Depression scorecard: Italy

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The Health Policy Partnership

About the depression scorecard project

The depression scorecard is a tool that aims to support the assessment of national-level performance in key aspects of policy, delivery and care for people with depression. The framework that underpins the scorecard was developed based on an international literature review and consultation with an expert advisory group.

The scorecard framework has been applied initially to four countries: Belgium, France, Italy and Romania, with findings summarised in individual scorecard reports. National-level findings were developed based on in-depth literature review and interviews with leading national experts in depression.

This scorecard focuses on Italy.

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Depression: why it matters

Depression is the most common mental health condition affecting people today.[1] The World Health Organization estimates that depression affects a staggering 4.3% of Europeans – 40 million people.[2] In light of the psychological effects of the COVID-19 pandemic, this number may now be even higher.[3]

Depression has a devastating impact on the lives of those affected, their families and societies more broadly. It is associated with numerous negative outcomes throughout a person's life, including poorer academic performance, reduced earnings, chronic illness, diminished quality of life and a higher chance of death.[4,5] It is the leading cause of suicide,[2] contributing to up to 60% of all suicides worldwide.[6] Up to 15% of people with untreated depression may die by suicide.[1] Stigma associated with depression may exacerbate suffering and prevent people from seeking and receiving quality care for their illness.[7-9] Depression also places a significant socioeconomic toll on European countries.

2.8 million
people are living with depression in Italy[10*]

€54 billion
cost of mental health (direct and indirect) annually[12*]

12%
of deaths in people aged 20–34 were due to suicide.[10*] Global estimates indicate depression may have contributed to up to 60% of all deaths by suicide[6]

5%
of people aged over 15 self-report having experienced depression in the past 12 months[10*]

Italy has 17 psychiatrists
per 100,000 inhabitants, which reflects the EU average[11‡]

3.5%
of annual overall health expenditure in Italy spent on mental health[13§]

3.3%
cost of mental health to annual GDP (direct and indirect expenditure), compared to 4.1% in the EU overall[12*]

*Data from 2015 ‡Data from 2018 §Data from 2017

Depression in Italy

Mental health in Italy underwent a significant reform in 1978,[14] with deinstitutionalisation of care, the abolition of psychiatric hospitals and the establishment of Departments of Mental Health intended to build community-based services offering multidisciplinary care.[15] The underlying premise of this reform was to manage mental illness like any other condition and shift the focus of psychiatry from 'custody, coercion and segregation' to 'treatment and care' for all patients.[15]

Implementation has been inconsistent, however, and there is wide variability in the availability of high-quality mental health services across the country, with significant differences between the North and the South.[15 16] For example, there is a threefold difference in the number of psychiatrists per population across the regions.[17]

Depression is thought to affect up to 2.8 million people in Italy.[10] Over a person's life, the risk of experiencing depression is estimated to be approximately 15%.[18] The COVID-19 pandemic has exacerbated the prevalence of poor mental health and depression in Italy, as it has around the world.

Despite these figures, depression is still not given the political priority and sense of urgency it deserves, and stakeholders have called for depression to be brought out of the shadows.[18] Italy needs a national strategy on depression, with adequate resources to support it across all regions. This will be vital to ensure that people with depression are able to secure timely access to the care, support and treatment they need.

The challenges faced are multifaceted. Italy significantly under-resources mental healthcare compared with other countries, and its resources are very unevenly distributed across regions. Access to diagnosis and care is insufficient: fewer than 50% of people with depression are appropriately diagnosed and treated.[18] Meanwhile, stigma around depression is pervasive.

Assessing depression management: the scorecard

This scorecard was developed to highlight to policymakers where change is most needed to improve the management of depression in Italy. It is our hope that this document may galvanise policymakers to work in close partnership with all stakeholders to reverse the course of depression in Italy, taking a comprehensive and preventive approach to address it in all its complexity.

The scorecard focuses on four key areas, identified as priorities for improvement:

1

Joined-up and comprehensive depression services

Integrated care – that is, a patient-centred system that supports the person with depression throughout their lifetime and with continuity across the health system – is essential to delivering adequate support and treatment. Integrating mental health services into wider health and social care services is convenient and can increase treatment rates, improve comprehensiveness of care and reduce overall costs.[19]

2

Data to drive improvements in depression care

Collecting and analysing robust and up-to-date data on depression is essential to ensure the right services are available to everyone who needs them. Monitoring patient outcomes helps to identify and inform good practice, and may give hope to service users that their mental health can improve.[19] Data on services can support clinicians, policymakers and people with depression to better understand what treatment options are available and accessible. More transparent data will also facilitate shared learning across all domains of depression care. New digital tools may have the potential to facilitate documentation for transparency and research purposes while retaining the anonymity of the user.[19]

3

Engaging and empowering people with depression

It is essential that people with depression – along with their families, friends and carers – are actively empowered to participate in depression care plans at all stages. Empowerment involves a person gaining information and control over their own life as well as their capacity to act on what they find important, which in turn will allow them to more optimally manage their depression.[20] Peer support, whereby a person who has previously experienced depression offers empathy and hope to others in the same position, can assist both people with depression and their peer supporter in their recovery.[21] Social systems, patient advocacy groups and other civil society organisations with access to underserved communities are critical in ensuring that mental health services reach everyone, including those who have 'slipped through the net'.[19]

4

Harnessing technology to improve access to care

Digital platforms such as those which facilitate remote therapy sessions and online prescription requests, as well as other depression-focused software, smartphone applications and virtual platforms, can allow greater choices of treatment for people with depression while supporting them to take more control of self-managing their condition. While virtual sessions cannot replace in-person therapy, they may be a flexible option to support people with depression between regularly scheduled visits. Health and social services may also use digital tools to facilitate data collection and monitor care.[22 23] In addition, people with depression may find it helpful to use digital tools to connect with others and reduce feelings of isolation.[24]

Summary scorecard for Italy

Joined-up and comprehensive depression services

Is depression included in either the national health plan or a specific plan for mental health?

Is there a government lead on mental health, with cross-ministerial responsibility to support a 'mental health in all plans' approach?

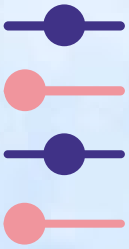
Is collaboration between primary care and mental health services supported and incentivised/encouraged/facilitated?

Are there guidelines on depression care developed jointly by primary care and psychiatry?

Is a range of therapeutic options reimbursed and available to people with depression, such as psychotherapy, counselling and cognitive behavioural therapy?

Are depression services available and tailored for at-risk groups?

- Young people
- Older people
- People in the workplace
- Homeless people

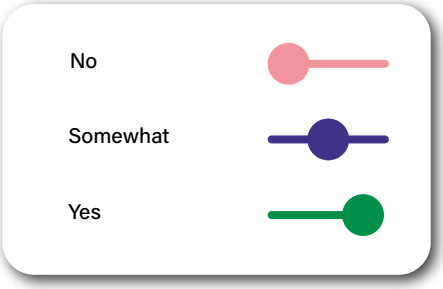


Data to drive improvements in depression care

Are data on people with depression systematically collected by the health system?

Are data on mental health services being used for planning?

Are patient-reported outcomes being measured systematically?



Engaging and empowering people with depression

Do guidelines or care pathways for depression recognise the importance of patient empowerment?

Were patient and carer representatives involved in the most recent national plan or strategy covering depression?

Is peer support recommended in depression care guidelines?

Do guidelines on depression recognise the role of families and carers in making decisions on the planning and delivery of care?

Do carers have access to financial aid to help them support their loved ones with depression?

Are peer support roles reimbursed?

Are there national associations advocating for the rights of:

- people living with depression?
- carers of people living with depression?

Harnessing technology to improve access to care

Can patients access depression support remotely (via telephone or the internet) in addition to services delivered face-to-face?

Do professional societies or guidelines recommend the use of remote services alongside face-to-face services?

Is remote support for depression reimbursed?

Are people with depression able to use telephone or online platforms that allow them to renew their prescriptions from home?

Joined-up and comprehensive depression services

Italy has had mental health policies in place for nearly 20 years, though specific policies on depression may be needed

In 2013, the Italian Ministry of Health, in collaboration with Interregional Mental Health Technical Group (Gruppo tecnico Interregionale Salute Mentale, GISM), created a National Mental Health Action Plan (Piano di azioni nazionale per la salute mentale, PANSM) which lists depression as a disorder of high prevalence and priority.[25] Depression is also a recognised risk factor in the National Prevention Plan of 2020–2025, where its bidirectional relationship with addictive behaviours and chronic disease is recognised, particularly in young people.[26]

In 2019, the Ministry of Health established an inter-ministerial Technical Working Group on Mental Health, which includes representatives from the Ministry of Employment and Social Affairs and other ministries, as well as other prominent healthcare players.[27] The group is tasked with monitoring the implementation of the Mental Health Plan objectives.[27]

Some stakeholders have called for an interparliamentary group to focus on the development of a national plan specific to depression, with input from all relevant stakeholders, including carer and patient organisations.[18]

Italy has a model of community-based mental health implemented in each region

Italy was a recognised pioneer in establishing a community-based, integrated care model for mental health after deinstitutionalisation in 1978, integrating hospital and community-based care. Mental health care is centralised within each local authority in a department of mental health (DMH),[28] which coordinates a range of services:

- Community Mental Health Centres offer adult outpatient psychiatry and include a wide range of providers. Their remit includes liaison with places of work and social integration for people with mental health issues.[17] Patients can access these services directly, without referral by a GP.[28 29]
- Day-care services offer mental health care in semi-residential facilities.[28 29]
- Residential facilities focus on both therapeutic and social rehabilitation, including accredited private facilities.[28 29]
- Psychiatric units in general hospitals are linked with the community care centres to ensure there is a thorough continuity of care for these patients.[28 29]

In practice, the provision of mental health varies considerably between regions, and continuity of care is often suboptimal

Although the DMH model is applied in all regions, significant differences exist in terms of local provision and continuity of mental healthcare between community and secondary care.[15 30 31] Italy has a low density of mental health staff – especially psychiatrists – compared with many European countries,[15] often leading to long waiting times for referred patients.

Some indicators suggest continuity of care appears to be worse in Italy compared with other European countries: for example, one recent study suggests that, on average, only 49% of people with a mental illness discharged from hospital are seen by a community physician within 30 days, compared with an average of 81% across Europe.[15]

Care is not well integrated between primary care and psychiatrists

There is a divide between the management of severe forms of depression – which are well covered by the DMHs – and moderate or less severe cases, which are mostly managed by primary care practitioners. An important issue is lack of specialist knowledge among general practitioners (GPs) on appropriate care pathways for depression.

According to experts interviewed, most GPs tend to treat depression symptomatically; poor adherence to antidepressants[32] and high rates of recurrence[18] are particularly prominent among patients with depression treated in primary care.

Collaborative care models between psychiatrists and GPs may help improve patient care

Several regions have designated care pathways for depression (Percorsi Diagnostici-Terapeutici-Assistenziali, PDTA), which are tailored to each locality.[33 34] Collaborative models of care between GPs and psychiatrists have also been created in a number of localities[34 35] and research suggests these lead to improved long-term remission for patients.[36]

Collaboration can take several forms: the psychiatrist can act as an adviser to the GP for both the diagnosis and management of the patient (see **Case study 1**); in severe cases, GPs can refer their patients directly to the psychiatrist; or the scope of practice for GPs can be increased to more actively treat the full spectrum of people with depression. Training initiatives for GPs by psychiatrists have also been undertaken in several regions.

Case study 1. Consultant liaison model, Bologna

In Bologna, a pilot model called the consultant-liaison model was trialled to increase the management of mental health patients within primary care.[37] In this model, the specialist psychiatrist meets with the GP to oversee care, and close links are established between specialists and primary care throughout the patient's care. The GP manages patient care in an effort to reduce unnecessary referrals to secondary care. At the same time, the model aims to increase GPs' skills in diagnosis and management of mental health conditions.[37]

Common pathways are needed for depression and other chronic conditions

Given the bidirectional relationship between depression and comorbidities, joint pathways with other common chronic conditions are needed. These help to guide GPs towards appropriate diagnosis and optimal treatment of depression in people presenting with other conditions.

Consultative models have also evolved in which psychiatrists play a consultative role to other specialists (e.g. cardiologists or internists) to ensure appropriate diagnosis and management of potential mental health issues in their patients.[38]

Approaches to prevention and care need to be tailored to the needs of people at highest risk of depression

The risk of depression is higher in people of lower socioeconomic status compared with other groups,[10] and calls for targeted efforts for lower-income populations. Closure of mental health services due to the COVID-19 pandemic has exacerbated gaps in the delivery of mental health services for all vulnerable groups, who may be more difficult to reach through remote consultations.[39]

The needs of underserved populations such as refugees and homeless people also need more attention in terms of resourcing and care planning.[15]

Greater attention is needed on the growing prevalence of depression in women

The prevalence of depression is two times higher in women than in men.[17] Compared with men, women tend to have more symptoms and more severe disease of longer duration, calling for tailored care strategies.[18]

Several comprehensive information campaigns around the risk of perinatal depression have been led in Italy, but more efforts are needed to address the risk of depression in women throughout all phases of life.[18]

One issue specific to Italy is the lack of psychiatric services for children and adolescents

A particular phenomenon in Italy is the poor connection between paediatric and adult psychiatry. Children under the age of 18 with mental illness are treated by neuropsychiatrists, whose training is neurology-based, whereas adults are treated by psychiatrists. There is a lack of trained neuropsychiatrists in many parts of the country, leaving a significant care gap for young people with depression.[38 40]

There is also a lack of hospital beds to provide inpatient services for young people with mental illness – which is increasingly problematic as the number of cases is rising.[41]

In a recent article, one expert estimated that there are only 92 hospital beds for children and adolescents with mental illness across all of Italy.[41] Gaps in available hospital beds mean that young people with severe depression or other complex psychiatric conditions are treated in paediatric wards, where medical staff are not appropriately trained to treat them.[41] Some paediatricians may try to refer them to adult psychiatric wards, but this is forbidden by Italian law.[40] Some regions are trying to address this issue by creating specific child and adolescent mental health services within the DMHs, but the situation varies across the country.[38]

Greater efforts are needed to talk to children early on at school about the risks of depression

Multisectoral initiatives between health, social care and education are needed to effectively prevent and manage mental health issues in children and adolescents.[26] There is a lack of school doctors/nurses with training in psychology or mental health in Italy, and too little investment in mental health awareness in schools to encourage children and teenagers to seek help for depression as they would for other conditions.[42]

There is also a need for training of healthcare professionals, particularly GPs, to recognise signs of depression in young people, which may manifest differently from those in adults.[42]

Differential diagnosis of depression in older people is needed

Greater attention must also be given to depression in older people. Approximately 41% of people in Italy over the age of 65 report having three or more symptoms of depression, which is much higher than the EU average (29%).[43] Differential diagnosis of depression is particularly important in older people with cognitive decline, which may mask manifestations of depression.

The coexistence of depression and dementia in older people is recognised in the most recent National Prevention Plan;[26] however, the coexistence of depression with other chronic conditions also needs to be acknowledged and built into medical training.

Data to drive improvements in depression care

The Information System for Mental Health is a dedicated information platform on mental health

A specific Information System for Mental Health (Sistema Informativo per la Salute Mentale, SISM) was established in Italy in 2018. It was set up as part of the national information system (Nuovo Sistema Informativo Sanitario, NSIS).[14 17 28] This integrated database contains data on prevalence, costs, service use, current staff and facilities, and hospital admissions for mental illnesses.

Data are provided by condition, classified by codes from the International Classification of Diseases (ICD-10), so specific data on depression are available. These data are published in Mental Health Reports, the latest one dating back to 2018.[17]

Patient-reported outcomes and data on the indirect costs of depression are lacking

Patient-reported outcomes data are not collected as part of the SISM, nor are they systematically collected across mental health services or facilities.

The indirect costs of depression, particularly lost productivity and carer burden, are also poorly quantified in existing data sources and would be helpful to better understand the social costs of depression.[44]

More efforts are needed to use data to guide service improvement

One of the goals of the SISM is to help the Technical Working Group on Mental Health guide appropriate polices to improve service delivery[25] at a national and regional level.[17] However, clinical data are not systematically linked to the SISM, making it difficult to interpret observed service utilisation patterns.

For example, hospital admissions data cannot be adjusted for the severity of different conditions in the SISM, so it is not possible to judge the appropriateness of care.[17]

Engaging and empowering people with depression

Patient and carer advocacy organisations that focus on depression and mental health have a strong presence in Italy

The importance of patient and carer engagement in the management of depression is well recognised in many of the local and regional care pathways on depression. Recent legislation has also created a dedicated fund to support carers of individuals who are no longer independent (e.g. due to mental illness).[47]

There are several civic society organisations engaged in depression and mental health operating at a national, regional or local level. For example, UNASAM (www.unasam.it/), which is an umbrella organisation for 70 non-profit organisations providing support to families affected by mental illness, has been actively involved in some of the earlier policy changes in mental health, and continues to provide support and training to carers of people affected by mental illness. The European Depression Association (EDA) Italia Onlus organises European Depression Day every year on 17 October, with events across the country (https://www.edaitalia.org/). Progetto Itaca (https://progettoitaca.org/) offers information, prevention, support and rehabilitation services to people living with mental illnesses and their families in several Italian cities, including peer-to-peer training (see **Case study 2**).

La Fondazione Onda (www.ondaosservatorio.it/en/), which is the national observatory for women's health and promotes gender-based medicine, has been particularly active in raising awareness of depression among women (see **Case study 3**). It launched an institutional document on depression and a manifesto with a 10-point call to action in 2019,[18 48] and organised regional round tables to encourage policy action on depression across the country in 2020. These round tables continued in 2021, involving national and local institutions, scientific societies, psychiatrists, GPs, patient organisations and the media. Fondazione Onda is now engaged in project STARGATE, which is designed to promote a shared culture on depression and is creating a document for healthcare professionals with national recommendations for early and appropriate care of people with depression. The document will be disseminated among institutions, the scientific community and the general public. It will later be contextualised at a regional level.

Case study 2. Peer-to-peer training on depression

Progetto Itaca has pioneered a peer-to-peer training programme for families affected by depression. It offers a course to families led by peers who have experienced a mental health disorder themselves. The course runs over sessions of two hours each and is free to access. It has been accredited by the National Alliance on Mental Illness in the United States and covers mental health generally, including depression. Participants are offered up-to-date information about medication, side effect management, relapse prevention, strategies to manage crises and stress management exercises. They are also signposted to available support services. The course is currently offered in Milan and Genoa (https://progettoitaca.org/en/progetto/peer-to-peer/).

Case study 3. Open days focusing on depression in women

Since 2013, the Fondazione Onda has organised open days on World Mental Health Day (10 October) to raise awareness of depression among women. All hospitals that have a 'pink certificate' (accreditation from the Fondazione Onda for being women-friendly, https://www.bollinirosa.it/) and other health settings around the country are invited to participate. The open day aims to encourage women affected by depression to seek appropriate diagnosis and care by raising awareness of depression and the clinical services and information available to them, removing the stigma strongly associated with it.[18]

Despite advocacy efforts, low awareness and stigma surrounding depression remain pervasive – ultimately affecting people's engagement in their care

It is estimated that fewer than 50% of Italians with depression are diagnosed and receive appropriate treatment.[18] A survey of the Italian population showed that many still perceive depression as a 'personal weakness'.[49] Stigma may act as a significant barrier for people to seek care, due to feelings of shame and low self-esteem, and a fear of the side effects of antidepressants.

Preconceived ideas about depression and antidepressants may also deeply affect individuals' attitudes to care and their adherence to treatment. They may significantly hamper people's engagement and sense of empowerment that they can achieve positive outcomes and recover from depression.

Harnessing technology to improve access to care

'Although we were unprepared for the need to use digital psychiatry, the pandemic saw us increasing our outreach to people with mild and moderate mental depressive and anxiety disorders by 30% thanks to digital solutions. There is certainly a lot of potential to use these technologies to improve mental health care in the future.'

Professor Antonio Vita, University of Brescia

The COVID-19 pandemic has focused attention on the potential of telemedicine in healthcare

Several Italian studies demonstrate the potential for telemedicine and remote services in depression,[50] [51] yet these approaches have traditionally been poorly integrated into psychiatric care.[52] This changed with the COVID-19 pandemic: with the closure of many outpatient mental health services,[39] psychiatrists were encouraged to conduct remote consultations, including remote psychotherapy, using recommended online platforms from their respective organisations. However, a lack of resources meant that phone calls or videoconferencing were only recommended for use in specific urgent patient requests and emergency cases – leaving many ongoing needs of people with depression unmet.[39]

This experience with remote psychiatry during the pandemic has, however, led to renewed focus on the potential use of remote technologies to improve psychiatric care. Priority applications that should be considered are: monitoring and improving patient adherence to therapy, remote consultations for people with mild or moderate depression, and providing psychosocial interventions to those who have difficulty going to hospital for clinical or other reasons.[38]

The legislation governing the use of telemedicine and remote psychiatry is evolving, but a lack of infrastructure remains a key issue for widespread implementation

Specific guidelines for the use of telemedicine were issued in 2012, which suggest that telemedicine needs to be fully integrated into established care pathways, with appropriate quality assurance and training.[53 54] A specific government guideline was also issued in 2009 on the use of telepsychiatry to link the various levels of healthcare (hospitals, general practice, emergency departments etc).[51 55]

A few months into the COVID-19 pandemic, the Ministry of Health and the Ministry for Technological Innovation and Digitalisation collected information on available digital solutions and possible strategies to address the telemedicine gap across all of healthcare.[54]

However, this did not lead to any change in infrastructure, and the provision of digital psychiatry and telemedicine remains highly heterogeneous across Italy.

Many care settings simply lack the appropriate infrastructure to deliver telemedicine and digital services,[54] and professionals often lack appropriate training to deliver remote care effectively.[56] Poor interconnection between telemedicine services across settings, heavy privacy regulations and a lack of clear guidance are also important challenges.[54]

Reimbursement for digital approaches is inconsistent

To be reimbursed under the public health system (SSI), digital approaches or technologies need to be included in the essential levels of care covered by the public health system (Livelli Essenziali di Assistenza, LEA). Yet the reimbursement status of different digital approaches seems to vary.

While remote hospital appointments are covered, many mobile phone apps used for monitoring require out-of-pocket payments by patients, limiting their acceptability by patients and physicians.[54] Funding of psychotherapy is also variable, with provision of online psychotherapy sessions still largely residing in the private sector.[57]

To ensure greater integration into standard depression care, quality assurance frameworks for digital technologies such as apps need to be improved

While apps may offer new and innovative options to deliver and monitor depression care services, greater efforts are needed to improve privacy policies and ensure they adhere to established quality standards.[56]

The 2012 guideline for telemedicine may serve as a helpful starting point, as it offers a quality monitoring framework with potential indicators, as well as regulatory guidance for the use of personal data and other salient issues.[53]

Conclusion and recommendations

> ‘Major depression has arguably received much less attention and investment compared to other conditions which have a similar clinical, social and economic impact.’
>
> **Luca Degli Esposti, CliCon**

Italy has a pioneering model in community-based mental health care; it has a sophisticated information system in which data specific to depression are available. Yet significant gaps in care remain – and disparities in access, quality and outcomes are evident across the country.

People simply do not talk enough about depression, nor recognise the urgency of addressing it. Depression affects people of all ages – with children and older people at enhanced risk. And with growing prevalence, there is an increasing cost of not addressing this condition in all its complexity. We need a cultural shift in attitudes towards depression and an integrated approach to care, focusing not only on quality health services but prevention and support through education, social rehabilitation and workplace efforts.[18]

Priority recommendations

Joined-up and comprehensive depression services

- Invest in specialist personnel trained in depression: psychiatrists, specialist nurses, rehabilitation experts and other mental health workers, particularly in community settings. At the same time, improve training for GPs on appropriate care pathways to ensure people with depression have timely access to the care they need.
- Build on collaborative models between primary and secondary care that have been established in some regions to improve continuity and appropriateness of care.
- Establish multidisciplinary care pathways in each locality/region involving GPs, mental health professionals and other specialists to provide a joint approach to the management of depression and coexisting chronic conditions, as this is often currently lacking.
- Encourage targeted, multisectoral actions to prevent and reduce disparities in access to care for depression in young people and all vulnerable populations, who are at greater risk of depression and currently relatively underserved.

Data to drive improvements in depression care

- Create linkages between administrative, clinical and quality-of-life data to better understand appropriateness of care and address gaps in quality of depression services.
- Better support people with depression in the long term by developing tailored care pathways e.g. by linking clinical data and data from the SISM and analysing them to help identify people who are at risk of recurring (treatment-resistant) depression.
- Invest in more systematic collection of indirect cost data (e.g. productivity loss and carer burden) to convey the societal costs of depression, and patient-reported outcomes data to understand the impact of care on people with depression. These costs are currently poorly quantified in existing data sources.

Engaging and empowering people with depression

- Create dedicated information and awareness campaigns to reduce stigma and communicate the message that depression is a condition like any other and needs to be treated as early as possible to improve quality of life.
- Ensure patient and carer advocacy organisations are engaged in service delivery and their expertise is represented in policy planning for depression.

Harnessing technology to improve access to care

- Address regional disparities in access to remote psychiatry for people with depression by ensuring adequate funding is available.
- Create dedicated educational programmes for psychiatrists, GPs and other professionals to help integrate new technologies into psychiatric care and reduce regional disparities in their availability.
- Integrate remote psychiatry and digital solutions to depression care into existing care pathways, through appropriate inclusion in clinical guidelines, professional training, and regulatory and reimbursement frameworks.

References

1. Centre for Suicide Prevention. 2015. *Depression and suicide prevention: resource toolkit.* Calgary: CSP
2. World Health Organization Europe. Depression. Available from: https://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/areas-of-work/depression [Accessed 11/06/20]
3. Pan K-Y, Kok AAL, Eikelenboom M, *et al.* The mental health impact of the COVID-19 pandemic on people with and without depressive, anxiety, or obsessive-compulsive disorders: a longitudinal study of three Dutch case-control cohorts. *The Lancet Psychiatry*: 10.1016/S2215-0366(20)30491-0
4. Linder A, Gerdtham U-G, Trygg N, *et al.* 2019. Inequalities in the economic consequences of depression and anxiety in Europe: a systematic scoping review. *Eur J Public Health* 30(4): 767-77
5. Cuijpers P, Vogelzangs N, Twisk J, *et al.* 2014. Comprehensive meta-analysis of excess mortality in depression in the general community versus patients with specific illnesses. *Am J Psychiatry* 171(4): 453-62
6. Ng CWM, How CH, Ng YP. 2017. Depression in primary care: assessing suicide risk. *Singapore Med J* 58(2): 72-77
7. Tavormina MG, Tavormina R, Nemoianni E, *et al.* 2015. A questionnaire to assess social stigma. *Psychiatria Danubina* 27 Suppl 1: S328-31
8. Muller R. 2020. Interview with Pooja Krishnaswamy at The Health Policy Partnership [Video conference call]. 20/11/20
9. Sabbe B. 2020. Interview with Pooja Krishnaswamy at The Health Policy Partnership [Video conference call]. 06/11/20
10. Istituto Nazionale di Statistica (Istat). 2019. *La salute mentale nelle varie fasi della vita.* Rome: Istituto Nazionale di Statistica (Istat)
11. Eurostat. Physicians by medical specialty. [Updated 10/07/20]. Available from: https://bit.ly/2ZlnS6x [Accessed 30/10/20]
12. OECD/European Union. 2018. *Health at a Glance: Europe 2018.* Paris/Brussels: OECD Publishing/European Union
13. World Health Organization. 2018. *Mental health atlas 2017.* Geneva: WHO
14. Italian Ministry of Health. Activities at national level: Basaglia Law. [Updated 01/10/20]. Available from: http://www.salute.gov.it/portale/temi/p2_6.jsp?lingua=italiano&id=175&area=salute%20mentale&menu=azioni [Accessed 10/11/20]
15. Barbui C, Papola D, Saraceno B. 2018. Forty years without mental hospitals in Italy. *Int J Ment Health Syst* 12(1): 43
16. Wang Y, Fattore G. 2020. The impact of the great economic crisis on mental health care in Italy. *Eur J Health Econ*: 1-14
17. Italian Ministry of Health. 2018. *Rapporto salute mentale: Analisi dei dati del Sistema Informativo per la Salute Mentale (SISM) 2018.* Rome: Italian Ministry of Health
18. Fondazione Onda. 2019. *Depressione: sfida del secolo. Unimpegno per contrastarla in attesa di un Piano nazionale.* Milan: Fondazione Onda
19. Beezhold J, Destrebecq F, grosse Holftorth M, *et al.* 2018. *A sustainable approach to depression: moving from words to actions.* London: The Health Policy Partnership
20. European Patients Forum. 2015. *EPF Background Brief: Patient Empowerment.* Brussels: EPF
21. Repper J, Carter T. 2011. A review of the literature on peer support in mental health services. *J Ment Health* 20(4): 392-411
22. European Commission. 2018. Tackling depression with digital tools. [Updated 04/06/18]. Available from: https://ec.europa.eu/research/infocentre/article_en.cfm?id=/research/headlines/news/article_18_06_04_en.html?infocentre&item=Infocentre&artid=48877 [Accessed 06/11/20]
23. Hallgren KA, Bauer AM, Atkins DC. 2017. Digital technology and clinical decision making in depression treatment: Current findings and future opportunities. *Depress Anxiety* 34(6): 494-501
24. Prescott J, Hanley T, Ujhelyi K. 2017. Peer Communication in online mental health forums for young people: directional and nondirectional support. *JMIR Ment Health* 4(3): e29-e29
25. Italian Ministry of Health. 2013. *Piano Di Azioni Nazionale Per La Salute Mentale.* Rome: Italian Ministry of Health
26. Italian Ministry of Health. 2020. *Piano Nazionale della Prevenzione.* Rome: Italian Ministry of Health
27. Italian Ministry of Health. 2019. Mental Health Technical Working Table. [Updated 01/10/20]. Available from: http://www.salute.gov.it/portale/temi/p2_6.jsp?lingua=italiano&id=5231&area=salute%20mentale&menu=azioni [Accessed 11/11/20]
28. Ferré F, de Belvis A, Valerio L, *et al.* 2014. *Italy: health system review.* Copenhagen: WHO
29. Piccinelli M, Politi P, Barale F. 2002. Focus on psychiatry in Italy. *Br J Psychiatry* 181(6): 538-44
30. Lora A. 2009. An overview of the mental health system in Italy. *Ann Ist Super Sanita* 45(1): 5-16

31. Lora A, Starace F, Di Munzio W, *et al.* 2014. Italian Community Psychiatry in Practice: description and comparison of three regional systems. *J Nerv Ment Dis* 202(6): 446-50

32. Degli Esposti L, Piccinni C, Sangiorgi D, *et al.* 2015. Patterns of antidepressant use in Italy: therapy duration, adherence and switching. *Clin Drug Investig* 35(11): 735-42

33. Rabboni M, Novel L, Bondi E, *et al.* 2013. *La depressione nel paziente adulto percorso diagnostico terapeutico.* Bergamo: Regione Lombardia ASL Bergamo

34. Berardi D, Ferrannini L, Menchetti M, *et al.* 2014. Primary care psychiatry in Italy. *J Nerv Ment Dis* 202(6): 460-63

35. Rucci P, Piazza A, Menchetti M, *et al.* 2012. Integration between primary care and mental health services in Italy: determinants of referral and stepped care. *Int J Family Med*: 10.1155/2012/507464

36. Menchetti M, Sighinolfi C, Di Michele V, *et al.* 2013. Effectiveness of collaborative care for depression in Italy. A randomized controlled trial. *Gen Hosp Psychiatry* 35(6): 579-86

37. Menchetti M, Tarricone I, Bortolotti B, *et al.* 2006. Integration between general practice and mental health services in Italy: guidelines for consultation-liaison services implementation. *Int J Integr Care* 6: 10.5334/ijic.152

38. Vita A. 2021. Interview with Suzanne Wait at The Health Policy Partnership [Zoom]. 01/02/21

39. Pelizza L, Pupo S. 2020. COVID-19 epidemic and public mental health care in Italy: ethical considerations. *Soc Psychiatry Psychiatr Epidemiol* 55(8): 1093-94

40. Di Giannantonio M. 2021. Interview with Suzanne Wait at The Health Policy Partnership [Zoom]. 06/11/20

41. Ilaria Betti. 2021. L'allarme del Bambin Gesù: "I giovanissimi si tagliano e tentano il suicidio: mai così tanti". [Updated 19/01/21]. Huffington Post Italia. Available from: https://www.huffingtonpost.it/entry/i-giovanissimi-si-tagliano-e-tentano-il-suicidio-mai-cosi-tanti-ricoveri-prima-della-pandemia_it_6006f714c5b697df1a09146e [Accessed 11/02/21]

42. Orthmann N. 2020. Interview with Suzanne Wait at TheHealth Policy Partnership [Zoom]. 18/11/20

43. OECD & European Union. 2019. *State of Health in the EU Italy Country Health Profile 2019.* Paris: OECD

44. Degli Esposti L. 2020. Interview with Suzanne Wait at TheHealth Policy Partnership [Zoom]. 20/11/20

45. Perrone V, Sangiorgi D, Andretta M, *et al.* 2020. Assessment of Patients Affected by Treatment-Resistant Depression: Findings from a Real-World Study in Italy. *JPsychiatry Psychiatr Disord* 4(3): 104-17

46. Senese F, Rucci P, Fantini MP, *et al.* 2018. Measuring costs of community mental health care in Italy: A prevalence-based study. *Eur Psychiatry* 51: 34-41

47. Economia. 2020. Bonus 2020: tutte le agevolazioni, incentivi e gravi per singoli famiglie. [Updated 13/01/20]. Corriere. Available from: https://www.corriere.it/economia/consumi/cards/manovra-2020-agevolazioni-incentivi-bonus-singoli-e-famiglie/caregiver-familiari-assistenza-disabili-gravi.shtml [Accessed 10/11/20]

48. Fondazione Onda. 2020. *Manifesto: Uscire dall'ombra della depressione.* Milan: Fondazione Onda

49. Munizza C, Argentero P, Coppo A, *et al.* 2013. Public beliefs and attitudes towards depression in Italy: a national survey. *PLoS One* 8(5): e63806

50. De Luca V, Baldi G, Bernardini M, *et al.* 2005. Nuove possibilità di valutazioni psichiatriche con sistemi web-based: uno studio pilota. *Riv Psichiatr* 40(5): 300-06

51. Di Carlo F, Picutti E, Sociali A, *et al.* 2020. Telepsychiatry: cracking the distance in mental health assistance. *Evidence-based Psychiatric Care* 6(2 Suppl 1): 8-14

52. Rosso V. 2020. Digital Psychiatry: past, present and future. *Evidence based Psychiatric Care: Journal of the Italian Society of Psychiatry* 6(2 Suppl 1): 3-7

53. Italian Ministry of Health. 2012. *National guidelines on telemedicine.* Rome: Italian Ministry of Health

54. Omboni S. 2020. Telemedicine During the COVID-19 in Italy: A Missed Opportunity? *Telemed J E Health* 26(8): 973-75

55. Bertetto Oea. 2009. *Linee Guida Per Lo Sviluppo Di Un Progetto Di Telemedicina. Parole chiave: aree decentrate, telemonitoraggio domiciliare, pazienti cronici.* Italy: Agenzia Regionale per i Servizi Sanitari – Area Organizzazione e ProgrammazioneEnte strumentale della Regione Piemonte

56. Rucco A, Vannini C, Miuli A, *et al.* 2020. Patients, clinicians and caregivers, all together now: GIADA's green light for mental health. *Evidence-based Psychiatric Care* 6(2 Suppl 1): 44-49

57. Cioffi V, Cantone D, Guerriera C, *et al.* 2020. Satisfaction degree in the using of VideoConferencing Psychotherapy in a sample of Italian psychotherapists during Covid-19 emergency. 2020 11th IEEE International Conference on Cognitive Infocommunications (CogInfoCom); 23-25 Sep 2020

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