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On May 13, 1978, the Italian Parliament approved the Law 1978/180 (popularly known as “Basaglia law”, from its promoter: the psychiatrist Franco Basaglia), concerning “Assessment and voluntary and compulsory treatment”. Soon afterwards, Law 180 was incorporated in Law 1978/833, which founded the Italian National Health Service. Undoubtedly, this law represented both a cultural and a medical revolution in the practice of psychiatry. Indeed, its main goal has been to warrant that psychiatric patients preserve their dignity, recognizing and protecting their rights. To this purpose, the 1978 psychiatric reform established four principal components: a) the gradual phasing out of Mental Hospitals through the cessation of all new admissions; b) the establishment of General Hospital Psychiatric Units for acute admissions, with a maximum of 15 beds each; c) more restrictive criteria and administrative procedures for compulsory admissions; and d) the setting up of Community Mental Health Centres providing psychiatric care to geographically defined catchment areas.

Thirty years have elapsed since Law 180 was approved. In this occasion, the Istituto Superiore di Sanità (ISS) has organized on September 24, 2008, the meeting “Thirty years after the approval of the Italian Law 180. Psychiatry before and after Franco Basaglia”. This was stimulated by the role directly or indirectly played in those years (up to the present time) by a few committed experts of the ISS, also in collaboration with colleagues of the Rome-based Istituto di Psicologia of the National Research Council. The idea of publishing the present monographic issue of the Institute’s journal has been inspired by the more relevant themes among those emerged and discussed during the meeting. Thus, the aim of this monograph is to assess the consequences and the perspectives of Law 180 thirty years after its approval. An overview of the mental health system in Italy opens the series of articles, examining the effectiveness of the Italian strategies to improve services for mental health care.

The series continues with an illustration of the enduring values underlying the law, which became an essential part of Italian public health culture. However, as reported in a paper devoted to social changes and psychiatric services, the meaning of “psychiatry” and the concept of “recovery” have been widely debated in the past years, emphasizing the urgent need to evolve new strategies, in order to promote a process of further innovation within the mental health services. A paper also provides a critical reflection on Law 180, analyzing its so-called “original sins” as well as the problems frequently encountered in its implementation.

The development of child and adolescent neuropsychiatry services is then described, from early deinstitutionalization, to rehabilitation, and interventions aimed at the social integration of children with mental disability. The paper also draws a picture of the Italian child and adolescent neuropsychiatry services, taking into account the different regional contexts.

A subsequent paper illustrates the national and international role of the National Union of Associations for Mental Health (UNASAM), the major Italian federation of families’ associations operating in the field of mental health. The paper also reports the results of a study commissioned to UNASAM by ISS, which was aimed at evaluating the quality of mental health services from the viewpoint of members of patients’ families.

A special emphasis is then given to problems and perspectives related to scientific research, training, and promotion of mental health, reporting the main results of coordinated, long-term evaluative studies conducted by the University of Verona on the South-Verona Community Psychiatric Service.

Furthermore, the issue contains an overview of the most recent European strategies and policies for mental health, describing the steps starting with the WHO Declaration and the Action Plan on Mental Health signed in 2005, to the “Green Paper” launched by the European Commission, until the recent “European Pact for Mental Health and Wellbeing” presented in 2008.

The role of the ISS on mental health promotion is also analysed, highlighting its contribution to the foundation in the eighties of the WHO Center for Research and Training in Mental Health in Italy and its role in a series of research projects such as “Progetto Nazionale Salute Mentale”, “PROGRES” (analysis of the characteristics of residential facilities) and “PROGRES ACUTI” (same for acute inpatient facilities).
Finally, two papers emphasize the highly significant contributions of Professor Pierluigi (Piero) Morosini, a life-long leader working at the ISS Epidemiology Department, to many of the research and training initiatives conducted in Italy in the field of mental health over the past three decades. Professor Morosini’s demise shortly before the September 2008 meeting evoked great emotion and unanimous regret for this great loss. The present issue of the Institute’s journal is gratefully dedicated to his memory.

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Summary. This paper intends to evaluate the mental health system in Italy thirty years after the psychiatric reform, using epidemiological evidence on the prevalence of mental disorders and the features of primary care and community mental health services (data from five Regions). The network of community mental health facilities appears to be complete as concerns Residential Facilities and Community Mental Health Centres, and less complete as concerns General Hospital Psychiatric Units. Substantial variation exists between Regions and between disorders, the treatment gap being smaller for schizophrenic than for mood disorders. High quality information is essential to improve mental health care; therefore, it should be systematically collected and extensively used to prime over the next decade a virtuous circle of positive changes.

Key words: mental health system, community care, Italy, psychiatric reform, treated prevalence.

INTRODUCTION

Thirty years ago the Italian psychiatric reform law (Legge 180) made radical changes to the whole concept of Italian mental health care, which, until then, had combined some components of community care with a prevalent mental hospital care. The new law, the above mentioned Legge 180, stated that community care must stand alone, and this led to the closing of mental hospitals. Thus Italy became the first developed country to base its mental health care solely on a community network of mental health facilities.

This process was neither linear nor uniform, and the effective closing down of the mental hospitals only took place twenty years later, at the end of the 1990s. This closing down process led to difficulties, from the point of view of both providing effective care to people with severe mental illness and of evaluating such care. This switch from institutional to community care should have opened wide horizons for research into mental health services. Research evaluation should have moved from enclosed hospital premises to community, and this, in practice, would have given us the possibility to study the resultant radical changes to mental health policy and to make an in-depth evaluation of the effects of such change. However there was only a limited monitoring of the dramatic change, and thus a partial evaluation of its aftermath, the big chance for such a mental health services evaluation was lost. In any case, for the first time in Italy, mental health professionals and academics were prompted by the psychiatric reform to make an evaluation of mental health care from an epidemiological point of view, and this led to the creation of local centres of excellence in psychiatric epidemiology and mental health care evaluation, as occurred in Verona [1, 2].

Apart from the experience gained in the centres of excellence that were set up, the evaluation of mental health care has been particularly advantaged over the last decade by three national surveys that carried out an in-depth evaluation of the network of community mental health facilities and by the growth of...
mental health information systems at the regional level. Today, it is possible to initiate a more systematic evaluation of the mental health system as the body of evidence in this area has increased enormously since the 1980s [3].

The goal of this paper is to evaluate the mental health system in Italy, thirty years after the psychiatric reform. Under the World Health Organization (WHO) perspective [4] a mental health system is defined as the structure and all those activities whose primary purpose is to promote, restore or maintain mental health. The mental health system includes organizations and resources focused on improving mental health. The building blocks of the mental health system are governance (including mental health plans and legislation), financing, mental health services, primary care, human resources, links with other sectors and an information system.

In this paper only the service delivery has been analyzed, i.e. mental health services and primary care, which forms the core of the mental health system. Any assessment of the other components exceeds the goals of this paper, although a complete analysis should take them into consideration.

The Goldberg and Huxley model [5] has been used to describe the Italian mental health system, and separate analyses have been made of the epidemiological evidence concerning the prevalence of mental disorders in the general population, in both primary care and community mental health services.

**MATERIALS AND METHODS**

This paper summarizes the results of major national epidemiological surveys, and analyzes the data from the mental health information systems of five Italian Regions (Emilia Romagna, Friuli Venezia Giulia, Lazio, Liguria and Lombardia).

Data from the regional information systems were collected in order to have comparable figures on patients treated in Departments of Mental Health (DMHs), on the patterns of care and on the activities provided by Community Mental Health Centres (CMHCs). These five Regions were chosen as they have well structured mental health information systems covering the whole Region. Indeed Emilia Romagna, Friuli Venezia Giulia, Lazio and Lombardia the flow of the mental health information is totally computerized, however only half the DMHs in Liguria computerize their data.

For the present study we calculated for the population the crude rates per 10 000 > 14 years old; no adjustment was made for the different Regional age compositions. For instance, the treated prevalence was calculated using as the denominator the total population of the five Regions (about 20 million people) and as the numerator the total number of patients treated in these five Regions.

The data give fairly reliable figures concerning the patients cared in DMHs, though there are still some methodological problems in comparing the Regions (e.g. the different network coverage of the private and/or residential facilities, there being no full information system coverage of the Residential Facilities in Liguria and Emilia Romagna). For the specific case of Lazio, data on the whole prevalence were not available, while only figures on patients treated in CMHCs were available. However the treated prevalence was estimated on the basis of the other regional mental health information systems, where the CMHC prevalence was about 95% of the overall treated prevalence. As far as concerns new cases, the evaluation of the diagnostic breakdown was hampered by the frequent lack of available diagnostic information (particularly in Friuli Venezia Giulia and Emilia Romagna where about 40% of the diagnoses were missing).

With regard to the activities provided by the CMHCs, there is wide diversity among the Regions in the classification of CMHC interventions. Therefore it was necessary to group the interventions according to a classification already used in analyzing community care [6]. Community contacts have been grouped in eight activities (psychiatrists’ clinical activity, psychotherapeutic activity, nurses’ activity, activity addressed to families, coordination activity, rehabilitation activity, social support activity, other activities). The present analysis should be considered an exploratory one as, in some cases, the goal of grouping the interventions was not completely achieved. One example is the activity addressed to families; in two of the Regions such interventions were certainly provided, but could not be identified among the data or were not monitored by the information system.

**RESULTS**

**Mental disorders in the community**

Using a summarized measure of population health, called the disability-adjusted life year or DALY (a time-based measure combining into a single indicator the years of life lost due to premature death and the years of life lived with a disability), the Global Burden of Disease Project [7] estimated that the burden of mental disorders in Italy is relevant: 2978 DALYs per 100 000 can be attributed to neuropsychiatric disorders, about 25% of the overall burden of disease in the country. If only mental disorders are considered, they amount to 11% of the burden, on adding also dementia and substance abuse this increases to 21%. Depression alone amounts to 7% of the global burden, while bipolar disorder, schizophrenia, obsessive-compulsive disorder, panic disorder are each 1%. Substance abuse accounts for 5% (alcohol use disorders 3% and drug use disorders 2%), while dementia is 4%.

In the last ten years the main results concerning mental disorder prevalence in communities come from two large surveys: the ESEMeD survey (ESEMeD: European Study of Epidemiology of Mental Disorders) and the Sesto Fiorentino study.
The ESEMeD survey [8, 9] was carried out in Italy in 2001-2003, and interviewed a sample of 4712 Italian citizens. The annual prevalence for common mental disorders was 7.3%, anxiety disorder was 5.1%, mood disorder 3.5% and alcohol disorder 0.1%. The most common mental disorders were major depression (3%) and specific phobia (2.7%). Women were twice as likely as men to report a mood disorder and four times as likely as men to report an anxiety disorder, while men were twice as likely as women to report an alcohol disorder. There was a high co-morbidity of mood and anxiety disorders.

Among the people with common mental disorders the use of health services is relatively scarce. Only one sixth (16.9%) used health services (20.7% of those with mood disorder and 17.3% with anxiety disorder). Among the health services users 38% were cared for only by a general practitioner, 27% only by a psychiatrist or psychologist, and about 28% by both professionals. In terms of severity, 12% of the Italian cases were serious, 35% moderate and 52% mild [10].

Wang et al. [11] have given a more in-depth analysis of the use of mental health services. With regard to the relationship between severity of disorder and use of health services in the Italian sample: half (51%) the people with severe mental disorder used health services, only a quarter (25.9%) of those with moderate disorders, and a fifth (17.3%) of those with mild disorders. Only one third (33%) of the people treated by the health services received minimally adequate treatment, defined as at least one month of pharmacotherapy plus at least four visits to any type of medical doctor or at least eight psychotherapy contacts. These results are quite comparable to those of other high income countries.

Faravelli et al. [12], assessing 2,363 residents in Sesto Fiorentino, reported that the one-year prevalence of any disorder was 8.6% (excluding depression and anxiety NOS “not otherwise specified”), and higher prevalence was found in women (12.1%) than in men (5.4%). In the last 12 months 4.6% of the sample had suffered mood disorders (excluding depression NOS), while for anxiety disorders the figure was 6% (excluding anxiety NOS). The two disorders with the highest prevalence were generalised anxiety disorders (3.5%) and major depressive episode (3.4%). Social impairment was present in 38.5% of people with mental disorders. The use of health facilities was higher than that reported by ESEMeD: among the population with mental disorders who sought help 87% sought help from their GPs and almost one third were in contact with mental health services, while 7% had no contact with health services.

Mental disorders treated in primary care
The most significant surveys of mental disorder prevalence in primary care settings were carried out in the 1990s. Compared with previous studies, these were far more methodologically advanced: a 12-item General Health Questionnaire was used as a screening tool, identifying cases with scores higher than the GHQ-12 threshold who were then subjected to a structured or semi-structured psychiatric interview.

In 1992 the Verona study [13] involved 1625 subjects. The overall prevalence of mental disorders among those attending primary care clinics was 12.4%, of these 6.7% suffered a depressive disorder (4.7% episodes of major depression and 2% dystymia) and 7.7% some anxiety disorder (general anxiety disorder 3.7%; panic disorder 1.5% agoraphobia, 0.6% other anxiety disorders 1.9%).

The Bologna study [14] replicated the Verona study, and involved 1647 subjects. The overall prevalence was the same (12.4%), but the prevalence of major depression was lower (3.3%) and that of general anxiety disorder higher (6.1%). The severity of impairment increased from sub-threshold cases to fully-fledged cases, and, among the latter, the severity of impairment depended on the extent of the depressive and/or anxiety symptoms. Compared with other mental disorders, major depression was evident because of its greater impairment and disability effects.

A third study focussed on depression [15], and involved 1896 subjects drawn from the different Regions. The prevalence of depressive disorder was 8.4%, with no differences according to geographical area. The severity of the cases was mild in 58% of cases, moderate in 36% and severe in 6%.

Mental disorders treated in mental health services
The Departments of Mental Health
In the Italian National Health Service, the Department of Mental Health (DMH) is the health organization responsible for specialist mental health care in the community, as stated by the Progetto Obiettivo “Tutela Salute Mentale 1998-2000” [16]. Within the Department there are various facilities: CMHCs, Day Care Facilities (DCF), General Hospital Psychiatric Units (GHPUs) and Residential Facilities (RFs). The DMH is in charge of the planning and management of all medical and social resources related to prevention, treatment, and rehabilitation in mental health within a defined catchment’s area.

The PROG-CSM survey [17] showed that in 2005 Departments of Mental Health were widespread in all Italian Regions, though the DMH level of complexity varied. More than half of the DMHs included not only Mental Health Services for adults, but also services for substance abuse, child and adolescent psychiatry, and clinical psychology services. Concerning the availability of the whole network of mental health facilities, about eight DMHs out of ten included RFs or DCFs and almost all had GHPUs, while day hospitals were less frequent (they were present in about half the DMHs). The level of complexity in terms of mental health facility availability is high in six DMHs of the ten, intermediate in a quarter and low in one of the ten.
Treated prevalence provides a measure of the capacity of the mental health system, i.e. the total number of people served within the mental health system. Treated prevalence can also be used to estimate the extent of mental health coverage, or, in other words, what proportion of the population with mental disorder is actually receiving treatment.

Data on one year treated prevalence at the DMH level were available from the five Regions (Figure 1). The total prevalence rate, not adjusted, was 158 per 10 000 over 14 years of age. The rate was higher in Liguria, lower in Lazio and Lombardia. Regional variability was not high (average 167, SD ± 24.4).

Table 1 shows the diagnostic breakdown from the one year prevalence data in three Regions (Figures from Liguria and Lazio were not available as far as treated prevalence), grouped by the 10th International Classification of Mental Disorders [18]. Note that the reliability and validity of diagnoses in an administrative data set is always open to question, but such figures are a useful tool for a better understanding of the priorities in mental health systems. In our data set, patients with schizophrenic disorders were about one third – one fourth of the patients being treated in public Mental Health Departments. In terms of frequency, the second most common diagnoses were mood disorders – Friuli Venezia Giulia and Lombardia, and neurotic disorders – Emilia Romagna. In all these Regions personality disorders amounted to about one tenth of the subjects. It was quite rare for patients with substance abuse to be treated in a DMH as there are specialized services set up for them. About one twentieth of the patients suffered an organic mental disorder.

With regard to the new cases treated in DMHs (Figure 2), the crude rate was 60 per 10 000 over 14 years old. The rate in Lazio was 3-fold that in Liguria and the Regional variability was higher for new cases (average 58, SD ±23.2) than for cases already under treatment, suggesting marked differences in terms of accessibility between Regions.

As far as concerns diagnoses, neurotic disorders represented the majority of new cases, though there was a considerable gap between Friuli (where they are a quarter) and Emilia Romagna (where they represent about a half) (Table 2). In Lombardia and Friuli Venezia Giulia one patient in four suffered mood disorder, while in Emilia-Romagna this was one in ten. The percentage of patients with schizophrenia was quite homogeneous (around 10% in all four regions). Personality disorders were a bit less than one tenth, with the exception of Friuli Venezia Giulia, where they were less than one twentieth. There is a growing need for care for organic mental disorders, not only in Friuli Venezia Giulia where they represent about a sixth of the new cases, but also in the other Regions.

Using the data of the annual prevalence in public DMHs and that on the utilization of mental

| Table 1 | Treated one year prevalence in DMHs of three Italian regions by ICD 10 diagnostic groups (percentages of cases with diagnoses) |
|---|---|---|
| Schizophrenic disorders | 30.9% | 24.9% | 30.7% |
| Mood disorders | 25.5% | 17.2% | 20.7% |
| Neurotic disorders | 19.2% | 33.8% | 20.6% |
| Organic mental disorders | 7.3% | 3.7% | 3.5% |
| Personality disorders | 6.5% | 11.8% | 11.6% |
| Disorders due to substance abuse | 2.9% | 2.1% | 2.6% |
| Others | 7.8% | 6.4% | 7.9% |

Fig. 1 | Treated one year prevalence, per Region, in Departments of Mental Health.
health facilities, it is possible to construct patterns of care (Table 3). The present analysis regards four Regions (Friuli Venezia Giulia, Lazio, Liguria and Lombardia) where both sets of data were available. Interpreting the data requires some caveats, because regional information systems differ in their coverage of mental health facilities (e.g. in Liguria there were no figures available for residential facilities).

CMHCs treated 93% to 97% of the patients cared for in DMHs. The percentage of acute patients treated in GHPUs varied from 5% in Friuli Venezia Giulia to 22% in Liguria. Only about one patient in twenty was cared for in Day Care or Residential Facilities, though in Friuli Venezia Giulia this figure increases to one in ten.

The treatment gap in schizophrenic and mood disorders

In order to evaluate the capacity of the mental health system to treat mental disorders it is useful to consider treatment coverage and treatment gap. Treatment gap can be defined as the difference between the prevalence of a specific mental disorder in a population and the proportion of affected individuals receiving treatment for the disorder. Alternatively, treatment gap can be expressed as the percentage of individuals requiring care but not receiving treatment [19].

Data concerning the coverage and the treatment gap for schizophrenic disorders cover only DMHs, private psychiatric practice or primary care were not included. In fact it can be assumed that patients with schizophrenic disorders will be cared only for through specialized mental health services. Thus the percentage of patients with schizophrenic disorders treated in such settings is a crucial indicator of the capacity of a mental health system to take care of severe mental illnesses. The Global Burden of Disease study (GBD) [7], estimated that the annual prevalence > 14 years old for highly developed European countries is 0.6%. The treatment prevalence for schizophrenia across Friuli Venezia Giulia, Lombardia and Emilia Romagna was compared to the estimates for schizophrenia from the GBD study. A perfect relationship between estimated rates for schizophrenia and treated cases is a score of 100. On comparing the GBD estimate (0.60%) with the treated prevalence of the DMH in these three Italian Regions (0.33%), the treatment gap is 57%.

The same exercise can be done for mood disorders. For mood disorders, the data analyzed both the DMH data and the estimates on cases treated in primary care. A GBD study and an ESEMeD survey for depressive unipolar disorders resulted in the same figures (3.5%), while the GBD study for bipolar disorders estimated the one year prevalence to be 0.5% for the developed European countries. Therefore the total one year prevalence for mood disorders is 4%. In the three Italian Regions the treated prevalence at the DMH level for mood disorders is 0.30%, while at the primary care level the estimate inferred from

| Table 2 | New cases treated in DMHs of three Italian regions by ICD 10 diagnostic groups (percentages of cases with diagnoses) |
|------------------|------------------|------------------|
| Mood disorders | 12.1% | 8.8% | 9.9% |
| Neurotic disorders | 25.8% | 13.4% | 27.0% |
| Organic mental disorders | 28.5% | 54.8% | 37.5% |
| Personality disorders | 13.8% | 6.9% | 5.0% |
| Disorders due to substance abuse | 3.7% | 9.0% | 7.3% |
| Others | 12.4% | 3.5% | 10.4% |
the Italian ESEMeD data is 0.54%. The results are impressive: there is very low coverage of mood disorders in both mental health services (7.6%) and in primary care (13.5%), thus the treatment gap is huge (79%). Data from Sesto Fiorentino are radically different, because in this site there is a extremely high coverage of primary care services and the treatment gap is practically absent.

The network of mental health facilities

Community Mental Health Centres (CMHCs) are the core of the community-based system. They cover all activities pertaining to adult psychiatry in outpatient settings, and manage therapeutic and rehabilitation activities delivered by DCFs and RFs.

During 2005-2006, the PROG-CSM survey [17] analyzed, at the national level, the network of CMHCs in 20 regions (except Molise), evaluating about 95% of Italy’s CMHCs.

The CMHC/resident ratio was about 1 facility per 80 460 inhabitants. With regard to fulltime staff, each CMHC had, on average, 4 psychiatrists, 2 psychologists, 2 social workers or rehabilitation therapists, and 7.7 nurses. This means about 24.8 fulltime professionals per 100 000 residents. There were few differences between geographical areas: Northern Italy averaged 25.9 professionals per 100 000 therapists, and 7.7 nurses. These inpatient facilities with a maximum of 15 beds were not widespread among the CMHCs: only in 18% of the CMHC could these programs be considered adequate.

The CMHC organization, integration and care continuity with other community DMH facilities was very satisfactory in more than 69% of the facilities. At the patient level, more 37% of the CMHCs developed high quality programs to ensure continuity and care coordination for severe mental disorders (including intensive home care, drop-out prevention programs). Integration with other community health and social services was excellent in 31% of the CMHCs, while it was totally inadequate in about 10%. Prevention and promotion programs were not widespread among the CMHCs: only in 18% of the CMHC could these programs be considered adequate.

The CMHC activity is analysed in greater detail, using data provided by the five Regions (Table 4). On the whole the crude treated-patient rate in CMHCs over a one year period was 148 per 10 000, and the variability among the Regions was small (average 158; SD ± 22). Instead, the CMHC intervention rate is 2402 per 10 000 and in this case there was greater variability among the Regions (average 2792; SD ± 1226). The main activities provided by the CMHC were the psychiatrists’ and nurses’ activities: they represented 60% of overall CMHC activity in the five Regions. Rehabilitative – socializing, psychotherapeutic and coordination activities were 6-10%, while social support activities and activities addressed to families were less than 5%.

Acute inpatient facilities

Within the DMH system, acute inpatient care is delivered in General Hospital Psychiatric Units (GHPUs). These inpatient facilities with a maximum of 15 beds (home visits, intervention in the community, etc.) outside the CMHC facility.

| Table 3 | Patterns of care: patients treated in DMHs by different types of facilities (percentages of patients cared for by each facility type in the overall DMH prevalence) |
| Residential facilities | 5% | 22% | 9% | 12% |
| Day care facilities | 8% | UN | 1% | 5% |
| Community mental health centers | 10% | 4% | 3% | 4% |
| (UN = unknown) |

The rate of patients treated in CMHCs over a three months period was 90.8 per 10 000 residents. Of this rate, the new cases (first visit to CMHC in 2004) were 38% of the three months period prevalence. On the whole sample, women made up 57%, and considering age, 42.5% were less than 44 years old, 36% were 45-64 and 21.5% were over 64.

With regard to diagnoses, psychotic disorders (mainly schizophrenic disorder) were about 29%, mood disorders 25%, anxiety disorders 22.5% and other disorders 23.5%. For the new cases the diagnostic breakdown was different: psychotic disorders were 14%, mood disorders 20%, anxiety disorders and other disorders each about 26%. A quarter of all the patients received community treatments (home visits, intervention in the community, etc.) outside the CMHC facility.

| Table 4 | Patients treated and interventions provided yearly by CMHCs, per region (rates per 10 000 > 14 years old) |
| Patients | Interventions |
| Friuli Venezia Giulia (2007) | 159 | 3.848 |
| Lombardia (2005) | 133 | 1.731 |
| Lazio (2005) | 138 | 1.709 |
| Liguria (2007) | 180 | 2.334 |
are closely linked with the CMHCs to ensure continuity of care.

The PROGRES-Acute Project [20] covered the network of acute inpatient facilities in 20 regions (except Sicily) during 2002-2003. Italy had a rate of 0.78 public acute-inpatient beds per 10 000 inhabitants, located in GHPUs (88%), University Psychiatric Clinics (10%) and 24-hour CMHCs (2%). The availability of public acute beds in Italy was approximately 20% less than the official national standard (1 bed per 10 000 inhabitants). The corresponding rate of private beds was 0.94 beds per 10 000 inhabitants. On the whole, in Italy, the rate of acute, short-term psychiatric beds (public and private) was 1.72 per 10 000 inhabitants. Not only did this rate (private plus public beds) present considerable variation across the different regions, the ratio being 8:1, but also the number of public beds varied greatly from the South to the North-East and Centre (by nearly a 1:2 ratio).

Concerning staffing: all public and private facilities had 24 hours coverage, with staff on duty at night. The 301 public facilities employed 8058 professionals, 86.5% of whom worked full-time. The number of staff in private facilities was much smaller (2384 professionals, of whom 1918 were working full-time). The figures show a full-time staff quota per bed in private facilities that is much smaller than in any type of public facility: in the public facilities the staff/patient ratio ranged from 1.44 to 5.17, showing that facilities for acute patients rely greatly on human resources; in contrast, ratios for private facilities were markedly smaller (0.45 staff/patient ratio).

The mean length of stay varies between facilities, with a median number of days per admission of 11.4 in GHPUs, 17.8 in University Psychiatric Clinics, 21.1 in 24-hour CMHCs and 37.6 days in Private Facilities. There was a substantial variation in the length of stay across the different areas: the mean length of stay in the northeast region was almost twice that in the central and southern regions. Even the number of public beds differs greatly between the southern regions and the north-east and central regions. Indeed, the different bed availability could account for the much shorter average length of stay observed for the south.

In 2001 the psychiatric admissions and the number of admitted patient-rates per 10 000 inhabitants in public facilities were 19.8 and 13.4 respectively, whereas in private facilities these were 6.9 and 4.4 respectively. The percentage of “revolving-door” patients (i.e. the patients who had had three or more admissions to the same facility) was similar in public and private facilities (8.7% versus 8.3%).

The percentage of compulsory admissions was 12.9%, and it varies from region to region. As a temporal trend the percentage of compulsory admissions decreased from approximately 50% in 1975...
A sample of the total population, 2962 subjects, was evaluated in greater depth [26]. Most were males (63.2%) who had never married, and more than 70% were over 40 years of age; 85% received a pension, most commonly because of psychiatric disability. A substantial proportion (39.8%) had never worked, and very few were currently employed (2.5%); 45% of the sample was totally inactive, not even assisting with domestic activities in the facility. Two-thirds had a diagnosis of schizophrenia (68.2%), while the second most frequent diagnosis was mental retardation (13.1%) and the third, personality disorder (8.5%). Co-morbid or primary substance abuse was uncommon. Mental illness had been long-lasting and severe: for seven out of ten patients the severe mental problems had begun more than fifteen years earlier, and in the last five years about fifty per cent of the sample had suffered persistent positive psychotic symptoms. Twenty-one per cent had a history of severe interpersonal violence, but violent episodes in the RFs were infrequent. The majority the total sample of RF residents (58.5%) had never been admitted to a mental hospital or a forensic mental hospital; almost 40% had been admitted, at least once, to a mental hospital, and 1.6% had been detained in a forensic mental hospital.

CONCLUSIONS
The treatment of common mental disorders in primary care: an unsolved problem

Two community surveys [8, 12] assessed the prevalence of common mental disorders in Italy to be about 7-8%, with very concordant figures. These prevalence estimates were generally lower than in parallel surveys carried out in other Western European countries. However on the crucial issue of service planning, namely the use of health services by those with mental disorders, we have radically different figures from these two surveys. Of the two, the Sesto Fiorentino estimates were more optimistic, but limited to one site, while if there is confirmation of the more pessimistic ESEMeD findings we must conclude that primary care accessibility for common mental disorders is particularly low. Given that the two estimates are widely divergent, there is an urgent need for definitive and concordant indications on the coverage of mental disorders in primary care.

About one tenth of the patients cared for in primary care suffer from some kind of mental disorder, and the prevalence of depressive episodes in this setting varies between 3.3% and 8.4%. However surveys like the two mentioned above do not provide a better understanding of the primary care role in the mental health system, because they do not include information concerning the adequacy of the treatment provided to these patients. The ESEMeD study [27] highlighted that in six European countries only one fourth of the patients with affective disorders received sufficiently adequate treatment in pri-
mary care. Further improvements for the treatment of depression in primary care, like the development of collaborative care [28], should be based on solid estimates of the existing adequacy of the usual treatments. Without this piece of epidemiological information it is not possible to adequately monitor the needed improving actions.

The burden of mood disorders is certainly large regardless of the primary care data used to choose for the estimates. A strategic goal for the National Health System is to bridge this gap: it cannot be tackled without proactive and sustained action at the primary care level and without developing a solid referral and back-referral system with mental health services. However, until now there has been a scarcity of both epidemiological information and strategic actions for improving the treatment of affective disorders at this level.

The core of the mental health system: the Departments of Mental Health

The DMH is the core of community mental health care in Italy: such departments are widespread throughout the country, though with different levels of complexity. With regard to the types of facilities present, the DMHs seem quite complete with the exception of day hospitals. The complexity of DMHs is high in terms of mental health facilities, while it is lower in terms of type of specialized clinical services (like child psychiatry, alcohol and drug abuse services) included in DMHs, given that four DMHs out of ten were limited to adult psychiatry.

The data from regional information systems in five Regions, covering about 20,000,000 people, have given us reliable annual figures for patients treated in public DMHs. Indeed, about 1.6% of the population was cared for by DMHs and new cases were 0.60%. The variability among the Regions with regard to new cases is higher than for treated prevalence, suggesting marked differences in terms of accessibility. In the 1980s data collected from psychiatric case registers on one treated prevalence ranged between 0.70-0.97%, while for new cases the range was between 0.12-0.23% [29, 30]. In the last thirty years the mental health system has grown greatly in terms of both treatment capacity (+89% for treated cases) and accessibility (+243% for new cases).

About one fourth of the treated cases in DMHs had schizophrenic disorders, and about a fifth mood disorders; among the new cases these diagnoses were less frequent, while neurotic disorders were the majority (from one third to half) and organic mental disorders a tenth. The DMHs are focussed on treating severe mental illnesses, which was also revealed by regional analyses on resource utilization [31].

As far as concerns public DMHs, the coverage for schizophrenic disorders is about 57%. This result is close to the NEMESIS survey in the Netherlands [32], but is questionable because it depends strongly on the prevalence estimates of population schizophrenic disorders. For example, if we use the other estimates [33, 34], the prevalence rates are lower (about 0.3%) and the treatment gap is practically 0%. In any case, even assuming uncertainty in prevalence, this indicator is useful to monitor system accessibility for patients with severe mental illnesses.

The patterns of care were strongly influenced by the mental health information system coverage, and by the structure of the different regional mental health systems in terms of available facilities. This last issue requires more in-depth analyses, as it is relevant for assessing the adequacy of the National Health System with regard to mental health care.

The network of community mental health facilities: mission accomplished?

Thirty years after the reform (Legge 180) the network of community mental health facilities seems complete, especially as far as concerns RFs, CMHCs and, partly, GHPUs, though a relevant variability still remains among the Regions.

Our analysis revealed that more than nine out of ten of the patients treated by Mental Health Departments had contact with the CMHCs. This means that CMHCs are the hub of community care, and are crucial to developing the whole system’s treatment capacity. The rate of professionals working in CMHCs was quite homogeneous for the North, Centre and South of Italy, though there are still differences among the Regions. The rate of patients treated at the CMHC level showed a range of between 130-180 per 10,000. Data from specific research on patterns of care [6] suggest that CMHCs are highly accessible, also for patients with severe mental disorders (in Lombardia about two thirds of the patients with schizophrenic disorders were treated solely by CMHCs). This preliminary analysis from five Regions showed marked variations in terms of contact rate and type of CMHC activities. Further research is needed to evaluate whether these differences derive only from different service delivery levels, or whether they were at least partly related to different information system characteristics. Indeed, the amount of care provided by CMHCs is a central issue for the development of community care: greater delivery of CMHC care calls for a larger CMHC capacity to provide intensive community treatment, in order to respond to acute cases without hospitalization and to implement innovative interventions (e.g. early interventions in psychosis or psychoeducational approaches).

Quite different is the situation concerning GHPUs, both in terms of bed availability and, in part, of structural adequacy [35]. The differences are still relevant among Regions and also geographical areas: in 2003, the rate of public beds in GHPUs in the centre and south of Italy was one third below the Progetto Obiettivo standard and that of the North. In the same geographical areas the Private Acute Facilities had double the beds of the GHPUs, but because of the different case mix between public and private facilities, and the often poorly structured coordination with the DMHs, it was practically impossible.
for private facilities to replace the care provided by GHPUs. In a country which has one the lowest rates of acute inpatient beds in Europe [36], and where day hospitals are not widespread, there is a high risk that the clinical needs of people with severe mental illness are not met during times of acute crisis if the public GHPU network is weak and the CMHCs are not able to care for these patients in the community.

Let us summarize the results of PROGRES: in Italy, many people with severe mental illness who, previously, would have been treated in mental hospitals are now cared for in residential facilities. However the historical gap in the mental health system of the 80s, i.e. the lack of RFs in the community, has been now filled. However there are still some problems to be tackled. First, the provision of residential beds varies greatly across the Regions. Second, analyses of the care process in residential facilities show large heterogeneity, and efforts should be made to improve the effectiveness, and coordination, of care within the Departments of Mental Health. Third, in recent years the number of beds in residential facilities is still rapidly increasing [37, 31], and further RF expansion could hamper, in terms of competition for resources, the provision of intensive and innovative community care by CMHCs. This last is a crucial issue for the development of community care, not only in Italy but also throughout Europe [38].

Information, strategic tool for improving the Italian mental health system

As stated by WHO, good information is needed to obtain a valid and reliable picture of a country’s mental health system [39]. Without high quality information it is not possible to reach a planning rationale, the governance of the system is severely hampered, and accountability at both the national and regional levels is impeded. Decision Support 2000+, a US national initiative, has highlighted that the quality of information determines the quality of mental health care [40].

Thirty years after the psychiatric reform there is still no electronically recorded national mental health information system interactive among the Regions, which is a severe gap in the Italian mental health system. The comparisons presented in this paper derive from a few Regions which, over the last ten years, have autonomously developed regional information systems. These figures from the five Regions are preliminary findings and still present some methodological weaknesses, but they give some insight into the enormous monitoring and evaluation potential within the mental health information system.

In 2001 the Regions and the Ministry of Health [41] made a joint statement concerning the implementation of a national mental health information system, but this has not yet been translated into action. Some of the problems met with in this paper, e.g. the comparison of CMHC activities because of differences in terminology, would be easily resolved if the Glossary of Community Mental Health Activities, included in the National Mental Health Information System Framework, was applied.

The lack of a national mental health information system severely hampers not only planning and monitoring, but also any analysis of the mental health system. To this day the only data available at the national level is derived from surveys (e.g. PROGRES surveys) that have analyzed, in-depth, the individual mental health facility networks; such data provided only a part of the comprehensive picture of the mental health system and were not at all suitable for monitoring changes as mental health information systems can.

How can epidemiological information help the mental health system in Italy? First, we should consider that a unique mental health system in Italy does not exist: after the 1978, Psychiatric Reform regionalizing mental health care, 21 regional mental health systems were developed and these differ greatly in terms of organization, network of facilities, accessibility, care delivered etc. Therefore these differences among the regional systems need urgent evaluation. Second, in the last thirty years much attention has been paid to the development of a network of community mental health services, therefore we should now focus on assessing the overall quality of these mental health systems. This requires to evaluate through mental information system data the usual dimensions of quality assessment, i.e. accessibility, adequacy, acceptability, continuity and effectiveness [42]. In Italy, as in the rest of the world [43], there is an urgent need for more research into the mental health system to explore these crucial issues.

However working only at the system level does not meet all the quality needs in the mental health system, also practices at the DMH level need changing. While our knowledge about effective mental health care is growing fast, putting such knowledge into practice and using it in day-to-day patient care often fails [44]. Pincus et al. [45] stated that in mental health care “The gap between the care that patients could receive and do receive is greater than a fissure, it is a chasm”. To fill such a gap, the authors suggest a more efficient dissemination of evidence to clinicians in order to strengthen the measure of quality, the improvement of the informative infrastructure needed for measuring and reporting quality, and the supporting of quality improvement practices at the locus of care. High quality information is also needed for implementing clinical governance at the DMH level [46].

There is growing consensus on the use of evidence-based clinical indicators for improving quality [47]. In Italy the SIEP DIRECT’S Project goes in this direction [48, 49]. This Project, conducted in 19 DMHs, evaluated the quality of care delivered to patients with schizophrenia through a set of indicators (www.eps-journal.com/custom/direct/2008_4-Instrument_2.pdf) based on NICE Guideline recommendations [50]. This tool may increase awareness of the strengths and weaknesses of customary mental care and open the door to improving actions.
From information to action: this is the virtuous circle that we should be implementing over the next decade, promoting high quality information and using it to improve mental health systems and clinical practices.

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Antonio Lora


Summary. This work reconstructs the atmosphere that developed in the city of Arezzo with the approval and application of Italian Law 180. A detailed description of the events, which saw this medium-sized community involved in what was to become an example for mental health policy, helps to illustrate the values underlying Italian Law 180. This endeavour was at once a scientific, cultural and political project making Italian Law 180 an undeniable part of Italian national heritage.

Key words: social inclusion, alliance, therapeutic community.

INTRODUCTION

Thirty years ago, on 13 May 1978, Italian Law 180 was approved abolishing mental asylums in Italy and proposing a model for all the civilized world. From that day on, existing psychiatric hospitals would have to be closed at the earliest possible date and no new structures could be built.

In presenting this achievement of civilization and humanity which required many years of political battle, we would first like to describe the experimental phase that lead to the overcoming of mental asylums, and how this task was faced in creative ways by the community of Arezzo. A reconstruction of this local experience, will help to illustrate the fundamental assumptions underlying Italian Law 180 which was essentially a cultural, scientific and political project. Still today, while in a different context, the implications of this project are relevant to social practices, institutional policies, health care and social services, patient and consumer associations and to all citizens in general.

A final preliminary comment to our reader: any inevitable recall of the past has the sole aim of safeguarding a necessary historical memory together with a recovery of the values, the culture and the strengths that have not only made history but also produced good results. Nonetheless, there have been moments when there was a breakdown in the face of obstacles, reticence and desertion, especially on the part of policy-makers.

HISTORICAL BACKGROUND

The 1960s concluded a period of great openness in Gorizia which began in 1964 and saw important cultural and political changes at both the national and the international levels. The efforts of Franco Basaglia to abolish mental asylums reached a traumatic conclusion due to the unavailability of the local administration to continue with the developments of the project.

All but ready to give up their fight, Franco Basaglia and his team publicly declared that the conditions necessary to continue the project did not exist in Gorizia because policy-makers had allowed themselves to be overcome by “conservative influence”.

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As Franco Basaglia reached Parma in 1970, the Province of Arezzo stepped up to continue the experience of Gorizia.

Agostino Pirella, friend and collaborator of Franco Basaglia, known for his scientific work and director of the Psychiatric Hospital of Arezzo, took on the scientific and political objective of closing the local mental asylum whose inmates numbered approximately 700 patients.

The project was based on two principles: on the recognition and promotion of the rights of patients who were considered a resource for their rehabilitation, and on an innovative concept of the role of health care operators who would now be seen as participants, committed in a concrete way to move beyond the asylum structure. The opening of the wards was the first visible sign of this change.

The approach was based on listening to and deciphering the life experiences of people. Care was taken to prepare projects for the recovery and rehabilitation of the individual with the participation of patients, health care professionals, volunteers, administrators and the local community. There was a concerted effort among the various stakeholders involved, all contributing to reaching the final objective.

This significant scientific effort and laborious exercise in democracy resulted in a novel, bold alliance between local and provincial political forces, democratic institutions, scientific leadership and a team of health care professionals, all determined to change direction.

A complex initiative which was at times contradictory, but always strongly participatory, it spanned the decade from 1970 to 1980 giving extraordinary results associated with and consequential to the closing of the mental asylums.

By the time Italian Law 180 was approved by Parliament in 1978, the path leading toward liberation of the Psychiatric Hospital of Arezzo had already been travelled. The structure had by then effectively been closed; only few patients still awaited their return to the reality of society.

In the place of asylums, scientific and political policy had established a territorial-based network of mental hygiene services, social services and rehabilitation centres to treat the mentally disturbed without physical and/or chemical containment and without risk of ostracism.

Arezzo, Trieste, Perugia, Parma and Ferrara shared initiatives analogous to the one described here and were points of reference for Law 180. All of these situations demonstrated how the law was not only necessary and right, but also feasible if supported by a new scientific paradigm and a novel system of assistance.

History will analyze the decisive factors that lead to the closing of the mental asylum in Arezzo. Here, we would like to reflect upon and highlight the effective results in the life of the community of Arezzo, in the scientific culture and in the nation as a whole during that period.

Hundreds of patients in Arezzo and thousands in Italy left the asylums and returned to society, worn out from years of internment. They were no longer fixed to containment beds, no longer forced to remain behind bars, and live in a motionless and senseless reality. They were now free to rebuild a sense of self-esteem and to return to living and planning their own existence, albeit with difficulty.

They needed to overcome the fears of leaving a “safe place” and entering into an unknown world that was perceived as hostile and unknown, yet attractive.

Patients, one by one together with the assistance of community and health care services, had to make choices and take responsibility for themselves. They had to call upon their most inner sources of vital energy.

Members of the community of Arezzo also were now freed of a constant reminder of the risk that they too ran of being committed to the local asylum. After all, anyone could fall victim to the often unpredictable psychic crisis which might have resulted in a more or less forced, but always harmful, period of internment.

Now that the Psychiatric Hospital of Arezzo, “Pieraccini”, was closed, all citizens had the right to be treated equally within the spaces of daily life and within those formal spaces of the public health care system without incurring any further damage from an asylum.

It was then that we began to see the first cases of “delirium tremens” in the general hospitals. These cases had previously been segregated and perhaps buried away forever within the area of asylums. It was then that we internists and non-psychiatrists fully regained our professionalism with respect to all patients, putting ourselves to the test with the most varied and, until that moment, neglected clinical cases.

The new open therapeutic community structure liberated not only the patients but also hundreds of health care providers, physicians and nurses from the role of control and containment. A role that was essentially oppressive, it distorted the true nature of the profession of mental health care provider.

Doctors and nurses, psychologists and educators, social assistants and therapists all fully recovered their professional role using their expertise for a human function. Certainly a more complex application of their skills than simply that of guard, it was once again a creative and gratifying endeavour.

It made sense to further develop, study, research, compare, collaborate and share results.

Each operator had their part of the responsibility for taking care of the patient to rehabilitate and to lead back to life.

With the liberation of the patients, policy-makers once again had the responsibility that had been delegated to psychiatry. No longer having the role of hiding contradictions and lacerations, policy-makers were now called to perform their intended func-
tion, that of promoting the rights of citizens and involving the population in reaching objectives of health and social well-being.

While patients, health care operators and volunteers analyzed questions that arose regarding the daily management of the hospital and the discharge programs, administrators were directly involved in finding solutions, discussing proposals, dealing with the prejudices nested within the community and opening paths of solidarity in all the social areas within and surrounding Arezzo.

Policy-makers found it necessary to open new spaces for coexistence and cohabitation and to create novel solutions for social inclusion. Not only for patients but for all citizens, healthy and ill, young and old, men and women.

Politics had its responsibilities and it fulfilled them through a variety of initiatives that included cultural and institutional relations, social organizations and the commitment of financial and human resources.

A consequence of these experiences of social upheaval was the strong impulse toward a reform of the entire system of social services.

Not by coincidence, contextually with Law 180 policy-makers set the objective of health care and social assistance reform.

At this point, we must make a consideration: so long as science, participation, and politics were allied in a strategic way to foster the right to full social citizenship, the nation progressed along the path toward greater civilization. When politics moved away from citizens to close itself within sterile power-plays, the nation saw periods of decreased attention to reforms, not to mention a cultural and democratic involution.

And yet that extraordinary cultural and political phase whose innovative fervour we have tried to recall here continues to bear fruit. This is for the simple reason that the values affirmed can never be cancelled from the culture or from the national horizon.

It is important to remember that when in 1970 we began to enter the psychiatric wards we were met with desperate scenes that recalled a lager. There were men and women without a flame of vitality who were undone, annihilated.

The putrid air and degradation left no space for hope of recovery and social inclusion. It seemed to be a triumph simply to get people on their feet after having been abandoned in filthy beds, on the floor, naked or just barely covered with grimy rags. Yet beyond the repulsive appearances, Agostino Pirella’s team discovered in each and every person, buried beneath the blanket of the mental asylum, that flicker of vitality that exists in every living being whatever their existential condition.

We were motivated by the moral conviction, which was subsequently scientifically confirmed, that within each person there is the possibility for rebirth. Even the most “regressed” person can be empowered to put into play an inherent and extraordinary capacity that people have to rise up from the lowest level of degradation and decline, be it a lager, a mental asylum or a prison.

It was clear to all of us that it was possible to reverse the annihilation using primary needs as the focal point of our approach. The focus was placed on this, the subjectivity of people, each one different, each one differently marked by life and by the asylum, but all potentially capable of coming out of the hell of the “Fondaccio” (a derogatory term for a women's psychiatric hospital ward).

Here is one of the enduring principles: it was not only right but it was possible to give all people hope and to build a project for treatment and social inclusion that involves and serves all.

This was true then as it is today, not only for the mentally disturbed but also for the many so-called chronically ill who inappropriately occupy the many social health care institutions of internment.

People reclaimed the road to return not alone or based on a service order, as proposed by some psychiatric hospital directors with their lists for discharge, but rather empowered by a collective effort and a therapeutic community. These people succeeded with the help of a health care and social project composed of humanisation and of solidarity. The provincial and local administrations were called upon as were the professionalism of health care operators and the willingness of the community of Arezzo.

Unlike many other examples in Italy where communities were involved in the closing of asylums, in Arezzo the point of departure was the last on the list, the most difficult, most chronic of the cases. Each individual, with their own personal life experiences and hopes, was accompanied and helped to reach their individual goal by calling upon their most dormant inner energies. At the same time, initiatives were taken to open each and every possible context for hospitality, availability and integration.

There was the belief that if the most challenging case could find social value then all the others would have benefited enormously.

Return into society was not merely an administrative procedure nor was it a discharge built upon techniques of rehabilitation. It was a health care and social project that necessarily involved the community and, on its behalf, associations that were directly interested.

Rather than a bureaucratic decision, it was a project of life shared by the individual and favoured by the receiving community.

The second enduring principle: a person does not come out from the abyss of illness alone but does so with a project of recovery and of life that calls together the energies present within the person and those that institutions and the community are able to make available.

Today, the community is little more than the context for mental health services. A welfare reform requires an active and responsible role of all the stakeholders in the community.
In the crucible of the mental asylum a veritable scientific revolution took place regarding primarily psychiatry but involving all the biological and social sciences. Franco Basaglia and all our psychiatrists, with Agostino Pirella leading the way, refused any delegation that the law and the political powers made to psychiatry to validate, in the name of science, segregation through asylums which is a violation of the most elementary of human rights.

Psychiatry returned to being a science of man, aimed at understanding that which lies beyond symptoms and appearances and at helping the more fragile to pursue their personal project for life, together with others.

Psychiatry reconsidered the multifaceted aspect of the individual as ‘sinolo’ (basic unit of matter) of the body and the mind and a synthesis of social relations. It searched for the necessary links with the other human sciences toward a greater knowledge of the state of psychic suffering and the construction of a project for recovery.

From the new scientific paradigm, and from within an asylum, a new health care and social practice evolved. This new practice favoured working together within the same space and time, ‘hic et nunc’, involving physicians and psychologists, nurses and social assistants. This concerted efforts enhanced the individuality of inpatients with assemblies within the wards and with weekly encounters among patients, health care operators, administrators and volunteers.

Thus, a new paradigm for assistance was born and tested. This group or departmental work, as it were, undoubtedly needs to be re-proposed within the practicality of health care services.

The entire practice of medicine today must pass from expectation to promotion, from the duality of the physician-patient relationship to group work that includes individual treatment making it more effective.

The third enduring principle is: the emancipation of the individual from the limitations resulting from psychic suffering and the subsequent social inclusion require a concerted effort on the part of all the sciences and all the professions collaborating side-by-side within a single framework of time and space.

This value still applies for the treatment and social integration of people with mental disturbances and with psychological and social difficulties.

This work of discharge from the institution and subsequent social integration was all but easy. We must not forget that society turned the mentally disturbed over to the asylum to protect itself from a danger that was legally certified; the mentally ill created a sense of fear and alarm.

Paradoxically, the mentally ill were afraid, too. Leaving the asylum they were facing an intimidating situation. Society for them was unknown, hostile and threatening.

Prejudice had contaminated the healthy and the ill. That unspoken hostility was overcome, albeit not completely conquered, by means of an immense cultural and political effort that saw both points of encounter and contrast. Above all, this was possible with the exit of patients from the asylums accompanied by initial co-habitation arrangements that gave life to the first “Family Homes” (“Case Famiglia”), scholastic integration, social activities and programs for “socially useful jobs” which were organized by the local administrations. All these activities contributed to reducing this hostility.

It took ten years.

The resistance to living with someone who is different served almost symmetrically to motivate a broad range of moral energies and ample willingness in the different communities in the area of Arezzo.

Little by little, as the experience of the Therapeutic Community proceeded, the more a person rebuilt a life project the stronger was the request to leave the institution, to push for social integration and for a humanisation of social relations.

A fourth enduring principle is: social inclusion advances and prejudice withdraws not as a result of ideological diatribes on existence and the essence of mental illness, but as a result of action. Intermediate-care facilities, the exercise of rights, a project for a better quality of life, co-habitation and good practices all contribute to effective services in mental health care.

Let us return to the asylum. Almost immediately, it became clear that the rehabilitation of people could not be limited to the confines of the institution even though it was open and organized as a therapeutic community. People needed to taste life as everyone lives it with the opportunities and adversities that define it.

The brief excursions into the world of the free and the summer holidays by the sea or in the mountains were no longer sufficient. All patients were asking for a home, a community with affective relationships, a job and the freedom to organize one’s own life.

Real life still awaited just beyond those walls even though they had been brought down.

It became increasingly clear that it was necessary to change the life of the “patient”, or “in-patient”, as it were, but it was equally essential to change the receiving social context.

Some suggested blocking the authorizations for discharge until society was better prepared without any knowledge or indication as to how or when this change might occur. What might have been an apparently wise position, was in reality hypocritical and cynical. It meant asking the ill citizens to suspend their life projects until the healthy ones came to their senses and freed themselves of their prejudice.

It was neither possible nor right to stop the process. It was equally impossible to hope in a spontaneous change in society as though it were capable of freeing itself, of its own initiative, of prejudice and the egotistical closure induced by petty convenience.

What was needed was a democratic discussion among political and social forces in order to devel-
op a collective awareness of the issues. Awareness was needed of aspects such as the concrete problem of co-presence in society of all its members and the mentally ill returning from ostracism. All citizens needed to be set before the urgent question of existence and cohabitation.

The fifth enduring principle is: social integration postulates an alliance between different subjects, between health care professionals and institutions and between these and the civil society, beginning with families. There must be an alliance to understand all the players implicated in the ethical, cultural and material changes within the social context.

This is an alliance that has grown from confrontation, from a dialectic of positions, sometimes from conflict, to reach a unity of intent for a higher and shared form of civil cohabitation.

The mentally ill left the mental asylums in hundreds, not spontaneously but with projects that were predisposed, carefully followed and democratically constructed. In this way, little by little we saw the fall of barriers that had been raised by laws, by social convention and by politics. These are the facts, the paths followed, the positions of the time; and these are the values which are and must continue to be the foundation of today’s work.

CONCLUSIONS
With our brief dissertation we have tried to reconstruct the reasons for a fertile period that involved numerous local contexts in our country. While elaborating primarily on the experience in Arezzo, our aim has been equally satisfied. The objective here was to highlight the essential, undeniable underpinnings of Law 180. While revealing itself to be more a law of principle than one of specifically organizational content, it represents a necessary call to face those permanent conditions of human existence that determine the problematic and contradictory backdrop of our time.

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Individuals, social changes and psychiatric services: continuity and innovation

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Summary. Over the last few years, psychiatry has had to deal more in depth with the mutation of social frames and of problems expressed by the community, which has changed itself, in particular at a cultural level. The historical attitude of psychiatry, which is to combine a scientific approach with recognizing the rights of all individuals involved in the healing system, can be very helpful in keeping services in touch with the new needs of society and places the neurosciences in a peculiar position.

Key words: psychiatry, community psychiatry, human rights, professional identities.

Towards a revaluation of “psychiatry” meaning

The cultural, scientific and technical debate, which has developed over the last decade in our field, has forcefully highlighted the necessity of rediscovering the meaning of psychiatry. This comes at a moment in when practices are particularly contradictory, but also the social image of the discipline and professionals.

The necessity of making an effort to reflect on the changes taking place in our operative field – overcoming the anxieties of strictly disciplinary logic with the risk of reductionist leaning – is not in dispute, however it is not as clear (or common) whether the cultures and the practices of institutional psychiatry constitute a definitive change in the approach towards the entire field of psychiatric disturbances. It appears to us that this is a central problem, which originates from visions which are many times dichotomic on psychiatrists and psychiatry, social and professional roles, scientific statutes, techniques and praxis, trivialized by the lexical clash (certainly not semantic) between the denomination of “mental health services” and that one of “psychiatric services”.

We believe that psychiatry is faced today with the momentous transformation of its scientific statute, treatment role, its social legitimization, with the necessity of a strong and clear stand. A stand which on a par with that which lead to moving beyond asylums and to the birth of the system of community psychiatry, amid a simplifying tendency and the preconceived notion of the scientific and therapeutic complexity of psychiatric action.

If various factors – social, generational, part of the discipline and of the identity itself of professionals – push towards a reductionist position [1], great attention must continued to be paid to the indomitable nature of human beings, and their suffering/diseases, to unitary factors of any kind. Otherwise one risks reopening a useless, misleading and unscientific debate on the priority of one of the fields (bio, psycho and socio) when on each, contemporaneously and evermore, the history of health and sickness of every person is declined.

What worries us is the persistence in our sector of ideological assumptions, culturally limited and scientifically misleading, which through the services, techniques, the praxis and also treatment relationships, are at times determined more by the visions and aprioristic positions of the operators than by the needs of the patients.

A new scientific paradigm, in equilibrium between biologic matrix and cultural-philosophic matrix – without which not only does one lose the person, his/her world and his/her consciousness, but also...
his/her mind and brain – can only be assumed by operators and services able to overcome the limits of the auto-referencing, of the models which cannot be considered even when needs, requests and persons are by now “beyond” our instruments of recognition and response and call for profound and radical innovations.

In summary, we are speaking of a return to the roots of psychiatry – intrinsically connected to the human sciences, as well as to those biological. This in the effort to move closer and understand first suffering and then also the disease.

THE STRATEGY OF THE INTEGRATED APPROACH TO FACE MENTAL SUFFERING

This change/widening of the boundaries calls for reflection on intervention techniques and settings, in the effort of matching psychopharmacological, psychotherapeutic and psychosocial intervention with a truly integrated approach. An approach which should be made with attention given to the real scientific evidence (with neither suggestions nor obliging subalternity) but also to the production of clinical evidence (by means of case monitoring instruments, medical records as well as care reports and clinical audit systems), which support all of the levels of intervention (that is a clinical capable of producing evidence also on psychotherapeutic treatments and on the complex gamma of rehabilitative and psychosocial interventions, rich in cases and poor in systematizations, evaluations and monitoring of the outcomes on a clinical note and of the quality of life and social inclusion of the patient); on intervention settings, understood not only as locations, but also as networks, acceptance of patients and treatment, flexible with respect to the phases of the disease, to the objective of the treatment, to the contexts and the individuals. To consider and practice a clinical open to techniques, instruments, diversified interventions: from the medicine to self-help groups, through complex couplings but always understood as interacting parts of a single clinical idea and therefore of a “single and strong” course of treatment.

This approach moves beyond the limits of waiting (one takes on what comes along) and becomes active and of clinical action, capable of joining the “individual” approach and “public health” approach. Capable that is of defining priority, in the single treatment but also in the politics of the services: early intervention, intervention in adolescence and preadolescence, attention to the new psychopathological expressivity (personality disorders and/or behavioural of various types) and to the new subjects (elderly, immigrants, people guilty of crimes, situations of severe social deprivation).

But also, leaving space in this “lofty” concept of the clinical (under the technical profile, but most of all ethical) for the patient, his/her idea of diseases, his/her expectations, his/her placement with respect to the objectives. We find, along the way, the sense of the new approaches in the attention to adhesion to and active and conscious participation of the patient in the treatment (reducing the non-consensus or the refusal of treatment to certain moments in specific pathologies, phases or individuals and overcoming a culture still diffused in which the psychiatric patient, as such, always or anyway tends to be unaware of his/her disease), of the resistance to treatment (not reduced in a simplified manner to the lack of response to medicine, but more often intertwining of genetic factors – about which we can expect significant results from research in the field of pharmacogenomics, in the direction of the personalization of treatment – personological and of context), of the “recovery” understood as finding oneself and meaning, also in the experience of suffering and disease.

THE CONCEPT OF “RECOVERY”

In this view attention becomes primal to the factors of recovery and to the role, in this direction, of the services. The concept of complex and multidimensional “recovery” as its various meanings demonstrate [2, 3] originally [4] “imply a process of recovery or of development of a valid sense of belonging and a sense of positive identity beyond that of one’s own disability, and therefore the reconstruction of one’s life in the broadest community, despite the limitations placed by such disease”.

Recovery, understood as recovery of the consciousness of sufferance and of disease does not identify with clinical healing, but rather with that which is social (all considered an ambiguous and “grey” category) and with the experience of rediscovery: journey, re-signification, achievement of consciousnesses, participation, active and lived citizenship, relationships of self-help and, most of all, not being solitary, inside or outside.

A category which is not clinical, therefore, but a sign of the change of the relationship with the disease, development of new abilities to cope, reaffirmation of the subject as a person, in addition to and not contrary to the identity determined by the disease.

Services, in this direction, must assume a function of support and of catalyst. Network interventions, development of opportunities and possibilities of choice, appropriate and personalized care, capacity of listening and giving voice, flexibility of interventions, being there over long periods of time, knowledge of how to recognize and enhance health within and beyond the disease, being accessible, present and involved. All of these become instruments/routes directed at a “recovery-oriented” clinical approach, the strong points of which appear to be: a) not to stop at categories; b) to verify and systematize daily practices; c) reject the (pseudo) sure solutions; d) develop and promote independent education as maintenance; e) maintain the capacity of thought during upheaval and emptiness; f) establish relationships and services of “proximity”; g) transform rigid, fragmented, standardized practices into personalized, connected, shared practices.
We believe that today it no longer makes sense to question ourselves further about the dispositions of a Law which - though being object of bitter conflict - has anyway left its mark not only on the history of psychiatric assistance but more generally on health assistance in our country. It makes more sense in fact to look at what the actual requirements are for the improvement of and adaptation to new problems and new needs.

DEPARTMENTS OF MENTAL HEALTH: STRIVING FOR INNOVATION

Elsewhere [5-7] we have tried to tackle these themes, in the form of provocation – we hope useful – and in the search of responses on the front of the real and actual confluence of the organizational and functional structure of the DSM (Department of Mental Health) to the development of practices of community psychiatry and to the necessary innovations. Some operational guidelines appear suitable to represent the necessary process of system remodelling, assuming as essential the “organization - function” ratio: a) differentiate the products; b) work on the times and on groups; c) combat the stigma; d) be aware in order to make aware.

There is no doubt that we are assisting a weakening of territorial psychiatric services, which is manifested at the level of territoriality, represent-ability, of collective identity, of protection of rights. This situation calls for work which is not ordinary of the refunding of the culture and of the practices of the psychiatrist and of the mental health of the community, in order to be able to come out of an impasse which is also a crisis of values, ideas, projects, sponsorship, networks, sociality, sustainability, citizenship.

Careful reflection on the problems of today must begin with revision of work methodology of services: the public nature (in the sense of the responsibility, not necessarily of the provider); the territorialization of the intervention; the organizational model; the continuity and the specialization of the intervention; the multi-professional culture, the centrality of the work of a team; the active behaviour towards user, also toward those who refuse or interrupt treatment; the intervention in “borderline” areas and institutions (prisons, judicial psychiatric hospitals – ospedali psichiatrici giudiziari, OPG –); work for social inclusion and the battle against stigma; support intervention for family members and caregivers.

In our opinion attention has recently been opportunely called [8] to the phenomenon of re-institutionalization, determined not only by limits in the processes of deinstitutionalization (non-homogeneous and partial realization, fall from social attention to the rights to citizenship of vulnerable subjects), but also by demographic changes (elderly persons alone and nuclear families), by the weakening of the social capital and by the disinvestment in the relationships of assistance and accessibility.

A DSM more capable of intercepting and responding to the new questions must be: based less on the organizational structure and more on planning; able to develop connections and to move away from autonomy and isolation; integrated with public resources and accredited providers; flexible in the capacity of provision of and also of coordination with the other social-sanitary services, within and without of the ASL (azienda sanitaria locale, local health entity), centred more on the user, on his/her request and needs, than on the offer; in equilibrium between territorialization and specialization (geographic area, treatment plans for pathologies, free choice), between centrality of the psychiatrist and centrality of the case manager.

In this direction we are dealing with calling attention to the clinical pertinence (not only organizational) in a context which fully assumes the challenge of the complexity and of the intertwining of factors, transforming the discovery of the complexity in method. The primary task of science, also in psychiatry, cannot be that of elaborating formal abstract models, but rather of trying to resolve human problems.

PERSPECTIVES IN PSYCHIATRIC FIELD

Faced therefore with a complexification of the scenarios, several paradigms which have oriented knowledge and practices in these years are revealed to be fragile and merit strong reconsideration. These include the definition of the actual and future field of psychiatric intervention from diseases to behaviours; the sustainability of the sophisticated technologies (for example, neuro-imaging and genetic research) in a view which always looks for an endogenous and endogenous context, also in psychiatry, cannot be that of elaborating formal abstract models, but rather of trying to resolve human problems.

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"... buried in language and in practices which are always more technicistic and bureaucratic ... is found in the crisis, the urgency, in the explosive moments, in the chaos. It is the raw word which makes a problem for technocratic rationality, a invalidated word and rendered mute by the hegemony of specialized proficiencies. The subject it is not is the one who talks a lot, but is not understood." (L. Blaise).
Elsewhere [9] we have tried to describe the everyday nature of the services through stories of persons and patients: Nneka, the “sans papier”; Alioscia, the adopted boy who is growing up; Evelyn and Rose Mary, the runaways from “who knows what”; Avito, the curious and ironic inventor; Giobatta, convinced that his doctor is head over heels in love with him; Giuseppe, who not even in a prison cell is able to let himself go… and even more.

The young and very young, women with and without children, psychiatric patients who become old and the old who go crazy, persons who have committed crimes, of all ages, social and cultural conditions.

The stories, and the reflections triggered by them, have not resolved our problem of professional identity, thirty years from the reform, but have served as an antidote to the ideological auto-referencing and – by now – also a bit pathetic. The central question seems to be, still today: how can we be useful but, most of all, where are we not needed? Nonetheless they have allowed us to grasp the sense and the value of several dimensions: the unorthodox meeting, the listening and in silence, the word rendered corporeal by the difficulty with verbal communication, action which speaks (doing something with) and even more. And this in meeting spaces without settings, that is without pre-established rules (and objectives, functions), to welcome and try to put together fragments of stories, persons, needs, memories, hopes, disappointments, failures, but also symptoms and diseases to treat. At times it seems one is welcoming castaways, who have come from “who knows where” or “how”, who carry the collective, cultural, existential, familiar, occupational, psychopathologic marks of survivors.

Perhaps the only possible route remains that of “monter et démonter sans cesse” always and anyway – as R. Castel [10] reminds us – an indispensable operation today, as much as it has been for the development of the processes of deinstitutionalization.

In this direction G. Tognoni [11], puts forward once again – “for a memory of content and methods” – the theses which were at the basis of the culture and of the ideal thrust of psychiatric reform: a) the overall stories of individuals – which include their life contexts and encounter/clash with institutions – are more important that their clinical diagnoses in determining the prognosis in terms of results; b) the institutional variables (presence or absence of services; quality, intelligence, organization of the operators; articulation of strategies of health assistance and non) are in fact the denominator and the vessel which allow single clinical interventions – diagnostic, therapeutic, rehabilitative – to be configured as an effective responsibility taken for problems, characterized by a natural story which is declined and decided over time; c) the quality of the services is in proportion to their capacity to guarantee cross-sectional articulation and longitudinal coherence, which targets cultural necessity, before organizational, to think and act in terms of circuits and courses of treatment; d) the true and ethical foundation of the logic of the responsibility taken for the patient-problem-need and of continuity of the attention-evaluation is in the recognition that the reference category is that of “human rights”, that is intrinsic to human beings: the needs-diseases, disabilities, lack of auto-sufficiency can be taken seriously (in their specificity and variability, in their expressions of severity-gravity or welfare-level of problem severity dependent) only if there are normally acknowledged as part of citizenship rights which are nonnegotiable.

In this reference frame, psychiatry, which had culturally predicted and institutionally tested some great intuitions of medicine and health research is today at great risk of marginality (cultural, methodological, scientific and organizational – managerial), which can only be avoided by investing in two fundamental theoretical-practical fronts: a) the development of an epidemiology of rights, as permanent operative model of evaluation of practices and services (early intervention, assistance continuity, reduction of disabilities, information, empowerment, struggle against stigma); b) attention to the person in his/her entirety, and not to the systematic aspects, which move away from psychopathological understanding and to the construction of effective treatment relationships.

Along the way problems are assessed connected with the professional identity of the operators. The pursuit of consciousness (or of the sense) of psychiatry today, and of its institutions/praxis, must consider these scenarios and actors in movement, which involve and characterize the complexity and specificity of our discipline in a new way.

In our “yesterday”, the identity of psychiatry (and more generally the mental health operator) was declined around the meeting of three levels: a) humanistic level, focussed on the attention on the person; b) scientific technical level, which constituted the reason for the professional decision; c) ethical level, which looked at the rights of those more weak, met with and known in the simplified frame of the entire institution.

Already in our present, but most of all in our future, the problems are more articulated. Science is on the brink among new challenges (and possible achievements) and old problems, among hypotheses and their transfer to the real world; among facts and stories, which are irreducible of the meeting between human beings. Technical proficienties move along on various aspects of the area of discipline and are not always possessed (nor possess-able) by every professional. The demand sees the change in needs, problems, diseases, persons, institutions and relationships among them. The social mandate, ultimately, appears, more so today than yesterday, to be a contradictory intertwining between reduction of the delegation to the technical with requirement for more information/participation, and anticipation of a “strong” behavioural science, capable of explaining and managing any event; amid shrinking of the
area of expertise with respect to encoded diseases to amplification of behaviours; among development of services concentrated on rights and the appearance again of responses characterized by institutionalization and control.

These reflections based on our vision of the problems in the field and for certain not free from subjectivity and passion, aim to contribute to opening horizons of thought and of individual and group observation.

“Opening” perspectives and minds is a fundamental process in our field, so we are not reduced to observing the world (the patient, disease and their intertwining) through keyholes, limiting the observation, and the resulting operational choices.

CONCLUSIONS
Thirty years from the reform, at what point are we, and what is needed?

At what point we are: closure of the psychiatric hospitals, and beginning of closure of judicial psychiatric hospitals; complete integration of psychiatry and infantile neuropsychiatry of the SSN (Servizio Sanitario Nazionale, National Health Service); change of disciplinary paradigms: complexity of techniques and treatments; new requirements of training (independent) and research.

For the development of these actions a new cultural, social, institutional, clinical, managerial, sustainability is still necessary, founded on several principles: development of the rights of the citizenship; struggle against all forms, old and new, of unnecessary institutionalization; clinical regime and monitoring of processes and outcomes of every treatment; increase in the multidiscipline nature of and multi-professionalism in the work of/for mental health.

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The Italian Law “180” thirty years after: from the unmet needs of sick people and families the duty of a critical reflection

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Summary. The law that in 1978 reformed the psychiatric assistance in Italy, the well known “Law 180”, represented an historical moment not only respect to the new modalities of the assistance to mentally ill people but also for the cultural and social approach to psychiatric illness. The closure of psychiatric hospitals and the beginning of the process of destigmatization of mental illness were its most relevant and historically significant elements. Despite of this, thirty years after the law and considering modes and results of its utilization, some critical remarks can be made, aiming at a further evolution in the modalities of the assistance to psychiatrically ill people.

Key words: psychiatry, psychiatric assistance, psychiatric reform.

INTRODUCTION

When in 1978 the Italian Parliament launched, in a measure almost as a surprise, the law of reform of the psychiatric assistance in Italy, soon definitively identified as the “180” or the “Basaglia Law”, despite its rapidly following factoring in the law of reform of the whole National Health Service, it had suffered, both in general public that particularly in the world of psychiatric care, a perception of being before a historic event, objectively and intentionally “revolutionary”, the scope of consequences of which appeared then, whether positive or negative, really not foreseeable.

The debate, almost always very intense, that in subsequent years and up to the current days has accompanied the applications, support and criticism of the law is well known and has certainly been one of the object of more intense scientific, cultural and political discussion in the modern history of care in Italy. Thirty years later, in a cultural context of full “Celebration”, it may however be appropriate, if not just morally right, to make some considerations that can stimulate a more detached reflection on certain principles, applications and results of the Law 180.

In the first place, we have to recognize the two main, magnificent “merits” of “180”: the reality of deinstitutionalization of the psychiatric assistance, with, initially in suddenly and deliberately provocative way and in a gradual and pragmatic suffered way in subsequent years, the closure of psychiatric hospitals and the beginning of the various forms of assistance “on the territory”, and the start of the process of destigmatization of mental patient, gradually affirmed in the medical as well as general vision.

Two welfare, ethical and cultural principles that today belong in a rooted and accepted way to the social and health culture of common opinion, namely the refusal of segregation of mental patient in a dimension of separation from the social context and of renounce to therapy, which was the insane asylum, and that of full recognition of the rights of mental patient as a person, received their first legislative recognition in the “180” and in reality only...
since 30 years belong in a practical way to the culture of Italian society.

In fact, the 180 has represented the end of a world and the beginning of a new world in the field of psychiatric care.

But the historical merits of the law must not exempt, with the wisdom that comes from observation over time of its practical consequences, from the duty of critical reflection.

As every truly innovative process, even the revolutionary psychiatric assistance reform in Italy has not been free from some “original sins” and some subsequent “difficulties”, whose assessment allows a more precise historical vision and gives reason of the persistent shortcomings and problems for the public care to mentally ill people.

THE “ORIGINAL SINS”

The influence of the political-cultural context

It’s naturally destiny of every social and political process be influenced by historical and cultural context in which it is realized. In the case of the “180” this influence was very strong, as was very strong in Italy at the time of its promulgation the power of influence and conditioning by the cultural and political context.

The 1970s had been the years of success of the antipsychiatry, a cultural, certainly not medical, movement, with a very clear-cut political characterization, which, very briefly, on the one hand attributed a dominant role in the origin of mental disorders to relational, family, psycho-social, economic, political factors and on the other hand denied any validity not only to the assistance model based on segregation but also, in a more extensive way, to the medical model itself of interpretation and treatment of mental suffering.

Linked in its origins to principles of psychiatric phenomenology and subsequently developed according to the use in social sciences of psychoanalytic paradigms and of knowledge about rules and paradoxes of interpersonal communication, the antipsychiatric culture was still very quickly characterized for its well-defined political orientation of Marxist nature, whose paradigms of interpretation of social dynamics were adopted, even in the reading and propositions of intervention in the field of mental illness.

Basaglia himself, even retaining a real awareness of mental disorder as a “disease”, was powerfully influenced by this vision and by a general political reading of social phenomena in which even the mental illness and its treatment were included. “The positions are in this dimension still clear and precise: the paternal authority is oppressive and arbitrary, the school is based on blackmail and on threat; the employer exploits the worker; the insane asylum destroys the mental patient” [1].

Basaglia, certainly the main inspirator of the “180”, but not its author and partly also critical of it, was not in himself an antipsychiatrist, but he was however strongly influenced by the principles of the antipsychiatric movement, which in turn, through its influence on general cultural climate of the period, involved in a direct way principles and content of the law.

The common psychiatric opinion, influenced by the texts of Laing, Esterson, Cooper, Szatz, Shatzman, Bateson, of the scientific followers of the “Group of Palo Alto”, as well as the public opinion, in turn affected by “historical” texts as those by Foucault or by movie productions of intense social penetration (as in the case of Somebody flew on the Cuckoo’s Nest, 1975) and in addition by a political and mediatic environment at the time strongly and often also uncritically conditioned by paradigms of Marxist culture, welcomed as “natural” the overrun of the psychiatric hospital institution, regardless of the specific possibility of providing alternative arrangements for assistance to the psychiatric patients and locating in a secondary position the efforts of scientific knowledge and scientifically based treatments in the field of mental disorders.

The conceptual approach to mental illness

From this derived one of the most identifiable principles underlying the law, even if more implicitly that explicitly stated, which is the clear-cut prevalence, in the interpretation of psychiatric disorders and in the principles of their treatment, of the socio-genetic model and of the social meaning of psychological discomfort respect to the biological-medical model of mental illness.

The “180” was repeatedly improperly accused of having denied value to the very concept of mental illness, as instead constantly stated by the antipsychiatric culture. This is not true and the reference to the existence of psychiatric pathology as such is at the opposite constantly present in formulations and in applications of the new rules.

But certainly the maximum attention was given to the generically “social” components of the factors involved in the origin of the disorders, viewed both relational as well as economic and political. From here the predominant interest for therapeutic strategies entrusted to psychotherapy of various kinds, psycho-social interventions or simple social assistance programs of Community therapy, etc., certainly coupled with measures more closely medical, as the pharmacotherapy, but with relegation of these applications in the context of limited significance of symptomatic or behavioural treatment of patients, without recognition of their real therapeutic value in the pathological processes at the origin of the disorders.

The biological origin, or simply the biological components of mental illness, was given a secondary importance and the search and the formulation of scientific models in this field were seen with mistrust and often subject to open or implicit disqualification.
Consequently it was implicitly made, or more often imposed to the eyes of public opinion, a dichotomy of models. One is a “progressive” vision, centred on sociogenetic components of the “psychological discomfort”, the foundation of the culture and policy of “liberation” and mostly realized according to “territorial” techniques and strategies, using only in the role of symptomatic treatments the opportunities provided by the pharmacotherapy.

On the other hand, a “conservative” vision, linked to the general model of understanding the biological origin of mental illness, anchored to the old view of the need of treatment of patients in hospitals and so implicitly also the guardian of the old culture of segregation.

The intolerance to the criticism

The Law 180 was from the beginning, for its innovation, the subject of open debate in both the psychiatric and public opinion. But in the same time, it occurred the phenomenon of the open intolerance by its authors or supporters to every form of criticism of the law, even if partial or given to pragmatic or minor aspects of its application and aimed at potential improvement of its application.

The strong original ideological aspect translated itself into a vision of every criticism in terms of attack or refusal to the spirit or the application of the law, in an open or underhand attempt to return to the past. The response to criticisms were invariably the disqualification of their authors, either individuals or medical, cultural or political part, accused of conservatism or “to want to go back to insane asylum” or however to the old way of vision of mental illness, the insinuation or the overt accusation to be raised by private interests, to serve the interests of pharmaceutical companies, etc.

An at least partial explanation of such rigidity, which was also strongly useful for the maintenance of the new status quo of the distribution of tasks that accompanied the development of the reform, can be detected, as already mentioned, in the determinant influence of ideological vision which surrounded the progress of the new project. The model of the reform, in fact, rationally based on a predominantly sociogenetic ground, was translated into the political reform under the ideological influence prevailing in that historical period, explicitly referred to “revolutionary” models. The intolerance to criticism of the law has represented over the years, despite the objective decrease of such attitude in front of the needs of its application, the ideological and in this sense also prejudicial defence of its value of revolutionary rupture respect to the past world of psychiatric culture and care.

The intolerance to the criticisms and the also prejudicial defence of the dictates of 180 have led not secondary consequences in the development of its applications.

The psychiatric and public opinion was divided, and remained divided in part until the present moment, between supporters and opponents, according to positions more adapted to different problems than the medical problems, on the basis of essentially total acceptance or refusal of the law, often characterized by inability to criticize and cultural conformism.

In front of the incompleteness of the results, inevitable for such a radical process of renewal, but unacceptable for an ideological vision of a revolutionary project, it was, and it still often is, referred to “the lack of structures”, according to a reference to the pragmatic-economic context, or to the “non-application of the law”, according to a pragmatic, not ideological defence mechanism.

In both cases, the result was that of a clear difficulty in the objective evaluation of any, but inevitable, limits of the effectiveness or of the inadequacy of the principles, as carried out in an self-referential context of criticism, such as that of the difficulty of an objective focusing of the really lacking elements in the principles or enforcement of the law and of the possibility of their adjustment and processing.

THE PROBLEMS OF THE ROUTE OF APPLICATION

The limitation of the areas of interest

In its historical goal to overrun the psychiatric hospital institution, the Law 180 was naturally aimed in the first place to the organization of the assistance of those patients who lived in the psychiatric hospital at the time of its promulgation and of those who, after they fell ill, would have been previously otherwise hospitalized. The first were represented, in addition to a large proportion of patients with mental retardation of various nature, mainly by chronic psychotic patients, in large majority affected by schizophrenia, the second by persons whose psychotic onset or worsening occurred after the law.

This has inevitably led the focusing of operational strategies, essentially geared to assist on the territory but also in the hospital psychiatric services of diagnosis and treatment (SPDC, Servizi Psychiatri di Diagnosi e Cura), in the clinically more severe areas, such as those of the psychotic diseases, both acute and chronic. The efforts of the planning of the new system of assistance addressed in a selective way such areas, both along the course of the processes of gradual closure of psychiatric hospitals, more or less slow with regard to the difficulties on the resignation of previously admitted patients, often dramatic and mostly minimized to the eyes of the public opinion, sometimes also with absolutely tragic individual implications, and in the organization of their assistance in territorial contexts of mental health centres and of the then defined “intermediate structures”, as therapeutic communities, family- houses, etc.

It was a massif effort, often objectively pursued with absolutely insufficient human and structural resources in front of the real operational requirements, which has however in facts led the provision of assistance to mentally ill people to coincide with the assistance to the most severe of them, patients with schizo-
phrenia and those suffering from more severe forms of mood disorders, patients that would previously be admitted in psychiatric hospital, and to the cases of personality disorders with more marked behavioural problems.

Other very wide areas of psychiatric pathology remained in the early stages completely excluded from the programs of assistance and only in a second time, and in so far in an absolutely incomplete extent, they were included in the field of interest of the public psychiatric care structures.

The area of mood disorders is one of most significant examples. As a matter of fact, only the most severe cases of affective disease receive aid in public centres, such as the cases of patients with severe bipolar disorder, in particular in the phase of excitement, and the patients with major depression with psychotic symptoms or suicidal behaviour or ideation, almost always only for the acute period of illness. The overwhelming majority of the other affective patients, even in cases of real clinical severity or personal and environmental suffering, meet often serious difficulties in being adequately followed at the structures of the departments of mental health (DSM, Dipartimenti di Salute Mentale) and seek assistance, in relation to different cultural or economic background, by general practitioners, private nursing homes and psychiatric clinics, private studies of psychiatrists and other specialists such as neurologists, endocrinologists, etc., psychologists and psychotherapists with very wide differences of theoretical approach, or other professional figures often offering also frankly “alternative” treatments respect to the official medical guide-lines, thus receiving therapeutic answers very variable also in relation to scientific orientation and real competence of the different professional figures consulted.

The percentage of affective patients treated in the structures of DSMs is in the facts absolutely lower compared to the needs of assistance by an area of psychiatric pathology whose incidence and severity is in constant growth.

The same issue appears of statistically even more greater entity in other fields of pathology of wide social impact, such as in a more clear extent that of anxiety disorders. Only the patients with more severe symptoms of obsessive-compulsive disorder are in some cases treated at the DSMs, while almost all of patients with other manifestations of pathological anxiety, also strongly debilitating as for example the panic disorder, seek help elsewhere or remain completely without it.

The same is valid for other areas of “minor” disease, such as the somatoform disorders, almost always treated by general practitioners, or the dissociative disorders and the sleep disorders, more often not treated, or treated by neurologists, or different types or doctors or psychologists, or professional figures of “alternative” competence.

If it is true that in a limited number of cases there is the attempt to treat at the DSMs, also in contexts of psychotherapy, patients with mood, anxiety, somatoform disorders, etc., it is indisputable that at present the size of the assistential response is mostly inadequate.

Also the very wide area of “double diagnosis” patients, that is subjects suffering from psychiatric pathology but also consumers of substance abuse, whose amount is absolutely exponentially growing, is mostly diverted and followed intermittently at the designated structures for assistance to addicted subjects, with the recognition of the psychiatric issue only in the case of acute behavioural emergency.

The limitations of “taking-in-load”

In front of the size of the organizational effort that has made possible to overrun the psychiatric hospital institution and the implementation of programs of territorial assistance, we have however assisted to an even more complete request for action along all the stages of the therapeutic program.

In particular, there have been the family associations to stress the need of further enlargement of the “taking in load” of the patients by the structures of DSMs in all stages of the assistential route, from the most strictly therapeutic to those more oriented towards programs of rehabilitation and reintegration.

One of the initial characteristics of the new system of assistance, in fact, that had at the beginning an often also dramatic impact but that has represented in any case until now a very serious problem, is the caring load generally attributed to the families of the patients, if not in theory at least very often in the real situations.

The loosening of the medical model and the tendency to reduce the recourse to the hospitalization, often very limited in time even within the SPDC, together with the very limited availability of residential facilities, led by facts the direct involvement of family in daily therapeutic tasks, only in minor part supported by the domiciliary activity implemented by DSM.

It was an essentially pragmatic problem, linked to prevailing organizational difficulties, but considerable at times in different orders of meaning.

In many cases, in fact, especially in the first time after the reform but also in subsequent periods and in a certain extent also at the present moment, the opportunity of the involvement of relatives was also associated with the pathogenetic vision which attributed to infrafamiliar relational dynamics a central role in the genesis of psychiatric disorders, also of the more serious ones. The type of theoretical approach of individual psychiatric operators was of course crucial, so to make also often neither complete nor homogeneous the overall intervention of DSM, but the idea, implicit or explicit, that family members that were in some way responsible in origin of mental suffering of patients should be directly involved in the care to these, almost to duty serving their original responsibility, oriented for a long time and in many cases the therapeutic projects of many DSMs.
Result of this attitude has been very often the increase of existential and psychological drama of family members of the patients, to whose difficulties of management of problems of ordinary care of the sick was added the guilt feeling for the disease of this.

The evidence, sometimes even incontrovertible, of the role of cerebral, genetic or in the broad sense biological components in the origin of the individual cases has not frequently been a sufficiently objective evaluation element in front of the theoretical assumptions of the operators. The feeling of abandonment often pleaded by family members of patients respect to the interventions of DSM has certainly recognized in this attitude a powerful factor of accentuation.

A crucial problem in this respect was also represented by the great difficulty of access to the hospitalization of patients also in conditions of relevant clinical severity. The Law 180 has in fact provided for the possibility of shelter for the psychiatric patients only in the particular conditions of acute state, so to justify the hospitalization, voluntary or compulsory, in the SPDC. In these have practically been admitted in the vast majority cases of onset or reactivation of psychotic schizophrenic or affective disorders, often on the basis of behavioral problems, with the exclusion of patients affected by diseases of other areas, as for example non-psychotic depressed patients.

To the frequent clinical need of such subjects to be treated as inpatients the response of DSMs was in the vast majority of cases completely insufficient. The persistence in different, but not all, the Italian regions of nursing homes and of some units of hospitalization in University polyclinics has in the fact just partially met the need, but the lack of structures in which to effect treatments for severe affective patients or for other not psychotic patients remains a substantial shortfall in the theoretical approach itself of the current programs of psychiatric care.

On the other hand, the problem of hospitalization remains a crucial point in relation to the programs of treatment of psychotic patients and to the therapeutic load attributed to their families.

Indeed in many cases the behavioral abnormalities of the psychotic patient, essentially the schizophrenic, are prolonged over time, as well as the difficulty or the refusal of acceptance of drug therapies. The hospitalizations in the SPDC, always of very short duration, meet only the need of intervention on the acute condition, but do not exhaust the real need of clinical trials related to therapeutic management of cases in which severity and chronic course coincide. However, the hypothesis to provide more prolonged hospitalization for psychotic patients, in the case also on a compulsory base, in facilities however included in the organization and in therapeutic programs of DSMs has constantly been rejected, mainly also for its possible symbolic meaning of return to segregational mode of assistance.

The significant restriction of the possibility of hospitalization of severe psychiatric patients for the time really needed to their treatment, certainly outside of any analogy with the previous logic of psychiatric hospital segregation, is a situation absolutely unique in the European panorama, a clear expression of the prevalence of ideological prejudice on the clinical need of patients and on the needs of the therapeutic potential of their environment of daily life, first of all the family.

**The mistrust towards Psychiatry as medical science**

Even if the “180” was not a law based on antipsychiatric paradigms and even if its inspiring, starting with Basaglia, never repudiated the intrinsically pathological nature of mental illness, it is clear that it was not the medical model of this to suggest the main principles of the law.

The already mentioned prejudicial vision of Psychiatry as a discipline whose social task was restricting without curing people who were potentially dangerous for the social balance and for its power relations, explicitly proposed by the antipsychiatric movement, forced first the authors of the law and then its supporters to a defensive position respect to the risk to be somehow charged to be in harmony with the vision of mental illness and its care they wanted in any case refuse.

The reduction of the view of the medical nature of Psychiatry and of the medical role of the psychiatrist compared to nature and role of other factors and of other operators represented so the first act of a process of removal of Psychiatry from other medical disciplines, to which corresponded an easing of interest or a substantial mistrust respect to the scientific research, in particular biological, in the field of mental illness.

The increment of interest towards theories and techniques of psychotherapy clearly founded on a scientific basis but still more distant from the medical models, was to some extent the compensation respect to this position of resignation to the most explicit references to psychiatric scientific discipline.

The concept that inspired this attitude may be summarized in a meaning of suspicion towards the scientific research on mental illness to reproduce a reductionistic vision, respect to the need to consider as primary the social factors associated with psychological discomfort, in front of the risk, or the intention, of recovery of criteria of stigmatization based on factors that can be defined as “biological”.

To this followed in consequence the lack of interest to research and developments in the field of psychopharmacological therapies, despite widely used to make possible the closing of psychiatric hospitals, framed in a closely symptomatic view.

Also an attitude of mistrust towards the pharmaceutical companies, strongly influenced by the initial political and cultural context and by the personal opinions in subsequent periods, played a significant role in the origin of this position.

The intensive and rapid development of Neurosciences in the years that followed the Law 180, the
enormous increase of the possibility of scientific investigation also in the field of mental disorders and the resulting amount of data and new assumptions of their somatic implication made difficult to maintain this position in time, gradually faded compared to the initial propositions.

What we are witnessing today is more simply represented no more by the prejudicial refusal of the research in the area of Neuroscience and of the models based on its results, but, at least still in a not secondary part of operators in the DSMs, by the reduction of importance attributed to these in relation to a substantial scepticism about the possibility to use them in clinical practice. According to the individual visions, also knowledge and opportunities provided by the development of psychopharmacology are evaluated both in terms of aware deepening and of persistent distrust respect their real potential therapeutic action, when compared to treatments active on factors more closely related to psychological or sociogenetic implications.

The initial distrust towards the medical model of Psychiatry persists today still in a large group of operators of DSMs, no more drawn up, in most cases, in terms of refusal of the possibilities provided by scientific techniques of knowledge and care of mental disorders, but in terms of a reminder of those models of primary intervention on psychosocial components of mental disorders that were in the same time underlying and product of the Law 180.

CONCLUSION

The Law 180 was the beginning of a new era in the psychiatric assistance in Italy. In the face of indisputable results obtained, a number of factors of principle and of problems of application have as a matter of fact partially limited effectiveness and completeness of its action.

After 30 years after entry into force, an attitude, on the part of its supporters and figures and institutions appointed to its application, more sensitive to listening of the proposals of critical reflection could represent, together with ritual celebrations, an opportunity to identify routes aimed to the necessary adjustments to the changed conditions of organization of care and scientific knowledge.

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The birth of child and adolescent neuropsychiatry: from rehabilitation and social inclusion of the mentally handicapped, to the care of mental health during development

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Summary. Child and adolescent neuropsychiatry services’ development is described from early deinstitutionalization, through to rehabilitation, intervention and social inclusion of children with disability. The issues that have changed the services in order to meet the growing mental health problem, and the protection of mental well-being through developmental years, are then dealt with in detail. Finally we draw a picture of the organization of child and adolescent neuropsychiatry services in Italy and in the different regional contexts.

Key words: childhood/adolescent, de-institutionalization, disability, psychological suffering, mental health.

INTRODUCTION

In treating this subject, I will focus on what I believe are the essential turning points, which have lead to the breakthrough in interventions offering an alternative to the institutionalization, and isolation of mentally handicapped children in the 1970's, and the creation of those services we now call child and adolescent neuropsychiatry or mental health for childhood and adolescence. Those first interventions developed services in various territories and the coverage, which was originally concerned only with disabled children, has progressively extended it’s goals and intervention areas but has developed in a fragmented and differentiated way due to the lack of specific national and regional planning.

The turning points can be identified as:
- the first interventions towards the deinstitutionalization of children and school marginalization processes;
- school integration policies for children with disabilities: Law 104 for the inclusion of children with disability;
- development of child and adolescent psychopathology and the creation of child and adolescent neuropsychiatry services;
- approaching strategies for the protection of mental health in childhood and adolescence;
- state services. Various service organization nets and their configuration in regional plans.

“SPECIAL” ITALY AND THE MARGINALIZATION OF CHILDREN IN THE 1960’S

The Mental Homes Institution, was at the centre of the controversy, which called for a radical change in mental health treatment in Italy in the 1970’s; the Law 180 of 1978 “Assessments, and voluntary and compulsory sanitary treatment” introduced a fundamental change in the way in which mental illnesses were treated, and radically shifted, from the idea that patients should be treated in institutions, to the idea that patients benefit by living in their own environment, close to relatives and in their own social area. Those who worked at the time in this area know perfectly well that Basaglia’s cultural and

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scientific elaborations concerning child psychiatry policies, didn’t primarily involve mental homes, but focused on other institutions which at the time represented the most evident sign of marginalization, and, unfortunately, of violence on children: social welfare homes for children and subsequently special school structures. The division of psychiatry policies, which in our country have developed into separate interventions for children and adults can clearly be seen in the first years of affirmation and renewal of mental health policies; for example, the Law 180 of 1978 doesn’t refer at all to under-aged children, even if their presence in mental homes was a considerable phenomenon. The relation between childhood and mental homes wasn’t considered in depth, or underlined, in those decades: information was poor and related scientific research was rare. The few publications which can be found, concerning this tragic side of the story of Italian mental homes, usually try to reconstruct the presence of children in mental homes by studying single mental homes, such as the one in Santa Maria della Pietà Hospital in Rome [1]. But the truth is that mental home’s experience in childhood has affected more deeply than we could think. Children with disabilities, not only intellectual, but also motor and sensory, including those labelled as “bad behaviour” were sent to mental homes; obviously children from poorer social classes were more likely to be institutionalized. Many authors, in the last few decades, have studied the story of mental homes in Italy and the development of psychiatric treatment; the great majority of their studies don’t even mention the presence of children in mental homes. “The silence that enfolds them is louder than their screaming. Victims of institution and sometimes of real tragedy, they don’t seem to exist, they’re often not even mentioned, and they appear even more isolated than adult “crazy people. They are the ones who won’t be rehabilitated, they will die in a mental home in a few years or end up being chronic patients and moved to the adult wards, or transferred to other mental homes or institutes” [1; pag. 15].

Unlike the presence of children in mental homes, there was considerable social attention and request for change at national level for the de-institutionalization of children from children’s institutes, and subsequently for a change in childhood marginalization policies, lead by special schools and classes, the “different classes”. The 1960’s were defined by a massive children’s institutionalization and by the proliferation of special classes nationwide. These processes have been the base of our country’s social and welfare politics. On the 31 December 1960, the statistical year-book of welfare and social security (Istat data, [2]) showed that institutionalized children were:

- 112 956 in orphanages;
- 87 594 in “institutes for poor and abandoned children”;
- 61 402 in permanent colonies, that is “institutes that accommodate lymphatic, anaemic and TBC prone children etc.”. In reality children were almost always hospitalized for social/economic reasons;
- 18 464 in institutes for “other categories of patients”;
- 10 081 in institutes for “mentally disabled people”;
- 8699 in the new orphanages for “internal upbringing”, 3768 of these children weren’t acknowledged by their parents;
- 7624 in institutes for “sensory impaired”;
- 3506 in institutes for “physically impaired”.

This meant that, on 31 December 1960, there were 310 326 under-aged patients hospitalized in isolation institutes. The first reasons for institutionalization were poverty and abandon, but there was also a very strong trend towards the isolation of the disabled, sensory or intellectual; in fact institutionalization was the basic model for rehabilitation and recovery from any disability.

We can’t even be sure of the number of functioning institutes because Istat’s data, on 31 December 1968, show 3871, while the National League for Maternity and Infants (ONMI) counted over 5000. Evidence of those days can be found in many court reports and related proceedings [3-5]. Two very sad and dramatic stories, emblematic of the level of violence that the institutional system had reached in those years, and events which had a deep impact on the public opinion at that time, showed the spreading of a system based on nepotistic tangles, economic interests and connivance inside of the institutional authorities who had completely abandoned any kind of control and supervision. In particular they also showed what was taking place inside the institutes for disabled children; two expressions of this are:

• the Maria Vergine Assunta in Cielo Institute in Prato, known as “Celestini’s Institute”; some of its executives and “educators” were sentenced, for serious acts of abuse on the hospitalized children, by the Florence Court on 3 December 1968. From the official records of the trial: “S. is ten years old, at the time of the events only seven. Testifying in front of the judge he had told of abuse, harassment by ... who had beaten him and hit him with a stick, had bathed him in cold water holding his head underwater and sometimes had made him lick dirt off the floor and other boy’s urine...”;
• the Santa Rita Institute in Grottaferrata headed by Maria Diletta Pagliuca, sentenced by the Corte d’Assise in Roma on 21 December 1971 also for “continual ill-treatment, and even worse, by the fact of having caused serious damage to 4 under-aged children and the death of 13 children in her care; with the further aggravation of having acted with purpose of profit”.

Violence, physical and psychical abuse, poor food, and a lack of basic hygienic conditions lead to the closure of both institutes and to a sentence for many of the accused.

It took a very long time to reach these sentences due to a very complex network of interests and cor-
ruption, which delayed and conditioned them. This network was called “assistance’s golden pasture” to underline how, economic and nepotistic aspects ruled and influenced assistance policies at the time. With regard to this we must remember how long it took to suspend and stop those savageries: it took 32 years to close the Celestini’s Institute and 18 for the Santa Rita in Grottaferrata, from the first reports of serious educational and structural deficiencies, and the violence which these children suffered, to the closure of these places, rightly defined “lager”. Another remarkable thing about these episodes is that the great majority of charges and accusations were made by private citizens, not by public, private or ecclesiastic authorities, which were directly responsible for the control and management of these institutes. The corrupt system had more than just an economical interest; we won’t go into how the official scientific bodies (medical, psychological or pedagogical) allowed institutionalization with continuous scientific alibis, passing off institutes as the main method for rehabilitation in cases of disability and mental illness in children. In regard to this corruption we give only one example: in spite of the fact that many years have gone by, and we still can hardly believe how a violent and sadistic woman such as “doctor” Diletta Pagliuca, could have been so well thought, in fact she was invited to lecture at the Montessori’s followers congress in 1957 [6].

Along with this institutional system was also a consolidated school policy of marginalization and exclusion, through the diffusion of “different” classes and special schools. Basically all socially deprived children together with those with low and medium intellect or language deficiencies were placed in these special schools and classes.

**“SPECIAL” SCHOOLS IN ITALY**

**School year 1966/67**

In 1966/67 [7] in the Italian schools there were 40 573 pupils in “differentiated” classes and 60 490 pupils in “special” schools.

A total of more than 100 000 children were placed in special schools; but if these numbers reflect just how common special schools and classes were, we must also point out how hard the selection system must have been, as we can see by the high number of students repeating the year in 1966/67: more than 500 000. This situation was revealed after studying official reports, mainly the Istat’s yearbooks, but these sources, due to their fragmented survey system and partiality of considered situations and data, it is very difficult to evaluate the actual effect which these marginalization processes had on the territory.

We can get a clearer picture from studies of smaller environments, where the documentation, not a priority at the time, gives us the chance to better understand the quality and quantity of the institutional children marginalization. One example is the survey that studied school and welfare institutions in the province of Modena [8; see Table 1].

It seems relevant, that the percentage of children in differentiated and special classes, reaches 4.1% of the total, especially if we compare it with today’s percentage of disabled children, that is now steadily set around 2% of the entire school population. It’s important to remember that in the province of Modena there were still more than 500 disabled children in institutes in 1972.

**THE GROWTH OF SERVICES AND INTERVENTIONS**

The reality of services today, shows an actual reinforcement in primary strategic planning in the interventions for the handicapped and disabled, but it is also an expression of how processes have strengthened, and changed, and how organisation and scientific development have grown in the last ten years. Some data may be considered representative of the latest development in interventions, which has become today’s “child and adolescent neuropsychiatry” or “mental health and rehabilitation during formative years”.

The first census carried out in Emilia Romagna regarding service quality, the rehabilitation of the handicapped and child neuropsychiatry, allow us not only to review the operative situation during the early 80’s but also confirm the rapid change in methods of intervention in a relatively short time since the 80’s [9; see Table 2].

From these results we have a clear picture of how the services were in the 70/80’s, where sensory impairments were strongly represented, along with physical and neurological pathologies, and the use of the service is mainly in the child and pre-adolescent age group: in fact in the 70’s the services cov-

<table>
<thead>
<tr>
<th>Table 1</th>
<th>The special and institutional context in the Province of Modena (years 1970-1972)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1972</td>
<td>Year 1970</td>
</tr>
<tr>
<td>Under-aged children with disabilities in segregating institutions</td>
<td>502</td>
</tr>
<tr>
<td>Pupils in “differentiated” classes</td>
<td>173</td>
</tr>
<tr>
<td>Pupils in “special” classes</td>
<td>520</td>
</tr>
<tr>
<td>Total</td>
<td>1195</td>
</tr>
</tbody>
</table>

*Pupils in “differentiated” and “special” classes on the total of children attending school (1972)*
Table 2 | The users of child and adolescent neuropsychiatry services in the Emilia Romagna Region. Distribution of specific pathologies. Confrontation of years 1980-1994

<table>
<thead>
<tr>
<th>CENSUS 1980</th>
<th>Regional register 1994</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, neurological pathologies</td>
<td>38.2%</td>
</tr>
<tr>
<td>Cognitive pathologies</td>
<td>26.4%</td>
</tr>
<tr>
<td>Sensory pathologies</td>
<td>16.6%</td>
</tr>
<tr>
<td>Total</td>
<td>81.2%</td>
</tr>
<tr>
<td>Relational and emotional problems</td>
<td>39.1%</td>
</tr>
</tbody>
</table>

During two decades of use, these services have undergone substantial changes: the number of cases of physical and sensorial pathologies has dropped significantly; this is due to various factors which require only a brief referral in this article: the profound changes in social environment and population, the diffusion of various campaigns for widespread prevention of illnesses such as German measles, the improved care of mothers during pregnancy and of newborn babies, and vast reforms in the health service network. The fall in the number of cases of psychical and sensory disabilities through the last decade is difficult to assess due to the much more complex assessment methods and treatments used today. In fact today’s services are faced with the need to acquire not only more sophisticated skills, but also different models of intervention in a network in continual evolution. Through the examination of recent data we find a greater stability in the activities related to language and learning difficulties, mental retardation and communication/social related problems, and the area defined as “mentally handicapped” in the past, is today more correctly referred to as part of the autistic range of symptoms.

Another important phenomenon which characterized the 80’s, through to the 90’s, was the involvement of health services in the child and adolescent psychological pathologies; this involved a larger number of interventions dealing with psychological and psychiatric problems and a growing number of adolescents making use of the services.

In brief the service’s register of Emilia Romagna’s users of child and adolescent neuropsychiatry shows that in 1998 1 in 2 users are in a condition of psychological distress, and in relation to year groups 1 in 4 is an adolescent.

THE EVOLUTION OF OPERATIVE STRATEGIES AND THE CONSOLIDATION OF SERVICES, REGIONAL DATA FOR PIEMONTE AND EMILIA ROMAGNA

Ulterior elements to consider when valuating the services and the consolidation of their activities, can be seen by confronting the latest data emerging from the data processing systems, in use in regions such as Piemonte and Emilia Romagna [10]. The data from these two systems make a perfect confrontation possible. The high percentage of patients in care in regards to the target 0/17 population (5.2% in Piemonte and 5.9% in Emilia Romagna), show how deeply rooted these services have become for the children and adolescents in these areas.

The same results have emerged from all other areas where the services are structured and solid. The consistency, in the numbers of users, is an indication of the number of children under care, whose level of handicap is estimated as stated in the Law 104.

The percentage of disabled children is approximately 2% of all school age children (2.1% in Piemonte and 2.3% in Emilia Romagna), a valid example of the national average. But the disabled children as stated in the Law 104, now represents only 30% of service users regionally, confirming the tendency of using the services for situations motivated mainly by the presence of psychological problems. Studies reveal that the pre-adolescent and adolescent age group represent 40% of total patients.

STRATEGIES FOR THE PROMOTION OF MENTAL HEALTH IN CHILDHOOD AND ADOLESCENCE

Healthy means not only the absence of illness, but the sense of well being, the protection of this is not the exclusive concern only of the health service, nor can mental health be seen as the exclusive role for mental health specialists.

Mental health also becomes a general political objective, no longer the sole responsibility of the health service but a joint effort and network for interventions; actions taken require consideration for the promotion of mental health not only within this sector but throughout the public health service, and all political bodies who are responsible for mental health through every phase of life of individuals [11, 12].

Mental health in children and adolescents, cannot be considered apart from the contest of the child’s life (family, school, social environment) and so from interacting with the family, specialised health network, services in schools and education, social services and independent social bodies.

And so, if the contrasts, disparities and need of integration between social health and education, through preventive measures, become the central base for programming the activities for health in all areas, the mental health and “culture of childhood” aims for actions in contrast to poverty and conditions of psychological and emotional deprivation and confronting the problem of families at risk, early school abandon, child labour and immigration. A mental health program for children and adolescents requires a prevention and care analysis as early as possible in relation to psychological problems in children. For a long time this objective has been evident in the various national and international agencies for child
health, but the operative strategies needed to reach this objective require a difficult and complex integration of the networks for child health services. Some data are already available to allow us to understand the dimensions and composition of the help needed, for example it could be useful to analyze data from the Rimini area, that keep together information from child and adolescent neuropsychiatry services and social services for minors [10].

By adding together data regarding the amount of patients using these two services we have a total percentage (12.1% of resident under-aged children) of patients in formative years that is very similar to the ones that national and international agencies have been showing in the last years.

User’s diagnosis underlines the diffusion and distribution of child and adolescent suffering (different expressions of distress, social and economical deprivation, situations that put development at risk) but also show how these needs have grown in the last few years.

Data give us the chance to notice some relevant aspects of this matter such as the growing number of young children living in difficult social and economical conditions. This has been acknowledged as one of the most common risk factors and with the worst consequences on children’s development. Between 2001 and 2005 the percentage of children admitted for economical difficulties has grown from 22% to 40% of the total of social service users.

Another relevant data is the growing number of immigrant children, coming from various countries, and of under-aged sent by the court to under-aged protection services (Table 3). On the total population of children from 0 to 17 we have a relevant percentage that are undergoing legal processes. Unfortunately we haven’t got many opportunities of confronting this data; it seems that this 1.2% of under-aged taken in charge because of legal processes can be considered representative of a much wider phenomenon if we think that the percentage of children with disability is 2% of the total population of under-aged (see Table 3).

There’s no doubt that neither single professionals nor specialized services can cope alone with such a huge number of children and adolescents suffering alone, what is required is a comprehensive political intervention, where national and regional governments, families and all health and educational services work together in defining goals, working out new strategies, monitoring results and organizing a rational use of suitable resources.

The intervention sphere is vast, so we must choose priority interventions, in relation to prevention, early diagnosis, and care, giving special attention to specified age groups. It seems reasonable to remind the goals shared by important internationally agency as the Department of Health and Human Services [13].

This National Agenda for Children’s Mental Health follows objectives written in the United States by the unified conference between the Department of Health and Human Services, the Department of Education and the Department of Justice; they call for objectives which take into consideration the amount of children suffering every day, due to the lack of a coordinated and integrated answer, to their emotional, behavioural and cognitive, needs from the system of services and working networks which were created for the exact purpose of taking care of them. These remarks lead to the following suggestions of priorities:

1. promote the acknowledgment of mental health as an essential part of children’s health;
2. integration mental health services for families, children and adolescents into the existing system for children and teenagers;
3. involve families and their views on children and teenagers, when scheduling the entire mental health care system;
4. develop and increase a private-public system able to support these efforts in an extensive way.

### THE CONDITION OF CHILD AND ADOLESCENT NEUROPSYCHIATRY

The child and adolescent neuropsychiatry services have suffered for a long time now, in various regions, from organizational incongruities, and strong limitations in relation to financial and human resources.

For this reason the Italian Child and Adolescent Neuropsychiatry Society ran a survey in 2007 in order to ascertain the real existence and consistency of services in the 20 Italian Regions.

The results of this survey show that:
1. in 12 regions child and adolescent neuropsychiatry services have been formally created;
2. in 8 regions they have a clear and unequivocal denomination;
3. 7 have a specific plan for these services inside the region;
4. only 3 have fixed organization in operational units;
5. 9 have not been allocated a specific budget.

In relation to a departmental location of the child and adolescent neuropsychiatry services in the 20 regions, we have the following situation:
- 4 merge directly with the Mental Health Department;
- 4 merge directly with the Mother/Infant Department;
- the other 12 merges in various ways.

<table>
<thead>
<tr>
<th>Table 3</th>
<th>Under-aged protection service users. Data from Rimini’s National Health Local Unit, years 2001-2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>2005</td>
</tr>
<tr>
<td>Under-aged immigrate children</td>
<td>23.4%</td>
</tr>
<tr>
<td>Nationalities</td>
<td>40</td>
</tr>
<tr>
<td>Under-aged children sent by judiciary measures</td>
<td>305</td>
</tr>
<tr>
<td>% of under-aged under care of the service</td>
<td>18.3%</td>
</tr>
<tr>
<td>% of total population of under-aged children</td>
<td>1.1%</td>
</tr>
</tbody>
</table>
Regarding specific skills for integration at school – as stated in the Law 104:
- in 15 regions out of 20, the support for integration in school is provided by the child and adolescent neuropsychiatry services, alone, or in collaboration with commissioned rehabilitation services;
- in 10 regions there is still no sign of the enforcement of this Law of February 2006;
- in 7 regions they depend directly on the Disabled Commission.

Regarding the presence of different services in the 20 regions:
- child and adolescent neuropsychiatry medical specialists are in every service;
- there is a variable presence of psychologists;
- therapists are represented in a very fragmented and diversified way (we rarely find all therapists in the same service or in an homogeneous way in the region);
- we rarely find professional educators;
- there are many social workers in Southern regions but none in the Northern ones.

We have data from 10 regions concerning the total number of workers: it differs from 1 every 680 children to 1 every 10 000 children in the 0-17 age range.

As for rehabilitation it’s external to the service:
- less than 20% in 4 regions every 20;
- 20-40% in 7 regions every 20;
- 40-60% in 4 regions every 20;
- 60-80% in 4 regions every 20;
- more than 80% in 1 region every 20.

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The role of UNASAM - National Union of Associations for Mental Health in Italy

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Summary. This paper, after an introduction on the origin, development and principal aims of the National Union of Associations for Mental Health (UNASAM), briefly describes what happened in the last 30 years in the field of mental health in Italy. This period covers roughly the lifespan of the Italian Law 180, from the beginnings, the closure of psychiatric hospitals, to the difficulties of present days. The second part of the paper is a summary of a study commissioned to UNASAM by Istituto Superiore di Sanità and conducted in collaboration with the Istituto di Ricerche Farmacologiche “Mario Negri” of Milan. This research was aimed at evaluating the quality of mental health services in four Italian Regions. Members of patients’ families participated with enthusiasm, filling up a questionnaire and engaging in fieldwork, which required more than 3000 working hours and produced significant and useful results.

Key words: mental health, mental health associations, mental health services.

INTRODUCTION

Since its foundation in 1993, the Italian National Union of Associations for Mental Health (UNASAM) is the major association of families operating in the field of mental health, being present in all the 20 Italian Regions. UNASAM is present in the board of two well-known international associations, namely the European Association of Families of Mentally Ill People (EUFAMI) and the World Association for Psychosocial Rehabilitation (WAPR).

The primary aim of UNASAM is to connect families and to represent them at three different levels: local, Regional and National Government. The main task is lobbying at these levels on several important issues, ranging from daily practices to development of laws, by-laws, and regulations. A secondary – but still significant – aim is to fight stigma and prejudice by educating people to a better knowledge and acceptance of mental health problems. A third aim is to educate families by initiatives periodically organized by our association at different levels and in collaboration with reliable partners, such as the Trieste mental health services.

To describe what happened in Italy from 1978 till now, from the point of view of the “end users”, is not an easy job. We could identify two periods, the first one, from 1978 to 1983, and the second one from 1984 till now.

During the initial years of transition, the obstacles to the radical changes introduced by the new law, the numerous mistakes due to the scarcity of appropriate know-how and the chronic lack of money, drove the new psychiatric services to a condition close to collapse. In the same period, a few family associations began to appear in the country, mostly with a specific (negative) purpose: to repeal, or, at least, to amend the “horrible Law 180”. In the front of such an outcry, the voice of the Trieste model was too weak and difficult to be heard.

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Nevertheless, the network of community mental health services began to grow and the civil rights of users became clearer and clearer to an increasing number of professional and lay people. New associations were started to support Basaglia’s ideas and goals and to defend Law 180 from harsh criticism and often vicious attacks. Cooperatives were started, providing job opportunities to users, while in the whole country the new law led to an increasing attention to mental health issues. The Italian Regions enacted local laws for mental health within the national framework of Law 180 as incorporated in Law 833, promulgated a few months later, which founded the Italian National Health Service (Servizio Sanitario Nazionale, SSN) and therefore cancelled the previous affiliation of psychiatric hospitals to the administrations of the Provinces. The closure of psychiatric hospitals began to be mandatory and this process, in spite of considerable difficulties, was slowly completed. In the meantime, all local associations had became favourable to the new approach, giving birth to our new federation of associations, UNASAM.

The main problem to be faced during the second period (1984 till nowadays) has been the full implementation across the entire country of a complete network of community mental health services for sufferers and for their families. A parallel problem has been the need to counter the numerous attempts to repeal Law 180, in order to re-establish psychiatric hospitals and to increase the constraints on patients’ right.

THE RESEARCH: “EVALUATION AND IMPROVEMENT IN MENTAL HEALTH CARE WITH ACTIVE PARTICIPATION OF VOLUNTARY ASSOCIATIONS”

In the years 2007-2008, the Istituto Superiore di Sanità commissioned to UNASAM a research project concerning the “Evaluation and improvement in mental health care with active participation of voluntary associations”. This study was conducted in collaboration with the Istituto di Ricerche Farmacologiche “Mario Negri” of Milan. The main goals were:

- to set up and implement a model for participation of psychiatric patients’ relatives to the evaluation of mental health services quality, with the aim of improving the know-how on evaluation methods and processes;
- to train patients’ relatives in evaluation methods and procedures;
- to obtain from relatives meaningful indicators of service quality, in order to negotiate improvements in services based on evaluation findings.

METHODS

The research was a cross-sectional study of relatives’ evaluation of service quality by means of an ad hoc questionnaire. To this purpose, various phases were planned:

1. following a review of the scientific literature, a first draft of a questionnaire aimed at assessing the quality of Italian mental health services was developed;
2. this draft was evaluated and refined by two “focus” groups, whose members were affiliated to UNASAM;
3. the final version of the questionnaire was set up. It was a self-administered anonymous questionnaire, with yes/no answers consisting of 55 items grouped in 13 areas:
   - (i) quality of the physical environment
   - (ii) staff attitudes and behaviour
   - (iii) staff professional skills
   - (iv) accessibility
   - (v) response to emergencies
   - (vi) care program
   - (vii) effectiveness
   - (viii) information
   - (ix) home visits
   - (x) interagency collaboration
   - (xi) respect of privacy
   - (xii) individual rights, advocacy and legal protection
   - (xiii) modes of intervention (availability, perceived usefulness, and responses to requests);
4. two workshops were held with the family members in charge of questionnaire distribution in the services, in order to instruct the participants about basic principles of data collection, evaluation methods and data analysis; to provide indications about contacts with staff members and relatives; to give instructions for questionnaire distribution and filling;
5. identification of a sample of mental health services in four Italian Regions, followed by contact with the services and requests for permission to conduct research;
6. questionnaire distribution in the busiest days and hours to the relatives attending the services for any reason in a three month period between October 2007 and January 2009.

RESULTS

A total of 2259 questionnaires from 46 centres in four Regions were collected and analysed (see Table 1). The features of the respondents are shown in Figure 1.

Most respondents perceived service environment as good, with figures varying between 83% and 90%; however, a high proportion (47%) found it difficult to get in touch with the service by phone. The highest level of satisfaction for the environmental quality was recorded in Lombardy (93%) and the lowest in Latium (78%). Staff attitudes, behaviour and professional skills were satisfying for 76%-94% of the respondents, with differences among Regions (e.g., 90% in Lombardy and 77% in Latium). Less than half of the respondents (43%) reported that they ever needed emergency interventions, and among those who needed them, 78% were satisfied with the help received. Most of the respondents (83%) said that they were
informed on the project of care of their relative; 61% felt involved in its planning and 55% in the outcome assessment (Emilia Romagna 62%, Latium 42%).

As concerns the effectiveness of interventions, 80% said that they received adequate support from the service; 34% found meaningful mental health improvements in their relative; 38% found their relationship with their relative improved. Only 28% of the respondents thought that home visits were necessary, and 72% of those who needed such visits received them. There were significant differences between Regions, with 24% of respondents in Latium reporting a meaningful improvement of their relative’s mental health versus 41% in Emilia Romagna.

Information on the health conditions of the relative were satisfying for 73% of the respondents, whereas information about family associations was satisfying for only 33%, and that about other sources of supports and care agencies for 25%. Only 37% answered that they were informed about the possibility of receiving financial help and/or legal aid. The collaboration between professionals within services was satisfying for 73% of the respondents, whereas the contacts between service professionals and general practitioners were adequate for only about one half (53%) of the family members.

The interventions received more frequently by the sick relatives were: psychiatric examination, 79%; individual psychotherapy, 35%; admission to psychiatric ward, 26%; financial help, 29%. More than one half of the respondents (61%) had one or more encounters with the psychiatrist, and 23% also received some psychotherapeutic intervention.

CONCLUSIONS

Family members participated with enthusiasm in both the research planning and its conduction, spending about 3000 hours of their time. The questionnaire used resulted to be an effective tool, which was easy to understand and to administer, even without the help of trained assistants; therefore, it would be useful to extend this research to all mental health services in all Italian Regions. The last section of the questionnaire, however, regarding the evaluation of interventions, should be improved, since family members had some problems in fully understanding how to use it.

As concern the results, we must take into account the common bias towards satisfaction and compliance usually found in satisfaction surveys. Dissatisfaction was at high levels concerning specific aspects of psychiatric care; therefore the following changes in the operation of mental health services appear to be necessary:

- clearer and fuller information should be provided about therapy programs;
- patients’ families should be more extensively in-

<table>
<thead>
<tr>
<th>Region</th>
<th>No. centres</th>
<th>Distributed</th>
<th>Returned</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lombardy</td>
<td>20</td>
<td>1720</td>
<td>1328</td>
<td>1328</td>
</tr>
<tr>
<td>Sardinia</td>
<td>9</td>
<td>437</td>
<td>384</td>
<td>384</td>
</tr>
<tr>
<td>Emilia Romagna</td>
<td>13</td>
<td>429</td>
<td>368</td>
<td>368</td>
</tr>
<tr>
<td>Latium</td>
<td>4</td>
<td>381</td>
<td>288</td>
<td>287</td>
</tr>
<tr>
<td>Total</td>
<td>46</td>
<td>2967</td>
<td>2368</td>
<td>2259</td>
</tr>
</tbody>
</table>
involved in programs aimed at monitoring and evaluating service quality;
- the relations between mental health personnel and general practitioners require considerable improvement;
- the readiness to perform home visits should be substantially increased;
- waiting lists must be shortened.

In conclusion, the relatives’ evaluation pointed out significant differences in quality rating depending on which aspect of mental health care was considered. Overall, however, the results of the present assessment of service quality were more favourable than originally expected. A further step should be to find resources in order to extend evaluation programs to users and to implement similar projects in all Italian Regions.

**Acknowledgement**

Professor Pierluigi (Piero) Morosini has been for many years our supporter and our link with the Istituto Superiore di Sanità for fruitful meetings, congresses and frequent exchanges of ideas in both institutional and occasional encounters. To his memory we wish to dedicate the present paper, since the research illustrated was conceived, projected and implemented thanks to his competence and generous help.

Submitted on invitation.

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Long-term monitoring and evaluation of a new system of community-based psychiatric care. Integrating research, teaching and practice at the University of Verona

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Summary. The South-Verona community psychiatric service (CPS) was implemented in 1978, according to Law 180, by the Department of Psychiatry of the University of Verona. Since then this CPS provides prompt, comprehensive and coherent answers to patients’ needs, psychological and social, as well as practical, while trying to decrease and control symptoms. Special emphasis is given to integrating different interventions, such as medication, rehabilitation, family support, and social work. The South-Verona experience was from the beginning associated with a long-term research project of monitoring and evaluating the new system of care. The research team has grown and expanded over the years and presently includes the following research units: a) environmental, clinical and genetic determinants of the outcome of mental disorders; b) psychiatric register, economics and geography of mental health; c) clinical psychopharmacology and drug epidemiology; d) brain imaging and neuropsychology; e) clinical psychology and communication in medicine; and f) physical comorbidity and health promotion in psychiatric patients. This paper summarises the main results of the coordinated, long-term evaluative studies conducted so far.

Key words: community mental health services, health service research, outcome assessment.

Riassunto (Monitoraggio e valutazione a lungo termine di un nuovo sistema di assistenza psichiatrica community-based. Integrare ricerca, didattica e pratica all’Università di Verona). Il Servizio psichiatrico territoriale di Verona-Sud è stato sviluppato nel 1978 dal Dipartimento di Psichiatria dell’Università di Verona secondo le indicazioni della Legge 180. La finalità del servizio è di fornire una risposta rapida, adeguata e coerente ai bisogni dei pazienti, sia sul versante psicologico che sociale e pratico, cercando allo stesso tempo di ridurre e controllare i sintomi. Particolare enfasi viene data all’integrazione di diversi interventi: farmacologici, riabilitativi, di supporto alla famiglia e di assistenza sociale. L’esperienza di Verona-Sud è stata fin dall’inizio associata con un progetto di ricerca a lungo termine per monitorare e valutare il nuovo sistema di cura. Il team di ricerca è cresciuto e si è allargato negli anni e attualmente include le seguenti unità di ricerca: a) determinanti ambientali, clinici e genetici dell’esito dei disturbi mentali; b) registro psichiatrico dei casi, economia e geografia della salute mentale; c) psicofarmacologia clinica e farmaco epidemiologia; d) brain imaging e neuropsicologia; e) psicologia clinica e comunicazione in medicina; e f) comorbidità fisica e promozione della salute nei pazienti psichiatrici. Questo articolo riassume i risultati principali dei vari studi valutativi condotti finora.

Parole chiave: servizi psichiatrici territoriali, ricerca sui servizi sanitari, valutazione dell’esito.

THE IMPLEMENTATION OF THE PSYCHIATRIC REFORM IN SOUTH-VERONA IN 1978 AND THE NEW SOUTH-VERONA COMMUNITY PSYCHIATRIC SERVICE

The South-Verona community psychiatric service (CPS) was implemented in 1978, according to Law 180, by the Department of Psychiatry (DoP) of the University of Verona. The latter dated back to 1970 and operated as one of the typical Italian University Departments of Psychiatry that were regarded as elite facilities with mainly teaching and scientific purposes. They generally treated the acute, less severe cases while most serious psychotics, long-term patients and patients compulsory admitted where hospitalised in the state mental hospital.

Inpatient and outpatient care was the primary treat-
ment offered. However, over the years, the Verona team decided to decrease inpatient care and improve outpatient care. At the end of 1977 the mean number of occupied beds was as low as 15 out of 36 available. This implied avoiding admissions from out of Verona Province. There was also in the team a strong interest and a commitment to the ideas of deinstitutionalization as they were spreading in Italy and close contacts were maintained with colleagues active in deinstitutionalization. Site visits involving both professionals and nurses were made to those places where deinstitutionalization was progressing [1].

In 1976 the staff began making family visits in teams of two or three people to provide on-the-spot crisis intervention in an attempt to avoid hospitalisation. Also, crisis intervention at the emergency room was intensified. The psychiatrist on duty was helped by a nurse of the team, who would participate in the assessment and would then ensure continuity of care. The door of the ward was kept always open; if very disturbed patients were admitted, efforts were made to minimize limitations to personal freedom by offering extra personal care.

Therefore, in 1978, when the reform law was passed, it found the workers of the DoP of the University of Verona ready to agree with the spirit of Law 180 from the outset. They offered to assume responsibility for the implementation of the law in one of the four districts of greater Verona, served by the Verona health authority (400 000 total population). The initial size of the catchment area was one of 75 000 population. Further additions over the years have then expanded to encompass a population of about 103 000 inhabitants. Such decision implied tackling the difficulties of community psychiatry and giving up some of the privileges of an academic institution (such as choosing patients), while keeping up with university duties (teaching and research).

The two dimensions of this map are place and time. Place refers to three geographical levels: 1) country/regional; 2) local; and 3) individual. The second dimension (time) refers to three phases: a) inputs, b) processes; and c) outcomes. Using these two dimensions we can make a 3x3 matrix to bring into focus critical issues for mental health care.

Thornicroft and Tansella [2, 3] have chosen to include the geographical dimension in the matrix because they believe that mental health services should be primarily organised locally, to be delivered to individuals in need. However, some of the key factors are decided regionally or nationally, for example overall financial allocations to the mental health sector. In this sense, therefore, the local level acts as a lens to focus policies and resources most effectively for the benefit of individual service users. It was selected time as the other organising dimension, as a clear sequence of events has been seen, flowing from inputs to processes to outcomes. In this model outcomes should be the most important element, and the mental health system as a whole should therefore be judged on the outcomes it produces.

This matrix model can assist, in a sense, the accurate diagnosis of dysfunctional mental health services so that corrective action can be applied at the right level(s) to improve care. At the same time, this model is not intended to be rigidly prescriptive. It can be taken as a tool to use in analysing problems, and then in deciding what action to take.

We will use the matrix model to describe the South-Verona community-based system of psychiatric care.

**INPUT. THE RESOURCES OF THE SOUTH-VERONA CPS AND THEIR DEVELOPMENT OVER THE YEARS**

**Psychiatric Care**

In Verona all community staff members are divided into three multidisciplinary teams, each serving a subsector of the South-Verona catchment area. The three teams are organised according to a “single staff module” to ensure continuity of care, both longitudinal continuity (through the different phases of treatment) and cross-sectional continuity (through the different components of the CPS). Within each team each patient is assigned to one particular member of the staff (case manager).

The style of intervention is psychosocial: the service aims to provide prompt, adequate and coherent answers to patients’ needs, psychological and social as well as practical, while trying to decrease and control symptoms. Special emphasis is given to integrating different interventions, such as medication, rehabilitation, family support, and social work. Case management, patient advocacy, and welfare provision are key aspects of these interventions. Special attention is paid to the most disabled and difficult to manage, as well as to chronic patients, with special support offered to the family when available [4].

The South-Verona CPS has different facilities and components.

- The Community Mental Health Centre is the hub of the CPS: the centre, located in a recently completely renovated historical three storey building with garden, not far away from the Academic general hospital, is open on weekday from 8 a.m. to 8 p.m. and on Saturday from 8 a.m. to 5 p.m.
Therapeutic programs include crisis intervention, day care for acute and chronic patients, rehabilitation and socialisation groups.
- The Psychiatric General Hospital Unit is a psychiatric ward of 15 beds located in the Academic general hospital.
- The Outpatient Department provides psychiatric consultations and individual and family therapy. Offices are located both in the general hospital and in the mental health centre.
- The Emergency Service is a consultation-liaison psychiatric service for the Emergency and Accident room of the general hospital, open 24 hours a day, seven days a week. It is run by a psychiatrist from our team, who is on call. There is also an emergency night and week-end service, run by two psychiatric nurses from our team, who are on call and may provide care in our residential facilities (flats and hostel), as well as at our patients’ homes, co-ordinated by the psychiatrist on call.
- Home Visits can be made to provide crisis intervention in response to emergency calls, but for chronic patients these are usually planned in advance and offer regular, long-term support and care to patients and their families with the goal of minimising relapses and hospital admissions.

Since the front door of the mental hospital was partially closed from 1978 and completely closed from 1982, an important aspect of our community-based service has been the provision of residential care for long-term patients. Residential facilities for 20-25 patients are also part of the South-Verona CPS. One of them is a 24-hour-staffed supervised hostel (12 places) while two more are partially supervised (12 places). Group homes have increased in number over the years especially for the work of a mutual-help group supported by the Service, which extensively uses the practice of mutual hospitality.

The South-Verona CPS clinical facilities include also: the Service of Psychosomatics and Clinical Psychology and the Service of Psychotherapy. The first one provides specialised outpatient care for patients with panic attacks and obsessive-compulsive disorders, as well as consultations for patients and doctors of other departments of the University General Hospital (800 beds). It maintains psychiatric integration with other hospital-based medical activities and ensures continuing contact with our patients when hospitalised for medical reasons. The Service of Psychotherapy provides individual and family psychotherapy and houses a Regional Centre for the Treatment of Eating Disorders.

The South-Verona CPS has the following distinctive features: 1) it is not experimental but is a long-term experience, implemented 30 years ago; 2) it was designed and is still functioning as alternative, not complementary to the old hospital-based system of care; 3) it is organised according to a “single-staff module”, to ensure continuity of care and to encourage full responsibility and commitment by the service; 4) it is well integrated, and allows easy and informal access to patients; 5) it is a public service run by the National health service.

Research
While implementing the new community-based system of care a structured programme of evaluative research in mental health, primarily dedicated to the monitoring and evaluation of the South Verona CPS was started [5]. The research units are located in a recently refurbished building, within the University General Hospital. The main research activities focus on epidemiological and social psychiatry (including 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 staff (more than 50 persons) includes now psychiatrists, clinical psychologists, computer scientists, physicists, geographers and social scientists, statisticians, technicians and secretaries.

Since that time many integrated and evaluative research projects have been completed and disseminated, with more than 550 papers published in peer-reviewed journals. Thus, the South Verona CPS is one of the most intensively evaluated mental health services in the world.

The DoP of Verona and the South-Verona CPS were designated by WHO as Collaborating Centre for Research and Training in Mental Health in 1987. Since then, the designation of our centre was confirmed every four years.

The research team has grown and expanded over the years and presently includes the following research units:
- Environmental Clinical and Genetic Determinants of the Outcome of Mental Disorders (Head: Prof. Mirella Ruggeri).

This research area includes two main topics: 1) measuring satisfaction with mental health services; and 2) assessing outcomes in routine clinical practice and performing follow-up studies of patients treated in mental health services. Patient satisfaction can be viewed both as a measure of outcome per se and/or as a factor in the process of care, influencing other outcomes. Outcome is measured according to a multi-dimensional assessment, i.e. an assessment which simultaneously takes into account: different perspectives (for example, from clinicians, patients, relatives, etc.); different outcome indicators; and various process variables.
- Psychiatric Register, Economics and Geography of Mental Health (Head: Prof. Francesco Amaddeo).

A psychiatric case register (PCR), managed by the DoP, which covers the same geographical area as the South-Verona community psychiatric service, was started on 31 December 1978 and...
has been in operation since that time. The South-Verona PCR is used for clinical, administrative and research purposes (longitudinal analyses of patterns of care [6], studies on incidence, prevalence and services utilisation; comparisons with other case-register areas; and costs of care and outcome [7]). The PCR is also used as a sampling frame for studies on specific groups of patients. For these studies the PCR is usually used in combination with other approaches, for example: follow-up and cohort studies and linkage with other databases. [8].

Another main research area is to study the effect of urbanicity, socio economic status and distance from services on the incidence and prevalence of treated patients, and on Mental Health Services utilisation (also using the health geography approach).

- Clinical Psychopharmacology and Drug Epidemiology (Head: Dr. Corrado Barbui).

This research area has two main objectives: 1) to describe the patterns of use of psychotropic drugs in routine practice; and 2) to assess the efficacy and tolerability profile of psychotropic drugs in experimental conditions [9].

Psychiatry is an interesting area for drug epidemiology studies, because the use of psychotropic drugs is linked to many epidemiological variables, such as: patient-related (diagnosis, length of illness), family-related (level of expressed emotions), setting-related (outpatient psychiatric services, psychiatric hospital), social-related (economic situation, work opportunities) and macro-variables such as local regulations and/or national laws. Systematic reviews of randomised clinical trials (RCTs) are the research approach adopted to assess the efficacy and tolerability profile of psychotropic drugs in experimental conditions. Systematic reviews, using meta-analytical techniques, combine the results of RCTs, and provide an overall summary measurement of treatment effect [10].

- Brain Imaging and Neuropsychology (Head: Dr. Paolo Brambilla).

This laboratory was established in the spring of 2003. A variety of neuroimaging techniques are being used to investigate the neurobiological bases of affective and psychotic disorders, particularly MRI investigations of bipolar disorder and schizophrenia. Specifically, the main aim of this Research Unit is to increase the knowledge of possible neural circuitry shared by these two conditions sustaining common psychopathological symptoms. We are also very interested in a greater understanding of the neural abnormalities underlying the brain anatomy of subtypes of psychotic spectrum (i.e., early onset schizophrenia, late onset schizophrenia).

- Clinical Psychology and Communication in Medicine (Head: Prof. Christa Zimmermann).

The application of the bio-psychosocial model in medical practice requires health providers to learn to integrate physician-centred and patient-centred communication skills when interacting with their patients. Patient-centred communication skills involve the collection of reliable information on patients’ health and life problems within reasonable time limits, the ability to establish and to maintain a collaborative relationship, and are associated with better health outcomes. These skills are taught in learner centred courses offering supervised exercises and video feedback [11, 12].

The main areas of interest which have been developed by this Research Unit during the last decade comprises the following: 1) the development and standardization of classification systems to measure doctor-patient interaction in primary care and in psychiatry; 2) the evaluation of the efficacy of training courses in improving communication skills of general practitioners and psychiatrists; 3) the application of sequence analyses to study doctor-patient interactions and 4) the study of the information-giving process in primary care consultations and in psychiatric outpatient intake interviews.

- Physical Comorbidity and Health Promotion in Psychiatric Patients (Head: Prof. Lorenzo Burti)

The project aims at studying the prevalence of physical comorbidity in mental patients with functional psychoses, in implementing preventive strategies related to dietary habits and physical exercise and studying their efficacy with a randomised controlled study. The Unit is also involved as partner in two related, EU funded, multicentre projects: ITHACA (Institutional Treatment, Human Rights and Care Assessment) and HELPS (European Network for Promoting the Health of Residents in Psychiatric and Social Care Institutions). The two projects aim at identifying evaluation instruments and disseminating best practice to improve the protection of human rights and dignity and the general health status of residents in mental or psychiatric hospitals.

Within this Research Unit a multicentre study of the network of Veneto regional centres for the treatment of eating disorders has been recently planned.

**Education and training**

Education and training is provided for undergraduate medical students, for post-graduate residents, for post-graduate Ph.D. students in psychology and psychiatry and for undergraduate students in psychosocial rehabilitation. Two Masters in advanced nursing are presently offered to psychiatric nurses in Verona and in side branch of the University in Bolzano. Short courses in psychiatry, medical and clinical psychology, psychosomatics, and psychogeriatrics are also provided for other schools of specialisation within the Medical School of the University of Verona.
How service utilization changed after the psychiatric reform?

Longitudinal monitoring of service utilization in South-Verona has shown that, between 1979 and 2007, hospital care consistently decreased whereas outpatient and community care, home visits and other community contacts, number of day care contacts and attendance at the day hospital and number of days in sheltered accommodation run by the CPS, all steadily increased (Figure 1).

The decrease in the use of beds was mainly because of the decrease of long-stay patients in the mental hospital and occurred whilst psychiatric beds for short and medium term stays were available. A comparison of in-patient admissions before and after the 1978 psychiatric reform showed that in 2007 (29 years after the reform), compared with 1977 (1 year before), there was a 6% decrease of in-patient admissions, with a 69% decrease in compulsory admissions (which never exceeded 22 admissions per year per 100 000 adult population), with a complete halt of admissions to state mental hospitals (Table 1a).

As a consequence, the mean number of occupied beds per day consistently decreased over time and in 2007, this figure was 72% lower than in 1977. This decrease is entirely due to the decline of the number of patients remaining in the state mental hospital. In 2007, the total number of beds occupied in both public and private hospitals was 29 per 100 000 adult South-Verona residents (Table 1b).

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<td>b)</td>
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<td>38</td>
<td>29</td>
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</tr>
<tr>
<td>In other public hospitals</td>
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<td>43</td>
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<td>26</td>
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</table>
**To what extent are service costs associated with clinical, social and service history variables?**

The growing movement in many European countries towards capitation-based systems for financing mental health care has generated increasing interest in developing appropriate models capitation formulae.

A study was conducted on all patients in contact with the South-Verona CPS during the last quarter of 1996 [13]. Clinical and service-related variables were collected at first index contact; 3 months later, patients were interviewed using the client services recipient interview. For those who completed both the clinical assessments and the services receipt schedule (n. = 339), one-year psychiatric and non-psychiatric direct care costs were calculated. Weighted backward regression analyses were performed. The most significant variables associated with psychiatric costs were: admission to hospital in the previous year; intensity and duration of previous contacts with South-Verona CPS; being unemployed; having a diagnosis of affective disorder; and global assessment of functioning (GAF) score. The final model explained 66% of the variation in costs of psychiatric care and 13% of variation in non-psychiatric medical costs. The model explains a higher degree of cost variance than previously published studies. In community-based services more resources are targeted towards the most disabled patients. Previous psychiatric history (number of admissions in the previous year and intensity of psychiatric contacts lifetime) is strongly associated with psychiatric costs.

Following these results, a further study was carried out to obtain a new, well-balanced mental health funding system, through the creation of: i) a list of psychiatric interventions provided by Italian CPSs, and associated costs; ii) a new prospective funding system for patients with a high use of resources, based on packages of care. Five Italian CPSs collected data from 1250 patients during October 2002. Socio-demographical and clinical characteristics and GAF scores were collected at baseline. All psychiatric contacts during the following six months were registered and categorised into 24 service contact types. Using elasticity equation and contact characteristics, the costs of care were estimated. Cluster analysis techniques allows to identify packages of care and logistic regression defined predictive variables of high use patients. Multinomial logistic model assigned each patient to a package of care. The sample’s socio-demographic characteristics are similar, but variations exist between the different CPSs. Patients were then divided into two groups, and the group with the highest use of resources was divided into three smaller groups, based on number and type of services provided. Our findings show how is possible to develop a cost predictive model to assign patients with a high use of resources to a group that can provide the right level of care. For these patients it might be possible to apply a prospective per-capita funding system based on packages of care [14].

**Do socioeconomic status, accessibility and distance affect the use of community-based psychiatric services?**

A study allowed to assess the effect of socioeconomic status (SES) on psychiatric service use in an Italian area with a well-developed CPS [15, 16]. An index of SES was calculated from nine census variables and grouped into four categories, ranging from SES-I-affluent to SES-IV-deprived, for each of 328 census blocks (CB) of our catchment area. Fifteen indicators of psychiatric service use were collected using the psychiatric case register. All patients resident in the catchment area, who had at least one psychiatric contact in 1996 (n. = 989), were included in the study. Indicators of in-patient, day-patient, out-patient and community service use showed an inverse association with SES. Only first-ever and long-term psychotic patients were equally distributed in the four SES groups. The inverse association between SES and most indicators of psychiatric service use suggests that the planning of community-based services and resource allocation should take into account the SES of residents.

The results highlighted that, in an area with a community-based system of care, socioeconomic characteristics of the place of residence are associated with psychiatric service use by patients. Socioeconomic status and distance from hospital or other community based services shouldn't prevent the access to the care, but for some type of care (day care, for example) there is a relation between services utilisation and nearness between place of residence and services. Accessibility is a many-sided concept, that regards many factors, like the cost of the travel, the availability of public transports, psychological and physical barriers, social and cultural factors and environment characteristics, as well as social capital and social cohesion. Further studies whose main aim is to analyse the effect of urbanity, socio economic status and distance from services on the incidence and prevalence of treated patients, and on Mental Health Services utilisation are presently in progress.

**Are inappropriate terminations of contact (dropping out of care) or single consultations with community-based psychiatric services predictable?**

Few studies have investigated so far factors which predict inappropriate terminations (drop-out) of clinical contact with mental health services. A study aims to identify patient and treatment characteristics associated with dropping out of contact with South-Verona CPS [17].

A three-month cohort of patients attending the CPS was followed up for two years, to identify dropouts. We identified 495 patients who had had at least one psychiatric contact of whom 261 had complete ratings for the GAF and the Verona service satisfaction scale (VSSS). In the year after the index contact, 70 (26.8%) terminated contact with the CPS; of these, 62.9% were rated as having inappropriate
terminations (the “drop-out” group) and 37.1% had appropriate terminations of contact. Drop-outs were younger, less likely to be married and their previous length of contact with services was shorter. No drop-outs had a diagnosis of schizophrenia. Multivariate analysis revealed predictors of dropping out. In a CPS targeted to patients with severe mental illnesses, those who drop out of care are younger patients without psychoses who are generally satisfied with their treatment.

Another study examined variables associated with having a once-only contact with the out-patient department of two community mental health services in Italy and Australia [18]. Two 8-year cohorts of patients, who had a new episode of care with out-patient psychiatric departments in South Verona and in Western Australia, were followed-up for 3 months after the first contact, to identify those patients who had no further contact with services. Potential determinants of once-only contact were analysed. Thirty percent of new episodes of care for persons who met the inclusion criteria of the study were once-only contacts with the service in South Verona. In Western Australia, the figure was 24%. Moreover, the proportion of once-only contact patients has increased over time in South Verona whereas, in Western Australia, it has remained stable. In Western Australia, once-only contact patients were younger whereas in South Verona they tended to be older. At both research sites, patients who had a once-only contact were more likely to be male and to have a less severe mental illness. The results of this study suggest that only clinical characteristics were significant determinants of this pattern of contact with services consistently at both sites: the less severe the patient’s diagnosis, the more likely the patient is to have a once-only contact. This may well indicate good screening at the initial point of contact by both sets of mental health service providers.

OUTCOME. ASSESSING TREATMENT EFFECTIVENESS IN “REAL-WORLD” PSYCHIATRIC SERVICES

In order to assist clinicians in making treatment decisions, data obtained from randomised trials should be integrated with information drawn from studies assessing treatment effectiveness as provided in “real world” health care settings.

Is mortality of psychiatric patients in an area with a community-based system of mental health care different to that of the general population?

A study conducted in South-Verona explored the effect of those causes of death considered avoidable [19]. All patients with an ICD-10 psychiatric diagnosis, living in the catchments’ area of about 100,000 inhabitants, seeking care in 1982-2005 (23 years) were included in this study. Standardised mortality ratios (SMRs) were calculated for each cause included those considered avoidable, using the mortality of the general population in the Veneto Region to estimate the expected number of deaths. For avoidable causes, a list derived from the Rutstein’s list and from an EC version set up in the 1980s was used, and then causes were divided into two groups: indicators of quality of: i) health care; and ii) health policies. The observed number of deaths for avoidable causes was four times greater than the expected (P < 0.01). SMR was higher for deaths preventable with adequate health promotion policies than for those preventable with appropriate health care. Males, alcohol/drug addicted and young patients had the highest avoidable SMRs. From these results it seems important the implementation, by specialist psychiatric services, of health promotion and preventive programs targeted to psychiatric patients. Another study [20] evaluated not only avoidable mortality, but the relation among mortality, causes of death and associated risk factors among psychiatric patients. Patients were followed-up over a 20-year period in an area where psychiatric care is entirely provided by community-based psychiatric services. Many of the mortality studies published so far were conducted in areas where hospital-based system of care are available for mentally ill. All subjects who had at least one contact with the South-Verona CPS during a 20 year period and who at the first contact or later received an ICD-10 psychiatric diagnosis were included in this study (59,139 person years). Total SMR of our psychiatric population was 1.88, mortality in out-patients was significantly high (SMR = 1.70, 95% C.I. 1.6 to 1.8), and, as expected, it becomes higher after the first admission (SMR = 2.61, 95% C.I. 2.4 to 2.9). SMRs for infectious diseases are higher among younger patients and extremely high in patients with drug addiction (216.40, 95% C.I. 142.5 to 328.6) and personality disorders (20.87 C.I. 5.2 to 83.4). Our data show that, also in a community-based mental health service, psychiatric patients are at almost twofold higher risk of death than the general population and this becomes extremely higher for those diagnosed with drug addiction or personality disorders.

Routine outcome assessment in mental health services should involve health-care providers and at the same time guarantee a satisfactory quality of data collected [21, 22]. Taking into account multiple perspectives (i.e., those of clinicians, patients and caregivers) and integrating these views is a necessary step when evaluating mental health outcomes. The outcome of mental disorders is heterogeneous and the relationships among multiple outcome variables are complex; thus specifically developed methodologies are needed in order to gain a deeper understanding of their reciprocal interactions. Clinical and social dimensions of outcome display different patterns of exacerbation and remission over time and might be influenced by different set of predictors and susceptible to specific interventions. To answer these questions, we have conceived the South
Verona Outcome Project (SVOP), whose protocol and main results will be described in the next paragraphs.

Is the assessment of outcome feasible in a routine community-based mental health service?

The SVOP is one of the few systematic outcome evaluations of a “real world” mental health service available in the international literature. It is a naturalistic, longitudinal research which aimed to assess the outcome of care provided by the South-Verona CPS. Its key-features are that: a) data collection has been conducted in the routine clinical practice setting of a well established “real world” psychiatric service; b) professionals engaged in clinical work have been systematically involved in the assessment process; c) the assessment included a comprehensive set of both clinician-rated and patient-rated outcomes; d) regular checks of the reliability and quality of the data collected have been performed.

Prevalence cohorts of patients on the caseloads of the South-Verona CPS were systematically assessed with a set of standardised instruments. Assessments took place twice a year, from April to June (wave A) and from October to December (wave B). During these periods all key-workers (psychiatrists or psychologists) were asked to assess at the first or, at latest, the second visit in the period, both first-ever patients and patients already in contact with the service. In wave A the assessment was made only by the key-professional on the basis of the patient’s condition in the previous month and included an assessment of global functioning, psychopathology, and disability in performing social roles. In wave B, the assessment was made both by the key-professionals (again the same assessments as in wave A, plus the assessment of needs for care) and by the patients, who were requested to assess their quality of life and satisfaction with mental health services in relation to their experience over the previous year.

All primary clinicians (psychiatrists and psychologists) were trained in the correct use of the standardised instruments. Training took place every year in the month preceding wave A and consisted of 5 training sessions. All instruments used showed good psychometric characteristics.

The SVOP was conducted between 1994 and 1997, with the assessment of a series of cohorts of patients attending the South-Verona CPS. More than 2500 patients have been assessed in a standardised way by clinicians, and more than 1000 patients have completed self-administered instruments. A comprehensive data set has thus been obtained, providing a valuable source of information that can be used for purposes of service planning and evaluation. As part of the SVOP a series of follow up studies were performed, including also patients which were not in contact with our service at follow-up. This comprehensive set of data was used in order to: a) identify changes occurring in the short and medium period in each of the indicators of outcome assessed; b) identify the predictors of favourable and unfavourable outcome in each area; c) analyse the link existing during the course of the time between the various indicators. Overall, the results obtained provided a deeper understanding of social, health-related, and service-related factors which influenced the outcome of mental disorders. Results from the SVOP clearly show that in “real world health services” the outcome of care is multifaceted, that it can be perceived differently if different perspectives are taken, but at the same time that such a complex picture can provide comprehensive information regarding the effectiveness of care provided in order to act as a feedback for improving clinical practice. It is hoped that the SVOP experience may be viewed as a framework model for future research initiatives to be conducted in routine services and that empirical findings derived from the rich data set of the SVOP may increase and reshape the body of knowledge for both mental health services professionals and administrators [21].

Which are the predictors of clinical and social outcome in patients receiving community-based mental health care?

A total of 354 patients treated in the South-Verona CPS were followed-up over 6 years (with assessments made at baseline, at 2 and 6 years) by using a set of standardised measures exploring psychopathology (BPRS) and social disability (DAS). GLLAMM models were used to explore longitudinal predictors of clinical and social outcome.

Psychotic patients displayed a clinical and social outcome characterized by complex patterns of exacerbation and remission over time; however a clear trend towards a deteriorating course was not found, thus challenging the notion that psychotics are not fatally prone to a destiny of chronicity. Non psychotics reported a significant reduction in the core symptom of depression and in the observable physical and motor manifestations of tension and agitation, and a parallel increase of complaints about their physical health. These data show that clinical and social dimensions of outcome are influenced by specific and different set of predictors. The results of this study confirm the need to implement naturalistic outcome studies conducted in the “real world” services in order to inform decisions and strategies to be adopted in routine clinical practice [23].

Which are the predictors of changes in needs for care in patients receiving community-based mental health care?

The study was conducted using a 4-year prospective longitudinal design. A cohort of patients from the South-Verona CPS was assessed at baseline and follow-up using the Camberwell assessment of need, both staff and patient versions. Predictors of needs’ changes were explored using block-stratified multiple regression analyses.
An overall stability for both patient-rated and staff-rated needs was found over time; however, significant changes in some specific need domains were found, such as self-rated health needs (improvement), self-rated social needs (deterioration) and staff-rated health needs (deterioration). Changes over time in self-rated and staff-rated needs are influenced by different and specific set of predictors, thus indicating that the two measures are not overlapping and convey different types of information. Our data support the adoption of a negotiated approach in which both staff and users’ views should be given equal weight when planning and providing needs-led mental health care [24].

**Which are strengths and weaknesses, in the patients’ perspectives, of a “real world” service and the characteristics that might be associated with service dissatisfaction?**

Service satisfaction was measured with the Verona service satisfaction scale (VSSS) across three subsequent waves of the SVOP; frequency distributions of scores in the various VSSS domains were compared. Service dissatisfaction proved to be one of the main causes for drop-out, especially in non psychotic patients. Many patients no longer in contact had mild to moderate problems, especially anxiety and depression and some social disability. Patients out of contact rarely sought help from other agencies [25].

The relationship between satisfaction with psychiatric care and a number of well-established mental health indicators, including socio-demographic, clinical and service intervention variables, was investigated using random-effects models. The organisation of service and the behaviour and manners of the professionals were the main service strengths. Weaknesses were identified in the physical layout of facilities, the lack of involvement of relatives, and in the information provided. Overall satisfaction was medium-high, while subjects with longer duration of service contact and higher disability were the most dissatisfied. The predictors we examined, however, explained only modest percentages of variance. Repeated, routine assessments of service satisfaction have provided a clear view of the South-Verona CPS’s strengths and weaknesses; this set of information was crucial for the continuous quality improvement process in the service [26].

**Which are the changes over three-years in caregiving burden and emotional distress in relatives of people with schizophrenia, and what are the factors predicting levels of caregiving burden?**

A cohort of 51 caregivers of patients with schizophrenia attending the South-Verona CPS was assessed over 3-years with the involvement evaluation questionnaire, European version (IEQ-EU). Predictors of care giving burden included both caregivers’ and patients’ characteristics and patterns of carers-patients interaction [27].

Baseline levels of family burden were high in worrying and urging domains. Fifty-one per cent of caregivers experienced significant emotional distress. Both overall burden and emotional distress improved. Higher patients’ psychopathology, higher numbers of patient-rated needs, patients’ lower global functioning, and patients’ poorer quality of life were found to be related to the severity of family burden. The only significant predictor of caregivers’ burden at follow-up was the baseline level of caregivers’ burden itself. On the basis of these findings, a policy addressing the caring burden of informal caregivers beyond patients’ symptoms reduction should be considered [28].

**FURTHER RESEARCH DEVELOPMENTS. THE ROAD AHEAD**

To complement information on the predictors of outcome and improve evaluation at the patient and service levels, we have recently conceived the Psychosis Incident Cohort Outcome Study (PICOS), that aims to integrate genetic, clinical and environmental data [29]. Specifically, the interaction between genetic and environmental events, as well as brain morpho-functional alterations, occurring during a critical period in neuronal maturation, has been hypothesized to contribute to onset of psychosis. However the specific role, the relative weight and the possible relationship among biological and environmental factors are far from being fully understood.

PICOS is a multisite collaborative research on one-year incident cases of psychoses attending mental health services in the Veneto Region. We hypothesized that patients with higher genetic load, in term of putative susceptibility genes (such as neuregulin 1, dysbindin and DISC-1), and morpho-functional brain abnormalities will display: 1) earlier onset; 2) more severe clinical condition at baseline; 3) worse clinical and social outcome. A network of 28 collaborating sites, covering about 80% of the Veneto Region (with a catchment area of 3 500 000 inhabitants), was established [30]: the network includes both mental health services providing care within NHS framework and mental health facilities working in the private sector. PICOS has a “modular” structure, as follows:

**Module 1 - Clinical and social evaluations**

The baseline data collection started in January 2005 and was concluded in December 2007. A total of 544 subjects were recruited; among these, 350 patients accepted to be interviewed with the set of the study instruments and completed the assessments (life events, premorbid adjustment, premorbid IQ, parental bonding, psychopathology, social disability, quality of life, needs for care).

**Module 2 – Genetics**

It includes the reconstruction of probands’ Family Tree for psychosis and techniques of molecular genetics. Blood samples from patients and their first-
degree relatives were collected for DNA analyses, which will be focused on putative susceptibility genes for psychoses. So far, the reconstruction of Family Tree for psychosis and the collection of venous blood samples for DNA analyses was performed in 280 patients. Blood samples from 170 first-degree relatives were also collected.

**Module 3 - Brain imaging**

It includes the evaluation of structural/functional brain abnormalities by MRI scans; a series of neuropsychological tests has been also performed in order to find possible correlations between brain abnormalities and specific brain functions. MRI scans are performed at baseline and at 1 year. So far, the evaluation of structural/functional brain abnormalities through MRI scans was conducted in 72 patients; neuropsychological tests were also performed on the same number of patients.

**CONCLUSIONS**

The thirty years experience conducted in South-Verona showed that it is possible and sustainable to run an academic community-based mental health service where there is a strong integration between innovative psychiatric care, scientific research and modern academic undergraduate and postgraduate education. The care provided everyday by such a service must be continuously informed by scientific evidence [31] and by the exchange of knowledge and experiences with other colleagues in the country and abroad. This is what has been happening in Verona for 30 years. On the other hand, it is worthwhile to underline that most research projects conducted so far are based on real-word psychiatric care and that the routine monitoring of clinical activities represents, since many years, the framework for epidemiologically-based evaluations of the outcome.

Finally, thanks to the coordination between innovative care and evaluative research, the South-Verona CPS provides undergraduate and postgraduate students with the opportunity to receive up-to-date education and training in settings very similar to those that they will find in their professional life.

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European strategies for mental health

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Summary. The most recent developments of strategies and policies in the mental health field in Europe are related to the World Health Organization (WHO) Declaration and Action Plan on Mental Health signed by all the Ministers of Health of all Member States in the European Region (2005). The Action Plan proposes ways and means of developing comprehensive mental health policies, listing 12 areas in which challenges are indicated and detailed actions are required. Afterwards the Green Paper on Mental Health has been launched by the European Commission for the definition of an European strategy. The more precise European Pact for Mental Health and Well-being has been presented in 2008. Many other international bodies (OECD, Council of Europe, etc.) have actively worked to stress the mental health issue. All are clearly referring to the Italian model, started 30 years ago.

Key words: mental health, World Health Organization, European Commission, Italian Law 180.

INTRODUCTION

The most recent developments of strategies and policies in the mental health field at European level could, in some way, be related to a crucial event which took place in January 2005 in Helsinki (Finland). At that time a Common Declaration [1] and Action Plan [2] on mental health were signed by all the Ministers of Health of the 52 Member States in the World Health Organization (WHO) European Region, together with the major nongovernmental organizations. The Helsinki Conference with the issue of the two documents can be regarded, at the same time, as the closure of a phase and the beginning of a new process.

From that moment and from that commitment, a number of actions have been started and a number of documents have been prepared by several international institutions, in order to support the shift from only shared principles and priorities to the promotion of real common actions and delivery of policies and services.

In this contribution to the “celebration” of 30 years since the issue of the Italian national law on mental health (Law 180/1978), I will try and briefly illustrate the major steps taken at European level by the different International actors towards the implementation of this new policy, never forgetting that in every official setting it is always mentioned that the whole process of affording mental health in a different way started with the “Italian experience” and the “Basaglia approach”.

WORLD HEALTH ORGANIZATION

The Mental Health Declaration for Europe is the instrument designed by Member States to commit themselves to work together in order to afford one of the most challenging threads to well-being of European citizens: mental illness.

To face this challenge they chose to act at several different levels, from preventing the major mental disorders and illnesses to promoting mental well-being, from tackling stigma and discrimination to supporting Community based care and services.

The scope, the priorities and the actions endorsed in the Declaration are translated into detailed commitments through a Mental Health Action Plan for Europe, attached to it.

Member States support the implementation of the Plan in accordance with their specific needs and re-
sources, but also with the basic idea of a common effort, over the next five to ten years, to formulate and evaluate policies and legislation that will deliver mental health activities aimed at improving the well-being of the whole population of Europe [3].

To achieve this scope, the Action Plan proposes ways and means of developing comprehensive mental health policies, listing 12 areas in which action is required:

1. promote mental well-being for all;
2. demonstrate the centrality of mental health;
3. tackle stigma and discrimination;
4. promote activities sensitive to vulnerable life stages;
5. prevent mental health problems and suicide;
6. ensure access to good primary care for mental health problems;
7. offer effective care in Community-based services for people with severe mental health problems;
8. establish partnerships across sectors;
9. create a sufficient and competent workforce;
10. establish good mental health information;
11. provide fair and adequate funding;
12. evaluate effectiveness and generate new evidence.

For each of these areas, all regarded as crucial, there is an accurate definition of the major challenges that the Countries in the European Region have in front of them, followed by a number of detailed actions which could (or should) be considered in order to give an answer to the needs of the population.

Moreover, all this can really offer a concrete basis, for willing Governments, to start working in mental health with a new shared approach, respectful of individuals, their rights and their potentialities.

The Action Plan also identifies 12 milestones towards which Member States have to move between 2005 and 2010, as a kind of working agenda:

1. prepare policies and implement activities to counter stigma and discrimination and promote mental well-being including in healthy schools and workplaces;
2. scrutinize the mental health impact of public policy;
3. include the prevention of mental health problems and suicide in national policies;
4. develop specialist services capable of addressing the specific challenges of the young and older people, and gender-specific issues;
5. prioritize services that target the mental health problems of marginalized and vulnerable groups, including problems of comorbidity, i.e. where mental health problems occur jointly with other problems such as substance misuse or physical illness;
6. develop partnership for intersectoral working and address disincentives that hinder joint working;
7. introduce human resource strategies to build up a sufficient and competent mental health workforce;
8. define a set of indicators on the determinants and epidemiology of mental health and for the design and delivery of services in partnership with other Member States;
9. confirm health funding, regulation and legislation that is equitable and inclusive of mental health;
10. end inhumane and degrading treatment and care and enact human rights and mental health legislation to comply with the standards of United Nations conventions and international legislation;
11. increase the level of social inclusion of people with mental health problems;
12. ensure representation of users and carers on committees and groups responsible for the planning, delivery, review and inspection of mental health activities.

WHO, in cooperation with the European Commission, has designed a study to follow up the actual implementation of actions suggested by the Plan, and signed by the Ministers.

The first step of this study has just been completed, and results are now available on the website of WHO, even if a discussion on them is still required and could become the job of next months. The study, called Baseline Project, has the objective of assessing the general situation of mental health in the Member States of European Union, but also in some other Countries of WHO European Region which have been able to collect data. The areas investigated cover the same major issues listed in the 12 milestones, and data collected could be the starting point for defining indicators capable of evaluating the impact of the Declaration and the Action Plan on the definition of new policies and strategies in the Countries involved.

EUROPEAN UNION AND EUROPEAN COMMISSION

As already said, many other activities have been started as a consequence of the Helsinki Conference and its call for action.

The European Commission, which has been a relevant partner of WHO in the Conference, is the first International Institution who has answered the invitation to contribute to concretize the general framework for action established by the Declaration and Action Plan.

If, on one side, European Union can only act on behalf of its Member States, on the other side it can go deeper in giving advices and in creating the right context for promoting action and cooperation.

So, in October 2005, a Green Paper on Mental Health was launched by the European Commission, with the idea of starting a debate among many different, interested and involved actors for the definition of an European strategy on mental health by also defining top priorities.

The “Green Paper. Improving the mental health of the population. Towards a strategy on mental health for the European Union” [4] is the document which has been offered to the discussion of European in-
Institutions, Governments, health professionals, stakeholders in other sectors, patient organisations, the research Community and civil society in general.

The added value of an action promoted by the Commission can be found in its power to establish a framework for exchange of experiences and field cooperation between Member States; to help in increasing the coherence of actions in the health and non-health policy sectors, not only in Member States but also at the larger Community level; and finally to allow, as said before, the involvement of a broad range of relevant stakeholders into building common solutions.

The key issues on which the Commission has proposed to focus, as part of an effective EU-strategy, could be resumed as follows:

1. promote the mental health of all, regardless of age, gender, ethnicity, social status, etc.;
2. address mental ill health through preventive action, involving individuals, families, communities and, more specifically, relevant sectors such as schools and workplaces;
3. improve the quality of life of people with mental ill health or disability through social inclusion and the protection of their rights and dignity, promoting a “change in paradigm” really capable of moving away from institutionalisation and putting people with mental problems in the middle of Community life;
4. develop a mental health information, research and knowledge system for the EU by harmonising existing information systems, developing international indicators, collecting reliable data and promoting international research.

While suggesting to discuss these aspects, the Commission also reminds that a large number of coordinated actions are already ongoing in Europe, and should be taken into account as a starting point to build upon. Successful examples are mentioned to start a confrontation aimed at modelling validated solutions on the different needs and situations of the different Countries.

Practical initiatives that could be promoted at European Community level are also suggested, so designing the Green Paper as a good tool for action.

Among the activities envisaged, the following are underlined:

1. creating a dialogue with Member States on mental health, through a forum that has been working for over a year, including meetings, working groups, web consultations;
2. launching an EU-platform on mental health, involving a variety of interested subjects in the discussion of priorities, the identification of best practices, the formulation of recommendations;
3. developing an interface between policy and research on mental health, so to enable the suggestion of research areas to be promoted on the basis of scientifically validated evidence.

The process of consultation and the analysis of all information gathered during a period of almost two years, have led to another important event, that took place in Brussels in June 2008.

What I am referring to is the EU high level Conference Together for Mental Health and Well-being, during which a new document has been presented and launched, the European Pact for Mental Health and Well-being [5].

It can be considered as the natural consequence of all the efforts started by the Green Paper in order to acknowledge the importance and relevance of mental health and well-being for all citizens of the European Union.

Again it is stated that complementary action and a combined effort at EU-level can help Member States in tackling the challenges we have to face in the field of mental health.

The Pact, even if recognising that primary responsibility for actions rests with any single Member State, tries and brings together a number of European institutions, states, associations and individuals, especially including people at risk of exclusion for mental health reasons, to support and promote mental health and well-being, as a reflection of their previous commitment to a longer-term process of exchange, cooperation and coordination on key topics.

There has been a selection of five priorities for which the participant in the Conference call for action:

1. Prevention of Depression and Suicide, since depression is recognised as one of the most common mental disorder and most dangerous risk factor for suicide;
2. Mental Health in Youth and Education, since early years and adolescence are regarded as crucial for building up good mental health in adulthood, and the educational system as the privileged setting for preventing disorders and promoting positive feelings, behaviours and life styles;
3. Mental Health in Workplace Settings, tackling into account both the promotion of well-being among workforce in general and the social inclusion of those suffering from some mental problem;
4. Mental Health of Older People, a central issue in an ageing Europe with a population more and more in need of support for remaining active and feeling part of society, so skipping some of the age related risk factors for ill mental health;
5. Combating Stigma and Social Exclusion related to mental disorders, attitudes that create barriers to recovery and risk to waste a rich human potential.

For each of these priority areas a Consensus Paper has been prepared [6], detailing the situation in Europe, the most relevant problems in the sector, some of the best practices that can be found in different contexts and the lines of possible future developments in seeking common solutions.

The Pact precisely aims at facilitating the monitoring of trends and activities in Member States and,
starting from European best practice, it should help deliver proper recommendations for effective actions in addressing the cited priorities.

As a conclusion of the statements included in the European Pact for Mental Health and Well-being, there is an invite to Member States, together with the larger civil society, to join Pact and to contribute to its implementation.

At the same time the European Commission and Member States should commit themselves to: i) establish a mechanism for the exchange of information; ii) work together to identify good practices and success factors in policy; iii) develop appropriate recommendations and action plans; iv) communicate the results of the common work through a series of conferences on the Pact’s priority themes over the coming years.

Finally, the European Commission is invited to issue a proposal for a Council Recommendation on Mental Health and Well-being during 2009.

By now, we can confirm that some of the actions envisaged have already started, since a first meeting of Governmental experts is scheduled in the coming weeks, with the aim of discussing the proposals of the Pact and suggesting an agenda for their translation into actions.

ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT (OECD)

Among many other activities of international bodies, the work of the Organisation for Economic Co-operation and Development (OECD) deserves to be mentioned, and specifically the ongoing Health Care Quality Indicators Project (HCQI), which responds to the growing interest by healthcare policymakers and researchers in OECD Countries in measuring and reporting the quality of medical care. The aim of this project is to collect internationally comparable data, reflecting the health outcomes and health improvements attributable to medical care delivered in OECD countries.

In the framework of this general approach, a Subgroup has been established for approaching the area of mental health, with the same objectives [7].

The task is proving to be quite challenging, since the data required for constructing indicators are not available in all the different Countries involved, the quality of data is not homogeneous across Countries and their comparability is still quite difficult to achieve.

The first exercise on schizophrenia and bipolar disorders is now in the phase of analysis and the Group is discussing further steps to be taken.

COUNCIL OF EUROPE

Also the Council of Europe has taken part into the process of opening a season of new attention to the theme of mental health.

At the end of 2006 the first meeting of the Committee of Experts on developing a Council of Europe mental health reference tool was held in Strasbourg, followed by a second meeting in 2007 and some teleconferences.

The major goal of this working group has been to review the already existing documents of the Council of Europe focussed on human rights and ethical and social cohesion components in national mental health policies.

From this review a model framework should be prepared, for Countries to use for: i) decision making; ii) priority setting; iii) defining and developing the basic principles of equity, access, non discrimination, safety, citizens participation.

The work is still ongoing, but it should be said that it has not yet reached its aims and the knowledge of its contents is still poor around Europe.

CONCLUSIONS

In addition to the above description of actions performed by the most important institutions in Europe, there are many other initiatives of international associations, scientific societies, working groups and so on.

All can be considered as examples, more or less scientifically based, more of less useful and validated, of wide and deep interest in the matter. Which always is a good and valuable signal of the attention that the issue of mental health deserves.

At the same time, we should again and again underline that there is a strong need for better coordination at international level, in order to avoid resource wasting and money consuming overlapping, and for better finalising common efforts, which is the real added value of cooperation at European level.

Finally, one thing that has to be reminded is that there has been, over the last few years, a larger and larger acceptance, in a still complex and sometimes conservative scenario, of the principles of the respect of human rights of mental ill people and of their centrality in the whole process of care, that Italy has started 30 years ago and has been implementing all along.

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References


The role of the Italian National Institute of Health in the National Project on Mental Health (1996-2000)

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INTRODUCTION

The National Project on Mental Health (Progetto Nazionale Salute Mentale, PNSM) [1] was approved in 1996 and financed with seven billion liras from the special fund established by the 1992 Health Act (DL.vo 402, art. 12) – a fund aimed at supporting research in public health and related activities of direct interest for the Italian National Health Service (Servizio Sanitario Nazionale, SSN). In fact, the Act of foundation of the SSN (Law 1978/833) had included the provisions of Law 1978/180; therefore, psychiatric services became SSN services, and it was a logical (but far from automatic!) consequence that research in mental health be supported by the aforementioned fund.

THE ANTECEDENTS OF PNSM

Before the launching of PNSM, the Italian National Institute of Health (Istituto Superiore di Sanità, ISS) had played a significant role in mental health research, starting shortly after the establishment of the Epidemiology Department in 1976, and particularly after Pierluigi Morosini came to work in this Department (for details, see previous articles in the present series).

In the mid-eighties, another initiative supported by ISS was the foundation of the World Health Organization (WHO) Center for Research and Training in Mental Health in Italy. This initiative originally proposed by the leaders of four groups who had considerable experience in psychiatric and psychopharmacological research: Carlo Lorenzo Cazzullo and Giorgio Racagni, of the Institute of Psychiatry and Institute of Pharmacology, respectively, at the University of Milan; Dargut Kemali, of the Institute of Psychiatry at the University of Naples; and Michele Tansella of the Institute of Psychiatry at the University of Verona. The latter institution had been a pioneer in experimenting on direct connections between research and training at University Medical Schools and mental health services of SSN, by operat-
ing as Department of Mental Health on behalf of SSN in part of the Verona area.

The proposal to create the Center was strongly supported by Norman Sartorius, Director of Mental Health at the WHO headquarters in Geneva. However, the development of SSN after the approval of Law 1978/833, including the provision that ISS operate as its technical-scientific body – which had triggered an additional significant increase in the Institute’s resources of personnel and funds, superimposed to the previous one following the ad hoc Act for the reorganisation of ISS (Law 1973/519) – had created a gap consisting of the fact that the main interlocutors of WHO in Italy were absent from the proposed plan for the new Center. At this point, an additional round of negotiations between the various parties led to the designation of the ISS Director, Francesco Pocchiari, as President of the Center, which could start the procedures aimed at evaluating candidatures for participation in the Center’s activities.

Quite rigorous criteria, based on an accurate examination of institutional research and related credentials and on site visits, were agreed upon and implemented by the evaluation group, which included Sartorius, the four original Italian proposers, and Pocchiari with the present writer assisting him as secretary of the Center. Two institutions were accepted in addition to those of the four original proposers; namely, the SSN Department of Mental Health in Trieste and the Istituto di Ricerche Farmacologiche Mario Negri in Milan. The former was the site where the development of various types of extramural services for mental patients had succeeded already in the seventies, under the guidance of Franco Basaglia, in eliminating long-term hospital stays before the approval of Law 180. (For this reason, Trieste had been previously included among WHO mental health services pilot study areas, as shown by the report in the ad hoc 1987 WHO publication [2]). The latter was an internationally well-known independent institution with a qualified record in psychopharmacological and mental health research.

Subsequent moves, however, were blocked by insurmountable obstacles. Specifically, the Center had an urgent need for a minimum of funds in order to enable the launching of multi-center joint projects involving the participating institutions, in addition to those performed by each one of them with own resources. The strenuous efforts of Pocchiari in this direction did not produce the expected results: and it was not a mystery that the main obstacle was the fact that ISS, having already succeeded in obtaining the leadership of important multi-center research projects (in particular those on tumours and AIDS), including the administration of the respective financial resources for both intramural and extramural work, was vetoed by various interested parties for any further “trespassing” into other areas, like mental health research. As a consequence, a zero sum game went on until the death of Pocchiari in January 1989, when it became evident that ISS could not afford keeping the responsibility of the leadership of the WHO Center.

Even with these limitations, the foundation and initial years of life of the Center produced significant positive results, ranging from a facilitated access to research and other funds for the participating institutions, to a more and more extensive role played by them on the national and international scenes. Specifically, experienced persons from the participating institutions, particularly the Trieste department, were repeatedly called to serve as service directors in various Italian regions and as advisors in foreign countries; that is, to help in the efforts to improve their mental health services, and in particular to phase out large institutions for long-term stays of mental patients.

THE NATIONAL PROJECT ON MENTAL HEALTH

A few years afterwards the situation started changing in a more favourable direction. After the aforementioned fund for public health research was established in 1992, ISS – thanks also to the fact that a qualified epidemiologist, Paolo Pasquini, had moved from his previous areas of work to research in the mental health area, which led to a considerable strengthening of the Morosini group – was able to propose an ambitious project (PNSM) which was strongly supported both by the Minister of Health, Elio Guzzanti, and by the ISS Scientific Advisory Council. Two of its members must be gratefully remembered for their qualified efforts to provide convincing expert opinions which led the Council to a unanimous favourable resolution; namely, Benedetto Saraceno, who was later to become the successor of Sartorius as Director of Mental Health at WHO, and Nicola Rizzuto, chair of Neurology at the University of Verona, where he had picked up the heritage of Hrayr Terzian, who had played an important role to promote the projects of Franco Basaglia and to support the approval of Law 180.

Rigorous conditions were implemented by an ad hoc scientific committee for the evaluation of proposals for participation in the PNSM, including three stages – ex ante, yearly verifications of progress on the basis of interim reports to be discussed in open meetings of all participants, and ex post. While the reader must be referred to the final report [1] and to the publications quoted therein for a detailed description of the various activities in PNSM, at least one example of their considerable scientific and operational value should be given here. This concerns a multicenter project conducted by the group at ISS, which had been further strengthened by the hiring with temporary contracts of Giovanni de Girolamo, a clinical scientist with previous considerable experience in research in the mental health area (including an extended period of work in the group of Sartorius at WHO), and other co-workers (see “Conclusions”). This project, named PROGRES (PROgetto RESidenze), was aimed (i) at taking a census of almost all Italian facilities, both public and private, for the rehabilitation of mental...
patients and (ii) at an evaluation of the features of a large random sample of these facilities, from several viewpoints, such as logistics, characteristics of the patients, profiles of the personnel employed, therapeutic and other types of intervention, etc. The results, published in qualified national and international journals, have been widely recognized as constituting a unique body of information on this important component of mental health services, considering in particular that the best work conducted in other countries on this topic has mostly been restricted to partial samples of the facilities in question.

AFTER PNSM

While PNSM was coming close to its end – which for example entailed the termination of the funding of the contract for one of the ISS unit leaders, de Girolamo – the ISS group drew up the draft of another ambitious project (PROGRES ACUTI) aimed at taking the census and evaluating the facilities for the care of acute patients, both public – the Servizi Psichiatrici di Diagnosi e Cura, SPDC, of SSN Mental Health Departments, and the ad hoc units in University Departments – and private. In the meantime, thanks to a large extent to the PNSM experience, the know and the know-how of mental health research, as well as the awareness of its relevance for improving the quality of mental health services, had spread to an extent which led the responsible authorities to start an important experiment; that is, to decide that the leadership of projects of research in mental health approved for financing with public funds should be assigned to individual Regional administrations which could rely on qualified mental health services. In particular, the leadership of PROGRES ACUTI was entrusted to the Region Friuli Venezia Giulia and in particular to the Trieste Department of Mental Health, with Giuseppe Dell’Acqua as principal investigator. The ISS unit, remaining in close contact with de Girolamo after his return to his previous position in the Bologna services, made a significant contribution to the success of this project which, again, resulted to be unique in its kind in the face of the more partial features of similar research conducted in other countries.

CONCLUSIONS

The experience in the leadership of PNSM as well as subsequent developments before and after the retirement of Morosini in 2008, shortly before his demise - including the formal founding in 2004 of a Mental Health Section in the ISS Center for Epidemiology - have allowed a progressive strengthening of research in mental health conducted at our Institute. It is not within the scopes of the present paper to illustrate these developments in any detail. It should at least be mentioned, however, that important projects supported by public funds have been repeatedly approved for conduction by the ISS group; for example, a project for the epidemiological surveillance in mental health, particularly concerning severe mental disturbances (Project SIME, led by Antonella Gigantesco) and a project for the screening and integrated management of depression in various types of medical services (Project SET-DEP, led by Angelo Picardi).

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