Country Profile Italy

Community-based Mental Healthcare Networks: Key Facts and National Priorities

Author(s):	Lead author: Antonio Lora Co-authors: Angelo Barbato, Antonella Costantino, Barbara D'Avanzo and Teresa di Fiandra
Version:	1.0
Date:	28.08.2023

Contents

This report arises from the Joint Action on Implementation of Best Practices in the area of Mental Health, which has received funding from the European Union through the European Health and Digital Executive Agency (HaDEA) of the European Commission, in the framework of the Health Programme 2014-2020, GRANT NUMBER 101035969 — JA-02-2020. The content of this report represents the views of the author only and is his/her sole responsibility; it cannot be considered to reflect the views of the European Commission and/or the HaDEA or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information it contains.

Introduction

The EU-Co-funded "Joint Action on Implementation of Best Practices in the area of Mental Health", short **JA ImpleMENTAL** has a duration of 3 years, lasting from October 2021 to September 2024. Detailed information can be found at the project's website JA ImpleMENTAL (ja-implemental.eu). It aims to promote and improve mental health structures, services, capacity and outcomes in participating countries in 2 specific areas:

- mental health reform (promoting community health services) and
- suicide prevention.

Two national best practices - mental health reform in Belgium and the Austrian suicide prevention programme SUPRA - serve as best practice examples. Selected components of these should be prioritised and implemented over the course of the JA in 14 i.e. 17 participating EU-countries. JA ImpleMENTAL comprises six Work Packages (WPs), four horizontal WPS and one for each best practice. WP5 on community-based mental healthcare aims to implement elements from Belgian Mental Health Reform, which is based on the principle of deinstitutionalization, i.e., the transition from care primarily provided in institutions to community-based care in order to improve mental health outcomes and quality of life and avoid unnecessary hospitalizations. In addition, the reform is based on the principles of rehabilitation and inclusion, decategorization, i.e., multisectoral cooperation, strengthening care in hospitals to make stays shorter, but with more intensive treatment, and the principle of consolidation, providing funds for pilot projects.

The present country profile is one of the major deliverables of the JA, presenting key facts of the national and local mental health system. It summarizes results of the recent situation analysis and needs assessment (SANA), lists lessons learned, recommendations, challenges and opportunities as well as outlining next steps necessary to scale-up, promote national/regional community-based mental health care services. The country profile forms a basis for strategy formulation, decision-making and commitment.

This country profile is based on a situation analysis conducted in two parts and subsequent needs assessment. We considered last data available, usually referred to year 2021. For the situation analysis, two questionnaires have been developed by WP5, one for the analysis of the situation regarding the overall health system and community-based mental health care at national level, and another one for the analysis at implementational level. Following the data collection, a SWOT analysis was conducted by the countries to assess the needs in terms of community-based mental health care.

1 Situation Analysis (SA)

1.1 Country, Health and Social System at national level

Italy is a parliamentary republic comprising 21 regions, each with substantial regional autonomy in many sectors, including healthcare.

Table 1: Population structure in the year 2021, expressed as number of persons, by age and sex

	Sex		
Age group	Male	Female	**Total**
<18	4,813,462	4,537,651	9,351,113
18 - 64	17,959,630	17,983,939	35,943,569
65+	6,093,134	7,848,397	13,941,531
Total	**28,866,226**	**30,369,987**	**59,236,213**

Healthy life expectancy at birth is 68.0 (1). A total of 24.9% of the population is at risk of poverty and social exclusion (2). Income inequality, expressed as the Gini coefficient, is 32.5 (3), and the total healthcare expenditure relative to the GDP is 8.7% (4). The proportion of numbers of YLD due to mental and substance abuse disorders to number of YLD due to all causes is 14.5% (5).

In Italy mental health care, as other health services, is provided by the tax-funded public National Health Service. All citizens are enrolled in the National Health Service and choose a General Practitioner or, according to age, a Primary Care Paediatrician, who oversees primary care and acts as a gatekeeper to specialist services. Private services are also available, some of them are reimbursed by the National Health Service, others are paid through private insurances or out-of-pocket. In 2019, before the pandemic crisis, health expenditure was 8,7% of the GDP, 6,4% was public, 2% out-of-pocket and 0,2% paid through private insurances (6). Access to mental health care through the National Health Service is free at point of entry, except for co-payments for some outpatient care interventions. Regions are responsible for planning, organizing, delivering, and monitoring health services, within the framework of national laws. A core benefit package of health services is guaranteed across the country and national funds are allocated to the regions to provide the full range of healthcare interventions. Although some regional systems have introduced innovative models of care, regional disparities in Italian health services remain a matter of concern. Social services are delivered by municipalities and are separated from the health services.

The COVID-19 pandemic severely affected Italy in 2020, dramatically increasing mortality. In response to this emergency, the health system was compelled to move resources from community to hospitals and from routine outpatient and community health activities to urgent hospital care for patients with severe COVID-19. In this way the waiting times for several health and mental health treatments were lengthened during pandemic and in some way the situation is still critical.

1.2 Mental Health System at national level

With the issue of a major psychiatric reform in 1978 (Law 180), Italy opened the way to a new model of psychiatric assistance that shifted care from institutionalization to community-based services, radically changing mental health care systems in the country and making it one of the pioneers in deinstitutionalised mental health care. Over a 20-year period, Italy progressively closed psychiatric hospitals and shifted towards a community-based model of mental health care. The last form of mental health institutions in Italy were forensic psychiatric hospitals, that have been progressively closed between 2015 and 2017, given the inadequacy of these services.

Most adult citizens with severe mental disorders are treated by the National Health Service specialist facilities. People with common mental disorders are often treated by general practitioners or by office-based private specialists. Over the last years, two aspects have been emerging as a matter of concern: the growth of differences among regions in terms of resource allocations and quality of service delivery, as well as the shrinking of funding for mental care, which is now 3.6% of public health expenditures.

As far as Child and Adolescent Mental Health Services (CAMHS) are concerned, Italy is one of the very few nations in which the medical specialty of Child and Adolescent Neuropsychiatry exists, and CAMHS are not only specific and separate from services for adults, but deal altogether with neurologic, psychiatric, cognitive and developmental disorders from 0 to 17+. Italy has a long-lasting CAMHS system, community based, integrated with hospital care and with social and education systems. Nonetheless, regional missions may differ widely from national and the reality of service organization throughout the country is highly not homogeneous and fragmented, both in resources and practices. CAMHS organization has been strongly influenced by the general principle that all people, and particularly children, regardless of disability, severity or any other problem, have the right to be integrated in mainstream school (more than 99.9% of all children in the state sector are in ordinary schools) and in the community, and to be supported in community-based facilities, avoiding as much as possible any kind of institutionalisation.

Mental health legislation is regulated by the General Law n. 833 and the MH Law n. 180, the 1978 reform laws that blocked the new admissions to mental hospitals with immediate effect, the readmissions few years later and finally closed all mental hospitals by year 2000. Moreover, Law 180 promoted voluntary treatments for mental health as a basic principle to access care, and introduced more restrictive criteria and procedures for compulsory admissions. The national mental health plans, approved in 1994 and 1999, stated the organization of the Department of Mental Health (DMH,) while in recent years (2013) another mental health plan (PANS - *Piano di azioni nazionale per la salute mentale)* coordinated the mental health activities among Regions, establishing common goals for mental health planning.

Mental health care for the adult sector is therefore provided by Departments of Mental Health (DMH), organized into a network of community services for defined catchment areas. Such services include Community Mental Health Centres (CMHC) providing outpatient and home care, General Hospital Psychiatric Wards (GHPW) for short-term admissions, Day care Centres (DC), Community Residential Facilities (CRF) and supported housing programs. Whereas outpatient, inpatient and day care is usually directly provided by public services, residential care in community residential facilities is often provided by private non-profit organizations funded by the National Health Service. Admission to residential care, however, is possible by referral of DMH only. Through the national MH policies in 1994 and 1998 and the national plan in 2013 the aim of deinstitutionalization has been achieved, and a community-based model of MH care, based on nationwide development of DMHs, has been implemented, even if the regions are not homogeneous in terms of resources invested and practices performed. Prevention and promotion of mental health is a duty of DHM as well.

On the whole, the supporting principles of community-based health care by Italian MH policies were deinstitutionalisation, development of community mental health services, user-centredness, participation of users and/or families in decision-making, intersectorality and cross-sector collaboration, multidisciplinarity and integrated care.

Child and adolescent mental health plans have been part of national mental health plans and of national paediatric plans until recently. In 2019, a specific National Plan for child and adolescent neuropsychiatric disorders has been approved for the first time (*Linee di indirizzo sui disturbi neuropsichiatrici e neuropsichici dell'infanzia e adolescenza)*. The procedures for transition of young patients from child-adolescent mental health services to adult mental health services are addressed at national level in the CAMH 2019 plan, and only eight out of 21 regions have provided clear local indications. it is also true that in most cases not all services have yet fully activated the corresponding procedures.

The care and treatment of persons with mental health conditions is fully included in the national health insurance system both for inpatient and outpatient care and the the majority of persons with mental disorders do not pay for mental health services. However, because of the insufficient accessibility to some psychological treatments, like psychotherapies, the patients frequently have to pay these treatments in the private sector. The total government expenditure on mental health is 3.6% (7) of the total health budget, not including the expenditure of the social sector. The share of people reporting unmet MH care needs due to financial reasons is 3.6% (8), while the main forms of government social support for persons with severe mental health conditions are available in the area of income, employment, education and social care.

Table 2: Facilities, number of beds and hospital admissions related to mental health in Italy in 2021 (9)

Indicator at national level		Number	Rate per 100.000 adult (*)/minor (**) population
Mental health hospitals	Facilities	0	0
	Beds	0	0
	Admissions	0	0
Psychiatric wards/units of general hospitals	Wards/units	347	0.7
	Beds	5,099	10.2
	Admissions	94,020	188.5
Mental health community residential facilities	Facilities	1,986	3.4
	Beds	26,180	52.5
	Admissions	10,669	21.4
Mental health inpatient facilities specifically for children and adolescents (***)	Facilities	36	0.4
	Beds	394	4.2
	Admissions	14,631	156.5
Mental health community residential facilities specifically for children and adolescents (***)	Facilities	80	0.9
	Beds	1,000	10.7
	Admissions	3,000	32.1

(*) For adult mental health services, the population for the rates is >17 years old (see table 1)
(**) For child and adolescent mental health services the population for the rates is <18 years old (see table 1)
(***) covering all Neuropsychiatric disorders

With regard to the continuity of care between inpatient and outpatient facilities, about 51%-75% of patients discharged from general hospital admission received a follow-up visit in Community Mental Health Centres within one month. The proportion of involuntary admissions out of total admissions is

5.9% in Psychiatric Wards in General Hospitals, while in Community Residential Facilities involuntary admissions are not allowed.

Table 3: Outpatient facilities and activities (9)

	Adult MH facilities		Child-adolescent MH facilities	
	Total number	***Ratio per 100.000 population(*)***	***Total number***	***Ratio per 100.000 population (**)***
Facilities	1,245	2.5	500	5.35
Visits	9,293,952	18.63	N/A	N/A

(*) For adult mental health services the population for the rates is >17 years old (see table 1)
(**) For child and adolescent mental health services the population for the rates is <18 years old (see table 1)

As for transition from CAMHS to adult services is concerned, there are different local approaches. In some contexts, procedures for transition have been developed, while only in few others specific teams managing the transition have been implemented. The transition age period is considered 16-20 years.

Regarding the MH care integration in primary health care, GPs in the MH system often treat common mental disorders and are the first source of referrals to mental health services. They prevalently provide psychopharmacological treatments, and not psychosocial ones.

Table 4: Mental health workforce in Adult Mental Health Services in 2021 (9)

	Adult MH service: number and rate (*)	
	Total number	**Rate**
Psychiatrists	4,286	8.6
Child psychiatrists	NA	NA
Mental health nurses	15,488	31.0
Psychologists	2,740	5.5
Social workers	1,568	3.1
Speech therapists	NA	NA
Occupational therapists	NA	NA
Others	14,452	29.0
Total	38,534	77.2

(*) data are Not Available for CAMHS

The shortage of workforce in AMHS and CAMHS is a matter of particular concern in the last years, the cuts in funding and choices in academic planning, particularly for doctors and nurses, are causing severe gaps in care delivery.

As far as the National Mental Health Information System (MHIS) is concerned, a specific MHIS exists for AMHS from 2015, while for CAMHS it will be active from 2023-2024 and it will deal with all child

and adolescent neuropsychiatric disorders and not only related to psychiatric disorders. A minimum set of mental health data/indicators has been defined at governmental level for adult MHS together with data that should be collected electronically in all the facilities and in all the Italian regions. A dissemination report focusing on mental health activities in both the public and private adult sector has been published yearly by the Ministry of Health in the last five years.

1.3 Health and social structure in Lombardy Region

Lombardy is the largest Region in Italy with a population of 10 million people. It is in the northern part of the country and includes the metropolitan area of Milan, the second largest Italian city.

Table 5: Population structure in Lombardy expressed as number of persons, by age and sex in 2021 (10)

	Sex		
Age group	Male	Female	Total
<18	830,670	782,236	1,612,906
18-64	3,075,446	3,006,736	6,082,182
>64	989,330	1,297,136	2,286,466
Total	4,895,446	5,086,108	9,981,554

The life expectancy is 85.4 years on average for women and 80.9 years for men in 2021 (10). Life expectancy is one of the highest in Italy, particularly for women.

Lombardy is an affluent area with limited unemployment rate ((5.6%), (11)), lower than the national one and one of the lowest in Italy, and a relatively even distribution of resources with a GINI coefficient of 0.28 (being the GINI coefficient between 0.24 and 0.36 in most Western countries, and values near 1 indicating a stronger concentration of resources) (11). 15.7% of the population have a high school achievement compared to 14.5% at national level. The rate of internal and external immigration is high with issues related to inclusion of immigrants from poor countries and refugees, and particularly unaccompanied foreign minors, for whom Lombardy is the second region after Sicily (11).

The target population of the pilot implementation are adolescents (12-18 years old) and young adults (18-29 years old). Table 6 shows the population in these groups of population.

Table 6: target population structure in of Lombardy expressed as number of persons, by age and sex (11)

	Sex		
Age group	Male	Female	**Total**
12-17 years old	300,451	281,727	582,178
18-29 years old	614,580	568,280	1,182,860

1.4 Community-based mental health care in Lombardy

Since the 1978 psychiatric reform, the Lombardy Region has implemented a large and well-structured network of community mental health services that today serves roughly 130,000 adult patients and 130,000 children and adolescents. Regional policies have been updated periodically through various Special Projects, Mental Health Regional Plans, Regional Directives for Adult and Child-Adolescent Mental Health Services. Key developments have been promoted and implemented to different extent

in the different DMH of Lombardy. According to the last regional plan *Piano Socio-Sanitario Lombardo 2019-2023* (PSSL), key areas for AMHS to be upscaled were:

- a stronger connection between general hospital and community services in order to improve continuity of care;
- reduction at onset of the periods of non-treated illness, with a corresponding shift of resources from chronic conditions to early identification of mental problems in the young and delivery of the appropriate support;
- shift of resources from the residential area (about 70% of the whole mental health expenditure for less than 5% of the users), adopting more flexible solutions either in the housing field, and with a meaningful increase of supported housing,
- integration of resources at patient level from mental health and social agencies defined in agreement with the patient's preferences and needs, in order to have stronger and more flexible strategies to support even people with severe mental illnesses in a condition as autonomous as possible;
- promotion of and support to peer support and users' network;
- given the increased incidence of borderline personality disorders, developing of specific skills through qualified training about evidence-based interventions.

In more general terms, the PSSL covers principles of user-centredness, recovery orientation, users' participation and service integration.

For CAMHS also key points are early detection and intervention, collaborative and neurodevelopmental sensible care. Nonetheless, in CAMHS the situation is very different from adult MHS, with very little availability of inpatient, day care and residential care for the patients in need, and 90% of care in outpatient facilities, unable to guarantee appropriate care intensity.

National strategies apply to the regional level in any case and, as already said, a National Plan for child and adolescent neuropsychiatric disorders has been approved in 2019 and ratified by Lombardy. Moreover, the PSSL 2019-2023 also specifies strategies for child and adolescent mental health and the documents on economic and programmatory rules (DEP) indicated high priority and resources implementations for CAMHS on four pillars, i.e. community care residential care and day care integrated with outreach care, inpatient care and low threshold care. Differently from the national level, in Lombardy there is a 2013 Regional document of recomendations for functional integration between AMHS and CAMHS and for transition age. Its application varies in the different MHDs, with some very interesting experiences is some DMHs and many critical situations in others. Moreover, the 2021 Regional Plan for Autism has indicated a very interesting pathway to transition, that focuses not only on single patient clinical transition but also on the anticipatory identification of new emerging needs for the transitioning population, and their intersectorial adressing.

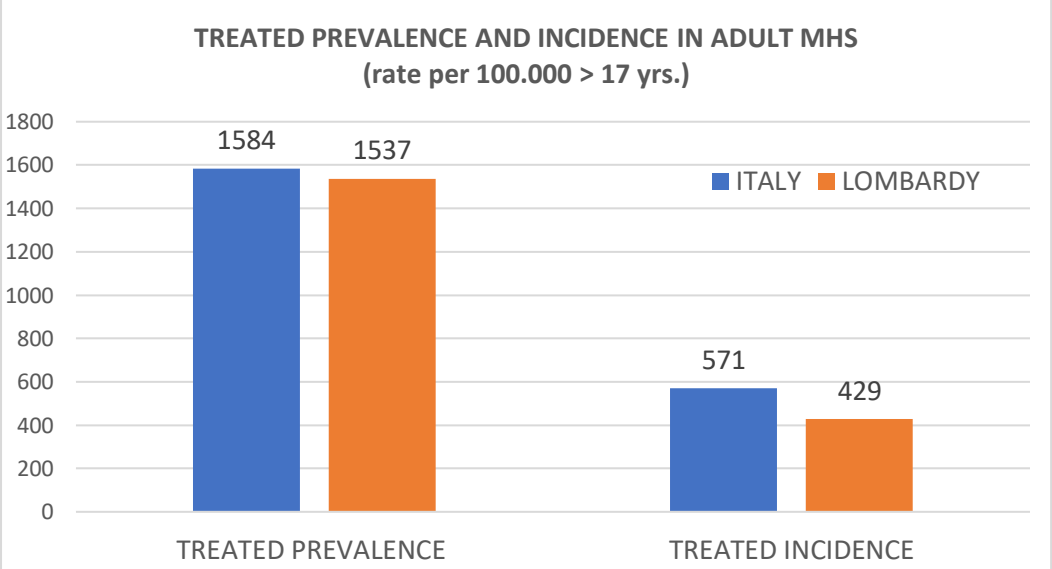
Adult MHS are substantially organized according to the DMH model, as in all other Italian Regions: a network of MH facilities in the catchment area, including CHMHCs, GHPW, DCs and CRFs are under the responsability of a Director. Outreach model does not exist as a service and it is a function of the community mental health services, used for specific populations and according to a need based approach. AMHS and CAMHS provide psychosocial interventions and social inclusion activities often through third sector organizations, which are paid accordingly. Social services outside the MH and CAMHS offer social inclusion opportunities as job placement, housing, recreational activities, and

financial support. Concerning the cross-sectoral collaboration, in Lombardy there is a long tradition of intergration of AMHS with social enterprises, NGOs focussed on mental health and families' associations. There are many third sector) organizations which provide information, orientation, psychological, social, and financial support independently from the public services and that can be accessed freely. These organizations can use trained and non-trained health workers, specialists who work for free, family members of people with mental disabilities.

Regarding mental health services, in the last years the main problems concern on the one hand the shortage of mental health staff in both child/adolescent and adult mental health services and on the other hand the cost of the community residential facilities that in the adult sector absorbs about two thirds of the regional mental health budget, and the paucity of daycare, inpatient and residential care for children and adolescents.

The COVID-19 pandemic hit Lombardy in a particularly severe way, making the care delivery in mental health services in 2020 very difficult. Only in 2021/22 the situation has slowly recovered.

Figure 1: Treated prevalence and incidence in the adult MHS in Italy and Lombardy (9)



In 2021 the rate of patients treated yearly in the AMHS in Lombardy is like that in Italy, while the rate of new cases in AMHS is slightly higher in Italy than in Lombardy (Fig.1) (9).

Table 7: Facilities, number of beds and hospital admissions related to mental health in Lombardy in 2021 (9)

Indicator at pilot area level		Number	Rate per 100.000 adult (*)/minor (**) population
Mental health hospitals	Facilities	0	0
	Beds	0	0
	Admissions	0	0
Psychiatric wards/units of general hospitals for adults	Wards/units	61	0.73
	Beds	809	9.7
	Admissions	14,796	177.2
Mental health community residential facilities for adults	Facilities	270	3.2
	Beds	4,147	51
	Admissions	2,281	27.3
Mental health inpatient facilities specifically for children and adolescents (***)	Facilities	7	0.4
	Beds	120	7.4
	Admissions	2,117	131.3
Mental health community residential facilities specifically for children and adolescents (***)	Facilities	27	1.7
	Beds	344	21.3
	Admissions	624	38.7

(*) rate per 100.000 per > 17 years old population
(**) rate per 100.000 per <18 years old population
(***) covering all Neuropsychiatric Disorders

Regarding inpatient care the rate of adult beds in Lombardy doesn't differ from that in Italy, while the rate of admissions in GHPW in Italy is higher than in Lombardy. As for the rate of beds in community residential facilities, it is the same of Italy while the rate of admissions is sligthly higher. The proportion of involuntary admissions in Psychiatric Wards in General Hospitals on the number of total admissions is 4.5% and it is relatively low compared to other Italian regions. In Community Residential Facilities involuntary admissions are not allowed. Concerning the follow-up of people with mental health conditions discharged from general hospital, 57% of discharged patients received a follow-up visit in Community Mental Health Centres within one month (9).

For CAMHS, the inpatient and residential beds rate, thou very critical, is higher than in the rest of Italy.

Table 8: Outpatient facilities and activities (9).

		Adult MH facilities		Child-adolescent MH facilities	
		Total number	***Ratio per 100.000 population (*)***	***Total number***	***Ratio per 100.000 population (**)***
	Facilities	287	0.3	182	1.1
	Visits	2,582,531	30,859	1.,140,000	70,679

(*) rate per 100.000 per > 17 years old population
(**)rate per 100.000 per <18 years old population

Regarding outpatient care, the rate of outpatient activities in Lombardy in MH services for adults is higher than in the rest of Italy.

Regarding the issue of transition from child/adolescent to adult mental health services the situation is mixed: in many services there are common procedures for a smooth transition and specific teams inside outpatient facilities are dedicated to the care of young patients in transition age at the onset, while it is rare to find specific outpatient facilities dedicated to care for young patients in transition age at the onset. The situation is very variable according to Local Health Unit organization, but it is nevertheless much better that in other regions.

Table 9: Total number of MH workers in your pilot area (9).

	In MH services (all)		In child & adolescent MH services	
	Total number	**Rate (*)**	**Total number**	**Rate (**)**
Psychiatrists	811	8.1		
Child and adolescent psychiatrists	350	3.5	350	21.7
Mental health nurses	2,296	23.0	118	7.3
Psychologists	621	6.2	317	19.7
Social workers	230	2.3	33	2.0
Speech therapists	400	4.0	400	24.8
Occupational therapists	654	6.6	100	6.2
Others	1,707	17.1	600	37.2
Total	7,069	70.8	1,918	118.9

(*) rate per 100.000 per total population
(**)rate per 100.000 per <18 years old population

Common mental disorders in adults are very often treated in Primary care. Concering borderline personality disorders, as well as other severe mental health conditions, General Practicioners refer to specialist care. For CAMHS, the relationship with Community pediatricians is very good and there is ongoing work for mental health promotion and early identification of all neurodevelopmental disorders, including psychiatric disorders. The regional guidelines are the same as the national ones. General Preactitioners act as gatekeepers to access to mental health services, while Community pediatricians work in tight integration with CAMHS. General Practitioners can prescribe any psychotropic drug with some exceptions related to specific drugs in which the prescription is only up to specialist centers, such as stimulants for ADHD and clozapine for treatment resistant schizophrenia. Psychosocial interventions are provided by specialized mental health services and social services, not by the primary care sector.

Regarding the Mental Health Information System, structure, resources, interventions and other activities data, as well as sociodemographic data of the population accessing the services, are specifically collected by Lombardy Region from all adult mental health services payed by the Regional Health System. For CAMHS, a specific database system is still missing and information have to be extracted from the general health database set. All the data are collected at regional level and then transmitted to the Ministry of Health. As far as dissemination is concerned, mental health data (for both public and private sectors) have been collected for general health statistics in the last two years, but they were not published in a specific mental health report.

The best practice to be implemented in Lombardy is aimed at improving the quality of mental health care in adolescent with conduct disorders and in young adult patients with borderline personality

disorder (BPD), both in adult MHS and CAMHS, also by increasing the accessibility to psychosocial care for these patients.

The number of patients aged 18-30 with BPD treated in AMHS in 2021 has been 591. No specific data exist for CAMHS, because a dedicated MHIS does not yet exist and data are currently extracted from a generalist dataset with no possibilities of appropriately extracting diagnosis, but we know that a relevant proportion of access to CAMHS in preadolescence and adolescence is due to complex conduct disorders. The care focussed on psychosocial evidence based treatments which will be implemented has a low level of dissemination in Lombardy: only 10-25% of the patients are receiving this kind of care and a small minority (10 – 25%) of relevant stakeholders have sufficient expertise. The relevant stakeholders will be essentially the mental health professionals working in the Community Mental Health Centres in AMHS and in Ambulatories in CAMHS. The number of MH professionals that could be included in training and after that in implementation in 27 DMHs of the Region is about 260 MH professionals in AMHS and at least 250 professionals from 27 CAMHS.

2 Needs Assessment (NA)

For defining the goal of the improving actions in the pilot site, we used the results of the reasearch project (QUADIM) carried out in four Italian Regions (one of them Lombardy, also coordinator of the project) in 2016-2019, assessing the quality of MH care delivered to severe mentally ill patients (12). This project showed that the quality of mental health care delivered in Lombardy in 2015 to young patients aged 18-24 with personality disorder at onset had to be radically improved. Only 16% of the young patients were assessed in a structured way in the early phases of the treatment, while one third of the patients did not receive any psychosocial intervention and only one third of relatives of these patients received interventions specifically addressed to them. Some of the indicators defined in this project will be used to monitor the success of the implementing action.

The SWOT was completed in March-April 2023 by the country team with representatives of stakeholders of CHMHS/AMHS and families associations. Two different SWOT outlines have been produced, one for CAMHS and one for AMHS.

Table 5: SWOT Analysis for CAMHS

Factor	Contents				
Strengths	1. a well structured network of CAMHS	2. CAMHS sensible to different develomental patterns	3. well developed intergration with educational and social services	4. specialized staff with expertise in the treatment of young patients with conduct disorders	5.investment in training
Weaknesses	1. shortage of CAHMS staff	2.few experiences in structured long-term implementation projects	3.lack of specifity of clinical pathways for these patients	4.insufficient/aspecific training	5.lack of MHIS for CAMHS
Opportunities	1. more attention after COVID-19 to mental health of young people	2.improving collaboration with AMHS	3.JA is an opportunity for learning about implementation	4.awareness of the need to integrate clinical and social aspects	5.collaboration with pediatric department
Threats	1. stigma related to adolescents with behavioural problems and drug use	2. limited intersectorial collaboration between CAMHS and social services	3.limited funding for CAMHS, AMHS and Substance Abuse Services	.	

Table 5A: SWOT Analysis for AMHS

Factor	Contents				
Strengths	1.a well structured network of mental health services	2.some specialized staff with expertise in the treatment of young patients	3.mental health information system able to track implementation activities	4.previous investments in training	5. Staff involved in training/implementation is regularly employed in MHS and not timely recruited for the project
Weaknesses	1. shortage of mental health staff	2.few experiences of MH projects with structured implementation process	3.structured assessment of the clinical and psychosocial needs in patients with BPD not frequent and lack of specifity of clinical pathways for these patients	4.families not always involved	5.organization of AMHS still focussed on psychiatrists
Opportunities	1. more attention after COVID-19 to mental health of young people	2. improving collaboration with CAMHS	3.JA is an opportunity for learning about implementation	4.awareness of the need to integrate clinical and social aspects	5.users & families' associations are interested to be involved
Threats	1. stigma related to young adults with behavioural problems and drug use	2.limited intersectorial collaboration between AMH and social services	3.limited funding for mental health services		

3 Reflection on SANA results

Some facilitating factors in Lombardy can support the implementation of this project:

- the network of AMHS and CAMHS is well developed and there is a deep interest in early treating adolescents with conduct disorder and young adults with borderline personality disorder.
- in the adult sector, MHIS is a useful tool to track the implementation of the project.
- professionals are well aware of the need to improve the collaboration between AMHS and CAMHS, sharing evidence-based interventions and activating a smooth transition from CAMHS to AMHS for these patients.
- the major adult's family's associations in Lombardy are willing to cooperate in this project.
- All staff involved in the training and implementation is regularly employed by the services and not timely recruited for this specific project. In this way the continuity and sustainability of care delivery after the conclusion of the JA is better assured.

However some barriers have to be considered as potentially affecting the implementation:

- In all the AMHS and CAMHS the shortage of personnel makes it more difficult to coordinate and deliver psychosocial care.
- For better delivering these interventions, AMH services should move from a model of care centred on psychiatrists to another one giving greater autonomy to the different MH professionals
- Despite the interest of MH professionals to treat patients affected by conduct disorders and BPD, there is still a certain level of stigma related to patients with these disorders who also present behavioural problems and drug use.
- The expertise on the evidence based psychosocial treatments of conduct disorders in adolescents and of BPD in young adults, is not widespread and frequently clinical pathways for these patients lack of specifity.

- There is not a widespread knowledge on how to implement community projects in a structured way even if, related to this issue, the support of the JA ImpleMENTAL might be very useful.
- The level of intersectoral collaboration of MH services with social services of the municipalities is not homogeneous in Lombardy, but this project might improve this integration.
- Finally, the lack of MHIS in CAMHS represents a problem for monitoring the activities performed in the implementation process for this sector.

4 Priorities

Box 1.

POTENTIAL SUCCESS FACTORS

- motivation of MH staff in learning psychosocial treatments based on evidences for caring adolescent patient with conduct disorder and young adult with BPD
- existing network of CAMHS and AMHS services and at least in some MH services staff specialized in the care of adolescents/young adults with severe mental disorders
- structured model of implementation of the best practice
  existing MHIS in the adult sector to monitor the implementation process
- All staff involved in the training and implementation is regularly employed by MH services and not timely recruited for this specific project. In this way the continuity and sustainability of care delivery after the conclusion of the JA is better assured.

PRIORITIZED MEASURES FOR PILOT IMPLEMENTATION IN ADULT MENTAL HEALTH SERVICES

1st STRATEGIC AREA: Ensure (strong) governance structures/mechanisms

- **Sub-strategic area 1.1.: Governance conditions**
- **Sub-strategic area 1.2: Building (consolidating or extending) and sustaining networks based on intersectoral, multidisciplinary and recovery-oriented approach (at pilot site)**
  a) Strategic Network Committee as decision-making body: *Building an implementation team and plan at regional level, representing the different stakeholders (July 2023-September 2023)*
  b) Network coordination function*: Structure the local implementation process and implementation team at local level (Department of Mental Health - DMH) (October 2023-November 2023)*
  c) Set-up intersectoral networks at pilot site: *The implementation team at local level should analyse the existing intersectoral networks and if needed improve and enrich them (October 2023- January 2024)*
  d) Develop/consolidate/extend collaboration of ALL relevant stakeholders across (health and non-health) sectors: *The intersectoral collaboration with social services and other agencies (e.g. job inclusion teams) at local level should be extended and improved for increasing social inclusion of these patients them (October 2023- May 2024)*
  e) Establish/consolidate/extend participation of users/families as equal partners (meso-level) - incl. recruitment, involvement of peer workers: *The implementation team at regional level*

will include representatives of the family associations [user associations are not common in Italy] (September 2023)

2nd STRATEGIC AREA: Development or transformation of MH services and interventions (incl. multidisciplinarity approach)

- **Sub-strategic area 2.1: Developing new (non-existing) OR transforming/adapting existing MH services (incl. reinforcement of multi-disciplinarity and improvement of evidence-base, quality, efficiency and continuity of services) in the areas of (five functions of the Belgian BP):**
  a) Prevention, support for mental health promotion, early interventions, screening, diagnostic: *Improve early intervention activities addressed to young (18-30 years old) patients with borderline personality disorders (BPD), increasing the delivery of evidence based psychosocial care by Community Mental Health Centres (CMHC) (October 2023- September 2024)*
  b) Prevention, support for mental health promotion, early interventions, screening, diagnostic: *Define care pathways for young patients with BPD, with a smooth transition from CAMHS and AMHS (October 2023- February 2024)*
- **Sub-strategic area 2.2: Developing/strengthening a human-rights based and user-centred recovery approach in service delivery**
  a) Participation of users/families in definition of their "recovery pathway" (micro-level): *The involvement of users in the definition of the individual service plan is already required in Lombardy, but this issue will be reinforced according to the implementation project (October 2023- September 2024)*
  b) Nomination of a "care referent" (or" case manager") as individual contact person of the user: *Nomination of care manager is already included in the individual service plans formulated by the CMHC in Lombardy, but this issue will be reinforced according to the implementation project (October 2023- September 2024)*
  c) Definition and use of "Individual Service Plans*: Individual service plans are already used in CMHCs in Lombardy, but they should be reinforced and updated, according to the implementation project (October 2023- September 2024)*

3rd STRATEGIC AREA: Extensive global training programme of stakeholders (in support of the reform & cultural change in service provision)

a) Developing and implementing training & capacity building for ALL relevant stakeholders (incl. training sessions, workshops, conferences, reflection days, seminars, thematic meetings, briefing, on-the-job training, internships abroad and coaching): *Provide training to staff in CMHCs on evidence-based psychosocial interventions to be included in the care of young adult with BPD (June 2023- January 2024)*
b) Developing and implementing training & capacity building for ALL relevant stakeholders (incl. training sessions, workshops, conferences, reflection days, seminars, thematic meetings, briefing, on-the-job training, internships abroad and coaching): *Provide training to the staff in CMHCs on the recovery approach (November 2023-February 2024)*

4th STRATEGIC AREA: Intensive continuous communication, information and awareness raising among/towards stakeholders and users (in support of the reform and a culture of change)

a) Internal communication, information and awareness raising (i.e. among stakeholders/partners): D*issemination at regional level about the project to the relevant stakeholders (October 2023- September 2024)*

b) Internal communication, information and awareness raising (i.e. among stakeholders/partners): *Inform at local level the Director of DMH and CMHC and relevant stakeholders (e.g. social services, local family associations) about the project and its developments (October 2023- September 2024)*
c) External communication, information and awareness raising (i.e. towards users and general public): *dissemination to population about the project at regional level (October 2023- September 2024)*

5th STRATEGIC AREA: Data collection, monitoring & evaluation

a) Monitoring the implementation process at regional level: *The progressive implementation of the best practice will be monitored through Mental Health Information System at regional level (October 2023- September 2024)*
b) Monitoring the implementation process at local level: *The progressive implementation of the best practice will be monitored at local level through feedbacks/information sent by each MHD to the regional level (October 2023- September 2024)*

5 References

(1) KNOEMA https://knoema.com/atlas/Italy/topics/Health/Health-Status/Healthy-life-expectancy
(2) STATISTA https://www.statista.com/statistics/619321/at-risk-of-poverty-rate-italy/
(3) World Bank https://data.worldbank.org/indicator/SI.POV.GINI?locations=IT
(4) Euro Health Observatory https://eurohealthobservatory.who.int/publications/i/italy-health-system-review-2022
(5) Global Burden of Disease https://vizhub.healthdata.org/gbd-compare/
(6) OECD https://www.oecd-ilibrary.org/docserver/5bb1946e-en.pdf?expires=1685798202&id=id&accname=guest&checksum=ADE2B34469EB9C67F2A35BC94525C634
(7) Italian Society of Psychiatric Epidemiology (2022) I Servizi e le Attività per la Salute Mentale nell'anno della Pandemia. Indicatori SIEP, SIEP-Quaderni di Epidemiologia Psichiatrica, n.9/2022
(8) OECD https://www.oecd.org/health/health-systems/Unmet-Needs-for-Health-Care-Brief-2020.pdf)
(9) Italian Ministry of Health https://www.salute.gov.it/imgs/C_17_pubblicazioni_3282_allegato.pdf
(10) ISTAT https://www.istat.it/it/files/2022/04/Report-Indicatori-Demografici_2021.pdf
(11) ISTAT http://dati.istat.it/Index.aspx?DataSetCode=DCCV_GINIREDD&Lang=en
(12) Sanza M. et al. (2023) Assessing the quality of the care offer for people with personality disorders in Italy: the QUADIM project. A multicentre research based on Healthcare utilization databases of Mental Health services. (submitted)

6 Corresponding authors

Antonio Lora (a.lora@asst-lecco.it) & Teresa Di Fiandra (terrydifi@gmail.com)