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Mental Health in Italy: Systems, Stigma, and Impact of COVID-19

Charley Nyzio
cnyzio6@gmail.com

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Charley Nyzio

Department of Psychology, Connecticut College

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Abstract

In 1978, Italy became the first European nation to radically change its mental healthcare system. Psychiatric hospitals were shut down, and a community-based publicly-funded system of mental healthcare took its place. This reform sought to restore dignity to those with mental illnesses through rehabilitation and increased participation in the community and daily activities. Though characteristics of marginalization and exclusion were relatively eliminated, covert stigmas surrounding mental illness remain a persisting problem. This review seeks to 1) evaluate the historical progression of mental health reform as well as the effectiveness of the current system of mental healthcare in Italy 2) explore theoretical perspectives of stigma and investigate the embeddedness of mental illness stigma (MIS) in Italian culture 3) review research regarding how to combat MIS, as well as criterion for effective anti-stigma projects 4) assess recent literature on the Italian response to the COVID-19 pandemic in terms of mental healthcare, and the extent to which the current system can withstand public health crises of such magnitude. More high-quality information regarding the effectiveness of the current system is needed to provide all people in Italy with equitable quality and access to psychological care.

Keywords: mental healthcare, healthcare reform, mental illness stigma, stigma reduction, COVID-19

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Models of healthcare across Europe tend to abide by the principle that citizens should have equal access to healthcare (Sadeniemi et al., 2018). Yet, differing models of service provision exist between European countries along with variable systems of mental healthcare specifically (Sadeniemi et al., 2018). Italy is widely acknowledged for its progressive community-based system of mental healthcare, encompassing a broad network of facilities to meet diverse care needs. In fact, the system of mental healthcare in Trieste, a small coastal city of Northern Italy, has been met with such success that its model has been celebrated by the World Health Organization as a model system and imported and emulated in over 40 countries around the world, including cities such as San Francisco and Los Angeles (LA)(Portacolone et al., 2015, Poggioli, 2021). LA, United States has long dealt with an inadequate system of mental healthcare, with county jail becoming the largest de facto mental health facility in LA county(Waters, 2020). To reform LA's failing system of mental healthcare, the city has attempted to replicate a Trieste-style model; ensuring that physical needs for food, clothing, and shelter are met for those with mental illness, forging connections with other community members, and supporting those afflicted in their pursuit of meaningful activities and employment (Waters, 2020). The exportation of Italian systems as models for mental health care is a testament to the success of the country's reform, beginning in 1978. A deeper dive into the intricacies of the system and its progressive implementation, however, is necessary to determine which aspects are efficacious as well as areas that may still need improvement.

Although compassionate and progressive in its approach to mental healthcare, Italy has yet to be freed from the clutches of cultural stigma surrounding psychological disorders. Mental illness stigma (MIS) is an omnipresent social phenomenon that transcends international borders

and is considered to be a global public health crisis (Krendle et al., 2020). Apart from stigmatizing attitudes displayed at the micro-level within cultures, the way in which countries construct their systems of mental health care is deeply affected by mental health stigma. In face of this challenge, some countries such as Italy have taken great strides to advantageously reform mental healthcare systems with hopes of not only improving the lives of individuals with mental illness but also combating the stigma surrounding mental illness more broadly. The extent to which this has been met with success should be analyzed to reveal effective strategies for combating MIS structurally, as well as through targeted projects, and realize the distance Italy may still have to travel to reach the goal of mitigating MIS.

This review is structured as follows: First, I seek to evaluate the historical progression of mental health reform as well as the effectiveness of the current system of mental healthcare in Italy. Second, I explore theoretical perspectives of stigma and investigate the embeddedness of MIS in Italian culture. Third, I review research regarding how to combat MIS, as well as the criterion for effective anti-stigma projects. Finally, I assess recent literature on the Italian response to the COVID-19 pandemic in terms of mental healthcare, and the extent to which the current system can withstand public health crises of such magnitude. Through analysis of existing literature, I hope to highlight concise perspectives and directions for which the system of mental healthcare in Italy should be improved.

Literature Review

History of Mental Healthcare

A mental health system is defined by Lora (2009) as the structure and all those activities whose primary purpose is to promote, restore or maintain mental health. In 1978, Italy became the first developed nation to radically change its mental healthcare to a system based on a

community network of mental health facilities alone. Prior to this year and the 'law 180', Italy's system of mental healthcare encompassed some components of community care but functioned primarily through psychiatric hospitals (Lora, 2009). 'Law 180' was not an immediate shutdown of all psychiatric hospitals but rather initiated their gradual closing, shifting towards a robust community-based system of mental healthcare. This law, also known as the Basaglia law, functioned essentially as a guideline for all 21 regions in Italy that were entrusted to draft and implement the law's general principles into their communities (de Girolamo et al., 2007). The four main components of this reform law included:

> " (1) the gradual phasing out of Mental Hospitals (MHs) through the cessation of all new admissions; (2) the establishment of General Hospital Psychiatric Units (GHPUs) for acute admissions, with a maximum of 15 beds each; (3) more restrictive criteria and administrative procedures for compulsory admissions (4) the setting up of Community Mental Health Centres (CMHCs) providing psychiatric care to geographically defined areas" (p. 84).

Italy now has universal healthcare for all Italian citizens provided by the National health service, and all citizens also have completely free access to unlimited healthcare including psychiatric care, as well as access to private inpatient psychiatric facilities (de Girolamo et al., 2007). Law 883 was implemented prior to law 180 in 1978 which abolished the mutual aid system of healthcare, replacing it with the national health service that provides universal health coverage to all Italian citizens. Presently, mental health services are organized through 211 DMHs across Italy with each DMH overseeing a geographically defined area corresponding to a Local Health Unit (LHU) (de Girolamo et al., 2007). Italy's mental healthcare system is

community-based, encompassing acute inpatient facilities, residential facilities, established in the

year 2000, as well as community health centers that opened in 2001(de Girolamo et al., 2007).

Acute inpatient facilities. Acute inpatient facilities deliver care within GHPUs, with

facilities having a maximum of 15 beds (Lora, 2009). These acute inpatient facilities are closely

tied with CMHCs to ensure that care for patients is continued into the long term after they leave

the facility (Lora, 2009). Within acute inpatient facilities, there are a varying number of public

beds between the South to the North-East and Center of Italy (by nearly a 1:2 ratio). Researchers

have noted a shorter length of stay by patients in the South, which can likely be attributed to

fewer beds being available in Southern regions compared to the North (de Girolamo et al., 2007).

In fact, some areas in the South having the fewest acute inpatient beds also show the greatest

concentration of private inpatient beds, indicating an inverse relationship (de Girolamo et al.,

2007). Due to the relative unavailability of public beds, care provided within the private mental

health sector functions as compensation. This solution is not equitable, however, since private

beds are not accessible to lower and middle-class Italians without the financial means to afford

this type of care. Lora (2009) reported also that the availability of public acute beds in Italy was

approximately 20% less than the official national standard (1 bed per 10,000 inhabitants). In

terms of private beds, the rate was 0.94 beds per 10,000 inhabitants (Lora, 2009). Therefore,

among acute inpatient facilities, there is regional variability in terms of access to beds, with

many areas falling short of the standard set by Law 180. Regional disparities are likely due to

variation in regional funding, as the Southern regions are less affluent than Northern. but also

due to a lack of a national mental health information system. This severely hampers not only

planning but also monitoring and analysis of the mental health system (Lora, 2009).

Residential facilities. Residential facilities in Italy provide long-term care for patients, oftentimes functioning as permanent homes for chronically disabled patients. These facilities are not often restrictive in terms of their length of stay and have been reported to sponsor a welcoming home-like atmosphere (de Girolamo et al., 2007). These facilities possess good environmental characteristics, including ample space for patients and access to gardens to spend their leisure (Lora, 2009). However, residential facilities have been found to restrict the daily lives and behaviors of the patients living there (de Girolamo et al., 2007). According to Lora (2009), 45% of the patients in a residential facility study were totally inactive, not even assisting with their facility's daily activities, and standardized assessment instruments and written treatment plans were rarely used. In 2000, Italy had a rate of 3.5 residential beds per 10,000 inhabitants over 14 years of age with marked variability (up to 10-fold) in the availability of residential beds among the varying regions (Lora, 2009). Much like other branches of the DMH, there is inconsistency in access to residential care between regions, despite there being a national standard.

Community Mental Health Centers (CMHCs). CMHSs are an essential component of the system of mental healthcare in Italy, covering all activities pertaining to adult psychiatry in outpatient settings and managing therapeutic and rehabilitation activities delivered by DCFs and RFs (Lora, 2009). CMHC's offer the majority of outpatient and non-residential care, and include multidisciplinary teams of psychiatrists, psychologists, social workers, nurses, and educators (de Girolamo et al., 2007). In terms of CMHC distribution in Italy, a survey reported by Lora (2009) found few differences between geographical areas: Northern Italy averaged 25.9 professionals per 100 000 residents (SD ± 11.5), Central Italy 28.3 (SD ± 7.4), and Southern Italy 23.7 (SD ± 6.9). There were, however, differences within some regions (i.e, Veneto vs Friuli Venezia

Giulia). According to Lora (2009) regional data collected from five regions of Italy including

Emilia Romagna, Friuli Venezia Giulia, Lazio, and Lombardia, revealed that CMHCs treated

93% to 97% of the patients cared for within the Department of Mental Health. This data

additionally revealed that a quarter of all the patients received community treatments (home

visits, intervention in the community, etc.) outside of the CMHC facility (Lora, 2009). In fact,

more than 37% of the CMHCs are reported to have established high-quality programs to ensure

care continuity for severe mental disorders (including intensive home care, drop-out prevention

programs (Lora, 2009). However, among the CMHCs, prevention, and promotion programs were

not widespread, with only 18% of programs among CMHCs considered adequate (Lora, 2009).

Another study conducted by Tansella et al (2005) evaluated the effectiveness of a community-

based mental health service focusing on severe mental illness in Verona, Italy. Results supported

a balanced care approach to mental healthcare, in which mental health services are provided

within community settings close to the population served, while hospitals maintain a backup

role; hospital stays are as brief as possible, arranged promptly, and utilized only when necessary

(Tansella et al., 2005). Therefore, an effective system is not reliant entirely upon community-

based mental healthcare establishments but works in conjunction with hospitals for emergent

cases.

In terms of utilization of mental health services in Italy, Wang & Fattore (2020) found

that half (51%) of Italians with a severe mental disorder in their study used health services, only

a quarter (25.9%) of those with moderate disorders, and a fifth (17.3%) of those with mild

disorders. Only one-third (33%) of the people treated by the health services received minimally

adequate treatment (Wang & Fattore, 2020). Adequate treatment was defined as at least one

month of pharmacotherapy plus at least four visits to any type of medical doctor or at least eight

psychotherapy contacts. While these statistics may seem relatively low or insufficient in terms of care achieved, the results of Wang & Fattore's (2020) study are not so different from those of other high-income countries.

While Italy's mental health care reform was a progressive step forward, it did not come without drawbacks and complications. Firstly, there was an issue of providing effective care to people with severe mental illness and evaluating such care upon shifting to a new system (Lora, 2009). Despite this challenge, previous research found there to be no increase in severe crimes committed by those with a mental illness, as the actual number of people placed in the six Italian forensic MHs has not increased since 1980 (Priebe et al., 2005). Another challenge involved regional inconsistencies, especially related to the funding towards community mental health facilities. Since different regions have varying standards regarding service provisions and organizational frameworks, there is a relatively uneven distribution of the reformed system (de Girolamo et al., 2007). Initially, after law 180 was implemented, researchers noted a service discrepancy between more affluent areas of Italy in the northern and central regions and the poorer regions of the South and the islands (e.g., Sicily and Sardinia) (de Girolamo et al., 2007). For Italy to achieve a more consistent system of mental healthcare, regional differences need to be addressed, with more funding and guidance allocated to less affluent areas. In sum, the model of mental health care reflects progressive ideals, yet its implementation has been geographically inconsistent, with rates of utilization being lower than what one might expect.

Mental Illness Stigma In Italy

Law 180 eliminated characteristics of marginalization and exclusion, restoring dignity to those with mental illnesses in Italian society through rehabilitation and increased participation in

the community and daily activities. Despite substantial progress accredited to this reform, covert stigmas surrounding mental illness persist. Mental Illness Stigma (MIS) is known to be present in Italy, although its relative prevalence compared to other countries has been sparsely researched. MIS comprises commonly held prejudices and beliefs that people with mental disorders are responsible for their disease because of their behavior, that they are violent, unpredictable, and dangerous, and that communication with them is difficult (Del Casale et al., 2013). Because mental illness stigma has substantial adverse impacts on the lives of those living with mental illness, it is a subject in need of further research.

Theorizing Stigma. Stigma has been applied to a range of theoretical orientations having varying definitions even between disciplines (Link and Phlen, 2001). Researchers from Link and Phlen (2001) posit that the term stigma should be applied when elements of labeling, stereotyping, separations, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold. In order for the stigmatization process to occur, exerted social, economical, and political power is necessarily present. When a group possesses the power to forcefully label and extensively stereotype a less powerful group to achieve discriminatory outcomes, three generic types of mechanisms may be employed including individual discrimination, structural discrimination, and discrimination that operates through the stigmatized person's beliefs and behaviors -- a phenomenon labeled internalized stigma (Link and Phlen, 2001). Self-stigma is defined as the process in which a person with a mental health diagnosis becomes aware of public stigma, agrees with those stereotypes, and internalizes them by applying them to the self (Link and Phlen, 2001). Among those who do seek treatment for a mental illness, self-stigma has also been suggested to play a role in non-adherence to treatment regimens.

Sigma is persistent and such a difficult issue to combat because these mechanisms of perpetuation are always subject to adaptation, or can emerge newly. If the mechanisms described above become blocked or embarrassing to use, new ones can always be created to continue the stigmatization of a certain group (Link and Phlen, 2001). For example, blatant mental health discrimination has been noted within U.S mental asylums as well as Italian, which have both previously engaged in dehumanizing, depersonalizing, and abusive practices. For example, US asylums relied heavily on means of control including hydrotherapy, as well as mechanical restraints such as straight jackets, manacles, waistcoats, and leather wristlets (Fabian, 2017). Similarly in Italy, asylum patients were locked in cages, tied in straitjackets, subjected to freezing water baths, electroshock, as well as lobotomies (Poggiolli, 2021). Doctors claimed these restrictive measures kept patients safe, but due to limited space and resources within asylums, it is clear these practices functioned more as a means of controlling overcrowded institutions (Fabian, 2017). While most of these abusive practices have been outlawed and US mental asylums have since shut down, a notable lack of parity in health insurance coverage exists in the US today, indicating residual discriminatory sentiment towards those with mental illnesses.

The stigma associated with mental illness in Italy is known to cause social exclusion, low quality of life resulting from discrimination, as well as hesitancy to seek out mental health services due to self-stigma (Zaninotto et al., 2018). Summarizing across multiple research studies, Zoppei & Lasalvia (2011) determine MIS generally as an obstacle to searching for and maintaining employment and finding housing; it encourages alcohol and substance abuse, increasing the likelihood of depression and suicide. Among those who do seek treatment for a

mental illness, self-stigma specifically has additionally been suggested to play a role in non-adherence to treatment regimens (Sirey et al., 2001).

Unfortunately, even those who work within the health field and interact directly with mentally ill patients have been previously reported in some studies to possess harmful prejudices associated with MIS. Specifically, Zaninotto et al., (2018) summarized a study revealing that psychologists and psychiatrists may have more negative ratings than the general public in terms of stereotypes, restrictions of the individual's rights, and social distancing. In this study, a survey was conducted on attitudes of mental health professionals and members of the public toward mental illness and their specific reaction toward a person with and without psychiatric symptoms (Nordt et al., 2006). Strikingly, psychiatrists held more negative stereotypes than the general population, and mental health professionals tended to favor the restriction of people with mental illness 3 times less often than the public (Nordt et al., 2006). However, lower rates of desire to maintain social distance were found towards patients with major depression among mental health professionals surveyed compared to those with schizophrenia (Nordt et al., 2006). Here, we see that some mental illnesses such as schizophrenia are viewed more negatively than other forms of mental illness such as depression, even among mental health professionals in this case. Findings of the study contradicted the idea that frequent contact with people with mental illness alleviates stigma, indicating that more extensive knowledge of mental health professionals did not reduce stereotyping or increase willingness to interact closely with those with a mental illness (Nordt et al., 2006). These stigmatizing attitudes among mental health professionals and nurses may also stem from media depictions that perpetuate the stereotype of mental healthcare as being poorly qualified labor, and also by professionals working in somatic care settings who rank psychiatric nursing lower than other nursing specialties (Cremonini et al., 2017). Ultimately, stigmatizing

attitudes among mental health professionals may lead to poorer consumers' satisfaction with

treatment as well as outcomes (Zaninotto et al., 2018). However, it is important to note that

attitudes among mental health professionals may not be generalizable as they differ depending

on a professional's patient case history, as well as the conditions and workload in which the

professional is operating.

Zaninotto et al's (2018) findings seem to contradict other theoretical perspectives on MIS

such as level of contact theory, which posits that those who have had close contact with

individuals with mental illness will possess lower levels of MIS. In contrast, other research

studies have supported this theory. In previous studies, mental health professionals' stigma-

related beliefs, feelings, and behaviors were positively influenced by contact. In fact, Cremonini

et al., (2018) conducted a study aimed at reporting attitudes held by psychiatric nurses and

mental care professionals towards the mentally ill among various care settings within an Italian

Healthcare Facility, and to identify any associated factors. Questionnaires were distributed to

evaluate these attitudes, revealing that all healthcare professionals showed sensitivity and

positive attitudes towards mental illness (Cremonini et al., 2018). These positive attitudes

included beliefs that people with mental illnesses should not be viewed as inferior, subjected to

coercion, or viewed as a threat to society (Cremonini et al., 2018). Researchers attributed these

attitudes to mental healthcare professionals' understanding of how stigmatizing mental illness

affects therapeutic processes as well as recovery (Cremonini et al., 2018).

Cremonini's (2018) study deviates from Nordt et al's (2006) research which reported a

desire of mental healthcare workers to remain socially distanced from those with mental illness

as previously discussed. Interestingly, nurses were reported in Nordt et al's (2006) study to have

slightly less positive feelings surrounding mental illness on all three factors of the Community

Attitudes Mental Illness Inventory (Authoritarian attitude, Benevolence, and Social Restrictiveness). This may be due in part to the fact that nurses are more directly and continuously interacting and caring for acute patients in ways that are more strenuous than other mental healthcare professionals (Cremonini et al., 2018). According to these authors, there are inconsistent findings investigating the relationship between levels of stigma and professional experience within the mental healthcare sector (Cremonini et al., 2018). Evidently, the level of contact theory is too vague, ignoring intersections of the nature of contact, the quality of the treatment environment, the beliefs surrounding mental illnesses supported by the treatment program, education, and understanding of treatment providers. These factors all play a role in the interactions between a patient and treatment provider, as well as the treatment providers' resulting beliefs about mental illness. It is also worth noting that while Cremonini's (2018) findings contribute to our understanding of mental illness stigma, particularly in Italy, the results cannot be generalized since the study sample was restricted to one area in Northern Italy. In sum, the production of stigma is multifaceted and involves the intersection between etiological beliefs, attitudes, prejudices, personal, and social problems, both toward mentally ill persons and in the mental disorders' perceiver, as well as the role of different cultures (Mannarini & Rossi, 2019). It is also not automatically removed or reduced due to simple contact or professional role alone. Previous research has yielded varying findings regarding the genesis of stigma and how to best combat it, indicating that MIS is a complex issue to assess and combat within the Italian context and elsewhere.

Despite drastic reforms to the system of mental healthcare in Italy, which have prioritized comprehensive and compassionate community-based care as well as patient rights, MIS remains a persistent problem in the general public as well. Prior to law180, patients in Italy were

considered to be socially dangerous, possessed irrecoverable mental disorders, and were thus locked away in mental hospitals, unable to participate in society (Nomesia, 2018). Since the enactment of the law, dignity and value has been comparatively restored to those suffering from mental illness. A central premise of law 180 was to shift the treatment of the mentally ill from concealment and control to an authentic relationship between therapists and patients, in which welcoming, listening, feeling the other was emphasized as an effective step towards the new system of psychiatric rehabilitation (Nomesia, 2018). While the drastic shift towards the restorative treatment of patients has been considered to be a success, there is an insufficient body of empirical evidence to determine whether this reformed community-based mental health system has contributed to reducing public stigma surrounding mental health in Italy, or whether it has affected the mental health literacy in the Italian population (Munizza et al., 2013). Munizza et al (2013) conducted a population survey on attitudes towards depression in Italy. Results suggested that Italians are aware of depression and showed that a direct or indirect experience with people experiencing depression favored less stigmatizing attitudes. These findings support the level of contact theory as a means of MIS reduction. Yet, 75% of the sample shared the belief that people suffering from depression should avoid talking about their problem, i.e. depression should be experienced in solitude (Munizza et al., 2013). Researchers reported, however, that these findings emphasizing the importance of self-reliance among those suffering from depression were consistent with another survey study conducted in Australia.

Here, we see firstly that cultures within countries such as Australia and Italy may sometimes share commonalities in ways in which mental illness is stigmatized. In this comparison, societal beliefs surrounding depression and self-reliance. Secondly, in the case of depression in Italy, people can simultaneously possess relatively positive and non-stigmatizing

attitudes regarding depression as well as more negative cognitions such as the belief that those

suffering from depression should keep it to themselves. This juxtaposition of attitudes regarding

depression sheds light on the greater issue at hand, being that stigma reduction is not a linear or

simple problem to solve. For example, to shift mental illness away from individual mental

fallacy, a biological explanation of mental illness may reduce the stigma associated with blaming

people for their mental illnesses. However, biological explanations may simultaneously increase

a desire for social distance and a sense of hopelessness surrounding the recovery process. The

idea that those with mental illness are 'permanently damaged' due to biological dispositions

reinforces a different facet of stigma.

Another key finding from Munizza et al's (2013) study was that the stigmatization

process reported among a sample of Italians was stronger than those reported in other countries

such as Canada. In addition to statistics previously outlined from Munizza et al's (2013) study,

researchers found that about one-third of respondents (31%) thought that people with depression

''can solve their problem by themselves if they want''), and a quarter of respondents (27%)

believed people experiencing depression ''are dangerous to others." Wang & Lai's (2008)

Canadian study investigated percentages of personal stigma by levels of depression literacy and

exposure to persons with depression, overall and by gender in a sample of adults. Researchers

found that over 45% of participants considered people with depression to be unpredictable, and

over 20% reported that people with depression were dangerous (Wang & Lai, 2008). Although

the Canadian study revealed less stigmatizing attitudes, the sample of participants was limited to

one city of Canada and is not necessarily representative of all Canadians' attitudes. Wang &

Lai's (2008) study used stratified, multistage probability sampling and was more representative

of the Italian national census population. Contrastingly, in other cross-cultural comparisons, the

percentage of responders endorsing that people suffering from depression are dangerous to others

is higher in the United States (33%) and Brazil (56%) compared to the Italians in Munizza's

study (27%) (Munizza et al., 2013). Authors of the study explained these results in terms of

cultural beliefs about depression, with Italians ascribing its onset to stressful situations

(nonspecific stress, and/or post-traumatic stress ensuing painful events such as bereavement or

divorce) while biological causes (such as brain diseases, parents suffering from depression, etc.)

are deemed less important. Here, we see that Italians may emphasize negative situations or

experiences as the driving force of mental illness onset (or at least depression onset) rather than

genetic predispositions, which are known to contribute to mental illness according to the bio-

psycho-social model and the theory of "gene-environment interaction." Knowledge of this

widespread attitude may be useful in terms of developing Anti-stigma campaigns in terms of

education on this model and how all three factors (biological, psychological, and social) play a

role in health and disease.

In addition, the Muzzina (2013) study summarized previous research further situating

Italian beliefs about mental health within the global context. Compared to surveys conducted in

Russia, Slovakia, Germany, and Australia, Italian respondents tended to view primary care

physicians and psychiatrists as less possible sources of help for depressive symptoms (Munizza

et al., 2013). Other research summarized by Munizza et al (2013) reported that in Italy, as well as

Spain, Austria, and Brazil, psychologists are generally seen as first-choice help for depression

problems since discussing depression with a psychologist is perceived to be less awkward than

disclosing one's depressive experiences with a family doctor (Munizza et al., 2013). While cross-

cultural comparisons can be helpful in terms of furthering our understanding of MIS

pervasiveness, research projects have variable resources and funding, and due to limitations,

some studies cannot fully capture a nation's consensus on subjects such as mental illness stigma. Therefore, more robust research is necessary cross-nationally to accurately compare levels of MIS, expand our understanding of mental illness stigmatization, and best mitigate its effects.

Apart from localized attitudes towards mental illness described above, the extent to which stigma influences how countries focus on and allocate mental health resources is important, yet difficult to study. The World Health Organization outlines that decisions regarding resource allocation for mental healthcare are often made on the basis of simple cost-minimization, and even sometimes on attitudinal factors such as stigma and desire to punish persons perceived as being personally responsible for their problems (Barbui et al., 2018). To alleviate widespread undertreatment of mental illness related to stigma would require accurate data on levels of MIS within a country, formal analyses of the burdens from illnesses and the cost-effectiveness of treatments, and models of mental healthcare that are designed by those free from ulterior motives for the sole purpose of improving the lives of those who are suffering or in need of help (Barbui et al., 2018). However, there is a shortage of rigorous data available to make these types of determinations worldwide, including in the case of Italy. Therefore, further research regarding the pervasiveness of MIS in Italy is required, as it is suggested to have serious implications in terms of policymaking within the mental health sector.

Combatting MIS in Italy

Despite the difficulty in assessing the effectiveness of the Italian mental healthcare system after its substantial reform within the global context, and the degree to which this reform has reduced stigma, efforts are in the works to reduce MIS within Italian culture. According to Link and Phlen (2001), combatting stigma needs to be 1) multi-structural, to correct both

individual and structural discrimination, and 2) must target and change the deeply held attitudes and beliefs of powerful groups responsible for stereotyping, setting apart, devaluing, and discriminating, or the approach must change circumstances to limit the power of such groups and reconfigure cognitions to a dominantly non-discriminatory pattern. Anti-stigma campaigns are widely believed to be a means to correct misinformation or contradict negative attitudes and beliefs surrounding mental illness in a given population. However, the relative usefulness of these interventions in changing social attitudes is difficult to ascertain. Zoppei and Lasalvia (2011) conducted a study aimed at identifying and evaluating Italian Anti-stigma projects to determine their effectiveness. A major point of contention surrounding Anti-stigma campaigns is the extent to which the bases of these projects are empirically validated, or if they are rather informed by confused and anachronistic ideologies (Zoppei & Lasalvia, 2011). Zoppei and Lasalvia (2011) have outlined a number of essential qualitative assumptions required for an Anti-stigma project to be useful. Translation from Italian to English of criterion from (p. 243) include:

1) "The constitution of a multidisciplinary local action committee (composed of mental health professionals, institutional figures, users of mental health services, family members, information workers, etc.) with the task of planning and implementing the project on the basis of the specific needs of the target group to which it is addressed; this, in addition, has the task of developing the specific objectives and actions, which will allow achievement of the prefixed goals."

2) Projects should be "aimed at specific social or professional groups, with relatively homogeneous targets (students, general practitioners, law enforcement officers). Generic Anti-stigma campaigns are likely to have a delayed effect and to be dispersed (as well as unnecessarily expensive).

3) The project development process must include "the involvement in the project of people who have (or have had experience of) a mental disorder (as a member of the organizational staff, secretarial staff, in the form of "testimonials", "advisors" of the project sponsors, etc.). Numerous evidence shows that favoring the contact of 'non-experts' with a person suffering from a mental disorder is an effective way to reduce the stigma and the fear that he/she is a "dangerous" person."

4) "The identification of appropriate ways to spread the message, through the proper use of mass media. The mass media (newspapers, television, internet sites, radio programs, etc.) should be used as useful allies in anti-stigma campaigns to spread reassuring and non-discriminatory messages."

5) "Another key qualitative element concerns the evaluation of the impact of the intervention, i.e., verifying whether the anti-stigma campaign has caused changes in thinking, knowledge, and attitudes of the recipients. A well-done anti-stigma project should aim to achieve permanent (or at least long-lasting) changes, modifying the potential sources that generate stigma and be able to document these changes."

6) "The project should aim to achieve permanent (or at least long-lasting) changes, modifying the potential sources that generate stigma and be able to document these changes."

7) An Anti-stigma project "should not last too long in time (or, worse, have an indefinite duration); a good project should define a priori the start and end date and should not last more than 3 years."

The second qualitative criterion of Zoppei and Lasalvia's guideline was informed by previous research conducted by Warner (2008) aimed at implementing local projects to reduce the stigma of mental illness. Warner asserts that the implementation of aspirational anti-stigma campaigns should not be aimed at the general population (for which there would be no scientific evidence to support them). Instead, the researcher recommends the implementation of projects aimed at specific social or professional groups, with relatively homogeneous targets (students, general practitioners, law enforcement officers) (Warner, 2008). In addition, the third criterion has been supported by numerous previous studies summarized cited by Zoppei & Lasalvia (2011), demonstrating that positive contact between "outsiders" and a person suffering from a mental disorder is effective in reducing stigma and the fear that he or she is a "dangerous" person.

After analyzing various Italian Anti-stigma projects based on these criteria, researchers found that past and existing campaigns were very heterogeneous in terms of design and purpose and unfortunately oftentimes limited, making them methodologically weak with results difficult to empirically verify (Zoppei & Lasalvia, 2011). For example, In Zoppei and Lasalvia's (20011) study reported that only one of 71 Anti-stigma projects evaluated include the establishment of a multidisciplinary local action committee, indicating a structural deficiency in almost all cases. Multidisciplinary local action committees should be utilized to define the potential sources of stigma at the territorial level to identify clear and measurable objectives, as well as cater the campaign to the target audience using adequate action strategies (Zoppei & Lasalvia, 2011).

A second critique of the projects analyzed was a lack of a target audience. While the majority of projects met this requirement, about one-third of Anti-stigma projects (32.4%) were aimed at the general public as opposed to a specific target audience (Zoppei & Lasalvia, 2011).

Specifically, projects with a target audience included 1) 28.1% of projects were aimed at schools and young people 2) 5.6% at users of mental health services 3) 2.8% at the families of users and voluntary groups working in the field of mental health 4) 1.4% at health workers, women in general and the police (Zoppei & Lasalvia, 2011). 23.9% of studies used different means of intervention and aimed at multiple target groups (for example, general population and families; patients, family members, physicians, practitioners, law enforcement, schools, and political/administrative institutions; patients and family members) (Zoppei & Lasalvia, 2011). According to these researchers and previous studies summarized by Zoppei & Lasalvia (2011), projects with large non-specific target audiences, such as in the 32.4% analyzed in this study, run a high risk of being ineffective.

A second principle provided by Zoppei & Lasalvia (2011) is the importance of incorporating people with mental illness in the planning of anti-stigma campaigns as well as providing insight into how the information is disseminated. This study's analysis showed that a high percentage of anti-stigma initiatives (more than half) did not consider the involvement of those who have experienced mental illness within the project. Fortunately, slightly more than half the projects analyzed met this requirement. Specifically, 21.4% were initiatives in which users of mental health services played the role of "testimonials" of their experience, 19% were initiatives of cooperation between patients and groups with mental disorders (school workshops, theater, etc.), and 16.6% were initiatives of cooperation between patients and groups with mental disorders (school workshops, theater, etc.) (Zoppei & Lasalvia, 2011). 16.6% of projects analyzed were aimed at/supporting/listening to people with psychological distress, and another 16.6% concerned sports activities and trips in which service users participated (Zoppei & Lasalvia, 2011). 9.5% of projects included research in which patients were involved in scientific

activities, 9.5% of projects included patients who had an active role in the organization, and finally, 7.1% involved cohabitation experiences between local families and service users (Zoppei & Lasalvia, 2011). Researchers posit that the lack of involvement of mental health service users found in 40.1% of projects analyzed could be a reflection of resistance to see the mentally ill as capable of expertise and as repositories of knowledge who could be integrated with the "scientific" knowledge of professionals (Zoppei & Lasalvia, 2011). Finally, an issue researchers found among the projects analyzed was a lack of availability of evaluation regarding the project's effectiveness or the results achieved. This is essential, as a comprehensive evaluation of the effectiveness of a project can indicate strategies that worked or did not, and better inform future Anti-stigma projects (Zoppei & Lasalvia, 2011). While it's promising that there are efforts in Italy to reduce MIS in the form of Anti-stigma projects, researchers warn that without explicit guidelines, incorporating the criterion listed previously, they run the risk of little to no impact (Zoppei & Lasalvia, 2011).

Other more specific projects have found success through educational interventions for teenagers as a way to reduce MIS. Del Casale et al., (2013) conducted research on a group of Italian high-school students aged between 16 and 18 years who underwent training consisting of constructive and interactive lessons with multimedia material aimed at mental-illness stigma reduction. Prior to being educated on mental health, students completed Haghighat's Standardized Stigmatization Questionnaire, a self-rated test on stigmatizing processes. The questionnaire looks into people's beliefs regarding other people's attitudes about a person viewed on a slide that is shown while participants fill in the questionnaire (Del Casale et al., 2013). For example, students were prompted as to whether a man whose picture is shown on the slide would be accepted as the spouse of their sister by the average individual (Del Casale et al.,

2013). Participant's answers ranged from "they would be very happy with this" to "not at all", with intermediate responses such as "they would be quite happy" and "they would like it little" (Del Casale et al., 2013). The questionnaire was distributed to participants in conjunction with the projection of a slide of one patient with a newly diagnosed psychiatric illness (Del Casale et al., 2013). The questionnaire asked the reader to answer questions about the way people could relate to such a patient (Del Casale et al., 2013).

After completing the questionnaire, participants were subjected to four educational interventions, each lasting one and a half hours. These lessons consisted of an explanation of the concept of stigma as well as the major mental disorders. Educational lessons also focused on the difference between neurosis and psychosis. A final component of the classes was a description of Italian community services focused on mental health and the function they serve in society (Del Casale et al., 2013). After the intervention, researchers measured the students' levels of stigma towards mental illness using Haghighat's Standardized Stigmatization for a second time. Researchers found that after the educational intervention, students displayed a significant reduction of stigma attributed to mental disorders by other members of the community due to the acquisition of new information about mental health (Del Casale et al., 2013). This reduction of stigma was indicated through a lower score on Haghighat's Standardized Stigmatization, indicating less stigmatizing beliefs surrounding those with mental illnesses. Researchers cited a lack of knowledge on mental health and psychic distress as being a key factor in determining the phenomena of social stigma, making early education a vital tool in positively reshaping attitudes towards those with mental illness (Del Casale et al., 2013). While it is sometimes difficult to empirically validate the effectiveness of an anti-sigma intervention, this type of study consisting of a specific focal intervention and a controlled pretest-posttest structure makes evaluation more

feasible. Experiments such as these are easier to assess than general population campaigns, for which you cannot determine who might have seen it, how many times, and under what conditions. In campaigns aimed at the general population, reaching people both pre and post-intervention is nearly impossible. Therefore, anti-stigma projects and campaigns should draw from conclusive research such as de Casale (2013) and implement the criterion outlined by Zoppei & Lasalvia (2011) for successful outcomes.

In addition to anti-stigma campaigns that include empirically-based components, it seems that anti-stigma projects utilizing education may be a helpful piece in the puzzle of combatting MIS in Italy. Generally, Anti-stigma projects can be divided into protest, education, and contact strategies. However, some researchers argue that the educational component alone, while useful, is not enough to tackle the issue of MIS in Italy and globally. Lasalvia et al (2019) approach this issue from the social justice perspective, arguing that the employment of people with lived experiences and stories of recovery are needed to challenge localized stigma and the promotion of community opportunities. Education as an anti-stigma tactic alone provides clarification on psychological concepts that are oftentimes misconstrued, false, or unclear from a perspective that is impersonal and academic in nature. What Lasalvia proposes is that contact is also a form of education, but one that comes from first-person experience with someone having a mental illness, incorporating aspects of their recovery and resilience. Since contact with people who have experienced mental illness and sharing their stories of recovery is a critical component of erasing discriminatory beliefs and replacing them with affirming attitudes, Lasalvia et al (2019) call to action professional voices to back and promote the hope and self-determination that color recovery stories. Due to their influential position in society, providers may be able to inform and

encourage other actors in power to counter stigma and advance Anti-stigma-geared policy
(Lasalvia et al., 2019).

Covid-19 pandemic, adverse mental health consequences, and the Italian Response

The emergence of the novel coronavirus disease (COVID-19) in late 2019 put substantial
strain on Italy's community-based system of mental healthcare, revealing that this idyllic model
may have some room for improvement in operating amid public health crises. COVID-19 has
been defined by the World Health Organization as a public health emergency (WHO, 2020).
Apart from the physical implications of COVID-19 including severe acute respiratory distress
syndrome and multi-organ dysfunction, the spread of the disease has also threatened the stability
of global public health and social systems, and enduring the COVID-19 pandemic has challenged
mental health globally (Talevi et al., 2021). Italy was the first European country to experience
the virus after its spread from Wuhan, China in February of 2020. As a response to the rapid rise
of COVID-19 cases, the Italian government implemented a nationwide lockdown including
travel restrictions, the mandatory closure of schools, as well as the halting of nonessential
commercial activities and industries (Rossi et al., 2020). Citizens were forced to stay at home
unless necessary, city parks were closed, and outdoor physical activity was banned (Pancani et
al., 2021). Unfortunately, Italy, along with other countries succeedingly affected, was caught
unprepared to manage a public health emergency of such magnitude (Lasalvia, 2021).

There was a shortage of resources available at the beginning of the pandemic, subjecting
Italian frontline workers to heavy workloads and high risks for infection (Lasalvia, 2021). As a
result of the intense restrictions imposed upon by the lockdown, fear, and anxiety surrounding
the virus, as well as the stigma surrounding close contact of frontline workers with COVID-19

patients, many Italians experienced adverse psychological effects impacting their mental health. Specifically, seven subgroups were identified to be psychologically impacted by the pandemic including: (1) the general population affected by restrictive measures generally, (2) people subjected to quarantine because of contact with an individual with an infection, who themselves were not positive, (3) people positive for the virus who did not need hospital treatment and were isolated at home, (4) people positive for COVID-19 who were hospitalized and have recovered, (5) health care personnel coordinating or providing care during the pandemic, (6) relatives of persons who died, and (7) patients in treatment for mental disorders (de Girolamo et al., 2021).

A study conducted by Pancani et al (2021) investigated the link between forced isolation and mental health, paying particular attention to the role of the regional contagion rate, offline and online social contacts, and the adequacy of living space during the first phase of the COVID-19 pandemic. Social isolation is linked to an increased risk of depression, suicidal thoughts, as well as the risk of early mortality (Pancani et al., 2021). Results of the study indicated that due to forced isolation in the first wave of COVID- 19, Italians of the sample experienced adverse mental health effects despite being in areas having a lower level of COVID-19 contagion (Pancani et al., 2021). Additionally, social deprivation was associated with repercussions for individuals' psychological well-being, with longer isolation potentially leading to worse mental health outcomes (Pancani et al., 2021). Online social contact was found to be a protective barrier against mental distress, with researchers finding a positive association between isolation length among areas of higher contagion and online social contacts (Pancani et al., 2021). Finally, adequate space was a determinant of adverse mental health impacts among quarantined Italians, with larger areas of confinement acting as a buffer (Pancani et al., 2021). The findings of the study suggest that the Italian mental health system must extend support amid the pandemic and

other future public health emergencies especially to those who have a limited social support

system, lack of access to online social interaction, and living spaces incompatible with lockdown

restrictions. Other studies have also emphasized the importance of providing tailored

interventions to specific groups such as people with preexisting psychiatric conditions, pregnant

women, persons in detention, international migrant workers, and international students (Talevi et

al., 2021). Pandemics are also known to cause a peculiar syndrome known as "headline stress

disorder", which is characterized by high emotional responses induced by reports from the news

media. Constant exposure to these reports may cause physical symptoms including palpitation

and insomnia as well as having the potential to further the progression of physical and mental

disorders (Talevi et al., 2021).

Of particular vulnerability to adverse mental health effects during the pandemic were

those working on the frontline of the COVID-19 response. A study conducted by Lasalvia et al

(2021) investigated the psychological impact of COVID-19 among primary care physicians in

the province of Verona, Italy during the first wave of the pandemic. Researchers found that

general practitioners at high risk of infection or who had been infected with COVID-19 had

increased levels of depression and burnout, supporting the impact of pandemic-induced fear and

uncertainty on mental health (Lasalvia et al., 2021). Among primary care physicians surveyed,

44.7% reported COVID-19-related traumatic events; among these, 35.9% developed symptoms

of post-traumatic distress, 36% reported symptoms of anxiety, 17.9% symptoms of at least

moderate depression, and 25.4% symptoms of burnout (Lasalvia et al., 2021). Researchers

highlighted that there was insufficient mental healthcare accessible to these frontline workers,

indicating a need for the implementation of psychological screening programs within primary

care or primary healthcare organizations. These programs would help identify general

practitioners at risk of mental health problems and aid them in getting psychological treatment if necessary (Lasalvia et al., 2021).

In terms of the effectiveness of Italy's mental healthcare system, it is interesting to note how mental health services responded, or failed to respond, to increasing demands for psychological care amid the COVID-19 pandemic. In an effort to manage and treat COVID-19 patients, many psychiatric wards in Lombardy have been reorganized to admit infected patients and many physicians and nurses who typically worked with the mentally ill were diverted to care for COVID-19 patients (de Girolamo, 2021). In addition, most day facilities for patients with psychiatric needs in Lombardy were temporarily closed, and restrictions were put in place within residential facilities severely limiting the mobility of long-term patients (de Girolamo, 2021). The pandemic has put significant stress on the Italian departments of mental health, especially outpatient clinics which became quickly overburdened, with limited appointment availability as well as home-visit availability for those with severe mental disorders (de Girolamo, 2021). As a consequence, many with severe mental disorders lacked access to the critical psychological care they needed during this time, and forced time spent at home with increased face-to-face time with family members, potentially leading to high amounts of conflict (de Girolamo et al., 2021).

Overall, the rapid ubiquitousness of the virus caught many departments of mental health and addiction ill-equipped to handle the surge of Italians' mental distress. However, the pandemic provided an opportunity to build on experience and improve the ability of the Italian mental healthcare system to withstand future health crises and mitigate subsequent adverse mental health effects (de Girolamo, 2021). De Girolamo et al (2021) determined that Italian departments of mental health need to better implement and utilize E-health technologies and procedures in order to manage public health crises such as the COVID-19 pandemic. These

technological interventions should also extend to those quarantined at home so that patients who

are immobilized have access to the psychological care they need. In sum, de Girolamo (2021)

calls for better leadership within the Italian department of mental health in managing disaster-

like situations from the psychosocial perspective. This would include 1) correctly informing the

population about risk 2) training and disseminating effective preventive and management

procedures for disasters 3) providing mental health support for frontline workers and rescuers 4)

support for those experiencing bereavement (de Girolamo et al., 2021). Despite having a

progressive system of mental healthcare, there remains a learning curve in Italy in terms of better

managing public health crises of the magnitude of the COVID-19 pandemic, especially in terms

of virtualizing psychological interventions to expand access to those in need.

Future Perspectives

Italy has been placed on somewhat of a pedestal as having a model system of mental

healthcare. In fact, the Trieste model is recognized by the World Health Organization as one of

the most advanced, community-based mental health care systems around the world (Poggioli,

2021). However, in the case of any large-scale organization, there is always room for

improvement. I have outlined the current state of mental healthcare in Italy, but what lessons

may we learn from the Italian experience? First, when switching from one system of mental

health care to another or reforming the current system, it is inadequate to simply shut down

facilities (De Girolamo, 2007). In the case of Italy, mental hospitals were gradually phased out

according to Law 180, along with the implementation of other appropriate facilities to provide

care. Italy's gradual reform was met with success in terms of maintaining care provision and can

be used as an example of how reform should take place. It should also be noted, however, that

while reform occurred throughout the entirety of the country and national standards were put in

place by law 180, an entirely uniform system of mental healthcare in Italy does not yet exist

(Lora, 2009). After the psychiatric reform of 1978, 21 regional mental health systems were

developed, varying greatly in terms of organization, network of facilities, accessibility, care

delivered, etc (Lora, 2009). These various health systems should be evaluated comparatively so

as to reveal differences (Lora, 2009).

While further analysis is necessary between these 21 systems, already recognized

disparities in access to psychological care remain cause for concern, particularly in terms of

regional inequities within Italy as well as for those with immigrant status. In 2003, the rate of

public beds in General Hospital Psychiatric Units in the center and south of Italy was one-third

below the standard established by law 180 and that of the North (Lora, 2009). Despite having a

progressive standard on paper, this is not the case in practice as the provision of residential beds

varies greatly across regions. This incongruence of distribution of public acute inpatient beds,

combined with the fact that day hospitals are not widespread, may risk the clinical needs of

people with severe mental illnesses not being met during times of crisis (Lora, 2009). During the

COVID-19 pandemic, we witnessed this unfortunate circumstance play out, where already sparse

acute inpatient beds were transferred for use for COVID-19 patients, and most day facilities for

patients with psychiatric needs were temporarily closed. As predicted by Lora (2009), the

COVID-19 public health crisis left many with severe mental disorders without sufficient access

to the critical psychological care needed.

Moving forward, more funds must be allocated to equalize rates of and access to acute

inpatient beds across regions to avoid overburdening the system during times of crisis. In terms

of disparities among immigrants, a study conducted by Rucci et al (2015) in Bologna, Italy found

that the probability of receiving any mental health intervention is similar between immigrants

and Italians, but that immigrants receive fewer interventions with shorter durations overall. In the

future, quantitative data from the mental health information system should be integrated in

conjunction with qualitative data on unmet needs from the immigrants' perspective to better

inform health care programs and policies (Rucci et al 2015). Notably, this study was conducted

in Bologna, a city in the Northern Italian region of Emiglia-Romana. Given that there are fewer

acute inpatient beds in the South of Italy, immigrants residing in southern regions may be of

particular concern in terms of access to psychological care. Future research may investigate

immigrants' access to psychological care in the South, as their experience may differ from those

in the North.

In terms of reducing MIS, Italy has demonstrated substantial efforts via projects and

campaigns (Zoppei & Lasalvia, 2011), but future endeavors should employ explicit guidelines

reflective of empirically based criteria for the most efficacious outcomes. Finally, technology

could be better utilized within the Italian system of mental health care; specifically, the

establishment of a national health information system, as well as greater use of E-health

technologies and procedures. Without high-quality information that a national health information

system would provide, it is more difficult to reach a planning rationale, the governance of

healthcare is severely hindered, and accountability at both the national and regional levels is

impeded (Lora, 2009). Therefore, there is a pressing need for a national mental health

information system. Additionally, E-health technologies can be used to aid in public health crises

such as the COVID-19 pandemic, but also for patients who may lack access to transportation or

social support necessary to bring them to a mental healthcare center.

In sum, there is much we have learned about the strengths and inadequacies of the Italian

mental healthcare system since its 1978 reform. Recently, the current right-wing government is

threatening to undermine Italy's model system. The regional government announced plans in

October of 2021 to close seven of Friuli-Venezia Giulia's 22 community mental health centers

and to reduce hours in remaining centers (Poggioli, 2021). This plan also entails reducing the

number of senior psychiatrists and department heads, while keeping numerous staff positions

unfilled. In response to these announcements, the international community has displayed

substantial backlash in the form of petitions (Poggioli, 2021). Backed and signed by international

psychiatrists, these petitions seek to "save one of the world's premier public mental health

services from being handed over to the private sector" (Poggioli, 2021, p. 1). While Italy does

not have a perfect system of mental healthcare, privatization holds other substantial risks.

Preserving progressive models such as Trieste is of utmost importance since its absence would

squander inspiration for other places to emulate it (Poggioli, 2021). Moving forward, Italian

lawmakers should reconsider this step backward as it would not only have negative implications

for the Italians of Trieste but also for other countries seeking a model for mental healthcare

reform. High-quality information regarding the effectiveness of Italy's current systems should be

continually sought out to ensure all people in Italy are provided with equitable quality and access

to psychological care.

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