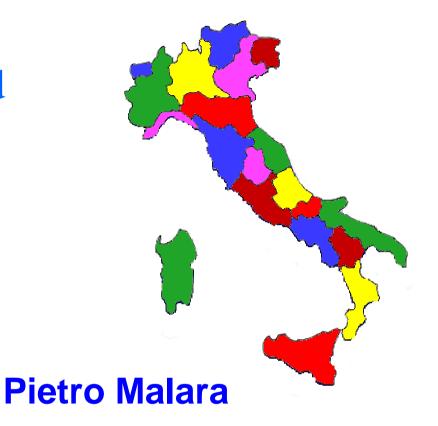
Mental Health in Italy
Regulatory System and
addressing documents
with special focus on
child and adolescent



Ministry of Health-General Directorate for Health Prevention –Unit VII www.salute.gov.it/

THE ITALIAN FRAMEWORK

- The first basic laws to reform mental health services implying a huge cultural and management change was issued in 1978
- Law 180 May.16.1978 and Law 833, December.23.1978
 Core mental health issues in both Acts are:
- Regions are responsible for health services
- Civil rights of mentally ill people are to be fully acknowledged
- Psychiatric Hospitals must be gradually closed or differently used; no more patients can be admitted in those existing hospitals, and old residents should be moved, except for those explicitly demanding to stay, in to outpatients services or therapeutic communities

THE ITALIAN FRAMEWORK

- The whole system of treatment is based on a network of community oriented facilities organized and coordinated by a department
- ➤ Treatment for acute problems is delivered in General Hospitals, in Wards named "Psychiatric Service for Diagnosis and treatment."(SPDC)
- Compulsory treatments should be limited as much as possible, both in number and in length. They should also be considered only as a first step in a treatment programme to be delivered in community services.

THE ITALIAN FRAMEWORK

 The Law 833/1978(the National Health system Reform still in force):

- Compulsory treatments are strictly regulated: they must be proposed by a physician only if alternative measures cannot be applied.
- ➤ The Mayor is in charge of delivering the recovery act proposed by a phisician and confirmed by the medical doctor operating in the Local Health Unit; it must be validated within the following 48 hours by the tutelary judge and must be terminated, as usually, by seven days.

- The Government Decree 7 April 1994:Target Project for mental health 1994-1996.
- The Government Decree 10 November 1999:Target Project for mental health **1998-2000**.
- The Gov. Decree 24 April 2000: Mother and child target Project 1998-2000
- National Laws for school integration of disabled children (legislative decree 16 April 1994 n.297)
- Regional Laws on activation of child and adolescent neuropsychiatric services (from 0 to 18 years)

Key issues

- Closure of Institutions for disabled children and of special schools
- Community based outpatient multiprofessional services in tight connection with family pediatricians and schools

Key issues (2)

- Nation wide organization of 0-18 child and adolescent neuropsychiatric Services (CANPS) dealing with three different areas:psychopatology, neuropsycology, neurology, mainly focused on outpatient facilities but including day care, therapeutic residential care and inpatient care. (hospital care)
- Special focus on early detection of child and adolescent mental disorders: integration protocols between development age and adult services in order to early detect at risk joung people and at risk cultures and context with the aim of containing mental disorder course.
- Multiprofessional approach, individual preventive and therapeitic plans, active promotion of mental helath and detection of at risk individuals in school, family and home settings

Key issues (3)

- Organization pattern focused on Mental Health Department(MHD) that includes:
- Mental Health Centre (CSM)
- Hospital Psychiatric Service for Diagnosis and Care (SPDC)
- Day Hospital (DH)
- Day Centre (CD)
- Residential Facilities (RF)

- Critical points and obstacles
- the 1978 national legislation ("Legge 180") devolved to Italian regions the responsibility of managing the transition towards community psychiatric care.
- Recent legislation emphasizes the role of the regions in planning, coordination and delivery of healthcare services (including MH services).
- Regional implementation process caused wide variation and disomogeneity across the 20 Italian regions
- each Italian region sets up its own mental health system
- limited monitoring of this dramatic change
- Inpatient beds very limited and activated only in 13/20 regions

- ➤ National lines for mental health (2 May 2008)
- MoH Decree 15 October 2010:National Information System for MH (SISM) (in 2012 started out collecting data from Regions, based on individual records)
- Guidelines for treatment of autism spectrum disorders in children and adolescents-National Institute of Health-(October 2011)
- ➤ National lines in the field of pervasive developmental disordes with special focus on autism spectrum disorders (November 2012).
- National Action Plan for mental health (January 2013)
- Addressing document on residential facilties for mental health in adults (October 2013)

THE ITALIAN FRAMEWORK: FOLLOWING ACTS 2008-2014 (2)

- Addressing document on residential and semiresidential health facilties for mental disorders in childhood and adolescence. (October 2014)
- Addressing document on Health care pathways for schizophrenic, mood and personality disorders (October 2014)



Key issues

- Three main areas of intervention: adult mental health,child and adolescent mental health (CAMH) health,integration with other health and social services.
- > CAMH targets:
- -Integrated regional network of multiprofessional services including rehabilitation to take care of child and adolescent connected with family, school and other life settings.
- -strenghtening integration between hospital and community level

Key issues(2) CAMH TARGETS:

- --supporting the continuity between CAMH and adult services notably in the age group 15-21 also by sharing operative protocols extended to family members with mental health troubles or substance dependency.
- early and appropriate interventions for severe MH problems and psychiatric emergencies in adolescence.
- early and appropriate detection of autism and other complex disabilities and relevant neurologic and neuropsychiatric diseases

Key issues(3) CAMH TARGETS:

- -better mental health interventions for young crime offenders.
- -introduction of a specific and appropriate data set and monitoring system

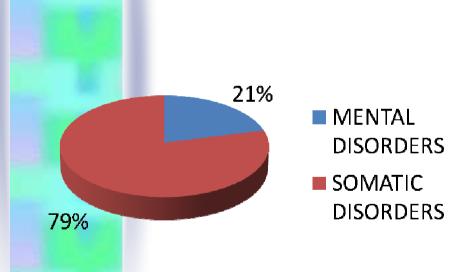
Critical points and obstacles

- Variability of CAMH Services and lack of specific structures nation wide.
- ➤ Inpatient beds for CANPS decrease (from 512 in 2008 to 324 in 2013)
- > Residential care and day services limited
- No specific data and information System for CAMH

BURDEN DUE TO MENTAL DISORDERS

 In Italy 21% of the global burden of disease measured in Disability Adjusted Life-Years (DALYs) can be attributed to mental and substance use disorders

DALYs



INCLUDING DEMENTIA AND

SUBSTANCE ABUSE

	DALYs
DEPRESSION	7%
BIPOLAR DISORDERS	1%
SCHIZOPHRENIA	1%
OBSESSIVE-COMPULSIVE DISORDER,	1%
PANIC DISORDER	1%
ALCOHOL ABUSE	3%
DRUG USE	2%
DEMENTIA	4%

MAIN DATA SOURCES

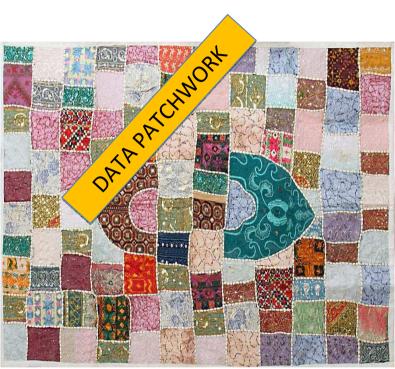
 1 national survey on the prevalence of mental disorders in the community (ESEMeD: European Study of Epidemiology of Mental disorders, 2000)

 3 national surveys on Residential Facilities (PROGRES, 2000), Psychiatric Wards in General Hospital (PROGRES Acuti 2002-2003) and Community Health Centers (PROGRES CSM 2005-2006)

 Data from 5 Regions (2009): Lombardy, Emilia Romagna, Friuli, Lazio and Liguria

 Data from Ministry of Health (2009)

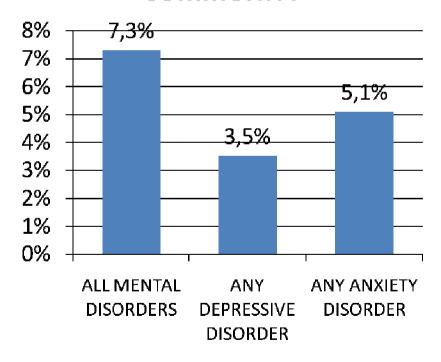
 Data from Lombardy, a Region where a regional case register is working from 1999.



PREVALENCE OF MENTAL DISORDERS AT COMMUNITY LEVEL

- ESEMED survey in 2001-2003
 interviewed a sample of 4712
 Italian citizens
- The annual prevalence for common mental disorders was 7.3%, The most common mental disorders were major depression (3%) and specific phobia (2.7%).
- 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).

COMMON MENTAL DISORDERS IN THE COMMUNITY





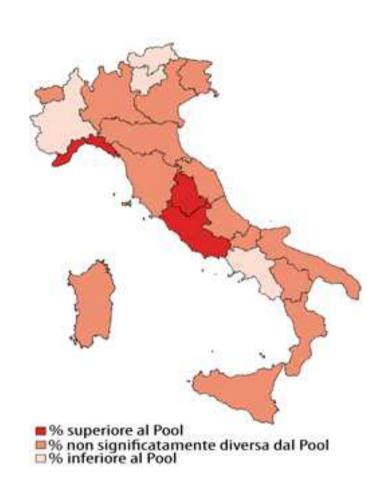
DEPRESSIVE SYMPTOMS IN ITALY (*PASSI*, 2010)

- PASSI (2007): national survey promoted by MoH
- about 20.000 phone interviews
- Depressive symptoms 6.4%
 (men: 4%; women: 9%)

To whom do people with depression call for help?

People with depression call for help from:

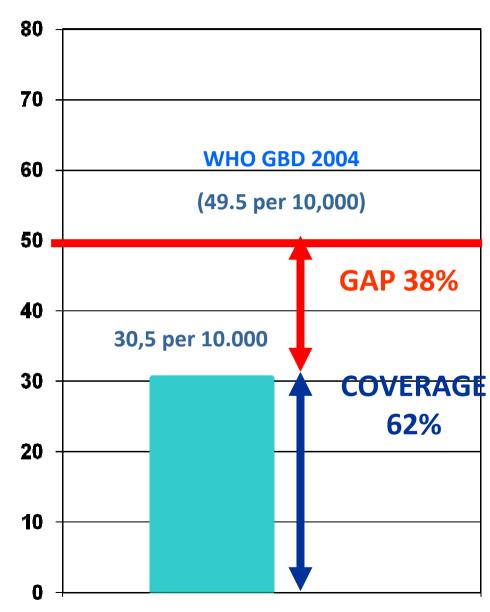
- doctors (34%)
- family members (19%)
- both (7%)



TREATMENT GAP IN SCHIZOPHRENIC DISORDERS

the treatment gap as
the absolute difference
between the true
prevalence of a
disorder and the
treated proportion of
individuals affected by
the disorder.

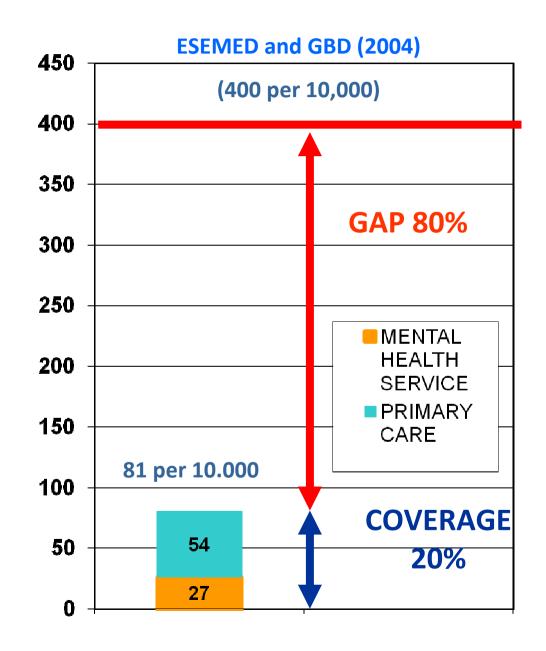
Public Departments of Mental Health in 5 Regions (2009)



TREATMENT GAP IN AFFECTIVE DISORDERS

Both unipolar (3.5%) and bipolar affective disorders (0.5%)

Data on service utilization for primary care from *ESEMeD* (54 per 10.000) and for mental health services (27 per 10.000) from *5 Regions*



DEPARTMENTS OF MENTAL HEALTH (DMH)

- Health responsible of the planning and management of all medical and social resources related to prevention, treatment, and rehabilitation in mental health
- defined catchment area (about 240.000 residents)
- 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.

COMMUNITY MENTAL
HEALTH
CENTER
(CHMC)

DAY CENTER (DC)

PSYCHIATRIC WARD IN GENERAL HOSPITAL (PWGH) COMMUNITY
RESIDENTIAL
FACILITY
(RF)

Concerning the availability of the whole
network of mental health facilities, about
eight DMHs out of ten included
Residential Facilities or Day Care Facilities
, almost all had Psychiatric Wards in
General Hospitals and all had Community
Mental Health Centers

TREATED PREVALENCE AND NEW CASES: DIAGNOSTIC BEAKDOWN IN 3 REGIONS

TREATED PREVALENCE

NEW CASES

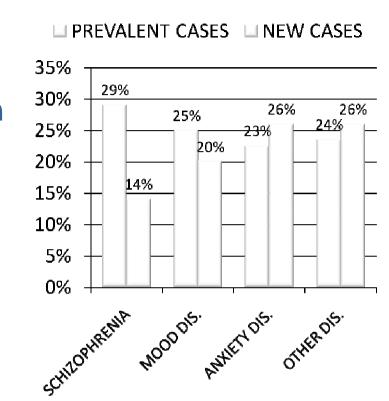
	FRIULI V.G. (2007)	EMILIA – ROMAGNA (2007)	LOMBARDIA (2005)		FRIULI V.G. (2007)	EMILIA – ROMAGNA (2007)	LOMBARDIA (2005)
SCHIZOPHRENIC DISORDERS	30,9%	24,9%	30,7%	SCHIZOPHRENIC DISORDERS	12,1%	8,8%	9,9%
MOOD DISORDERS	25,5%	17,2%	20,7%	MOOD DISORDERS	25,8%	13,4%	27,0%
NEUROTIC DISORDERS	19,2%	33,8%	20,6%	NEUROTIC DISORDERS	28,5%	54,8%	37,5%
ORGANIC MENTAL DISORDERS	7,3%	3,7%	3,5%	ORGANIC MENTAL DISORDERS	13,8%	6,9%	5,0%
PERSONALITY DISORDERS	6,5%	11,8%	11,6%	PERSONALITY DISORDERS	3,7%	9,0%	7,3%
DISORDERS DUE TO SUBSTANCE ABUSE	2,9%	2,1%	2,6%	DISORDERS DUE TO SUBSTANCE ABUSE	3,7%	3,5%	1,0%
OTHERS	7,8%	6,4%	7,9%	OTHERS	12,4%	3,5%	10,4%

COMMUNITY MENTAL HEALTH CENTERS

(CMHC)

- CMHCs are the core of the community-based system: 95% of DMH patients are in contact with CMCHs.
- CMHCs cover all activities
 pertaining to adult psychiatry in
 outpatient settings, and
 coordinate activities delivered
 by day care and residential
 facilities.
- About 700 CHMCs: 1 facility per 80 460 inhabitants.
- The rate of professionals working in CMHCs was quite homogeneous in Italy,
- 1/4 of all interventios outside the

DIAGNOSES



for patients with severe mental disorders (in Lombardia about two thirds of the patients with schizophrenic disorders were treated solely by CMHCs)

DELIVERED ACTIVITIES IN CMHCs

ACTIVITIES PROVIDED BY CMHCs (percentages)

ACTIVITIES	TOTAL
CLINICAL PSYCHIATRISTS' ACTIVITY	29%
PSYCHO THERAPEUTIC ACTIVITY	8%
NURSES' ACTIVITIES	31%
ACTIVITY ADDRESSED TO FAMILIES	4%
CARE COORDINATION ACTIVITY	6%
REHABILITATIVE AND SOCIALIZING ACTIVITY	9%
SOCIAL SUPPORT ACTIVITY	4%

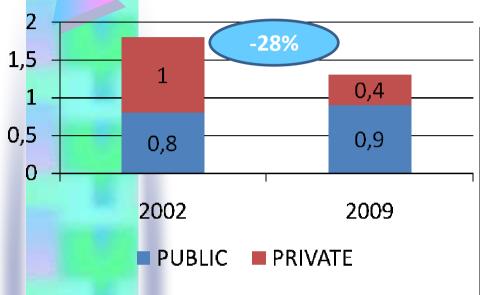
PATIENTS TREATED AND INTERVENTIONS PROVIDED YEARLY BY CMHCs PER REGION (rates per 10.000 > 14 years old)

	PATIENTS	INTERVENTIONS
FRIULI V.G. (2007)	159	3,848
EMILIA- ROMAGNA (2007)	179	4,339
LOMBARDY (2005)	133	1,731
LAZIO (2005)	138	1,709

One year outpatient rate in CMHCs of 4 Regions was 148 per 10 000 > 14 years old, while intervention rates was 2402 per 10 000.

ACUTE BEDS IN ITALY IN 2002 AND 2009 BY PROVIDER (rate per 10.000 > 17 years old)

ACUTE PSYCHIATRIC BEDS





ACUTE BEDS (OECD 2008)

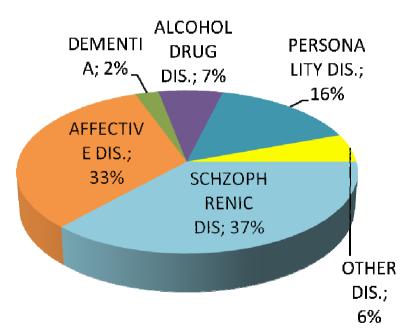
	PUBLIC BEDS	PRIVATE BEDs	TOTA L
NOK I HEN	1,2	0,8	1,6
CENTRAL ITALY	0,8	0,3	1,0
SOUTHERN ITALY	0,9	0,3	1,0

3,0 2,5 2,0 1,5 1,0 0,5	ITAL	Y											
0,0	Mexico	United	Spain - Israel -	Denmark _	Poland _	United	Austria _	Greece _	Korea _	France _	Norway _	Switzerland _	Belgium

ACUTE PSYCHIATRIC BEDS

- In 2008 admission in acute psychiatric beds were 26.3 admissions per 10.000 > 17 yr
- The percentage of the compulsory admissions on the total (private + public sector) was 4.6% in 2008
- Multiple admissions for the same patients were 30.4%
- The lenght of stay in PWGHs was 11.2, in other public wards 12.3, while in private facilities was 30.6

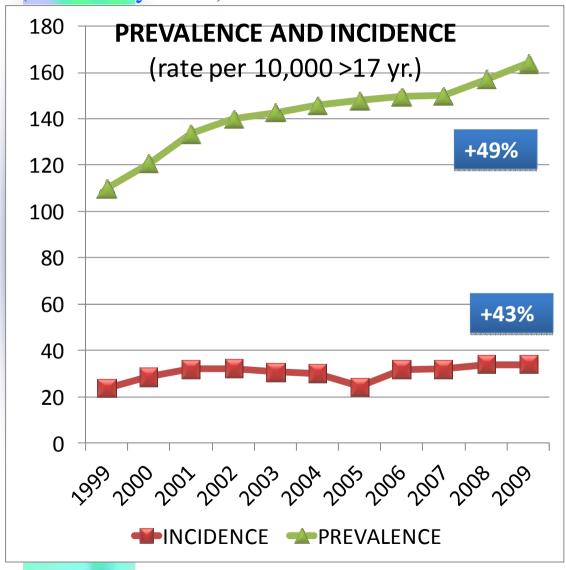
ADMISSIONS BY DIAGNOSIS (MoH 2008)



QUALITY OF CARE FOR SEVERE MENTAL ILLNESS (ACCESSIBILITY, CONTINUITY OF CARE AND APPROPRIATENESS)

ACCESSIBILITY: TREATED PREVALENCE AND INCIDENCE

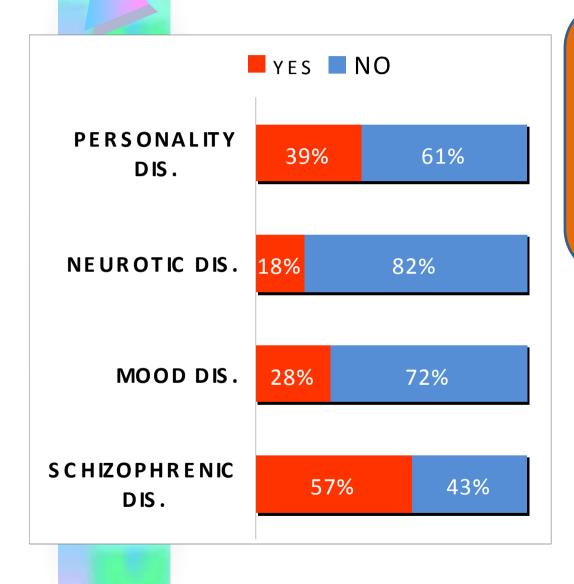
(Lombardy 2009)



- In Lombardy from 1999 to 2009 the prevalence rate in DMHs increased of 49%, while the incidence rate of 43%
- The users are prevalently female over 45 years old
- Frequently users are married and are working and as far as new cases have high level of education

CONTINUITY OF CARE

(Lombardy 2008)



CONTINUITY OF CARE:

At least one contact every 90 days in the 365 days after the first contact in the year

 Continuity of care is assured to severe mental illness (schizophrenic and personality disorders)

ADEQUACY OF CARE – 1

(Lombardy 2007)

MINIMALLY ADEQUATE TREATMENT

(Wang et al. 2007)

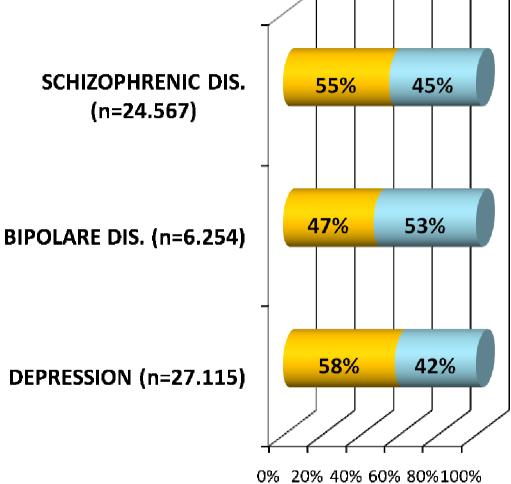
.. At least two months of treatment with specific psychotropic drugs

+

4 visits with psychiatrist OR

8 psychotherapeutic sessions

(only for depression)



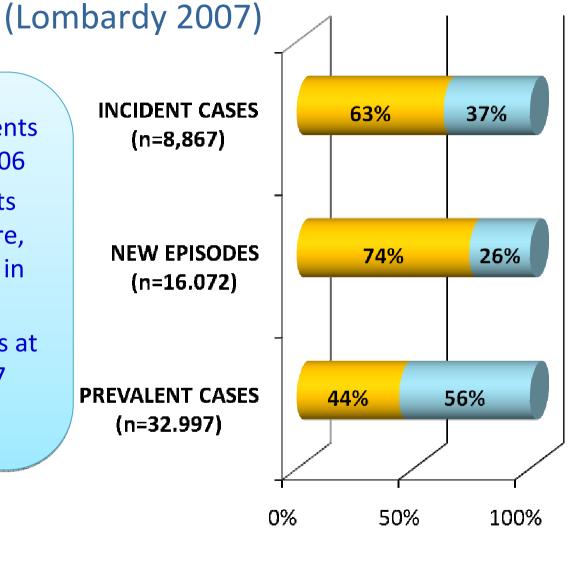
■ INADEQUATE ■ ADEQUATE

ADEQUACY OF CARE-2

PREVALENT CASES: patients already treated in 2006

NEW EPISODES: patients already treated before, but without contacts in 2006

INCIDENT CASES: patients at first contact in 2007



■ INADEQUATE ■ ADEQUATE

AN AGENDA TO IMPROVE THE MENTAL HEALTH SYSTEM

MONITORING MENTAL HEALTH SERVICES

- At regional level in 7 Regions regional MH information systems are actually working
- MoH is now implementing national MH information system:
 - The model is psychiatric case register,
 - collecting data from all the facilities of DMH and
 - focused on the patient







- The treatment of common mental disorders in primary care is needed to bridge the treatment gap in common mental disorder.
- Prevention and promotion activities addressed to the general population are not common
- The early treatment of psychosis in young people is frequently implemented in DMHs
- Departments of Mental Health treat prevantely SMI, but now an increasing number of patients with common mental disorders is entering in the MH system.
- The dilemma is to ensure both accessibility for common mental disorders and continuity/ appropriateness of care for SMI

CONCLUSIONS:THE ITALIAN FRAMEWORK, CRITICAL POINTS AND WHAT WE HAVE TO DO

- Shortage of hospital beds dedicated for adolescent M.H. disorders.
- ➤ Better integration between CAMH and AMH services through innovative integrated operative models and shared individual therapeutic plans to bridge the gap and assure continuity of care
- Shortage of semiresidential(much more) and residential (in south Regions)facilities for CAMH.
- Lack of data set and information system for CAMH
- > Avoiding or limiting the institutionalization.
- Identification of a set of indicators to measure the quality and appropriateness of interventions for CAMH.

Thank you for your attention

