

# Development of Community Mental Health Services: The Case of Emilia-Romagna Italian Region

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## SUMMARY:

Italian psychiatry has gained International attention after its radical reform of 1978, which established the progressive closure of mental hospitals and the establishment of community services throughout the country. However it is technically inappropriate to talk about Italian psychiatry as the devolution process has transferred to the regions all competences about policy, planning and evaluating health services. This explains the variety of “community psychiatries” that can be found along the peninsula and the reasons of interest that can arise from their comparison.

The development of community psychiatry in Emilia-Romagna, a region of 4 million inhabitants in Northern Italy, has proceeded through two partially overlapping phases of deinstitutionalization (1978-1997) and development of integrated mental health departments (1990-2008). The analysis of raw data about allocation of resources and professional capital development give way to tentative comparisons with the current Portuguese situation of implementation of a similar reform.

In 2006 the regional Council launched a three year project aimed at rethinking the welfare system and the integration of social and health services, considering the dramatic social and demographic changes occurring in the region. This project has implied also a three year process of redrafting mental health policy finalised in the Emilia-Romagna Mental Health Action Plan 2009-2011 approved by the council in

March 2009. It basically follows two strategies: integration of health and social services and further qualification of health services. The former is pursued through a reshaping of the planning and commissioning bodies of both health and social services, previously separated and now merging. They are taking responsibility on many issues related to mental health care, such as prevention, mental health promotion, supported employment, supported housing, subsidies, self-help. The improvement of community services is an objective to be achieved through formal accreditation and quality assurance mechanisms and through a widespread system of participation of users and carers to all levels of planning and monitoring.

**Key-Words:** *Community Psychiatry; Policy; Planning; Mental Health Reform.*

## DESENVOLVIMENTO DE SERVIÇOS DE SAÚDE MENTAL COMUNITÁRIOS: O CASO DA REGIÃO ITALIANA EMILIA-ROMAGNA

### RESUMO:

A psiquiatria italiana ganhou a atenção internacional após a sua reforma radical de 1978, que estabeleceu o progressivo encerramento dos hospitais psiquiátricos e a criação de serviços comunitários em todo o país. No entanto, é tecnicamente inadequado falar na “psiquiatria italiana” porque o processo de desconcentração transferiu para as regiões todas as competências sobre po-

lítica, planeamento e avaliação dos serviços de saúde. Isso explica a variedade de “psiquiatrias comunitárias” que podem ser encontradas ao longo da península e as razões de interesse que podem surgir a partir da comparação entre elas. O desenvolvimento da psiquiatria comunitária na Emilia-Romagna, uma região de 4 milhões de habitantes no norte da Itália, prosseguiu em duas fases parcialmente sobrepostas: desinstitucionalização (1978-1997) e desenvolvimento de serviços integrados de saúde mental (1990-2008). A análise dos dados brutos sobre alocação de recursos e desenvolvimento profissional permitem ensaiar algumas comparações com a actual situação de Portugal na implementação de uma reforma semelhante. Em 2006, o Conselho Regional lançou um projecto para repensar o sistema de bem-estar e a integração dos serviços sociais e de saúde, considerando as dramáticas mudanças sociais e demográficas ocorridas na região. Este projecto implicava também um processo de reformulação da política de saúde mental concluído no “Piano Attuativo Salute Mentale 2009-2001” da Emilia-Romagna aprovado pelo Conselho Regional em Março de 2009. O processo segue basicamente duas estratégias: a integração dos serviços de saúde e sociais e uma maior qualificação dos serviços de saúde. A primeira é alcançada através de uma reformulação dos órgãos de programação dos serviços de saúde e sociais, previamente separados e agora fundidos. Ambos estão a assumir a responsabilidade sobre muitas questões relacionadas com a saúde

mental, tais como prevenção, promoção da saúde mental, emprego apoiado, apoio à habitação, subsídios e auto-ajuda. A melhoria dos serviços da comunidade é um objectivo a ser alcançado através da acreditação formal e controlo da qualidade através de um sistema generalizado de participação dos utentes e prestadores de cuidados a todos os níveis de planeamento e monitorização.

**Palavras-Chave:** Psiquiatria Comunitária; Política; Planeamento; Reforma da Saúde Mental.

## INTRODUCTION

Italian psychiatry is probably more debated than known in the international arena. Law 180 of 1978 introducing a radical community psychiatry system has drawn worldwide attention, giving space to debates and comments ranging from enthusiastic<sup>1</sup> to frankly disparaging<sup>2</sup>. Historical analyses of how the reform movement took momentum, produced a law and how it was enacted can be found elsewhere<sup>3,4,5,6</sup>. Also the literature trying to ensure an empirical evaluation of Italian psychiatry is becoming vast<sup>7</sup> but is far from the scope of this article, in which I shall try to outline the development, the current situation and future direction of mental health services of region Emilia-Romagna, one form of implementation of the reform among the many that can be found across Italy.

## ITALIAN COMMUNITIES AT A GLANCE

Italy is a country of 56,995,744 inhabitants (21<sup>st</sup> October 2001 census) and its economy constitutes the 7<sup>th</sup> largest Gross Domestic Product (GDP) in the world<sup>8</sup>. It has the 5<sup>th</sup> highest life expectancy at birth the world (76.9 years for men and 83.3 for women)<sup>9</sup>. Administratively it is divided into 20 regions and 109 provinces. Due to its historical fragmentation in many sovereign states until unification in 1870, still today striking differences in social and economic processes persist across the nation. Per capita income, economical activities, distribution of wealth, rates of unemployment, development of welfare services are still very different in Northern-Central regions and in the Southern ones. Acknowledging changes in the Constitution approved in 1999 have transferred most administrative powers to regional councils and notably all functions related to planning and managing health services. It is actually inappropriate to talk of Italian psychiatry. Law 180 applied to the whole nation, but very simply forbade new admission to mental hospitals and wrote new rules for involuntary admissions, but gave to regions the task to develop alternative community services, without any significant central role in coordinating and harmonizing such development. This explains the remarkable differences in models and implementation of psychiatric services whose landscape has once been described

as “patchy and confused”<sup>10</sup>. We would rather speak of *Italian psychiatries*.

Emilia-Romagna is a region in Northern Italy, with capital Bologna and with 4.337.966 inhabitants<sup>11</sup>. It is considered to have one of the highest human development indexes in the country. Until the recent economic crisis, Region Emilia-Romagna had the highest per capita income, educational levels and occupational rates in Italy. Its economy is reasonably balanced among industrial agriculture, a network of medium and small scale industries, a large tertiary sector with particular development of educational institutions (four large universities, accounting globally for more than 200.000 students). Emilia-Romagna has been studied sociologically by several anglo-saxon authors as a case of remarkable social cohesion, collective efficacy and promotion of social capital<sup>12</sup>, although this is rapidly changing under the pressure of extremely rapid demographic changes. Generally speaking, Italian society still relies very much on family links. Some comparative studies<sup>13,14</sup> have shown that over 70% of patients with psychosis live with their family, in an accommodation they own and in which they have lived for about twenty years. Patients are usually protected from certain psychosocial stresses (e.g. housing and finances) but quite dependent on significant others, whose involvement in the care process is almost always required. Families are fundamental stakeholders in health administration and their associations

have become very influential on national and regional mental health policies (e.g. becoming providers of mental health services or supporting bills of reform).

Due to the rapid social and demographic changes the Regional Council of Emilia-Romagna has decided to redraft its policy in social and health services, through a participative process that lasted about three years. The result of it has been the approval of the first integrated Health and Social Plan (2008), which has a significant impact in mental health service provision. This will be outlined later in this article.

## HEALTH CARE AND PSYCHIATRIC SERVICES

Italy is running a National Health Service (NHS) since 1978, when a comprehensive public health policy was adopted. NHS absorbs about 6% of the whole GDP, while 2-3% of it is spent in additional private health services. About 5% of NHS resources are allocated to child and adult psychiatry, excluding drug abuse and learning disabilities services. It is generally held that the implementation of a NHS achieved good results in the Northern regions but failed most of its promises in the South, mostly because of pre-existing social and economical backgrounds<sup>12</sup>.

The NHS is organized through 206 Local Health Trusts (*Aziende Unità Sanitarie Locali* – AUSL), eleven of them in Emilia-Romagna, each caring

for a geographically-defined population of 200-800.000 inhabitants. They have full economic accountability and reasonable autonomy in planning, managing and evaluating services. Each AUSL comprises one Mental Health Department (*Dipartimento di Salute Mentale* – DSM) which provides comprehensive psychiatric care for the population and manages on a unitary basis the set of services established as necessary by national policy documents<sup>15</sup>:

1. Community mental health centers (CMHC's),
2. Day-hospital/day-care rehabilitation centers,
3. Psychiatric wards by the general hospital (*Servizio Psichiatrico di Diagnosi e Cura* - SPDC),
4. Non hospital residential medium and long term facilities (NHRF).

One point of interest for foreigners in studying the Italian systems may be the fact that community psychiatry has been the national policy for more than thirty years, not just one possible policy competing with others, such as hospital psychiatry. Furthermore this policy has received several different implementations across the country, so one could actually learn from achievements and pitfall of each one. Remarkable regional and sometimes sub-regional differences can, in fact, be found as to standards (i.e. number of beds, allocation of resources to each unit within the department), integration of private services within DSM and

integration with child psychiatry, drug abuse and learning disabilities services.

### **DEVELOPMENT OF COMMUNITY PSYCHIATRIC SERVICES IN EMILIA-ROMAGNA**

The regional psychiatric system as it is today is the result of a process started with law 180 of 1978, which decided basically five things:

1. All mental hospitals were to be gradually phased out, with a halt to all new admissions;
2. General hospital psychiatric wards (SPDC's) each having a maximum of 15 beds were established;
3. Severe limitations in procedures for compulsory admissions and in their length (maximum 7 days, renewable weekly) were set;
4. Community mental health centers (CMHC's) to provide psychiatric care to geographically defined areas were established;
5. All new and old public psychiatric services were integrated within the NHS.

The 1980's were spent in establishing CMHC's, in deinstitutionalising patients from the mental hospitals, usually moving them into small scale NHRF's and establishing the network of SPDC's by the general hospital.

A few strategic points resulted crucial in bringing these plans to an end:

1. Resources freed from the progressive closure of large scale mental hospitals were shifted to the newly established community mental health services;
2. Many (not all) professionals accepted to move from old to new services and a long period of intensive on job training took place. Collaboration among professionals, scientific societies, and consumers' organizations was encouraged. The tradition of creating *ad hoc* regional interdisciplinary panels on specific problems has consolidated and so far has produced several dozens of regulations and guidelines;
3. A substantial amount of resources was used for planning and coordination. A regional service for psychiatry was established to coordinate and supervise the whole process and is still in action. It has always been directed by a mental health professional and located within the regional administration. It has worked much in drafting regional legislation, policy and plans, allocating resources, establishing and monitoring standards of care, promoting education, innovation and evaluation.

Many professionals remember the 1980's as the golden age of community psychiatry and, indeed, it was a pioneering time of renewal and expansion of services, born from nothing, exploring the potential of a vision, stemming from a few pilot experiences around Italy and Emilia-Romagna as well.

The 1990's were spent in establishing the coordination of all these facilities under the DSM and in adapting existing services to the new chronic population that was emerging. Only in 1997 the last regional mental hospital was closed, bringing a 19-year process to an end. A critical issue of the 90's was also the integration of economic and quality assurance elements within the management of clinical teams, as required by policies and laws affecting all health services. Throughout the 90's the actual number of professionals employed by the NHS in psychiatry decreased about 10% and so did the number of psychiatrists. At the same time the number of users increased, the awareness of rights to treatment in the population and consumers' association increased as well, and work became much more tight

and intensive. The 90's and the first years of the new millennium were an age of normalization, following on to the revolution of the 80's, maybe with less enthusiasm, but probably more in contact with both the actual burden of suffering in the community and the socio-economical context where care develops. Just a few data can account for these two decades process of closure of old institutions and development of the new ones: Table 1 shows the provision of services at three endpoints (1978, 1993 and 2008). It is clear that in 1978 most resources were allocated in the mental hospitals and little in the community, in 1993 the proportion reversed, and in 2008 they are allocated to a variety of community services coordinated locally by the DSM.

Sector	Services	1978	1993	2008
Hospital	Mental Hs beds	5.191	1.077	0
	GHPW beds	103	175	237
	Private clin. Beds	438	438	87
Residential	Residential short	258	344	802
	Residential medium	331	676	340
	Supported housing	307	312	1.050
Community	CMHC N.	41 /129	41/136	43/140
	MH staff	?	3.036	?
	Day care /PHC	4	46	58

**Table I** – Emilia-Romagna mental health service provision at three endpoints (1978, 1993, 2008); GHPW: General Hospital Psychiatric Wards; CMHC: Community Mental Health Centers.

## **SOCIAL CHANGES AND THEIR IMPACT ON HEALTH NEEDS**

Emilia-Romagna regional psychiatry represents today a complex community system, which has completed its transition from hospital based psychiatry more than twenty years ago. CMHC's are well established, and their multiprofessional teams ensure general psychiatric evaluation, comprehensive care and, often, good assertive outreach to about 2% of the general population. An interesting mix of phenomenology, psychodynamics, clinical and social psychiatry constitutes the cultural ground of these services. The actual number of hospital beds and facilities is among the lowest in Europe and one recent comparison of psychiatric laws of all European Union's countries acknowledges that the Italian law and system are posing the lowest level of formal coercion over the patient<sup>16</sup>. Additional hospital beds are acquired from private clinics under allowance schemes, but the total number of beds in hospitals remains low. The area of medium/long term non-hospital residential facilities has seen a large expansion during the 90's and now accounts for more beds than the hospital sector<sup>17</sup>.

This system is now facing new and partially unexpected challenges, which may endanger its ability to meet our population needs. These challenges are partially due to internal problems, but mostly to the rapidly changing profile of the population under our care. Emilia-Romagna has reached, over the last three decades, impor-

tant objectives in terms of human development: per capita income, gross regional product, very low unemployment rates for both men and women, and higher educational levels. These results were achieved thanks to changes in the whole economic processes, which on the other side produced some unfavourable effects on the social tenure of the communities and the families. Emilia-Romagna has had for more than 20 years the lowest birth rate in Italy (and Italy has had the lowest in Europe for many years), the distance among generation has increased enormously, time devoted to care of family duties has become scarce, citizens have left cities for suburban areas breaking traditional ties and finding difficulties in establishing new ones. The decrease of population has been replaced by immigration which now constitute about 10% of residents, but which have comprehensible difficulties in integrating into the local societies. As in most western societies, the crisis of traditional families has taken place and also the use of substances has become rampant. As one distinguished Italian demographer wrote, Italy has now "too much family, too less children"<sup>18</sup>. All in all, the protective effect of a traditional society has become weak and living in contexts based on individual rights and duties has come in contrast with values of solidarity and mutual help, still perceived in the society. These changes seem to be common to most western societies, but the uniqueness of the Italian case is that they were very rapid and in 30 years we evolved from rural to industrial, and then to postin-



dustrial society – steps that in other European countries took almost 100 years.

This has had a huge impact on health and social services provision:

1. More often than not, health problems present with social problems and they cannot be tackled by the informal social network of families and volunteer organizations – the child with learning disability of a lonely mother, the schizophrenic patient living with a 85 year old mother with cognitive problems, the depressed employee fired from a factory and divorced – both social and health problems (almost unknown in these terms twenty years ago) require a much more integrated and sophisticated network of services to meet the needs in the community;
2. The actual number of people with mental disorders or disabilities is increasing. Southern Europe has scored low in European studies about mental disorders (i.e. in the ESEMED study) as depression and anxiety and we could infer that this is due to the protective effect of social bounds in these societies, but this is not true anymore;
3. More often than not, health problems present with comorbidities – the schizophrenic patient abusing stimulants; the 50-year-old patient with mental retardation showing impaired medical conditions; the elderly patient with both cognitive and depressive disorders – which are more and more common and call for integration within the health system

## **CURRENT DEVELOPMENTS AND FUTURE DIRECTIONS**

Taking all these aspects into account, the Regione Emilia-Romagna has recently adopted its first “Health and Social Plan 2008-2010”, completed by the “Mental Health Action Plan 2009-2011”<sup>19</sup>, which redraw the system of health and social care. The main points of this radical change are the following:

1. Health trusts and municipalities are obliged to plan, manage, finance and evaluate together their social and health service provision. Joint bodies entitled to all these activities are set and receive the financial resources for managing the overlapping of social and health services;
2. Health trusts and municipalities must coincide as to geographical areas of their activities, a basic principle of public health approach. These areas are called districts, they range from 100 to 400.000 inhabitants and each of them may comprise several municipalities but refers to just one trust;
3. Regional government organization reflects this effort of integration, e.g. there is just one Ministry coordinating health and social services.

For mental health services provision there are several implications stemming out from these changes:

1. Mental health services are provided within a Mental Health Department (DSM), which



aggregates all mental health, drug abuse and child neuropsychiatry, in order to assure the maximum of integration among these services;

2. DSM services are entirely responsible for the provision of health services, with the aim of guaranteeing integration with primary care, emergency services, and geriatric services as well as providing equal access to ethnic minorities groups. Recovery-orientated service policies introduce a limit to the use of residential facilities and promote the expansion of outreach, self-help and clubhouse experiences (all quite developed but not homogeneously);
3. Mental health services are now responsible also for the provision of care in prisons and in forensic hospitals;
4. All issues regarding subsidies, housing, employment, long term residential settings, promotion and preventions are managed jointly with municipalities in these newly established bodies (*distretti*) which have the resources to do that.

Professional integration is the challenge. Whether the objective of meeting the needs of our population will be reached or not is matter for evaluation in a decade time.

## CONCLUSIONS

As early as 1950, Italian psychiatry was reported in international scientific papers for

its obsolete and repressive institutions<sup>20</sup> and so it did until the Reform law in 1978. Probably, because of this delay, deinstitutionalization has met in Italy its more radical form and produced a complex and multifaceted system of community psychiatry. Emilia-Romagna is one of the multiple facets, whose distinctive features may be considered good availability of resources, accurate planning, participative processes and active search for both national and international comparison and collaboration.

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