

Universidade NOVA de Lisboa
Faculdade de Ciências Médicas



**Policing and planning
Child and Adolescent Neuropsychiatry:
the reform process in Bologna 2009-2014**

Project Work of Master in Mental Health Policy and Services

Candidate: Paolo Feo

Supervisor: Professor Angelo Fioritti

2014

Acknowledgements

I warmly thank Professor Benedetto Saraceno, for his guidance in choosing this course, for the passion he renewed and for the trust he transmitted me along this path.

I gratefully thank all the faculty members for their great teachings, and with them I thank all the friends of the course, for letting me feel part of a big committed and united community.

I gratefully thank Professor Angelo Fioritti for his sincere and kind encouragement and lucid supervision, especially during the thesis draft, and Dr Marilisa Martelli for her warm constant support. I am also grateful to all those who aided my work and presence in Bologna: Giuliana Venturelli, Dr Licia Bruno, Dr Simona Chiodo, Dr Carlotta Gentili, Dr Giancarlo Marostica, Francesca Chimetto, Franco Mongelli, Loredana Freddi, and all the reform working group for the warm welcome I received.

I sincerely thank Silvia, Tommaso and Francesco.

Contents

Acknowledgements.....	iii
Summary.....	v
List of abbreviations.....	viii
Role of the candidate within the project work.....	ix
Why reforming policy in developed high resources population.....	1
Bologna.....	2
Italian setting and Policy document Emilia Romagna.....	3
Framework of Italian Legislation, Policies and Services.....	3
Child and adolescent neuropsychiatry.....	4
Emilia Romagna Policy.....	6
Department of Mental Health and Addictions in Bologna.....	8
Adult Psychiatry Area.....	10
Addictions Area.....	11
Child and Adolescent Neuropsychiatry Area.....	11
Units.....	11
Interfaces.....	14
Description of care.....	15
Secondary and tertiary care.....	18
Primary care.....	20
Informal care.....	20
Consensus development process.....	22
Background.....	22
“Our idea of CANP”.....	24
Actors.....	24
Stages.....	25
Evidences.....	27
Local Plan.....	33
Strategies.....	33
Reform of second and third level.....	33
Retrieving primary care.....	34
Including informal.....	34
Actions.....	35
Expected outcomes.....	36
Conclusions.....	38
References.....	39

Summary

Since the Regional mental health plan 2009-2011 was approved in Emilia Romagna, Italy, the Department of mental health and addictions (DMH-A) of the Bologna local health trust developed as a laboratory aimed at innovating the mental health system locally. Since 2012, the Child and Adolescent Neuropsychiatry (CANP) Area, section of DMH-A, converged in the reform.

The reorganization aims at responding to the evolving needs of the population in a transforming society and to the mission shift of services toward better and more ambitious care, against a progressive decrease in resources.

Through the activity of a large multidisciplinary working group, representative of the CANP Area professionals and through feedback by the family associations, crucial points to be revised were identified and elaborated, so that a strategy was developed.

Strong of a tradition based on community and solidarity, the CANP values of citizenship and integrated care stand high, but those of innovation, participation and verifiability are renewed and enhanced through a partnership strategy pursuing realistic and measurable aims.

A local plan was developed to systematize the CANP care practices and regulate the roles of the other empowered care levels. To achieve homogeneity and measurability of care, age-condition specific and flexible care pathways were identified, and articulated through the different care levels within the optimal mix of mental health services framework. Secondary and tertiary care was provided with: appointment of topic areas experts to disseminate knowledge and skills at community level, and to better link the hub and spoke oriented services; introduction of the case manager for complex individual treatment plans to ensure continuity of care. Primary care was retrieved as main potential partner for the regulation of access to CANP services and for the delivery of formal care at community level. Informal care was empowered by the family associations inclusion through the ongoing reform and by the enhancement of subsidiary projects implementation with families and local authorities.

The reform is still ongoing, and both the finalization and monitoring of the activated internal innovations and the broadening of alliances with other levels of care will be crucial for future success.

Key words: child and adolescent neuropsychiatry, mental health services, mental health plan, reform, Bologna.

Resumo

Desde a aprovação do plano de saúde mental regional 2009-2011 em Emilia Romagna, na Itália, o Departamento Local de Saúde Mental e Perturbações Aditivas (DLSM-PA) de Bolonha tem desenvolvido um projecto de reforma cujo objectivo é inovar o sistema de saúde mental local. Desde 2012, a Área de Neuropsiquiatria da Infância e Adolescência (NPIA), secção do DLSM-PA, também convergiu na reforma.

A reorganização visa responder à evolução das necessidades da população numa sociedade em transformação e à mudança de missão dos serviços, no sentido de um atendimento mais compreensivo e de melhor qualidade, num contexto de uma diminuição progressiva dos recursos.

Através da actividade de um grande grupo de trabalho multidisciplinar, representativo dos profissionais da área de NPIA e contando com importantes contributos das associações de famílias, os principais pontos a serem revistos foram identificados e elaborados, de modo a desenvolver uma estratégia de acção.

Com uma forte tradição alicerçada na comunidade e de solidariedade, os valores de cidadania e cuidados integrados da NPIA mantêm-se como fundamentais, mas os de inovação, participação e verificabilidade são renovados e ampliados através de parcerias estratégicas com objectivos realistas e mensuráveis.

Um plano local foi desenvolvido para sistematizar as práticas assistenciais da NPIA e regulamentar as funções dos outros níveis de prestação de cuidados. Para atingir a homogeneidade e a mensurabilidade do atendimento, foram identificados itinerários de cuidados flexíveis, específicos para a idade e situação clínica, articulando os diferentes níveis de atendimento num modelo ideal de estrutura dos serviços de saúde mental. Nos níveis de cuidados secundários e terciários foram nomeados peritos em áreas temáticas para divulgar conhecimentos e competências na comunidade, e para coordenar a rede hub e spoke de cuidados. Foi ainda criada a função do terapeuta de referência para planos de tratamento individual complexos, com o objectivo de garantir a continuidade dos cuidados. O nível de cuidados primários foi recuperado como o principal parceiro para a regulação do acesso aos serviços de NPIA e para a prestação de cuidados formais na comunidade. Os cuidados informais foram capacitados com a inclusão das associações de familiares no processo de planeamento da reforma em curso e pelo reforço da implementação de projectos com as famílias e as autoridades locais.

A reforma continua, e tanto a finalização como a monitorização das inovações criadas, como a ampliação de alianças com outros níveis de cuidados, será crucial para o seu sucesso futuro.

Palavras chave: neuropsiquiatria da infância e adolescência, serviços de saúde mental, plano de saúde mental, reforma, Bolonha.

Resumen

Desde que el plan mental ha sido aprobado 2009-2011 in Emilia Romagna, Italia, el Departamento de salud mental y adicciones patológicas (DSM-AP) del centro local de salud de Bologna quiso desarrollar un laboratorio con el fin de innovar el sistema de salud a nivel local. Desde el 2012 el Área de Neuropsiquiatría de la Niñez y Adolescencia (NPNA), parte del DSM-AP, implementó la reforma.

La reorganización intenta responder a los cambios de la población in términos de necesidades que se desarrollan en una sociedad en transformación y por eso que el intento ha sido mejorando los servicios gracias a una mayor y ambiciosa atención en un momento donde se había un decremento progresivo de recursos.

A través de un gran grupo de trabajo multidisciplinar, representantes de los profesionales del área de NPNA por medio de los feedback de las asociaciones de los familiares, identificaron puntos cruciales para poder ser analizados y elaborados, de tal manera la estrategia ha sido identificada.

Fuerte de una tradición basada en la comunidad y la solidaridad, los valores NPNA de ciudadanía y atención integrada son muy destacados, pero aquellos de la innovación, de la participación y de la verificabilidad han sido renovados y integrados a una estrategia de colaboración consiguiendo objetivos realísticos y medibles.

Un plan local ha sido desarrollado para sistematizar las prácticas de cuidado del NPNA y regular los papeles de los demás niveles de cuidado obtenidos. Para conseguir homogeneidad y mensurabilidad del cuidado, la específica edad-condición y el camino flexible de cuidado han sido identificados y desarrollados a través de diferentes niveles de cuidado dentro de la óptima combinación de una estrategia de servicios de salud. Los cuidados secundarios y terciarios han sido preparados con: cita de expertos de temas principales para difundir el conocimiento y las competencias a nivel de la comunidad y para mejor alinear los servicios del hub and spoke; la introducción de un responsable de cuidado para atención individual compleja y de tal manera asegurar la continuación del cuidado. El cuidado primario ha sido rescatado como mayor potencial colaborador para la regulación del acceso a los servicios del NPNA y para la entrega del cuidado formal a nivel de la comunidad. El cuidado informal ha sido conseguido por la integración de las asociaciones de las familias a través de la reforma en curso y por el fortalecimiento de la implementación de proyectos subsidiarios con las familias y las autoridades.

La reforma sigue en curso y tanto la finalización y el monitoreo de las innovaciones internas producidas como el ampliar alianzas con otros niveles de cuidado va a ser crucial para el futuro éxito.

Palabras clave: neuropsiquiatría de la niñez y adolescencia, servicios de salud mental, plan de salud mental, reforma, Bologna.

List of Abbreviations

ADHD	Attention deficit, hyperactivity disorder
ATRS	Aid, Technical and Rehabilitative Service (<i>Servizio Assistenziale, Tecnico-Sanitario e Riabilitativo</i>)
CANP	Child and Adolescent Neuropsychiatry (<i>Neuropsichiatria Infanzia e Adolescenza</i>)
CMHC	Community Mental Health Centres (<i>Centri di Salute Mentale</i>)
DMH-A	Department of Mental Health and Addictions (<i>Dipartimento di Salute Mentale e Dipendenze Patologiche</i>)
DTCP	Diagnostic & Therapeutic Care Pathways (<i>Percorsi Diagnostico-Terapeutici Assistenziali</i>)
LHT	Local Health Trust (<i>Azienda Unità Sanitaria Locale</i>)
MH-CUFP	Mental Health Committee of Users, Families and Professionals (<i>Comitato Utenti, Familiari e Operatori – Salute Mentale</i>)
NHS	National Health System
PHC	Primary health care
WHO	World Health Organization

Role of the candidate within the project work

The candidate started his collaboration with the Bologna Local Health Trust (*Azienda Unità Sanitaria Locale* – LHT) in March 2013. As child neuropsychiatrist attending this *Master in Mental Health Policy and Services*, he was assigned to provide public mental health advice through the ongoing reform process of the Child and Adolescent Neuropsychiatry (*Neuropsichiatria Infanzia e Adolescenza* – CANP) Area by the Director of the Department of Mental Health and Addictions (*Dipartimento di Salute Mentale e Dipendenze Patologiche* – DMH-A) – and project work supervisor – and by the Director of the CANP Area, this included in the DMH-A.

This task was and is currently accomplished by: a) supporting the CANP dedicated improvement groups in contextualizing and redefining the CANP Services within a multilayered mental health system framework; b) building capacities, mentoring and supervising the groups in drafting an operational manual on CANP care pathways; c) actively attending part of the planned meeting of the groups with the user and family associations, these being contributing actors of the CANP Services reorganization; d) collecting data from the CANP Services Information System and contributing to the identification of indicators to monitor and evaluate the progressive implementation of the CANP Area reform; e) disseminating the ongoing process through presentations at national congresses. Extended report of these activities is integrated in the present project work.

Since March 2013, the candidate has carried out his role through direct presence at the DMH-A as well as distance guidance of the CANP improvement groups through regular and frequent contacts via email and telephone. The candidate's presence at DMH-A was partly formalized by contracts as trainer in three continuing medical education courses: three days in May, June and November 2013 (total 15 hours); three days in April 2014 (total 24 hours); three days in June 2014 (total 24 hours). In addition, the candidate informally met the improvement groups, or selected subgroups, monthly in order to effectively mentor and supervise them, and attended the above mentioned meetings with user and family associations (ten full days since September 2013 to June 2014).

In addition, since June 2014, the candidate is assigned a 18 months fellowship by the DMH-A (attendance: 2 days per week) on the current Eating Disorders program including the Bologna LHT and two adjacent LHTs in the same Region (Emilia Romagna). The program is articulated across the CANP and Adult Mental Health community and dedicated services and across the dedicated Nutrition and Dietetics Services – outpatient, semi-inpatient, inpatient and residential facilities. The fellowship task is to collaborate with the existing dedicated team by strengthening its public health approach toward further definition and implementation of the program. The fellowship assignment will not only involve the candidate in the specific program, but will give him the opportunity to more closely keep contributing to the ongoing general reform process of the CANP Area in Bologna.

Why reforming policy in developed high resources population

Reforms are priority when the present status of things does not meet human needs. Mental health is no exception, nor it is in high resources settings.

In fact, even in richest countries, the World Health Organization (WHO) recommendations set at the beginning of the millennium to protect and improve the mental health globally¹ are far to be adequately met.

The indirect, but pragmatic consequence of the cultural and ideological bases of such resistance to human development, can be highlighted by simply counting the resources dedicated to mental health in high income countries. The Mental health atlas 2011² shows how allocation of health budget to mental health is much lower than the contribution of the neuropsychiatric disorders to the global burden of disease³ (5% vs 26%). In addition, more than half of mental health budget in high income countries is still allocated to mental hospitals, fully substituted by community-based systems only in three European countries – Iceland, Italy and Sweden. More than half high income countries do not provide follow-up care at majority of facilities, and almost half are not equipped for providing psychosocial intervention, while the management and treatment of mental disorders in primary care is still inadequate. Therefore, it would not seem coincidental that the treatment gap for mental disorders in these setting ranges from 35% to 50%⁴.

Using the same simple strategy of counting resources to measure the unmet needs of children and adolescents is still harder. The Child and adolescent mental health atlas 2005⁵, instead of measuring resources, seems to measure the difficulty in measuring resources, even in high income settings. The atlas acknowledges the lack of specific resources as one of the main barriers to care worldwide, and shows how even in highly resourced settings child and adolescent mental health policies and programs seem to be less represented than for adults, and information systems less developed. Likewise, a wide European survey highlights a worse degree of coverage and quality of services for children and adolescents than for adults⁶, while the atlas reports that lack of services involves all levels of care, ranging from dedicated beds in facilities different from institutions to poor integration with the primary care. Such scenario is in contrast with the higher prevalence of disorders estimated in childhood and adolescence compared to adulthood¹ and with the documented frequent lifelong impact of early mental disorders⁷. Due to this paradox, it would not seem casual that the treatment gap for children and adolescents is even higher than for adults.

We could argue that, if barrier to adult mental health care is represented by an ideological resistance, barrier to child and adolescent mental health care, even in high resources population, is neglect.

But not only insufficient responses make reforms necessary. In fact, on the other hand, also changes of population needs urge reforms.

Bologna

Bologna is the capital of the Region Emilia Romagna, situated in Northern Italy. Emilia Romagna has reached, over the last three decades, one of the highest human development indexes in the country: it had the highest per capita income, educational levels and occupational rates in Italy. It is considered as a case of noteworthy social cohesion, collective efficacy and promotion of social capital. The cultural ground of its virtuous community oriented mental health services is a mix of phenomenology, psychodynamics, clinical and social psychiatry.

Nevertheless, this system is now facing new and partially unexpected challenges, which may endanger its ability to meet the population needs. These challenges are partially due to internal problems, but mostly to the rapidly changing profile of the population. In fact, the high human development index was reached within the framework of the whole national economic growth, which also produced some adverse effects on the community and families.

The regional birth rate has been the lowest in Italy for more than twenty years and the distance among generations has increased; time devoted to families has become scarcer, cities were left for suburban areas, disrupting traditional bounds without easily establishing new ones. The decrease of the population has been replaced by immigration, which now constitute more than 10% of residents and experiments reasonable difficulties in integration in the local society. Increase of divorces and of atypical unconnected families, as well increase in substance abuse also occurred.

As a whole, there was a relative loss of the values of solidarity and mutual help, in favour of more individualistic attitudes. If this shift is common to most western societies, peculiarity of the Italian setting is that it evolved very rapidly.

Therefore, health problems are more frequently embedded and need a more integrated response and sophisticated network of services; in addition, the prevalence and comorbidity of mental disorders and disabilities is increasing as, at least, an indirect consequence of the weakening of social bounds. At the same time, scientific knowledge advanced in the field of mental health, and rehabilitative techniques and technologies improved, thus supporting a mental health services mission shift to the higher ambition of caring better and increasing the care coverage.

Taking together these considerations, it is clear that, also in high resources settings, reforms seem necessary to respond to reciprocal interactions between population needs and services transformations.

Italian setting and Policy document Emilia Romagna

Framework of Italian Legislation, Policies and Services

A recent paper by Ferrarini et al⁸ has reviewed the development of the Italian mental health policies after the Basaglia reform. It will be here summarized and integrated with other sources, to present an overview of the Italian framework.

The Law 180 was approved in 1978 and by the same year it was incorporated into the Law 833/1978, which established the still ongoing Italian National Health System (NHS). The law 180 was leaving to the twenty Italian regions the task to translate its principles to norms, methods, and timetables, therefore its application was profoundly influenced by regional differences.

After a first inefficient attempt in 1994⁹, a second national mental health plan was launched in 1998, the Targeted mental health care plan 1998-2000¹⁰, to make the reform application homogeneous on the national territory. In addition to their impact on deinstitutionalization process, the two national plans progressively set the structural framework of present services organization: the first established the Departments of Mental Health and the network of Community Mental Health Centres (CMHC), the second provided a set of mainly structural standards of care to be achieved, in order to shift the approach from traditional psychiatry to a more prevention and promotion oriented model under the coordination of Departments of Mental Health. It also provided practical suggestion to achieve this aim, including the formulation of individualized treatment plans, integration with primary health care (PHC) and Social services, provision of evidence based interventions, involvement of the family, self-help groups, stigma reducing programs. The second national plan is still operational and standards of mental health care refer to it, but its implementation at regional level was, and still is, modulated by regional and local plans for mental health.

Regional plans became necessary after the financial autonomy acquired by the regions for health management in 1992, and the establishment of Local Health Trusts (*Azienda Unità Sanitaria Locale* – LHT) network and associated health budget allocations. Over time, regional variability in service provision had diminished, but variability among regions remained.

A new policy document, the National strategic plan for mental health¹¹, was issued in 2008 to reduce inter-regional differences and to underscore the need to standardize services across the country.

NHS absorbs about 6% of the gross domestic product, while about other 2-3% is spent in additional private health services. About 5% of NHS resources are allocated to the child and adolescent and adult psychiatry services, excluding drug abuse and learning disabilities services.

Child and adolescent neuropsychiatry

Italy is the only western country where the care for child and adolescent mental disorders and neurological diseases are still covered by the same specialty, that therefore keeps this peculiarity in its name.

The Italian Child and adolescent neuropsychiatry (*Neuropsichiatria dell'Infanzia e dell'Adolescenza* – CANP) was founded in 1947 by Giovanni Bollea, neuropsychiatrist influenced by Oscar Forel, Lucien Bovet, André Repond, Jean Piaget. He imported and further developed the Swiss, French, British and U.S. models of “medical-pedagogic centres” and the concept of multidisciplinary team for specific understanding and care of developmental age mental health and disorders¹².

The interdisciplinary nature of CANP in between the mental and the maternal and child health, though representing a potential cultural resource, has often been a barrier to its fluent identification, and self-identification, and has nourished dynamics of exclusion, and self-exclusion. The CANP was excluded by the Law 180, and was still mentioned among the “non psychiatric services that have operational boundaries affecting mental health” in the 1994 first national mental health plan⁹.

CANP finally found its formal regulation within the mental health system in the Targeted mental health care plan 1998-2000¹⁰, being included among the Department of Mental Health sections as a defined operational field where a developmental and ecological, intersectoral, approach is crucial for early prevention and intervention, and whose links with adult psychiatry are explicit.

In 2000, as a confirm of its interdisciplinary – or double – nature, and without disconfirms of the prior convergence in the mental health plan, CANP is also included in the National maternal and child health plan 1998-2000¹³, where operational links to this field are also underscored.

CANP has recently received growing attention at both legislative and policy level. The National health plan draft 2011-2013¹⁴ and the National mental health action plan 2013¹⁵ have both highlighted the need for improving the CANP care provision and have called for integrated and coordinated response at national, regional and local level. In the meanwhile, the Senate has approved a motion¹⁶ to commit the Government in favour of child and adolescent mental health care, to acknowledge its relevance, to develop a dedicated national informative system, to promote and empower a clinical and research network addressed to the identification of evidenced and cost-effective interventions, and to establish a standing committee of experts and families in regular contact with the Parliament and Senate.

A schematic description of some CANP services organization indicators in the 20 Italian regions shows how the mental health services variability is widely reflected at structural and operational level also on CANP services¹⁷ (Table 1):

Table 1. CANP services organization in the 20 Italian regions

	Regions (N)
CANP services have been established	17
CANP services have been established by ≥ 1 regional deliberation	17
The CANP services denomination is clear	13
A CANP permanent table is established at regional level	7
Community CANP services are included in:	
<i>Dept maternal and child health</i>	6
<i>Dept mental health</i>	6
<i>LHT are free to choose the Dept</i>	5
<i>Other</i>	2
<i>Do not exist</i>	1
Hospital CANP services are included in:	
<i>Dept maternal and child health</i>	6
<i>Dept neuroscience</i>	3
<i>Dept paediatrics</i>	2
<i>Mixed (2-3 Depts)</i>	5
<i>Other</i>	2
<i>Do not exist</i>	2
Community and Hospital CANP services are structured in the same LHT (18 out of 20 regions)	9
CANP services conducted a regional survey of CANP disorders	13
Services ensuring meetings in schools as for the Law 104/1992 ⁱ	
<i>CANP</i>	12
<i>Private accredited</i>	1
<i>Both</i>	7
Regions adopting the regulations of the Law 104/1992 in schools	
<i>Yes</i>	12
<i>No</i>	5
<i>Other</i>	3
Routine use of International diagnostic codes	
<i>Always</i>	11
<i>Partial</i>	7
<i>Never</i>	2
Used code (18 out of 20 regions)	
<i>ICD-10</i>	15
<i>ICD-9CM</i>	3
Use of informative system	
<i>All or most activities</i>	7
<i>Some activities</i>	9
<i>No</i>	4
Percentage of private accredited rehabilitative activities	
<i>0-50%</i>	12
<i>51-100%</i>	8

ⁱ Law 104/1992 is the legislative reference "for the assistance, social integration and rights of *handicapped* people".

Emilia Romagna Policy

The socio-demographical changes affecting the regional population, and the mental health services mission shift overviewed in the previous section urged a reform of the regional mental health system.

Within the context of the first integrated Regional Social and Health Plan 2008-2010¹⁸ aimed at realizing a universalistic, equal, territorially and regionally based welfare system, the Regional mental health plan 2009-2011¹⁹ was developed after a consensus process lasted almost three years.

The broad framework of values, objectives, scopes and strategies make this plan more similar to a policy than to a properly defined plan. It is not by chance that it is possible to read: *“General aims of the Emilia Romagna policy are: the promotion of psychological and social wellbeing of the citizens and residents in their territory, the protection of the right to health, of the rights of citizenship of persons affected by mental disorders and addictions, of any sort and severity, at any age of life”*.

The policy is based on the principles of destigmatization, participation, continuity of care, innovation, measurability.

The two main dimensions of the policy are the care system and the community system. In fact, the main strategies are:

- community care: emphasizing social capital maintenance, health promotion, prevention, and proposing organic interventions for a variety of disorders at all ages
- integration: within health services, and between social and health services

In other words, this public health approach aimed at integrating appropriate individualized care with promotion and prevention at community level through ages.

Participation was broad and multidisciplinary: actors were from health sector – mental health, other trust departments, universities – and social sector – region, municipalities, educational institutions, Social services, Justice system, profit and no profit private, users and families, voluntary associations and foundations.

The scopes of the community system are articulated by essential level of care:

- community services: income, housing, sheltered housing, employment, mental health promotion, cross-sectional subsidiarity, prevention
- semi inpatient services: as rehabilitation and family relief
- residential services: integrating health facilities with social and health facilities (housing)

The scopes of the care system are articulated in: CMHC, crisis management, psychiatric wards, residential sector, prison psychiatry, CANP, clinical psychology, training, research.

CANP is defined as the “*network of networks*” for its role of connecting and coordinating not only different areas of care, but also the care dimension with the community dimension. Innovations and improvements in individual care are needed at any level, as well as the activation of programs of care and intersectoral tables. The more stressed innovations regard the case management and supported employment, early intervention and crisis management, prison psychiatry, dual diagnosis and child adult transition.

Department of Mental Health and Addictions in Bologna

The catchment area of the Bologna LHT covers 50 Municipalities and is divided in 6 Health Districts (Figure 1): Bologna City, West Pianura, East Pianura, Casalecchio di Reno, San Lazzaro di Savena, Porretta Terme.

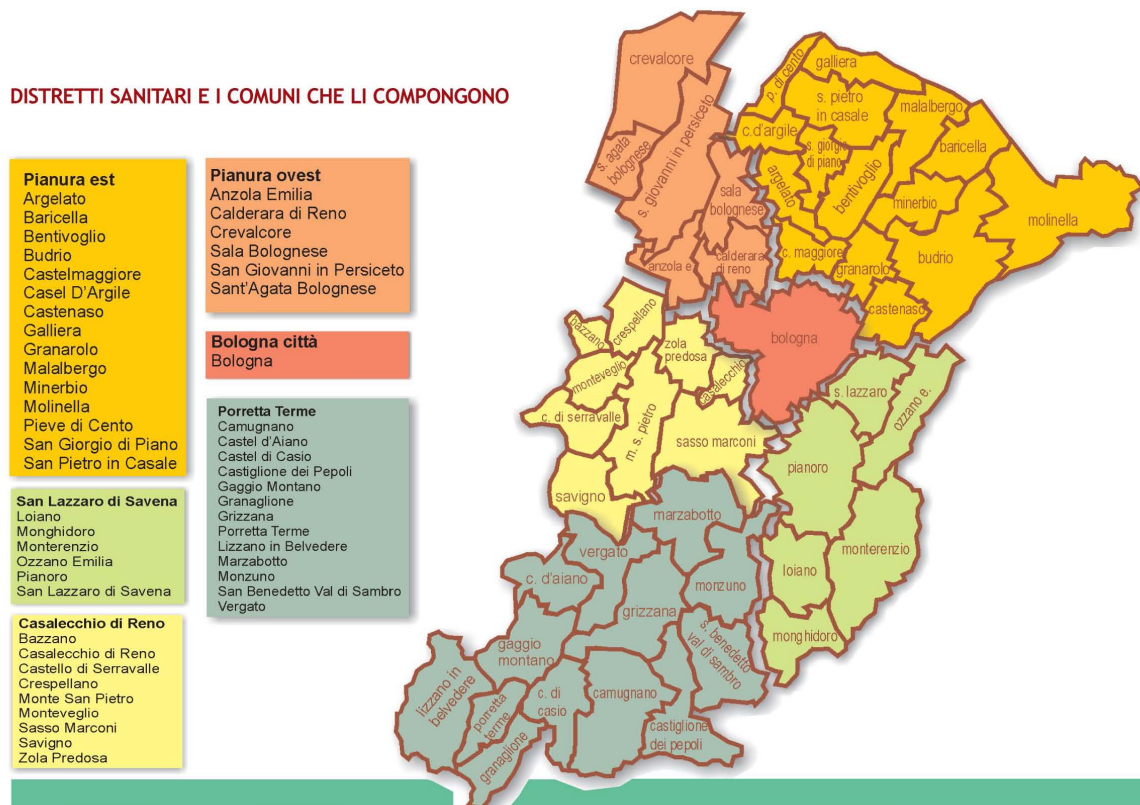


Figure 1. Bologna LHT Health Districts and corresponding Municipalities

The Bologna LHT as it is now was established in 2003 by Regional Law²⁰, as a result of the unification of the prior 3 LHTs covering the same catchment area. In 2005, the first steps were made for shaping the newborn LHT by the approval of the Certificate of Incorporation²¹, which also defined the foundation of the Department of Mental Health, and the deliberation of the Trust Organizational Regulations^{22,23}, though these documents were further updated and modified in the following years.

Despite these modifications, the management areas hegemony continued to be mainly bound to their territoriality, consistent with the distribution of the prior 3 LHTs, but after over three years of discussions, the management areas were turned into topic oriented areas transversally distributed over the catchment area, in order to prioritize the functional structure of the homogeneity of service provision and access to services²⁴.

This substantial governance shift endorsed and shaped the draft of the Organizational Regulations of the Department of Mental Health and Addictions (DMH-A), approved in 2009²⁵. Despite revisions and additions made in the meanwhile, they still state the mission

and the main structure and organization of the DMH-A, in line with those of the trust and coherently with the Targeted mental health care plan 1998-2000¹⁰, with the National strategic plans for mental health 2008¹¹ and with the Regional mental health plan 2009-2011¹⁹.

As defined by the Departmental Organizational Regulations, the DMH-A consists of 3 main subject Areas, which aggregate the Units (*Unità Operative*) of: CANP, Adult Psychiatry, Addiction Services. An integrating component of the DMH-A is the Aid, Technical and Rehabilitative Service (*Servizio Assistenziale, Tecnico-Sanitario e Riabilitativo* – ATRS), which structures the nursing, technical and rehabilitative staff. The ATRS is articulated in Aid Areas (*Aree Omogenee Assistenziali*), hierarchy of which is parallel to that of the subject Areas and Units.

The Units collaborate with: hospital facilities, paediatricians and general practitioners, Social services, municipalities, educational institutions, prefecture, judicial and penitentiary institutes, profit and non-profit private associations, included user and family associations.

The DMH-A is structured, according to homogeneous groups of organizational units, in Departmental Areas and Aid Areas. While the CANP Area and the Addictions Area correspond to homonymous Departmental Areas, the Adult Psychiatry Area consists of more than one Departmental Areas. The Departmental Areas aggregate Complex Units (*Unità Operative Complesse*), Departmental Units (*Unità Operative Semplici Dipartimentali*), Simple Units (*Unità Operative Semplici*), while the Aid Areas aggregate Aid Units (*Unità Assistenziali*).

The Complex Units and the Departmental Units directly refer to Departmental Areas, while Simple Units refer to Complex Units. The difference between Complex and Departmental Units therefore consists in the respective presence or absence of Simple Units related to them.

While medical doctors – psychiatrists, child and adolescent neuropsychiatrists and other doctors – and psychologists are assigned to the Departmental Areas, the other members of the multidisciplinary teams are assigned to the Aid Areas. These are: nurses, mental health nurses, physiotherapists, developmental neuro-psychomotility therapistsⁱⁱ, speech therapists, educators, pedagogists, social workers, art and music therapists, occupational therapists.

The organizational model of the DMH-A addresses the need to keep together two principles: to anchor its activities to the local context – the districts – and at the same time to ensure equity and homogeneity to all users within the catchment area.

The DMH-A is therefore articulated in:

ⁱⁱ This curriculum is peculiar of the Italian CANP: it addresses the areas of neuro-psychomotility, neuropsychology and developmental psychopathology

- management structures at trust level – Departmental Areas and Aid Areas – and a functional Area of directional support staff;
- management structures at over-district level;
- processes/ projects across the Units/ Aid Units;
- management structures at district level, consisting in Units and Aid Units.

It is noteworthy that some specific processes or projects at Departmental, or subject Area or Departmental Areas level, across the Units/ Aid Units, are formally and actually coordinated and managed by ATRS members. In other words, through its organizational and managerial autonomy, the ATRS directly contributes to the DMH-A service planning and mission achievement.

In addition, as envisaged by the Regional mental health plan 2009-2011¹⁹, the user and family associations have been integrated into the Department as Mental Health Committee of Users, Families and Professionals (*Comitato Utenti, Familiari e Operatori – Salute Mentale*; MH-CUFP). The MH-CUFP is composed of a majority representation of members appointed by the voluntary and rights protection associations and organizations and by the Trade Unions of Retired Persons focused on mental health or directly involved in mental health related activities, as well as of trust representative as the Director of DMH-A, Directors of Departmental and Aid Areas, Administrative Director of DMH-A and Director of Department of Social and Health Activities. Through the MH-CUFP, user and family associations play an active role in decision making and in monitoring the quality and appropriateness of services, may be accredited for running specific services or trust funded subsidiary activities.

As a whole, the DMH-A management structures are: the Administrative Service, the Aid Areas and the Departmental Areas. These are grouped within the three subject areas as follows. Special attention will be given to the CANP Area, focus of the present project work.

Adult Psychiatry Area

It is appointed to provide for an adequate and homogeneous response to the needs of adults – aged ≥ 18 years – with psychiatric disorders. It is articulated in the following Departmental Areas:

- CMHC, providing for outpatient and home care, with special attention to severe cases. The Area consists of 4 Complex Units, comprehending 9 Simple Units, and 2 Departmental Units.
- Residential Facilities (*Residenze Psichiatriche*). It has recently been cancelled to favour the empowerment of residential service integrated in CMHC, but it originally provided for the management of the residential facilities and of the supply contracts with the accredited private facilities, by ensuring quality and integration with the CMHC network during diagnosis, treatment and rehabilitation. It was an over-district

level structure and it consisted of 1 Complex Unit, comprehending 2 Simple Units, and 2 Departmental Units.

- Crisis Management (*Emergenza Urgenza*), providing for hospitality to users asking for voluntary or subject to involuntary admission to psychiatric wards in General Hospitals. It also provides for integration with accredited private facilities with beds available for crisis management and with the CMHC network for the reintegration after discharge. It is an over-district level structure and it consists of 3 dedicated Complex Units (*Servizi Psichiatrici di Diagnosi e Cura*) open 24 hours a day.

Addictions Services Area

It carries out prevention activity aimed at contrasting addictions and provides for care of persons with substance abuse disorders. It is an over-district level structure and it consists of 1 dedicated Complex Unit, comprehending 3 Simple Units, and 6 dedicated Departmental Units (*Servizi Tossicodipendenze*).

Child and Adolescent Neuropsychiatry Area

The CANP Area carries out activities of prevention, diagnosis, care and rehabilitation for children and adolescents aged 0-17 years affected by sensorial or neuromotor impairments, neurological diseases, neuropsychological or psychopathological disorders.

Following is the picture of the CANP Area structure and activities set before or at the beginning of the ongoing reform process, as defined by the Organizational Regulations of the DMH-A²⁵ and by the Organizational Plan of the Departmental CANP Area approved in 2011²⁶.

Units

The Area was, and still is, articulated in 2 over-district level Complex Units, compositions of which have changed during the reform. The CANP Area Director is also Head of one of the two Complex Units – the Community CANP Unit. The Area and the two Complex Units are sided by an Aid Area and two Aid Units. A mixed team of such components refers for clinical quality and governance, risk management and training and tutoring.

The architecture of the two Complex Units before the reform process was the following:

- The Community CANP Unit (*Unità Operativa Complessa NPIA Attività Territoriale*) consists of 6 Simple Units distributed over the corresponding 6 LHT Districts, with two exceptions: the most populated District of Bologna City, is covered by 2 Simple Units – West Bologna and East Bologna –, while the Casalecchio di Reno and Porretta Terme Districts are covered by a single Simple Unit – Casalecchio/ Porretta.

Given the vast area covered by each Simple Unit, they provide the services in different Community Centres (*Poli di Erogazione Territoriali*) distributed over their catchment areas as follows: West Bologna, 3 Community Centres; East Bologna, 3; West Pianura, 2; East Pianura, 6; Casalecchio/ Porretta, 7; San Lazzaro di Savena, 3. The 24 Community Centres are open 40 hours per week – over 5 or 6 days – and part of the activities of their multidisciplinary teams is carried out off site on the territory. The Units/ Community Centres, and associated Aid Units, represent the spokes holding the majority of the Area case load, delivering an integrated community service for the prevention, diagnosis, care and rehabilitation for all the CANP impairments, diseases and disorders.

- The Specialized Services CANP Unit (*Unità Operativa Complessa NP/IA Servizi Specialistici*) consisted of 3 Simple Units, the first two located in Bologna, the third originally distributed among the West and East Pianura, representing the Area hub at over-district level, in some cases delivering direct curative service, mainly giving advice for the Community CANP Unit service provision:
 - Developmental Psychiatry and Psychotherapy (*Psichiatria e Psicoterapia dell'Età Evolutiva*), recently moved to the Community CANP Unit, providing for three services: Crisis Management Day Hospital in the Bologna LHT General Hospital (*Ospedale Maggiore*); Juvenile Justice Module for children and adolescents convict at the Juvenile Prison; Semi-inpatient Psychiatric Centre, delivering a therapeutic-educational-rehabilitative service for adolescents.
 - Regional Centre of Cognitive and Language Disorders (*Centro Regionale Disturbi Cognitivi e Linguistici*), providing for both diagnostic and rehabilitative advice to the Community CANP Unit and to CANP Services at second – regional – level, and direct brief term intensive rehabilitative programs for children and adolescents with developmental disorders.
 - “Centres” Unit (*Centri*), now moved and distributed to the Community CANP Unit, providing for three services: Early Infancy Clinical Centre (*Centro Clinico Prima Infanzia*), dedicated to combined diagnosis and treatment of toddlers and preschool children aged 0-3 years and their caregivers; “Light many fires” Centre (*Centro Accendi Molti Fuochi*), providing indirect care through pedagogic guidance to Educational Institutions; “Open space” Centre (*Centro Spazio Aperto*), semi-inpatient occupational service for adolescents with moderate and severe disabilities.

Some care pathways were already implemented by the Specialized Services CANP Unit in 2011²⁶. One facility in the centre of Bologna, the Roncati Court (*Corte Roncati*), represents an Area physical hub, hosting the Regional Centre of Cognitive and Language Disorders and the facilities where such care pathways or specific

projects are still run: Regional Centre for Assistive Products (*Centro Regionale Ausili*), Centre for Assistive Technology (*Centro Ausili Tecnologici*), “Gardener’s House” Centre (*Casa del Giardiniere*). Following are the pathways of care already put into service in 2011:

- Bologna LHT autism pathway: based at the “Gardener’s House”, LHT spoke and Central Emilia Wide Area hub – over-trust, sub-regional level – for functional diagnosis and rehabilitation, as for Regional Decree²⁷.
- Auditory disability pathway: dedicated to diagnosis and therapeutic-rehabilitative indications for hearing loss, with headquarter at the Centre for Assistive Technology, as for Regional Decree²⁸.
- Specific developmental disorders of scholastic skills pathway: intensive rehabilitation cycle supported by specific software, accessible at regional level, based at the Centre for Assistive Technology.
- Advanced medical hospitality for people with disabilities - DAMA project (*Accoglienza Medica Avanzata per le persone con Disabilità - DAMA*): a dedicated and comfortable priority access at LHT first aid, general hospitals and specialist medical and dental units for children, adolescents and adults with disability.
- ADHD project: centre for diagnosis and integrated care for attention deficit hyperactivity disorder (ADHD), comprehensive of pharmacological treatmentⁱⁱⁱ, originally based at the Developmental Psychiatry and Psychotherapy Unit, now moved to the Community CANP Unit, West Bologna Simple Unit.

Some of the above mentioned facilities are private accredited or contracted for specific projects, and the Specialized Services CANP Unit coordinates their implementation directly or through the Simple Units. These are: Regional Centre for Assistive Products, Centre for Assistive Technology, “Open Space” Centre, “Light many fires” Centre, and the Semi-inpatient Psychiatric Centre.

In addition to care activities, the Specialized Services CANP Unit plans and implements research and training projects on specific issues identified either by the department, trust or region – i.e. autism, adhd, specific developmental disorders of scholastic skills, assistive devices – addressed to lay and/or health professionals at Central Emilia Wide Area or regional level.

ⁱⁱⁱ In Italy the pharmacological intervention for ADHD (either with methylphenidate and atomoxetine) is in experimental phase 3, therefore still subject to restriction.

Interfaces

The Area interfaces are multiple and complex, ranging from intra-departmental to intra-trust, among Trusts, and external.

Intra-departmental interfaces are with both other Areas, especially with the CMHC of the Adult Psychiatry Area to ensure continuity of care, but also with the Units of the Addiction Area.

Main intra-trust interfaces are those with the Department of Primary Care – with paediatricians and general practitioners, as well as with community paediatrics, Family Advice Bureaus (*Consultori Familiari*) and “Youth Space” (*Spazio Giovani*), advice bureau dedicated to youth –, with the Department of Emergency – Units in paediatric and general hospitals –, Department of Maternal and Child Health – Paediatrics Unit and Neonatology and Neonatal Intensive Care Unit in the *Ospedale Maggiore* where CANP Area staff carries out intense consultation service –, and with the Department of Social and Health Activities to integrate the management of continuity of care with the Adult Psychiatry Area.

Some programs or projects are shared with other trusts, both at regional level and sub-regional level; in fact, Bologna LHT is part of the above mentioned Central Emilia Wide Area, comprehending also the adjacent Imola and Ferrara LHTs.

Main external interfaces are with Social services, municipalities, educational institutions, the Youth Justice system, profit and non-profit private associations, family associations, foundations.

Particularly relevant is the presence of two trust and external institutions providing for child and adolescent neurological and mental health care in the Bologna LHT catchment area, thus making the CANP Area structural and operational organization more intricate. These are the following:

- Neurological Sciences IRCCS (*Istituto di Ricovero e Cura a Carattere Scientifico delle Scienze Neurologiche*): it is a Bologna LHT institution, provided with funding autonomy, combining care and research activities in the field of neurology. Its services partially overlapping with the CANP Area are:
 - CANP Unit, providing for outpatient, day hospital and inpatient services supplied with a cognitive neuropsychology and a neurophysiology laboratory. The Unit is hub at over-district level for neurological and neuromuscular diseases included epilepsy, muscular dystrophy, migraine and headache syndromes and rare neurological diseases, integrating its activity with that of the Community CANP Unit (Spokes), and for etiologic investigations of autism spectrum disorders, when referred by the above mentioned “Gardner’s House”. The CANP Unit also provides neurological consultancy to the Paediatric Emergency Unit in the main General Hospital in Bologna and consultancy to all hospitals for all children affected by neurological disabilities at over-district level.

- Rehabilitation Unit (*Medicina Riabilitativa Infantile*), outpatient, day hospital and inpatient services. It is a second level hub for regional and extra-regional users, providing in depth diagnostic, pharmacological, surgical and rehabilitative service for severe neuromotor disabilities as palsies and neuromuscular diseases, prescribing physiotherapy assistive products. One of its two facilities, dedicated to diagnostic, rehabilitation planning and assistive products prescription, is located in the Roncati Court and interacts with the Regional Centre for Assistive Products and Centre for Assistive Technology.
- University of Bologna “Alma Mater Studiorum”, CANP Complex Unit: providing outpatient and inpatient service for neurological diseases included epilepsy, cerebral palsy, migraine and headache syndromes, and rare neurological diseases; developmental disorders of scholastic skills and early psychomotor delay; and eating disorders.

Description of care

Some data may be useful to quantify the service dimensions; following are data relative to 2013, service data are relative to the Community CANP Unit^{iv}.

Minors residents in the Bologna LTH catchment area are 131,831 (ratio M:F = 1.1), representing 15.14% of the total population (n = 870,507). Residents in Bologna City are 51,574 (39.0% target population). Foreign minors are 21,678 (16.4% target population)^v.

Community CANP Unit Professionals are as follows^{vi}: child and adolescent neuropsychiatrists 16.7; psychologists 14.9; physiotherapists 19.5; developmental neuro-psychomotility therapists 2.7; speech therapists 30.6; educators 10.4; total resources are 94.8, almost double than high income countries median rate².

Total users are 8,541, including 375 persons aged 18-21 years (4.4% total users); ratio M:F = 1.8 (range: min = 1.4 at 14-17ys, max = 2.0 at 3-10ys). Minor users represent 6.2% of the minors target population; their distribution among ages is 1.7% at 0-2ys, 5.0% 3-5ys, 8.5% 6-10ys, 8.2% 11-13ys, 6.2% 14-17ys. Foreign users' gender ratio and percentage of foreign minor total target population are the same as those of total users.

Total disable children and adolescents according to the national Law 104/1992^{vii} are 3,100, including 245 persons aged 18-21 years (7.9% total disable and 0.9% target population in the same age range). Total minor disable are 2.2% of the target population, while minor foreign disable are 2.9% of the corresponding target population. The distribution of users and disable children and adolescents among districts and age range is presented in Table 2.

^{iv} Source: ELEA information system for Community CANP Unit users/ activities. Data retrieved 07.14.2014.

^v Residents as for 01.01.2013. Source: <http://statistica.regione.emilia-romagna.it/servizi-online/statistica-self-service>

^{vi} Data are expressed by weighted units/100,000 population

^{vii} Law 104/1992 is the legislative reference "for the assistance, social integration and rights of *handicapped* people".

Table 2. Community CANP Unit users and persons with disabilities 2013 by district and age range

	0-2 years			3-5 years			6-10 years			11-13 years			14-17 years			Total		
	Users (N)	Disable (N)	Disable (%)	Users (N)	Disable (N)	Disable (%)	Users (N)	Disable (N)	Disable (%)	Users (N)	Disable (N)	Disable (%)	Users (N)	Disable (N)	Disable (%)	Users (N)	Disable (N)	Disable (%)
Bologna City	135	31	0.33	409	122	1.34	1,073	408	2.87	623	278	3.35	560	279	2.65	2,800	1,118	2.17
East Pianura	101	10	0.22	208	45	0.92	612	204	2.64	365	166	3.72	360	194	3.74	1,646	619	2.31
West Pianura	36	1	0.04	140	32	1.20	351	90	2.16	204	65	2.65	178	62	2.17	909	250	1.71
Casalecchio di Reno	67	2	0.07	222	39	1.17	524	154	2.88	264	106	3.62	256	125	3.49	1,333	426	2.35
Porretta Terme	15	0	0.00	109	16	1.03	285	53	2.16	146	50	3.45	120	44	2.33	675	163	1.88
San Lazzaro di Savena	32	6	0.30	101	21	0.99	328	102	2.89	184	75	3.56	158	75	3.08	803	279	2.29
Total	386	50	0.22	1,189	275	1.16	3,173	1,011	2.70	1,786	740	3.41	1,632	779	2.94	8,166	2,855	2.17

Percentage of disable persons are referred to corresponding target population

New cases in 2013 were 2,862: 39.0% aged 6-10ys, 21.2% 3-5ys, 16.8% 11-13ys, 13.5% 14-17ys, 8.5% 0-2ys, 0.9% 18-21ys. Percentage of first consultations made within 90 days ranges from 63% (for 6-10ys) to 94% (for 0-2ys).

The access to the Community Units service is most often direct (60%), frequently mediated by schools (32%), followed by referrals by the PHC network of paediatricians, general practitioners, Family Advice Bureaus and community paediatricians (21%), less frequent are the referrals by other health facilities (12%) and even less by Social services and Youth Justice system (4%) (Figure 2). The access to the Specialized Services Units should be formally mediated by referral of the Community CANP Units, but exceptions occur for direct referral from hospitals or other trust and extra-trust – regional or national – specialized facilities.

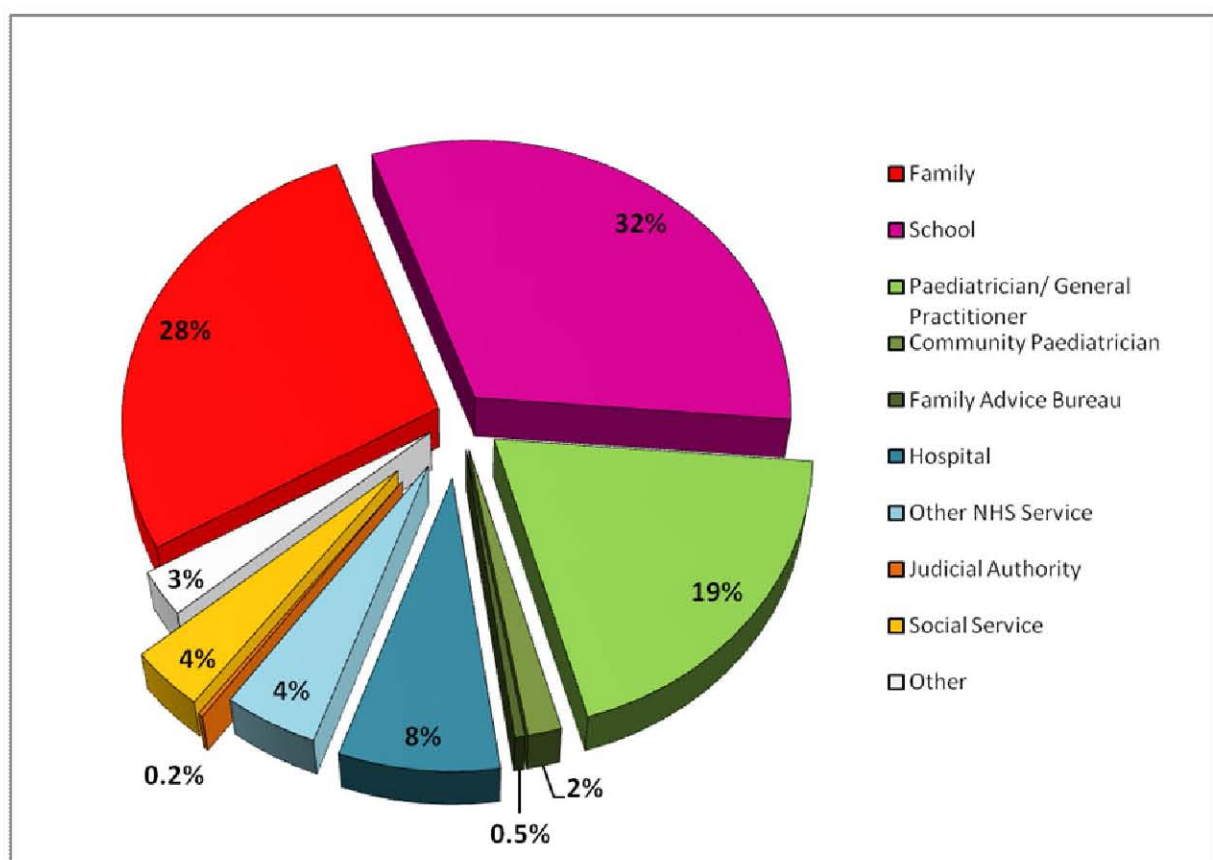


Figure 2. The referral system to the Community CANP Unit

The diagnostic system used is the ICD-10 multi-axial classification of child and adolescent psychiatric disorders²⁹. The most frequent diagnoses are Axis II (Specific developmental disorders: 36%), followed by Axis I (Psychiatric disorders: 24%), Axis IV (Associated medical conditions: 21%), Axis III (Intellectual level: 11%), and Axis V (Associated psychosocial conditions: 8%). The distribution of the frequency of diagnoses among age ranges is shown in Figure 3.

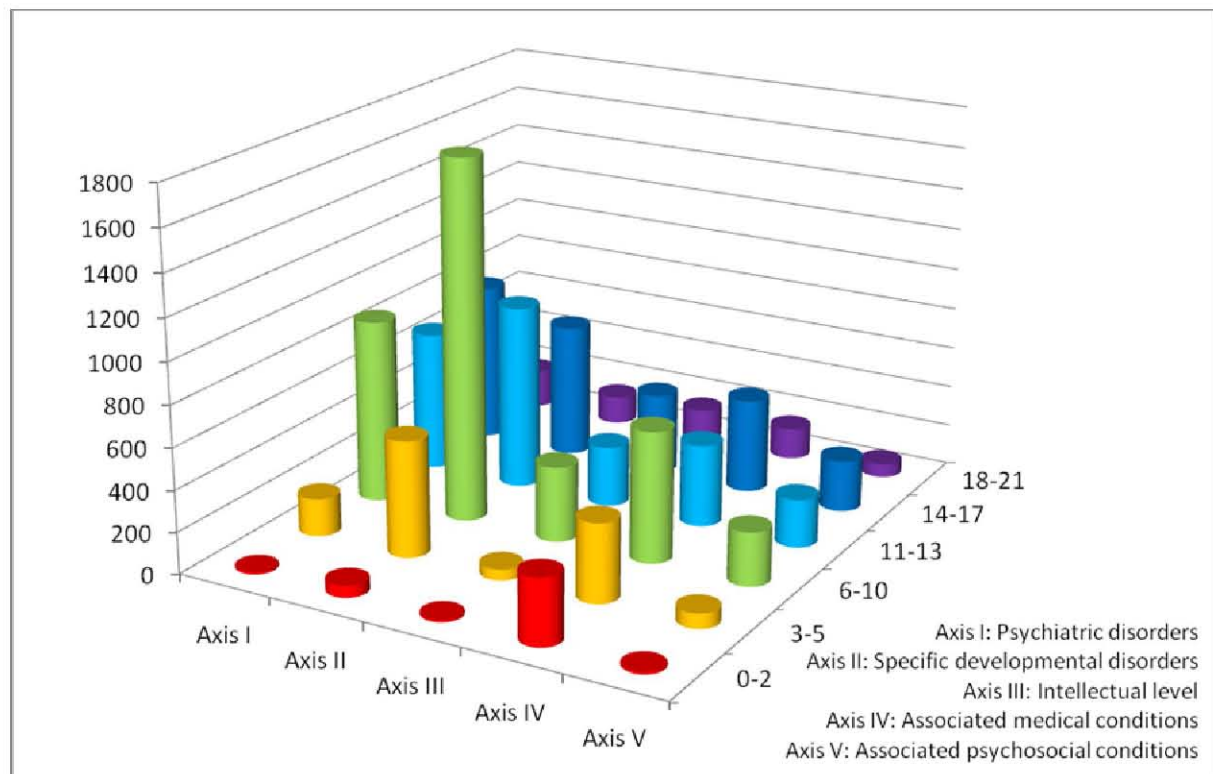


Figure 3. Distribution of the diagnoses by ICD-10 Axes and age range

The total number of contacts at Community CANP Unit was 111,722, including 3,170 for users aged 18-21 years (2.8% of all contacts). Rate per 10,000 minors was totally 8,234.2; percentage of contacts at different age ranges was 38.1% for 6-10ys children, 19.7% for 3-5ys, 17.3% for 14-17ys, 16.0% for 11-13ys, 6.1% for 0-2ys.

The delivery of care by the CANP Area has been fully tax funded up to August 2014. An out of pocket progressive copayment mechanism has been introduced since September, after long internal discussion on if and how to conform to the general trend of other departments and DMH-A Areas – the CANP Area has been the last in the LHT in introducing such novelty.

Following is a general description of care delivery and network, leaving a more detailed description – especially of critical issues – to the next chapter.

Secondary and tertiary care

The CANP Area scope is strongly community oriented, and is structured as an outpatient, semi-inpatient, inpatient, residential and home care.

The resources described suggest how the two DMH-A principles of taking into account the local capitals and achieving equity and homogeneity of care are articulated in the CANP Area through a hub and spoke service oriented model, with hub corresponding to mixed secondary-tertiary care and spoke to secondary care facilities, and with the two instances respectively represented by the Specialized Services and Community CANP Units.

Despite differences between the Specialized and Community Units, all of them provide specialist visits and consultations, which include multi-professional assessments. In cases where an intervention is necessary, a therapeutic-rehabilitative-educative plan is processed by the multi-disciplinary team. The project is shared by the levels of formal and informal care involved, first of all by the family. The project is intended as part of a global life project, connected to the different systems of child ecology³⁰, within the framework of social and health care and social inclusion. It then activates a individualized care pathway which can include, depending on the need:

- psychotherapeutic and, in case, integrated pharmacologic interventions
- rehabilitative interventions through speech therapy, physiotherapy, psychomotor therapy, educational therapy, social rehabilitation
- certification pursuant to Law 104/1992 and formalities and periodical meetings with teachers to secure adequate support for inclusive education^{viii}
- advice to educational institutions for minors non benefiting of the Law 104/1992 facilitations
- prescription and testing of prostheses and assistive devices
- support to the family in its task of child and adolescent care, comprehensive information and guidance on the opportunities offered by the trust second level, extra-trust and private accredited services, with an appropriate accompaniment in their eventual use.

Admissions to inpatient service for crisis management are run by the same psychiatric wards in general hospitals in use for adults (*Servizi Psichiatrici di Diagnosi e Cura*).

Adolescents with chronicle psychopathology and/or disabilities are usually cared up to the age of 21 years in collaboration with, respectively, the Adult Psychiatry Area or the Department of Social and Health Activities or both, in case of double diagnosis. In fact, especially for those still attending schools, the CANP Units keep following up the adolescents until the end of the high school courses which is typically at 18-19 years, but is frequently delayed in case of disable persons.

In addition to what described above, some structural and operational changes occurred in the LHT, DMH-A and CANP Area anticipated to some extent the further modernization developed during the reform.

In fact, since 2010, the Bologna LHT developed 28 specific Diagnostic & Therapeutic Care Pathways (*Percorsi Diagnostico-Terapeutici Assistenziali – DTCP*), that is to say optimized sequences and timed interventions of the various professionals aimed at particular

^{viii} Special classes were abolished in Italy in 1977 by the Law 517/1977, which identifies flexible educational models entrusted to specialized teachers, that enable cross-cutting forms of integration, inter-class experiences or group activities.

diagnoses or procedures plotted to minimize delays, maximize the use of resources and to ensure the quality of care. DTCP are under direct management of the LHT Clinical Director as often integrating activities of more than one Department. Five DTCP involve the CANP Area, most of them were drafted by June 2012, and all still have to be approved and fully implemented. They concern: Child at risk of developing chronic disability, Childhood neuromuscular diseases, Child epilepsy, Autism, Child with eye problems.

Meanwhile, some other pathways of care have been activated by the Specialized Services CANP Unit in addition to those mentioned above, addressing visual disability and neuromotor disabilities. In addition, since 2012, a dedicated activity for the protection and mental wellbeing of non accompanied minors was implemented in Bologna City by the Developmental Psychiatry and Psychotherapy Unit.

Finally, responding to a LHT direction addressed to shorten the waiting list and requiring to accomplish 80% of first consultations within 90 days, in September 2012 the relative practice was regulated in the CANP Area by defining access priorities and appropriateness of response through the identification of an optimal composition of the multidisciplinary assessment team^{ix}, assessment procedures and times, delivery of an integrated intervention plan. The process started in Bologna City and it is extended to almost the whole territory.

Primary care

The CANP Area link with the PHC network of paediatricians and general practitioner is fluctuant, ranging from chances of valid referral and back-referral mechanisms to frequent direct access and/or scarce participation or involvement of the PHC professionals in the CANP intervention projects.

Despite the implementation of a Regional program of integration between PHC and specialized mental health care since 2000 – The Leggieri project^{31,32} – also at early ages³³, and systematic seminars on priority conditions are still regularly held by CANP professionals for PHC doctors, the relationships between the CANP Units and paediatricians and general practitioners are mainly depending on the sensitivity and interest of the single professionals, or on traditions of diverse reciprocal relationships in the different local settings.

Informal care

The Bologna rich social capital is reflected in the multifaceted interaction of the CANP Area with this care level. As above depicted, the active parties range from national institutions like Youth justice and state schools, to local institutions like the Social services or nursery,

^{ix} The multidisciplinary team is composed by a child and adolescent psychiatrist, psychologist and variable number and typology of members of the rehabilitative staff according to the child age and diagnostic hypothesis.

kindergartens and schools managed by the municipalities, to profit and non-profit private associations and family associations at national, regional, trust, over-district or district level. In addition, the inclusion of the voluntary and family associations in the DMH-A as a mixed lay-professionals Committee – the MH-CUFP – with its CANP section born in 2012, generates an internal interface for care delivering.

Briefly, the relationships may be summarized in three categories: external consultancy as for the Youth justice system; cooperation in the individual therapeutic-rehabilitative or community projects for all other actors, encompassing specific complex interventions for many conditions and support for most vulnerable populations; and shared decision making with the MH-CUFP.

Consensus development process

Background

The reform process of the CANP Area is to be contextualized in a wider framework of management reinterpretation and subsequent actions implemented at Trust and Department level during the last four-five years.

As mentioned above, at the end of 2008 a management shift from the old territorial fashion to a topic domain was accomplished by the Trust²⁴, introducing the opportunity to reconsider the departments aims and strategies. This is also true for the DMH-A.

In this line, since 2010, the Direction of the DMH-A is assigned to one of the main architects of the Regional mental health plan 2009-2011¹⁹, giving further impulse to its local declension.

In 2011 the milestones for future DMH-A development were presented in the manifesto "Our idea of department"³⁴. The document acknowledges the richness and diversity of the experiences and resources consolidated in the department through the last century, and stresses the contribution of present internal streams and external institutions to respect its values and to achieve its aims, but admits how this capital still needs to be better highlighted and systematized. It underlines how the present attenuation of ideological positions, the clearness of the reference strategic plans at Trust and Regional level, and the establishment of the Trust organization subsist as optimal conditions to achieve the synthesis of polycentric resources into a unitary policy, necessary to focus the attention on good practice and professional development as well as on clinical governance.

On the one hand, the document stresses how the structural and operational model set by the Department Organizational Regulations²⁵, though representing a required starting point, could neither substitute the cultural identity of the department, nor satisfy the need of governance of such a complex and multifaceted system. Responding to these lacks, since 2011 the Directional support staff was progressively organized to implement quality development, accreditation, risk management, training, logistic, communication, relationship with the users, information system and management control, promotion and prevention, social and health and professional inclusion coordination. In addition, in 2011 District Coordinators were appointed to the task of harmonizing the Departmental Areas activities at this level, and of integrating them with those of the Primary Care and Public Health Departments through regular meetings with the equivalent representatives of these bodies. Contemporarily, experts in specific topic areas were assigned an Office of high specialty (*Incarico di Alta Specialità*) consistent with their excellence. These professionals are psychiatrists, child psychiatrists, and psychologists; they are points of reference for specific topics at departmental level, promoting professional development. Among these topics,

three closely relate to the CANP Area: neonatology, early onsets, child and adolescent psychopathology, severe behavioural disorders, service monitoring and evaluation.

But the core of “Our idea of department” is the definition of a local policy: it fully adopts the high values and general aims of the Regional mental health plan 2009-2011¹⁹, and sets a strategy to achieve realistic, measurable, and evaluable aims. The strategy is articulated in four key points:

- *More care, more specificity.* Care pathways are proposed as balancing public health and technical-professional perspectives, integrating generalized and stand alone service models.
- *More community, less institution.* Rethinking of the community care that, after the deinstitutionalization process ended in 1997 in Bologna, has been scenario of the development and increasing autonomy by the private accredited residential sector. As new evidences show effectiveness and life quality improvement by community care programs, these should be implemented substituting residential care where possible; at the same time more transparency, coordination and audit is needed for the governance of the private sector.
- *Participation.* Emphasis is given to the relevance of the citizens’ participation and decision making as guarantee of transparency, especially through the shift from a polycentric to a unitary policy. Effort to include the MH-CUFP in decision making is recommended and further development of subsidiarity is proposed.
- *Social and health integration.* Adopting the Regional social and health plan¹⁸, the DMH-A carries out full social and health assistance. Though trust and local authorities are the recommended partners and equity of access should prevail on any vulnerability and disease priority, this model is inhomogeneously implemented at district level, so that the DMH-A resources are increasingly dedicated to social activities. An essential review of the model is required at trust level, otherwise, alternatively, the department should proceed differently in each district.

As a consequence of “Our idea of department”, two parallel reform streams flew through the Adult Psychiatry and CANP Areas: respectively, “Our idea of mental health”³⁵ and “Our idea of CANP”.

“Our idea of mental health” specifies the strategies mentioned above within its scope:

- *More care, more specificity.* Empowerment of the first level community service, developing more modern tools of care and rehabilitation; development of the networks connecting second and third level units and programs dedicated to specific disorders (i.e. eating disorders) or to vulnerable populations that hardly accede to services.

- *More community, less institution.* Reduce the hospital and residential care and empower the community care with early, tailored interventions implemented at community level.
- *Participation.* Impulse and support to subsidiarity, in addition to the already standing representative body of MH-CUFP.
- *Social and health integration.* Introduction of health budget, empowerment and collaboration in housing programs, further development of professional inclusion and integrated support to vulnerable, excluded populations.

Briefly, the actions implementing these strategies are: shift of some hospital and residential beds to new established CMHC provided with residential service, logistically integrated with PHC Centres – through this action 3 beds for adolescents in dedicated rooms within residential facilities will be activated; retrieval of and empowerment of the Operations Centre for admissions and residential care, to improve the coordination of these services across the public and private facilities; empowerment of the team dedicated to housing programs and increase of coordination of private/ subsidiary programs; central clinical governance of the private residential facilities in order to contrast the ongoing trans institutionalization phenomena; further development of subsidiary programs; modernization of CMHC individualized care programs through the introduction of health budget and individual placement and support, and integration of such programs with early interventions comprehensive of intensified adoption of updated pharmacological intervention protocols, cognitive psychotherapy to users and psychoeducation support to the family, case management.

“Our idea of CANP”

Actors

A large and heterogeneous group, representative of the CANP Area professionals, Directional support staff and MH-CUFP members, contributed to the process at different levels.

The working group of mental health professionals consisted of 80 members: almost 60 from the Community CANP Unit/ Aid Unit and almost 20 from the Specialized Services CANP Unit/ Aid Unit, plus some members of the Directional support staff. Briefly, the CANP professionals were the Area Director, Heads of each Simple and Complex Unit – child and adolescent psychiatrists –, Officers of high specialty, Heads of Aid Units and selected staff representative of the variegated multidisciplinary teams from all Districts.

The results of their work in progress were then periodically reviewed through meetings with MH-CUFP or its sections, that enabled the proposals correction, enrichment or adjustment.

Stages

“Our idea of CANP” started on October 1 2012, in a plenary session (Table 3). Four main issues were identified and relative working subgroups were formed: “the charter of CANP commitments: what to do and what not to do”, pathways between Specialized and Community services, CANP interfaces, communication and relationship with families and family associations.

At the end of October two meetings took place: the first of the CANP Area Direction – Heads of Complex Units/ Aid Units – and a member of the Directional support staff, the second including the working subgroups coordinators and facilitators to further focus and adjust the topics to be developed.

Two official meetings were held at the beginning of November by the working subgroups to start the activities that continued informally during the subsequent months; these sessions were followed by sharing the programs within the CANP Area MH-CUFP, and presenting the work plan in plenary session during the same month.

In December, a second meeting with the CANP Area MH-CUFP preceded the presentation of the work in progress to the Director of DMH-A, President and Vice-president of MH-CUFP in plenary session.

In January and February 2013 similar meeting sequences were organized. The subgroups work advanced, and in January it was presented again to the CANP Area MH-CUFP, revised by a new CANP Area Direction and Directional support staff member meeting, and resubmitted to the Director of DHM-A and President of MH-CUFP by a dedicated CANP committee. At the same time, at the end of January the Family Associations composing the MH-CUFP met in order to discuss the work development and commit the President of MH-CUFP to bring their requests to the CANP staff. At the beginning of February two working group plenary sessions summarized the work done up to then, results were then presented to the CANP Area MH-CUFP, a new meeting was held by the family associations composing the MH-CUFP, and finally, all the actors examined the state of art of “Our idea of CANP” in plenary session and presented it to the Director of DMH-A and to the Trust General Manager.

The activities had suffered a slowdown up to May when, after a thematic and a CANP Area MH-CUFP meeting, a series of two plenary seminars was held in May and June. The seminars included two topics: one regarding ethnopsychiatry in order to stimulate a more appropriate approach with the increasing number of foreign users; the other related to public health and optimal mix of mental health services^{36,37} – held by the candidate, at that time introduced in the reform process – in order to contextualize the subgroups work up to then and further develop it within an explicit public mental health framework. During the seminars, most of the prior and new highlighted issues were resumed into one: the development of a care pathways operational manual. As a consequence, the four previous working subgroups were recombined into three new subgroups, drafting different topic areas of the manual: neuromotory disabilities, developmental disorders, psychopathology.

Table 3. Stages of the Consensus Process

Activity	2012			2013			2014													
	Oct	Nov	Dec	Jan	Feb	...	May	Jun	...	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Working group Plenary Session	1	19			1,6															
CANP Area Direction	25			11																
CANP Area Direction & Working subgroups coordinators and facilitators	29																			
DMH-A Direction, MH-CUFP President and Working group			10 PS	13,15 D- CANP -C	18 PS + LHT GM															
Working subgroups*		3,4								17#		12#	17#		12#	4#				
Public MH Seminars & development of Care Pathways operational manual							29# PS	14# PS				28# PS				27#	8,9#		4,20, 24#	
CANP Area MH-CUFP		8	5	9	7		14				1			17			17#			
Familiy Associations				29	14															
Thematic MH-CUFP							6 NMD			18 CC, 26 LD		14 HI & VI, 26 PP						22 HI, 27 VI, 30 ASD	11 CC#	
CANP Area Direction & MH-CUFP Director																21	8,29			
MH-CUFP																				22#

Note: numbers indicate dates

* Since June 2013 the 4 initial subgroups turned into 3 subgroups developing different areas of the Care Pathways operational manual

Presence of the candidate

ASD: autism spectrum disorder; CC: continuity of care; D-CANP-C: dedicated CANP committee; HI: hearing impairment; LD: learning disabilities; LHT GM: trust General Manager; NMD: neuromotory disabilities; PP: psychopathology; PS: plenary session; VI: visual impairment

The draft of the manual was supervised by the candidate in the following months, through two meetings with the working subgroups coordinators and facilitators in September and in November; the work in progress and feedback obtained from MH-CUFP in the meanwhile was then shared in third plenary seminar at the end of November. In fact, in September two thematic MH-CUFP meetings were held after those of the subgroups, a CANP Area MH-CUFP took place in October, and other two thematic MH-CUFP meetings were finalized in November before the plenary seminar.

The candidate's supervision continued through monthly meetings in December 2013, February and March 2014, while another CANP Area MH-CUFP meeting took place in January.

Since March, a new sequence of alternate MH-CUFP groups and working groups meetings started, in order to accelerate the closing of the work in progress: a restricted meeting between the CANP Direction members and the MH-CUFP President preceded a new series of three largely participated working groups seminars held by the candidate, followed by three meetings with MH-CUFP – one open to the whole CANP Area MH-CUFP representative and working subgroups coordinators included the candidate, two between the CANP Direction members and the President of the MH-CUFP.

Three thematic MH-CUFP meetings were held in May and one in June, and a new series of three seminars held by the candidate were organized in June. In fact, while the participation to working subgroups by representatives of the Specialized Service Complex Units had been poor since May 2013, a growing interest for the ongoing process and their wish to catch it up emerged in March 2014. Therefore, finally, a mixed representation of the two Complex Units joint in June, in order to officially share and harmonize their activities.

The state of art of “Our idea of CANP” was finally presented at a Departmental MH-CUFP meeting on July 22. The work is still in progress, but a clear strategy has now been developed.

Evidences

Since the first phase, several issues were highlighted as requiring a response through the service reorganization.

- The “what to do and what not to do” group stressed the need to regulate the access, care and discharge. They proposed:
 - to regulate the referral by the PHC professionals comprehensive of a focused diagnostic question
 - to introduce an off-pocket participation to the first consultations
 - to monitor the direct access to the CANP rehabilitative staff by colleagues of the National Health System with other specialties^x

^x Portion of the CANP rehabilitative staff total hours is dedicated to rehabilitation of conditions referring to other specialties as orthopaedics, phoniatics, physiatrics.

- to close the access: to children with non relevant phono-articulatory disorders as rhotacism, stigmatism or with atypical swallowing; to children of clear social pertinence – i.e. multitude of children whose parents are separating –; to children with learning disabilities in high school requiring a neuropsychological assessment at Community Unit
- to update the map of trust and extra-trust resources to refer children and families to, at any care phase
- to further regulate the composition of the specific multidisciplinary teams according to the care pathways planned for the specific, individual, conditions
- to have the ongoing care plans monitored by such multidisciplinary team
- to activate individual or group child and/or family brief psychotherapies in all Simple Units for children suffering from mild-moderate psychopathologies
- to activate coordinated psychotherapy operational teams, with dedicated hours, to deliver long lasting interventions – if needed – to children with severe disorders
- to detect and share knowledge and skills on group activities at over-district level (psychoeducation, relaxation, art therapy, augmentative and alternative communication, etc)
- to regulate the rehabilitative interventions through defined duration cycles, through measurable outcomes identified in advance, and consistency with inherent guidelines or trust DTCP; to make those professionals with advanced skills in specific or rare conditions available among the Simple Units
- to optimize the regular meetings with teachers concerning disable children – beneficiaries of the Law 104/1992 – by carrying them out at CANP facilities or at central school sites, grouping more than one child per meeting, including the educators/ pedagogists in the meetings concerning adolescents attending high schools
- The group working on pathways between Specialized and Community Services pointed out the vulnerabilities of the internal link of the hub and spoke system. They proposed and/or highlighted the need:
 - to define the access procedures from Community to Specialized Services where lacking and to simplify the relative referral forms by using the intranet
 - to centralize the Early Infancy Clinical Centre from East Pianura to Bologna City, to facilitate referrals from the whole Trust catchment area
 - to centralize some functions of the Developmental Psychiatry and Psychotherapy Service as weekly meetings and experiment with new educational programs in the community to facilitate the discharge and subsequent social and health integration
 - to unify the information systems of the two Complex Units
 - to use innovative technologies to facilitate meetings, i.e. videoconferences

- to appoint Specialty Referents in all Simple Community Units to enhance the appropriateness of referral to Specialized Services and to serve as advisers for colleagues within their Unit
- to enhance the treatment programs implemented by the Specialized Services: group therapy for adolescents and families at the Developmental Psychiatry and Psychotherapy Service; enrichment of the ADHD treatment with group psychotherapy, teacher training, relaxation and cognitive self regulation for children
- to enhance the integration of the two Complex Units activities during some key phases of the treatment paths, such as shared response to families and treatment plan draft or adjustments, or in training on assessment and intervention for bilingual children
- to enable direct access to the Regional Centre of Cognitive and Language Disorders for new cases of suspect learning disabilities in adolescence and exclusive indirect treatment through schools from 6th grade in absence of disabilities regulated by the Law 104/1992
- to enable the Specialized Services staff to deliver treatments in the Community Centres

One critical point was also identified:

- the lack of psychiatric wards and residential facilities for exclusive children and adolescents use and relief to families
- Many critical points emerged through the work of the CANP interfaces subgroup. As a whole it was stressed the need of more regulated interactions and clarification of actual powers through the renewal and update of the memoranda of understanding at intra-departmental, intra-trust and extra-trust level, especially with:
 - CMHC Area and Addictions Services Area, to further regulate the continuity of care and related care sharing during this passage – especially for persons with psychopathology, intellectual disability and neuromotory impairments. Of course, this process would also involve the Social and Health Activities Department
 - Crisis Management Area, to find a possible solution to the lack of dedicated beds and environments for adolescents in psychiatric wards
 - Neonatology and Neonatal Intensive Care Unit at the Bologna LHT General Hospital (*Ospedale Maggiore*), to optimize the actual consultancy by the CANP staff through substitution of referrals to CANP Area with the early activation of a habilitation, family counselling and follow up program within the Unit for preterm newborns who will not need future CANP care
 - Neonatology and Neonatal Intensive Care Unit at the University of Bologna General Hospital (*Policlinico S. Orsola Malpighi*) – extra-trust facility –, to redefine the discharge, procedures and appropriateness of referrals

- CANP Unit at the University of Bologna General Hospital, to regulate the occurring unshared overlapping diagnostic procedures and interventions
- Schools, as mentioned by the “what to do and what not to do” group, also highlighting the inhomogeneity of actualization of shared activities at district and sub-district level
- Local authorities, underlying the inhomogeneity at the same levels of educational interventions for prevention and care of psycho-social conditions in and out of schools, as well as of services complementary to health care, such as transports, etc
- Social services, as well as some schools are managed by local authorities, thus presenting the same inhomogeneity of relationships above mentioned. Critical issues also involve the management of unaccompanied minors
- Youth Justice system, to optimize or activate actual rehabilitative paths for adolescents under its authority
- The subgroup involved in the communication and relationship with families and family associations consulted the CANP Area MH-CUFP to have its feedback about the perceived unaddressed need that could have a no cost cultural shift in care delivery. The families were mainly asking what they reconfirmed also in subsequent meetings along the whole reorganization process:
 - respect for the pain
 - appropriate relational and communicative empathic attitudes
 - person and needs centred policy and organization, claiming for the assignment of case managers and accuracy in the continuity of care
 - model centred on the family as a protagonist in the wider scenario
 - appropriateness of the first consultation in terms of relational attitude and timed procedures
 - multidisciplinary assessment
 - chance of an alternative clinical consultation at different care levels
 - effective mix between territoriality and specialization of services
 - therapeutic plan shared with the family as decision maker and monitoring actor
 - adequate and systematic treatment to pursue specific individualized objectives
 - appropriate connection between health and other sectors
 - prevention at all levels

The group then renewed the need of deeper adoption of the concept of centrality of the person and family as well as of the life project in the articulation of neurological and mental health care, advancing some proposals:

- to enhance the care of family perceptions and the facilitation of an opportunities network for families

- to improve the understanding and communication with foreign families through linguistic mediation
- to explicitly assess and integrate the family resources and potentialities in the therapeutic-rehabilitative-educative plan
- to adopt an operational framework that facilitates a more empathic relationship, the accessibility of information, the activation of resilience processes, a more active role of the family in the formulation and monitoring of the treatment plan
- to expand the psychoeducational activities within the treatment plan at family and group level
- to develop and expand the training for families about clinical conditions and relative rights legislation
- to further integrate the use of already active self-help groups in the therapeutic plans
- to activate innovative experimental interventions
- to further develop the participated interventions

Despite the abundance of remarks and proposals, and despite the appropriateness of most of them, when the candidate joint the process a lack of an integrated vision was prevailing at the base of the work in progress slowdown. Therefore, through two full days interactive training sessions, basic public mental health elements were presented, with special focus on the WHO framework of optimal mix of mental health services³⁶ (Figure 4), in order to build capacities and facilitate the working group's more aware participation to a strategy that could collect and organize their prior considerations, as well as enhance the generation of new questions from this wider perspective.

First relevant step was the deconstruction of the mainly clinical approach that had led the groups activity up to then. The professionals were complaining about the incompatibility of the increasing case load and higher requests by families unmediated by the prevalent direct access versus unvaried or reduced available resources. The definition of mental health need, mainly perceived as disease to be treated, could be articulated into a wider range of meanings for majority of which the direct specialized intervention was clearly no longer the optimal response. This process went together with the presentation of the multilayered care system model, thus enabling a new singling out of the CANP Area identity within this context and the increasing awareness of its need of a task shifting to manage its development and relationships with interfaces, identified as active partners in the optimal response to differentiated needs.

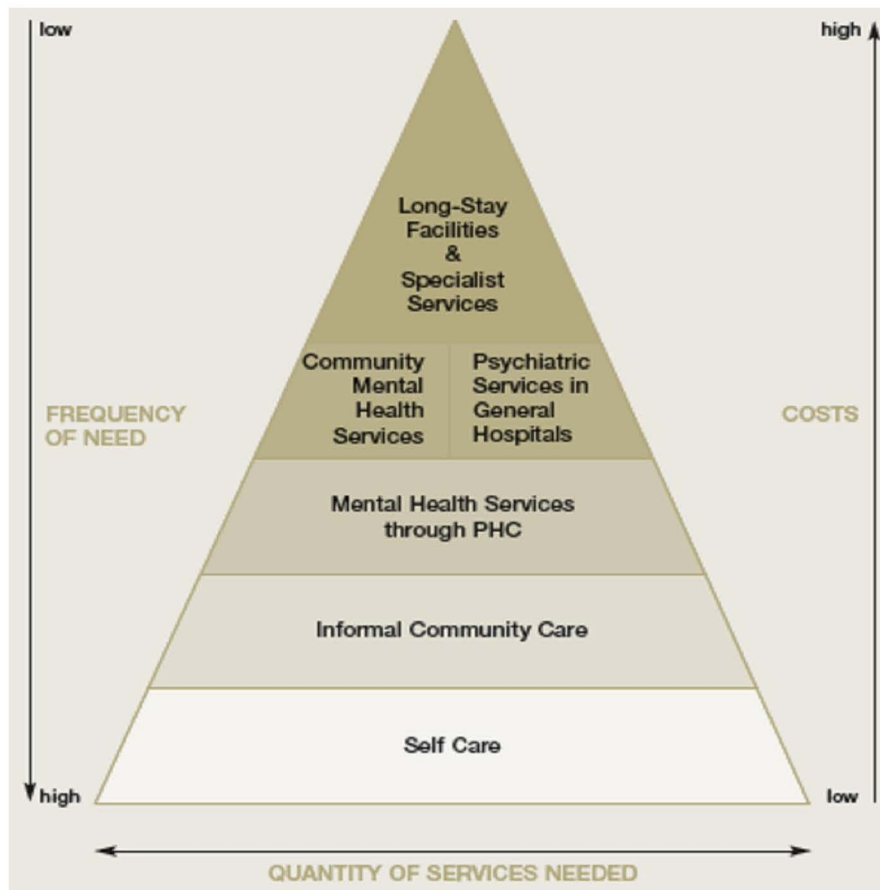


Figure 4. The optimal mix of different mental health services

Some new issues emerged through this process, which had not been mentioned in the previous subgroups activities: the CANP Area focus shift from direct intervention to the role of coordinator of a systematized service response; the potentially more active role of the informal and primary health care; no previous mention to the lack of priority access through referral by the PHC service; the relevance of inhomogeneity of care approach and delivery within the CANP Area across districts and Units; the awareness that Community and Specialized Services Units – up to then exalted as the main barrier to an integrated care – actually represent slight subdivisions of tasks within the same level of care and a more widely differentiated scenario.

Second step was to focus on how the working group could keep contributing to the reform process from this new perspective. This was achieved by facilitating the identification of a tool that could collect and translate into operations the preceding achievements, in order to support the CANP Area Direction in shaping an integrated strategy. The assembling tool was thought as a care pathways operational manual that could integrate the CANP Area statement of clinical appropriateness, definition of roles of the different levels of formal and informal services and regulation of the intersectoral links procedures.

The coordinators and selected professionals of the four previous groups were disaggregated and recombined into three new groups to draft the relative manual sections of neuromotory disabilities, developmental disorders and psychopathology. Members were assorted

according to their excellence and to generate multidisciplinary working subgroups, so that each group was diversely composed and comprehended professionals appointed of Office of high specialty.

The key points of the care pathways manual are:

- Pathways concern topics for which there is no other existing regulation such as regional programs or trust DTCP.
- Care pathways are defined as homogeneous prevention and care paths for age range and conditions. Basic age ranges considered are 0-2, 3-5, 6-10, 11-17 years; further subdivisions or grouping of these categories may vary according to some specific conditions. Conditions are not univocally related to diagnoses, but may be differentiated within the same diagnosis for diverse severity of symptoms or disability or, on the contrary, more than one diagnosis may be grouped within the same pathway if this is homogeneous for all the diagnoses.
- For each pathway the role of the interested levels of care is described from admission to discharge. Roles are articulated upon inclusion and exclusion criteria, assessment and monitoring procedures and tools, intervention, discharge criteria, regulation of interfacing procedures; new proposals and critical points are annotated at the end of each pathway and were drafted also for presently regulated pathways.
- The pathways described do not univocally correspond to what implemented by the CANP Area or other actors up to now, some assessment tools and procedures as well as some interventions were updated taking into account evidence based treatments or practices experienced elsewhere with good outcomes. For this purpose a review of scientific literature and national and international guidelines or consensus was carried out previously. Of course innovations concerning other actors are only proposals, and represent object of future negotiation with the involved parties.
- In each pathway the sequence and dose of interventions has been stated as far as possible in order to introduce, enhance and facilitate the process and outcomes monitoring and evaluation.

Care pathways almost completed up to now: cerebral palsy, auditory and visual impairments, specific language disorders, ADHD, specific developmental disorders of scholastic skills, intellectual disability, early behavioural and emotional disorders (0-5 years), internalizing disorders (anxiety and depression), externalizing disorders (personality and conduct disorders), crisis management (mood disorders and early onsets). Other care pathways in progress: early psychomotor delay (0-3 years), specific developmental disorder of motor function, eating disorders.

Local Plan

Strategies

In line with the “Our idea of department” and with the “Our idea of mental health”, the strategies of the “Our idea of CANP” pursue the fulfilment of realistic and measurable aims that can be articulated along the different levels of care.

Reform of second and third level

A cultural advancement is stemming, raising the awareness of self-contextualization within a broader scenario of potential mental health services, moving the CANP professionals from a static clinically oriented posture to dynamically acceding to a required task shift to be effective actors of the reform. This process has already enabled a new self-definition:

- the organizational hub & spoke, specialized and territorial combined model is confirmed through the reform to ensure appropriateness of care, in continuity with the structural and cultural stratification inherited from the past decades, but
- constant monitoring of care pathways implementation will now measure the evidence of the integration of the two instances
- the homogeneity of care aimed by pathways should itself facilitate the monitoring and evaluation of the whole service, thus responding also to sustainability exigencies dictated by an increase of demand in front of relative decrease of resources
- at the same time, the pathways of care degree of flexibility will enable to modulate the balance between homogeneity of care and equity of access with individualized intervention plans beyond evidences

Explicit institutionalization was left far beyond by CANP in virtuous Italian regions after the overcoming of the medical-pedagogical institutions and special classes. Nevertheless other forms of crawling institutionalization may be as well identified in the paternalistic approach that to some extent still abundantly characterize the Italian CANP. Against this aura and in support of the care pathways implementation

- some additional tools are identified at community level to give impulse to appropriate innovative interventions and to their adherence and management: local Specialty Referents and case managers

Because of structural constraints, more critical remains the admission to inpatient services and to residential facilities that keeps occurring, respectively, in adult facilities and in sites far from the original residence often after long waiting time.

- A satisfactory readjustment in the community, though representing a further critical step after discharge, should be better addressed by the above mentioned introduced tools.

Retrieving primary care

The role of paediatricians and general practitioners, and in general of the PHC, was rethought:

- PHC is integrating part of the decentralization of care, through mechanism of appropriate filter and referral, as well as of effective back referral
- the involvement of the paediatricians and general practitioners has always been considered in any pathway of care, and special attention has always been paid in identifying procedures or tools limiting as much as possible their overburden
- the rapprochement between primary care and CANP will be successful only through essential sustainment at departmental level

Including informal

Another aspect of the underlying cultural advancement undertaken is participation:

- a mutual approach between CANP professionals and family associations has characterized the reorganization through its unfolding up to now, with growing unity of purposes experienced along this process
- further steps are expected in sharing with MH-CUFP the implementation strategies of DTCP being drafted and in enhancing subsidiary programs
- also the collaboration with local authorities growing: example is the establishment of Integrated Community Teams (*Equipes Territoriali Integrate*) and of Minors Assessment Units (Unità di Valutazione Minori) in Bologna City, dedicated to the joint monitoring of the admission of minors in residential communities
- further development of joint intents between Social services and CANP as well as overcoming of local disparities are wished and supported

Actions

In 2013 some structural and operational changes have been finalized:

- two Simple Units were moved from the Specialized Services Unit to the Community Unit: Developmental Psychiatry and Psychotherapy Unit and “Centres” Unit
- the CANP information system was developed and enriched with essential links:
 - all CANP Simple Units except two were connected with each other, though data from the two Complex Units are not totally compatible yet

- some data essential for the continuity of care and shared management were linked with the Adult Psychiatry and Addiction Areas information system, with few exceptions
- linkage was implemented between the CANP Area and the paediatricians and general practitioners network, but not with the rest of PHC services

Other actions have already been undertaken, more closely related to the ongoing reform. Some of them finalized, while others still in progress:

- the pathways of care operational manual is almost finalized
- new offices are being assigned:
 - Specialty Referents are being identified among the multidisciplinary teams at simple unit, district or over-district level according to their physical availability for main topics: neuromotoric impairments, sensorial impairments, developmental disorders, eating disorders, and other psychopathology. They are thought of a double function of supervising clinical management and enhancing knowledge and skills at local level, but also of ensuring high quality of questions to the Specialized Services or other hub or third level facilities
 - Case manager is being introduced in the care delivery organization, consisting of rehabilitative professionals, to coordinate the accesses to different services for children and adolescents with complex conditions
- two new dedicated teams were established to ensure specificity of care at community level toward identified priority conditions:
 - the Early Infancy Clinical Centre specialized team will maintain its previous function of early prevention and intervention extending its activity up to 5 years children
 - a qualified team has been activated for transcultural consultation and care
- Nine subsidiary projects are ongoing in Bologna City. Two of them were activated in 2013, adopting the 2011 Regional directive for children fostering care³⁸ and the Regional guidelines for care of children and adolescents victims of maltreatment or abuse³⁹, to support the appropriate insertion of adolescents in residential facilities:
 - the Integrated Community Teams
 - the Minors Assessment Units

Next future plan is to dedicate one of each these teams and units to unaccompanied minors.

Expected outcomes

Future development of the reform will depend on internal and external factors:

- what can be already stated in the care pathways operational manual about a new internal organization must be finalized and activated

- such finalization will be essential for more accurately monitoring the service quality and intervention effectiveness
- indicators of the reform actual implementation are being selected
- the degree of external responsiveness to the CANP partnership strategy by other levels of care will also be crucial for the success of the reform. After the positive feedback by the families through the MH-CUFP, it will now be essential to gain the factual alliance of
 - the Department of Primary Care
 - the LHT Neurological Sciences IRCCS
 - the University CANP and Neonatology Units
 - educational institutions

Conclusions

In spite of the possible sterile renewal of the enduring class conflict between adult psychiatry and child and adolescent neuropsychiatry – typically, the first more pragmatic and powerful, the second more creative and idealistic, both narcissistically convinced to be right – something much more interesting and valuable is fermenting in the living laboratory of the Bologna Department of Mental Health and Addictions.

In fact, the reciprocal recognition of the other's resources have progressively generated virtuous joint intention dynamics. The family associations are integral part of the experiment, and themselves have been able to modulate through the process some prior unrealistic ambitions or provocative relational styles, to gain an authentic constructive role.

More technically, the partnership strategy is gathering positive results up to now: the high values and ambitions, and the sound public health conceptual framework of the Regional mental health policy, aiming at integrating community with care and, transversely, to integrate systematized with individualized effective intervention, are being translated into practice through the active participation of the CANP Area professionals, and with the entrustment of the family associations.

The traditional hub and spoke model is confirmed, not disrupting the homeostasis of the experimental conditions, but supporting the identity consistency of the CANP Area professionals despite changes, and reassuring the families.

Some tools developed by the CANP staff itself, such as the care pathways, are almost ready to be used in the routine practice, and the appointment of the specialty referents and case managers will be above all an acknowledgement of the capacities for the involved professionals.

Next are two delicate steps. Again, they will require a synthesis between solid methodology, to monitor the ongoing changes, and renewed participative skills, to gain new intra-departmental, extra-departmental and extra-trust alliances for the actual roles redistribution. In fact, facilities for crisis management of children and adolescents, the continuity of care for persons with intellectual disability during the passage to adulthood, the integration between primary care and mental health care, and the more participative roles of schools and local authorities do represent slippery steps along the intervention pyramid that still need effective solutions.

But the experiment is on, and CANP and DMH-A now hold good cards for... new understanding and new hope.

References

- ¹ WHO. *The World health report: 2001. Mental health: new understanding, new hope*. World Health Organization; 2001.
- ² WHO. *Mental health atlas 2011*. World Health Organization; 2011.
- ³ WHO. *The global burden of disease: 2004 update*. World Health Organization; 2008.
- ⁴ Demyttenaere K, Bruffaerts R, Posada-Villa J, Gasquet I, Kovess V, Lepine JP, Angermeyer MC, Bernert S, de Girolamo G, Morosini P, Polidori G, Kikkawa T, Kawakami N, Ono Y, Takeshima T, Uda H, Karam EG, Fayyad JA, Karam AN, Mneimneh ZN, Medina-Mora ME, Borges G, Lara C, de Graaf R, Ormel J, Gureje O, Shen Y, Huang Y, Zhang M, et al; WHO World Mental Health Survey Consortium. Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *JAMA* 2004, 291:2581-90.
- ⁵ WHO. *Atlas: child and adolescent mental health resources: global concerns, implications for the future*. World Health Organization; 2005.
- ⁶ Levav I, Jacobsson L, Tsiantis J, Kolaitis G, Ponizovsky A. Psychiatric services and training for children and adolescents in Europe: results of a country survey. *Eur Child Adolesc Psychiatry* 2004, 13(6):395-401.
- ⁷ Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry* 2005, 62(6):593-602.
- ⁸ Ferrannini L, Ghio L, Gibertoni D, Lora A, Tibaldi G, Neri G, Piazza A; Italian Mental Health Data Group. Thirty-five years of community psychiatry in Italy. *J Nerv Ment Dis* 2014, 202(6):432-9.
- ⁹ Ministry of Health. *Progetto obiettivo tutela salute mentale 1994-1996* [Targeted mental health care plan 1994-1996]. 1994. Decree 04.07.1994.
- ¹⁰ Ministry of Health. *Progetto obiettivo tutela salute mentale 1998-2000* [Targeted mental health care plan 1998-2000]. 1998. Decree 11.01.1999.
- ¹¹ Ministry of Health. *Linee di indirizzo nazionali per la salute mentale* [National strategic plans for mental health]. 2008.
- ¹² Bollea G. *I centri medico-pedagogici* [The medical-pedagogic centres]. *Il lavoro neuropsichiatrico* 1947, 1(2):359-64.
- ¹³ Ministry of Health. *Progetto obiettivo materno infantile 1998-2000* [Targeted maternal and child health plan 1998-2000]. 2000. Decree 03.16.2000.
- ¹⁴ Ministry of Health. *Schema di piano sanitario nazionale 2011-2013* [National health plan draft 2011-2013]. 2011.
- ¹⁵ Ministry of Health. *Piano di azioni nazionale per la salute mentale* [National mental health action plan]. 2013.
- ¹⁶ Senate of the Republic. *Mozione sulla tutela della salute mentale in età evolutiva* [Motion on the protection of child and adolescent mental health]. Approved 10.03.2012.
- ¹⁷ Italian Society of Child and Adolescent Neuropsychiatry (SINPIA). *Il libro bianco* [The white book]. <http://whitebook.sinpia.eu/>
- ¹⁸ Emilia Romagna Legislative Council. *Piano sociale e sanitario 2008-2010* [Social and health plan 2008-2010]. Deliberation n175/2008.

-
- ¹⁹ Emilia Romagna Regional Council. *Piano attuativo salute mentale anni 2009-2011* [Mental health plan 2009-2011]. Decree n313/2009.
- ²⁰ Emilia Romagna Regional Council. *Istituzione dell'Azienda Unità Sanitaria Locale di Bologna – modifiche alla legge regionale 19/94* [Establishment of the Bologna Local Health Trust – amendment of the Regional Law 19/94]. Regional Law n21/2003.
- ²¹ Bologna Local Health Trust. *Approvazione dell'atto aziendale* [Approval of the trust certificate of incorporation]. Deliberation n4 01.28.2005.
- ²² Bologna Local Health Trust. *Approvazione regolamento organizzativo aziendale* [Approval of the trust organizational regulations]. Deliberation n161 07.07.2005.
- ²³ Bologna Local Health Trust. *Approvazione regolamento organizzativo aziendale – parte II* [Approval of the trust organizational regulations – part II]. Deliberation n325 12.29.2005.
- ²⁴ Bologna Local Health Trust. *Provvedimenti in merito al regolamento organizzativo aziendale* [Measures regarding the trust organizational regulations]. Deliberation n218 11.06.2008.
- ²⁵ Department of Mental Health and Addictions. *Regolamento di organizzazione dipartimentale*. [Regulations of departmental organization. Department of Mental Health and Addictions]. 2009.
- ²⁶ Bologna Local Health Trust. Department of Mental Health and Addictions. *Piano organizzativo dell'area dipartimentale NPJA*. [Organizational Plan of the Departmental CANP Area]. Issued 10.11.2011.
- ²⁷ Emilia Romagna Regional Council. *Programma regionale integrato per la assistenza territoriale alle persone con Disturbo dello Spettro Autistico (PRIA): obiettivi 2011-2014* [Regional program for integrated community care for people with Autism Spectrum Disorder (PRIA): objectives 2011-2014]. Decree n1378, 2011.
- ²⁸ Emilia Romagna Regional Council. *Screening uditivo neonatale e percorso clinico ed organizzativo per i bambini affetti da ipoacusia in Emilia-Romagna - Approvazione linee guida per le aziende sanitarie* [Newborn hearing screening and clinical and organizational pathway for children affected by hearing loss in Emilia-Romagna - Approval of guidelines for Local Health Trusts]. Decree n694, 2011.
- ²⁹ WHO. *Multi-axial classification of child and adolescent psychiatric disorders: The ICD-10 classification of mental and behavioural disorders in children and adolescents*. Cambridge: Cambridge University Press; 1996.
- ³⁰ Bronfenbrenner U. *The Ecology of Human Development: Experiments by Nature and Design*. Cambridge: Harvard University Press; 1979.
- ³¹ *Psichiatria e medicina di base: il progetto della Regione Emilia-Romagna: atti del Workshop, Bologna 12-13 marzo 2001* [Psychiatry and primary care: the Emilia Romagna project: acts of the workshop, Bologna March 12-13th 2001]. Bologna: Compositori; 2001.
- ³² Emilia Romagna Region, Department of Health Policies. *Programma regionale "Giuseppe Leggieri", Integrazione tra cure primarie e salute mentale. Report 2013* [Regional Programme "Giuseppe Leggieri", Integration between primary care and mental health. Report 2013]. Emilia Romagna Region, 2013.
- ³³ Emilia Romagna Region. *Neuropsichiatria infantile e Pediatria. Il progetto regionale per i primi anni di vita* [Child and adolescent neuropsychiatry and Paediatrics. The regional project for the early ages]. 2006. Dossier 126/2006.
- ³⁴ Bologna Local Health Trust. Department of Mental Health and Addictions. *La nostra idea di dipartimento* [Our idea of department]. Bologna, 04.13.2011.

³⁵ Bologna Local Health Trust. *Provvedimenti in merito al regolamento organizzativo aziendale: modifiche all'assetto organizzativo del Dipartimento di Salute Mentale - Dipendenze Patologiche. Allegato 1* [Measures regarding the trust organizational regulation: modifications to the organizational structure of the Department of Mental Health and Addictions. Annex 1]. Deliberation n69 04.30.2014.

³⁶ WHO. *Organization of services for mental health*. (Mental health policy and service guidance package). World Health Organization; 2003.

³⁷ Funk M, Saraceno B, Drew N, Lund C, Grigg M. Mental health policy and plans : promoting an optimal mix of services in developing countries. *Int J Ment Health* 2004, 33(2):4-16.

³⁸ Emilia Romagna Regional Council. *Direttiva in materia di affidamento familiare, accoglienza in comunità e sostegno alle responsabilità familiari* [Directive concerning foster care, insertion in community and support for family responsibilities]. Decree n1904, 2011.

³⁹ Emilia Romagna Regional Council. *Linee di Indirizzo regionali per l'accoglienza e la cura di bambini e adolescenti vittime di maltrattamento e abuso* [Regional Guidelines for the reception and care of children and adolescents who are victims of maltreatment and abuse]. Decree n1677, 2013.