013*) (Ministry of Health, 2011a). At the time of writing, this last release is still in draft form. In the section devoted to mental health, some key areas were pinpointed:

- Children and adolescents' mental health;
- Old people's mental health;
- Suicides;
- Mental disorders related to substance abuse;
- Mental health within prisons and security services;
- The physical well-being of mentally disordered individuals.

Table 1 provides a list of all mental health strategies and plans in Italy.

Table 1. Mental health strategies or plans

Mental health strategy or plan	Years	Major priorities
Targeted Mental Health Care Plan (*Progetto per la Tutela della Salute Mentale 1994-1996*)	1994-1996	• Creation of Departments of Mental Health (DMHs) (Dipartimento Salute Mentale – DSM) • Planning the final closure of mental health hospitals
Targeted Mental Health Care Plan (*Progetto per la Tutela della Salute Mentale 1998-2000*)	1998-2000	• Definition of structural, technological and quality standards of new community mental health facilities to replace mental health hospitals
National Strategic Plan for Mental Health (*Linee di indirizzo nazionali per la salute mentale*)	2008	• Increasing collaboration between local and Regional governments • Homogenisation of DMHs' services across the territory
Italian Mental Health Action Plan (IMHAP) (*Piano di azioni nazionale sulla salute mentale*)	2013	• Early interventions • Mild to moderate mental disorders • Severe mental disorders • Children and adolescents' mental health

1.2. Mental health legislation

23. Italy's mental health legislation comprises one national law on the principles of mental health provision, twenty separate regional laws and separate legislation from two autonomous Provinces, consistent with the fact that the planning, management and administration of health services are constitutionally devolved to the regions.

24. National Mental Health Law 180/1978: The national law on mental health, Law 180 (or Law Basaglia), was approved on 13 May 1978. From 1978, the broad national law has remained unchanged, whereas regional laws have been revised several times.

25. The 1978 national law on mental health covered four principal elements:

- The immediately effective ban on new admissions to existing mental hospitals and on the building of new mental hospitals or similar facilities; a planned gradual closure of existing mental hospitals;

- The establishment of psychiatric wards within general hospitals, with a maximum of 15 beds each;

- The promotion of community-based services – Community-based Mental Health Centres – put in charge of the full array of mental health needs in the community (prevention, care and rehabilitation);

- The establishment of the CTO, the Compulsory Treatment Orders (*Trattamento Sanitario Obbligatorio*, TSO), which asserted that compulsory admissions for mental illness would focus on patients' health needs and should be temporary, exceptional and highly monitored by medical staff and a court of Justice (see below).

26. Law 180 was incorporated as Articles 33, 34, 35 and 64 into Law 833 of 31 December 1978 (hereafter, Law 833/1978). Law 833/1978 reformed Italy's entire health system.

27. Art. 33-35 of Law 833/1978: The Compulsory Treatment Order (CTO) (*Trattamento Sanitario Obbligatorio* – TSO) was introduced with Law 180 and is currently regulated by Law 833/1978 (Art.33-35). It covers carrying out assessments and providing treatments to mentally disordered individuals who refuse to be treated. There are three major conditions under which the CTO could apply: the person is affected by some kind of mental health illness and subsequently needs urgent medical treatment; the person refuses to be treated; besides hospitalisation, there is no other timely and appropriate measure that could be undertaken to treat the person. The implementation of a CTO occurs both at the medical and judicial level: after two medical doctors make a formal request to the relevant Local Health Authority for the patient to receive the CTO, the mayor of the city (*Sindaco*) approves or denies it within 10 days from the referral. Though extendable, the CTO has a maximum duration of seven days (see section 1.2. on seclusion and restraint).

28. Law 68/1999: Law 68 on the right to work for people with disabilities (*Norme per il Diritto al Lavoro dei Disabili*) implemented a system of integration into the employment market. This legislation triggered a significant change, as Law 482 of 1968 focused mainly on a charitable philosophy that did not allow disabled people to feel integrated into the employment market and entitled to a proper wage for their work. In this respect, Law 68 focused on matching the work potentialities of disabled people with a work position, while not putting an additional burden on the firms concerned. This legislation was adopted after several trials were conducted in some Local Health Authorities in the Northern regions, as professional training and work integration were devolved to the regions and local authorities.

29. Law 67/2006: "Measures for the safeguard of disabled people who are victims of discrimination" (*Misure per la tutela giudiziaria delle persone con disabilità vittime di discriminazioni*) is a legal framework aiming to protect the civil and political and economic rights of disabled individuals and protect them from stigma and discrimination.

30. Prime Ministerial Decree/2008 (*Decreto Presidente del Consiglio dei Ministri* – DPCM): approved on 1 April 2008, the 2008 DPCM requires the eventual transfer of health care responsibilities from the prison service (Department of prison administration; Department of Juvenile Justice) to the NHS. The Prime Ministerial Decree/2008 specifies which clinical-rehabilitative interventions should be

considered health interventions to be provided and monitored by the Ministry of Health and which ones were security measures that were to remain under the responsibility of the Ministry of Justice. It also reaffirmed that care and mental health interventions were provided through territorial and regional bodies, as was first implemented by Law 180 for civil psychiatry (see section 4.3. for further information).

31. Decree of 15 October 2010: Most recently, the decree of 15 October 2010 made way for the implementation of the long-awaited national Mental Health Information System (*Sistema Informativo Salute Mentale* - SISM) in order to ensure the viability of the Essential Levels of Assistance (*Levelli Essenziali di Assistenza* - LEA) and especially to:

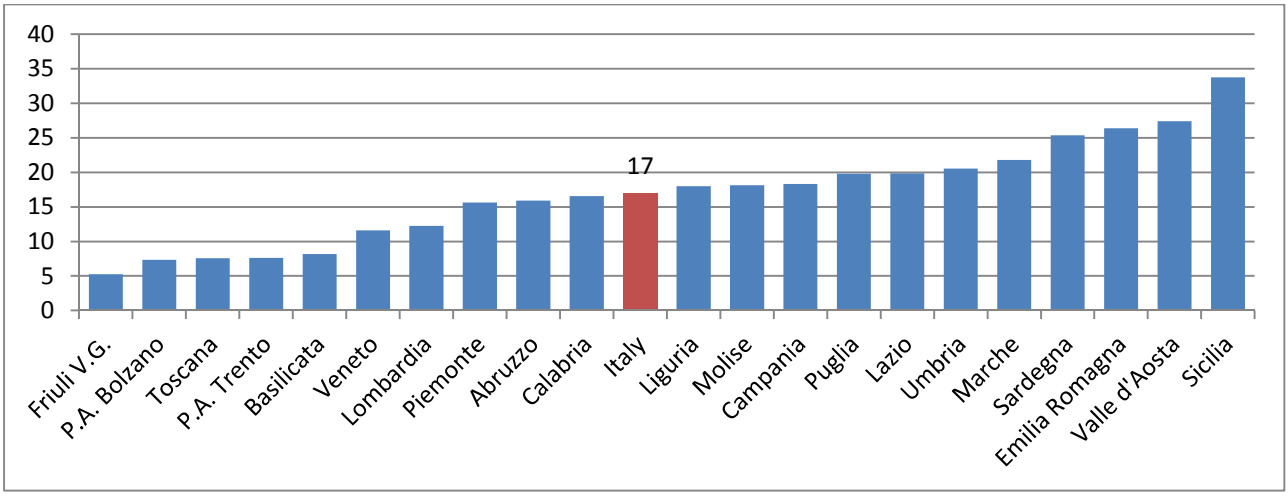
- Monitor the activity of mental health services and analyse their volume and treatment patterns;
- Support the managerial activity of the Departments of Mental Health, in order to evaluate their efficiency and utilisation of resources;
- Support the process of elaborating structural indicators on both regional and national levels.

(For further information on the mental health information system see section 3.5.).

Detainment, restraint and seclusion rates

32. CTOs accounted for 50% of total admissions in 1975 (3 years before the introduction of Law 180), whilst the figure dropped to 20% in 1984 and to approximately 14% in recent years (De Girolamo *et al.,* 2006a). CTOs (as a percentage of total psychiatric discharges) have increased slightly across the period 2005-2008, from 14.16% of total psychiatric discharges in 2005 to 14.55% in 2008 (ISTAT, 2011). In regions where public beds are scarce (Sicilia, Valle d'Aosta, Emilia Romagna and Sardegna), CTOs are twice as frequent as in other regions (De Girolamo *et al.,* 2006a; Ministry of Health, 2011b) (see Figure 1).

Figure 1. CTOs discharge rates per 100 000 population, by region – 2010



Source: Ministry of Health (2011b). Rapporto annuale sull'attivita di ricovero ospedaliero. Dati SDO 2010. [Annual Report on hospitalisation activities]. Ministry of Health, Directorate General for Planning, Office IV, 2011.

2. POPULATION CHARACTERISTICS

2.1. Prevalence of mental ill health across the population

33. The WHO Global Burden of Disease Project estimated that, in Italy in 2001, 2 978 DALYs[1] per 100 000 population are ascribable to neuropsychiatric disorders, representing approximately 25% of the overall burden of disease in Italy. In 2001, depression represented 7% of the total burden, substance abuse accounted for 5% (with alcohol use disorders representing 3% and drug use disorders 2%) and dementia 4%. Bipolar disorder, schizophrenia, obsessive-compulsive disorder and panic disorder each represented 1% of the total burden in Italy (Lopez *et al.,* 2006).

Prevalence of mild to moderate mental ill health

34. Two main mental health epidemiology studies were conducted in Italy over the last ten years: the "European Study on the Epidemiology of Mental Disorders" (ESEMeD) (Alonso *et al.,* 2003; De Girolamo *et al.,* 2006a; De Girolamo *et al.,* 2006b) and the Sesto Fiorentino Study (Faravelli *et al.,* 2004). Other epidemiology studies were conducted by the National Institute of Statistics (ISTAT, 2010) and the National Institute of Health (ISS, 2012a).

35. The ESEMeD is an international mental health survey of six countries (France, Germany, Belgium, Italy, Spain and Holland) conducted by the WHO in 2001-2002 (Alonso *et al.,* 2003). Managed by the National Institute of Health (*Istituto Superiore di Sanità* – ISS) and conducted among 4 712 Italian citizens, the survey found that the annual prevalence of mild to moderate mental illness was 7.3% in Italy in 2001 (De Girolamo *et al.,* 2006a).

36. Major depression, specific phobias and dysthymia (chronic depression) were the most common mental illnesses, with a lifetime prevalence in Italy of respectively 10.1%, 5.7% and 3.4%. Post-traumatic disorder, social phobia and general anxiety disorders had a lifetime prevalence of approximately 2%. Other mental illnesses covered by the survey (panic attacks, agoraphobia and alcoholism) had a relatively low prevalence (below 2%) (De Girolamo *et al.,* 2006a). Women presented a higher risk of exposure to mental disorders, although alcohol use disorders were more common among men. High-risk populations included separated/divorced people and widowers, along with unemployed people (twice as likely to suffer from depression), housewives (twice as likely to suffer from any kind of mental disorder) and physically disabled people (eight times as likely to suffer from mental disorders). Moreover, the ESEMeD study gave evidence that people are likely to suffer from different mental disorders at the same time (co-morbidity). About 40% of people who suffered from depression in the considered year also experienced anxiety disorders, and 27% of people who suffered from anxiety disorders also suffered from depression. Although the statistical significance is questionable, the ESEMeD study also found that the prevalence of mental illness (especially depression and anxiety disorders) was higher in Southern Italy and the Islands (Sicilia and Sardegna) than in Northern and Central Italy (De Girolamo *et al.,* 2006a).

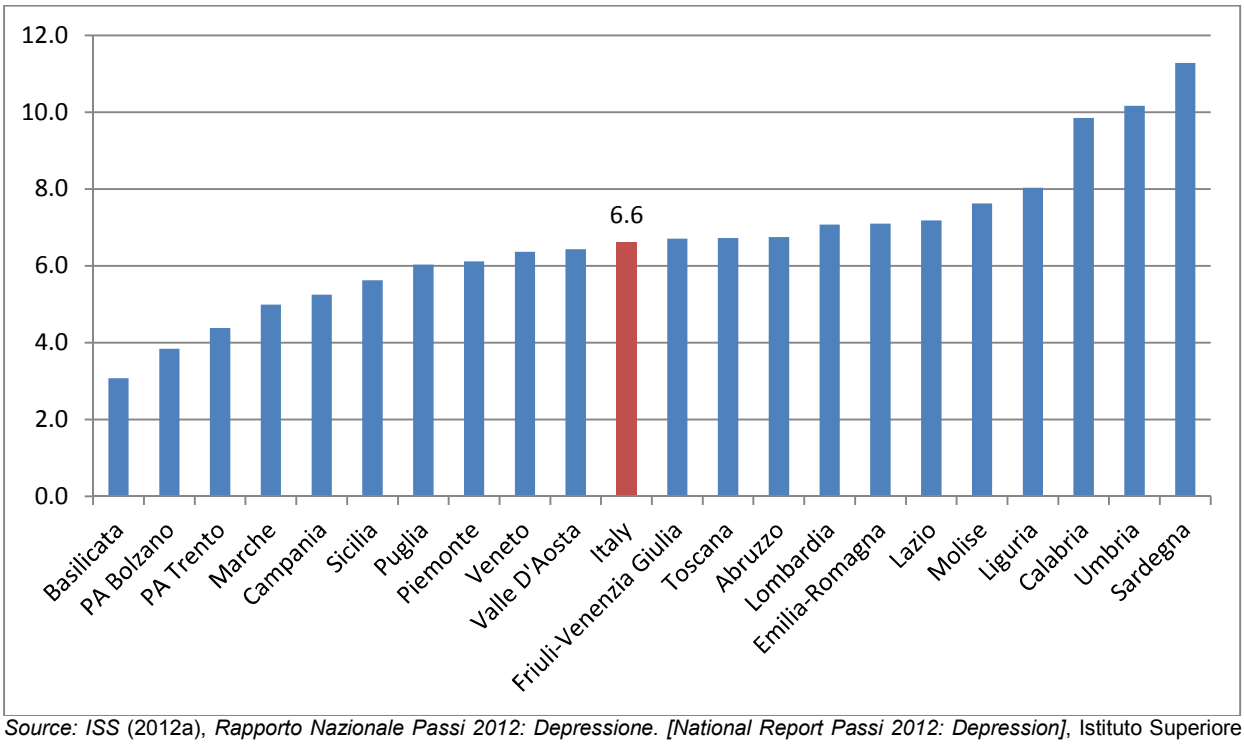
37. The second epidemiological study was conducted over 2 363 residents in Sesto Fiorentino (Toscana), and reported that 8.6% of people were suffering from some kind of mental illness, with anxiety (3.5%) and depression (3.4%) being the most frequent type (Faravelli *et al.,* 2004).

[1] "Disability-adjusted life years" (DALY) is a measure of the population's health that combines into a single indicator the "*years of life lost due to premature mortality and the years of life lost due to time lived in states of less than full health*" (WHO).

38. More recently, ISTAT published data on mental health prevalence indicating that 4.3% of the total population suffers from some kind of "neurosis", whilst the figure is more than double (9.8%) for people aged over 65 (ISTAT, 2010).

39. According to a national survey conducted by the Cnesps of the National Institute of Health (*Istituto Superiore di Sanità* – ISS) over a pool of Local Health Authorities in Italy (85% of all ASLs) in the period 2009-2012, 6.6% of people (adults aged 18-64) referred with probable symptoms of depression (see below), although differences exist across regions (see Figure 2). Of these individuals, 58.2% sought some kind of help: 32.5% consulted a doctor (GP or specialist), 18.2% turned to their family and 7.5% asked for help from both a doctor and their family, whilst the remaining 41.8% did not seek any help *(ISS, 2012a*). The instrument used to screen for depression symptoms was the Patient Health Questionnaire-2 (Phq-2). The purpose of the Phq-2 is not to establish a final diagnosis or to monitor the severity of symptoms, but rather to individuate people with probable symptoms of depression to be referred to mental health specialist services (Kroenke *et al.,* 2003).

Figure 2. Percentage of people living with probable symptoms of depression, by region – 2009-2012

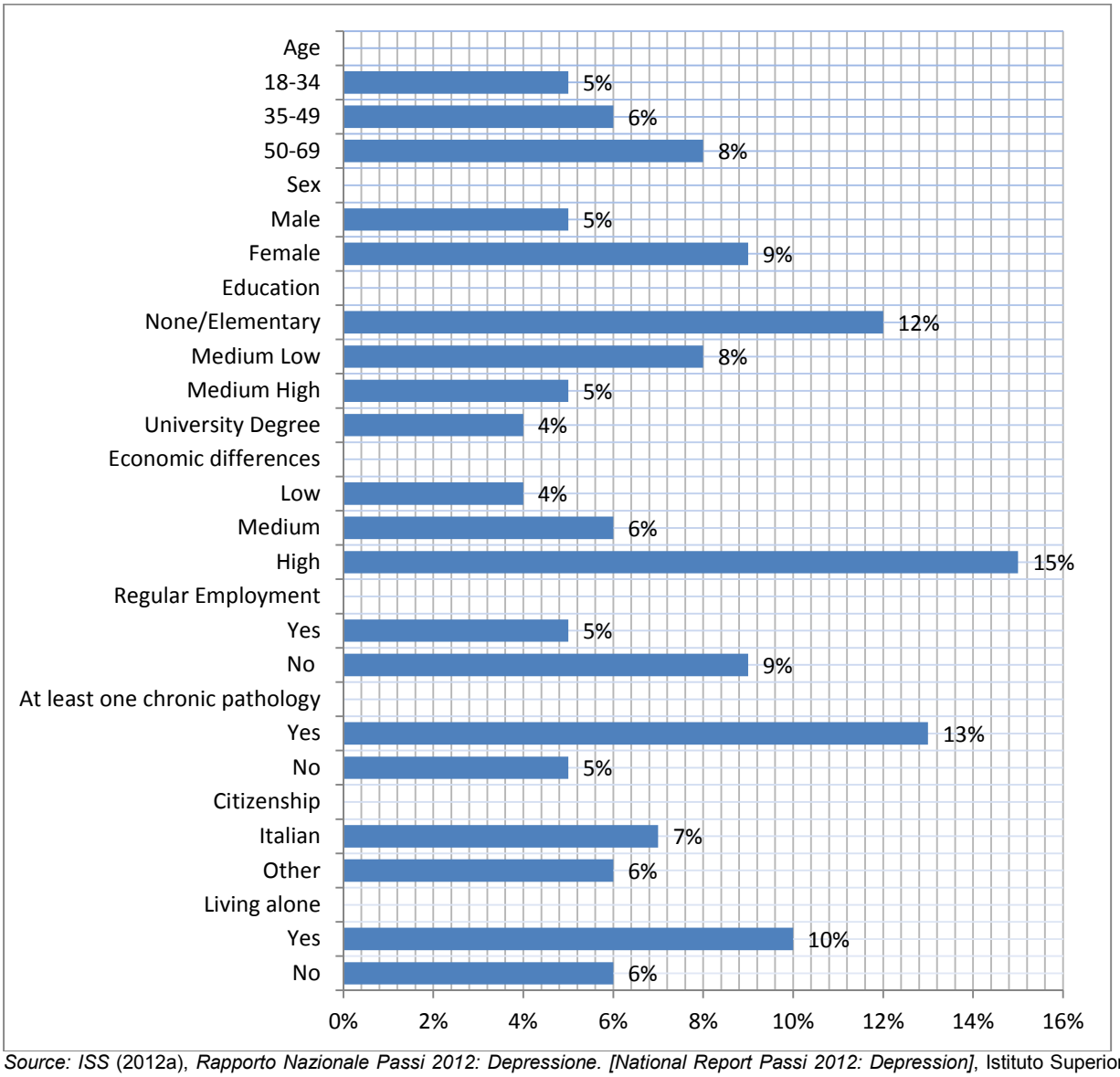


Source: ISS (2012a), *Rapporto Nazionale Passi 2012: Depressione. [National Report Passi 2012: Depression]*, Istituto Superiore di Sanità (ISS), Il Centro Nazionale di Epidemiologia, Sorveglianza e Promozione della Salute (CNESPS), Progetto Progressi delle aziende sanitarie per la salute in Italia (Passi). [Online] Available http://www.epicentro.iss.it/passi/rapporto2012/depressione.asp Accessed 06/11/2013.

40. The CNESPS-ISS study showed that the frequency of symptoms of depression increases with age, and in general women, people with a low level of education, people with lower incomes, individuals with no regular employment, people suffering from at least one chronic pathology (ictus, cardiovascular diseases, cancer, diabetes, respiratory diseases and chronic liver illness), and people living alone are more likely to show symptoms of depression (see Figure 3), as are Italian citizens when compared with foreign residents. However, it is often observed that these characteristics are correlated. A further analysis

conducted by the CNESPS-ISS confirmed the association of depression with all the aforementioned characteristics, with the exception of age (ISS, 2012a).

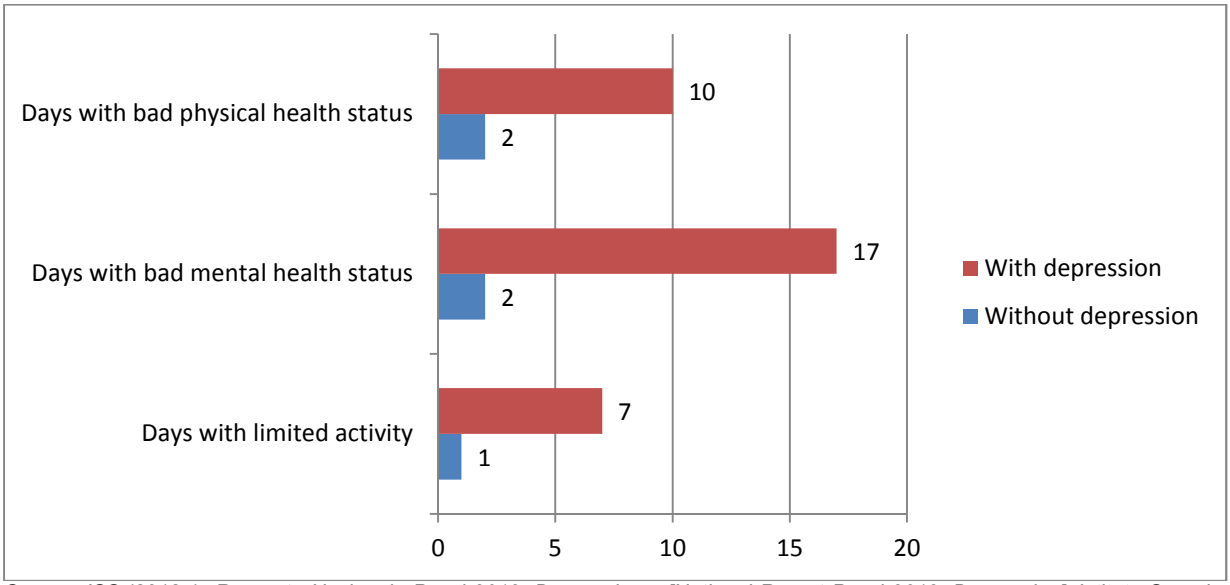
Figure 3. Probable symptoms of depression by socio-demographic characteristics – 2009-2012



Source: ISS (2012a), *Rapporto Nazionale Passi 2012: Depressione. [National Report Passi 2012: Depression]*, Istituto Superiore di Sanità (ISS), Il Centro Nazionale di Epidemiologia, Sorveglianza e Promozione della Salute (CNESPS), Progetto Progressi delle aziende sanitarie per la salute in Italia (Passi). [Online] Available http://www.epicentro.iss.it/passi/rapporto2012/depressione.asp Accessed 06/11/2013

41. Only one-third of people referring with some probable symptom of depression define their general health status as "good" or "very good", compared to 71% of people not showing any probable depressive symptom (see Figure 4).

Figure 4. Days with limited activity, days with bad mental and health status and days with bad physical status, in the 30 days preceding the survey – 2009-2012



Source: ISS (2012a), *Rapporto Nazionale Passi 2012: Depressione. [National Report Passi 2012: Depression]*, Istituto Superiore di Sanità (ISS), Il Centro Nazionale di Epidemiologia, Sorveglianza e Promozione della Salute (CNESPS), Progetto Progressi delle aziende sanitarie per la salute in Italia (Passi). [Online] Available http://www.epicentro.iss.it/passi/rapporto2012/depressione.asp Accessed 06/11/2013

Prevalence of severe mental ill health

42. The project PROGRES-CSM found that, in 2004, there were approximately 32 000 new cases of schizophrenia in Italy, representing an annual incidence of 73.6 per 100 000 population. This figure was calculated on 541 Community Mental Health Centres (CMHCs) and on a population of 43 539 857 inhabitants. However, significant differences were registered across regions, with Calabria, Tuscany and Sicily registering a much higher incidence compared to Lazio, Liguria and Lombardia (Gonella *et al.,* 2008).

43. The project S.E.M.E. on the epidemiological surveillance of severe mental illness (*Sorveglianza epidemiologica dei disturbi mentali gravi*) (CCM, 2011) was started in May 2009 and is organised and managed by the National Institute of Health (*Istituto Superiore Sanità* – ISS). The aim of the S.E.M.E. project is to determine the prevalence of severe mental illness in Italy by gathering data from 22 Community Mental Health Centres (CMHCs) (*Centro Salute Mentale* – CSM) across 15 regions in Italy.

44. During the first year of implementation, 17.7 individuals per 100 000 population were treated for a severe mental health problem within the 22 CMHCs selected. This figure, however, is likely to underestimate the actual prevalence of severe mental illness within the population, in that it does not take into account patients treated by private mental health specialists, patients hospitalised within psychiatric wards in general hospitals, or patients who are not receiving any treatment. Psychotic disorders, including schizophrenia, represent the majority of cases (40%), followed by bipolar disorder (30%), major depressive disorder (19%) and nervous anorexia. Data from the first year of the implementation also show that 48% of patients with severe mental illness have a low level of education (< 8 years of education), 48% live with their families, 40% are unemployed, and 87% live in very poor or modest economic conditions. The study

found that the median period between the first symptoms and the first contact with a CSM is 4 years (CCM, 2011), suggesting the failure of the mental health system in Italy to promptly intervene at the first stages of severe mental health problems.

45. Studies exist on the estimation of severe mental illness also at the regional level. For instance, in 2006 a study estimated the prevalence of severe mental health problems across 10 Departments of Mental Health (DMHs) in the Lombardy region, using the HoNOS (Health of the Nation Outcome Scales) to assess patients' mental health status. It was estimated that, within mental health services in the Lombardy region, there were 3.1 per 1 000 suffering from some kind of severe mental illness every year (aged over 14) (Lora *et al.,* 2006).

Children and adolescents' mental health status

46. The Italian pre-adolescent mental health project (PrISMA) is a two-phase study that was conducted on 3 418 participants using the child behaviour checklist/6–18 (CBCL)[2] and the development and well-being assessment (DAWBA)[3] with the aim of estimating the prevalence of mental disorders among pre-adolescents living in urban areas. The results showed an overall prevalence of mental disorders among children and adolescents of 8.2% for the CBCL and 9.8% for the DAWBA. Internalising disorders (anxiety, panic, depression disorders and other inner-directed states) were significantly more frequent (6.5%) than externalising disorders (negative, destructive beheaviours) (1.2%). An older age, having repeated a grade, living with a single parent, a lower level of maternal and paternal education or lower socio-economic status or income were positively correlated with a higher prevalence of mental health problems. It is noteworthy that 80% of the participants with some kind of mental disorder, however, did not seek professional help (Frigerio *et al.,* 2009), suggesting that the treatment gap is, as was the case for adults (De Girolamo *et al.,* 2006), an issue of paramount importance that needs to be addressed in Italy.

Elderly population mental health status

47. The CNESPS-ISS conducted a study on "Mental Health and Social Seclusion across people over age 64" (ISS, 2012b). The percentage of individuals showing probable symptoms of depression is higher for elderly people than for adults, and the frequency of probable symptoms significantly increases with age. In fact, in the period between 2009 and 2010, over 20% of old people had probable symptoms of depression compared to 7% of adults aged 64 and younger, with an even higher rate for people 75 and over (25.3%) than for people between 65 and 74 (18.8%). In general, women (25.1%) are more likely to show probable symptoms of depression than men (22.3%) (ISS, 2012b).

48. Depression is highly disabling among old people, as people with probable symptoms of depression reported to have, in the 30 days preceding the survey, approximately 15 days with limited activity against 3 days reported by individuals not suffering from any depressive symptoms. Two out of three people sought help from the family or a doctor, whilst the remaining 33% did not. It is noteworthy that social seclusion is a topic of paramount importance, especially across the eldest population. Almost 9% of the people interviewed neither participate in any collective meeting nor have any kind of contact with society (telephone call, meeting, etc.) during a "normal week". As shown in the CNESPS-ISS, women, people over age 75, individuals with a lower level of education and people with lower incomes

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[2] CBCL is a questionnaire filled out by parents designed to assess social competence and behavioural problems in children and adolescents aged 6-18.

[3] The DAWBA explores the following psychopathological areas: separation anxiety, simple phobia, social phobia, panic disorder with/without agoraphobia, post-traumatic stress disorder (PTSD), obsessive-compulsive disorder, generalised anxiety disorder, major depression, attention deficit and hyperactivity disorder, beheavioural disorder, and less common disorders.

were more likely to be socially isolated, with subsequent concern for their health and mental health status (ISS, 2012b).

49. The results of the Health Watch Report (*Rapporto Osservasalute*) showed that almost 30% of people over age 65 were living alone in 2009, with women being significantly above the average (Sabetta, 2012) (see Table 2). However, living alone does not necessarily mean being isolated, as it could also be a sign of autonomy.

Table 2. Percentage of people over age 65 living alone, by region and gender, 2009

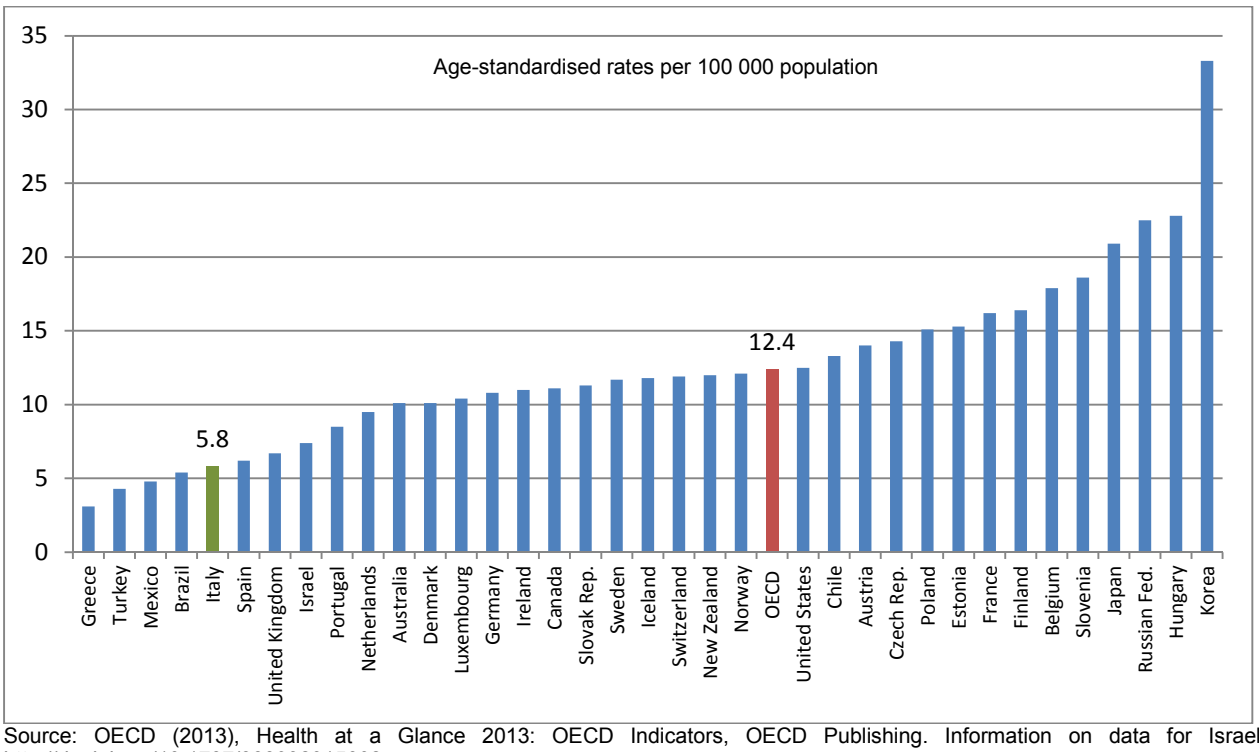
Regions	Men	Women	Total
Piemonte	20.1	38.8	30.9
Valle d'Aosta	17.0	44.1	32.6
Lombardia	14.0	37.7	27.8
Bolzano-Bozen	15.8	37.6	28.2
Trento	14.5	39.8	29.4
Veneto	11.1	35.4	25.2
Friuli Venezia Giulia	14.9	36.4	27.5
Liguria	20.5	43.6	34.1
Emilia-Romagna	15.5	38.3	28.6
Toscana	14.1	30.9	23.8
Umbria	13.6	35.9	26.4
Marche	10.8	32.0	22.9
Lazio	18.8	42.4	32.4
Abruzzo	11.4	35.1	25.0
Molise	15.3	38.7	28.8
Campania	14.8	35.7	26.9
Puglia	14.3	38.9	28.3
Basilicata	12.1	41.9	28.9
Calabria	13.4	41.7	29.4
Sicilia	14.7	41.8	30.2
Sardegna	15.8	37.8	28.3
Italy	**15.1**	**38.0**	**28.3**

Source: SABETTA, T. (2012), *Rapporto Osservasalute 2011 [Health Watch Report 2011],* Osservatorio Nazionale sulla salute nelle Regioni Italiane. Available: http://www.sossanita.it/Primo%20Piano/osservasalute2011.pdf.

2.2. Suicide

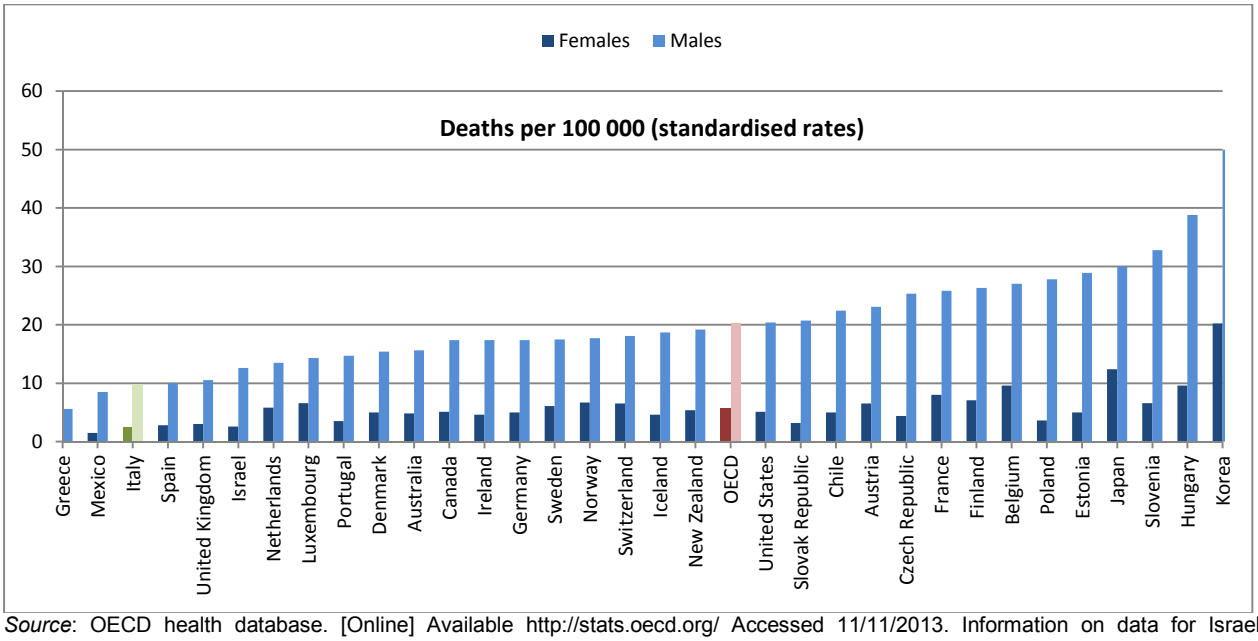
50. Italy has one of the lowest suicide rates within OECD countries, with 5.8 suicides per 100 000 population in 2010 compared to an OECD average of 12.4 (see Figure 5). In line with other OECD countries, suicide rates are higher for men than for women (Figure 6).

Figure 5. Suicide per 100 000 population in OECD countries, 2011 or latest available year



Source: OECD (2013), Health at a Glance 2013: OECD Indicators, OECD Publishing. Information on data for Israel: http://dx.doi.org/10.1787/888932315602.

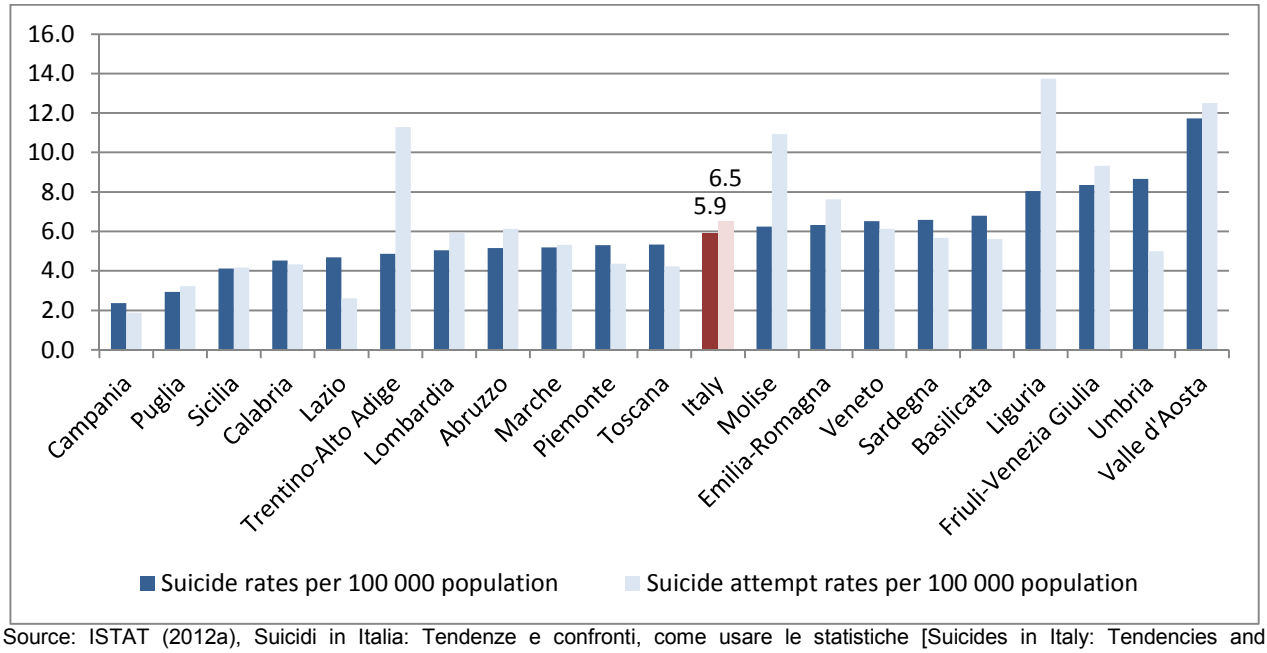
Figure 6. Suicide per 100 000 population by gender in OECD countries, 2011 or latest available year



Source: OECD health database. [Online] Available http://stats.oecd.org/ Accessed 11/11/2013. Information on data for Israel: http://dx.doi.org/10.1787/888932315602.

In 2010, there were 3 048 deaths from suicide in Italy, representing 5.9 suicides per 100 000 population (ISTAT, 2012a). One in three people who committed suicide during 2010 were reported to be suffering from some kind of mental health problem (1 100 cases) (ISTAT, 2012a). The suicide rate has decreased considerably, from 8.3 per 100 000 population in 1993 to 5.1 per 100 000 in 2010. Southern regions (such as Campania, Puglia, Sicilia, and Calabria) show clearly lower suicide rates compared to the national average (see Figure 7).

Figure 7. Suicide and suicide attempt rates per 100 000 population by region – 2010



Source: ISTAT (2012a), Suicidi in Italia: Tendenze e confronti, come usare le statistiche [Suicides in Italy: Tendencies and comparisons, how to use statistics], Istituto Nazionale di Statistica, Roma, 2012.

51. The ESEMed Study investigated suicide according to three phenomena: *suicide ideation*, *suicide planning* and *suicide attempt*. The lifetime prevalence of suicide ideation was 3%, the prevalence of suicide planning 0.7% and the prevalence of a suicide attempt 0.5% (De Girolamo *et al.,* 2006a).

2.3. Other indicators

52. The Ministry of Health, through the Mental Health Information System (SISM), is working on the development of national indicators for mental health, including clinical indicators. However, at the time of writing clinical or outcome indicators for mental health do not exist at the national level (see section 3.5.).

3. POLICY AND GOVERNANCE

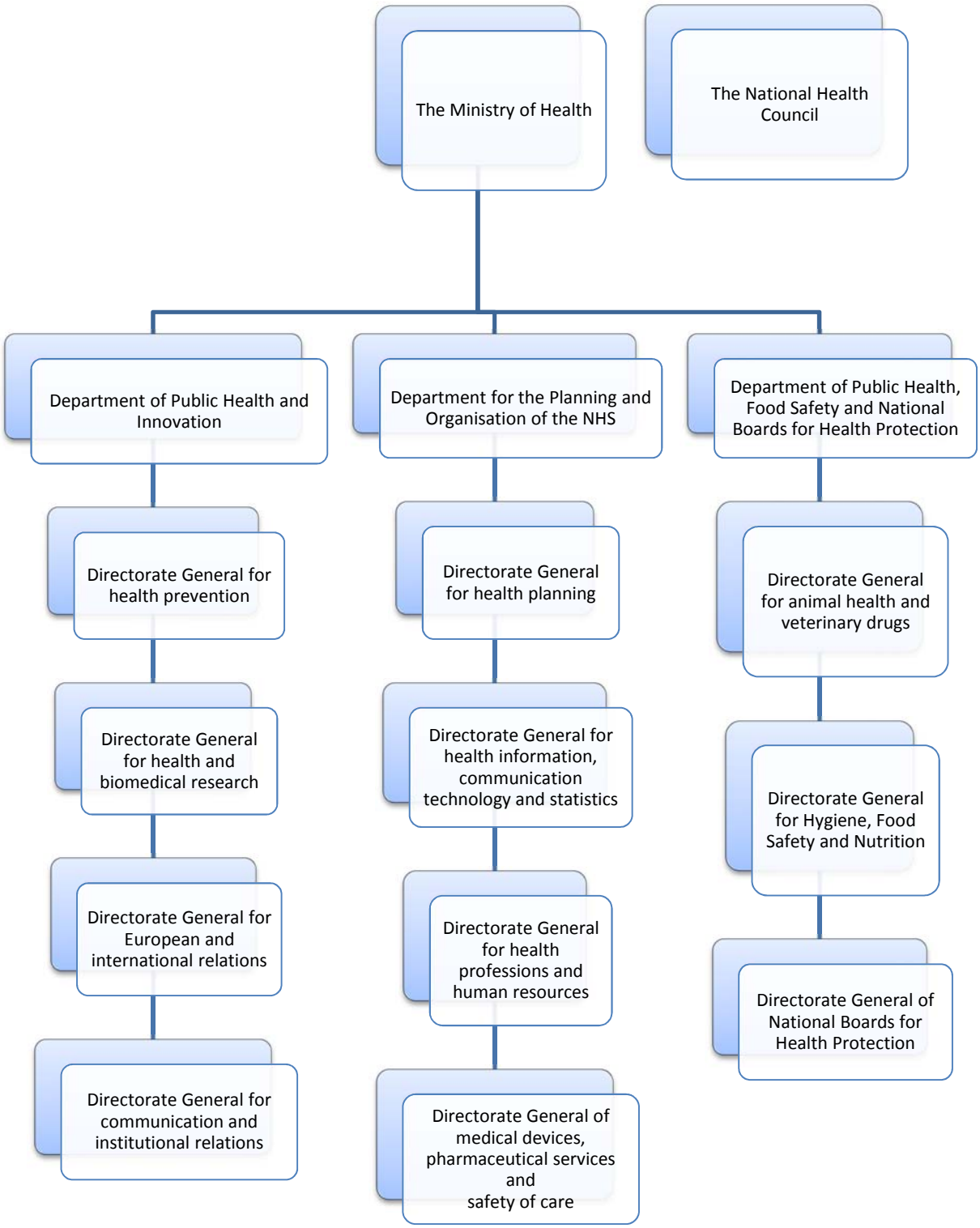
3.1. Governance and organisation of the health system

53. The National Health Service (hereafter NHS) (*Servizio Sanitario Nazionale* – SSN), established in 1978, provides universal coverage free of charge at the point of use to all Italian citizens. Under the Italian Constitution, the organisation and administration of the health system in Italy is run at the national, regional and local levels.

54. At the national level, the central government is responsible for providing framework legislation that draws up general principles of organising, financing and monitoring the NHS. The Ministries involved in the provision of health care are responsible for ensuring the general principles of the national health care system. The central government is also responsible for setting the Essential Levels of Assistance (*Livelli Essenziali di Assistenza* – LEA), a basic health care package that must be available to all residents throughout the country (see section 3.5.).

55. The Ministry of Health is the main central institution responsible for health care planning, financing, and monitoring and for setting the healthcare regulatory framework. The Ministry of Health currently oversees three major departments: 1) the Department for the Planning and Organisation of the NHS, responsible for the planning of health policies dealing with the organisation of NHS services, which is in charge of the administration of the Italian Information System (SIS), including the Mental Health Information System (SISM), and for providing pharmaceuticals and medical devices; 2) the Department of Public Health and Innovation, in charge of safeguarding health and well-being of all Italian citizens, communicating with institutional and international bodies, and promoting scientific and technological research; 3) the Department of Veterinary Care and Food Safety, with Italy being one of the few countries in the world in which veterinary care is managed by the NHS (see Figure 8). However, the organisation of the Ministry of Health is currently under revision.

Figure 8. Organisational chart of the Ministry of Health



56. Other public bodies, including the Ministries and national institutions, also play a pivotal role within the health care sector. The Ministry of the Economy and Finance has a critical role in defining the health care budget and subsequently allocating resources across regions. The Ministry of Social Affairs is involved in the administration of social services provided within NHS infrastructures. The National Health Council (*Consiglio Superiore di Sanità*), established in 1847 by the Edict of Carlo Alberto, provides scientific and technical advice to the Ministry of Health. The Directorate General for the Coordination of Mental Health Consulting Bodies (*Direzione generale degli organi collegiali per la tutela della salute*) coordinates the work between the Ministry and other health care and scientific health bodies, including the National Institute of Health (*Istituto Superiore di Sanità* – ISS) and the Italian Pharmaceutical Agency (*Agenzia Italiana del Farmaco* – AIFA). The ISS, founded in 1934 and currently accountable to the Ministry of Health, is the main national public institution conducting technical and scientific research in the health field. The AIFA, founded in 2003 under the authority of the Ministry of Health and the Ministry of the Economy and Finance, coordinates all activities related to pharmaceuticals, including public and private research, production, distribution and monitoring, pricing and reimbursing policies.

57. The core of regulatory, planning, delivery and monitoring activity is, however, directly managed at the regional level. The regions have gained prominence following the adoption of legislative Decree No. 229/1999, which increased the legal power devolved to regional governments. In fact, under the umbrella of national legislation, legislative functions are left under the control of regions, which provide regulatory frameworks for financing, organising and monitoring the health sector. Regional governments are responsible for delivering a health care benefits package through a network of Local Health Authorities (*Azienda Sanitaria Locale* – ASL) as well as public and private licenced hospitals. Regional governments directly set the resources to be allocated across the Local Health Authorities, define their geographical boundaries and appoint general managers. Based on the National Health Plan and on local needs, the regions are also responsible for designing a three-year health plan and monitoring activities on health care delivery across the territory.

58. A range of intermediary bodies are responsible for ensuring continuous connections between the central Government and the regions.

59. The Standing Conference on the Relations between the State, the Regions and the Autonomous Provinces (*Conferenza Stato Regioni et Unificata*), established in 1988, promotes collaboration between the regions and the central government. Composed of the representatives of the government and the presidents of the regions, the Standing Conference is the major consultative body for legislative activities involving a regional dimension.

60. The National Agency for Regional Healthcare (*Agenzia Nazionale per i Servizi Sanitari Regionali* – AGENAS) plays an important role in giving technical and operational support to the Ministry of Health and the regions in the work to develop NHS strategies. Among other tasks, the AGENAS carries out monitoring of the NHS, provides evaluative analysis of the efficacy of the LEAs and makes recommendations for the organisation of the NHS.

3.2. Governance and organisation of the mental health system

61. At the local level, each Local Health Authority integrates a Department of Mental Health (DMH), which is in charge of mental health prevention, care and rehabilitation within defined catchment areas. Special focus is devoted to crisis situations and rehabilitation, although the DMHs are in fact in charge of the full array of mental health care provision.

62. The DMHs refer to a population of 150 000 inhabitants, as set in the Targeted Mental Health Care Plan 1998-2000 (Ministry of Health, 1998a); in 2010, there were 208 DMHs in the whole Italian

territory (Ministry of Health, 2011c). The DMHs embed multi-disciplinary teams composed of psychiatrists, psychologists, nurses, social workers, educators, occupational therapists, personnel with specific training therapists, personnel with specific training in psychosocial rehabilitation and secretarial staff. National standards for mental health staff require at least one professional per every 1 500 inhabitants (Ministry of Health, 1998a), and although regional differences exist, these standards are met in almost every Italian region. The DMHs manage a variety of inpatient and outpatient mental health services, including Community Mental Health Centres (CMHCs), Day Care Facilities (DCF), General Hospital Psychiatric Units (GHPUs), and Semi-residential and Residential Facilities (RFs) (see Figure 9). The Director of the DMH is responsible for coordinating the activities performed by all services belonging to the DMH's network.

- Community mental health centre – CMHCs **(***Centro di Salute Mentale – CSM***).** In charge of planning and coordinating interventions, this service is accessible to patients, even without a general practitioner's referral, at least 12 hours a day from Monday to Friday and half a day on Saturday. The CMHC evaluates demand from patients and can thus direct them to appropriate mental health services or provide direct intervention. It also arranges domiciliary visits and is involved in consultation–liaison interventions at the local level (see section 4.1.).

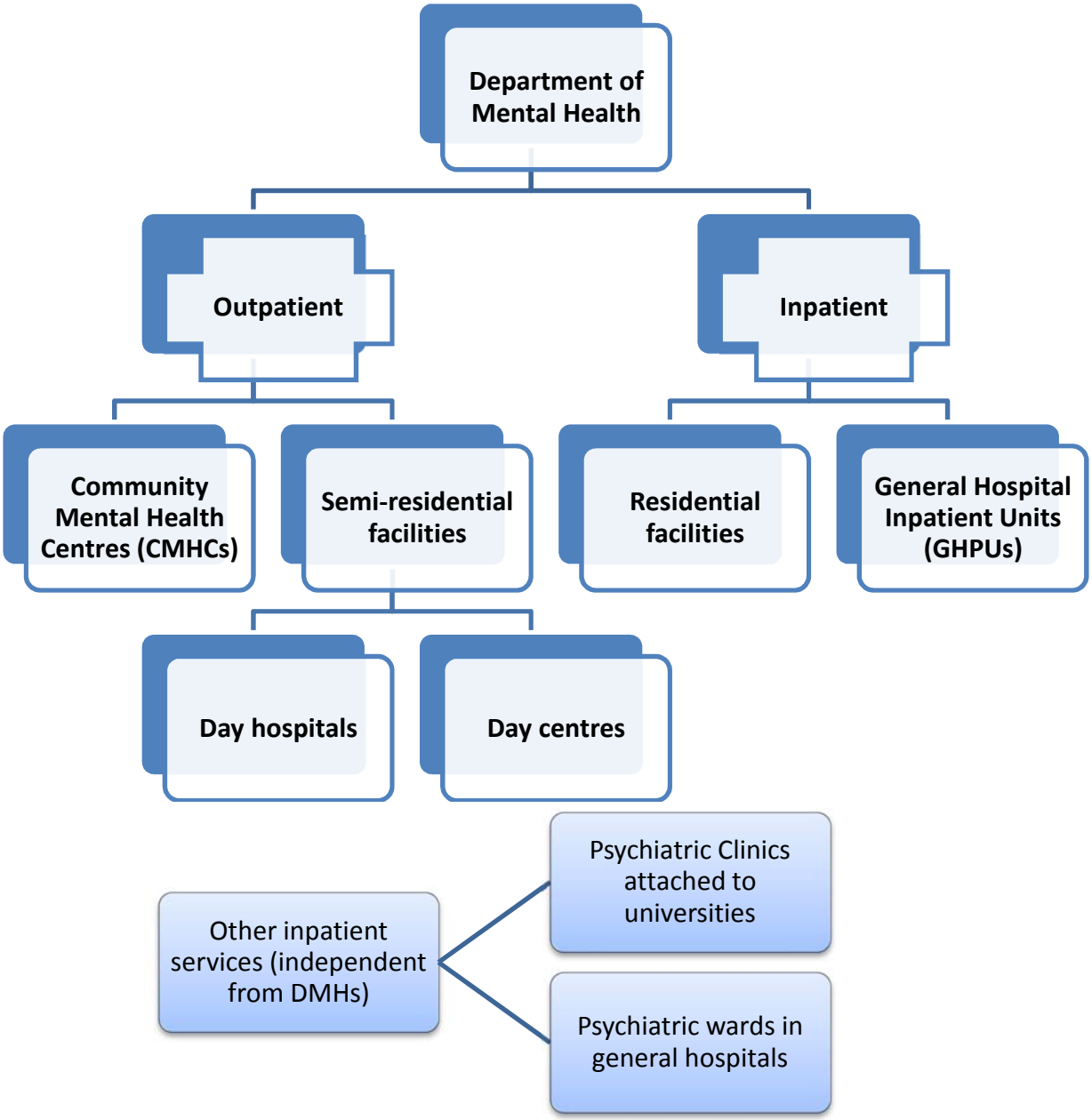
- General Hospital Psychiatric Units (GHPUs) – *Servizi Psichiatrici di Diagnosi Cura* (SPDC). Located in hospitals that have an emergency department, this service is in charge of short-term crisis interventions and eventually refers patients to the CMHC for outpatient care and other interventions. Patients are admitted either on a voluntary basis or under CTOs. National standards require that a maximum of 1 bed per 10 000 inhabitants is provided (Ministry of Health, 1998a), and each GHPU provides a maximum of 16 psychiatric beds (for CTO rates, see section 1.2.i; for further information on GHPUs, see section 4.1.).

- Semi-residential facilities – Day-centres and Day hospitals *(Centri Diurni e Day-Hospital*). These facilities have therapeutic and rehabilitative functions, with programmes promoting self-care, everyday-life activities and individual or collective interpersonal relations in day centres. The day centres are open at least eight hours a day six days a week and have their own medical team, sometimes complemented by social workers and volunteers. Day centres can be managed either by the Department of Mental Health or by private partners, in which case conventions with the Department of Mental Health guarantee the continuity of care. The main goal of Day Hospitals is to reduce the number and length of hospitalisations by providing comprehensive diagnostic evaluations and health interventions in the short and medium term. Day Hospitals can be located within the hospital or in external structures linked with the Department of Mental Health (see section 4.1.).

- Residential facilities – RFs (*Strutture residenziali*). RFs are separate from hospital facilities and are in charge of part of the therapeutic-rehabilitative programme for patients with strictly psychiatric needs. These rehabilitative programmes are conceived to help people utilising local resources in order to better integrate into the community. In this respect, residential facilities must not constitute a long-term housing solution. By law, they must comprise a specific number of beds linked to the intensity of care – but not more than 20 – and must be located in easily accessible urban areas in order to avoid social isolation (see section 4.1.).

63. Together with the aforementioned mental health services provided through DMHs, there are other mental health facilities that collaborate with the DMHs but are not directly dependent on them. These include Psychiatric Clinics attached to universities (*Cliniche Psichiatriche Universitarie*) and psychiatric wards in general hospitals, which both provide mental health inpatient services.

Figure 9. Organisation of secondary mental health care



3.3. Current mental health strategy and recent mental health policy

64. The last national mental health plan was released in January 2013 – The Italian Mental Health Action Plan (IMHAP) (*Linee di Azioni Nazionale per la Salute Mentale*) (Ministry of Health, 2013). The IMHAP identifies four priority areas, including: early intervention, mild to moderate mental illness, severe mental illness and children and adolescents mental health. In order to deal with these priorities successfully, a set of strategies and a variety of relevant indicators has been developed. For each priority area, the IMHAP identifies the key objectives to be achieved, the related actions to be undertaken, the evaluation tools to be used, as well as a set of indicators for monitoring whether the objectives are being met (Ministry of Health, 2013).

65. Despite the recommendations of the 2008 National Strategic Plan for Mental Health (*Linee di indirizzo nazionali per la salute mentale*) (Ministry of Health, 2008a), children's mental health services differ substantially across regions in terms of the quality and quantity of facilities. Besides the need to develop a uniform provision of children's mental health services across the territory, there is also the need for better integration of the services, especially between children's and adults' mental health services. Adult mental health priorities include: early interventions, mild to moderate and severe mental illnesses, suicide prevention and the fight against stigma (Ministry of Health, 2013).

3.4. Mental health strategic initiatives

Stigma campaign

National initiatives

66. The Italian Ministry of Health has conducted several anti-stigma campaigns in order to draw attention to mental health care. The first one, in 2005, focused on the exclusion of people suffering from mental illnesses and aimed at fighting stigma attached to mental illnesses with slogans such as "He's not different than you. Mental illness can be cured" ("*Non è diverso da te. Curare i disturbi mentali si può.")* and "No prejudice, no exclusion" ("*Nessun pregiudizio, nessuna esclusione"),* featured in a television spot. Family/users associations played a major role in this first campaign, with each segment of the communication programme being devolved to them under general supervision by the Italian Ministry of Health: the television spot was managed by the UNASAM; the national day for mental health and several other events around the country were hosted by the Idea foundation (*Fondazione Idea*); the informative brochures were encharged to the Diapsigra association, and a website www.fuoridallombra.it was created by the Arap association.

67. The second stigma campaign on mental health – "Mental health disorders can be cured: more information, less discrimination" (*I disturbi mentali si possono curare: più informazione meno discriminazione*) – was conducted on April 2006 with the aim of fighting discrimination against people suffering from mental illness and informing the youth about mental health issues. In order to do this, the campaign was managed jointly by the Italian Ministry of Health and the Italian Ministry of Education, as well as by universities. The campaign's main objectives were to:

- Stimulate creativity by allowing students and university staff to participate in the making of the campaign;
- Encourage interest about mental health in schools and in education programmes;
- Increase knowledge about and an understanding of mental illness and how it can be treated and cured;
- Promote initiatives to improve behaviour towards mental illness;
- Promote specific actions in order to prevent and fight discrimination and prejudice in targeted social groups.

68. The tools used to realise the 2006 campaign against stigma included the publication of an informative brochure in the widely circulated newspaper *La Repubblica* and the distribution of the campaign message across major websites specifically addressed to young people through internet banners.

69. Apart from national initiatives against stigma, the core stigma campaigns in Italy have taken place at the regional and local levels. To quote but a few, The "Regional Network of Mental Health Users of Tuscany" ("*Rete Regionale Toscana Utenti Salute Mentale*") (for further information on the Regional Network in the Toscana region, see section 3.6.), or Mental Health Week in Emilia Romagna, promoted by the Local Health Authority of Reggio Emilia in collaboration with the municipality of Reggio Emilia, is now in its 7th edition. During Mental Health Week, debates and lectures are organised and movies and books on mental health are presented. The events are attended by "sane" individuals as well as people with mental disorders who have an opportunity to share their experiences and participate in the public debate.

Regional and local best practices

Box 3. Stories of recovery (*Storie di guarigione*)

The literary competition "Stories of Recovery" (*Storie di Guarigione*) has been organised in Biella (Piemonte region) through the involvement of all the local institutions and the local groups active in the promotion of mental health and well-being. Two outstanding artists in Italy (the poet Alda Merini – with a personal history of schizophrenia – and Michelangelo Pistoletto – painter and sculptor) accepted to serve as Presidents of the Jury. The competition was dedicated to Emanuele Lomonaco, head of the Mental Health Department in Biella, who promoted the competition and died of heart failure during the early development phases of this initiative.

All the Community Mental Health Centres (CMHCs) in Italy, along with all the local groups already involved in editing or publishing poems or tales written by users or ex-users, were invited to participate in the literary competition. A web campaign was developed to promote the initiative. The organising committee received more than 550 contributions (poems, tales or autobiographies) from all Italian regions. The Jury selected nine winners, who were all invited to the closing ceremony in the main theatre in Biella. All the winners received a financial reward and their manuscripts were published in the book *La scrittura della guarigione* [*Writing the Recovery*] (Storie di guarigione, 2009).

Most of the funds raised to carry out the initiative came from local institutions and foundations. The estimated direct cost (excluding personnel in the local institutions) of the initiative was EUR 35 000.

This initiative promoted the participation of all the family and user organisations in Italy, raised awareness on recovery issues among mental health professionals, and gave a voice to mental health services users, offering them an opportunity to write their personal stories. The initiative received formal acknowledgements by the President of the Italian Republic, who awarded the programme with a silver medal for its high social value. Also, the Italian Ministry of Health and Ministry of Culture as well as a variety of sectors within the regional administration in Piemonte formally supported the initiative.

(For further information, see www.provincia.biella.it/docCatPolitichesociali.407.201.25.2.2.html).

Box 4. Stigma across medical professionals

Stigma and discrimination towards individuals suffering from mental health problems is also present among medical professionals (Sartorius, 2002; Magliano *et al*., 2004). This is of particular importance, considering that mental illness is often associated with cancer and cardiovascular and metabolic diseases (WFMH, 2010). Several authors pointed out that the care needs of patients with mental illness are not always taken seriously. There is a general tendency among medical professionals to associate patients' physical complaint with their mental health problems, to underestimate the severity of their symptoms and suspect that they are imaginary. When admitted to a hospital department for a physical illness, these patients are treated with disrespect by professionals, wait longer for a specialist consultation and are soon transferred to a psychiatric unit (Aydin *et al.,* 2003). This situation negatively influences the quality and appropriateness of medical care provided to patients with mental disorders and makes it more difficult for these patients to talk about their own physical problems with medical staff.

For the above-mentioned reasons, exploring beliefs about mental illness among medical professionals is important in order to devise strategies for modifying prejudices and discriminating behaviours toward persons with mental illness.

A study was conducted in 2010 in order to examine the beliefs of medical students about the causes of schizophrenia and the possibility of treatment and recovery. The study was carried out during the period April-June 2010 on 194 medical students attending the last two years (5th and 6th) of their training course at the Second University of Naples and was supported by all the professors involved in lessons in the reference period. Attitudes were assessed by using a validated questionnaire (Magliano *et al.,* 2011; Magliano *et al.,* 2012).

The results showed that 159 students (82%) identified schizophrenia in the case-vignette. As for the causes of the case-vignette disorder, the students most frequently cited heredity (81%), stress (69%), psychological trauma (45%) and misuse of street drugs (44%). Heredity was considered the most important and the most frequent cause of the case-vignette condition by 53% and 33% of the respondents, respectively. Only 24% of respondents firmly believed that persons with the considered disorder could completely recover in the future. At the same time, 73% of respondents said that it was completely or partially true that individuals with the case-vignette condition were dangerous and 86% that they were unpredictable. Moreover, 57% firmly believed that people are frightened by persons with this disorder and 56% stated that people don't know how to behave with them, nor understand the difficulties experienced by these patients (Magliano *et al.,* 2011; Magliano *et al.,* 2012).

These findings clearly suggest that stigma is present among the "future doctors" as it is in the general population. As a consequence, tailored measures are currently being implemented in order to respond to this situation, *i.e.* "ad-hoc" lessons on recovery and prejudices towards persons with mental disorders, especially schizophrenia, have been planned, involving both medical students and professors from several physical and surgical disciplines; a participatory research group of students from different medical disciplines has been created and trained to devise peer-to-peer strategies to raise awareness among students about stigma in mental illness.

Box 5. C'era una volta la città dei matti

"*C'era una volta la città dei matti*" ("Once upon a time there was the town of fools") is a movie directed by Marco Turco, which was broadcast by the Italian national public broadcasting organisation (RAI) and watched by over 7 million people. The movie is based on the true story of Franco Basaglia and his experience in two mental hospitals, Gorizia and Trieste, where the process of closing all the mental hospitals in Italy began. The object of the movie is to provide an overview of the changing approach towards mental illness that eventually led to the approval of Law 180 in 1978.

The Department of Mental Health in Trieste consulted on the preparation of the script by defining the historical context and assessing the scientific contents of the movie. The movie is currently available with English subtitles, and it has already won 3 international Prizes (Shanghai, Monte Carlo and Rome Film Festivals) for its ability to address the issues of stigma and prejudice.

The movie triggered a public debate on stigma, inclusion and the rights of people with mental illness, *e.g.* it has been used by WHO Offices, Italian Institutes of Culture and other countries to promote the debate on de-institutionalisation.

Mental Health in the workplace

70. Pro.P – Programme for the reintegration into the workplace of people suffering from mental health disorders – was launched in 2006 with the aim of facilitating the integration of mentally disordered people into the labour market. The programme was started by the ISFOL (Institute for the development of Vocational Training – *Istituto per lo sviluppo della formazione professionale dei lavoratori*) and supported by the Ministry of Labour and Social Policies. Since its establishment, the programme has implemented a vast range of activities, including: the establishment of institutional networks within regions; training programmes for operators within regional mental health facilities; integration plans for mentally disordered people into the labour market; and the development of a comprehensive information system. Whilst some regions – Lazio, Piemonte, Puglia, Toscana and Umbria – were part of the programme since its inception, other regions have joined later, such as Veneto, Campania and Sardegna in 2010, Marche in 2011 and Molise in 2012.

71. However, it is worth saying that programmes aiming to include mental health disordered people in the workplace are routinely performed by CMHCs, whilst Pro.P is only a research project aimed at optimising and improving these activities.

3.5. Monitoring and good practice guidelines in the health and mental health services

72. The current Italian mental health system is not so easy to fully evaluate and monitor, since provision of care is presently delegated to regions and Local Health Authorities that operate in an autonomous way under national "framework legislation". Nevertheless, in recent years, monitoring has been reaffirmed as a crucial objective by the Italian Ministry of Health.

Information systems and registers

73. The Targeted Mental Health Care Plan 1998-2000 required that each Department of Mental Health (DMH) in Italy provides an information system to gather data on mental health prevalence and the services provided (Ministry of Health, 1998a). The 1999 Decree (D. L. 229/99) also required that regions have health information systems.

74. A thorough information system was recently developed to improve the monitoring of health services in Italy: in this respect, the National Health Information System (*Sistema Informativo Sanitario* - SIS) developed by the Ministry of Health is currently in charge of collecting aggregated data and information on services on a yearly basis. An additional recent promising tool for monitoring mental health services is the National Mental Health Information System (*Sistema Informativo Salute Mentale* - SISM), which is based on individual user's records. The SISM has been officially approved through a National Decree in October 2010 and is being implemented in all Italian regions, some of which already have prior experience of gathering aggregated information concerning mental health. The SISM is designed primarily to guarantee the Essential Levels of Assistance and provides information on services, personnel and some characteristics of clients and treatments. Moreover, the SISM is moving towards the establishment of a set of national mental health indicators, including clinical indicators.

75. However, at the time of writing there are different stages of development of regional mental health information systems, with information systems in some regions – such as Piemonte, Lombardia, Lazio, Emilia-Romagna and Toscana – being relatively more developed than other regions. For instance, in some southern regions, not all DMHs provide a mental health information system, as set by the current legislation. Because the development of a mental health information system is not expensive per se, the obstacles to implementation should be sought in the differing cultural environments across regions rather than in the existence of economic constraints.

Outcomes and indicators

76. Given that there are different stages of development of regional mental health information systems, and that some regions are unable to provide good mental health data, there are currently not many mental health indicators available at the national level, whilst mental health indicators at a regional and local level are more available (see Box 6).

77. Some information on the prevalence of mental ill health as well as the performance of mental health facilities at the national level is being provided by studies conducted by the National Institute of Health (ISS, 2012a; ISS, 2012b; ISS, 2012c), the National Centre for Prevention and Control of Diseases (CCM, 2011) and other international studies, *e.g.* the EseMED study (De Girolamo *et al.*, 2006a). Moreover, Italy has experience of routine outcome measurements that have used the Health of the Nation Outcome Scales (HoNOS) at the national level, involving about twenty DMHs in Italy, *e.g.* in the Lombardy region, Tuscany, Liguria and Lazio. The results of the last two studies, covering 2009-2010 and 2010-2011, will be published in the near future.

78. In recent years, regional efforts have been undertaken to obviate the dearth of mental health indicators at the national level. Regions such as Piemonte, Lombardia, Lazio, Emilia-Romagna and Toscana, which are endowed with a qualitative mental health information system, have been able to provide evidence-based reports on the state of mental health in the population and on the quality of services provided (Tibaldi *et al.*, 2008; Gaddini *et al.,* 2008; Lora, 2006; Bignami *et al.,* 2008; Lora & Monzani, 2013). Some regions have developed a set of clinical indicators for mental health. For instance, the Italian Society of Psychiatric Epidemiology (*Società Italiana di Epidemiologia Psichiatrica* – SIEP), has developed a set of clinical indicators for schizophrenia, depression and bipolar disorders in the Lombardy region. The indicators were defined based on available data from a vast range of information systems in Lombardy, including pharmaceutical indicators, the general health care system and the psychiatric information system (Lora & Monzani, 2013). The Lombardy region has relatively more sophisticated information systems than other Italian regions, so while other regions may not yet be in a position to replicate this study, it is hoped that the presentation of the results will at least provide an impetus for them to do so in the not too distant future.

Essential Levels of Assistance (Livelli Essenziali di Assistenza – LEA)

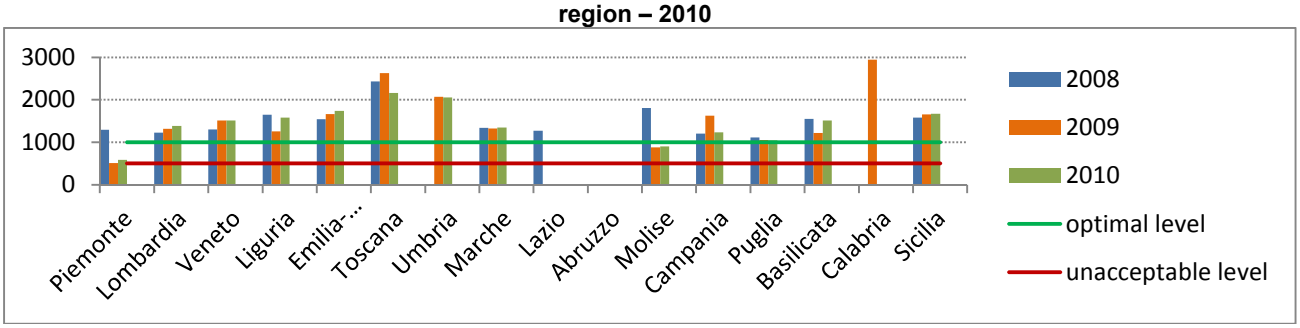
79. Following the release of the Prime Ministerial Decree of 29 November 2001 (*Decreto del Presidente del Consiglio dei Ministri*), the Government established Essential Levels of Assistance (*Livelli Essenziali di Assistenza* – LEA), defined as services and facilities that the NHS is responsible for ensuring, free or with users' co-payments, to all Italian citizens.

80. The implementation of LEAs has led to the reinforcement of a "target culture" and the setting of health-related performance indicators in Italy. Monitoring the levels of assistance reflects the performance of all health care providers regarding the quality, appropriateness and cost-effectiveness of care. In 2008, further legislation redefined the LEAs, which now include over 5 700 types of public health services for prevention, treatment and rehabilitation. Chapter IV, Art. 25, 26, 32 of the LEAs directly refers to mental health. Particular focus is given to mental health community-based services and to children's and adolescents' mental health care.

81. Besides their standard-setting functions, LEAs are also a monitoring tool that is used both to measure the performance of the health services and to efficiently allocate resources across regions. The Standing Conference between State and Regions of March 2005 gave powers to the LEA Committee to verify whether the regions are complying with their obligations to deliver the Essential Levels of Assistance (LEAs) to their inhabitants. In order to do this, the LEA Committee developed the "LEAs grid", a set of indicators that assign a score to each of the LEAs delivered across regions. For each indicator, an optimal and a minimal value is set, and the more the value moves away from the optimal value, the lower the score given to the service. The LEAs grid allows decision-makers to make comparisons between regions by giving a broad picture of the strengths and weaknesses of each region in delivering the LEAs.

82. The last evaluation of LEAs was released in 2012 (Ministry of Health, 2012a), with indicators based on data collected in 2010. At the time of writing there is only one indicator designed to capture the delivery of LEAs for mental health, although the set of indicators is revised annually and might change in the near future. The mental health indicator is designed to capture the activities of the CMHCs and is defined as "the number of patients per 100 000 population taken over by Community Mental Health Centres". The optimal level includes values equal or superior to 1 000, whilst values equal or inferior to 500 are deemed inadequate (see Figure 10). With this design, however, the mental health indicator is unlikely to describe the quantity or the quality of mental health services provision, in that it does not take into consideration epidemiological and demographic differences across regions and does not give any indication about the quality of the services provided and the clinical results achieved.

Figure 10. Number of patients per 100 000 population taken over by Community Mental Health Centres by region – 2010



Source: Ministry of Health (2012), Adempimento "mantenimento dell'erogazione dei LEA" attraverso gli indicatori della griglia Lea. Metodologia e Risultati dell'anno 2010 [Compliance with the provision of LEA, through indicators of the LEA grid. Methodology and results of 2010 data], Directorate General for Health Planning. Office IV, Ministry of Health, 2012.

Box 6. South Verona Community Psychiatric Service (CSP)

The South Verona Community Psychiatric Service (CSP) was first established in 1978 by the Department of Psychiatry (DoP) of the University of Verona. Since 1987, the DoP of Verona and the CSP of South Verona have functioned as the Collaborating Centre for Research and Training in Mental Health of the WHO.

In the 30 years since its establishment, the CSP has been providing a comprehensive range of services, including a Community Mental Health Centre, a psychiatric ward located in the Academic general hospital, today with 15 beds, an outpatient service, an emergency service, home visits and the Service of Psychosomatics and Clinical Psychology and the Service of Psychotherapy (an outpatient and a home service, respectively). The CSP of South Verona is totally funded and run by the NHS.

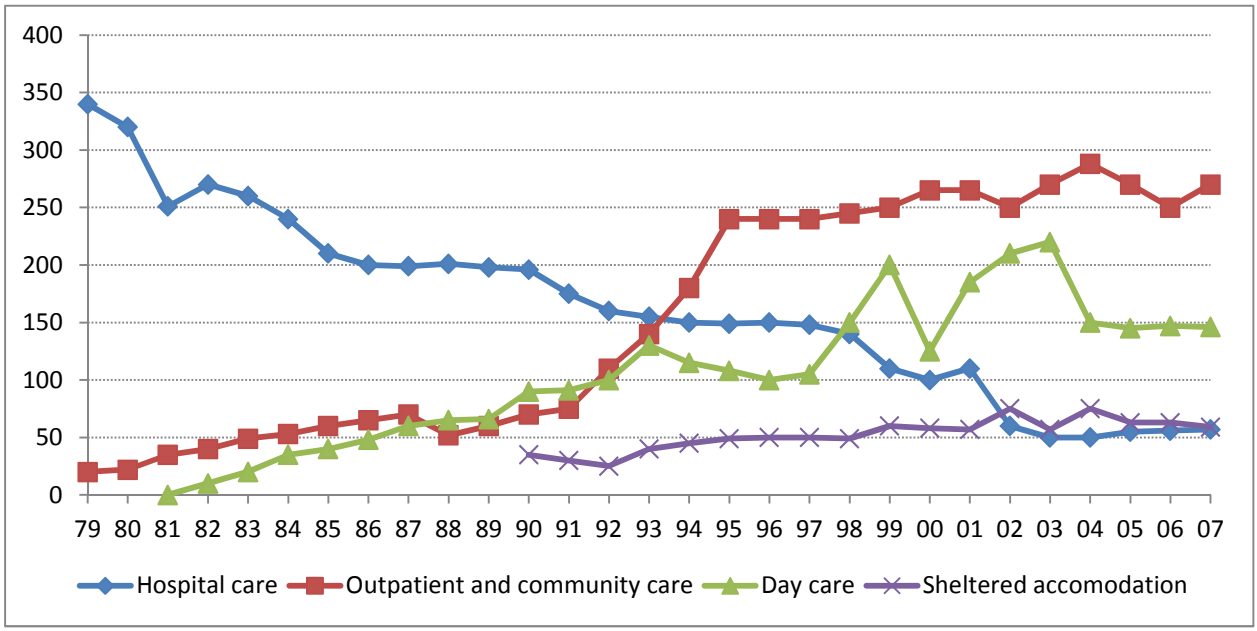
Starting as a long-term research project for monitoring and evaluating the new system of care established after the implementation of Law 180, the CSP managed to couple innovative psychiatric care with scientific research and academic education. One of the major peculiarities of the academic community-based mental health service is the paramount importance given to monitoring and evaluation, making the CSP of South Verona one of the most intensively evaluated mental health services in the world. The CSP also represents the major centre for psychiatric research in Italy, including research on epidemiological and social psychiatry, economics and geography of mental health studies, genetics and neuroimaging of schizophrenic and bipolar disorders, clinical psychopharmacology, communication in medicine and evaluation of mental health services. The CPS has conducted a large number of research studies, including work on the following areas:

- Service costs associated with clinical, social and service history variables;
- The effects of ssocioeconomic status (SES), accessibility and geographic distance from mental health services on the use of community-based psychiatric services;
- Predictions about patient drop-out from mental health care;
- Differences in the mortality of psychiatric patients between areas with a community-based system and the general population;
- The South Verona Outcome Project (SVOP) – an outcome evaluation of mental health care provided by the South Verona CSP;
- Predictions of clinical and social outcomes of patients in touch with community-based services;
- Predictions of the changing needs of psychiatric care;

- The relationship between satisfaction with psychiatric care [measured through the Verona service satisfaction scale (VSSS)] and a number of mental health indicators (including socio-demographic, clinical and service intervention indicators).

After the adoption of Law 180, the CSP of South Verona experienced a shift from institutionalisation towards community-based mental health services. From 1979 to 2007, data show that hospital inpatient health care has dramatically decreased in favour of increasing outpatient and community care, home visits, number of day care contacts, attendance at the day hospital and number of days in sheltered accommodation run by the CPS (see Figure 11). In fact, from 1977 to 2007, there was a decrease of 6% in inpatient admissions, with a 69% fall in compulsory admissions. The mean number of occupied beds fell significantly to 72%, mainly due to the closure of state mental health hospitals (Amaddeo *et al.,* 2009).

Figure 11. Patterns of care (ratios per 1000 adult South Verona residents) – 1979-2007



Source: Amaddeo, F., L. Burti, M. Ruggeri and M. Tansella (2009), "Long-term monitoring and evaluation of a new system of community-based psychiatric care. Integrating research, teaching and practice at the University of Verona", *Annali Istituto Superiore Sanità* 2009| Vol. 45, No. 1: 43-53, Italy.

Health and mental health research

83. Health research is an important focus for the Italian Ministry of Health: the first Conference on Health Research was held in Cernobbio in November 2010 and represents a first step in a long-lasting process. The conference aimed at encouraging networking and collaboration between all of Italy's research bodies and at promoting the work of the Italian Health Research Network, an agency that is designed to connect Italian researchers working abroad with researchers working in Italy.

84. Italian agencies involved with health (and mental health) research in Italy include the Italian Ministry of Health, the Italian National Institute for Health (*Istituto Superiore di Sanità* – ISS), the local Scientific Institutes for Admission and Care (*Istituti di Ricovero e Cura a Carattere Scientifico* – IRCCS[4]), the National Research Council (*Consiglio Nazionale di Ricerca* – CNR), the universities, and the

[4] The IRCCS are top research hospitals (16 public hospitals and 16 private ones) funded by and under the governance of the Ministry of Health.

pharmaceutical and medical equipment firms. The National Commission for Health Research (*Commissione Nazionale per la Ricerca Sanitaria*) is in charge of drafting and elaborating research projects and guidelines for national scientific and sanitary research as well as suggesting research topics to international and European research programmes. The National Centre for Disease Prevention and Control (*Centro Nazionale per la Prevenzione e il Controllo delle Malattie* – CCM) has also implemented several research projects concerning mental health (for further information on research activities undertaken by the CCM, see http://www.ccm-network.it/en_what_is_CCM). Both the National Commission for Health Research and the CCM are national bodies directly attached to the Ministry of Health.

85. Italy's participation in the international epidemiological survey conducted by the WHO in 2001-2002 among six countries (Italy, France, Germany, Belgium, Spain and the Netherlands) demonstrates the country's significant contribution to mental health research. The ESEMeD study has in fact provided invaluable information on mental illness prevalence, the utilisation of mental health services and pharmaceutical use.

86. From a domestic point of view, in 2003 the Italian Ministry of Health also implemented a National plan to encourage the regions and autonomous provinces to implement projects for prevention in mental health: from December 2005 to June 2006, the Ministry of Health held several seminars to present the results of these projects for each theme.

National guidelines

Guidelines for Early Intervention for Schizophrenia (Linee Guida: Gli interventi precoci nella schizofrenia) (2007)

87. Following evidence that reducing the duration of untreated psychosis is related to a more benign disease course, in 2007 the National System for Guidelines (*Il Sistema nazionale delle Linee Guida* – SNLG) of the National Institute of Health (*Istituto superiore di Sanità* – ISS) issued the Early Intervention for Schizophrenia Guidelines (*Linee Guida – Gli interventi precoci nella schizofrenia*) (SNLG, 2007), whose aim is to provide a set of directives giving support to all occupational groups engaged in providing assistance to these patients.

National Guidelines for Mental Health (Linee Guida per la Salute Mentale) (2008)

88. The 2008 National Guidelines for Mental Health reaffirmed the necessity to enforce the effective integration of people suffering from mental illness into the employment market through the concerted action of all Departments of Mental Health. DMHs should in this respect be in charge of ongoing professional training, assistance in the search and obtaining of a job opportunity, promotion of social firms and social cooperatives as well as innovative social projects involving *e.g.* microcredit (Ministry of Health, 2008b).

Autism spectrum disorder guidelines

89. Albeit autism falls beyond the scope of this analysis, it has gained growing interest from policy-makers over the past decade in Italy. A national guideline – Treatment guidelines for the autism spectrum disorder (ASD) in children and adolescents (*Il trattamento dei disturbi dello spettro autistico nei bambini e negli adolescenti*) (SNLG, 2011) – was recently published, with the aim of providing direction on the use of evidence-based treatments and defining best practices for appropriate interventions with children and adolescents (0-18 years old) suffering from developmental disorders, including autism.

3.6. User involvement: consumer associations, family associations and other NGOs

90. National legislation highlights the importance of citizens' involvement in the decision-making process and promotes the establishment of consumer and family associations. The 1978 law establishing the NHS, for instance, promoted community involvement in the decision-making process. At the regional level, Local Health Authorities have established a complaint system for citizens to make complaints and suggestions and thus to participate in improving the health system. Following legislation in 1995, all public and most private health care providers are obliged to release an annual Health Service Chart (*Carta dei Servizi*), which is designed to inform the public about waiting times, complaint systems and quality indicators. In addition, in 2003 further legislation required that all public administration institutions, including health care institutions, establish an Office for Public Relations (*Ufficio Relazioni con il Pubblico* (URP)) to provide information to the public and monitoring the quality of services from the users' point of view. Although national legislation has highlighted the importance of citizens' involvement in the decision-making process and encouraged the establishment of consumer associations, each region has reacted differently to these directives (Lo Scalzo *et al.*, 2009).

91. With respect to mental health, human rights for people suffering from mental disorders were a central issue addressed by Law 180, as previous legislation had implied that a person committed to an asylum would automatically have their civil and political rights suspended and could be permanently committed against their will without judicial consent and generally not allowed to leave the mental hospital. However, there is currently no public body in Italy, whether national or regional, in charge of monitoring and assessing the human rights protection of patients in mental health services. This task has been progressively devolved to patient and family associations, which have in fact always collaborated with the Italian Ministry of Health.[5]

92. Italy has several national and regional user/consumer and family associations spread out across the country. Some of them have been active since the 1960s, although most started to become more involved in the 1980s, after Law 180 was promoted. Over 150 of these associations have gathered since 1993 under the umbrella of the Italian National Union of Associations for Mental Health (*Unione Nazionale delle Associazioni per la Salute Mentale*, UNASAM), which now stands as the main association/federation of families concerned with mental health issues. The UNASAM aims to promote and defend the rights of mentally ill people by getting involved in policy-making and the legislative/regulation process on the local, regional and national levels. The federation was in fact actively involved in developing the two National Plans for Mental Health and contributed to the organisation of the

[5] The Ministry of Health's website lists the following associations: *Psicologi-Psicoterapeuti, Psichiatria Democratica* (PD) , *Unione Nazionale delle Associazioni per la Salute Mentale* (UNASAM), *Associazione Difesa Ammalati Psichici Gravi* (DIAPSIGRA), *Associazione Riforma Assistenza Psichiatrica* (ARAP), *Associazione Italiana Tutela Salute Mentale* (AITSAM), *Fondazione IDEA* , *Fondazione Italiana per il Volontariato* (FIVOL), *Caritas Italiana, Comunità di S. Egidio, Comunità di Capodarco, Lega italiana contro i disturbi d'ansia, d'agorafobia, di panico* (LIDAP ONLUS), *World Psychiatric Association* (WPA), *Forum della Salute Mentale.*

first Government Conference on mental health in 2001. Another goal of the association is to connect the families of people suffering from mental disorders and get them involved in regular events hosted by the association in collaboration with the mental health services. It also works to eliminate prejudice and stigma about mental illness by informing the general public (Muggia, 2009) through active participation in broad communication campaigns, as with the Ministry of Health campaign on mental health in 2005. One of the main points made by the UNASAM in its 2010 address is that involuntary admissions, when they are accompanied by excessive restraint and a "closed-doors" policy, constitute an infringement of a patient's human rights, especially when these measures are met with accidental death as has been reported in Sardegna, Puglia, Campania and Emilia- Romagna[6] in recent years. In addition to being present in all 20 Italian regions, the UNASAM is also on the board of international associations such as the European Association of Families of Mentally Ill People (EUFAMI) and the World Association for Psychosocial Rehabilitation (WAPR) (Muggia, 2009).

93. In addition to collaborating with the associations, the Italian Ministry of Health has also worked in close interaction with the Council of Europe in order to issue the Council's recommendations[7] for the protection of the human rights and dignity of people with mental disorders (adopted by the Committee of Ministers on 22 September 2004 at the 896th meeting of the Ministers' deputies).

94. Associations of users/consumers are also developing in several regions. Among them, the "Regional Network of Mental Health Users of Tuscany" (*Rete Regionale Toscana Utenti Salute Mentale*) (hereafter the Regional Network) stands, since its establishment in 2006, as one of the most active associations on mental health issues, including patients' rights and the social exclusion of people suffering from mental disorders (the link to the website is http://www.retetoscanausm.org/sito/).

95. All activities undertaken by the Regional network have been developed in the different Provinces of the region, with the general aim of creating a network of support and exchanges among patients. The Regional Network is part of the Regional and National Councils and as such takes part in the definition of strategies and policies at both the regional and national levels.

96. So far the Regional Network's programme has led to a structured activity aimed at combating stigma by helping the population to recognise the dignity of persons with mental problems. The promotion of rights and citizenship has been pursued by favouring the search for jobs (patient cooperatives are now active in the labour market), by supporting housing (many independent group-apartments have been created) and by advocating patients' right to an education and to create their own families. The experience is being repeated in other Italian regions (*i.e.* Liguria), and some projects are moving towards a European dimension (*i.e.* the sports programme in Livorno has started to set up a European network).

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6 In this respect, the case of Franco Mastrogiovanni (which received significant media coverage), a Sicilian teacher who died in a psychiatric inpatient ward after being constrained for 4 days in August 2009, is especially emblematic of the human rights issues raised by the UNASAM.

7 The Council of Europe's recommendations concerning the protection of the human rights and dignity of people with mental disorders, and its explanatory memorandum (2004).

4. ORGANISATION AND DELIVERY OF SERVICES

97. The level of use of mental health services by people with mental disorders is relatively low in Italy. According to Wang *et al.* (2007), half of the people suffering from a severe mental illness, a quarter of those suffering from moderate disorders and a fifth of those with mild disorders used the health services.

98. Another study conducted in three Italian regions (Friuli Venezia Giulia, Emilia Romagna and Lombardia) showed that the estimated treatment gap – the percentage of people needing treatment but not receiving it – accounted for 79% for mood disorders, whilst a lower rate (57%) was recorded for schizophrenia (Lora, 2009).

4.1. Adult mental health

Primary care

General Practitioners (GPs)

99. Primary care in Italy is of paramount importance for mental health care, especially for the treatment of patients with mild to moderate mental health problems. Usually General Practitioners directly treat symptoms of depression and anxiety, whilst patients with severe mental health disorders are generally treated by secondary care. Unlike in other health care systems, in Italy GPs do not act as gatekeepers to secondary care, as there is open access to all levels of care (primary, secondary and tertiary care) (WHO, 2011). For instance, Community Mental Health Centres, which represent the core of intervention planning in the Department of Mental Health, are freely accessible to patients without the necessity of being referred first. It was found in the WHO ESEMeD study (2001-2002) that 38% of the people who have had contact with the NHS for mild to moderate mental health symptoms consulted their GP, while 21% consulted a psychiatrist, 6% consulted a psychologist and 28% consulted a GP and a mental health professional jointly (De Girolamo *et al.,* 2006a). These figures give evidence of the importance of GPs in treating mental illness, as over half of contacts about mental issues were made with a GP. This in part results from the fact that current legislation in Italy allows GPs to prescribe psychotherapeutic medicines (WHO, 2011). Italy is among the OECD countries with the lowest rates of GPs per population: in 2011, there were 45 878 General Practitioners, *i.e.* 0.76 per 100 000 population. This figure has decreased slightly over the last 15 years, as there were 47 157 GPs in 1995 (0.83 rate per 100 000 population) (OECD health database 2013).

100. Recently, Law 189/2012, approved on 8 November 2012, set out "urgent measures to promote the development of the country through a better health care system". The Law defines precise guidelines on the work of GPs and their relations with secondary care services. Italian GPs do not work in group practices or in looser networks, but generally practice individually. However, the importance of integration between the general practitioner and mental health services was acknowledged in Italy with the implementation of several pilot experiments, leading to the adoption of a primary care consultation-liaison model in 1999 that was first tested in the city of Bologna (Emilia-Romagna) (see Box 7).

Box 7. Mental health and primary care: the "Leggieri" programme – Emilia Romagna

The programme "G. Leggieri" was first implemented in a Community Mental Health Centre (CMHC) in Bologna (Emilia Romagna) in 1999, and in 2002 the service was implemented in the metropolitan area. The model aims primarily at building cooperation between GPs and a dedicated team of consultant psychiatrists, resident psychiatrists, psychologists and nurses; improving the quality of treatment of all mental health problems; and modifying the pathways of care, by treating mild to moderate mental health problems in primary care and severe mental health problems in secondary care.

The consultation-liaison system was designed as a "go-between" for general practitioners and mental health services and often takes place in CMHCs. According to the "stepped care" model adopted by the Leggieri programme, three different approaches could be implemented, depending on the severity of the case. Individuals with mild mental health problems are directly treated by GPs. People with moderate mental health problems are treated by GPs in conjunction with the support of CMHCs, which provide either a simple consultation or suggest a treatment. People with severe mental illness are treated by CMHCs, and there is a follow-up consultation with patients by GPs after the treatment is finished (Menchetti *et al.,* 2006).

In order to monitor the outcomes of the programme on Local Health Authorities in the Emilia-Romagna region, a questionnaire is regularly submitted to all Local Health Authorities across the region. The latest results show that the number of GPs in contact with CMHCs has increased steadily from 2009 to 2011 by 16% (Regione Emilia-Romagna, 2012).

Secondary care

101. Secondary care in Italy is of crucial importance for the treatment of people suffering from some kind of mental disorder, especially severe mental health problems. Individuals can access secondary care (both inpatient and outpatient) services without a referral from a GP. Since the approval of Law 180, inpatient mental health services have been gradually replaced by outpatient mental health facilities, in line with the decade-long process of de-institutionalisation and the closure of all mental hospitals.

102. Following the closure of all mental hospitals in Italy, the core of inpatient mental health services is currently provided by residential facilities, psychiatric wards in general hospitals, Psychiatric Clinics attached to universities (*Cliniche Psichiatriche Universitarie*) and General Hospital Psychiatric Units. Among outpatient facilities there are Community Mental Health Centres and Semi-residential facilities.

Outpatient care

Community Mental Health Centre (CMHCs) – ***Centro di Salute Mentale (CSM)***

103. Community Mental Health Centres (CMHCs) represent the core of outpatient interventions and are primarily responsible for planning and coordination. In 2009, there were 1 387 CMHCs in Italy, a rate of 4.17 per 150 000 population (over 18) (Ministry of Health, 2011c). However the variability from one region to another is sometimes very significant (for instance, Valle d'Aosta has 11.27 CMHCs per 150 000 population, whereas Molise has only 1.11 per 150 000 population) (see Table 3).

104. During the years 2005-2006, a national survey including 20 of 21 regions (except Molise) and covering 211 Departments of Mental Health and 707 CMHCs (about 95% of existing CMHCs) was conducted with the aim of evaluating the compliance of CMHCs with the national standards set within the Targeted Mental Health Care Plan 1998-2000 (Gonella *et al.,* 2008; Munizza *et al.,* 2011; Ministry of Health, 1998a). The 2005-2006 PROG-CSM survey found that the proportion of female users in CMHCs amounted to 57% in the considered sample. Diagnoses of users of CMHCs included: psychotic disorders such as schizophrenic disorders (about 29% of sample), mood disorders (25% of sample), anxiety disorders (22.5% of sample) and other disorders (23.5%). For the new cases treated by CMHCs: psychotic disorders

amounted to 14% of the sample, mood disorders 20%, and anxiety disorders and other disorders were each about 26%. 25% of treatments, such as home visits and intervention in the community, took place outside the CMHCs.

105. Contacts with CMHCs (especially integration and care continuity) and with other Department of Mental Health services were satisfactory for about 69% of the facilities, while they were considered inadequate in about 10% of CMHCs. With respect to follow-up community care, the study showed that about 37% of the CMHCs in the considered sample were involved in developing high-quality programmes focusing on continuity and care coordination for severe mental disorders. Tthese programmes included, for instance, intensive home care and drop-out prevention programmes. However, promotion and prevention programmes remained quite absent from most CMHCs, as only 18% had developed such programmes to a satisfactory level (Gonella *et al.,* 2008).

Table 3. CMHCs per 150 000 population, number of DMHs and number of DMH users, by region

Region	Community Mental Health Centres		Departments of Mental Health	
	CMHCs	CMHCs per 150 000 population (aged 18 and above)	DMHs	Average number of users per DMH 2009
Piemonte	77	3.07	25	150 347
Valle d'Aosta	8	11.27	1	106 462
Lombardia	309	5.71	29	280 084
Prov. Auton. Bolzano	9	3.38	n.a.	n.a.
Prov. Auton. Trento	10	3.53	1	424 605
Veneto	82	3.03	21	193 478
Friuli Venezia iulia	17	2.43	6	174 819
Liguria	22	2.37	5	278 775
Emilia Romagna	130	5.31	11	333 620
Toscana	129	6.14	12	262 791
Umbria	14	2.77	4	189 294
Marche	23	2.61	13	101 490
Lazio	119	3.81	12	389 980
Abruzzo	18	2.41	6	186 736
Molise	2	1.11	3	89 954
Campania	61	1.98	15	307 646
Puglia	63	2.85	10	332 089
Basilicata	5	1.53	5	97 938
Calabria	34	3.10	11	149 639
Sicilia	206	7.59	10	407 302
Sardegna	49	5.19	8	176 884
Italy	**1 387**	**4.17**	**208**	**239 645**

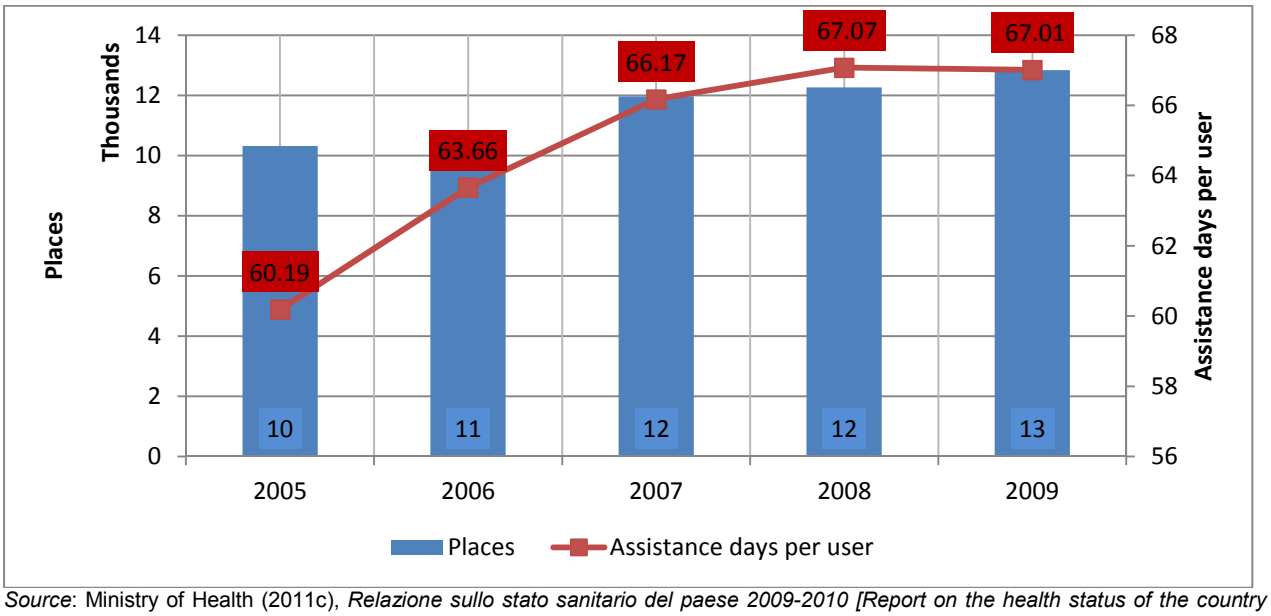
Source: Ministry of Health (2011c), *Relazione sullo stato sanitario del paese 2009-2010 [Report on the health status of the country 2009-2010],* Ministry of Health, Directorate General for health information, communication technology and statistics, 2011.

Semi-residential facilities

Day centres and day hospitals – Centri Diurni e Day-Hospital

106. The number of semi-residential facilities has increased slightly over the past years, from 755 in 2007 to 763 in 2009 (see Figure 12). The number of places has increased together with the number of assistance days per user, reflecting an increase in the activities of this type of mental health service (Ministry of Health, 2011c).

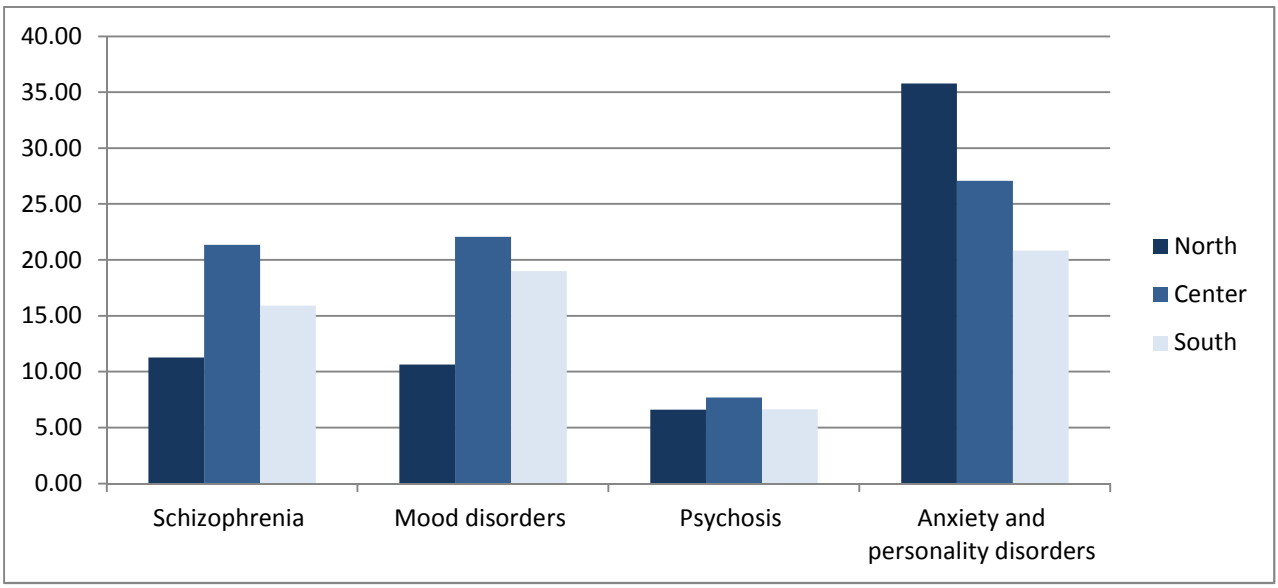
Figure 12. Semi-residential facilities per 100 000 and places provided, 2005-2009



Source: Ministry of Health (2011c), *Relazione sullo stato sanitario del paese 2009-2010 [Report on the health status of the country 2009-2010],* Ministry of Health, Directorate General for health information, communication technology and statistics, 2011.

107. In 2008, a rate of 24.96 inhabitants per 100 000 population used some type of semi-residential facility, ranging from 6% (for psychosis) up to 35% (for anxiety and personality disorders) of total hospitalisations (see Figure 13) (see Table 5 for further information on Semi-residential facilities across regions).

Figure 13. Percentage of cases treated in day hospitals out of total hospitalisations by geographic area and morbidity – 2008



Source: ISTAT (2011), Ospedalizzazione dei pazienti affetti da disturbo psichico [Hospitalisation rate of patients with mental health disorders]. Istituto Nazionale di Statistica 2011 [Online] Available http://www.istat.it/it/archivio/19637 Accessed 18/03/2013.

Inpatient care

108. Overall, inpatient mental health activities have decreased over the past decade, in line with the parallel increase in outpatient mental health services. Within inpatient mental health care, the number of public psychiatric beds has dropped steadily since 1975, along with the number of admissions and the average length of stay for all diagnosis groups. The situation of Residential Facilities (RFs) is significantly different. The number of RFs and RF psychiatric beds has increased over time, parallel to a decrease in assistance days per user, with subsequent concern about the quality of mental health care being delivered within these facilities. Moreover, the average length of stay is particularly high in RFs, which too often provide assistance with daily activities rather than therapeutic support.

General Hospital Psychiatric Units (GHPUs) – Servizi Psichiatrici di Diagnosi Cura (SPDC)

109. The PROGRES-Acute Project conducted by the ISS evaluated the network of acute mental health inpatient facilities in all regions (except Sicily) during the period 2002-2003. Psychiatric beds were located in GHPUs (88%), and Psychiatric Clinics attached to universities (*Cliniche Psichiatriche Universitarie*) (10%) and Day Hospitals (2%) (De Girolamo *et al.,* 2007b).

110. With a rate of 1.08 total psychiatric beds[8] per 10 000 inhabitants (over 18) (0.97 public and 0.11 private accredited beds), the availability of public acute beds in Italy was slightly above the national standards in 2009 (1 bed per 10 000 population) (Ministry of Health, 2011c) (See Table 4).

[8] Private psychiatric beds are not included. Private accredited beds – which are considered as public beds – are included (see Box 6 for further information on the accreditation process)

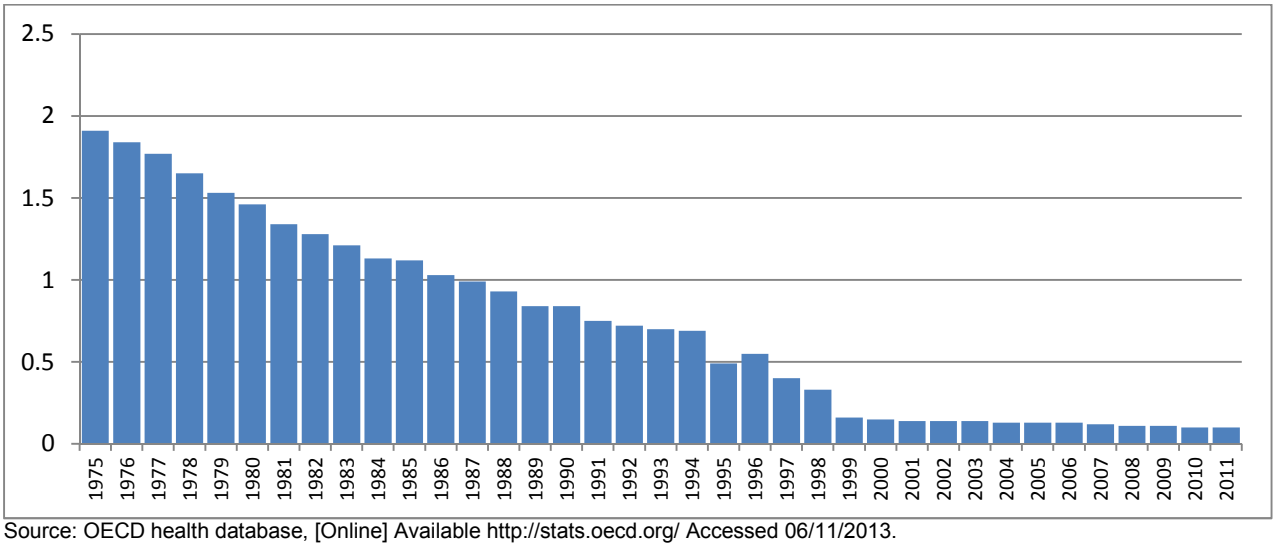
Table 4. Public and accredited private psychiatric beds, by regions – 2009

Regions	Public psychiatric beds		Accredited private psychiatric beds		Total Public and accredited private psychiatric beds		
	Total public beds	Psychiatric beds x 10 000 population (aged 18 and above)	Total accredited private beds	Accredited private beds x 10 000 population (aged 18 and above)	Total public and accredited private beds	% public beds	Total beds x 10 000 population (aged 18 and above)
PIEMONTE	338	0.899	560	1.490	898	37.6	2.389
VALLE D`AOSTA	23	2.160	0	…	23	100	2.160
LOMBARDIA	862	1.061	14	0.017	876	98.4	1.078
PROV. AUTON. BOLZANO	71	1.780	0	…	71	100	1.780
PROV. AUTON. TRENTO	48	1.130	0	…	48	100	1.130
VENETO	590	1.452	339	0.834	929	63.5	2.286
FRIULI VENEZIA GIULIA	44	0.419	0	…	44	100	0.419
LIGURIA	215	1.542	0	…	215	100	1.542
EMILIA ROMAGNA	265	0.722	271	0.738	536	49.4	1.461
TOSCANA	308	0.977	156	0.495	464	66.4	1.471
UMBRIA	44	0.581	0	…	44	100	0.581
MARCHE	128	0.970	15	0.114	143	89.5	1.084
LAZIO	344	0.735	0	…	344	100	0.735
ABRUZZO	119	1.062	40	0.357	159	74.8	1.419
MOLISE	33	1.223	0	…	33	100	1.223
CAMPANIA	214	0.464	160	0.347	374	57.2	0.810
PUGLIA	239	0.720	20	0.060	259	92.3	0.780
BASILICATA	44	0.899	0	…	44	100	0.899
CALABRIA	124	0.753	35	0.213	159	78.0	0.966
SICILIA	489	1.201	140	0.344	629	77.7	1.544
SARDEGNA	88	0.622	0	…	88	100	0.622
ITALY	**4 630**	**0.929**	**1 750**	**0.351**	**6 380**	**72.6**	**1.280**

Source: Ministry of Health (2011c), *Relazione sullo stato sanitario del paese 2009-2010 [Report on the health status of the country 2009-2010],* Ministry of Health, Directorate General for health information, communication technology and statistics, 2011.

111. Parallel to the increase in community-based mental health services, the number of psychiatric beds in Italy has dramatically decreased over the last 35 years (see Figure 14), in line with the decrease in the overall number of hospital beds (OECD health database 2013).

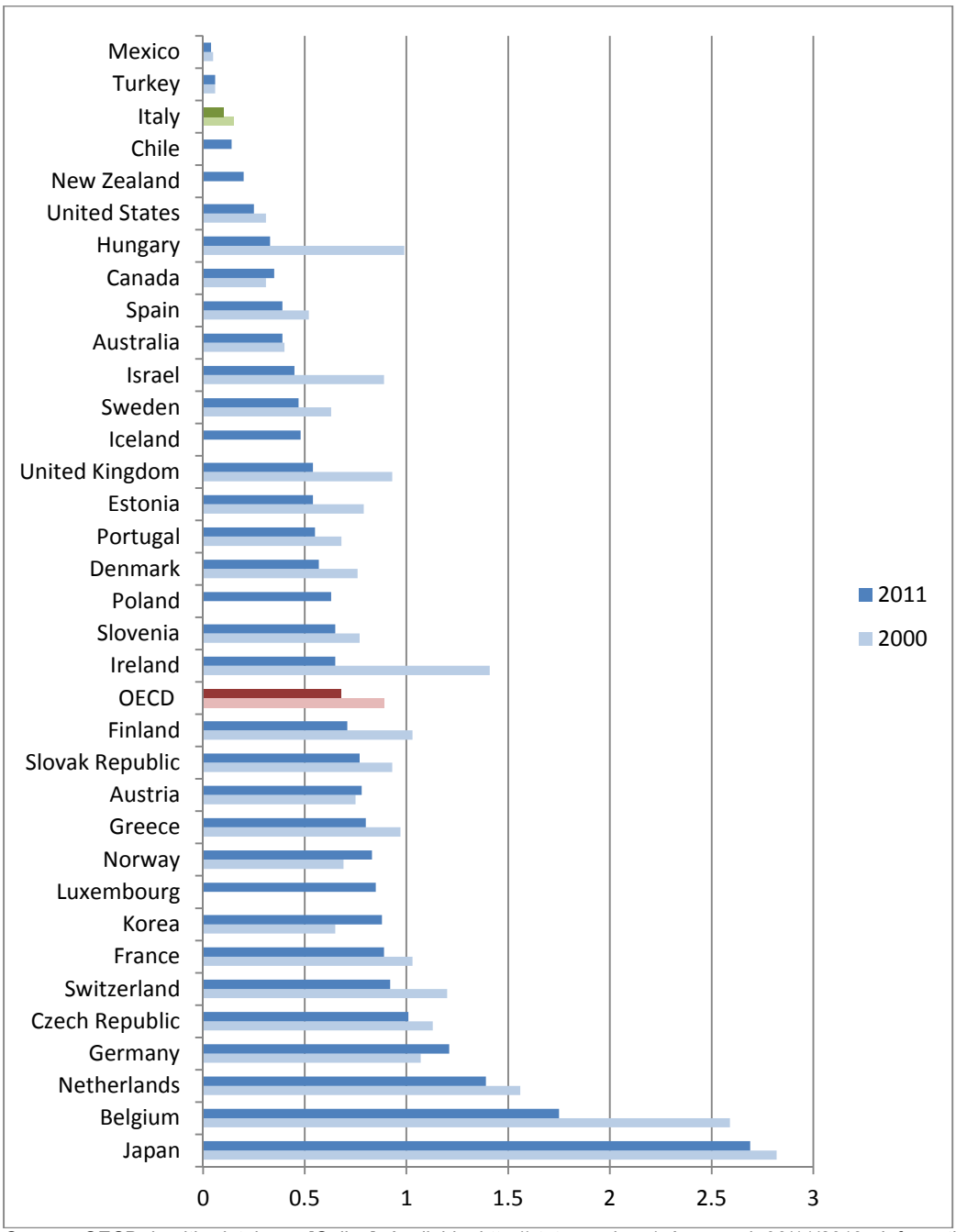
Figure 14. Number of psychiatric beds per 1 000 population – Italy 1975-2011



Source: OECD health database, [Online] Available http://stats.oecd.org/ Accessed 06/11/2013.

112. The decrease in the number of psychiatric beds in Italy is in line with the decrease in the number of psychiatric beds that occurred over the last 10 years in almost all OECD countries (see Figure 15).

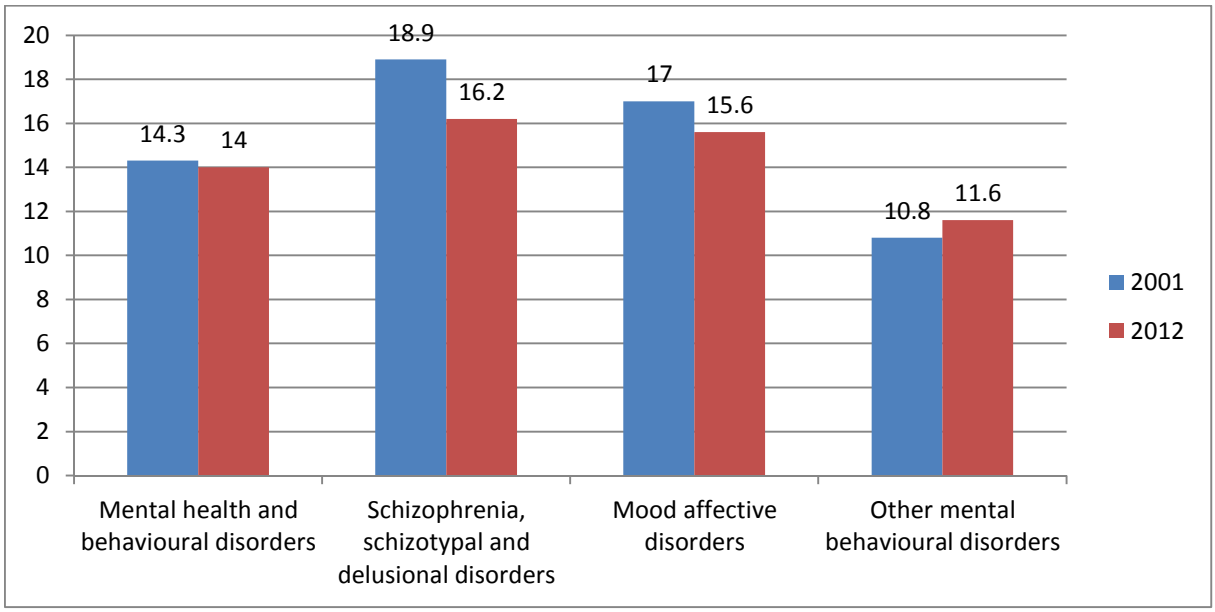
Figure 15. Psychiatric beds per 1 000 population in OECD countries, 2000-2011



Source: OECD health database [Online] Available http://stats.oecd.org/ Accessed 06/11/2013. Information on data for Israel: http://dx.doi.org/10.1787/888932315602.

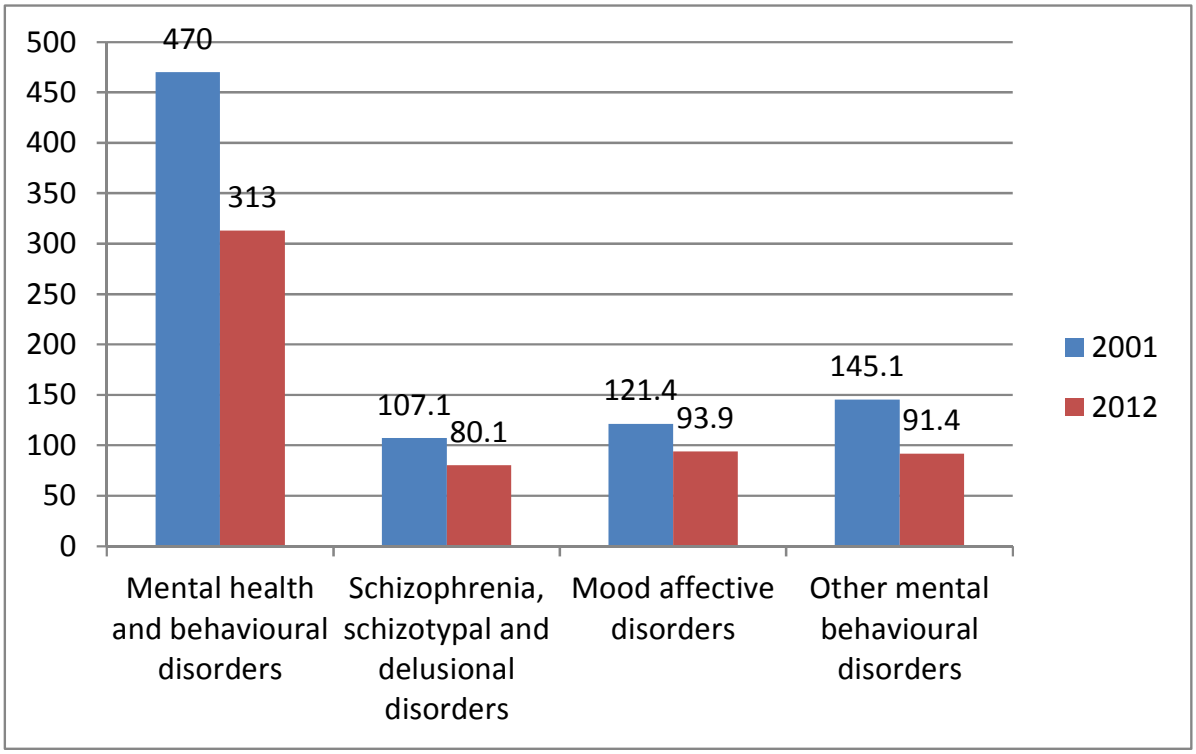
113. From 2001 to 2012, there has been a significant drop in both the length of stay within inpatient services and discharge rates (hence admission rates) per 100 000 population for all the morbidity groups, as shown in Figures 16 and 17.

Figure 16. Average length of stay by morbidity – Italy 2001-2012



Source: OECD health database, [Online] Available http://stats.oecd.org/ Accessed 18/03/2013.

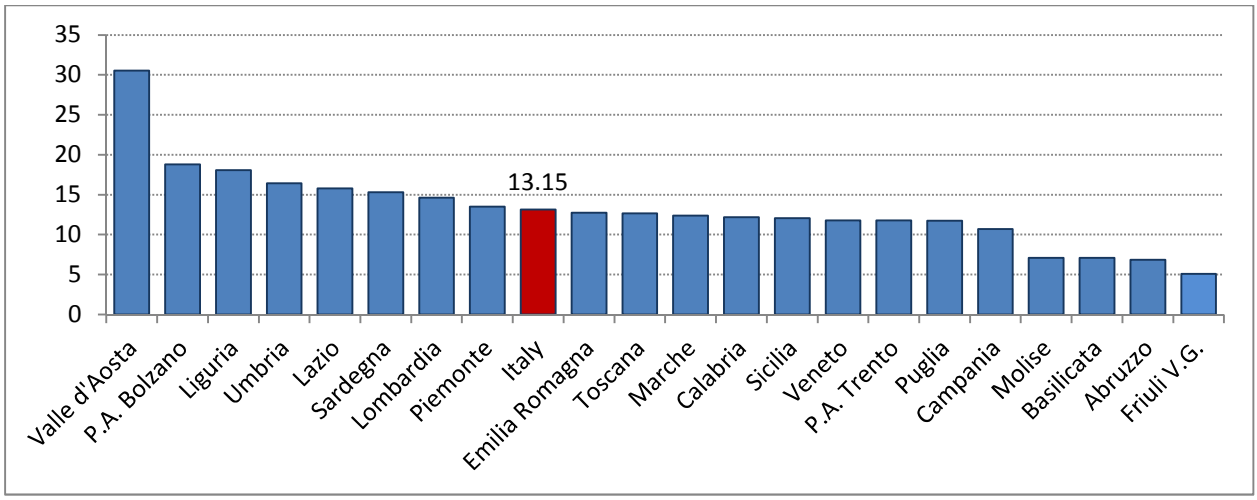
Figure 17. Discharge rates per 100 000 population by morbidity – Italy 2001-2012



Source: OECD health database, [Online] Available http://stats.oecd.org/ Accessed 18/03/2013.

114. The unplanned re-admission rate is an indicator measuring the quality of inpatient mental health services, in that it captures the percentage of people who are re-hospitalised within 30 days of discharge. The OECD is currently using this mental health indicator for schizophrenia and bipolar disorders to make comparisons across countries. Data show that, compared to other OECD countries, Italy is faring well for both schizophrenia and bipolar disorder, with a rate below the OECD average. However, differences exist across regions, as shown in Figures 18 and 19 (Ministry of Health, 2011b).

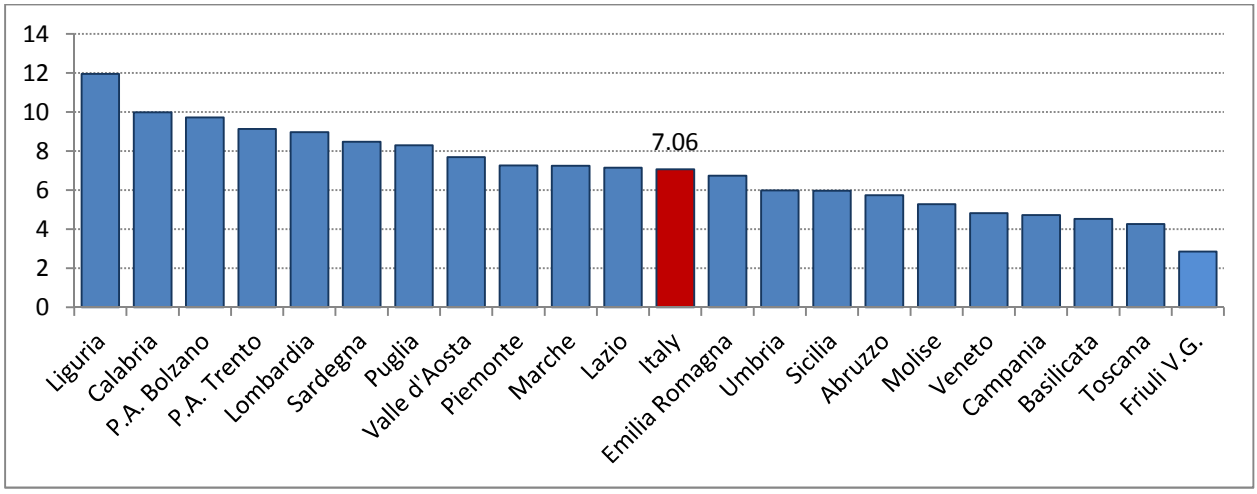
Figure 18. Unplanned schizophrenia re-admission rate* (same hospital) (out of total schizophrenia discharges) by region – 2010



*Unexpected re-admission rate within 30 days of discharge.

Source: Ministry of Health (2011b), Rapporto annuale sull'attivita di ricovero ospedaliero. Dati SDO 2010. [Annual Report on hospitalisation activities], Ministry of Health, Directorate General for Planning, Office IV, 2011.

Figure 19. Unplanned bipolar disorder re-admission rate* (same hospital) (out of total bipolar disorder discharge) by region – 2010



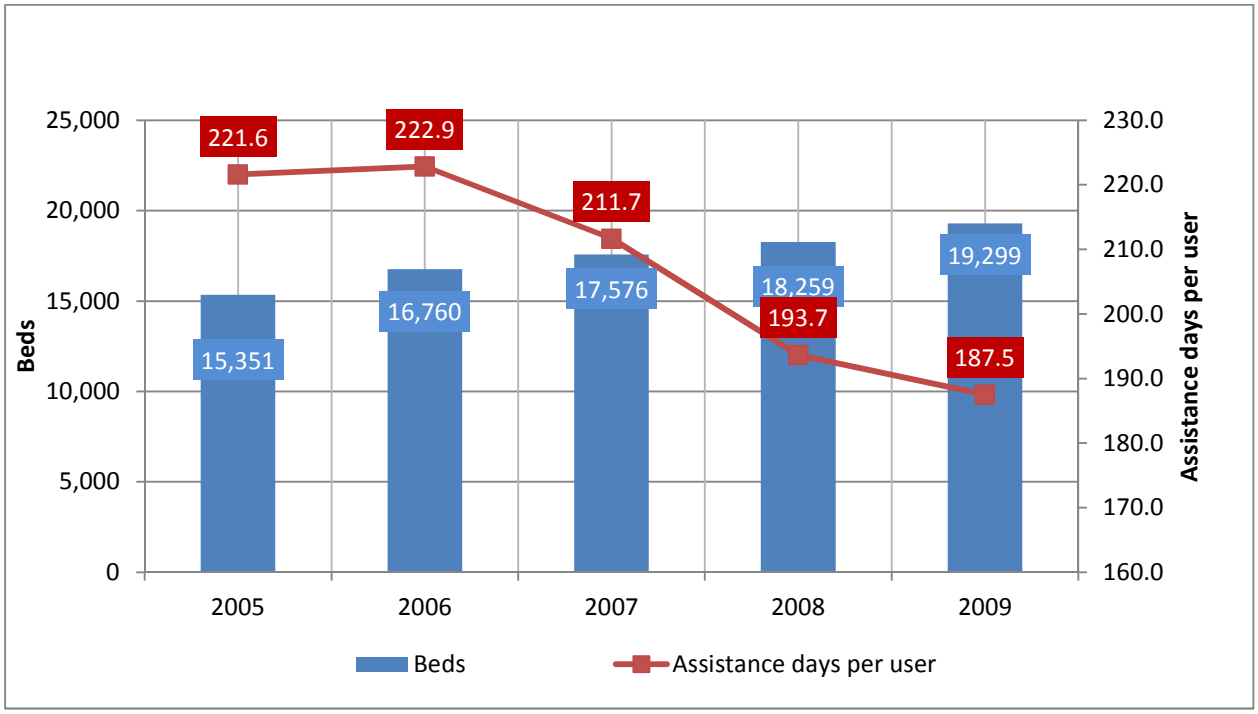
*Unexpected re-admission rate within 30 days of discharge

Source: Ministry of Health (2011b), Rapporto annuale sull'attivita di ricovero ospedaliero. Dati SDO 2010. [Annual Report on hospitalisation activities], Ministry of Health, Directorate General for Planning, Office IV, 2011.

Residential facilities (RFs) – Strutture residenziali

115. Parallel to the decrease in the number of psychiatric beds in inpatient facilities, the number of residential facilities has increased from 1 577 in 2007 to 1 679 in 2009, along with an increase in the number of psychiatric beds in RFs (passing from 15 351 in 2005 to 19 299 in 2009). However, the number of assistance days per user has decreased by 16% in RFs from 2005 to 2009 (see Figure 20) (Ministry of Health, 2011c).

Figure 20. Number of assistance days per user and psychiatric beds provided in RFs, 2005-2009



Source: Ministry of Health (2011c), *Relazione sullo stato sanitario del paese 2009-2010 [Report on the health status of the country 2009-2010],* Ministry of Health, Directorate General for health information, communication technology and statistics, 2011.

116. The overall number of Residential Facilities is much higher compared to the number of Semi-residential facilities in Italy. This might be due to the fact that the core of outpatient services is provided by CMHCs. However, the overall number of users is higher in Semi-residential facilities compared to RFs, and this is due to the nature of the services provided (outpatient and inpatient respectively) (Ministry of Health, 2011c). Significant differences exist across regions in terms of the number of assistance days per user provided, with 91 days per user in Emilia Romagna compared to 312 days in Puglia within RFs and 26 days per user in Calabria compared to 333 in Molise within Semi-residential Facilities (Ministry of Health 2011c) (see Table 5).

Table 5. Services provided by residential and semi-residential facilities, by region – 2009

Region	Residential facilities				Semi-residential facilities			
	Residential facilities	Beds	Users	Assistance days per user	Semi-residential facilities	Beds	Users	Assistance days per user
Piemonte	260	2 301	1 972	268.21	47	1 130	2 770	66.90
Valle d'Aosta	2	31	31	292.39	1	11	16	113.19
Lombardia	288	3 691	5 894	209.01	160	2 496	6 857	71.83
Prov. Auton. Bolzano	8	129	233	180.97	6	67	386	54.46
Prov. Auton. Trento	14	148	195	194.66	7	109	456	36.36
Veneto	186	1 822	2 128	252.06	118	1 750	4 006	70.25
Friuli Venezia iulia	36	265	759	104.94	20	286	1 212	38.16
Liguria	63	834	945	264.16	18	302	1 010	60.64
Emilia Romagna	205	1 839	6 198	91.81	66	1 004	3 660	52.65
Toscana	127	819	1 114	202.39	68	1 092	2 073	90.49
Umbria	40	333	363	275.93	16	220	322	91.72
Marche	36	444	587	251.63	16	234	468	91.94
Lazio	76	1 357	3 855	111.43	51	1 412	2 217	68.08
Abruzzo	34	759	886	295.51	10	201	284	122.40
Molise	6	60	69	315.68	6	17	18	332.94
Campania	92	931	1 358	196.47	72	1 073	2 851	50.83
Puglia	81	1 243	1 006	312.76	28	529	588	211.99
Basilicata	25	284	354	238.10	4	70	63	190.79
Calabria	17	353	364	148.70	9	84	578	26.57
Sicilia	50	1 290	1 667	249.38	30	560	1 894	41.21
Sardegna	33	366	397	224.75	10	188	301	68.29
Italy	**1 679**	**19 299**	**30 375**	**187.52**	**763**	**12 835**	**32 030**	**67.01**

Source: Ministry of Health (2011c), *Relazione sullo stato sanitario del paese 2009-2010 [Report on the health status of the country 2009-2010],* Ministry of Health, Directorate General for health information, communication technology and statistics, 2011.

117. In 2000, a broad national survey – the PROGRES study – conducted by the Italian National Institute of Health (ISS) investigated the network of RFs in Italy. During phase 2 of the study, data was gathered on 267 facilities accommodating 3 005 patients in 20 out of 21 regions (except Molise). According to the second phase, 36.8% of patients residing at the time in the sample RFs were female (Munizza *et al.,* 2011).

118. RFs accommodate patients mostly for long-term stays: 35% of patients residing in RFs were there for the past 3 years or more and 75% had no formal limitation on the length of their stay. Resident turnover is particularly low, with few new admissions and fewer discharges (on the sample considered for phase 2, 25% of RFs hadn't discharged any patient in 2000 and 25% discharged only 1 to 2 patients in 2000) (Munizza *et al.,* 2011). As a result, for many chronic patients RFs represent a permanent home ("home for life") instead of a temporary housing solution. This feature sometimes makes it difficult to assess the transition from old-style mental institutions to residential mental health facilities, although there has been substantial change in the background culture, the reduced number of patients and the type of care provided.

Complementary/alternative/traditional practitioners

119. Most of the complementary/alternative/traditional practitioners contacted by people suffering from a mental illness in Italy are religious officials. Religion, a traditional source of relief from pain and distress, is an important feature in the lives of many Italians, fewer than 15% of whom declare being agnostic or atheist (ARDA, 2013). Italy appears to be the most religious country in the WHO ESEMeD study, with religious advisors being the most involved in providing help for mental health issues. The use of religious advisors indicates both the preeminent role of religion in Italy and a certain reluctance to label one's issues as mental problems. According to the ESEMeD study, during the year preceding the survey

0.4% of respondents had contacted a religious advisor to help with psychological distress (this figure is equal to that of France and Belgium). Among people seeking help with a mental health problem, 3.6% addressed religious advisers exclusively, while 5.5% used both religious and formal help (De Girolamo *et al.,* 2006a).

120. For a practical example of the organisation of the adult mental health system, see Box 8.

Box 8. Organisation of mental health services in the city of Trieste

The organisation of psychiatric services in the city of Trieste (201 814 inhabitants) has beentransformed since 1971, following the activities of Franco Basaglia and his team and resulted in the closure of the San Giovanni psychiatric hospital in 1980 along with the setting up of a network of community-based services. This model of community-based mental health services has been implemented acrossthe whole Region Friuli Venezia Giulia (1 217 864 population) as a regional model, focussed on "strong" comprehensive 24 hour Community Mental Health Centres, equippedto respondto the most severe conditions and psychiatric episodes and to support clients in their ordinary life in a view of recovery and social inclusion. Recognised as an experimental pilot area of mental health de-institutionalisation by the WHO in 1974 (Babini, 2009), considered as an example of proven success in 2001 (WHO, 2001), the DMH of Trieste has been first appointed Collaborating Centre by the WHO in 1987 and most recently it was designated the WHO Lead Collaborating Centre for Service Development in the framework of WHO-Euro Helsinki Declaration and Action Plan in 2005 (Rosen *et al*., 2012).

Currently the Department of Mental Health (DMH) in Trieste manages four Community Mental Health Centres (CMHCs) – open 24 hours/7 days a week and provided with 4-8 beds each – each competent for a catchment area of approximately 60 000 inhabitant. Started with the aim of reducing psychiatric hospital admissions and promoting rehabilitation and social re-integration, the four CMHCs provide the core of mental health services in Trieste. The General Hospital Psychiatric Unit (GHPU) provides inpatient mental health services, but its 6 beds are mainly used as a filter for emergency situations at night, and normally do not admit patients for more than 24 hours. Instead, patients are referred to the CMHC of the area where they live or to other appropriate services as soon as possible. In addition to the four CMHCs and the GHPU, the DMH also includes a rehabilitation and residential support service, where there are about 45 beds in group-homes and supported housing schemes whose main aim is to encourage users to move from living together towards an individual home with the required daily support. In addition, there is a network of 15 social cooperatives and also associations encompassing carers and users as well as other lay people involved.

Available indicators suggest that Trieste is delivering effective care that contributes to good patient outcomes. Compulsory Treatment Orders (CTOs) discharge rates in the Region Friuli Venezia Giulia are one of the lowest in Italy, with 5 cases per 100 000 population per year compared to a national average of 17 (see Figure 1) (Ministry of Health, 2011b). Moreover, two thirds of people under the CTOs were treated within CMHCs rather than in inpatient facilities in 2005 in Trieste (Mezzina & Johnsons, 2008). Suicide rates have decreased from 25 to 11 per 100 000 in the city of Trieste over the last 15 years, possibly as a result of a proactive preventionprogramme (Dell'Acqua *et al*, 2003).Mental health services in Trieste do not make use of restraint measures, such as locked doors and mechanical restraint (Rosen *et al*., 2012; De Girolamo, et al 2007).

160 clients per year receive a personal budget in order to fulfil the aims of a joint and shared plan of recovery in the areas of housing, work and social relationships. This represented about 18% of the overall budget of the DMH in 2011, while about 4% is devoted to economic aid, training grants, leisure and projects with NGOs (extra-clinical activities) (see Table 6). About 180 people are in professional training every year on work grants, and 20-25 of these find paid employments each year in the Trieste job market, many in the field of social cooperation and about a third in private firms. The remaining budget was spent on personnel (about 55%), health budget (more than 17%) and pharmaceuticals (almost 6% of total expenditures) in 2011 (Mezzina R., in Fioritti & Amaddeo, forthcoming).

Table 6. Cost of mental health care by sector, Trieste, 2011

Sector	Costs	% of total mental health Expenditures
Personnel	€10 313 388	54.88%
Pharmaceuticals	€ 1 082 762	5.76%
Clients personal budgets	€ 3 506 499	18.66%
Extra-clinical activities	€ 669 283	3.56%
Health budget	€ 3 221 582	17.14%
Total	€18 793 514	100.00%

Source: Mezzina in Fioritti, A. and F. Amaddeo (forthcoming), "Community mental health care in Italy today", *The Journal of Nervous and Mental Disease*.

4.2 Children and adolescent mental health

121. Infant Neuropsychiatry Services (*Servizi di Neuropsichiatria Infantile*) are today the core of young people's mental health care in Italy, although these facilities are reported to have significant limitations in terms of management, finance and human resources. According to the Targeted Mental Health Care Plan 1998-2000, the Departments of Mental Health (DMHs) should also integrate the care of child/adolescent mental health in the Infant Neuropsychiatry Services (Ministry of Health, 1998a). However, not all Local Health Authorities have put their DMHs in charge of child/adolescent mental health, and some have devolved this mission to maternal/infant care departments and others have yet to present a comprehensive plan for taking care of child and adolescent mental health.

122. In 2007, the Italian Child and Adolescent Neuropsychiatry Association (*Società Italiana di Neuropsichiatria dell'Infanzia e dell'Adolescenza* – SINPIA) ran a national survey in all Italian regions to gauge the state of mental health services for children and adolescents (Nardocci, 2009). The outcome showed the inappropriateness of child and adolescent mental health services provision, in that only 12 regions out of 20 have established formal neuropsychiatry services, of which 8 have a clear denomination, 7 have a specific strategic plan for their catchment area and only 3 have a fixed organisational structure. Moreover, management responsibilities are in most regions ambiguous: in 4 regions neuropsychiatry services merge with Departments of Mental Health, in 4 regions they merge with Mother/Infant Departments and in the remaining 12 regions they are managed by a variety of services (Nardocci, 2009).

123. The current deficiencies in the provision of mental health services for the youngest population groups have historical roots. Law 180 disregarded child and adolescent mental health care. For instance, on 31 December 1960 there were 310 326 children hospitalised in isolated institutions (ISTAT, 1963): 112 956 in orphanages; 87 594 in "institutes for poor and abandoned children"; 61 402 in permanent colonies, *i.e.* "institutes that accommodate lymphatic, anemic and TBC prone children, etc."; 18 464 in institutes for "other categories of patients"; 10 081 in institutes for "mentally disabled people"; 8 699 in the new orphanages for "internal upbringing"; 7 624 in institutes for the "sensory impaired"; and 3 506 in institutes for the "physically impaired". Running in parallel with these institutions was a system of special schools and "different" classes for socially deprived children and children with medium intellect or language deficiencies (ISTAT, 1963). Following a variety of well-documented scandals in child and adolescent mental health institutions, Law 104 on the rights of disabled people, including children and adolescents, was approved in 1992. Although most regions have fully implemented Law 104, some are still lagging (Nardocci, 2009).

124. The draft National Health Plan 2011-2013, along with the most recent Italian Mental Health Action Plan, highlighted the unsatisfactory state of the provision of child and adolescent mental health services in Italy and called for an integrated and coordinated response at the national, regional and local levels. In particular, there is the need to: establish a comprehensive monitoring system for child and adolescent mental health; reorganise neuropsychiatric services in a homogeneous and efficient way throughout Italy; encourage early intervention on the onset of the mental health illness; and facilitate cooperation and coordination between mental health services and pediatric services, schools, community social services and commissioned private health services (Ministry of Health, 2011a; Ministry of Health, 2013).

125. Although falling beyond the scope of this paper, recent strategies are being promoted to provide policy direction in the field of autism disorders, *e.g.* the "Action Plan for the improvement and promotion of qualitative and appropriate interventions in developmental disorders, with a particular reference to autism disorders" *(Linee di indirizzo per la promozione ed il miglioramento della qualità e*

dell'appropriatezza degli interventi assistenziali nel settore dei Disturbi pervasivi dello sviluppo, con particolare riferimento ai disturbi dello spettro autistico) (Ministry of Health, 2012b).

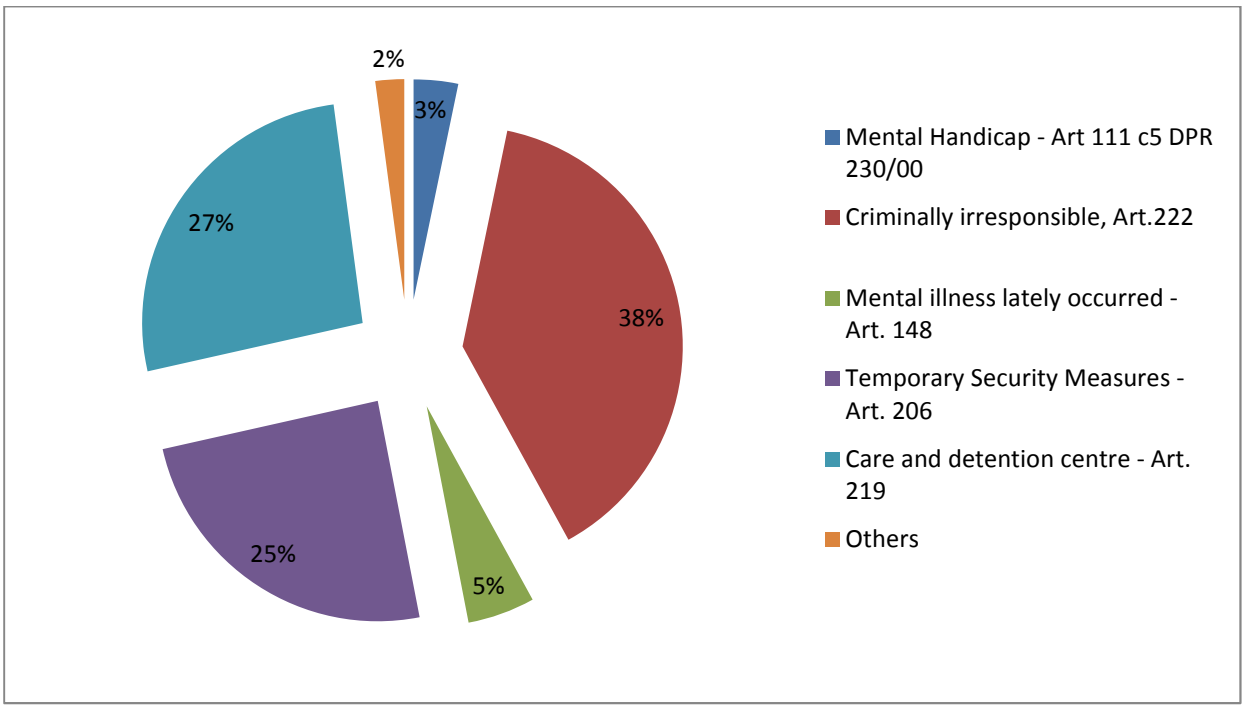
4.3. Forensic mental health

126. Since the mid-1970s, "Judiciary Psychiatric Hospitals" (*Ospedali Psichiatrici Giudiziari* – OPG, forensic inpatient units) have replaced the former criminal asylums in Italy. Despite the aim of Law Basaglia to close all former mental hospitals in 1978, the protection and health care of mentally disordered offenders was disregarded by Law 180. As a consequence, forensic inpatient units established in 1975 were kept open and remained more or less unchanged. There are currently 6 forensic inpatient units in Italy: the Judiciary Psychiatric Hospital of Barcellona Pozzo di Gotto (Sicilia); the Judiciary Psychiatric Hospital of Reggio Emilia (Emilia Romagna); the Judiciary Psychiatric Hospital of Montelupo Fiorentino (Toscana); the Judiciary Psychiatric Hospital of Castiglione delle Stiviere (Lombardia); the Judiciary Psychiatric Hospital of Napoli (Campania) and the Judiciary Psychiatric Hospital of Aversa (Campania). Due to the implementation of Law 9 (see below) and the current process of closure of all OPGs, the number of inmates decreased from 1 378 in July 2011 to 972 in June 2012, and the figure is continuing to fall.

127. The Italian Penal Code (hereafter p.c.) is a binary code, requiring detention for "sane" offenders and security measures for mentally disabled people. As established by Art. 88 and 89 p.c., offenders are not criminally liable if, at the moment of the offence, they were not capable of "understanding and intent" (*capacità di intendere e di volere*) because of mental impairment. Inmates who experienced mental health impairment during the execution of the sentence (Art. 148 p.c.), people with a severe mental handicap (Art. 111 D.P.R. 230/2000) and people with partial mental disorder (Art. 219) are also eligible for being detained in an OPG, upon verification that they are socially dangerous (Art. 203 p.c.). Under Art. 222 p.c., security measures consist in at least 2, 5 or 10 years detention in Judiciary Psychiatric Hospitals (depending on the severity of the crime committed), after which, under Art. 208 p.c., the patient is subject to re-examination of his/her social dangerousness by the surveillance judge, rather than being automatically discharged after the sentence is served, as is the case for sane inmates.

128. As of July 2011, the legal status of patients was as follows: 534 patients declared criminally irresponsible and involuntarily placed in an OPG under section 222 of the Penal Code; 338 patients whose provisional placement in an OPG had been ordered under section 206 of the Penal Code (Temporary Security Measures); 68 sentenced prisoners requiring psychiatric care placed in the OPG under section 148 of the Penal Code; 364 patients declared partially criminally irresponsible and placed in a "care and detention centre" (*Casa di Cura e Custodia)* under section 219 of the Penal Code; and 45 patients declared mentally handicapped under section 111 c5 DPR 230/00 of the Penal Code (see Figure 21).

Figure 21. Legal status of inmates in OPGs, July 2011



Source: Italian Parliament (2011), Revisione sulle condizioni di vita e di cura all'interno degli Ospedali Psichiatrici Giudiziari [Review on life conditions and health care standards within OPGs],
Available: http://www.senato.it/documenti/repository/commissioni/servizio_sanitario16/Relazione_OOPPGG_doc_XXII-bis_4.pdf
Italian Parliament, Senate, 2011.

129. Formerly linked to the Penitentiary Administration, the Italian forensic inpatient units were put under the responsibility of the Ministry of Health by Prime Ministerial Decree/2008 (Ministry of Health & Ministry of Justice, 2008a). More precisely, Prime Ministerial Decree/2008, which took effect on 14 June 2008, entrusted the regions and Local Health Authorities with health care responsibilities over prisons, juvenile justice services, as well as the OPGs (Ministry of Health & Ministry of Justice, 2008a). The "Guidelines for the operations of the NHS to protect the health of detainees and inmates in prisons and minors subjected to penal measures" (*Linee di indirizzo per gli interventi del Servizio sanitario nazionale a tutela della salute dei detenuti e degli internati negli istituti penitenziari, e dei minorenni sottoposti a provvedimento penale*) (Ministry of Health & Ministry of Justice, 2008a) and the "Guidelines for the interventions in Judicial Psychiatric Hospitals and Care Homes" (*Linee di indirizzo per gli interventi negli Ospedali Psichiatrici Giudiziari e nelle case di cura e custodia*) (Ministry of Health & Ministry of Justice, 2008b) were approved as a complement to Prime Ministerial Decree/2008. The former identifies optimal paths for the prevention and treatment of mentally disordered offenders, in order to achieve the LEAs; the latter is a programmatic document that defines a three-phase process for the harmonisation of safety and sanitary requirements within OPGs (Ministry of Health & Ministry of Justice, 2008b). Nevertheless, the implementation of Prime Ministerial Decree/2008 was disregarded by the Sicily region, which has not transferred health competencies to the NHS for the administration of the Psychiatric Hospital of Barcellona Pozzo di Gotto.

130. The National Strategic Plan for Mental Health (Ministry of Health, 2008a) mentioned forensic inpatient units as one of the elements in mental health services that required special attention. In this respect the National Strategic Plan for Mental Health suggested that:

- People admitted in OPGs (especially people acquitted with total/partial mental disorder) should be reassessed and a category of inmates should be set up for rapid discharge and possible use of the NHS services, especially mental health services;

- Inmates should be taken care of from their first admission to an OPG from the perspective of managing their rehabilitation and social reintegration, with active collaboration with the concerned Departments of Mental Health;

- The discharge of inmates who have come to the end of their security measure should be planned with the concerned regions and local actors in order to ensure effective social inclusion;

- All necessary actions must be taken on a regional level to enforce alternative projects to the admission in OPGs through the continuity of the relationship between the Departments of Mental Health and the Courts of Justice;

- Inmates formerly sent to penitentiary facilities before being admitted to OPGs should reintegrate their former facilities with a guarantee that all health interventions and rehabilitative programmes would be performed in the penal institutions.

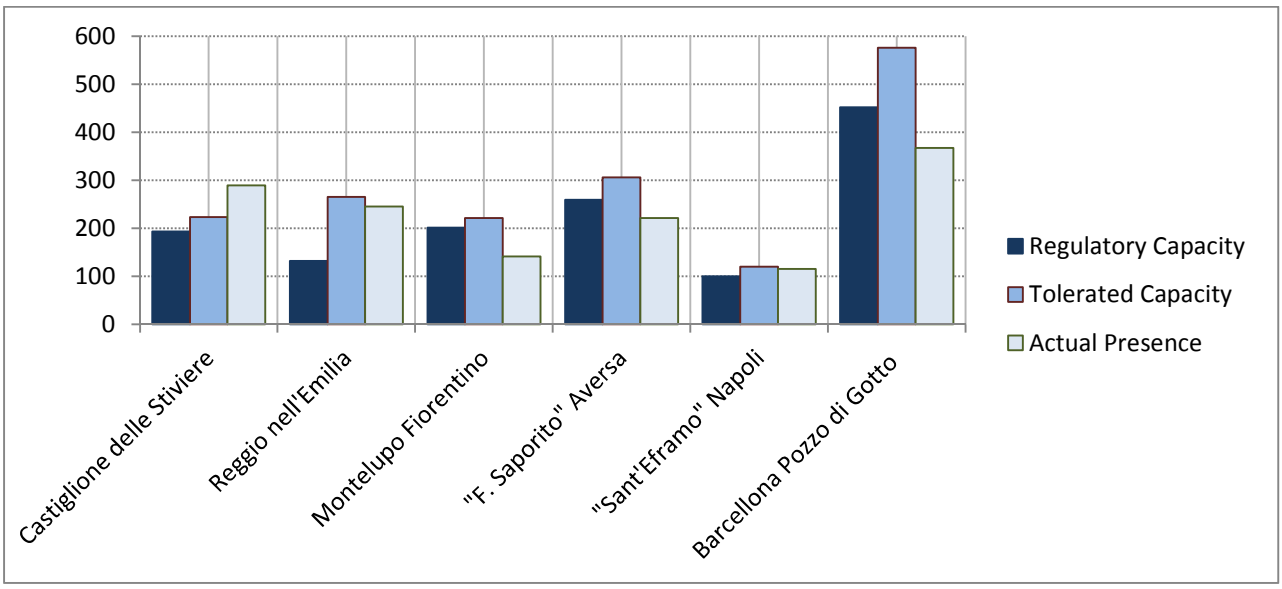
131. In 2010, the European Council for the Prevention of Torture (CPT) published a Report summarising the outcomes of the inspections conducted into some security facilities in Italy, including prisons, mental health wards within general hospitals and OPGs (Council of Europe, 2010). The Council visited the OPG of Aversa and concluded that "[t]he gravity of the situation observed at the Aversa OPG calls for a more determined response from the Italian authorities, preferably at national level" (Council of Europe, 2010:62). Other visits into OPGs were conducted in 1992, 1996 and 2000 and reported more or less the same situation.

132. Under Art. 82 of the Italian Constitution, a Parliamentary Commission of Inquiry into the efficacy and the efficiency of the National Health Service (*Commissione Parlamentare di Inchiesta sull'efficacia e l'efficienza del Servizio Sanitario Nazionale*) (hereafter the "Commission"), was set up in 2008 to monitor the quality of both public and private health services provided in the whole territory and to control the actual implementation of health policies, thus providing the Parliament and the Public Administration with comprehensive indications on the state of health services provision in Italy. The Commission was composed of 20 senators and 1 President and holds, for the entire period of the legislature (5 years), the same powers and limitations conferred on the legal authorities. Following the above-mentioned recommendations of the National Strategic Plan for Mental Health (Ministry of Health, 2008a), part of the work undertaken by the Commission was devoted to the investigation of the operation of Italy's OPGs. The Commission organised regular unannounced on-the-spot inspections during the years 2008-2011 into each of the 6 OPGs and carried out interviews with OPG directors and with consumer associations (such as Psychiatric Democracy – *Democrazia Psichiatrica* and StopOPG).

133. The outcome of the investigation revealed the inadequacy of primary and secondary health care provision in all OPGs, with the exception of the Judiciary Psychiatric Hospital of Castiglione delle Stiviere, and in particular: "severe and unacceptable" hygienic and sanitary conditions, with a structural setting more similar to prisons than average psychiatric services provided in Italy; health and social care personnel shortages; and inadequate clinical treatments, including improper use of physical and pharmacological restraint. In some extreme cases, the rooms/cells were overcrowded (some even had bunk beds, contrary to the prison authorities' guidelines); for half of the structures, the number of inmates exceeded the facility's regulatory capacity, whilst in one case the number of inmates exceeded the structure's tolerated capacity (see Figure 22); the management of cleaning services was unclear and remained undelivered or left to patients; insufficient basic primary health care and specialist mental health

care was provided, with significant staff shortages of physicians and nurses and a complete absence of psychiatrists and/or psychologists; the use of drugs was not duly certified or appropriately recorded, with evident breaches of current legislation (art. 60 e ss. del D.P.R. 309/199); and brutal restraint measures, besides being contrary to Art. 32 of the Italian Constitution – "the law can in no case violate the limits imposed by respect for the human person" – were not regularly reported in the patient's clinical diary (Italian Parliament, 2011).

Figure 22. Regulatory capacity, tolerated capacity and actual presence of inmates in the 6 OPGs – July 2011



Source: Italian Parliament (2011), Revisione sulle condizioni di vita e di cura all'interno degli Ospedali Psichiatrici Giudiziari [Review on life conditions and health care standards within OPGs],
Available: http://www.senato.it/documenti/repository/commissioni/servizio_sanitario16/Relazione_OOPPGG_doc_XXII-bis_4.pdf
Italian Parliament, Senate, 2011.

134. Following the inspections, in July 2011 the Commission published an evidence-based "Review of life conditions and health care standards within OPGs" (*Revisione sulle condizioni di vita e di cura all'interno degli Ospedali Psichiatrici Giudiziari*) (Italian Parliament, 2011). In addition to encouraging the actual transfer of responsibilities from the penitentiary administration to the NHS in the Psychiatric Hospital of Barcellona Pozzo di Gotto (Sicily) as required by Prime Ministerial Decree/2008, the review provided a number of recommendations for the renewal of mental health legislation and the subsequent overrun of the OPG model.

- Specific legislation on mentally disordered offenders should be approved as a complement to Law 180. The new model should couple mental health treatment with adequate security measures.

- The Departments of Mental Health (DMH) should be directly responsible for taking charge of mentally disordered offenders. The new model should be based on the provision of evidence-based mental health treatment used as a form of health care, rather than restraint and control measures used as a form of punishment. For this to happen, additional resources should be allocated to DMHs. With these financial and human resources, the DMHs should provide mentally disordered offenders with small therapeutic communities (maximum 20 hosts) across a range of security levels in the whole territory.

- In order to avoid the perpetual extension of temporary security measures, which in some cases results in the so-called "*ergastolo bianco"*[9], the Penal Code should be substantially modified. In this respect, the length of security measures should be clearly defined when the sentence is pronounced, as is the case in Spain. This is in line with the broader idea that the length of the detention period within an OPG should not exceed the penalty provided in prison for the same violation. A valuable alternative to this proposal would be to ensure that the level of social danger posed by inmates is established by an adequate psychiatric medical board, rather than by the surveillance judge.

- Going even beyond the scope and legal powers of the Commission, the Review suggests that the actual duality of the Penal Code, adopting distinct custodial measures with respect to sane and insane patients, should be replaced by a univocal approach.

135. Other concrete actions were undertaken between 2009 and 2011 in Italy to overrun OPGs, through the establishment of National Committees (*Tavolo di Consultazione permanente sull'attuazione del DPCM 1 aprile 2008* and the *Comitato Paritetico per le problematiche degli Ospedali psichiatrici giudiziari*).

136. Legislation was approved in February 2012 (Law 9) by the Italian Government, according to which all OPGs should be closed by 31 March 2013. Law 9 also required that, following the closure of the OPGs, people who are no longer considered to be socially dangerous should be taken over by Departments of Mental Health, whilst other patients are integrated into new security mental health facilities of smaller size (20 hosts). The Ministry of Health established a working group with the aim of defining the structural, technological and organisational requirements for the construction of the new secure mental health facilities. Suggested by the aforementioned National Committees and approved by the Parliament, further legislation settled that:

- The new structures should be differentiated by the severity of the pathology;

- The new facilities should be publicly owned, in virtue of the fact that in Italy the execution of a penal sentence is under the responsibility of the public administration;

- The new services should host a maximum of 20 inmates.

137. In order for the legislation to be implemented in a timely way, the Italian Government earmarked funding totalling EUR 272 million, with EUR 174 million for the construction of new infrastructures destined to host socially dangerous OPG inmates and the remaining EUR 38 million for 2012 and EUR 55 million for 2013 to be allocated to regions and provinces for running and managing activities.

138. Due to the impossibility of creating alternative mental health infrastructures on time, the closure of the OPGs was postponed to spring 2015.

4.4. Minority and excluded groups

Elderly population

139. Due to a low fertility rate and high life expectancy at birth, Italy has the highest ratio of elderly people to the total population of any country in Europe and comes second country in the world after Japan

[9] *Ergastolo Bianco*, literally "white life sentence". It is the situation under which security measures are continuously extended up until the point that detained people are in security facilities for their entire lives.

(Altis, 2013). People aged 65 and over represented approximately 20% of the total population in 2009, with the 65-74 age group representing 10% and those over 75 another 10% of the ratio (Sabetta, 2012).

140. The prevalence of depression among older people (over 64) is higher compared to adults (18-64 years). Between 2009 and 2010, over 20% of the elderly were suffering from depression, compared to 7% of adults in general, with a higher rate for people over 75 (25.3%) than for people from 65 to 74 (18.8%) (ISS, 2012b) (for further information see section 2 on prevalence).

141. Mental health services for people aged above 64 are not differentiated from adult mental health services, so that services described in section 4.1 are also available to older people.

142. The Italian Psychogeriatrics Society (*Società Italiana di Psicogeriatria,* AIP) is a non-profit organisation aiming to tackle mental health problems among the eldest population. The AIP promotes training programmes among medical (GPs and psychiatrists) and non-medical (nurses, psychologists) personnel; promotes and undertakes research studies; organises national conferences and meetings and promotes the dissemination of knowledge through magazines, books, newspapers and its website (http://www.psicogeriatria.it/home/); helps in developing programmes and policies for the improvement of the mental health status of the eldest population; and provides consultancy to both private and public organisations.

Migrant population

143. From 2002 to 2011, approximately 3.5 million foreigners immigrated into Italy, a rise from 200 000 in 2002 to more than 500 000 in 2007 and 300 000 in 2012 (ISTAT, 2012b). Since February 2011, an increasing number of people from North Africa migrated to Italy following the Arab Spring. Differences in immigration rates exist across regions, with northern and central regions – Lombardy (80 000) Lazio (47 000), Emilia-Romagna (35 000) and Veneto (32 000) – having a higher number of foreign immigrants compared to other regions (ISTAT, 2012b). These figures do not take into account all the "irregular" immigrants who do not have permission to stay in the territory. It was estimated that 150 000 irregular immigrants were living in the Lombardy region in 2009 (Civenti *et al.,* 2012).

144. The mental health agenda in Italy is giving increasing importance to the recent intensification of migration flows and the significant increase of immigrant populations residing in the territory. Multiculturalism is a key point of the National Strategic Plans for Mental Health, with the policy document emphasising the importance of integrating linguistic/cultural mediation in the range of services provided by mental health facilities (Ministry of Health, 2008a).

145. Today, access to health care services for irregular immigrants is incomplete and uncertain, whereas regular immigrants have the same rights to access health services as citizens. Nonetheless, the latter do not benefit from the services in the same way as citizens do, a phenomenon that in the literature is called the "implementation deficit". This is mainly due to the characteristics of the services (community services, as opposed to hospitals), the stigma related to the utilisation of mental health facilities and the absence of multicultural specialistis able to decode mental health symptoms while taking into account cultural differences (Civenti *et al.,* 2012).

146. Regional programmes have been implemented in recent years to gauge the state of mental health among immigrants in Italy and to adapt mental health facilities to provide services more suited to this population group. A concrete instance of this process is the project on "Migration and psychiatric disorders in child, adolescent and adult mental health" (*Migrazione e disagio psichico nell'età evolutiva e verso l'età adulta*), which was developed and implemented in 2007 in the Lombardy region following evidence that over the past years child and adolescent immigrants accessed mental health services twice as much as

Italian citizens, that they dropped out from mental health services very frequently and that they dropped out of school three times as frequently as Italian children and adolescents. As mentioned above, the Lombardy region has the highest number of immigrants of any region, and this holds for young immigrants as well. In Milan, for instance, 20% of all adolescents have a history of migration (*e.g.* immigrant minors without their parents, first- and second-generation immigrants).

147. The project "Migration and psychiatric disorders in child, adolescent and adult mental health" aims at improving mental health services for the immigrant population through a variety of different activities, including the following: linking mental health services with other services, *i.e.* schools, in order to ensure prompt intervention in the early stages of mental health disorders; providing qualitative and pertinent hospitalisations for immigrants (both in mental health and other health sectors); providing prompt, cross-cultural responses, through the development of multicultural teams within mental health services, as well as the provision of informative brochures in different languages; providing mental health services for immigrant offenders suffering from mental health problems; and linking child and adolescent mental health services with adult mental health services in order to guarantee the continuity of mental health assistance. Moreover, since 2010 mental health services in the Lombardy region have organised an ad hoc information system in order to gather epidemiological data from immigrants who access mental health services for the first time.

148. Running in parallel with the regional initiatives is a national discussion among experts, including mental health experts, on the topic of migration. The National Focal Point Italian Infectious Diseases and Migrant (NFP) is a network of experts in the field of infectious diseases within the migrant population. The working groups were established in 1997 in the context of the "AIDS & Mobility" project and today are coordinated by the National Institute of Health (ISS). During the XI Conference, which took place in 2012, the NFP focused on the correlation between mental health, culture and infectious diseases within the immigrant population in Italy. The Conference concluded that mental health control could have a positive effect on infectious disease control within the immigrant population (ISS, 2012c).

Post-earthquake organisation and delivery of mental health services in L'Aquila

149. On 6 April 2009, an earthquake (6.3 Mw) hit the city of L'Aquila (Abruzzo) – in central Italy – a town with 72 000 inhabitants and a health district of 105 000 residents. The earthquake caused the death of 309 people, with more than 1 600 individuals injured, among whom 200 were severely injured and hospitalised and 66 000 displaced. Approximately 44 000 found an accommodation in tented camps close to their place of residence, and a further 20 000 were housed in hotels on the Abruzzo Adriatic Sea coast. Others stayed with friends and relatives throughout Italy (Casacchia *et al.,* 2012).

150. Natural disasters like earthquakes are traumatic events that can cause severe psychological distress. A study was conducted between April 2009 and January 2010 among 187 young people seeking help at the Service for Monitoring and early Intervention against psychological and mental suffering in young people (SMILE) at the L'Aquila University Psychiatric Department. The aim was to evaluate the presence of Post-Traumatic Stress Disorder (PTSD) in the sample. 44.2% and 37.4% respectively showed high and moderate levels of psychological distress. 66.7% reported the presence of a significant post-traumatic symptom (Post-traumatic Syndrome), while a diagnosis of PTSD was made in 13.8% of the sample (Pollice *et al.,* 2010). This is in line with other studies showing that natural disasters produce high psychological distress. A study assessing the prevalence of Acute Stress Disorder (ASD) among individuals seeking help at the General Hospital Psychiatric Unit of the San Salvatore Hospital following the earthquake showed that, despite the high level of psychological distress (GHQ-12 ≥20, cut-off value) found in 65.6% of the subjects, only 6 subjects (4.9%) could be considered affected by "full" ASD, whereas 48 subjects (39.3%) could be considered affected by "partial" ASD (Casacchia *et al.,* 2013). A study conducted on some 1 078 young adults (mean age 21.4 ± 5.6) to assess mental health status and the

increase in substance use (tobacco, alcohol and cannabis) after the earthquake, showed that 314 people (29.1% of the sample) had an ICD-10 diagnosis of anxiety disorders (43%), mood disorders (34%), PTSD (16%) and psychosis (7%). 57% of these 314 people increased their consumption of alcohol, 41% of tobacco and 22% of cannabis (Pollice *et al.,* 2011a). Another study gave evidence of a significant increase of first episode psychosis (FEP) after the earthquake (Pollice *et al.,* 2011b).

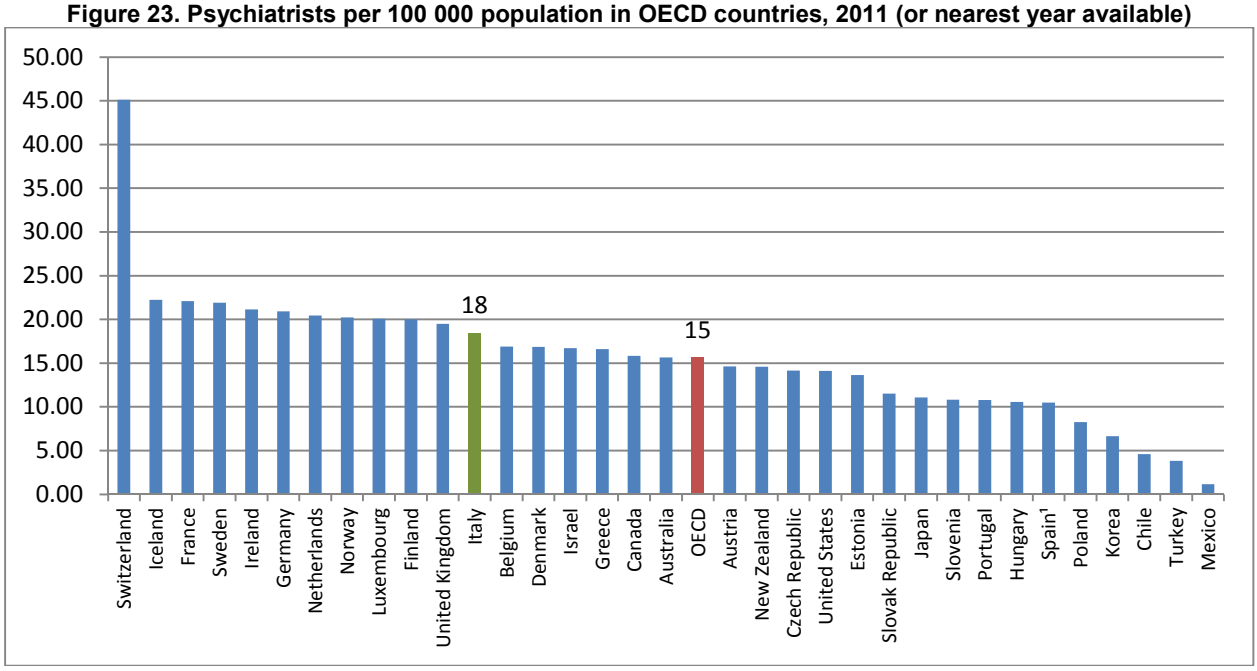
151. The project *Programma di Supporto Psicosociale Emergenza Sisma* (SPES) (Psychosocial Support and Earthquake Emergency) was establish to give mental health support to people seeking help after the earthquake in L'Aquila. Approved on May 2009 and granted by the Italian Ministry of Health, the project was carried out in a tent. SPES currently includes three main areas of intervention: (1) assessment of the earthquake's impact on the general population; (2) cooperation with GPs *i.e.* training of GPs in the identification and psychological management of traumatic events; (3) support of secondary mental health services in the region, such as training in Evidence-Based Medicine (EBM) and treatments for PTSD. After the earthquake, it was hypothesised that most residents had found a way to recover through "writing and telling the story". As a consequence, a large number of materials (books, web-blogs, videos) were produced by residents and a database of memories was implemented. Many collective demonstrations were organised and showed the will to actively participate in the process of reconstructing the civil and scientific life of the town (Casacchia *et al.,* 2012).

4.5. Human resources and training

Psychiatrists

152. In Italy there were 18 per 100 000 population, placing Italy slightly above the OECD average (see Figure23).

Figure 23. Psychiatrists per 100 000 population in OECD countries, 2011 (or nearest year available)



Source: OECD health database, [Online] Available http://stats.oecd.org/ Accessed 18/03/2013.

153. Medical students can become psychiatrists after obtaining their medical degree (5-year programme, with a special focus on communication skills, role-playing and empirical know-how since 1996) by completing a 4-year postgraduate training in a university or in mental health services under

proper agreement with a school of psychiatry. The training specifically requires that aspiring psychiatrists treat at least 80 patients; provide psychotherapy to at least 20 patients under supervision; give psychometric tests to at least 40 patients; take part in at least 10 rehabilitation programmes and 5 controlled clinical trials on psychotropics; give at least 20 psychiatric consultations; be on call 50 times; and become familiar with forensic psychiatry.

154. Guidelines and approaches, especially concerning training in psychotherapy, forensic psychiatry and psychiatric rehabilitation, can vary from one school of psychiatry to another, and psychotherapy is much less used than a strictly biological approach. Despite psychotherapy training being relatively insufficient to ensure proper know-how, students who have completed the 4-year training are considered licensed psychotherapists.

Psychologists

155. Psychologists play an active role in the consultation-liaison process set up to link GPs to mental health professionals (see Box 7). The WHO Mental Health Atlas (WHO, 2011) has reported that Italy as having one of the lowest numbers of clinician psychologists in Europe, with a ratio of 2.58 psychologists for 100 000 inhabitants in 2011.

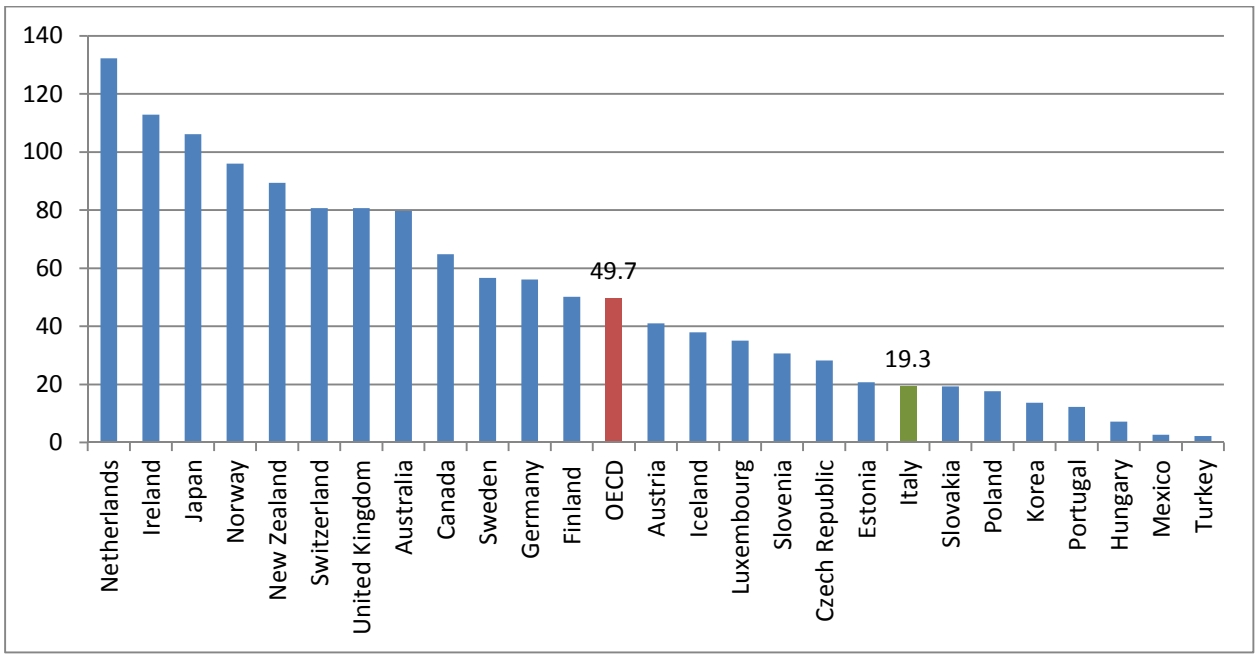
156. Contact with psychologists is low overall in Italy. For instance, the ESEMeD study found that only 6% of people had addressed a psychologist with the NHS for a psychological issue (De Girolamo *et al.,* 2006a) with the general impression being that psychotherapy is costly: concretely, the Bersani decree of 2006 (D.L. 4/7/2006 n. 233 c.d.) has abolished minimum tariffs for psychotherapy sessions, with regional orders of psychologists setting up varied rates for consultancy and therapy sessions (usually from EUR 35 up to EUR 115) (for further information on tariffs see http://www.psy.it/tariffario.html).

157. Aspiring psychologists have to complete a 3-year programme (bachelor's degree) followed by a 2-year programme (master's degree) in psychological specialties. In order to be licensed within the NHS system, students must then complete an additional 4-year postgraduate training. Aspiring psychotherapists must complete a 4-year postgraduate training in a university with a psychotherapy programme or in certified private facilities.

Mental health nurses

158. The number of mental health nurses (relative to the population) was well below the OECD average in 2011, with approximately 19 mental health nurses per 100 000 population in Italy in 2011 (see Figure 24).

Figure 24. Mental health nurses per 100 000 population, 2011 (or nearest year)



Source: OECD (2013), Health at a Glance 2013: OECD Indicators, OECD Publishing.

159. Aspiring nurses must complete a 3-year university-based programme, resulting in a bachelor's degree in nursing. Seminars covering psychological and psychiatric topics constitute a small part of the overall training (total of 105 hours out of 1 500 hours), as does practical training in mental health facilities (total of 100 hours out of 3 000 hours). Accumulating a certain amount of credits can also make students eligible for a master's degree in mental health.

5. MENTAL HEALTH CARE FINANCING AND EXPENDITURE

5.1. Financing of mental health services

160. In 1978, the NHS introduced a fully tax-based public health care system founded on the principle of universal coverage, whilst a narrower share was left to users' out-of-pocket payments (co-payments for public services and the purchase of private services) and voluntary health insurance. Funds are allocated by the Government as a general health budget to the regions, and then the regions allocate their budget to Local Health Authorities according to their needs and priorities. The allocation of financial resources to health sectors, including mental health, is made at the regional level, resulting in a wide variability across regions. Each region in Italy has financial and managerial autonomy, resulting in Local Health Authorities being responsible for their own budget and financing mental health services that they consider appropriate and responsive to local needs.

161. The formula for allocating financial resources has always been a source of debate in Italy. On the one hand, focus was given to the "horizontal" equity of access of health services, on the other hand there was concern about agreeing an allocation formula that could take into account regional and local peculiar needs ("vertical equity"). The progressive establishment of a system of fiscal federalism resulted in the abolition of social insurance contributions in 1998 and the subsequent inception of a regionally collected system of tax financing. General taxation started playing an increasingly marginal role, redistributing resources across regions with a more contracted tax base in order to ensure equal provision of health care services across the 20 regions (Lo Scalzo *et al.,* 2009). Moving away from a system based on historical spending, a weighted capitation rate was eventually introduced in 2003. The allocation formula took into consideration the Essential Levels of Assistance – defined as the minimum level of care that the NHS must guarantee to all citizens – and specific population characteristics, such as the size of the weighted population, demographic density, epidemiology, infant mortality rates and the number of health facilities (Tibaldi *et al.,* 2006).

5.2. Provider payment mechanisms

162. In Italy the public health care sector is composed of public facilities and private accredited facilities. Private accredited facilities are considered as fully public structures, as they are financed by the NHS and provide services on behalf of the NHS (see Box 9).

Box 9. The process of accrediting private facilities

The Law regarding NHS accreditation in Italy was adopted on 14 January 1997 (Dpr. 14.01.1997). Most recently, a new legal framework – *Disciplinare sulla revisione della normativa dell'Accreditamento* – was approved on 20 December 2012, which slightly reformed the 1997 Law. The 1997 Law defined the minimum structural, technological and organisational standards that need to be fulfilled by any health facility in order to be accredited to the public sector. Although the accreditation process has to comply with the national guidelines outlined by the Ministry of Health, the 1997 Law devolves to regions the responsibility to define quality standards for the accreditation process. Regional criteria are often stricter than national standards. The 1998-2000 National Health Plan deemed the accreditation process to be the best way to select health services providers on the basis of quality standards, in that it certifies that accredited facilities are in compliance with the standards in force and requires accredited structures to be regularly monitored (Ministry of Health, 1998b).

163. A tailored budget is established for inpatient, outpatient and long-term residential and semi-residential facilities. Some inpatient facilities (psychiatric wards in general hospitals, GHPUs) are reimbursed for the hospitalisation of patients with mental illness on the basis of the diagnosis-related group (DRG) system. Post-hospitalisation rehabilitation activities are reimbursed on the basis of national tariffs. For most outpatient facilities (*e.g.* CMHCs), specialist mental health care tariffs are established at the national level. The daily tariffs of residential and semi-residential facilities depend on the type of assistance provided (intensive, extensive care). In particular, tariffs for residential facilities vary significantly across regions (OECD Mental Health Questionnaire, 2012). However, a document reviewing cost standards and tariffs in RFs has been drafted and should be approved in the near future.

General Practitioners (GPs)

164. Before the inception of the NHS in 1978, GPs were remunerated through the patient's mutual fund. Charging a fee for each given service, a GP's salary depended directly on the number of services provided. Since the establishment of the NHS, GPs can decide whether to work full-time or part-time for the NHS, and they are remunerated by Local Health Authorities on a capitation basis. The capitation formula is calculated by multiplying the number of patients enrolled on a GP's list by the payment per capita. Treating patients privately on a fee-for-service basis could also represent an additional source of revenue, provided that the provision of private services does not interfere with the time devoted to the regular provision of primary care services for NHS patients (WHO, 2011).

165. Every three years an agreement is signed between the central government and the GP trade unions. The agreement determines the terms and conditions of the contract, including payment levels, duties, GP responsibilities, in addition to the maximum number of patients enrolled on a GP's list (Lo Scalzo *et al.,* 2009). Apart from the national agreement, GPs also sign regional contracts, which define the conditions for delivering supplementary services and earning incentives and for participating in targeted training programmes.

5.3. Mental health care expenditure

166. There is no data available on mental health care spending at the national level. This is due to the fact that the regions and Local Health Authorities are totally autonomous in the allocation of financial resources to health care sectors. However, it was established through the Conference of Regions (*Conferenza delle Regioni*) that no less than 5% of the local health budget should be allocated to mental health services (WHO, 2011). Nonetheless, this is a general guideline rather than the actual mental health care expenditure at the regional level, with some regions consistently allocating more than 5% of their health budget to mental health care, and other regions less.

167. Although national data on mental health expenditure is not available, regional and local studies have been performed to track mental health spending. For instance, the city of Trieste regularly tracks the financial resources used for providing mental health services, a model that has been implemented in the entire region of Friuli-Venezia-Giulia (see Box 8).

Pharmaceutical expenditures and consumption

168. The pricing and reimbursement of pharmaceuticals are handled by the Italian Pharmaceutical Agency (*Agenzia Italiana del Farmaco* – AIFA). The negotiations on drug pricing/reimbursement are subject to several criteria:

- The cost/effectiveness ratio must be positive for a new drug to be covered by the NHS (*i.e.* a new drug must present an adequate alternative treatment for a pathology compared to other available treatments for the same therapeutic indications);
- The risk/benefit ratio must be higher than that of other available drugs for the same therapeutic indications;
- The economic and financial impact on the National Health Service must be evaluated;
- The cost of the therapy must be preferable compared to other products of the same effectiveness;
- Market shares must be evaluated;
- A comparison of the drug's price and consumption in other EU countries must be made.

169. Pharmaceuticals under class A and H[10] are fully reimbursed by the NHS, with the user paying a fixed price per box, whereas pharmaceuticals under class C and C-bis[11] are paid entirely by users' out-of-pocket fees.

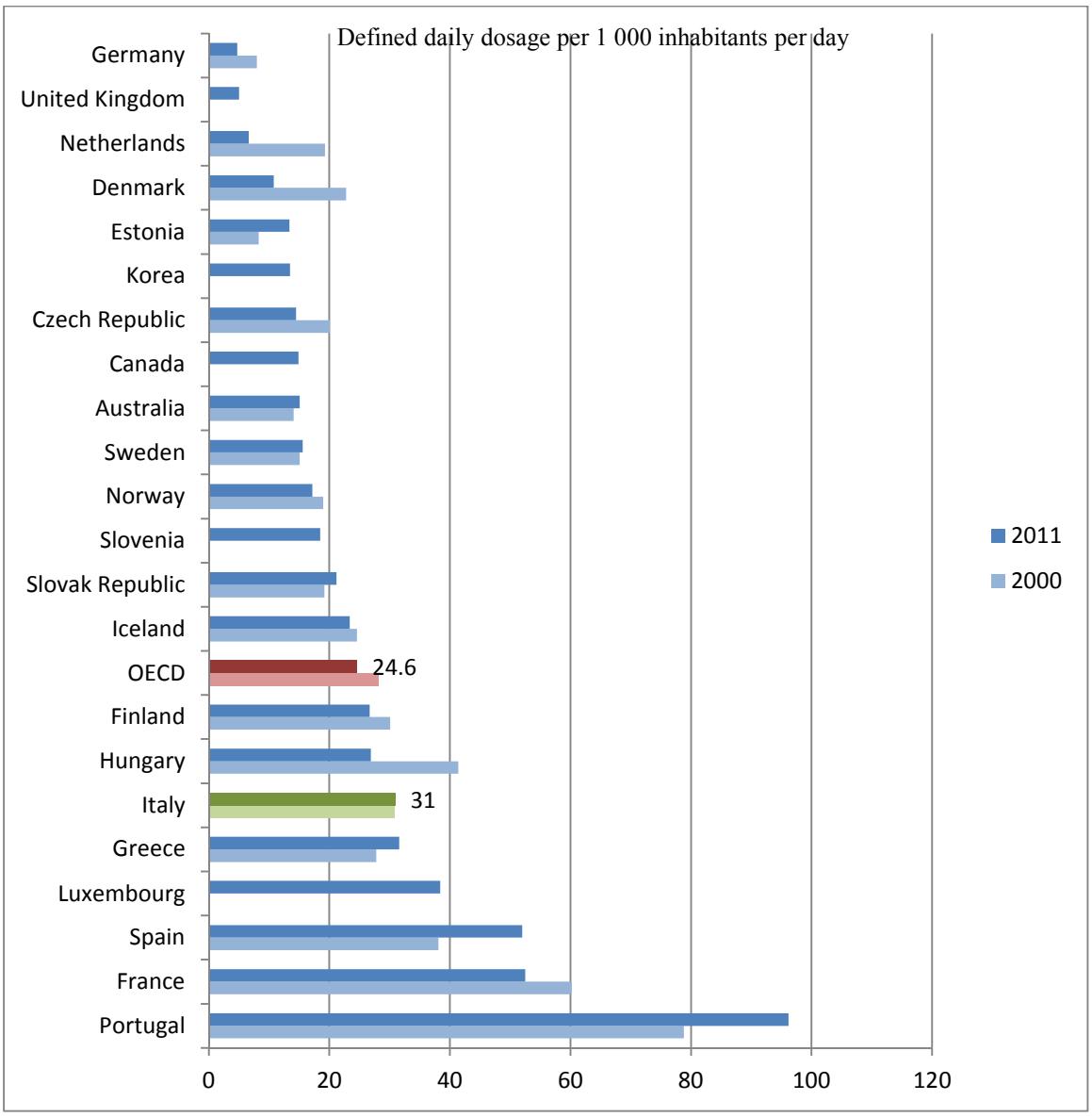
170. Total spending for Central Nervous System pharmaceuticals accounted for EUR 3.410 million in 2011, representing the second-highest pharmaceutical national spend. 42.5% of this figure was entirely financed by the NHS, 17.5% was refunded by public institutions and the remaining 40% was financed by users through out-of-pocket payments (70% of which belongs to class C) (OsMed, 2012).

171. The consumption (in DDD/1 000 population) of anxiolytics in Italy is stable since 2000, and slightly above the OECD average in 2011 (see Figures 25).

[10] Pharmaceuticals under class A are dispensed in pharmacies, whereas those under class H are dispensed in hospitals and health care clinics only.

[11] Pharmaceuticals under class C require a medical prescription, whereas those under class C-bis don't.

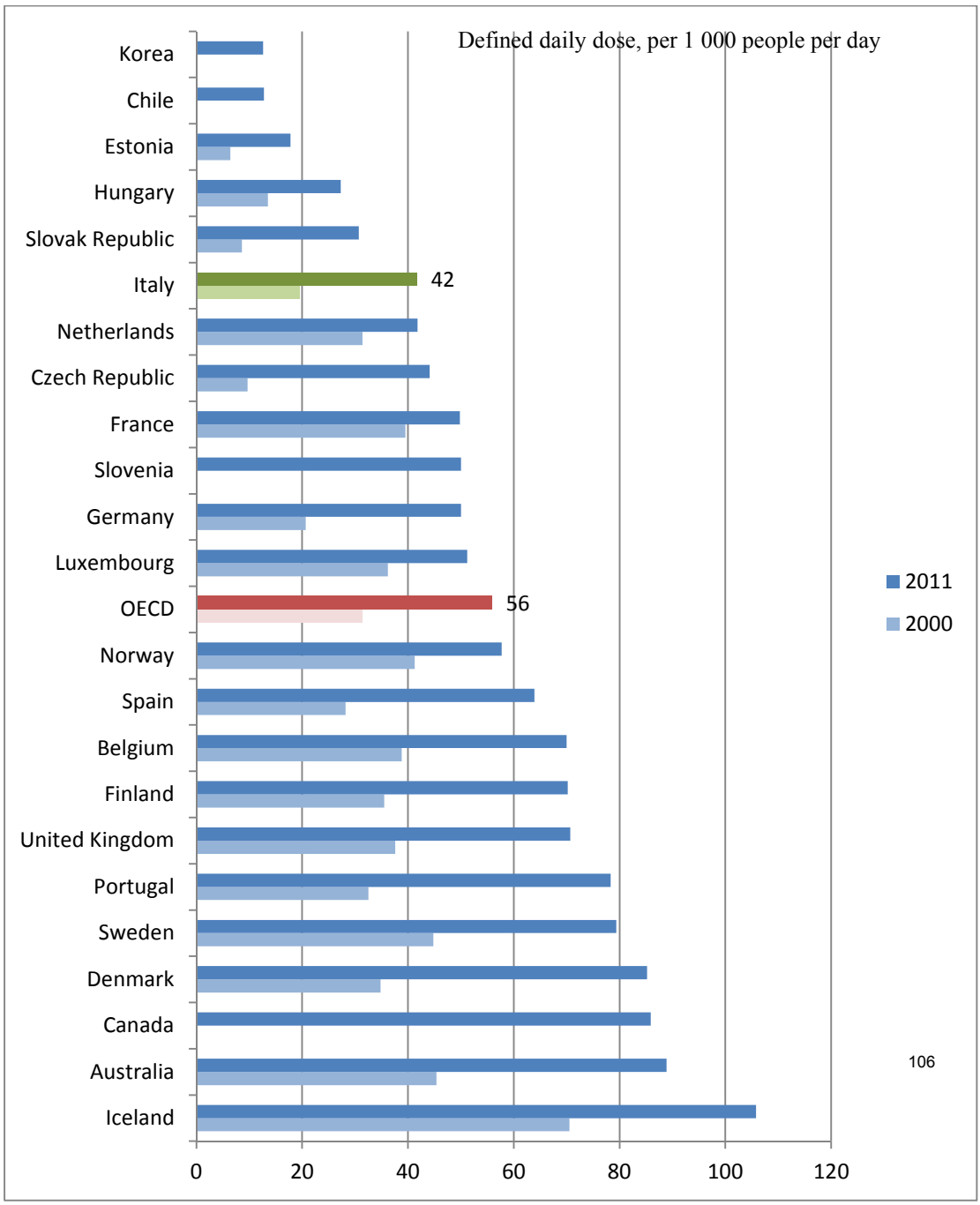
Figure 25. DDD of anxiolytics per 1 000 population in OECD countries, 2010 or latest year available



Source: OECD (2013), Health at a Glance 2013: OECD Indicators, OECD Publishing

172. Conversely, in 2011 the consumption of antidepressants was lower in Italy compared to the OECD average. In line with all OECD countries, the consumption of antidepressants has increased over the past decade in Italy (see Figure 26).

Figure 26. DDD of antidepressants per 1 000 population in OECD countries, 2010 or latest year available



Source: OECD (2013), Health at a Glance 2013: OECD Indicators, OECD Publishing

173. This increase in the consumption of antidepressants could be explained by a variety of factors: increased cases of depression within the general population, and the growing attention that primary health care specialists are devoting to mental health (OsMED, 2012). The OsMed (2012) study also provides an analysis of the use of antidepressants. It was estimated that only 1 out of 4 people being treated with antidepressants has exceeded the 2009 Nice guidelines on depression and used the treatment for more than

6 months. Bolzano, Trento and Friuli Venezia Giulia were the most compliant with the Nice guidelines, whilst Basilicata and Calabria were the less compliant (OsMed, 2012).

174. Unlike antidepressants, the consumption of antipsychotic drugs decreased in 2010 from the previous year (from 3.01 in 2009 to 2.80 DDD/1000 population per day), in line with the steady decrease that has been observed since 2001 (Sabetta, 2012).

6. DISCUSSION, INNOVATIVE PRACTICES AND CONCLUSION

6.1. Discussion and key messages

175. One of the most important peculiarities of the mental health system in Italy is the shift from hospital-centred services to community-based mental health facilities that occurred over the last thirty years. This de-institutionalisation process abandoned old approaches of social seclusion and stigmatisation of people with mental health disorders in favour of their social re-integration into the community (Mezzina, 2005). Italy's long history of de-institutionalisation is now culminating in the process of closing all the Judicial Psychiatric Hospitals, which are the last form of mental health institutions still found in Italy. The next step towards the accomplishment of this de-institutionalisation process would be the improvement and reorganisation of Residential Facilities (RFs), which in some cases provide mental health assistance rather than therapeutic care, without a real connection with the community or limits on the length of stay. This is of particular interest in that an important portion of mental health financial resources are allocated to RFs, with a reduced budget allocated to other mental health services, *e.g.* CMHCs. Whilst there is an urgent necessity to re-define national standards, a document addressing these issues is under approval by State and Regions.

176. Running in parallel with de-institutionalisation was the process of federalisation, with regions gaining growing responsibilities with respect to the central Government in the management of financial resources, the settling of regional standards, the definition of regional policies and the management of services. If on the one hand regional autonomy promotes tailored interventions based on local needs, on the other hand it also intensifies existing differences across regions in terms of the provision of mental health services, the efficacy of information systems, tariffs and organisation. This is particularly true with respect to child and adolescent mental health services, whose organisation differs particularly from region to region and where in some cases psychiatric services do not always collaborate with Infant Neuropsychiatry Services. Whilst there are increasing efforts towards the development of a more bilanced relationship between the Ministry of Health – whose objective is to set National standards – and the regions – whose scope is to organise and manage mental health services – there is still the need to guarantee greater homogeneity across regions.

177. As discussed earlier in this chapter, progress is being made in the development of mental health information systems. However, mental health information systems should be implemented throughout all Italy's regions, and benchmark indicators on the quality of mental health services should also be developed. Moreover, a second step for the development of mental health information systems would be to include epidemiological data in addition to data on the services provided. The development of efficient information systems would also allow the Ministry of Health to develop a set of clinical and outcome indicators on mental health at the national level. Although the Ministry of Health is currently moving in this direction, there is still progress to be made at the regional level to collect qualitative data.

178. Although epidemiological studies have been conducted on the prevalence and incidence of mental health problems in specific areas or selected population groups, there is still the need to conduct epidemiological studies on the general population at the national level. So far the focus has been on the population accessing a sample of mental health services. However, the results of such epidemiological studies are unlikely to represent the general population, first of all because people not accessing mental health services are not being represented, and second because the population sample is not drawn from the

entire population but from specific pilot areas, thereby biasing the results of the estimation. The existence of national epidemiological data on the general population would allow the Ministry of Health to adopt targeted interventions, to promote tailored mental health policies and to develop outcomes and clinical indicators to allow benchmarking both domestically within the country and internationally across countries.

179. Last but not least, data and indicators on mental health outcomes should be accompanied with data and indicators on mental health inputs. There is still the urgent need in Italy to provide qualitative and reliable information on mental health expenditures both at the regional and national level, in order to fully evaluate the performance of the mental health system and measure whether resources are being allocated in an efficient and optimal way.

6.2. Ongoing mental health agenda

180. Besides defining a set of priority areas, as is discussed in section 3.3., the Italian Mental Health Action Plan (IMHAP) (*Linee di Azioni Nazionale per la Salute Mentale*) (Ministry of Health, 2013) also suggests a variety of mental health areas to be included in the mental health agenda in the upcoming months/years. The IMHAP proposes developing a set of national guidelines and/or specific action plans on: suicide prevention; personality, mood and eating disorders; mental health in migrants and residential and day treatment facilities; and autism disorders, which was very recently addressed by a national guideline (SNLG, 2011), and an action plan approved by the Ministry of Health and the Regions (Ministry of Health, 2012b).

6.3. Outstanding and innovative initiatives: best practice examples

- The formal process of closing all the Judicial Psychiatric Hospitals, promoted by the joint efforts of the Ministry of Health, the Ministry of Justice and the Regions, and accelerated by the Parliamentary Commission of Inquiry into the efficacy and efficiency of the National Health Service (*Commissione Parlamentare di Inchiesta sull'efficacia e l'efficienza del Servizio Sanitario Nazionale*) (section 4.3).

- The development by the SIEP of a set of clinical indicators for depression, schizophrenia and bipolar disorders. These clinical indicators are a crucial tool for improving the quality of care and carrying out evidence-based interventions to treat severe mental health disorders (section 2.3).

- The experience of the South Verona community psychiatric service (CPS) (section 4.5).

- Local activities undertaken to fight stigma (section 4.5.).

- The development of a more structured approach to the treatment of mild to moderate mental health disorders in primary care, *e.g.* the consultation-liaison model developed in Emilia Romagna (section 4.1.).

GLOSSARY

- Governance refers to the exercise of political, economic and administrative authority in the management of a country's affairs at all levels (WHO).

- Mild generally refers to relatively few core symptoms (although sufficient to achieve a diagnosis), a limited duration and little impact on day-to-day functioning (NICE, 2011).

- Moderate refers to the presence of all core symptoms of the disorder plus several other related symptoms, duration beyond that required by minimum diagnostic criteria, and a clear impact on functioning (NICE, 2011).

- Severe refers to the presence of most or all symptoms of the disorder, often of long duration and with very marked impact on functioning (for example, an inability to participate in work-related activities and withdrawal from interpersonal activities) (NICE, 2011).

- A user / consumer / patient is a person receiving mental health care. These terms are used in different places and by different groups of practitioners and people with mental disorders (WHO, 2011).

- Family comprises members of the families of persons with mental disorders who act as carers (WHO, 2011).

- Mental health policy: The official statement of a government conveying an organized set of values, principles, objectives and areas for action to improve the mental health of a population (WHO, 2011).

- Mental health strategy/plan: A detailed pre-formulated scheme that details the strategies and activities that will be implemented to realize the objectives of the policy. It also specifies other crucial elements such as the budget and timeframe for implementing strategies and activities and specific targets that will be met. The plan also clarifies the roles of different stakeholders involved in the implementation of activities defined within the mental health plan. Mental health programmes are included within the mental health plan category. A mental health programme is a targeted intervention, usually short-term, with a highly focused objective for the promotion of mental health, the prevention of mental disorders, and treatment and rehabilitation (WHO, 2011).

- Mental health legislation: Mental health legislation may cover a broad array of issues including access to mental health care and other services, quality of mental health care, admission to mental health facilities, consent to treatment, freedom from cruel, inhuman and degrading treatment, freedom from discrimination, the enjoyment of a full range of civil, cultural, economic, political and social rights, and provisions for legal mechanisms to promote and protect human rights (e.g. review bodies to oversee admission and treatment to mental health facilities, monitoring bodies to inspect human rights conditions in facilities and complaints mechanisms) (WHO, 2011).

- Psychiatrist: A medical doctor who has had at least two years of post-graduate training in psychiatry at a recognized teaching institution leading to a recognized degree or diploma (WHO, 2011).

- Nurse: A health professional who has completed formal training in nursing at a recognized, university-level school for a diploma or degree in nursing (WHO, 2011).

- Psychologist: A health professional who has completed formal training in psychology at a recognized, university-level school for a diploma or degree in psychology (WHO, 2011).

- Social worker: A health professional who has completed formal training in social work at a recognized, university-level school for a diploma or degree in social work (WHO, 2011).

- Mental health outpatient facility: A facility that specifically focuses on the management of mental disorders and related clinical problems on an outpatient basis. These facilities are staffed with health care providers specifically trained in mental health (WHO, 2011).

- Mental health day treatment facility: A facility that provides care for users during the day. The facilities are generally available to groups of users at the same time and expect users to stay at the facilities beyond the periods during which they have face-to-face contact with staff and / or participate in therapy activities. Attendance typically ranges from a half to one full day (4 – 8 hours), for one or more days of the week (WHO, 2011).

- Psychiatric ward in a general hospital: A ward within a general hospital that is reserved for the care of persons with mental disorders (WHO, 2011).

- Community residential facility: A non-hospital, community based mental health facility that provides overnight residence for people with mental disorders. Usually these facilities serve users with relatively stable mental disorders not requiring intensive medical interventions (WHO, 2011).

- Mental hospital: A specialized hospital-based facility that provides inpatient care and long-stay residential services for people with severe mental disorders. Usually these facilities are independent and standalone, although they may have some links with the rest of the health care system. The level of specialization varies considerably; in some cases only long stay custodial services are offered, in others specialized and short-term services are also available (WHO, 2011).

- Forensic units: forensic units care for people with mental disorders who have come into contact with the criminal justice system. They may also be called secure units or special hospitals (WHO, 2008).

- Community mental health services: secondary or specialist care (care that cannot be provided by a primary care physician). At its most basic, it may be office-based private care or, more often, outpatient clinic (polyclinic) provision for assessing and treating mental illness by a trained mental health professional (such as a psychiatrist or psychologist). It can also be provided by a multidisciplinary team (community mental health team) comprising psychiatrists, mental health nurses and often psychologists and social workers. They usually provide care for the inhabitants of a clearly defined catchment area (such as a borough or town). Care is provided in a variety of settings (such as clinics, people's homes and day centres). An alternative structure is the

community mental health centre, where several teams run a range of services, one of which is assessment and care outside the hospital (WHO, 2008).

- Secure psychiatric beds "Secure mental health services provide accommodation, treatment and support for people with severe mental health problems who pose a risk to the public. Sometimes known as 'forensic' mental health services, secure services work predominantly with people who have been imprisoned or admitted" directly to hospital through the 1983 Mental Health Act following a criminal offence. (Centre for Mental Health, 2011)

- Stigma: A stigma is a distinguishing mark establishing a demarcation between the stigmatized person and others attributing negative characteristics to this person. The stigma attached to mental illness often leads to social exclusion and discrimination and creates an additional burden for the affected individual (WHO, 2008).

- Prevention: Mental disorder prevention focuses on reducing risk factors and enhancing protective factors associated with mental ill health with the aim of reducing the risk, incidence, prevalence and recurrence of mental disorders (WHO, 2008).

- Primary health care (PHC): Encompasses any health clinic that offers the first point of entry into the health system. These clinics usually provide initial assessment and treatment for common health conditions and refer those requiring more specialized diagnosis and treatment to facilities with staff with a higher level of training and resources (WHO, 2011).

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