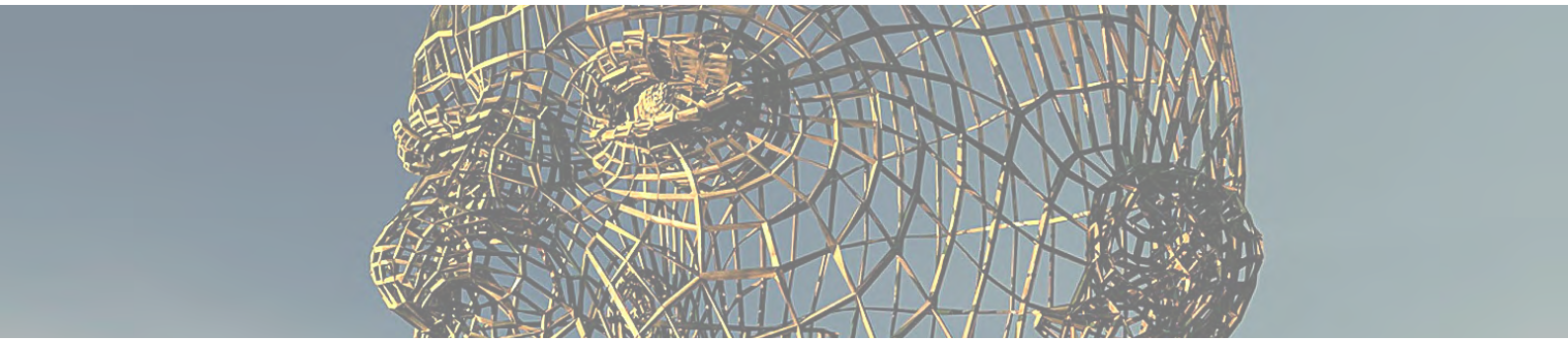
IPRS

PSYCHOANALYTIC INSTITUTE
FOR SOCIAL RESEARCH

PsychCare

PSYCHIATRIC SERVICES FOR REFUGEES

GUIDELINES FOR INTEGRATED MENTAL HEALTH CARE OF FORCED MIGRANTS



PROJECT SPONSORED BY OPEN SOCIETY FOUNDATIONS
WWW.OPENSOCIETYFOUNDATIONS.ORG
WITHIN THE MENTAL HEALTH PROGRAM

INDEX

FOREWORD

by *Sandra Zampa* – Undersecretary of State at the Ministry of Health

PsychCare Project - Psychiatric Services for Refugees from 'Istituto Psicoanalitico per le Ricerche Sociali' (Psychoanalytic Institute for Social Research) has the merit of combining the two specific areas. It ranges from the analysis of the more strictly health aspects, to an excursus on psychiatric reform laws and regulatory applications, and further more to the increasingly complex functions of mental health centers, to the role of the various subjects involved, to the definition - also through the presentation of good practices - of paths for holistic care, regarding a problem that only apparently may seem a mere segment of the wider health issue of one of the most fragile categories in our country: forced migrants.

According to the United Nations High Commissioner for Refugees estimations, we live in a world where every two seconds a person is forced to leave his/her home because of conflict or persecution[1].

In the final decades of the last century, immigration to our country was mainly economic, refugees were few and tied to specific situations, such as in the case of Chilean refugees or the first Kurds. In the new century, on the other hand, the number of refugees has greatly increased, both in the world - where they are almost 26 million, mainly received in countries close to those from which they came - and in Europe. Italy, with its central position in the Mediterranean, has become one of the main ports of arrival. The majority of those who arrive do so at the risk of life and by applying for asylum once they enter Italian soil, since, under the Dublin Treaty, the responsibility lies with the country of first landing. Thus, the refugees and asylum seekers of today are no longer those coming only from specific countries, but a large proportion of people who come to Italy from Africa (mainly) but also from Asia and Central and South America. They are people who have lived complicated life events, often traumatic.

The UNCHR reminds us that "forced migration" is not a legal concept and, just as for the concept of "migration", there is no universally recognized definition [2].

And yet, whatever the definition you want to attribute to people forced to leave their home places, becoming "foreigners" in other lands, for all of them, what Levy-Strauss stated was: "physical integrity does not resist the social and cultural disintegration "[3]. This is what emerges

[1] https://www.unhcr.it/risorse/statistiche
[2] https://www.unhcr.it/news/rifugiati-e-migranti-faqs.html
[3] C. Levy-Strauss "Lo Stregone e la Magia" (1949). The concept, although referring to the context of magic and shamanism in the populations studied, is well suited to the condition of forced migrants

from reading some of the contributions contained in the study: the physical and mental integrity of a human being are inescapably correlated with the social and cultural condition and with life context. In the case of forced migrants, the traumatic events suffered have a great weight on the dramatic interruption of normal conduct of their existence in known and familiar places. Often, in fact, forced migrants have been forced to leave their country because they are persecuted for political, religious, ethnicity or gender belonging, or even because they are victims of local crime colluded with the state apparatuses which cannot assure their protection, or finally because they are victims of trafficking for sexual exploitation. The passage in Libya, moreover, exposes them to new (and sometimes even more serious) traumas: sold as slaves, sexually abused, imprisoned in detention centers on the verge of survival, tortured for ransom. Finally, many also risk dying at sea during the crossing of the Mediterranean, and perhaps have seen their friends or family perish in those circumstances.

The subsequent landing in a foreign land, the lack of knowledge of the local language and culture, the condition of precariousness and suspension in relation to the complex legal and bureaucratic procedures, constitute further heavy elements which exacerbate the condition of estrangement and profoundly affect physical and mental integrity of these people. In this context, unaccompanied foreign minors represent the most fragile victims of a forced exodus with an uncertain but certainly dramatic outcome in terms of psychological fallout. So why is the investigate and ascertains of mental health status of forced migrants so important?

Mental health of asylum seekers and refugees is a central theme of migration medicine, both for the suffering experienced by many of these people, and for the repercussions it has on the migratory path, and therefore on the success of their insertion in the society hosting.

If these are the problems to be addressed, the first point to be underlined is that a coordination effort is needed between all the players involved, because the promotion of mental health in these people does not boil down to health care, but must be implemented internally a network of interventions that provides, as mentioned in the project, legal support, a credible training and job start-up plan, an overall insertion in the public life ganglia of the host country. All of this is not only useful for the host country - which could thus have human capital for growth, rather than reducing it at social and assistance costs -, but is fundamental for the psychophysical well-being of those who seek asylum or are refugees. A hope for the future is also an indispensable condition for learning to live with the weight of a traumatic experience.

The second point is specifically healthcare, and, with reference to Italy, concerns the structuring of easily accessible mental health services, open to transcultural relations, competent for the identification and treatment of victims of intentional violence and torture. The Ministry of Health has developed guidelines, also mentioned in the study, agreed with the regions and autonomous

bodies. These are the: "*Guidelines for the planning of assistance and rehabilitation interventions as well as for the treatment of the mental disorders of the holders of refugee status and subsidiary protection status whom have suffered torture, rape or other serious forms of psychological, physical or sexual violence ",* published in March 2017. They indicate in detail the path for the identification, taking charge and rehabilitation of people who, having suffered serious interpersonal trauma, need a support system that is not only medical but more generally psychosocial. Despite the efforts, not all territories are adequately trained to manage cross-cultural relationships with complex patients such as traumatized migrants, and moreover, in some local realities the accessibility and usability of services is still difficult, especially for those who are in strong need. The recent reorganization of the reception system also makes the application of ministerial guidelines even more complex. It must be emphasized that National Health Service as it is thought today, is often inadequate to respond to health needs of forced migrants and also of those in conditions of extreme marginality. Therefore, a substantial cultural change is needed to guarantee everyone the right of access to treatment, also by activating outreaching methods. An answer to these needs is given by the *Istituto Nazionale per la promozione della salute delle popolazioni Migranti e per il contrasto delle malattie della Povertà* (INMP) (National Institute promoting health of migrant populations and to fight illnesses caused by poverty -INMP), supervised by the Ministry of Health which operates as a reference center of the national network for issues of assistance in the social-health field linked to migrant populations and poverty, as well as a national center for transcultural mediation in the health field.

Promoting the mental health of forced migrants is a complex action that is played on several levels. For this reason, we should thank the Psychoanalytic Institute for Social Research and all those - scholars, academics, institutions, operators, associations, local authorities - who have made themselves available contributing in various capacities to the study and definition of the paths outlined in the project.

Programs, research, initiatives which concern particular social and clinical fragility of the population are always to be welcomed with favor, in particular when they concern a part of the population that is among the most exposed and not always sufficiently protected such as forced migrants. The hope is that more and more synergies and stable collaborations will be created between institutions, public bodies, local bodies and associations to systematize investigations, indications and projects at the service of the population to whom they are suited and able to support political decision-makers in taking organic measures that truly respond to the realities to which they are directed.

PSYCHCARE PROJECT - PREFACE

by *Pietro Bartolo* – Vice-Chair of the Committee on Civil Liberties, Justice and Home Affairs – European parliament

---

Psychcare Project places at the center of the research and proposals the integrated mental health care of forced migrants. It therefore deals with people who have been forced to leave their home country due to geopolitical upheavals in many African and Asian countries and in particular the applicants for international protection. First the "Context" is analyzed with the support of the discussion between Maxima Libertas and Anna Maria Petta of Crossing Dialogues Association of Rome.This introductory chapter discusses the mental health profile of asylum seekers and refugees. From the analysis carried out, a complex picture emerges made of factors which may have a negative impact on the mental health of asylum seekers and refugees, linked to trauma, vital difficulties and problems with respect to the first reception phase.

The most frequent mental disorders in refugees and asylum seekers, in fact, are reactive in nature. Among the most frequent are the PTSD (post-traumatic stress disorder), reactive depression and anxious syndromes. It is underlined how these pathologies are attributable to extreme traumas such as: repeated interpersonal violence, voluntarily inflicted by a person and / or a group, in a situation of deprivation of liberty. It is highlighted that there is a difficulty in finding a homogeneity of the tools of diagnosis and data collection which are conditioned by the place and time of the survey. The authors, in relation to asylum seekers' mental health profile, state that the available epidemiological data, among the various assessments, have highlighted the increase, after 2011, of psychosis in young males, coming from the countries from which asylum seekers currently come from. In this subgroup the rate curve appears to have followed soaring far exceeding other migrants and of Italians (Aragona 2020). In essence, vulnerability has increased significantly in this segment of population and people need hospitalization more often. This coincides, temporally, with the disintegration of the Libyan state, with the consequent chaos, which led to an increase in departures (even of people who had not planned to come to Europe) and an increase in serious traumatic experiences in this specific country (incarcerations, beatings, forced labor, malnutrition and dehydration, abuse and physical and sexual violence, torture). The authors hope for activities which will help to make sense of this often disorienting experience and point out that it is also necessary that these people are also supported in the integration process, in the hosting country, through interventions to promote education and professional start-up. Giulio

Corrivetti, Director of the Department of Mental Health - ASL Salerno, in his article "The Law of Psychiatric Reform: a goal of civilization between organization and rights", traces the salient points of the Psychiatric Reform in Italy, of which Franco Basaglia was a pioneer, highlighting how he has worked with strength and determination, to break down the walls of asylums, also understood as intangible barriers, between those who consider themselves sane and therefore acceptable, compared to those who are placed outside a supposed normalcy and therefore to be marginalized. The author highlights the fact that mental illness stigma has marked Europe's history. It also poses a reflection on the law of psychiatric reform, as a milestone of civilization between organization and rights. Corrivetti notes the importance of the community system, in which, in addition to treatment and rehabilitation actions, prevention and promotion activities, must be considered through dynamics which may involve an entire community, in order to favor a dimension of treatment that does not operate only as psychiatric discipline, as a medical discipline limited to a simple professional service with a prevalent clinical imprint, still capable of promoting mental well-being as a broader system of protection of citizens' mental health. By promoting socio-health integration, the author hopes to overcome the stigma on mental illness and a better treatment system in light of the new acquisitions in terms of treatment and of the problems related to mental health, even of migrants, given that in these situations add stigma to stigma. Roberta Aria and Anna Brambilla from ASGI organization, in the study on "Ownership and effective access of forced migrants to mental health services in light of the impact of recent migration regulations" analyze the impact on effective access of forced migrants, in particular of applicants for international protection to mental health services, of reforms introduced by converted legislative decree 113/2018 with Legislative Decree 132/2018 with particular reference to changes in the field of reception, personal registration and humanitarian protection. In this sense, it analyzes the difficulties in accessing health services. It is underlined how the various acts that make up the so-called Common European Asylum System contain open definitions of vulnerabilities and specific provisions that should guarantee the necessary attention to the particular needs with which vulnerable international protection applicants are bearers. The authors evaluate how, despite the specific attention reserved by the European legislator to applicants for vulnerable international protection, the transposition of these provisions into the national legal systems of the various States belonging to the European Union has occurred unevenly, with consequent disparities in the categories of applicants considered vulnerable. The vulnerability refers to people suffering from serious illnesses or mental disorders and to people who have suffered torture, rape or other serious forms of psychological, physical or

sexual violence. It is very painful to note that, at times, these already painful experiences are accompanied by inadequate reception conditions, inefficiencies, delays and real abuses also in the European Union. People are detained at sea for days even after being rescued, pending authorization for landing. Vulnerable asylum seekers (with all the criticality that this definition entails) would need procedural guarantees and specific rules from the Common Asylum System. Only in the national systems of Italy, Poland, Malta and Cyprus asylum seekers are included in the so-called "vulnerable categories". The authors underline how urgent it is to refine attention to those invisible wounds that, after some time, can compromise up to making a free and safe life in the country of arrival impossible. In this regard, two significant cases are reported concerning the story of two young men; one hosted in Palermo and the other in Mantua. In both situations, the difficulties encountered by both men and the operators in managing the vulnerable condition are described. The work of Giancarlo Santone, UOSD Health Center for forced migrants-Sa Mi. Fo. of the ASL Roma l, deals with the elaboration and transposition of the guidelines for the programming of assistance and rehabilitation interventions as well as for treatment of mental disorders of the holders of international protection who have suffered torture, rape or other serious forms of psychological violence, physical or sexual. The author argues how important it is to note that the significant transformations that have affected the reception system in recent years would require a revision of the guidelines, especially regarding the procedures for early identification of psychopathological problems. To this end, he notes that, in most reception facilities for asylum seekers, the figure of the psychologist is no longer envisaged. The author reports that comparison and elaboration process which have led to the drafting of the current guidelines had a major impetus in 2010, a year in which just over 12,000 requests for international protection were presented throughout the country and the so-called "refugee crisis" was still a long way off.

Another reflection of particular interest concerns the one concerning the role of the cultural and / or linguistic mediator for the understanding of the psychopathological phenomena expressed by forced migrants. Massimiliano Aragona deals with this problem, who believes that specific skills are needed in this sector, because it is the context that requires it. The author emphasizes that the mediator himself becomes part of the treatment factors operating in the clinical meeting. The figure of the mediator is indispensable to avoid mis-understandings during a relationship of transcultural help. After assessing the context in which the problems of forced migrants develop, the Psychcare project (10 September 2018 - 9 September 2020) is working on defining proper guidelines about the methodology followed and the results obtained to date. It is specified how the project is carrying out participatory

advocacy action on the issue of mental health protection of forced migrants, with the aim of improving the ability to take charge of services aimed at protecting the most vulnerable segments of the migrant population in four regions Italian: Lazio, Lombardy, Campania, Sicily. The choice of regions was made on the basis of representativeness with respect to the presence of forced migrants, but also on the basis of the significant variety with respect to the organization of the Health Service and the available territorial resources. The reflections that led to the drafting of the project and the conclusions reached in the carried-out work, appear exhaustive and interesting.

We share the value of the work done to define the guidelines, the result of the attempt to continue breaking down the walls, not just physical ones, which divide our societies making them more fragile. The project therefore deserves to be brought to the attention at a European level. It should be underlined that for many years Italy has found itself directly involved in the phenomenon of forced migration, with important numbers of arrivals. The long-gained experience, allows to make careful assessments on the system weaknesses', with respect to the protection of mental health of migrants and allows to underline the risks related to prejudice and discrimination. The proposals developed were born from a careful recognition of the critical issues encountered by operators in many years of experience. In particular, the difficulties relating to the early emergence of problems and prevention, the lack of homogeneity of responses from services are highlighted. Some services place barriers to access even where they are not foreseen. It must be recognized that these critical issues, in a more subtle form, are present in all the other countries of the Union.

In addition to the encountered critical issues, the project takes into consideration some examples of good practice such as the experience of the Ethnopsychiatry Service of the ASST Grande Ospedale Maggiore Niguarda that moves within the framework of ethno-psychiatry, the Vulnerable Milanese Network for Applicants and Holders of International Protection in Milan, the word groups for the support of asylum seekers in Mantua and the training of the Linguistic Mediators by Centro Penc, which is located at the Guarantor of Childhood and Adolescence of the Municipality of Palermo.

The experiences, good practices and reflections shared by Italian specialists and social workers within the Psychcare project deserve to be taken into consideration as they represent a heritage that the whole of Europe can draw on, also in view of a desirable greater involvement of all Member States in the reception of asylum seekers arriving in Europe. Indeed, it should never be forgotten that health represents a collective value and that migration can be considered as the litmus test of the state of health of European democracy

and the ability of the Member States to effectively guarantee people's rights. The Psychcare project moves towards this direction.

THE CONTEXT

PsychCare
PSYCHIATRIC SERVICES FOR REFUGEES

IPRS

THE MENTAL HEALTH PROFILE OF ASYLUM SEEKERS AND REFUGEES

by *Maxima Libertas* and *Anna Maria Petta* - Crossing Dialogues Association, Roma

Introduction

Dealing with this theme requires two brief premises.

First of all, compared to the immigrant population in Italy in more or less recent times, the asylum seekers and refugees is a particular subpopulation. In other words, there is a large number of foreigners residing in various capacities in Italy. This is a structural phenomenon that has stabilized for some years. Just over 8% of the Italian population is made up of people of foreign origin, and this means that, given the uneven distribution in the area, in some areas it even reaches 15%. From a mental health perspective, all migrants can have:

a) a first phase of 'Transculturation Stress'. Someone coined the term Ulysses Syndrome[4] for post-migratory suffering while adapting to the new society;
b) everyone suffers more or less intensely from a condition known as "double absence", which is not a mental disorder per se, but more like an identification of oneself that can be an enriching factor, due to a sense of belonging, but also to psychological vulnerability[5].
c) all of them may have been subjected to discrimination, all the more so in recent years in which the traditionally very tolerant and open approach that characterized the Italian population has partially changed due to often politically motivated hate campaigns;
d) anyone can have difficulty accessing care and taking care of linguistic and / or cultural problems;
e) many individuals may actually have difficulty accessing healthcare and registration due to bureaucratic issues or the inability to bear the costs of therapies, etc.

[4] Greenhalgh (2016), in a report on the health contexts of the World Health Organization (WHO), delves into the definition of Ulysses Syndrome which is first described by Dr. Joseph Achotegui (2015). It manifests itself with a combination of physical and psychological symptoms (e.g. headaches, insomnia, anxiety, irritability). This syndrome is defined as an extreme form of migratory mourning, the symptoms of which are the consequence of extreme stressors, forced removal, migratory travel, lack of goals and failure of the migratory project, social isolation and adaptation difficulties in the host country. However, this condition is not officially included in the classification of mental disorders by WHO.

[5] In the analysis of Algerian immigration to France, Abdelmalek Sayad (2002) coined the term "double absence" to indicate the condition of the migrant which makes him only partially absent from the country of origin and at the same time not fully present in the host country. Sayad defines the migrant as "Atopos" or as one who is "out of place, without place" in both countries that define his non-existence from the point of view of his identity.

Compared to this more general population, asylum seekers and refugees are much lower numbers (an estimated 0.31% of the Italian population), therefore in theory more than manageable with a minimum of programming. However, on the one hand an insufficient programming to which various ministerial and regional guidelines have tried to give impetus with, to date, still unsatisfactory results, on the other hand specific health needs and clinical-therapeutic complexity make this population worthy of a particular focus.

The second premise is necessary with respect to the cultural approach in mental health. Given the numbers, one in ten patients who access mental health services are likely to be of foreign origin (in various situations this is already the case). This being the case, it would be unthinkable to create specifically ethno-psychiatric centers for everyone, so it becomes necessary for all services to acquire the basic skills to refine their cultural sensitivity and to adequately use the contribution of cultural mediators, in order to be able to give adequate answers on the spot. Compared to this general scenario, as we will see, asylum seekers and refugees may have more specific health needs and therefore dedicated routes and teams can be organized for them. In this case, given the lower numbers, you can also think of centralizing the skills in a service for each ASL, unless the territorial extension is such as to compromise the use of the service to people who live in places distant from the structure. Given these necessary premises, the first question to ask is: what do asylum seekers and refugees suffer from? Secondly, are there more specific conditions than those mentioned above?

The mental health profile of asylum seekers and refugees

The epidemiological data available on this topic are influenced by various factors. First, where was the investigation done? It is one thing to do it in a clinical context, where access is already pre-selected by the healthcare need, it is another thing to do it in a reception center rather than in the general population, another thing is to do it among those who have ended up living for street. Then, in what period were they performed? Psychopathological cadres change over time, so it is one thing to do the investigation upon landing, it's another after six months or after years. Another question is: with what tools was the investigation carried out? Because depending on whether the diagnosis has been made in a clinical way, with more or less structured interviews, with self-administered questionnaires, etc., the health profile changes and consequently the numbers of positive cases diverge.

Finally, it is necessary to consider the "legal" typology. Refugees are the holders of international protection, or those who have received a positive opinion from the territorial commission (or, in the event of an appeal, from the court) about their asylum application (usually actual refugees and holders of subsidiary protection are merged). On the other hand, the question of asylum

seekers is quite different, because this is an extremely heterogeneous category. It includes: a) those who have applied for asylum and are waiting for the territorial commission; b) those who have been denied in committee but await the outcome of the appeal; c) those who have been "dublined", that is, have made the asylum request in another European country where it is ascertained that they had entered Europe through Italy, and therefore they are sent back to us for new ruling; d) lately even those people who, having entered the Balkans or other routes, have applied in a European country, have been denied there and since they feared deportation back to their countries of origin they decided to come to Italy and try again to make a new application, hoping that our country will be more “lenient”. The differentiation is purely a legal-administrative one, but behind these differences there are tortuous paths of life and therefore various psychological reactions that cannot fail to be relevant for the resulting mental health profile. This said, not all of these differences have been considered in scientific reports, so let's see what is actually reported, with an emphasis on studies of the population present in Italy. There is general agreement on the idea that the most frequent mental disorders in refugees and asylum seekers are reactive, i.e. Post-Traumatic Stress Disorder (PTSD), Reactive Depression, Anxious and Maladjustment Syndromes. Other symptoms are often secondary, coming after the basic reactive disorder (e.g. substance abuse as an attempt to manage the most disturbing symptoms, somatization and in particular tension-related headaches caused by stress, etc.). More specifically, PTSD is the usually more frequent disorder, found already in the first weeks after landing (Crepet et al., 2017). In this study, its prevalence is 31% (followed by Depression, 20%, and Anxiety Disorders, 11%). However, in reality this figure is probably overestimated, because it’s reported on the 385 subjects who agree to undergo a psychological evaluation, while the starting population was 668 people who had participated in psycho-educational groups (in turn a subpopulation of the guests of the centers, whose number was not specified in the article). The data on reception centers in a more advanced phase tell us that 40% of those who have psychological suffering, who are 36% of the sample, have a PTSD (Nosè et al., 2018). Therefore, in this study carried out on the SPRAR centers (the current SIPROIMI, but in a phase in which there were also asylum seekers among the users, not only people already entitled to protection), the prevalence of PTSD over the total number of guests tested would be 14.4%, therefore lower than in Crepet et al. (2017). In another study, which has the advantage of evaluating both CAS and SPRAR but the disadvantage of using an indirect methodology, the prevalence is even lower. In this case, a diagnosis of PTSD had been made to 4.53% of the hosts, more frequently among those of the CAS than of the SPRARs (5.16 vs 3.97%), followed by the diagnoses of Adaptation Disorder and Disorders of the 'Mood (Petta, 2019). Here the data was probably underestimated because a part of the user could have escaped the diagnostic formalization, not having been assessed from

a psychological point of view. However, in the population of asylum seekers and refugees it can be asserted with good reliability that the disturbances are of a reactive kind (according to studies) and that the prevalence of PTSD, which is the most frequent disorder (this too is generally accepted in the studies) is between 5 and 30% depending on the population studied and the research methodology. In short, we are far from an epidemic, but they are people who are sick and whose symptoms interfere significantly in the path of adaptation to the host society, so they must be considered with great attention.

Compared to the other psychopathological phenomena most frequently reported in this population, one figure to underline is that of addictions, especially to alcohol, cannabis and other drugs. On this there are not many epidemiological data but it is fairly consistent experience of the operators in the field that they are frequent problems, which tend to increase the more people are in a state of marginalization (maximum among homeless people). It is believed that a portion of these abusive behaviors is to be considered as an attempt, in itself even more problematic than the problem to be solved, to manage the most disturbing symptoms, especially hyper-arousal and insomnia, typical of traumatized patients as well as people who mull over their current problems of social discomfort. Compared to the somatic expression of mental suffering, the so-called somatizations, various researches (eg Aragona et al., 2011 and 2012a) show that they are extremely frequent: at least a quarter of the patients (25.6%) seen inside basic healthcare centers dedicated to migrants has a somatization syndrome, with important implications for the choice of therapies. For example, mistaking somatization for inflammatory pain involves inappropriate prescribing of anti-inflammatory medicines, running the risk of the condition becoming chronic and possible iatrogenic damage. On the other hand, and this is the most relevant data in this instance, migrants with PTSD have more somatizations, almost all the symptoms of PTSD are more frequent in somatizers, and as the number of post-traumatic symptoms increases, so does the risk of having a somatization syndrome. Somatizations have been interpreted as a sentinel symptom of a possible hidden post-traumatic pathology: the traumatized person may not speak of his post-traumatic suffering, which remains substantially invisible, while he may request help for the symptoms he experiences in the body. It is therefore important that the doctors, as well as the operators who deal with reception and assistance, are prepared to catch any indicators that it may possibly be a victim of violence they are dealing with.

Another area of great interest related to post-traumatic symptoms, and typical of asylum seekers and refugees, concerns cognitive functions. In fact, having suffered important intentional trauma involves problems in terms of concentration and memory, of fixation but also of re-enactment of autobiographical memories (see Petta et al., 2018 on the latter point). In particular, difficulty in accessing specific memories of one's life was found in asylum seekers and political refugees with

Post-Traumatic Stress Disorder and depression (Graham et al., 2014). This phenomenon is defined as Overgeneral Memory, it can derive from the interruption of the recovery process of the memory trace, in which the search is truncated at a general level without accessing more specific memories. A central role can be determined by ruminations and therefore also by intrusive thoughts, by information coding deficits, by the avoidance of negative emotions related to traumatic events or by issues of executive control. These data are also confirmed by previous studies on asylum seekers and other groups of patients with PTSD (Moradi et al., 2008; Lagarde et al., 2009; Koso et al., 2012). A further problem with the autobiographical memory is the coherence of memory trace reported after a certain period of time. Herlihy et al. (2002) found the presence of greater discrepancy especially in the peripheral details of the autobiographical memories of asylum seekers interviewed on the memory of two events, one traumatic and the other non-traumatic. Finally, the mastery of executive functions has also been investigated in relation to post-traumatic symptoms and negative scientific associations have frequently been found to emerge linking PTSD and executive functions (Stein et al., 2002; Kanagaratnam & Asbjornsen, 2007; Leskin & White , 2007; Woon et al., 2017). More precisely, Ainamani et al. (2017) found, in asylum seekers and political refugees, the presence of a negative correlation between post-traumatic symptomatic severity and performance in tests evaluating executive functions in a group of Congolese refugees, particularly in women. A further study also reported difficulties in numerous cognitive domains: problems of abstract reasoning and poor cognitive flexibility, slowness in performing tasks, attention deficits (Kiaris et al., 2020). In the study by Nosè et al. (2018) problems with concentration emerge among the most frequent symptoms among the guests of SPRAR centres (in 22% of the people accepted, or in 60% of those who report psychological difficulties), while Petta's report (2019) indicates attention deficits, in learning skills and in planning respectively in 14.8, 12.6 and in 10.1% of the guests of CAS and SPRAR. In general, the study of cognitive functioning requires a reflection on the cultural validity of the tools used, so it must be considered as preliminary. However, since a compromise in the cognitive functioning of the person also has an impact on the psycho-social functioning and therefore on the chain of integration in the host country, a plan remains to be carefully considered in assessing possible vulnerabilities.

Finally, a separate mention should be made about psychosis. It must be said immediately that there is agreement between the various epidemiological findings that the rates of psychosis are low in absolute terms, even if being a young migrant in socio-economic difficulties means putting together three risk factors that increase the relative risk of incidence of psychosis (Lasalvia et al., 2014). However, although rates appear low in absolute numbers, an interesting finding emerges from a recent study on psychiatric hospitalization rates. In Italy, hospitalization rates for

psychiatric diseases among foreigners were traditionally lower than those among Italians, and this dynamic has remained unchanged even in recent years, at least as regards migrants in general. If, on the other hand, the population of young males from the countries from which asylum seekers currently arrive is selected, what has been seen is that after 2011 the rate curve of this subgroup has soared, far exceeding both that of other migrants and that of Italians (Aragona et al., 2020). In essence, it is as if there were a greater vulnerability in this population that leads people to hospital more often, and this coincides temporally with the disintegration of the Libyan state, with the consequent chaos that has led to an increase in departures (including people who had not planned to come to Europe) and an increase in serious traumatic experiences in that country (incarcerations, beatings, forced labor, malnutrition and dehydration, abuse and physical and sexual violence, torture). The ministerial source of data for this study (hospital discharge forms) does not allow a finer analysis based on schooling, whether or not you are an effective asylum seeker / refugee, etc. However, the data are sufficient to suggest that something new is taking place in that population, that the mental health profile is no longer as good as that of migrants who arrived in previous eras, and this poses a challenge to the national health system. This suggestion is also confirmed by a qualitative survey conducted on a sample of social and psychiatric workers in Italy: “From the interviews carried out within the private sector with long experience of treating psychopathologies among migrants, and also with psychiatrists operating in public structures, a different typology of the current migrant has emerged that often presents itself with an already compromised psychic substrate, with a reduced resilience capacity and in the absence of a clear migratory project "(Medici Senza Frontiere, 2016).

Trauma, life difficulties and hospitality

As we’ve seen, most of the mental health problems presented by asylum seekers and refugees are reactive to life situations and in particular to traumatic events. In psycho-traumatology we speak of potentially traumatic events to refer to those events that the person suffers directly or of which he is witness, or which he becomes aware of if it concerns people of his close circle, characterized by "real death or death threat, serious injury , or sexual violence "(American Psychiatric Association, 2013). In recent years even more than in the past, due to the geopolitical upheavals in many African and Asian countries, for these applicants for international protection each of these events may have occurred, and in addition there is often a specificity linked to the intentional nature of the situations of violence to which they were exposed. This means that someone has committed brutal acts on someone else aimed at inflicting pain and / or death in a voluntary and conscious way. This entails a greater peculiarity of the trauma, also called "extreme trauma": repeated interpersonal violence, voluntarily practiced by a person and / or a group, in a

situation of deprivation of liberty. Often asylum seekers and refugees are "forced migrants", in the sense that they were forced to leave their country of origin precisely because of events that exposed them to traumatizing experiences, so the trauma experienced in the country of origin is a important factor in the causal chain of events leading to the PTSD that we observe in Italy. However, not all people exposed to psycho-traumatic events actually develop PTSD, as there is no direct cause-effect relationship but there are intermediate factors such as the characteristics of the traumatized individual, his psychological defenses (resilience and ability to cope), the cultural, family and religious affiliations, the way in which he integrated the event into his own subjective and cultural experience, from which his own then derives, and what he makes of it. Furthermore, the development of PTSD also depends on the context in which the traumatic episode occurred and on the events that followed the trauma. Some of them can mitigate the traumatizing aspects, while others instead may build a dramatic chain reaction, which further complicates the results. This brings us to the concept of secondary traumatization, by which we mean the reactivation of the traumatic experience through new events. In the case of our patients, the passage to Libya is of great importance, because it is a source of serious and systematic interpersonal violence, in extreme living conditions. There is hardly a single Sub-Saharan woman who has not been raped in Libya, just as there's hardly a man who's been locked up in some collection center, governmental or otherwise, without being brutally and repeatedly beaten, sometimes to the point of torture and, indeed, summary execution. And then there is the crossing of the Mediterranean, with shipwrecks, naval blockages, etc., events that can all have re-traumatizing effects. Thus, it can be said that most people arrive in Italy with a baggage of previous traumatizing experiences (in their own country and/or during the trip), so it's not surprising that PTSD is the most frequent psychopathological reaction that we find in Italy.
Then there are the added difficulties that are found upon arrival in Europe, when the condition of vulnerability exposes the individual to further re-traumatization, for various reasons such as: a) the insufficient protection of some parts of the reception system (think for example of migrants hosted in overcrowded centers where frictions between groups of guests are highly likely); b) the traumatic situations linked to the new internal barriers (think of migrants, often families with the elderly and children, who have been fired at with rubber bullets and tear gas at the Balkan borders); c) the fact that part of the people leave the reception circuit. Those in transit, for example, who leave before being registered, or, at this particular time, the holders of humanitarian protection status (who risk being removed from the centers following the new law 132/2018, and end up in the street which triggers phenomena of social marginalization that make their exposure to new abuses and traumas more likely). These events, in addition to having a possible intrinsic psycho-traumatic effect due to their seriousness (think of the violence against

women victims of trafficking), are often pathogenic because they reactivate the original traumatic experience with which they are associated. There are also further post-migration difficulties to consider (boredom, discrimination, poor access to services, bureaucratic delays, concerns for one's life and that of family members, fear of expulsion, poverty etc.). Research shows that post-migration living difficulties (PMLD) have a defined pathogenic role. In particular, the risk of refugees and asylum seekers developing PTSD seems to increase with greater exposure to more experiences of this type, with an increase in the severity of the symptoms, a resistance to the therapeutic process and a greater difficulty in the process of social integration (Aragona et al., 2012b).

All of this is with regards to PTSD, but we have also seen that among the most frequent psycho-pathological reactions in the population we are talking about there are mood disorders (mainly reactive depressions) and adaptation disorders, the latter linked to difficult post-migratory conditions mentioned above, but without a post-traumatic picture: the person is worried, he does not sleep because he dwells on the things that concern him (the residence permit, the job, the condition of the family members left in the country of origin, etc.), complains of headaches, etc. Again, reducing PMLD would have a powerful effect on preventing these problems. In fact, if reducing the risk of incurring pre-migratory traumatic experiences is complex and requires a long international work against inequalities and conflicts in many areas of the world, the time is much shorter to intervene on life difficulties in a post-migration situation. Moreover, an improvement in the reception system depends on the direct responsibility of the host country, so it is easily modifiable, provided there is the will to do so.

Having said that, another relevant aspect concerning the reception phase in the host country is that relating to health needs. In fact, when a picture of suffering emerges, it becomes important to intercept it promptly because with adequate support, things can improve, avoiding emergency and/or chronic hospitalizations. Unfortunately, the data tells us that apart from a few centers specifically dedicated to migrants, mental health services do not shine for their openness: an investigation has shown that in 8.33% of centers, the psychologist reported that the patient is accompanied to the Center of Mental Health (CSM) by an operator because if he goes alone he will be sent away without an appointment (Petta, 2019). In the same report, the CSMs have low evaluation scores (while it is a little better for the psychiatric wards (SPDC)) with indices such as "staff availability and empathy", "availability of cultural mediators", level of training, both in psycho-pathology of migrations than in the management of post-traumatic reactions, and "willingness to take charge". In short, if it is true that a reception venue (such as the CSMs and SPDCs) focuses on relations, it creates an environment conducive to more interpersonal connections, which in itself has therapeutic value, because it allows the person to recover his

dignity, rediscovering his capacity for interpersonal relationships (Mazzetti and Geraci, 2019), the Health services and in particular territorial mental health services, still have a way to go in this direction.

Conclusions

An analysis of what is reported in this chapter reveals a complex picture of factors that can have a negative impact on the mental health of asylum seekers and political refugees. It is therefore necessary to take this into account in the therapeutic report, considering the role of pre-migratory, migratory events and post-migratory living difficulties. First of all, a greater cultural sensitivity is needed that can facilitate the therapeutic process, allowing the patient to engage in a course of treatment and to access it not only in emergencies. Another important aspect is the need to enhance prevention through targeted interventions such as providing support in the period prior to the evaluation of the territorial commission, as well as during the waiting period. These activities encourage the prevention of psychological distress and any re-traumatization also due to unawareness of the procedure to be followed for asylum requests, not being prepared for questions and any refusal, etc. Therefore, activities that help give a meaning to this often-disorienting experience will be useful. Finally, on a different level, it is necessary for these people to also be supported in the integration process in the host country through interventions that promote education and professional development.

Bibliography

Achotegui J. (2015) The Ulysses syndrome: the immigrant syndrome with chronic and multiple stress. Amazon (Kindle edition).

Ainamani H.E., Elbert T., Olema D.K., Hecker T. (2017) PTSD symptom severity relates to cognitive and psycho-social dysfunctioning–a study with Congolese refugees in Uganda. European journal of psychotraumatology, 8:1283086.

American Psychiatric Association (2013) Diagnostic and statistical manual of mental disorders, Fifth Edition (DSM-5). American Psychiatric Association, Washington DC.

Aragona M., Pucci D., Carrer S., Catino E., Tomaselli A., Colosimo F., Lafuente M., Mazzetti M., Maisano B., Geraci S. (2011) The role of post-migration living difficulties on somatization among first-generation immigrants visited in a primary care service. AnnIstitSup Sanità, 47:207-213.

Aragona M., Pucci D., Mazzetti M., Geraci S. (2012b) Post-migration living difficulties as a significant risk factor for PTSD in immigrants: a primary care study. It J Pub Health, 9:67-74.

Aragona M., Rovetta E., Pucci D., Spoto J., Villa AM. (2012a) Somatization in a primary care service for immigrants. Ethnicity & Health, 17:477-491.

Aragona M., Salvatore M.A., Mazzetti M., Burgio A., Geraci S., Baglio G. (2020) Is the mental health profile of immigrants changing? A national-level analysis based on hospital discharges in Italy. Ann Ig, 32(2):157.

Crepet A., Rita F., Reid A., Van den Boogaard W., Deiana P., Quaranta G., Barbieri A., Bongiorno F., Di Carlo S. (2017) Mental health and trauma in asylum seekers landing in Sicily in 2015: a descriptive study of neglected invisible wounds. Confl Health, 11:1.

Graham B., Herlihy J., Brewin CR. (2014) Overgeneral memory in asylum seekers and refugees. Journal of Behavioral Therapy and Experimental Psychiatry, 45:375-380.

Greenhalgh T. (2016) Cultural contexts of health: the use of narrative research in the health sector. Copenhagen: WHO Regional Office for Europe; 2016 (Health Evidence Network (HEN) synthesis report 49); [cited 2017 Jun 16]. Available from: http://www.euro.who. int/__data/assets/pdf_file/0004/317623/HEN-synthesisreport-49.pdf

Herlihy J., Scragg P., Turner S. (2002). Discrepancies in autobiographical memories—Implications for the assessment of asylum seekers: Repeated interviews study. Bmj, 324(7333), 324-327.

Kanagaratnam P., Asbjørnsen A.E. (2007) Executive deficits in chronic PTSD related to political violence. Journal of anxiety disorders, 21:510-525.

Kiaris F., Petta A.M., Begotaraj E., Libertas M., Lai C., Spitoni G.F. (2020) Profilo cognitivo nei migranti con sintomi post-traumatici. Abstract presentato al Congresso Nazionale SIMM, Roma.

Koso M., Sarač-Hadžihalilović A., Hansen S. (2012) Neuropsychological performance, psychiatric symptoms, and everyday cognitive failures in Bosnian ex-servicemen with posttraumatic stress disorder. Review of psychology, 19:131-139.

LaGarde G., Doyon J., Brunet A. (2010) Memory and executive dysfunctions associated with acute posttraumatic stress disorder. Psychiatry research,177:144-149.

Lasalvia A., Bonetto C., Tosato S., Zanatta G., Cristofalo D., Salazzari D., Lazzarotto L., Bertani M., Bissoli S., De Santi K., Cremonese C., De Rossi M., Gardellin F., Ramon L., Zucchetto M., Amaddeo F., Tansella M., Ruggeri M.; PICOS-Veneto Group. (2014) First-contact incidence of psychosis in North-Eastern Italy: influence of age, gender, immigration and socioeconomic deprivation. Br J Psychiatry, 205:127-134.

Leskin L.P., White P.M. (2007) Attentional networks reveal executive function deficits in posttraumatic stress disorder. Neuropsychology, 21:275.

Mazzetti M., Geraci S. (2019) Immigrazione e salute mentale. Violenza, psicotraumatologia, politiche per la salute e tutela assistenziale. In: Perocco F. (a cura di) Tortura e migrazioni. Edizioni Ca' Foscari, Venezia: 380-402.

Medici Senza Frontiere (2016) Traumi ignorati. Richiedenti asilo in Italia: un'indagine sul disagio mentale e l'accesso ai servizi sanitari territoriali. Medici Senza Frontiere, Roma.

Moradi A.R., Herlihy J., Yasseri G., Shahraray M., Turner S., Dalgleish T. (2008) Specificity of episodic and semantic aspects of autobiographical memory in relation to symptoms of posttraumatic stress disorder (PTSD). Acta psychologica, 127:645-653.

Nosè M., Turrini G., Imoli M., Ballette F., Ostuzzi G., Cucchi F., Padoan C., Ruggeri M., Barbui C. (2018) Prevalence and Correlates of Psychological Distress and Psychiatric Disorders in Asylum Seekers and Refugees Resettled in an Italian Catchment Area. Journal of Immigrant and Minority Health, 20:263-270.

Petta A.M., Kiaris F., Aragona M., Begotaraj E., GobboCarrer E., Curcio V., Lai C., Spitoni G.F. (2018) Cultural adaptation of the Lifespan Memory Interview in the Asylum Seekers (LMI-AS). Dialogues in Philosophy, Mental and Neuro Sciences, 11:19-31.

Petta A.M. (2019) Indagine sui bisogni sanitari e di salute mentale dei rifugiati e richiedenti asilo ospiti dei centri di accoglienza nel territorio di Roma. Crossing Dialogues, Roma.

Sayad A. (2002) La doppia assenza. Dalle illusioni dell'emigrato alle sofferenze dell'immigrato. Cortina Editore, Milano.

Stein M.B., Kennedy C.M., Twamley E.W. (2002) Neuro psychological function in female victims of intimate partner violence with and without post traumatic stress disorder. Biological Psychiatry, 52:1114-1119.

Woon F.L., Farrer T.J., Braman C.R., Mabey J.K., Hedges D.W. (2017) A meta-analysis of the relationship between symptom severity of Posttraumatic Stress Disorder and executive function. Cognitive neuropsychiatry, 22:1-16.

THE PSYCHIATRIC REFORM LAW: A MILESTONE IN CIVILIZATION BETWEEN ORGANIZATION AND RIGHTS

by *Giulio Corrivetti*, ASL Salerno

Preface

The past century is marked by flows, currents and movements that have characterized the history of Italian people, intensifying some contrasts and accelerating the innovations coherent with our culture's development and progress. Numerous reforms have emancipated our country within the international panorama through battles, recognition and laws to protect rights that should be guaranteed to all citizens. These reforms awarded Italy international recognition as a humane, innovative country poised towards modernity that believes in the constitutional right to be assumed innocent until proven guilty. The health care reform is one of these innovations and, before that, the psychiatric reform, which saw the breakdown of limits and prejudices, overcoming the confines of the impossible and demonstrating that physical and mental health are goods that a civil society must guarantee to its citizens. We should all remember that the Psychiatric Reform Law preceded Law 833/78 by six months. Mental health became a good to be protected, for every individual, through the utilization of health and socio-health strategies. Public health became a right and not a luxury produced by actions aimed at the prevention, treatment and rehabilitation of the citizen within their community. The law regulated the establishment of a departmental mental health protection service - with the aim of preventing, treating and rehabilitating mental health issues - within a Local Health Unit (Unità Sanitaria Locale also known as U.S.L.) and within the totality of general services to protect health (this was also innovative, because until then treatment for the mentally ill fulfilled custodial mandate and was not fully part of healthcare). That law sanctioned and guided the gradual transcendence of the psychiatric hospitals. In this way the world of health assumed the functions of psychiatric assistance, which fell under the management of the provinces, public institutions for assistance and charity (known as IPAB) and other public bodies that, provided for the hospitalization and treatment of individuals with mental illness when law 23 December 1978, n. 833 went into effect.

The current situation

Today, forty years after the emission of the innovative laws, it is even more evident, thanks to scientific data, that health is the product of a virtuous and convergent interaction that involves all the systems: social, health, education, research, justice, and so on. One does not protect physical

health and mental health with the simple provision of professional services, even if of high quality with well-qualified professionals, but through the continuous maintenance of the conditions that support well-being, that promote the active participation of citizens, recognizing the rights of the most fragile, reducing the risk factors, and promoting protection factors against environmental stress. In essence, by respecting the role of the social determinants of health and disease.

The World Health Organization, following the historic change sanctioned in Italy in 1978, has continuously embraced the values and model undersigned in our country. This was a significant moment in our history at the same time as other contrasts in our country led to explosions in public squares and in politics, marking the epoch with regrettable and even dangerous episodes. The year was truly rich in contradictions and anticipations.

Of course, in an environment that was so problematic, but also full of cultural and social turmoil, the "Basaglia Law", by closing asylums, made a definitive opening to some sacrosanct truths that science, clinical work, and data, even more so than social science and law, confirmed to be right. It is difficult to individuate (amongst all of the fights that took place during the 20th century) a battle of equally valor in its defense of those most in need. A battle which was followed with deep enthusiasm on the pages of the newspapers and other media at that time.

The departmental service for the protection of mental health

Upon the emission of the psychiatric reform law, the services for the protection of mental health were programmed to undergo a departmental reform in order to guarantee the provision of care to individuals in need of psychiatric assistance, including the provision of life-long care and in order to implement interventions designed to favor solutions outside of the hospital, therapeutic continuity and reintegration within the social tissue, linking it with other local health and social offices. The service's tasks fell within the functions of prevention, diagnosis, treatment, and rehabilitation, guaranteeing the continuity and organic nature of the local interventions with ambulatory and in-home services, thereby implementing health education interventions in a coordinated and programmed manner.

Local services were structured to guarantee the continuity and organic nature of the interventions and activities by implementing interventions that corresponded to consumers' real needs, favoring solutions that did not involve hospitalization. In order to do this, assistance provided as an alternative to hospitalization is implemented by promoting initiatives and utilizing, in a therapeutic manner, adequate resources and structures capable of following the individuals where they live in order to return consumers to the social fabric and preventing hospitalization, which is solely inserted in the local social reality in order to allow for community participation.

Today the D.S.M. of the AA.SS.LL is a Single Management Structural Department (Dipartimento Strutturale a Direzione unica). It is a complex macro-structure with autonomous management and technical-organization recognized as a negotiating subject with Agency Management. It manages the DSM's resources and programs, promotes, implements, coordinates and verifies that prevention, treatment, rehabilitation and social reinsertion of consumers via socio-health integration. The Department acts via the Operational Mental Health Units (*Unità Operative di Salute Mentale (UU.OO.S.M.)*), which are complex structures whose jurisdiction is district and/or multi-district based. These ensure the implementation of the activities described above, taking on, for a certain area, all of the management and coordination functions for the provision of treatment for consumers in that community. The UU.OO.S.M. have their center of gravity in the Mental Health Centers.

The service system for treatment and the provision of care

A system of care for mental health is guaranteed by the totality of public and private services in the area that are a part of the processes of diagnosis, treatment, rehabilitation of individuals with every type and severity of mental health issues during any and every phase of life. In a certain way this system represents the mission of the Department of Mental Health, which, in many Italian regions, also plans and manages pathways and structures for the treatment of pathological addictions and pathologies of childhood and developmental age. This system is organized in a network with adequate interconnections between services that are interconnected with other health and social services as well as specialists on multiple levels in a multi-disciplinary manner.

The *Mental Health Centres* (CSM) are positioned key actors, serving as management hubs for the treatment and provision of care of individual consumers. The centres play a central role in the psychiatric services network for adults and, in some areas, represent the only body that represents the entire Operational Unit, with peripheral ambulatory offices. These represent the regular access point for consumers where the most part of evaluation and service provision for the population takes place; the offices have the mission of ensuring the continuity of care and constitute the centre of gravity of the entire services network; the centres are also responsible for case management and care provided in hospitals, residential services and, today, in the provision of services for prison inmates.

The *Mental Health Centres'* mandate includes individual case management and response to the emotional, cognitive and behavioural needs of a given population; this may take place via socio-health integration, which is necessary for managing patients with serious and chronic mental illnesses. This is the most important institutional mandate.

These centres also manage cases in hospitals and residential setting that can be decided, authorized and coordinated by the personnel that cares for the patient on a daily basis. With these functions the CSM takes on the de facto responsibility of limiting access to the Psychiatric Services for Diagnosis and Care in favour of keeping care local; this may involve using residential services. To achieve these objectives personnel must use a methodology based on personalized care (which is re-evaluated periodically) on the basis of an Individualized Therapeutic Rehabilitative Plan (PTRI). This instrument has become the management system used to maximize the impact of interventions via management criteria established by case management and project management.

The intent was to move the place in which psychosocial rehabilitation interventions are provided as close as possible to the patient's regular place of living, with interventions designed to reacquire necessary skills, reaching significant objectives in their personal life, including legitimate goals of re-attaining a social role and employment.

Understood this way, the psychosocial approach tends to value the person's abilities and talents, utilizing treatment and rehabilitation schemes geared towards empowerment and the maximization of freedom in action and autonomy in order to make the person and their context accountable. Work on rights and recognition of the differences and marginality of individuals has to support rehabilitative modalities that are agreed upon within the entire care system and rooted in the community system, based on the principles of autonomy and accountability; these modalities include self-help, assisted living and work placement either in the free market, or supported by professional training.

The CSM is involved in the community system, just as the other entities within the Department of Mental Health (e.g., NPIA, SerD, local agencies) and contributes to promoting integration between social and health services while operating and providing its own services at the local social services offices.

Organizational chart for the mental health services system

Day Centers (Semi-residential activities)

In regards to semi-residential centers (or day centers), it should be noted that these structures are closely tied to the Mental Health Centers with whom they develop and implement psychosocial rehabilitation protocols written, shared and re-evaluated for each patient, including group work and the maximization of individuals' unique traits.

The Operational Mental Health Unit (Unità Operativa di Salute Mentale) assures the functioning of the psycho-social rehabilitation via these semi-residential facilities that have to be located in appropriate offices with adequate social space as well as, and above all, have to be utilized by the staff's significant skills in fostering rehabilitation, directing the interventions on the basis of scientific evidence. The personalized rehabilitative projects are activated both in the office and in the consumer's world. For patients with highly compromised personal and social functioning (e.g., early onset schizophrenia with primarily negative system and reduced cognitive functioning), the semi-residential environment serves both a support function and a rehabilitative function. For patients who are primarily compromised in relational and social terms the semi-residential activities represent an educational and re-socializing opportunity while primarily helping mediating the complexity of life.

Within semi-residential facilities, families, as well as individuals in need of assistance, often become virtuous resources for co-management and the promotion of therapeutic changes.

The residential sector for adults

Every UOSM has residential options (protected communities, group homes, group apartments) in order to implement the therapeutic and rehabilitation mental health plan in all of its variations in accordance with personalized care plans.

The residential facilities constitute a resource within the Department of Mental Health (DSM) as individuated in the project Objective Mental Health Protection 1998-2000 (DPR 1 November 1999). Residential treatment always falls under treatment provided by the Mental Health Center (CSM) that develops the Primarily Rehabilitation Based Individual Treatment Plan (PTRI). Consequently, placement in a residential facility, within the National Health Service, occurs solely under the care of the Mental Health Center. The National Commission for the definition and updating of the Essential Assistance Levels (LEA) in the classification and provision of continuous psychiatric residential assistance (residential), has individuated two macro-typologies: (1) *therapeutic-rehabilitative* services and (2) *socio-rehabilitative* services.

Based on the rehabilitative intensity of the program implemented and the level of intensity of the assistance provided, there are three typologies of residential facilities:

1. Intensive therapy residences
2. Long-term treatment residences
3. Socio-rehabilitation treatment facilities

The residential psychiatric sector initially developed as an alternative to Psychiatric Hospitals in order to support the process of deinstitutionalization. The sector then underwent a period of continuing expansion, which was probably over-dimensioned, based on emerging needs for increasing rehabilitation opportunities that represented alternatives to hospitalization. It is obviously necessary to restate that the Mental Health Center remains the focus point for plan development, coordination and management of the provision of clinical-assistance services for patients with complex needs; this includes the entire stay in a residential setting.

The Emergency-Urgency System

The totality of local health services (non-hospital) provides the responses to the emergencies and urgent situation in the psychiatric field. An urgency is a severe acute situation that requires immediate therapeutic intervention (e.g., crisis involving mania or agitation, delirium and/or hallucinations, anxiety or depression). Every document and law that deals with the topic of psychiatric emergency has always taken up and supported the cardinal principle of psychiatric reform, which underscores the importance of preventing the highest number of emergencies possible via a continuous community presence. The Mental Health are responsible for developing an appropriate emergency-urgency plan. This plan must include the definition of procedures for

providing voluntary and compulsory health treatments (ASO and TSO respectively) and management procedures for emergency-urgency situations, which should involve the lowest level of institutionalization possible, reducing or avoiding, where possible, the use of hospitalization via the Psychiatric Diagnosis and Care Services.

The Psychiatric Diagnosis and Care Services provides voluntary and compulsory health treatment and certifications during hospitalization for individuals with mental health problems. The Hospital Psychiatric Services and the Operation Unit of the local DSM agree on protocols for cooperation, the treatment plan as well as the modalities and timing for the demission of patients to each of the UU.OO.S.M.

Within hospital-based services, the treatment must aim to be as appropriate as possible: guidelines designed to reduce the use of restraints on patients need to specified. Every form of restriction of liberty must be rigorously formalized and the patient's right to information must be fully respected. Physical contact practices must be limited to cases of extreme need and in the sole interest of the safety of the patient and the individuals in their immediate presence.

The community system

The policies that protect the health and well-being of a community, the attention that needs to be paid to the social determinants of mental health impose a management structure and a prevision based on a particular understanding of health where by it is understood as a good the protection of which is more of a value than an objective. If the general mission of a Department of Mental Health – as a system for local psychiatric care – remains that of focusing on prevention, treatment and rehabilitation for all mental illnesses, then its specific mission, as organized psychiatric system designed to guarantee an array of "essential services", should be formulated on the basis of the health policies developed at the national or regional level and local strategies (regional or entity based) for the allocation of resources. It is a matter of establishing a hierarchy of functions, taking into consideration the fact that the DSM's primary mission is that of intercepting and receiving needs, finding answers and giving a voice to fragile and marginalized members of the community.

In this perspective, beyond treatment and rehabilitation, one should consider activities related to prevention and promotion via dynamics that can involve an entire collective. Beyond this perspective, the discipline of psychiatry, as a medical discipline, simply limits itself to offering a professional service that is primarily clinical in nature with a focus on disease and not on health or psychic well-being, which represents a broader system for protecting citizens' mental health.

Therefore, the system turns to the social and collective sphere, which is strongly influenced by a social way of life, economic cycles and the vitality of local institutions. The dimension of a

community system integrates services with local services playing a key role. A system understood this way is based on concepts, operationalization and interventions with a high level socio-health integration.

The vision of services based on community psychiatry, which emerged from the alternative Italian experiences and all laws, has focused the prospect for development in the departmental model as an organizational reference model, in the centrality of the public services, in the approach for accrediting institutions and professionals, and in the centrality of the provision of care to patients with mental health issues, whether serious or not so serious.

Every intervention targeting citizens' mental health attributes value to a specific social soul; in this way, every social intervention cannot exclude the subjective health and well-being from the individuals that comprise a community. This is the foundation of socio-health integration which is articulated via individual plans. This is also why, in every local area, one must act via multi-professional tools such as the Integrated Evaluation Unit (UVI) that represents the operational system with which to implement the integration. An individualized plan is discussed, developed in its particularities and signed after multi-disciplinary work by a team. This is the means by which to fully involve local services, making them accountable.

More than 40 years after the emission of the "Basaglia" law, today it is legitimate to ask if the Mental Health Departments, with their current organizational and functional configuration, are still to be considered community psychiatric services. Why this question? Because in many areas throughout the country there has been a reduction in the values and methodologies that initially characterized the public services system and its community model. Today it is legitimate to re-propose the objective of re-establishing the theoretical and operational horizon of community medicine and psychiatry on the basis of new scientific evidence and the social upheaval we are witnessing today in order to reconstruct a coherent technical, scientific and value-based model. The switch to a business model within the health system and the mutations of the technical aspects of treatment plans have led to a significant change in the organization and in the practices for providing local psychiatric services.

This means, ultimately and as always, to start from concrete services and practices to try to understand the critical issues, but also the most modern and innovative potential.

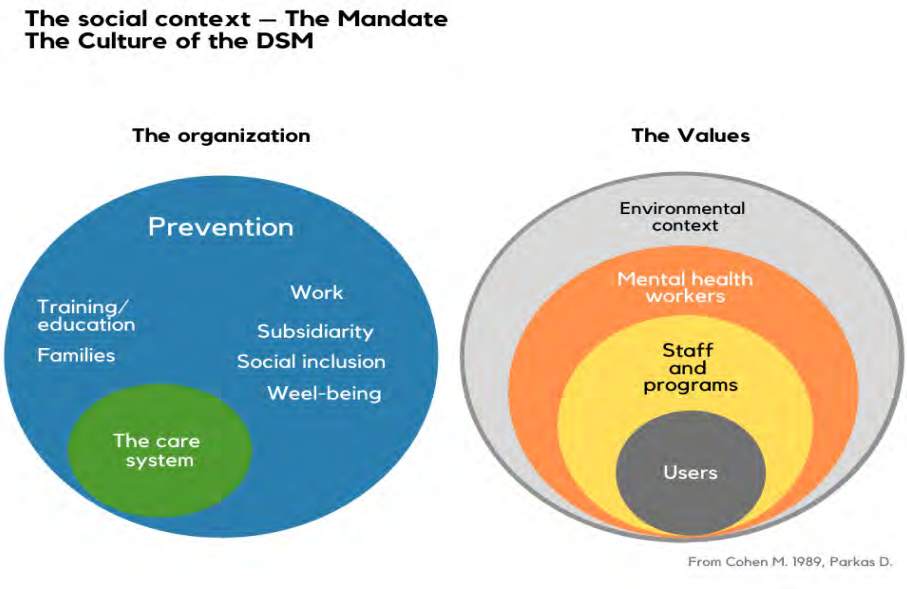
Socio-health integration

From what has been said it becomes clear that socio-health integration in the field of mental health defines various areas of action that characterize the community health system. These actions, in fact, in regards to the LEA, fall along the axis of territorial interventions, on the axis of semi-residential ones and lastly of the residential one.

What is meant by territorial level of assistance? This refers to the non-hospital dimension of assistance, which is a priority in following consumers long-term (including throughout their life). This primary objective for the protection of the mental health of a population moves first and foremost along a *prevention* level via the coordination of all actor and all the forces that contribute to the development of a given area, involving its actors and systems (the world of health, the world of education, the world of justice, the world of social services, etc.). The departmental structure guarantees the utilization of both primary and secondary prevention. Network-based work has an advantage due to the agreement between public bodies (province, cities, schools, ASL) to produce agreement in regards to the prevention of disability and the recovery of consumers. The next step is characterized by the *promotion of mental health*. The promotion of mental health consists of fighting the attitudes tied to conditions of stigma, marginalization and discrimination that affect the level of suffering amongst consumers and their relatives. This action involves the diffusion of a healthy culture of personal and social well-being, implementing the values of solidarity and social recognition that constitute a community's most noble patrimony; this entails implementing initiatives to promote the right to active and participatory citizenship for citizens with mental health issues.

Another application is the *commitment to subsidiarity* according to which services to individuals are provided based on needs, the relational dimension and the values of subjectivity and the rights of the individual. Today more than even it is necessary to commit to looking for innovative answers to better support the personal and social needs of persons with mental health issues.

The figure that follows exemplifies the interrelation between contexts, culture and values in a modern socio-health system.



It is still important to focus on guaranteeing the provision of comprehensive and global care that brings us closer to the consumers, above all via residence-based work in an integrated form (social and health) in order to assure the added value of the assistance and socialization, which serve as a guarantee for the principle of citizenship and equality, so that the person with mental health issues can possess the same rights as every other citizen. This requires a commitment to support income, with all available tools, such as special work placements and other forms of economic assistance.

And finally, housing policies: In the last decade innovative supportive living, or "light residency", have become more diffuse within community psychiatry. This experience brings into evidence the primarily implicit paradigms that apply to these practices, condition the characteristics and the outcomes. Beyond being an outcome of therapeutic processes, living autonomously in a dignified and autonomous home that is integrated in the social fabric is obviously considered an "ideal" objective for treatment and rehabilitation of people with serious and chronic mental health issues. Supported housing represents an approach that has become common in various countries, gaining recognition as a best practice. *This represents a* reversal and is hence founded first and foremost on the disjunction between accommodation and assistance. It follows that the need for lodging and the need for assistance can be brought into focus and evaluated separately. One can respond to the needs for treatment and assistance with a "real home" that is dignified and non-transitory in addition to flexible network of in-home assistance.

Finally, *job placement*: law 180 of 1978 determined, for psychiatric patients, the possibility of reclaiming their rights, but the question that remains open today in regards to mental health practices is how to transform the formal right into substance. In fact, the citizenship of psychiatric patients does not entail the simple restitution of their formal rights, but the construction of their substantial rights. It is only within this construction (i.e., affective, relational, material, housing, productive) that rehabilitation is possible. Psychiatric patients have always been "put to work" to pass the time, for the production of artistic objects, and to substitute the work done by facility staff; this represents an occupational, but sterile rehabilitation method. Understood this way, work has had a sterile value, just to pass the time or as a therapeutic excuse where, however, everything was always the same and not productive. In the experience alternative to the asylum, initially undertaken in Trieste, the first experiences involved work cooperatives; this led to the end of occupational therapy in 1972 and full right to work. Today every form of job placement have very different objectives in that they have abandoned the logic of occupational therapy in favour of full job autonomy which is possible through real internships and job placement. Research demonstrates that job placement represents one of the most effective forms of rehabilitation.

The National Mental Health Action Plan

In 2014, the Ministry of Health published the *National Mental Health Action Plan*, which frames the institutional mental health mandate within the Essential Assistance Levels and aims to guarantee health and socio-health services within the therapeutic-rehabilitative programs for individuals with psychiatric problems and/or their families. The plan covers these four areas:

1. Ambulatory and home-based therapeutic-rehabilitative and socio-rehabilitative services in accordance with the individual treatment plan;
2. Diagnostic, therapeutic, rehabilitative and socio-rehabilitative services in semi-residential settings in accordance with the individual treatment plan;
3. Diagnostic, therapeutic, rehabilitative and socio-rehabilitative services in residential settings as part of intensive and extensive care, in accordance with the individual treatment plan;
4. Assistance and socio-rehabilitation services, including social and labour re-insertion programs, both in residential programs involving long-term care and in the community, in accordance with the individual treatment plan.

The Ministry of Health, in accordance with indications from the World Health Organization, has adopted this "National Mental Health Action Plan". The plan contains a series of international indications defined in the Declaration and Action Plan of Helsinki from the WHO Europe (2005), MH Gap from WHO Geneva (2008), the UN Treaty on the Rights of the Child, and UN Convention on the rights of persons with disabilities, transposed in Italy with Law 18/2009, the Guidelines for Mental Health from 20.3.2008 and the 2010-2012 Health Pact. From a methodological point of view, the specification of priority actions for health needs and interventions calls for the definition of mental health objectives for the population, the definition of actions and actors, and finally defines the criteria and indicators for verification and evaluation that the Ministry of Health is currently monitoring via the "interregional mental health working group".

The working group individuates some homogenous areas for intervention and, at the same time, offers methodological indications useful for delineating innovating projects that are functional for addressing the typologies of identified priority needs. To this end the group selects some *priority needs* upon which to develop treatment plans that can be applies to the onset areas – early interventions, the area of common mental health issues, the area of serious persistent and complex mental health issues, and the area of childhood and adolescent mental health issues.

The working methodology indicated essentially involves treatment plans and innovative programs that the Mental Health Services, notably the Mental Health Centers and local services, and the Services for Neuropsychiatric Issues in Childhood and Adolescence work to develop and provide

on the basis of the differentiation of needs and specific projects for proposed clinical intervention as exemplified in the summary table below.

Hence, the suggested methodology is based on the need to work on specific and differentiated intervention projects based on the evaluation of persons' needs and the implementation of treatment plans capable of intercepting the populations' real needs as indicated in the table below.

TREATMENT PATHWAYS IN THE CONTEXT OF INNOVATIVE INTERVENTION PROGRAMS TO BE ACTIVATED					
AREAS OF NEED	**TERRITORIAL INTERVENTIONS**	**CONTINUITY OF CARE, INTEGRATION**	**NATURAL NETWORKS, FAMILY EMPOWERMENT**	**RELATIONSHIP BETWEEN HOSPITAL AND TERRITORY**	**RESIDENTIAL REHABILITATION ASSISTANCE PROGRAMS**
Orientation, early interventions	Consultancy, Intake, management	Schools, general practitioner and PLS, Local plans, Health District, DSM-NPIA	Family, community centers, self-mutual help groups, cooperation and employment agencies	DEA, SPDC, Pediatrics	Day Centers, rehabilitative therapeutic community
Common disorders (depressione, anxiety disorders)	Consultancy, intake	General practitioner, Health district	Family, self-mutual help groups	DEA, Psychiatry in collaboration with hospitals	
Severe and complex disorders	Management (integrated intervention, case manager)	General practitioner, Local Authorities, local plans	Family, self-mutual help groups, associations, volunteer organizations, cooperation and employment agencies	DEA, SPDC, internal Medicine (Neurology, Geriatrics)	Rehabilitation and care facilities, RSA, housing light support and social housing
Disorders in adolescence and developmental age	Consultancy, Intake, management	NPIA-DSM, Schools, PLS, free clincs, local plans, health district	Family, community centers, associations, volunteer organizations	DEA, Pediatrics, Neonatology and dedicated hospital services	Therapeutic communities for minors, residential facilities of social assistence and health care, educational communities, day-care therapeutic facilities, innovative services, etc..

A similar methodology should be acquired by Italian territorial services for taking charge of migrants' emotional, cognitive and behavioral problems.

Psychotherapy within public services

This problem brings us to address another point, that of the practice of psychotherapy in public services, that is, more exactly, what is meant by psychotherapy in public services, if and how psychotherapy in the public can be different from that practiced in the private sector. This problem is often treated by means of a rich series of common spaces and cultural stereotypes. For example: psychotherapy in the private sector is said to be "better" than that in the public. Every phenomenon can be different than another, but this affirmation does not tell us much if one does not clearly specify what the differences are. And here the difficulties arise to go beyond the common places. So let's see some of these common places: the possibility of moving the psychotherapy, from a private setting to a public setting, appears to be complex, especially if

understood as a simple reproduction of a treatment, within which a two-way relationship takes place between a therapist and a patient. Psychotherapy, in a public setting, has to take into consideration specific differences in the setting.

First, considerations tied to concrete aspects of the setting need to be considered; this includes the physical structure of the Department, the organization of spaces and time, and the relationship with a team and the time dedicated to work. Despite this, the propensity to include clinical psychology in the Mental Health Centers represents an indicator of the good quality of the services. Therefore, psychotherapy conducted in a Department of Mental Health involves consideration of a meta-setting consisting of the structure as a whole, which defines the operator-user relationship with regard to different technical aspects. In a context such as the Department of Mental Health the relationship between the therapeutic alliance and transfer comes to include elements belonging to the public structure. The therapeutic alliance must be scaled down to a wider setting in which all operators become the object of projections, identifications and transfer experiences.

Conclusions

In asylums, everyone was equal; every individual story was reduced to a profound homogenization to marginality, to regression, to neurodegeneration. Only the inauguration of a public services network, local and hospital-based, prepare to welcome every face of psychic suffering, every form of psychiatric distress, every need for treatment, in whatever period of the person's live, made it possible to re-shape psychiatry manuals, the categories and the different expression of personal destinies. It is no longer the inability to cure, no longer the use of exclusion, but the declination of diverse functional and structural modules coordinated within a departmental network of ambulatory, residential and hospital-based services. In these interacting strati, the different characteristics of the diverse behavioral disturbance appeared easier to distinguish in regards to their specificity and categorical and dimensional characteristics, in their multi-form manifestations, to the point of identifying the extent to which the biological dimension, the psychological dimension and the role of environmental factors developed a richer palette of psychopathological identities. Differences and exchange have provided psychiatry, via its epidemiology and clinical work, an incredibly rich flow of data that made it possible to individuate the role of protective factors and risk factors, which are essential in enhancing the recovery statistics. In this way psychiatry finally entered medical disciplines and, from this new center point, contributed to understanding the physio-pathological mechanisms, presenting as evidence the multiple analogies that mental illnesses and other disease have in common. The increase in the incidence of many pathologies forced the health system to increasingly move the

center point for assistance towards more local offices as opposed to hospitals (as was initially specified in the heuristic scheme of mental health services), rediscovering the recently defined Diagnostic Therapeutic Assistance Plans as the ideal means for the non-hospital management of chronic mental health problems.

In some areas of southern Italy, the asylum represented a center of economic power, jobs and local development, while, for patients and their families it represented a destiny comprising deportation and exclusion. The high concentration of psychiatric hospitals and beds made our region the place of deportation for people coming from Sardinia, Calabria and Sicily. These were people who could not enjoy contact with their families for years at a time.

A crack in the history of southern Italy in the second half of the 20th century is heavily influenced by the culture and the economy that surround that institution. Campania has survived on the asylum industry (5 civil asylums and 3 Judicial Psychiatric Hospitals between Naples and Salerno). The critical phase and the fight to close the Psychiatric Hospital occurred between 1965 and 1975 (these are years of Sergio Piro's alternative experience within the walls of the OP of Materdomini). The reform phase covers the period between 1976 and 1983 (the Frullone and the Bianche and in part also the "Umberto I" of Nocera Inferiore hosted discussion groups, seminars, students from various faculties, and psychiatry students thereby creating an idea lab). All of this ferment of reflection and initiatives were determined to take off, then came the Regional Law of Psychiatry n. 1 of 1983; this an innovative example and model of departmental organization that represented a unique and original model even in other Italian regions. All of this was a prelude to the third phase, characterized by the constitution of the first local services, which took place between 1984 and 2000.

From 1978 to today, mental health services have received increasingly few patients with schizophrenia and increasingly more fluid and temporary forms of psychotic suffering. The population of consumers has changed: more young consumers with multi-problematic behavioral problems require multi-disciplinary and complex therapeutic interventions and strategies. Integration with child neuropsychiatry and addiction services has increased significantly.

Today, mental health services are based on the methodology of recovery. This implies, alongside the ambulatory and home-based clinical interventions, interventions targeting social involvement, training and support with employment. In this way the objectives of recovery become not only clinical healing, but also social healing based on the criteria of "subjective well-being", quality of life, social participation, and autonomy. Recovery interventions are the cornerstone of hope for a better future founded on the social contract, personal power and the defense of rights.

What happened in the last forty years: great hopes and great disappointments.

There are certainly more therapeutic tools, but also the certainty of how much needs to be done to fully understand the problems of neurodevelopment and be able to give birth to discoveries that are useful for revolutionizing the therapeutic field.

What neuroscience has demonstrated to us today: the brain is social and the result of relations that form and modulate its plasticity.

Today, even the neurosciences increasingly define themselves as social neurosciences. What discovery would have been made on a population of patients where all of them are the same and their brain is in functional regression? The Italian discovery of mirror neurons, among the many discoveries made of the brain in the last 40 years, has further validated the a-therapeutic nature of the asylum, even more so than any existentialist philosophy, the growing sociology, politics and alternative psychiatry. In fact, the Parma scientists, 20 years after the Basaglia Law, proclaimed that the human learning process, just as any other mammal, is first and foremost based on motor imitation and that the brain replays an intentional consonance in the pre-linguistic, pre-logic and pre-rational phase. It is evident, therefore, that anyone, although rich in his own history, biography and identity heritage, ended up imitating regressive behavior, if forced to live, all the time of his life, in filthy, stinky and overcrowded halls where they shared body swings, the incessant smoke of cigarettes and an indistinct chatter, alternating with screams that evoked only desperation.

The psychiatric reform law has made our country noble; the practitioners that today dedicate their energy in the variety of services for the protection of mental health and defense of those who are left behind and marginalized, defend the objective of civilization that has been reached in our community: tolerance of disability and diversity was not, and is not, sufficient. The goal is rather their human, social and legal recognition.

This milestone brings resources and development to humanity, science and to our hope for a better future.

TWO SIGNIFICANT CASES

MANTUA

Before receiving the refusal of the application for international protection, A., a young Nigerian guest of a CAS (Extraordinary Reception Center) had never expressed any discomfort, apart from some occasional disagreement with the other guests, which however had never been considered worrying. Since his arrival in Italy, he has always been welcomed in small structures and followed individually. In conjunction with the refusal, he was transferred to a different structure, because the center where he was meant to go had to undergo some restructuring.

The appeal is unsuccessful and, although the appeal is initiated, the right to asylum for A. ceases. The boy begins to show evident signs of discomfort: he finds himself lurking in the dark in other people's rooms, sleeping on the ground in front of the caretaker's door. The 2 psychologists of the cooperative, who do not have much previous experience, try to contact the public CPS (Social Psycho Center): they get an appointment which is set 3 months away. They try to get an earlier date through the intervention of the general practitioner, who, however, sees no urgency and therefore does nothing. In the following days the situation worsens. A. leaves the center on foot, in the middle of winter, dropping his clothes behind him: at 2 am he is found half naked lying on the edge of an extra-urban roundabout, in a state of hypothermia. They proceed to the first hospitalization in SPDC. At his discharge from hospital, the psychiatrists point out that the social services are not responsible for the health services: it is therefore decided to enter A. again in a CAS, but also in a small structure, the situation is not sustainable. A. has frequent crises that often occur outside the center: the CAS operator becomes de facto charged with looking after A., even in the eyes of law enforcement officers. Moreover A. often runs away from the CAS.

In the following 6 months 7 hospitalizations are performed in TSO, with increasingly heavy pharmacological treatments and different diagnoses being made each time. There are also increasing difficulties in admitting him, because his situation is not considered dangerous and the danger does not justify the forced admission (even if he lies on the roadway). Meanwhile A. is unrecognizable, prostrated by drugs, he no longer has a home or a community.

His sister is tracked down in Spain, she visits him and keeps in touch, but the woman has recently given birth, she finds herself in a very fragile situation and does not show any intention of taking charge of her brother, who is also in a legal limbo and cannot leave Italian territory.

At present, the psychiatry ward assures A. of two beds, one in the CRA (apartment group) and one in the SPDC, based on how he feels and his willingness. The Municipality of Mantua has activated a para-educational intervention, paying an educator / mediator for 15 hours a week plus 5 of any

urgencies, to go regularly to the hospital, take him out, help him do gymnastics and try to restore what strength is left in A. Once a week the local social services activate a Nigerian psychologist and mediator, and organize a small group of 4 in the hospital: to pray, to speak to him in his language, to support him in this regard. The SPDC recognizes a general improvement and has decided to involve its own operators, so that the specific skills of the structure can grow.

PALERMO

A Malian boy, holder of subsidiary protection, is brought to the ARCI Porco Rosso club in Ballarò (Palermo) in a catatonic state by a person who presents himself as his brother, but then disappears. Volunteers contact the UNHCR office for vulnerable cases like this and a psychologist from the PENC Center, a private social services association. Given the seriousness of the situation, the psychologist suggests taking him to the emergency room. The wait lasts all night and only two volunteers stay with the boy during these long hours. After admittance in the psychiatry ward, a three-week hospitalization is ordered.

After hospitalization, it emerges that for a sentence imposed when he was a minor, the boy must undergo a trial period: for this reason he is temporarily transferred to Licata (about 170 km away). In the meantime, the ARCI volunteers try, in collaboration with the specialists of the General Hospital of Palermo, to request an insertion into a SPRAR structure for vulnerable people, but the requests remain unanswered. Returning from the trial period, 6/8 months later, the boy remains without any housing solution and ends up living on the street. During the months spent in Licata, no further psychiatric visit was carried out and the antipsychotic therapy prescribed during the first and only hospitalization in Palermo was continued. The young man, living on the street, soon stops taking his prescribed medicines and the situation starts to deteriorate. The volunteers, given the seriousness and danger of the situation, begin by transmitting all medical documentation to all potentially competent institutions: Central Services, social workers of the Municipality of Palermo (and for information to the councilor for social policies), juvenile court. A first attempt is made for the territorial psychiatric services to charge of him, for which they initially declare themselves not competent, citing the fact that the boy is homeless and should be referred to a specific CSM in charge of this type of situation. However, they are unable to accompany him: the indicated CSM, to which he is referred to, is out in the boonies, the boy does not have a cell phone and is still very disoriented, so he is unable to show up for an appointment at a specific time. After further reminders to the Municipality, a SERT psychiatrist becomes available, who offers to intervene on site when called upon: the patient however does not continue to cooperate, taking charge by the CSM is not achieved and, in general, no suitable solution can be found. Meanwhile,

on two occasions the boy heavily harasses the female workers of the voluntary associations operating in the neighborhood, aggressing them. In the first case, a TSO is attempted, but this is not successful: the ambulance operators say they can intervene only if the violence is still ongoing on arrival and refer the case to the law enforcement officers who, in the meanwhile, have arrived. Since the operator who was aggressed does not intend to lodge a complaint, due to the obvious discomfort of the boy, nothing is done. On the second occasion the boy smashes a glass bottle during a crisis and with it injures a person: even in that case the health workers, despite the presence of the injured person and in front of the testimony of several operators who had witnessed the scene, reiterate that TSO is only possible if the fact is still going on when the operators arrive.

Due to the constant fights, the boy often appears bleeding, with pieces of glass stuck in his arms. ARCI and Centro Astalli are forced to deny him access, because he is becoming increasingly aggressive and tries to attack female workers. However, he remains in the neighborhood, the volunteers try to accompany him to the emergency room when he is seriously injured, even if he then sleeps on the street, tears off the dressings and the wounds become infected. Even when he reaches the emergency room, it is never considered appropriate to seek a psychiatric consultation, despite what the operators say, who feel increasingly helpless and abandoned, forced to take on exaggerated and disproportionate responsibilities.

ENTITLEMENT AND EFFECTIVE ACCESS OF FORCED MIGRANTS TO MENTAL HEALTH SERVICES IN LIGHT OF THE IMPACT OF RECENT CHANGES IN INTALIAN IMMIGRATION LAW

by *Roberta Aria* and *Anna Brambilla*, ASGI

This contribution aims to analyze the impact on the effective access of forced migrants, in particular those applying for international protection, to the mental health services after the reforms introduced by the legislative decree 113/2018 converted into Law 132/2018 with particular reference to the changes regarding reception, registration and humanitarian protection.

In order to proceed with the proposed analysis, a brief overview of the relationship between mental distress and international protection looks useful, especially in the light of Italian and European legislation and the indications contained in the "*Guidelines for the planning of assistance and rehabilitation interventions as well as for the treatment of the mental disorders of the holders of refugee and subsidiary protection status who have suffered torture, rape or other serious forms of psychological, physical or sexual violence*" published by the Italian Ministry of Health in March, 2017.

Under European Union law, asylum seekers who, due to their individual characteristics or circumstances are most vulnerable, constitute a distinct category of applicants for international protection which enjoys specific procedural guarantees and special conditions for their reception.

In this sense, the approach of the European legislator appears to be partially different from that of the European Court of Human Rights which instead, starting from the well-known sentence rendered in the case of M.S.S. v Belgium and Greece[6], highlighted how asylum seekers should be considered as belonging to a particularly vulnerable and disadvantaged group with a specific need for protection, recalling the principle according to which certain categories of disadvantaged and vulnerable subjects should be guaranteed enhanced special protection.

The various acts that make up the so-called Common European Asylum System contains open definitions of vulnerabilities and specific provisions which, in the intention of the legislator, should be aimed at ensuring the necessary attention to the particular needs that are held by vulnerable applicants for international protection.

[6] Case no. 30696/09, M.S.S. c. Belgium and Greece, with sentence dated 21 January 2011.

In particular, the EU Directive 2013/33 containing rules relating to the reception of applicants for international protection includes, in art. 21, "people suffering from serious illnesses or mental disorders and people who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence" among vulnerable people whose protection needs should be given particular consideration both in the organization of reception measures and for procedural purposes.

Member States must also ensure that asylum seekers who have suffered torture, rape or other serious acts of violence receive the necessary treatment for the harm caused by such acts, in particular access to appropriate[7] medical and psychological assistance or care, and ensure that these vulnerable holders of international protection receive adequate health care, in the same way as for the receiving country's own citizens[8].

Despite the specific attention paid by the European legislator to vulnerable applicants for international protection, the transposition of these provisions into the national legal systems of the various States belonging to the European Union took place very unevenly, with consequent disparities in the categories of applicants considered vulnerable; specifically as regards applicants with mental or psychiatric disorders, these are considered vulnerable people only in the legal systems of Italy, Poland, Malta and Cyprus while Greece includes those with post-traumatic stress disorder among people with special needs, in particular the survivors and relatives of the victims of shipwrecks[9].

In Italy, the legislator's choice was to transpose the provisions on vulnerabilities contained in the European Union documents into the internal legal system in a substantially unchanged way, indeed expanding in some cases the granted protection.

According to art. 17 of the Legislative Decree no. 142/2015 implementing EU Directives 2013/33 and 2013/32, the measures for the reception of applicants for international protection must take into account "the specific situation of vulnerable people, such as minors, children and unaccompanied minors, the disabled, the elderly, pregnant women, single parents with minors, victims of human trafficking, people suffering from serious illnesses or mental disorders, people for whom it is or has been ascertained that the victims of genital mutilation have suffered torture,

[7] Art. 25 Directive 2013/33 / EU laying down rules relating to the reception of applicants for international protection.

[8] Art. 29 Directive 2004/83 / EC of 29 April 2004 laying down minimum rules on the attribution of the status of refugee, or person otherwise in need of international protection, to third-country nationals or stateless persons, as well as minimum rules on the content of the recognized protection.

[9] AIDA, The concept of vulnerability in European asylum procedures, ECRE, 2017.

rape or other serious forms of psychological, physical or sexual violence or related to sexual orientation or gender identity".

For holders of international protection, art. 27 of Legislative Decree no. 251/07 establishes that, regardless of their vulnerability, they have the right to the same treatment recognized to the Italian citizen in matters of social and health care and provided for the provision of assistance and rehabilitation interventions as well as for the treatment of mental disorders of holders of refugee status and subsidiary protection status who have suffered torture, rape or other serious forms of psychological, physical or sexual violence.

The "Guidelines for the planning of interventions of assistance and rehabilitation as well as for the treatment of mental disorders of the holders of refugee status and subsidiary protection status who have suffered torture, rape or other serious forms of psycho-logical violence, physical or sexual "elaborated, over almost three years, by a special Technical Table and published in 2017 by the Ministry of Health, constitute the basis for the implementation of these provisions and represent an important tool for identification, registration and certification of torture victims and for the definition of tender specifications relating to first reception centers[10].

In accordance with national legislation, the Guidelines provide indications so that special services for vulnerable people[11] are also ensured, to be guaranteed even in first reception centers[12], in collaboration with the ASL (Local Health Services) responsible for the territory and that continued therapeutic care is also guaranteed, even during the transfer of charges between the first reception performed by the refugee assistance system and the general social-health care system.

In general, according to Italian legislation, applicants and holders of international protection must agree to a compulsory registration with the national health service[13] in whose territory they reside or, in the absence of it, in whose territory they actually live, with the same conditions as for Italian citizens[14]; pending registration with the nation's health service, urgent or in any case essential,

[10] Guidelines for the planning of interventions of assistance and rehabilitation, as well as for the treatment of the mental disorders of the holders of refugee status and subsidiary protection status who have suffered torture, rape or other serious forms of psychological, physical or sexual violence, p.7.

[11] The Guidelines refer to both applicants and holders of international protection who have suffered torture, rape or other serious forms of violence; according to the Guidelines, about 25-30% of the refugees have experienced torture, rape or other forms of extreme violence and the activities aimed at promoting the identification of the victims of torture should begin, compatibly with the different arrival contexts, as soon as possible, also through interviews with the medical-psychological staff of the host structure (pages 31 ff.)

[12] Art. 10 Legislative Decree no. 142/2015

[13] Art. 34 legislative decree no. 286/98

[14] Art. 42 apr 394/99

albeit continuous, outpatient treatment for illness and accident is nevertheless ensured in public facilities and other accredited venues where preventive medicine programs are extended to safeguard individual and collective health[15].

The document containing "Indications for the correct application of the legislation for health care to foreign populations by the Italian Regions and Autonomous Provinces", adopted by the State Conference of Regions in 2012[16], adopted to standardize health care pathways for the foreign population, also states that, for the purposes of registration, applicants for international protection are not obliged to state the address of their legal residence and, in the absence of such an address, can simply make a self-certification of actual residence or a declaration of hospitality.

As regards mental health, the Decree of the President of the Council of Ministers of 12 January 2017 which redefined the essential levels of assistance states, among its provisions, that the National Health Service is required to provide for all members, including those attributable to health services, territorial socio-health, semi-residential and residential socio-sanitary assistance for people with mental disorders.[17]

If the picture outlined so far looks clear, it seems that the protection of applicants for international protection and forced migrants with special needs due to mental disorders or traumatic experiences, suffers from significant distortions in practice.

The examples of the young Malian from Ballarò and the Nigerian asylum seeker who is a guest of a Reception Center in the Mantua region are exemplary in this sense.

In the first case, the discomfort overflows at a time when the person already has subsidiary protection but is probably due to previous disturbances, which arose when he was a minor, and equally probably was never correctly assessed. The response of the Services appears to be inadequate even in the following phase when, despite the clear regulations regarding health protection and access to health care even in the absence of residence, they declare themselves competent due to the fact that the subject is considered homeless.

[15] Art. 21 leg. decree no. 142/2015 and art. 34 leg. decree no. 286/98

[16] STATE-REGIONS CONFERENCE held on 20 December 2012: Agreement between the Government, the Regions and the autonomous Provinces of Trento and Bolzano on the document containing "Indications for the correct application of the legislation for healthcare to the foreign population by the Regions and autonomous Provinces ". Repertory of Acts no .: 255 / CSR of 20/12/2012

[17] According to art. 33 of the Prime Ministerial Decree: "In the context of semi-residential and residential healthcare, the National Health Service guarantees for people with mental disorders, after assessment, the definition of an individualized therapeutic program, and therapeutic-rehabilitation treatments with programs of different intensity, complexity and duration.

In the other case, the mental discomfort affecting the subject of Nigerian origin applying for international protection seems to be determined by the obstacles he encountered in the migration path. Although the operators of the center realize his malaise, this is initially underestimated by the general practitioner, then treated through TSO and pharmacological therapies - and only in the end, with a great effort of coordination and a significant commitment in terms of resources, dealt with through the territorial services, does the effort prove to be adequate. Despite the protections offered by our legal system, applicants for international protection, holders of international protection, migrants who are victims of trafficking and serious exploitation and other categories of vulnerable foreign citizens continue to this day to be denied the full protection of the right to healthcare, also understood as psycho-physical well-being, both because of illegitimate practices and linguistic or cultural barriers that in many cases effectively prevent access to services but also due to political decisions adopted at national and regional levels.

In this sense, the same State Regions Agreement of 2012 on healthcare for the foreign population was implemented differently by the various Italian Regions[18].

As regards the Regions of interest for the present research, whereas the Lombardy Region[19] limited itself to simply providing, on an experimental basis, the registration of underage children of non-legally-resident foreign parents, but without assigning a pediatrician, and without addressing any of the provisions contained in the document, the Lazio Region[20], the Campania Region[21] and the Sicily Region[22] all have fully accepted the agreement, bringing only small changes to its content regarding minors.

In particular, the Lazio Region, in the document accompanying the implementation decree, notes that despite the provisions of the agreement, it is in fact impossible to proceed with the registration into the SSN (National Healthcare Service) of foreign minors, children of non regularly residing parents, because they lack a National Insurance number.

[18] For further information, refer to the Dossier of the State Regions Agreement and P.A. prepared by the Italian Society of Migration Medicine https://www.simmweb.it/archivio-sito/index-29.html?id=397

[19] Lombardy Region Resolution X / 1185 of 20/12/2013; see also Lombardy Region Circular of 21 January 2014: H1.2014.000215.

[20] Decree of the (acting) Commissioner of 8 March 2013 n. U00077

[21] Campania region. Regional Council Resolution n.111 of 27-05-2013

[22] Region of Sicily, decree n. 1791 of 26-09-2013, published in GURS n.49 of 31-10-2013; see also Sicily Region - Department of Health brief dated 06-03-2014

The Region of Sicily, on the other hand, decided to circulate its own guidelines to all healthcare providers in the region regarding the registration of foreign minors into the SSN, guidelines that health companies must adopt in order to register EU and EU foreign minors with the specific Eni and Stp codes, while the Campania Region has provided for the registration in the SSR exclusively for non legally resident non-EU minors who are holders of a tax code, but it does not allow registration for EU minors who hold an Eni code.[23]

At national level, if in 2016 - 2017 the system tried to react, albeit with great difficulties, to the growing need for transformation and identification of adequate tools to meet the needs brought on by the large numbers of applicants for international protection from Libya,[24] the subsequent regulatory interventions have had devastating effects not only on the foreign population but also on all the various figures called upon to take care of them.

The legislative decree n. 113 of 4 October 2018, then converted with l. December 1, 2018 n. 132 and the adoption of new tender specifications for reception centers[25] have resulted in the exclusion of applicants for international protection, and of holders of humanitarian protection status, from access to second-level reception, now called Siproimi[26], and in a reduction of reception services guaranteed within the first reception centers and other 'ad hoc' reception centers.

In particular, the new tender specifications provide for a reduction in pro-per-capita expenditure from 35 euros per day to 26-18 euros per day depending on the type and size in the center, with a consequent decrease in the number of operators, a strong downsizing of linguistic mediation services, social assistance and legal information and the elimination of the psychological assistance service.

Although it is understood that "the guests of the centers have access to the services of the national health service" and that "a complementary health care service calibrated in relation to the type and size of the centers is also ensured" the reduction in expenditure is, in fact, preventing adequate management of the most vulnerable subjects, especially in the phase in which the

[23] Campania region Regional Council Resolution n.111 of 27-05-2013

[24] For a survey of the tools, see *Protection of the health of migrants*, Dossier of the Protection System for Asylum Seekers and Refugees, January 2018.

[25] Tender specifications, approved by Ministerial Decree of 20 November 2018, concerning the supply of goods and services for the management and operation of the reception centers, pursuant to the law decree 30 October 1995, n. 451, converted by law 29 December 1995 n. 563, of the reception centers referred to in articles 9 and 11 of Legislative Decree 18 August 2015, n. 142 and the centers referred to in article 10-ter and 14 of Legislative Decree 25 July 1998, n. 286 and subsequent modifications, with relative attachments.

[26] Protection system for international protection holders and for unaccompanied foreign minors.

automatic exemption from the sharing of healthcare expenses is no longer envisaged. The total absence of indications regarding the provision of services specifically tailored to the needs of vulnerable subjects, first of all for those suffering from psychiatric disorders or who are victims of torture, represents, according to some[27], a violation of the obligations deriving from the Reception Directive and from the Legislative Decree no. 142/2015 and a failure to protect the "essential nucleus" of the fundamental rights of the person, and in particular of applicants for international protection, also guaranteed by the Constitution.

The new formulation of art. 4 c. 1 and c. 1-bis of Legislative Decree 142/2015 on the basis of which the residence permit for asylum request constitutes an identification document but does not constitute a title for the registration of personal data has been interpreted divergently also by the Judges causing confusion also with respect to the possibility of registering the holders of other types of residence permits to the registry[28].

The permanence in the system of all the above mentioned provisions, regarding access to health care for foreign citizens even in the absence of residence and the provision pursuant to art. 5 c. 3 of Legislative Decree 142/2015, for which asylum seekers access to the services provided on the territory must be ensured in the place of residence, has not prevented many ASLs, banks, post offices, employment centers from excluding applicants asylum from a whole series of rights and services which are indispensable not only to encourage integration but also to avoid a worsening of the precarious situation and possible conditions of mental and physical malaise. Similarly, the legislator's intervention, aimed at eliminating the atypical humanitarian protection clause, albeit attenuated by later jurisprudence[29], has not only created confusion and tension between beneficiaries, operators and service workers but has also left a void of protection that, as will be examined below, was only partially covered by the introduction of new types of residence permits.

For the territorial commissions before and for the judges afterwards, humanitarian protection, gives the right to a two-year renewable residence permit, even convertible into a work-residence permit. This was in fact a way to offer protection to people with varying forms of objective and

[27] See Nicoletta Vettori, public reception service and fundamental rights of asylum seekers. Profiles of illegality of the reform introduced by the legislative decree 113/2018, Law, Immigration and Citizenship, File n. 3/2019.

[28] Among the various contributions we note, "The registration of asylum seekers. A survey of the legal landscape after the conversion of the decree 113/2018 ", Francesco Ferri and Livio Neri, available at the link https://www.asgi.it/asilo-e-protezione-internazionale/liscrizione-anagrafica-dei-richiedenti- asilo/

[29] In particular, with sentence no. 29460/2019 the United Sections of the Court of Cassation have adhered to the majority orientation, considering the security decree non-retroactive and confirming the need for comparative assessment for the recognition of humanitarian protection.

subjective vulnerability including "*the existence of serious pathologies or serious psycho-physical conditions that cannot be adequately treated in the country of origin*"[30].

Furthermore, before the entry into force of Legislative Decree 4 October 2018, n. 113, the foreign citizen with a serious illness or who was in a delicate psychophysical condition, could obtain the recognition of humanitarian protection not only following the rejection of his / her application for international protection and the simultaneous transmission of the documents to the competent Police HQ , as already examined, but also following an application submitted directly by the citizen to the Police, documenting precisely the existence of objective and serious personal situations, so as not to allow his removal from the national territory[31].

With the declared intention of typifying the forms of complementary protection, the legislator intervened on Legislative Decree 286/98 introducing three new types of residence permit: the first "for medical treatment" (art. 19, paragraph 2, letter d -bis) the second "for calamities" (art. 20-bis) and the third "for acts of particular civic valor" (art. 42-bis).

Regarding the residence permit for medical treatment, it should first be noted that issuing of this type of permit is directly linked to a ban on expulsion aimed at protecting the right to healthcare. More specifically, this residence permit is governed by paragraph 2 letter d) bis of art. 19 by virtue of which: “Expulsion is not permitted, except in the cases provided for in article 13, paragraph 1, against foreigners who are in particularly serious health conditions, ascertained by means of suitable documentation issued by a health facility public or by a doctor affiliated with the National Health Service, such as to cause significant damage to their health in the event of their return to their country of origin"[32].

With this communication, the Ministry also specified how the assessment of whether or not the foreign citizen can receive adequate care in the country of origin should not be left to the Police Headquarters but to the competent Italian or foreign diplomatic representations[33].

[30] The National Commission for the Right of Asylum, as part of its task of addressing and coordinating the territorial commissions, with circular 3716 of 30.07.2015, in indicating by way of example, and not exhaustively, the cases of vulnerability in the presence of which the Commissions, not using the hypotheses for the recognition of international protection, would have had to transmit the documents to the Police HQ for the issue of the permit for humanitarian protection, had also referred to this specific hypothesis, also recalling several rulings of the Court of Cassation.

[31] Art. 11 apr 394/99.

[32] Contrary to the practices found at some Police Headquarters, the reading of this circular shows that, in the presence of certain pathologies, the fact that the foreign citizen may or may not receive the types of treatment required in the country of origin is completely irrelevant, the damage to health being the determining factor, in the event of interruption of treatment, which would entail the return trip of the foreign citizen to his/her country.

[33] This means that, in case of refusal of this permit, the competent Police Headquarters should motivate the permit on the basis of an opinion expressed by the diplomatic representation in the absence of which an appeal could be

The legislation does not regulate how the request for this residence permit is made. However, from a first assessment, it emerged that in some Police offices the application for the issuance of a residence permit could only be made by the interested party and in the appropriate offices, this because of certain difficulties arising from the request of this type of permit especially in the presence of certain pathologies, while at other Police Headquarters the request could also be made by a lawyer with a specific power of attorney and via certified e-mail. Similarly, discordant practices are also taking place in the Territorial Commissions, given the lack of precise instructions on this point, in the presence of asylum seekers affected by serious illnesses or who report a delicate psychophysical condition.

In some cases, the Commissions do not evaluate these conditions and / or pathologies in any way, believing that they have no competence on the issue of the permit for medical treatment, while in other cases they limit themselves to noting how the reported psycho-physical condition can be protected through the release by the Police Headquarters of the permit for medical treatment, effectively placing the decision back into the hands of the competent territorial Police Precinct. The various practices implemented by local police headquarters and commissions are proving to be seriously detrimental to forced migrants in conditions of extreme vulnerability, in particular for asylum seekers affected by mental disorders, to whom in many cases no form of protection is recognized anymore.

This is all the more true if one considers that the residence permit for medical treatment, also due to its limited duration subject to discretionary assessments regarding the issue and renewal, appears to be potentially suitable to offer protection in the presence of specific pathologies but risks being inadequate in the presence of pathological conditions due to serious psychophysical disorders, which, in the case of forced migrants, could also be caused by torture and mistreatment suffered in the country of origin or during the journey.

In order to overcome this limit, it will be necessary to recall the Police Headquarters on the need to interpret the new rule in keeping with the Constitution, also on the basis of that consolidated jurisprudential orientation that has already recognized the protection of the right to healthcare as a limit to the expulsion of the foreign citizen[34].

---

lodged before the ordinary Court, as the judicial body is competent for assessing the existence of the necessary requirements for the issuing of the residence permit for medical treatment.

[34] At the supranational level, we note in particular the ruling rendered by the European Court of Human Rights in the Paposhvili case c. Belgium (ruling on 13/12/2016), with Belgium being judged guilty of the violation of art. 3 of the Convention, modifying its previous orientation regarding the expulsion of migrants in serious health conditions (case N. c. United Kingdom, 26565/05). As regards national jurisprudence, see in particular the Constitutional Court, sentence no. 252/2001; Cass. SS.UU., sentence, n. 14500. For further information, Cecilia Corsi, The right to healthcare when tested by migration, available at the link https://www.regione.emilia-romagna.it/Affari_ist/rivista_1_2019/Corsi.pdf

In the same way, it will be even more fundamental to urge the territorial commissions to consider, in the presence of an asylum seeker affected by mental disorders, both the origin of these disorders and whether the individual can be exposed, in the event of returning home, "to the risk of an intentional deprivation of care "[35]or of acts of persecution such as to supplement the conditions for the recognition of international protection.

In this sense, pending interventions that allow to face the negative consequences of the regulatory choices of the last period, the consultation of experts "on particular aspects in matters of health, culture, religion, gender or matters inherent to minors ", as envisaged by Legislative Decree 25/08[36], but hitherto still diregarded by the Commissions, could prove to be the key to granting forced migrants the right protection, at the very least from a legal point of view.

[35] In this sense, the European Court of Justice ruling of the Grand Section rendered on April 24, 2018 in case C 353/16 relating to the recognition of subsidiary protection in favor of asylum seekers affected by trauma resulting from torture inflicted in the country of origin.

[36] Art. 8 Legislative Decree 25/08.

GUIDELINES FOR THE PLANNING OF THE ASSISTANCE AND REHABILITATION INTERVENTIONS AS WELL AS FOR TREATMENT OF INTERNATIONAL PROTECTION HOLDERS' MENTAL DISORDERS WHO HAVE SUFFERED TORTURE, RAPE OR OTHER SERIOUS FORMS OF PSYCHOLOGICAL, PHYSICAL OR SEXUAL VIOLENCE: PROCESSING AND TRANSPOSITION

by *Giancarlo Santone,* UOSD - Sa.Mi.Fo. - ASL Roma 1

The elaboration process

As part of the activities of the European Refugee Fund 2008-2013, the financing of various projects with the aim of improving interventions in favour of vulnerable categories of applicants/holders with international protection, has created the opportunity to establish a national network of public bodies and of private social sector. Together engaged throughout Italy in territorial experiments on the reception and taking charge of forced migrants' victims of torture and extreme violence. From this network a comparison and a reflection shared among all the participants has begun: the Italian situation regarding the reception and rehabilitation of torture victims appeared characterized by the absence of a national plan defining action strategies, roles, functions and methods coordination of the various public services involved, including healthcare companies, as well as ways of conducting scientific monitoring on the phenomenon.

The various projects funded on the subject of assistance to victims of torture, made emerge clearly from a moment of verification and synthesis of the results achieved had been reached, with the purpose of coming to a fully operational design of the services, all to be guaranteed to the victims of torture or extreme violence. Furthermore, the interventions carried out up to that time, were considered exclusively related to the organization of the reception of refugees and therefore with relevance of the Ministry of the Interior: still the relevance of the entire matter had not been understood, in terms of the protection of individual and collective health which had not received specific attention from the central health authorities. The experience achieved during the "Away from violence" network, lived in harmony with other positive experiences, has allowed us to highlight how the insertion of torture victims in reception and rehabilitation structures exclusively dedicated to them, should actually be avoided, since the rehabilitation for victims are much more effective if carried out in contexts characterized by the "normality" of social relations with the local community. On August 2010, at the conclusion of the "Away from violence" project, the scientific committee had pointed out the need to reach the definition of a

national program; this program would allow to deal organically with the issue of taking charge of torture victims. The suggested path brought to the establishment of a working table between the Ministry of the Interior, the Ministry of Health, the Ministry of University and Research and the Central Service of the Protection System for Asylum Seekers and Refugees (SPRAR), the UNHCR and other stakeholders, including those responsible for RES projects who had brought new elements to the topic and carried out innovative experiments.

An important opportunity arose when, in 2013, Italy found itself in the need to transpose the European directive 2011/95 / EU "containing rules on the attribution, to third-country nationals or stateless people, with the qualification of beneficiary of international protection, on a uniform status for refugees or for people entitled to benefit from subsidiary protection, as well as on the content of recognized protection "[37]. This European directive, provided with the introduction of planning activities and measures tool enabling the integration of beneficiaries with international protection, it paid very specific attention to the issue of psycho-physical rehabilitation of victims of torture or extreme trauma, thus providing: "Member States provide adequate health care, including if necessary, the treatment of mental disorders, in the same way as for citizens of the Member State that granted protection, to beneficiaries of international protection who have special needs"[38]. It was therefore considered appropriate to organize a national conference entitled "Italy asylum land -Reception, assistance, integration of refugees: European standards, innovative territorial practices and proposals for a new shared national system ", held in Parma on 30 November 2013. The meeting, which was attended by the Minister for Integration Cecile Kyenge, some representatives of the Ministry of the Interior and Laurens Jolles, UNHCR delegate for southern Europe, represented the opportunity to start the setting up the experiments carried out up to that moment and representing the contents of shared reflection to institutional interlocutors.

The full involvement of health authorities was laid down in the legislative decree 21 February 2014,n.18: «Implementation of Directive 2011/95 / EU laying down rules on the attribution, to third-country nationals or stateless persons, of the status of beneficiary of international protection, on a uniform status for refugees or for persons entitled to benefit from subsidiary protection, as well as on the content of the recognized protection», with art. 27 comma 1-bis stating: «The Ministry of Health adopts guidelines for planning of assistance and rehabilitation

[37] Published on the *Official Journal of the European Union* the 20th December 2011, L. 337.

[38] Directive 2011/95 / EU of the European Parliament and of the Council on 13th December 2011 laying down rules on the attribution, to third-country nationals or stateless persons, of the status of beneficiary of international protection, on a uniform status for refugees or for persons with the entitlement to benefit from subsidiary protection, as well as the content of the recognized protection (recast), art. 30.

interventions as well as for the treatment of mental disorders of the holders of refugee status and subsidiary protection status who have suffered torture, rape or other serious forms of psychological and physical violence or sexual, including any specific training and updating programs towards healthcare personnel. To be implemented within the financial resources available under current legislation». The guidelines tool, responded to the recognized need on providing indications for the implementation of appropriate and uniform interventions throughout the national territory, through paths for the identification, taking charge and treatment of victims of intentional violence and torture, in continuity between the reception system for refugees and the social and health care system.

Therefore on September 12, 2014, with the Executive Director of the Prevention Director, integrated with D.D. May 12, 2015, a technical round table was set up which involved the following organizations: United Nations High Commissioner for Refugees UNHCR, Association of Doctors against Torture, Association for Legal Studies on Immigration, Interdisciplinary Coordination of the CIAC-AUSL Parma Social Partner, Italian Caritas, Astalli Center, Forced Migrants Health Center ASL Rome 1, State-Regions Conference with representatives of Basilicata, Campania, Emilia-Romagna, Lazio, Marche, Sicily, Tuscany and Umbria, Italian Refugees Council, National Institute for the Promotion of Health of Migrant Populations, Ministry of Interior, Ministry of Health, Migration Medicine Italian Society, Italian Society of Child and Adolescent Neuropsychiatry, University of Cassino and of Southern Lazio. After intense preparatory work, the decree of the Ministry of Health was published in the Official Gazette on April 24th, 2017 «Programming Guidelines for assistance and rehabilitation interventions as well as for mental disorders treatment of refugee status and status holders of subsidiary protection who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence "with the relevant schemes for the various health interventions to be performed. The guidelines, as described at the time of the State-Regions and Autonomous Provinces Agreement which preceded the ministerial decree, have the objective of protecting applicants for international protection when in particular vulnerability conditions, at any stage of the recognition, protection process, wherever they are hosted, creating the conditions for victims of traumatic events to effectively access the procedures provided by the standard and to be adequately protected.[39]

Guidelines Scope

The European Directive 2011/95 / EU, transposition of which started the process of defining the Guidelines, applies to "holders of refugee status and subsidiary protection status who have

[39] With Ref to M. Mazzetti, S. Geraci, Immigration and Mental Health. Violence, psychotraumatology, health policies and care protection, by F. Perocco, Torture and migration, Venice 2019, pages 395-96.

suffered torture, rape or other serious forms of psychological, physical or sexual violence ". However, since the start of the work of the Technical Table, it seemed important to ensure that the field of action required by law was not limited to those who have successfully completed the administrative or jurisdictional process of recognition of international protection. To provide effective assistance, taking measures, taking in to account the importance of timely intervention, it was essential to include applicants for international protection among the recipients of the measures. For this reason, as specified in the introduction of the document, the guidelines have general indications, valid in every context and circumstance and provide indications on specific interventions. These are to be implemented in a differentiated way according to the different places and contexts in which the application for protection is presented and whatever the legal status of the foreigner who presents it (person who has just arrived in our country with regular entry or in a state of need, person already residing in Italy, person already present but not regularly residing, person previously expelled and not detained, person expelled and detained at for the purpose of carrying out the removal, etc.).

It is clear that the legal and social precariousness which affects forced migrants for the duration of the asylum procedure, poses additional challenges compared to the already complex application of the provisions of the legislation. In a recent report released by the Italian Society of Migration Medicine[40] with regard to the critical aspects relating to social and health care for applicants for international protection, highlights the negative impact on health of the poor conditions of the structures assigned to the first reception. These are generally represented by centers with high capacity and essential services, which have very long residence times and which host people in conditions of health, social, psychological and psychiatric vulnerability, although they do not represent a suitable place for taking charge of these conditions. In the CAS and Hubs, despite the considerable lengthening of time spent in first reception, measures for the protection of health are not equally implemented as the second reception disputes, such as enrolling in the SSR, assigning the general practitioner prevention procedures such as vaccinations, screening for latent tuberculosis infection and other preventive medicine programs. The critical issues relating to the reception pathways within the CAS are underlined, in which the scarcity of resources, compared to the number of people accepted, does not allow the construction of procedures for taking care and responding to complex health needs. In addition, the high turn-over of social and health workers working in reception does not encourage continuity of paths and does not contribute to the development of skills in the field. In general, the lack of training courses to support social and health workers and the need to build multidisciplinary tools and approaches

[40] Footprints Project, Territory Analysis Report critical issues and resources. WP2- Coordination of territorial interventions, by the Italian Society of Migration Medicine, pp. 89-90.

for the social and health care of people emerge, including aspects of cultural competence and medical and cultural anthropology. It is also underlined the fact that, because of the difficulty of carrying out the migratory project and in the absence of resolving paths, in some territories there is an increase in psycho-social suffering with the consequent increase of psychiatric disorders diagnosis which can pose limits to the integration path and development of autonomous capacities.

Construction guidelines evidences

Applicants and holders of international and humanitarian protection are a population at high risk of developing psychopathological syndromes due to the frequent incidence of stressful or properly traumatic experiences. They are people generally forced to leave their country to avoid persecution or the concrete risk of suffering it. They can also be escaping from contexts of generalized violence caused by wars or civil conflicts in their country of origin. Furthermore, during the migration process, they are often exposed to accidents and additional traumas caused by the danger of the trip that can materialize in situations of psychophysical humiliation, exploitation, detention, violence and aggressions of various kinds, including sexual, refoulment, malnutrition associated with the impossibility of being treated. The basic assumptions of the guidelines are to provide an adequate response, it is urgent to start the programming of operational tools, characterized by an integrated multidisciplinary approach, useful to assist this new multicultural, heterogeneous user, marked consistently by the traumas suffered. Certainly, an appropriate reception to the complexity of needs and to the protection of the rights to which these subjects are bearers, requires a reorganization of health services, with the definition of procedures, skills and training activities for staff, made difficult even by the limited resources available. However, the fact that the legislator has believed that the implementation of the guidelines must be made of "committed resources", that is, without specific funding but in the context of ordinary funding, because already lacking, is complicating the process, given the progressively decreasing number of operators, on duty in the Mental Health Departments in many areas of Italy.

Early detection and prevention of psychopathological problems

All forced migrants are to be considered as subjects at risk, due to the frequency and intensity of the traumatic experiences that each of them faces, before departure, during the journey and in the new context of life. Such experiences do not necessarily and automatically translate into

psychopathological disorders,[41] just as migrants who cannot be traced back to the legal categories of international protection may have experienced traumatic experiences, even very significant ones. However, in the light of several studies, it can be estimated that 33-75% of survivors of extreme trauma, develops in the period following the traumatic experience, a frankly psychopathological disorder, which potentially impacts also on subsequent generations (the so-called transgenerational torture). This correlation justifies specific attention to the target group of forced migrants to ensure a correct and early clinical-diagnostic evaluation, which addresses an appropriate and timely medical, psychological and social treatment. Unlike the typical manifestations of other psychopathological pictures, clinical manifestations of complex post-traumatic disorders, are multifaceted and insidious and, by their very nature, difficult to detect and diagnose, especially for doctors and psychologists without specific training and experience. The risk of misrecognition or of an incorrect diagnosis, in such cases, is very high and the disturbances can remain latent even for long periods of time. It is not uncommon for an undiagnosed complex post-traumatic disorder to be the cause of repeated and prolonged failures of an asylum seeker on his path to autonomy. Of particular importance, especially for clinical relapses, is the trend in the natural history of complex post-traumatic disorders, which have the tendency, in the absence of a correct diagnosis and adequate and specific therapeutic interventions, to become chronic or have an unfavorable prognosis. The timeliness of adequate treatment in specialized skills services is therefore crucial for the future of these people and has an indispensable early and correct diagnosis as a prerequisite.

An active and prompt involvement is required during early emergency, not only from health workers, but of all operators potentially involved in the reception and protection of forced migrants. Ideally anyone who is in contact with the person (volunteers, social workers, teachers, etc.), should be able to grasp the health needs and report them to the competent professionals, in the context in which the migrant is at the time (ship rescue, hub, reception center, etc.). This allows a second level assessment, which confirms or not the presence of psychiatric disorders,

[41] The definition of "vulnerability" used in the legislation relating to applicants and holders of international protection leads to various ambiguities. According to the legal definitions currently in use, in fact, people are correctly vulnerable "for whom it has been ascertained that they have suffered torture, rape or other serious forms of psychological, physical or sexual violence or related to sexual orientation or gender identity, the victims of genital mutilation ", but also people already suffering from mental pathology. However, in this way we end up confusing "violent events, even objectively horrible, and such as to provoke a profound reaction in us who listen to the story, with what is called trauma in the clinical setting. In fact, trauma means injury, injury, vulnus. The event therefore causes a trauma, it is not in itself a trauma; indeed, as we shall see, it would be more correct to say that it can cause trauma. After all, what happens in the field of is no different, if we consider it properly field of physical traumatology, in which it is not the accident that must be treated by the orthopedist, but the fracture caused by the accident. ": E. Vercillo," Introduction ", in E. Vercillo-M. Guerra (edited by), Trauma clinic in refugees: a thematic manual, Mimesis Edizioni 2019, pp. 15-16. This implies that not all at-risk ("vulnerable") subjects must be sent for taking charge in psycho-medical pathways.

and eventually send the person to third level structures, available in the territory, which can guarantee a complete path of taking charge. In order for this to happen, the training of the operators is fundamental, who must acquire awareness about the symptoms and sentinel behaviors that can suggest the presence of a disturbance or a difficulty. The guidelines are distinguished in three levels of training required: an "awareness" action aimed at all operators, in order to make them aware of the vulnerability profile of the assisted people and their rights. The second level of "facilitation and support" is intended for operators involved in the multidisciplinary process, operating in the various contexts of treatment of forced migrants, to provide operational and organizational elements consistent with the context of assistance intervention in a logic of global taking charge. Finally the third level of "specific training", aimed at certain professional figures and multi-professional groups, with the purpose of achieving specific skills assistance.

Certification and taking charge

The guidelines also contain an in-depth analysis on the certification of the physical and psychological outcomes of intentional violence, supporting the application for international protection. To be reliable, the certification must not be removed from the overall path of taking charge of the migrant from a medical, social and legal point of view.

The certification tool can be useful for other aspects related to the legal process, such as:

- inform the territorial commission about the "psychological" difficulties that the applicant can manifest during the reconstruction of events;
- ascertain serious disabling states or long-lasting illnesses, which lead to fragility and / or the need for prolonged and continuous investigations and specialist treatments, as well as give indications of the consequences of a forced return to a social context, where the applicant has suffered episodes of torture or violence, affecting mental health;
- inform the involved organization, about the impossibility for the applicant, to take the hearing due to his physical or mental health conditions;
- provide an impact assessment that the timing of the procedure may have on the therapeutic path or on the course of the symptoms of the asylum seeker victim of torture, giving indications on the opportunity to anticipate or postpone the hearing of the applicant;
- give indications on the opportunity that the applicant should be assisted during the hearing, due to the particular condition of emotional fragility or serious psychopathology.

An important discussion point, during the preparatory phase, concerns the identification of the subjects who could issue this type of certification. Preferably this activity should involve public structures, but it is important not to lose the skills acquired by the social private sector, gained over the years and on the territories. Furthermore, it is necessary to consider the criticality posed by the fact that the medico-legal certifications are not included in the LEA, services that healthcare companies are obliged to guarantee. Therefore, the solution was drawn up by the ASL and / or the Regions with a list of centers authorized to issue certifications, with no prejudice to the obligation of the private social certification organizations, to inform the ASL territorially in this regard; in order to plan the services necessary for the taking charge paths.

Guidelines' transposition and future prospects

The Regions will have to implement, contextualize and make operational the indications received, for this reason some ministerial projects have been proposed. To date, only the Lazio Region, with the Regional Council Resolution no. 590 of 16 October 2018, "Indications and procedures for the reception and health protection of applicants for international protection", has taken over the national document by following its approach, recalling its principles and adapting the indications to the regional organizational context. Therefore, the application of the guidelines through the structuring of dedicated services is still very lacking. In many territorial contexts, in fact, there are no recognition and rehabilitation paths for victims of intentional violence, still in other contexts there are professionals with specific skills in the field of ethnopsychiatry. These experts are in limited numbers, therefore unable to cover the existing need. Even where reference figures are found, support services are scarcely accessible, such as rehabilitation and taking care of psycho-social suffering within the public service. Overall, this area is mainly declined in terms of ethnopsychiatry, with poor collaboration with forensic medicine and with an insufficient implementation of rehabilitation services. In the absence of instruments capable of interpreting suffering in an anthropological and cultural key, medical procedures are often used, with unnecessary and often ineffective performance.[42]

Projects funded with FAMI funds are currently underway to strengthen the capacity of local services to adequately identify and take charge of international protection holders affected by specific vulnerabilities encouraging the adoption of the guidelines in the various regional contexts: in particular with Footprints project, which involves the Ministry of Health, in partnership with the Italian Society of Migration Medicine (SIMM) and the Association of Permanent Conference of Council Chairs of the master's degree course in Medicine and Surgery (APCCLMC) and the I Care

[42] Footprints Project, Territorial analysis of critical issues and resources Report. WP2- Coordination of territorial interventions, by the Italian Society of Migration Medicine, pages 89-90.

project, which has the Emilia Romagna Region as its leader and involves Lazio, Sicily, Liguria, Tuscany, Friuli Venezia Giulia, Marche and Valle d'Aosta.

An important note goes to the significant changes that have affected the reception system in recent years, this would require a revision of the guidelines, especially as regards to the procedures of early identification of psychopathological problems: in most of the reception facilities for asylum seekers, in fact, the psychologist profile is no longer expected. Since the guidelines drafting, members of the Technical Board had suggested that a periodic review should be envisaged, because the scenarios relating to forced migration are by their nature susceptible of relatively rapid and only partially foreseeable transformations. It is desirable that the significant decrease in the arrival of forced migrants in Italy, which has been recorded in the last year, does not lead to a decrease in the necessary commitment to develop adequate responses to complex socio-health needs of this population. The process of comparison and elaboration which has led to the drafting of the current guidelines has moreover had an important boost in 2010, a year in which just over 12,000 requests for international protection and the so-called " refugee crisis ”was still a long way off.

THE ROLE OF THE CULTURAL AND/OR LINGUISTIC MEDIATOR FOR THE UNDERSTANDING OF THE PSYCHOPATHOLOGICAL PHENOMENA EXPRESSED BY FORCED MIGRANTS[43]

by *Massimiliano Aragona*

Introduction

The role of the cultural and/or linguistic mediator in a particular setting such as the one to be presented requires specific skills. They are specific because it is the particular context that is, and therefore a preliminary treatment of these general aspects becomes necessary so that the mediator's work can make sense by becoming part of the factors of care at work in the clinical meeting. Understanding the other within the therapeutic relationship is an unavoidable and fundamental theme for any therapeutic practice in mental health.

Obviously, it concerns every therapeutic encounter (and in general every human encounter), but it becomes particularly thorny in the cross-cultural context when not only the linguistic differences but also those of meanings, values and expectations, put the relationship at risk of misunderstanding.

The first part will present examples of possible levels of misunderstanding that need to be managed during a cross-cultural helping relationship. To these will be added further elements deriving from the specificity of the condition of victims of intentional violence, which will also be discussed. In particular, we will focus on the concept of retraumatization, because learning to prevent this phenomenon is a fundamental part of the clinical approach in situations of this type.

In the second part we will deal with how the phenomenological-hermeneutic tradition has approached this problem of understanding the other, suggesting that some of the tools that it provides allow us to have a better definition of how nature and culture intersect in each unique psychopathological experience. It will be argued that the Jaspersian concept of understanding, the phenomenological attitude towards *epochè*, and the hermeneutic model of the formation of symptoms developed by the Cambridge school, are applicable in the cross-cultural context. Here they help us not to lose our way, swinging dangerously between extremes of a reductionist neo-phrenology insensitive to cultural differences on the one hand, and ethnocentrism on the other. The latter certainly has the advantage of underlining the importance of culture, but also carries with it the risk of locking the individual in a cage woven with the traditions of his supposed group,

[43] Reprint of the report presented at the conference on "The device of cultural mediation in mental health services. Work tracks to define guidelines and intervention models ", Frascati, 24 june 2015

without considering the importance of personal change that so strongly pushes forward the migration project.

The helping relationship in the context of migration

As we said, this essay, although quite theoretical, is based on the long, concrete experience gained in providing medical aid to migrants. As Caizzi and Mazzetti write (2014, p.23), they are often "people who are 'invisible' to society, to politics, and to those they meet on the street, and invisible are also their wounds, because the experience of having undergone and being survivors of violence leaves a psychic pain that often accompanies a sense of shame that pushes patients to hide, to shy away from other human beings. The aim of the project is to identify them, welcome them, treat them and offer them an opportunity to rediscover themselves as individuals capable of living a full and dignified life." It is in these concrete settings that the meeting between clinician and patient takes place, often surrounded and helped by other important professionals (mediators, educators, social workers, etc.). And this clinical encounter is a source of mutual knowledge, of ever-renewed attempts at mutual understanding but also with the ever-looming risks of possible misunderstandings. In the most quoted Italian paper on the topic of possible misunderstandings in the encounter with the migrant patient, Colasanti and Geraci (2000, p.214) write that "The encounter with the migrant patient therefore proves fraught with difficulties. Difficulties of language, of culture, of expectations, difficulties with health issues, with geography, epidemiology, the nosology related to the migratory process itself, and with the sociology of health." Through a semiotic analysis of the intentional levels of the text, the same authors identify five levels of possible misunderstanding. The first level concerns pre-linguistic communication, or the general difficulty of communicating one's own subjective experiences that we can all meet and that in the encounter with the migrant are enriched with further nuances: "When we ask" Do you feel sick? Yes, doctor. "What does it mean to feel sick. The expression 'to feel sick' becomes usable to indicate something but without specific names that can designate. There are no possible nomenclatures. And if this level of anomaly of inner malaise is universal, it is multiplied a thousand over in the immigrant who is unable to connect with the doctor, to try other possibilities to talk about his inner being." (Colasanti e Geraci, 2000, p.216) In the next paragraph we will see how psychopathologists have developed models and tools to try to grasp and make sense of this ineffable prima facie subjectivity.

The second level of possible misunderstanding is the purely linguistic one, where the difficulty is given both by the diversity of the language, and by the diversity, in the various languages, of the relationship between the word (the signifier) and the concept / concepts it designates (the meaning). For example, "In Somali 'kili' means kidneys, but kili in Somali refers to the anterolateral

abdominal skin area, while in common Italian usage, by kidneys we mean the latero-rachid dorsal area. The arbitrariness of the sign can be remedied with a translation of the nomenclature. But the arbitrariness of the value of a meaning can only be remedied with a reinterpretation of similar but not equal concepts. When an Italian says he has kidney pain, it means he has low back pain. In Somali it may instead mean pain in the ascending or descending colon region. (Colasanti e Geraci, 2000, p.217)

The third level is that of the extra-linguistic translation of symbols. For example, the word cancer, which in western patients can evoke images of death, does not do the same in patients from countries where it counts less among the causes of death. Conversely, for an African mother to know that her baby has anemia can induce an emotional shock because, while in Europe anemia is an easily treatable condition, in other places it's synonymous with malaria and is therefore considered life threatening.

The fourth level is the most strictly cultural one. Culture is "a complex set of symbols, values and representations, on the basis of which man explains and organizes his presence in the world." (Diasio, 2000, p.183). It operates mostly on an implicit level: you know how you behave and what you mean in a certain context because you were born in it. But things change drastically when you emigrate, because we come up against sudden and unexpected misunderstandings that force us to reflect explicitly on the difference. For example, the same gesture can be a greeting in one cultural context and an insult in another. There are thousands of examples of this type. What is obvious one day is suddenly no longer the next and forces us to review it. Think back to our common sense of modesty: for an Italian woman to whom the doctor says "get undressed" it is a sign that the doctor wants to do a proper check-up, which bodes well for their professionalism, especially in these times when doctors limit themselves to doing prescriptions. But for a woman from another background? Also, an accurate medical history is again a sign of the clinician's accuracy. But what if it's for someone who comes from a place where "The wise does not ask why, he knows"? And if a psychotherapist asks the patient "Now that we understand your problem well, what do you think you can do to deal with it?", what answer can be expected from one who thinks "If I came to you it is because you have the power to act"? And so on, until we get to the not infrequent scenario where, in the mindset of the western clinician, if a patient is sick, the causes of the sickness are to be found in the sick person and that is where one must activate the resources to get better, while the patient believes that if he is sick it is because there is another person using his own powers to harm him.

Finally, the last level is that of the different philosophical and religious conceptions from which a consciously argued vision of life emerges. Once again, even at this level, misunderstandings can

emerge in the therapeutic relationship that must be addressed and discussed if there is to be adequate compliance with the therapeutic proposals.

Following the conclusions of Colasanti and Geraci (2000, p.219), the greatest lesson that remains in dealing with these possible levels of confusion when meeting with migrant patients, is the awareness of the enormous space "that divides men when they must speak about their pains and the enormous closeness that unites them. The psyche weaves tireless threads that should serve to understand each other, thin silk threads that we continually break and continually recreate. Yet the existential experience, being here and now, unites everyone."

If these are the main levels to be considered in the helping relationship with migrant patients, it is still necessary to add the specificities that derive from having been the victims of intentional violence. According to international literature, the main clinical cases that appear following exposure to a psycho-traumatic event are listed in a special section of the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) (American Psychiatric Association, 2013). Among them, Post-Traumatic Stress Disorder (PTSD), a syndrome very common among our patients, about which we will talk when we consider the role of certain some symptoms in the relationship. However, we must specify that the psychopathological literature has shown us that psycho-traumatic reactions can be manifold, with symptoms and syndromes that go far beyond those codified by the DSM. This is to be read both in the larger sense, in that there are many more possible symptoms than those coded as strictly post-traumatic, for which we speak of "complex" post-traumatic disorders, and with respect to the completeness, or otherwise, of the picture.

The most common post-traumatic symptoms include intrusions of thoughts, memories and sometimes flashbacks that reproduce the trauma which was experienced. This causes the person to appear distracted, and perhaps their behavior risks being misunderstood as a lack of interest. At other times the person enters a state of momentary dissociation from the state of consciousness, getting lost in a void or perhaps staring at a point in the room, rather than speaking and gesturing as if someone was there. All this runs the risk of mistaking this for a psychotic hallucinatory state, with consequent inappropriate therapeutic actions. Lastly, in all these cases, the common denominator is the difficulty to concentrate, which is another symptom listed in the PTSD construct and can involve a double risk of misunderstanding: the patient can be seen as uninterested, while what the clinician says (or what is reformulated by the mediator) can be only partially grasped by the patient, thus making the interaction ineffective. Still, other typical symptoms of PTSD are those of avoidance (of places, people, memories, etc., which refer to the traumatic experience). During the session, the patient can suddenly become reluctant and, if the possibility of this underlying experience is not known, the behavior can, once again, risk being misunderstood. Furthermore, among the symptoms of PTSD there is the inability to remember

important aspects of traumatic events, which is a typical problem of misunderstanding especially at a crucial moment in the history of a refugee: in front of the hearing committee. An experienced clinician knows that these are typical signs of post-traumatic dissociative amnesia, so the temporal sequence of events falls apart and the patient ends up reporting an ever-changing sequence of the events that remain etched in his memory, omitting other aspects of the narrative. This is a sign of seriousness in the study of these symptoms and it may sometimes be necessary to alert the commissioner who makes the evaluation, and the linguistic mediator himself, that these are signs of a post-traumatic situation and not, as sometimes it is misunderstood to be, a series of contradictions on the part of one who is telling tales. But if these are symptoms that we would also expect in American soldiers returning from war territories (PTSD is often reported as a clear example of a social construct aimed at economic interests: in this case the right to reimbursement for veteran care), DSM itself opens up the possibility that different cultures can present and formulate symptoms in other ways. Among them, one characteristic, though by no means specific, way is through somatizations, or stress disorders, which do not have a patho-physiological explanation and are thought to be the somatic expression of a psychological suffering. Somatizations are very frequent among migrants (Aragona et al., 2012a), and it has been suggested that, being significantly linked to trauma and PTSD, they could be a signal that alerts the doctor of the possible presence of an unreported post-traumatic disorder (Aragona et al., 2010). Somatizations are part of those "idioms of distress" that transcultural literature often speaks of to indicate a culturally mediated way of expressing suffering. One example is the sudden headache that blocks the story of a traumatic experience which is evidently too painful to remember; other, less evident examples of somatizations are linked to skin conditions, the gastrointestinal tract, the heart, as well as various pain syndromes, sometimes connected to the traumatic experience through complex pathways of symptom formation on which the cultural matrix has great influence.

We could go on at length about the symptoms, but what has been written so far may be sufficient to convey a fundamental principle: mediation in this particular area is not only linguistic nor only cultural, but must take into account specificities related to the relationship of treatment and the particular psychopathological conditions in place, so that the same technical precautions the clinician adopts to establish, maintain and manage a good therapeutic relationship must in some way also involve the activity of the mediator, which is an integral part of the clinical process.

A few more words need to be spent regarding the concept of secondary re-traumatization, with which we refer to those factors which, although they did not cause the onset of post-traumatic symptoms, nevertheless act by worsening their course and complicating their evolution by means of their power to reactivate the original traumatic experience or by amplifying the loss of meaning,

which is an intrinsic feature of trauma-generating events. Studies converge (Silove et al., 1997; Steel et al., 2011; Schweitzer et al., 2011) in highlighting that, between the original pre-migratory traumatic events and the onset of a worse / more complicated / chronic post-traumatic symptomatology, there is a space in which these re-traumatizing events play a fundamental role. This is because, as is well known, a person who has suffered intentional violence is more sensitive and likely to be re-traumatized by subsequent events that have similar qualitative (though not always serious and intense) connotations (Mazzetti, 2008). Well, "it is widely known that in their attempt to get to Europe our migrants run multiple risks of re-traumatization: when they see their companions die in the passage through the Sahara or in the mountains between Afghanistan and Pakistan; when they risk being captured and imprisoned in Libya; when in prison they are deprived of all dignity, beaten and subjected to sexual violence; when they are held in slavery by raiders or unscrupulous employers, to whom they have turned to earn enough to continue the journey; when they are beaten on the street because they are Afghan (in Iran) or because they are sub-Saharan (in Libya and sometimes in other North African countries). And then, as if all this was not enough, when you die under the wheels of a semi truck between Greece and Italy, or when you are shipwrecked off Lampedusa island, or when you end up in a concentration camp that someone still insists on calling a reception center. And finally, in the small but painful experiences of difficult everyday life, made of discrimination, denial of rights, slowness in carrying out asylum practices, poverty, exposure to dangers, concern for the fate of the family members left at home, sense of despair and uselessness, etc. etc... It must be clearly said that the studies are agreed on the fact that all the measurements taken converge in claiming that the re-traumatizations linked to post-migration life difficulties are responsible for a significant worsening of post-traumatic symptoms, both specifically included in the PTSD (Aragona et al., 2012b; 2013), and those "sentinel" symptoms such as somatizations (Aragona et al., 2011). Not only that, it is now clearly demonstrated that migrants who are locked up in centers such as the CIE (detention centers), after years of this experience, are still feeling bad and have significantly worse levels of functioning and social integration than those who have been welcomed with adequate reception procedures (Steel et al., 2011). It's not only a matter of civilized reception policies (which would already be enough), but also a medical problem, of preventing post-traumatic pathology "(Aragona, 2014, pp.100-101). And regarding the subject in discussion, this fundamental preventive work is meant to take into account, in a culturally sensitive way, the possible re-traumatizing stimuli which are to be avoided, both in the arrangement of the therapeutic setting and in the relational modalities. So, the mediator must be aware of this, because it is important that he knows how to avoid attitudes or words that could be re-traumatizing, and at the same time he will provide valuable information to the clinician on the experiences communicated by the patient about what happens

in the relationship, so as to achieve the best therapeutic relationship. This issue of re-traumatization is so important that, in extreme and fortunately rare cases, it may even be necessary to do away entirely with mediation or some of its components, such as in the case of a patient who avoids meeting people from his country because he is afraid that government agents may be hiding among them. In cases such as this, it may be worth considering if it is appropriate to insist or if it is better to give up mediation altogether, or perhaps limit it to a linguistic mediation performed by a person who speaks the language but comes from another country.

Understanding the 'other' in psychopathology

The theme of mediation confronts us with a radical version of the problem of how we can understand the 'other' and his experiences, especially if, as in psychopathology, many of these experiences are subjective and not directly observable from the outside. This is a problem that affects every human relationship, in every area, and which has found its technical declination in psychopathology, in the field of phenomenological-hermeneutics. In the field of psychopathology in migratory conditions, there is therefore the added factor that the 'other' who needs to be understood comes from another place, from other habits, traditions, etc. In short, from another cultural sphere. This has always raised the 'nature vs. culture' debate: can psychopathological phenomena be assimilated to symptoms expressing diseases, and seen as entities of natural origin, or are they cultural constructs? The approach will change depending on the answer to this question. For the "naturalist" the important thing is to make the diagnosis in the right way and give the correct therapy, regardless of where the patient comes from. Instead, for the "culturalist" it's the culture that created the disturbance and therefore it is within the framework culture of origin that the disturbance must be treated. Needless to say, these are extreme positions, and the nature-culture relationship is most probably more complex (and varying depending on the case), with large spaces of interrelation. We will conclude this paragraph by illustrating the recent models that allow us to find our way around how this relationship works. For now, however, it is useful to start from the beginning, that is, how psychopathology conceptualized the technical and human act of understanding the 'other', his experiences and his psychopathological phenomena. The concept of understanding (Verstehen) was introduced into psychopathology by Karl Jaspers (1959/1964, p.30) to mean "the intuitive vision of the spirit, from within." That is, the act of understanding consists in a radically different attitude from that of the one we have called "naturalist" above: "When we consider psychic life we have two ways available: either we transpose ourselves internally in others, we identify with them, we 'understand', or we consider individual elements of the phenomena in their connection and in their succession as data" (Jaspers, 1959/1964, p.113). To better illustrate this, Jaspers starts from the analysis and

description of the individual phenomena and then goes to their connection. Following this thread, we move from the individual elements (sensitive perception on the one hand, static understanding on the other) to their connection (through explanation and genetic understanding, respectively). This is where the distinction arises, within the concept of understanding, between static understanding and genetic understanding.

The first was very well characterized by Achella (2004, pp. 71-72): "Understanding [...] starts from observation "from within". On the basis of this procedure, the doctor starts from the description of the individual phenomena of the patient's lived experience, thanks to the phenomenological method, and thus, through empathy (Einfühlen), identification, inner transposition (Hineinversetzen) he tries to revive (Nacherleben), to bring back the patient's experience." In the words of Jaspers (1959/1964, p.59), as the comprehending psychopathologists that we are “we must represent to ourselves what really happens in the patient, what he has really experienced, how something has arisen in his conscience, as he feels." This is achieved through an act of intuitive identification which, however epistemologically problematic, constitutes the essential foundation of our work: the psychopathologist "not only makes an impartial observation, as in making a measurement, but in the act of scrutinizing the soul, he must understand and take part. There must be within him an identification with the other, which consists in an attempt to transform into an actor who identifies with the character while remaining himself "(Jaspers, 1959/1964, pp.23-24). As has been underlined, "in this both technical and human movement of internal resonance with the experiences of the ‘other’ and at the same time of the ability to remain objective, the essence of static understanding and, we could say, of the whole work of the psychopathologist, arises" (Aragon, 2009, p.34).

If static understanding concerns the ability to "bring to the present" what the other feels at a given moment, and therefore has to do with the possibility of fully conceiving the individual phenomena present in the consciousness of our interlocutor (a task that Jaspers assigns to phenomenology), genetic understanding works by relating mental phenomena to one another, illuminating how they "arise spontaneously from each other, from within, according to an understandable nexus and through sense relationships" (Cantillo, 2001, p.26). Jaspers himself (1913/2004, pp.98-99) is very clear in respect to his choice of words: “Phenomenology provides us with a series of fragments, mere elements of the psychic reality as it is lived. We immediately wonder how they are connected. In some cases, we understand how the psychic clearly derives from the psychic. Thus, and only with respect to the psychic, we understand how the aggressed individual becomes furious, the deceived lover becomes jealous, in other words, how from a motive will derive both a decision and a fact. In phenomenology we bring into the present single qualities, single states, we understand statically, here instead we grasp the derivation of one from

the other, we understand genetically. In static understanding (phenomenology) we dealing with the cross section of the psychic, so to speak, whereas in genetic understanding (comprising psychopathology) we're looking at the longitudinal section."

So, in its articulations, understanding emerges as a hermeneutic method within a therapeutic relationship based on human encounter, on the exchange of meanings, on the appreciation of personal motivations. In other words, it is a purely humanistic point of view within the care relationship, which opens us up to the sphere of subjectivity and culture in which it is learned. However, it is equally interesting to note that Jaspers is very careful not to press this point of view to the absolute, he also recognizes value in the 'naturalist' approach that tries to see phenomena as objects and explain them scientifically. In short, for Jaspers, understanding is an act of intuitive identification that makes us relive the experience of the other (empathy), and is to be considered as one pole of a relationship between methods that includes the explanation (Erklären) as the other pole, and all of this within a context of methodological pluralism (see Aragona, 2013; Villareal & Aragona, 2014).

In the years to follow, Jaspers' contribution, phenomenological psychopathology, began to question a lot about the characteristics and limits of understanding, with a Heideggerian turn that brought the debate more clearly on the "culturalist" side of the argument. In this context, understanding was no longer an act of empathic identification, but an act of interpretation and self-interpretation that would allow for the 'way of being' of the 'presence' to emerge, in other words, 'being there' (Dasein). Without going into technicalities that are out of place here, in phenomenological psychopathology, the way to proceed can be shown as follows: through a preliminary delimitation of the field we focus on the phenomena of consciousness as they actually manifest themselves, putting aside our previously mentioned opinions about how things should be in theory (this is what phenomenologists call *epochè*, or "phenomenological reduction"). So, we try to access the meaning that all this has for the other, in particular by studying how the other person "designs" his being in the world: how he structures his space, his time, his way of relating with others, etc. It follows that if the symptoms are no longer the issue but the way of being in the person's world, then a different way of being is not necessarily a sign of illness. This means that the healthy/sick, normal/pathological categories become fluid. And then the other becomes the bearer of his own values that must be seriously considered within the relationship, and Culture can only be a determining matrix of how psychopathological values and phenomena are structured and how they condition each other in a given person, in a given epoch and within a social and cultural context of belonging. It is no coincidence that, while speaking about the issue of the encounter between the clinician and the suffering individual, Stanghellini (2013, p.340) should mention the anthropologist De Martino immediately after claiming that "the relationship

between interviewer and interviewee is a relationship of co-presence : a significant consequence of this is the reduction of the interviewer's power due to the transformation of his relationship with the other, from a subject-object relationship to a subject-subject partnership. In this context, interviewing means negotiating a cross-cultural construct, and seeking meaningfulness equals connecting two horizons of distant meanings."

There are few doubts regarding these settings of classical psychopathology, originally born in a European context and without pretensions in the cross-cultural context, and that they open an important path towards a culturally oriented reading of psychic suffering. Indeed, the phenomena are no longer mere data to be observed and described (as in the positivist and empiricist traditions that still play a large part in the approaches of dominant psychiatry, in particular the North American one). On the contrary, the psychopathological phenomena have to do with a construction of meaning within a relationship, and it expresses the whole world (not only personal, but also social and cultural) of both parties of the relationship, the clinician and the "patient". However, it is one thing to enunciate the importance of what has just been said, and another to have credible models even from the scientific point of view of how "nature" and "culture" intertwine in co-construction, in the clinical encounter, of psychopathological phenomena. For example, Berrios (2013, p.42) notes that everyone generally admits that culture is important for psychiatric symptoms, but then, "in the idea of the phenotype, when you ask what exactly the role of culture is in the formation of the phenotype, people start thinking about it and say, "Well, it's in the content of the symptoms. If you were to be Chinese or Peruvian you would have other objects of your hallucinations. "But that's all they admit. From their point of view the shape is absolutely universal. My point is that this is not enough; the question is "How deeply does culture shape mental symptoms?"".

It is therefore on this issue that is so important to us that the Cambridge school has focused, in an attempt to indicate how brain activity and semantic plan intersect in giving life to our clinical pictures. In this way, it continues the path already indicated by classical psychopathology. But while for Jaspers the two levels proceed in parallel (explanation and understanding both necessary but distinct), and while for many phenomenologists what matters is only the cultural level (Callieri used to start his relationship with the phrase "Man is both natural and cultural. I choose to deal with the first ", echoing in this the note that Binswanger made to Freud in their famous conversation), for the Cambridge school the two levels intersect in different ways according to the case. In other words, mental symptoms are formed (or, better, constructed) as a result of complex interactions between brain signals and "semantic" information, the proportion of which will vary from symptom to symptom (Berrios, 2014). In particular, this model suggests there are four "pathways" that can give rise to different types of mental symptoms and that can

account for their structural heterogeneity. Here we will focus on the path (a), which best of all illustrates the interrelation between the neurobiological and the semantic-cultural level. It concerns subjective experiences, the phenomenon par excellence of the study of psychopathology. Unlike other cases, in which brain activation directly corresponds to a behavioral effect, there are situations in which a specific brain activity does not produce a visible effect but rather a change in the flow of consciousness, or a subjective experience. The experiences in question can be communicated directly or it is necessary to elicit them, in both cases the subject reports them as something that takes place in his sphere of consciousness (in the first person, as we say today). Now, for the person to be able to talk about it, it is necessary before she identifies the experience she is experiencing. This requires the ability to identify, differentiate and name the experience in question. This is particularly evident in the case of experiences never tried before and, in some way, strange or ineffable, such as in the case of the mood that immediately precedes the onset of a delusional state (the so-called Wahnstimmung). Here the person has the feeling that something new happens, try something never tried before. At this stage Berrios (2013; 2014) speaks of a still undetermined experience which he calls "primordial soup". Initially the patient will be baffled by this experience (what is externally seen in mimicry as perplexity), then he will try to make sense of this experience, and to do this he will use the categories available to him. From this process will begin a first "getting into shape", a first interpretative "construction" of the experience, and this will inevitably be done by resorting to what the person has available, namely the categories of personal, family, social and cultural meaning , through which you can try to delimit and name your experience. This means that, for the same starting neuro-cerebral signal, the way in which the corresponding experience is put into shape to be communicable depends on multiple variables of meaning. It follows that different people with different personal characteristics, rather than different levels of education, rather than different cultural contexts of belonging, will be able to call the same basic experience differently. This is another possible way of conceptualizing the phenomenon of "idioms of distress" and the question of personal illness experience that medical anthropology deals with. In other words, that a given experience is expressed as depressed mood, a sense of fatigue, pain etc., can depend not only on the basic brain activity that triggers the experience, but also on those non-biological factors (personal and cultural) that configure the original signal giving rise to the final phenomenon. And at this point a further step takes place, because the person who talks about his psychopathological experiences speaks to a clinician who in turn has a series of categories of meaning available to frame what is said. It will be only at the end of this "negotiation of meaning" within the clinical meeting, that the psychopathological phenomenon will acquire its final definition, thus becoming "objective". Therefore, psychopathological phenomena are not

simply a ‘given’, but are the final product of a complex culturally contextualized hermeneutic co-construction process.

Conclusions

In this paper, a general theme was addressed which is the basis of the discussions on the subject of mediation in care settings: the question of how we understand the other person who is in front of us, which also implies that of how he sees us and how we self - we understand in our work, in a recursive process of progressive mutual tuning in which the mediator is inserted as a sometimes decisive element. Obviously not all the possible implications have been discussed, and we have chosen to focus on some points that in a context of care seemed to have the greatest need for conceptual clarification.

We started from the theme of possible misunderstandings in the clinical-patient relationship, highlighting the general elements that must be considered in every therapeutic relationship that takes place in intercultural contexts. The first thing dealt with was the difficulty of naming one's own subjective experiences, which made us immediately enter the general problem of understanding, which then in the second part deepened to the point of defining psychopathological phenomena as co-constructions of meaning. within the therapeutic relationship. We then went on to consider the possible linguistic misunderstandings, and here too it was highlighted how the difficulty does not consist only in not understanding a language, but in the variability of semantic references, i.e. the relationship between the word (the signifier) and the concept / concepts it designates (meaning). Then the "extra-linguistic" aspect of the symbols was discussed, that is, the fact that people can associate very different emotional reactions to the same word (we took the example of the word anemia, which in certain contexts becomes synonymous with very serious disease). Finally, the role of the more typically cultural factors has been highlighted which make even normally implicit communication aspects become ambiguous if in different contexts, for which it is necessary to make them explicit, and of the philosophical, religious, etc. orientations.

It is clear that for each of these points the role of the mediator cannot be limited to that of a simple translator. He must be able to make the different semantic nuance that hides behind the use of corresponding terms, help the person to fully express the meaning of his request for help, and help the clinician to understand it; it must also help the patient to understand what is happening and what the clinician is doing, and he must help the clinician to understand the sense of the patient's responses to his intervention, and so on in a recursion of levels and meanings that extends over the time of the interview.

As if this were not already complex enough, we also reviewed the specificities related to the particular psychopathological condition of the victims of torture and intentional violence, as well as those related to the type of setting that is used for therapy. It cannot be thought that the mediator must know the possible psychopathological reactions beforehand, even if a diffusion to all operators involved in the management of migrants of basic knowledge in this area is important for the prevention of secondary re-traumatization, and therefore should be encouraged. What is important, then, is not so much that the mediator is already prepared for these contents, but that in the setting there is always an open possibility of meta-communication to be able to talk about it and clarify it on specific points both in the contents and in the procedures adopted. In the psychopathological field, the mediator is an integral part of the therapy, and therefore must "move" relationally appropriately and consistent with the therapeutic objectives, and here it is the responsibility of the clinician to explain well to the mediator what can be expected in the meeting with the patient and what the mediator is expected to do or refrain from doing. Obviously, here too you cannot expect a training already completed on everything, but every meta-communication space is a good opportunity to do this training "live". Just to give an example, once a mediator tells me at the end of the session "Sorry, but do I have to translate even when the patient says bad words to you?" In certain contexts, mediation can mean bringing the parties closer together, so a mediator whose aim is to help the migrant person is likely to refrain from translating swear words if they are addressed to the commissioner who is examining his asylum request. But in psychopathology the thing is very different, and as a clinician I need to have information like this, because it says something about the relationship and it is on it that I have to work. The same goes for inconsistencies in narratives; what I expect is not that the mediator fills the holes of the narrative giving me a coherent story, I need more to know if the patient makes logical jumps, if the associative connections are in order, if between word, mimicry and emotions expressed there is or there is no congruity, etc. It is from these formal nuances that a good diagnostic and therapeutic orientation can often be made, and again it is the responsibility of the clinician to pass on the importance of this to the mediator.

Finally, a short note on the protection of the mediator. The patient is not only the victim and witness of the violence suffered. He is also a traumatizing agent, because in telling us what happened to him, he exposes us in turn to traumatic experiences that can generate suffering. If this applies to the clinician, it is all the more true for the mediator, both because he usually does not receive specific training on this, and because his personal life experience can resonate with what the patient tells, making him more vulnerable to possible psycho-traumatic effects. It is therefore particularly important to provide a space at the end of each session in which, once the patient is greeted, the other people who took part in the session can stop to discuss what

happened, giving sufficient time and space to the possibility of bringing out the emotional experiences. This too is prevention of post-traumatic reactions, and again if the responsibility for the process is primarily the clinician's, however, the mediator is an active and fundamental part of it.

In conclusion, we have also tried to show the practical aspects of the issue, but by placing everything within a more general discourse that allows us to make sense of the practical proposals. In the opinion of the writer, doing psychopathology in the field of migration is fundamental not because it opens the perspective to cultural issues, but because it allows us to see more clearly how our work is always intrinsically and fundamentally cultural, even with Western users. We can therefore conclude by saying that "personal, family and socio-cultural factors always cooperate in shaping the so-called" idioms of distress ". Some patients report their suffering in the most usual and "expected" symptomatic form in their socio-cultural context. Other patients may shape similar experiences in a more idiosyncratic way. In both cases, the same original experience is given a shape according to personal and cultural factors "(Aragona & Marková, 2015).

Bibliography

Achella S. (2004) Nota introduttiva. In: Jaspers K. Scritti psicopatologici. Guida, Napoli: 67-79.

American Psychiatric Association. (2013) Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Washington, DC: American Psychiatric Association.

Aragona M. (2009) Il mito dei fatti. Una introduzione alla filosofia della psicopatologia. Crossing Dialogues, Roma.

Aragona M. (2013) Empatia e psicopatologia: analisi storico-epistemologica del concetto di comprendere in Karl Jaspers. Journal of Psychopathology, 19: 14-20.

Aragona M, Catino E, Pucci D, Carrer S, Colosimo F, Lafuente M, Mazzetti M, Maisano B, Geraci S. (2010) The relationship between somatization and posttraumatic symptoms among immigrants receiving primary care services. Journal of Traumatic Stress, 23: 615-622.

Aragona M, Marková I. (2015) The hermeneutics of mental symptoms in the Cambridge School. Revista Latinoamericana de Psicopatologia Fundamental, 18: 599-618.

Aragona M, Pucci D, Mazzetti M, Geraci S. (2012b) Post-migration living difficulties as a significant risk factor for PTSD in immigrants: a primary care study. Italian Journal of Public Health, 9: 67-74.

Aragona M, Rovetta E, Pucci D, Spoto J, Villa AM. (2012a) Somatization in a primary care service for immigrants. Ethnicity & Health, 17: 477-91.

Berrios GE. (2013). Formation and meaning of mental symptoms: history and epistemology. Dialogues in Philosophy, Mental and Neuro Sciences, 6: 39-48.

Berrios GE. (2014) Per una nuova epistemologia della psichiatria. Fioriti Editore, Roma.

Caizzi C, Mazzetti M. (2014) L'esperienza di *Ferite Invisibili*. In: Aragona, Geraci S, Mazzetti M. (a cura di): Quando le ferite sono invisibili. Vittime di tortura e di violenza: strategie di cura. Pendragon, Bologna, 2014: 23-27.

Cantillo G. (2001) Introduzione a Jaspers. Laterza, Roma-Bari.

Colasanti R, Geraci S. (2000) I livelli di incomprensione tra medico e paziente migrante. In: **Geraci S.** (a cura di) Approcci transculturali per la promozione della salute. Edizioni Anterem, Roma: 213-220.

Diasio N. (2000) Differenze culturali e percezione di salute. In: Geraci S. (a cura di) Approcci transculturali per la promozione della salute. Edizioni Anterem, Roma:182-192.

Jaspers K. (1913/2004) Psicopatologia generale (prima edizione). In: Jaspers K. Scritti psicopatologici. Guida, Napoli: 81-126.

Jaspers K. (1959/1964) Psicopatologia generale, VII Edizione. Il Pensiero Scientifico Editore, Roma.

Mazzetti M. (2008) Trauma and migration. A transactional analytic approach towards refugees and torture victims. Transactional Analysis Journal, 38: 285-302.

Schweitzer RD, Brough M, Vromans L, Asic-Kobe M. (2011) Mental health of newly arrived Burmese refugees in Australia: contributions of pre-migration and post-migration experience. Australian and New Zealand Journal of Psychiatry, 45: 299-307.

Silove D, Sinnerbrink I, Field A, Manicavasagar V, Steel Z. (1997) Anxiety, depression and PTSD in asylum-seekers: Associations with pre-migration trauma and post-migration stressors. British Journal of Psychiatry, 170: 351-357.

Steel Z, Momartin S, Silove D, Coello M, Aroche J, Tay K.W. (2011) Two year psychosocial and mental health outcomes for refugees subjected to restrictive or supportive immigration policies. Society, Science and Medicine, 72: 1149-1156.

Stanghellini G. (2013) Philosophical resources for the psychiatric interview. In: Fulford KWM. (Ed). The Oxford handbook of philosophy and psychiatry. Oxford University Press, Oxford: 320-355.

Aragona M, Villarreal H. (2014) El concepto de "comprensión" (Verstehen) en Karl Jaspers. Vertex, 25: 262-265.

THE PSYCHCARE PROJECT: METHODOLOGY AND OUTCOME

PsychCare
PSYCHIATRIC SERVICES FOR REFUGEES

IPRS

THE PSYCHCARE PROJECT: METHODOLOGY AND OUTCOME

The guidelines for the integrated care of mental health of forced migrants contained in the second part of this publication have been developed within the PsychCare - Psychiatric Services for Refugees - project funded by the Open Society Foundations (OSF - www.opensocietyfoundations.org) among the activities of the Public Health Program. Over a two-year period (10th September 2018 – 09th September 2020), the project is carrying out a participatory advocacy action on the topic of protecting mental health of forced migrants, aiming to improve the ability on taking charge of services which have the objective of protecting the most vulnerable segments of the migrant population, specifically in four Italian regions - Lazio, Lombardy, Campania and Sicily. The four territories were chosen because they are particularly representative with respect to the presence of forced migrants, but also because they are characterized by significant variety with respect to the organization of the health service and the available territorial resources.

The psycho-social well-being of migrants and asylum seekers, protection matter, despite some virtuous experiences distributed throughout the national territory, has not received sufficient attention in Italy, especially in terms of planning social and health services. Various ministerial and regional guidelines have tried to give an impulse to the implementation of more adequate policies, but so far with unsatisfactory results.[44] On the other hand, specific health needs and clinical-therapeutic complexities make this population, although numerically contained, worthy of a particular focus.[45] It should also be noted that social workers, especially those from reception facilities, generally have a much less thorough knowledge of the territorial mental health services than they have of the other health services: there are still many uncertainties regarding their functioning and their purpose. This is not surprising, especially if one takes into-account the fact that the health reform law of 1978, has not yet found a full and homogeneous application in Italy.[46]

[44] On this issue, please refer to the contribution of G. Santone, Guidelines for the programming of assistance and rehabilitation interventions as well as for the treatment of mental disorders of the holders of international protection who have suffered torture, rape or other serious forms of psychological and physical violence or sexual: elaboration and transposition, pp. 49

[45] On the specificity of the mental health needs of forced migrants, see the contribution of M. Libertas and A. Petta, The asylum seekers and refugees mental health profile, pp. 9

[46] For a presentation of the Italian model of territorial psychiatry, see the contribution of G. Corrivetti, pp. 21

There is no doubt that to support the capacity of national reception system in order to operate effectively, in this field, it is necessary to promote cultural growth of the system as a premise for methodological and operational improvement. The Psychcare project intends to contribute by promoting a shared reflection on how to protect the psycho-social well-being of migrants and asylum seekers, especially those included in the reception system, and how to promote greater and punctual involvement of the National Health System in taking care of health in order to guarantee access to more suitable services, for all territories.

The Psychcare project advocacy action is divided into three distinct but synergistic lines of activity, all of which, necessary for the achievement of the comprehensive objective and therefore carried out simultaneously and functional to each other.

The advocacy action, starting point was the realization of a state of the art assessment with respect to the access of forced migrants to mental health services in four Italian regions, representative of the national panorama, in order to identify fragility, improper practices, system delays, cultural and other barriers, and possible responses at local and national level. The survey, the results of which are briefly presented in this chapter, was also aimed at identifying and enhancing effective, successful operating practices experimented in the examined territories.

During the information collection process, a raising activity of widespread awareness was launched, aimed at stimulating reflection and raising awareness towards the actors on the mental health issue of forced migrants. The project proceeded to create a community of variously interested people (health service operators, reception structures and social services, territorial representatives of the institutions ...), who participated directly or indirectly in all phases of the project, from the identification of critical issues on to identifying proposals and recommendations.

The third aspect on which the project intervened was the strengthening of networking between the various stakeholders (networking). At a local level, the project represented an opportunity to promote comparison between the different actors involved in various capacities in the reception and care of forced migrants, so to identify shared solutions and more suitable operational models. Meanwhile, direct and indirect contacts where facilitated together with a comparison between all people involved at national level, together through the sharing of a periodic newsletter containing updates on project activities and reports of relevant initiatives, events and publications. The proposed activities were, therefore, an opportunity to empower the services in the individual territories, to consolidate existing collaborations and create new opportunities. But right from the start the project set out to maintain a broader view in all its phases, so that the joint community work of stakeholders from the four regions, could produce useful indications for the improvement of the national system as a whole.

We also believe that this work's outcome can also be a useful contribution from a European perspective. Indeed, the very concept of international protection cannot fail to include adequate health protection, including mental health. For this reason, it would be desirable to define common guidelines and strategies at a European Community level to protect and promote the mental health of forced migrants at all stages of their journey in Europe, from arrival to their full integration into the host communities. The "vulnerability" and "specific needs" concepts, as formulated in the Directives relating to asylum procedures and reception conditions are obviously not sufficient to guarantee adequacy and uniformity in responding to the needs of forced migrants, with the risk of excluding from protection and integration paths for the people who most need protection.

The italian reception system

Italy has gained a long specific experience regarding the protection of forced migrants' mental health: despite the territorial fragmentation and the contradictions of the Italian asylum system, experiences, good practices and reflections shared by specialists and social workers represent a heritage to which the entire European Union can draw on, despite the national differences with respect to the organization of the reception system, welfare in general and the health service.

It should be emphasized that the first year of activity of the PsychCare Project coincided with a moment of profound transformation in the Italian reception system, following the entry into force of the security decree (then law 1 December 2018 / n. 132): asylum seekers they have been excluded from the SPRAR reception system, which were reserved for holders of international protection and unaccompanied foreign minors, moreover regulations relating to the issue of the residence permit for humanitarian protection have also been modified. Meanwhile, specifications relating to extraordinary reception centers (CAS) were revised, which to this day, welcome almost all asylum seekers, with a significant reduction of resources and the elimination of services for social inclusion and professional figures, including of the psychologist. The process of adjusting standards of first reception facilities with a view to building a single national reception system, which had been ongoing since 2014, was abruptly interrupted by the new measures, with an opposite sign. The effects of the new provisions began to be visible already in the first few months of year 2019: territorial networks were weakened and the number of migrants remained excluded from the reception and integration measures has grown, aggravating situations of vulnerability in the territories. The reflection prompted by the Psychcare project has been part of a debate that has been underway for some time and which has, to some extent, followed the entire evolution

of forced migrants' reception in Italy, which has always been characterized by inhomogeneity and contradictions[47].

Specifically, to the context, the definition of the role and responsibility of the reception system when the accepted people are carriers of mental suffering is a delicate matter. The reflection started within the SPRAR starting from 2008, which could be summarized in the principle of ensuring in such cases "dedicated and specific, but not separate paths" [48], gave some important method ideas[49], but also over time generated a partial misunderstanding with respect to the places or structures' functions which were dedicated to the reception of mentally ill forced migrants. The clear inadequacy to ensure appropriate reception conditions of the CAS, to the specific needs in this sense, the more marginal role of the Municipalities and the increasingly limited involvement of local health companies in the centers' management, have created the widespread feeling among the operators that there is the need to create "more places to transfer problematic people". Although this is not the spirit with which the SPRAR had addressed the issue, the fact that the SPRAR reception dedicated to people with specific vulnerabilities (such as people with disabilities or with physical and mental health problems) has always remained numerically

[47] The process started with the unified conference of 10th July 2014, which had sanctioned the agreement between various levels of national and local government for a progressive overcoming of the emergency logic which had until then, characterized the Italian reception system, through the integration of all types of centers in a single system, and was abruptly interrupted by measures of the opposite sign. Today the law also distinguishes rigidly between a "first reception" intended for asylum seekers, contracted out to private managers, characterized by minimum and even lower standards than previously envisaged in the CAS, and a "second reception", which corresponds to the SPRAR (today called SIPROIMI), reserved only for holders of international protection and unaccompanied foreign minors, which guarantees individualized and integrated paths of social inclusion, in explicit connection with public services. This transformation, which had already been anticipated by practice in many territories, creates the paradoxical effect of weakening and further impoverishing the type of reception. This affects the largest number of people during the period following their arrival in Italy, where it is crucial to ensure a high level of protection and specific attention to the emergence of any vulnerabilities. More over, the highest reception standards are reserved for a very small percentage of people, largely negating their effectiveness by giving them access after many months (if not even years) to stay in Italy for an extremely short period of time, conspicuously insufficient with respect to the declared purpose (six months).

[48] See A. Signorelli, "The public service at the reception service", by S. Farotti and M.S. Olivieri (edited by), *Refugee mental health: a new design for reception*, Central Service Notebooks, Central Service of the Protection System for asylum seekers and refugees, Rome 2011, p. 22.

[49] These generic principles formalized in year 2011, reiterate that integrated reception, according to a holistic and multidisciplinary approach, in case of people with mental discomfort, they must be strengthened "so that taking charge can be effectively global and not focused solely on health treatments". This must happen through "triangulation, that is to say a strong dialogue and collaboration between local authorities, public social and health services, entities managing the SPRAR territorial projects and all the other institutional and private social actors". The full local authority assumption of responsibility with regards to the reception and with respect to the individual person, who once exiting the reception project will likely continue to be "on site" and contacting local social and health services, as the rest of the resident citizenship ", plus a full collaboration of the local health companies, both for the direct management of the guests and for" the supervision of the reception project team "and the" cultural promotion "in the area: cf. S. Farotti and M.S. Olivieri (edited by), *Refugee mental health: a new design for hospitality*, cit., Pp. 73-74.

and geographically very limited, it made unsustainable, a full application of the indicated method. Today, in the light of the choice of not creating a single reception system, the issue of mental health of guests and operators of reception facilities arises with particular urgency.

The context's transformation, which has been outlined, made the change that the Psychcare project proposes to promote even more urgent and necessary: a first and foremost cultural transformation, which restores priority to the promotion of the mental health of migrants and social workers through a more correct responsibility recognition of all involved stakeholders.

The Psychcare project activities

The Psychcare project planning, chronologically distinguished three phases of activities which all had as their common denominator the tension factor, towards the search of a shared vision with regards to the protection of forced migrants' health and an agreement on the need for a shared reflection to move on the same direct action, in the following areas:

a) reconnaisance / assessment (September 2018-September 2019);
b) analysis and first drafting of the guidelines (September 2019-February 2020);
c) building consensus, strengthening territorial networks and validating the guidelines (February 2020-June 2020).

The methodology with best fit to the need, to simultaneously pursue the various objectives of the Psychcare project, was the participatory **research-action** (PAR Partecipatory Action Research), "A systematic investigation carried out in collaboration with those involved in a problem [...] for an action aimed at change"[50]. The group of stakeholders gradually identified therefore participated, in the manner described here, by identifying critical issues, in gathering useful information, reflecting and analyzing the collected elements to formulate suggestions for improvement. Furthermore, as part of the survey, the researchers had the opportunity to visit places and services and also to be active witnesses to some specific projects related to the mental health of forced migrants.

1. Reconnaissance / assessment

In the first phase of the project, a significant number of stakeholders were contacted and met in the four identified regions. The assessment activity had a twofold objective: on the one hand, to

[50] S. Tilakaratna, A Short Note on Participatory Research. Paper presented to a seminar of Sri Lankan social scientists and community specialists in January 1990.

capture the system fragility from a local and national perspective; on the other, to gather information regarding the territories' existing best practices, focusing on strengths and elements of replicability. The methodological approach chosen to carry out the survey was the **qualitative investigation**.

Listening directly to local actors involved in the reception and care of forced migrants has also enabled in some cases, to acquire some quantitative estimates of the need for care and the presence of migrants in the different types of service, which however have a purely indicative character, not being based on a systematic collection of consolidated data.

Having combined raising awareness and networking during the research, has allowed listening to a wide range of actors in different ways: psychiatrists, psychologists and social workers of local services, operators and psychologists of reception centers, operators and volunteers from third sector associations/organizations, active bodies involved in services to forced migrants, represented by local institutions.

Considering the time period in which the survey was carried out, as mentioned in the introduction, significant transformations of the investigation context took place, care was taken to maintain a good degree of flexibility in the survey, in order to intercept the elements at best of its transformation. It was seen as necessary, therefore, after a few months, to update the interview tracks used, nonetheless, above all, it was the involvement of the interviewees in the subsequent phases of the project, which allowed to maintain an open dialogue with some of them and to discuss some issues also after the first interview.

For the survey, of the qualitative survey, four typical tools were chosen:

- *Snowball sampling*. From the beginning, a sample of respondents was renounced, because belonging to a statistical validity, given that the limits of the intervention did not allow to proceed in this direction. Moreover, the qualitative nature of the survey rather suggested the adoption of a sampling strategy on a relational basis. We therefore opted for the snowball sampling technique: having identified a first group of people to interview, starting from the stakeholders who -in the four areas covered by the survey- were more experienced and active in relation to mental health issue of forced migrants, each was asked to indicate other people whom could be involved in the survey.
- *Systematic investigation.* In parallel, we proceeded to systematically contact the heads of Mental Health Departments of the analyzed territories, to integrate the point of view of the most sensitive and committed actors with a more representative perspective of the level of effective awareness of the services. *Semi-structured one2one interview,* when possible always on a *face2face* method, otherwise as phone

interview in the other cases. Qualitative interviews are, "extended" conversations between the researcher and the interviewee, during which the researcher tries to obtain the most detailed and in-depth possible information, on the research topic. Like the other qualitative techniques, the primary objective of the interview is to access the perspective of the interviewee, grasping his/her conceptual categories and his interpretations of reality. The semi-structured interview is led by the interviewer on the basis of a flexible and non-standardized questioning scheme and provides a track reporting the topics that must necessarily be addressed during the interview. Despite the common track, the conduct of the interview can vary based on the answers given by the interviewee and on the basis of the individual situation. The interviewer, in fact, cannot deal with issues not foreseen by the track but, unlike what happens in the structured interview, he/she can develop some topics that arise spontaneously during the interview if believes that these topics are useful for understanding the interviewee. In short, the trace of the semi-structured interview establishes a sort of perimeter within which the interviewee and the interviewer have freedom of movement allowing the latter to deal with all the necessary topics for cognitive purposes. The interview trace used as part of the Psychcare project survey, which in the case of telephone interviews was shared with the interviewees in advance of the appointment, is shown in the attachment (Annex No. 1).

- *Focus group.* This technique is a carefully planned discussion, to obtain information on a specific area of interest; it takes place as a group interview led by a moderator who, following a more or less structured track, offers the participants some inputs. Compared to the one2one interview, the focus group has the advantage of allowing interaction and comparison between different subjects, with the possibility of dynamically bringing out a critical review of the positions expressed by each, as well as bringing to light details and perspectives that a single interviewee could overlook. The moderator launches a discussion topic and waits for the response to be generated by the discussion group, following the interaction and dynamics that arise between the participants. In the survey carried out within the Psychcare project, this tool was particularly useful also for capturing the quality of the relationships existing between the territorial stakeholders and their degree of satisfaction with respect to each other's interactions. Each focus group lasted about 3 hours. The driving questions used by the facilitators were largely defined on the basis of the territorial data and the ideas collected through direct observation and individual interviews carried out previously, starting from an essential grid that we report in the attachment. As in the case of semi-

structured interviews, the grid used (Attachment 2) for focus groups with operators and in focus groups in which only migrants participated[51] , they are differentiated and in the second case it seemed appropriate to formalize some specific operational guidelines for the facilitators, in consideration of the delicacy of the covered topics together with the need to ensure full respect of the people involved.

From the following table it can be seen as a total of **251 people** were involved in various capacities in the survey. The total number of carried out individual interviews was 79, as face2face interviews and telephone interviews. The total number of participants in the focus groups was of 172 subjects. In each of the four regions, 2 to 4 focus groups were organized, facilitated by IPRS psychoanalysts and researchers.

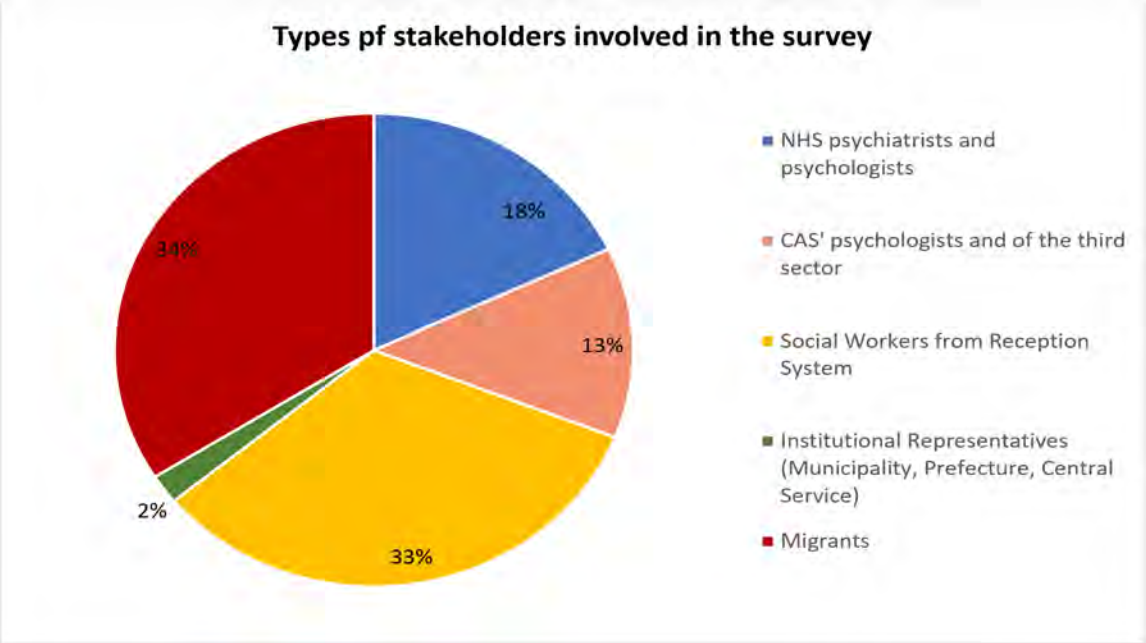
Territory	***one2one Interview***	**Focus group participants**	**Total**
Lazio	21	66	87
Lombardy	20	36	56
Campania	28	36	64
Sicily	10	34	44
Total	**79**	**172**	**251**

As regards to the **type of stakeholder** involved in the survey, a balance was thought between health service representatives, social workers and migrants. With regards to the latter, care was taken to include people of different nationalities and gender among the interviewees, at different stages of their migration path, using the most suitable and appropriate method and adapting, when necessary, the different tools. Particularly relevant and useful, for the recognition purpose, was the possibility of listening to migrants whom arrived in Italy since a certain number of years, and are now involved, as social workers or linguistic-cultural mediators, in the reception system and in local services aimed at forced migrants. The survey saw the direct involvement of a total of 86 migrants, between individual interviews and focus groups. In total, 5 focus groups involved exclusively migrants (1 in Lazio, 2 in Campania, 1 in Lombardy and 1 in Sicily).

[51] It is important to specify that some migrants have also been involved in the focus groups with the operators, as social operators or linguistic-cultural mediators.

Participants in the Psychcare survey:

- 76 health workers (44 psychiatrists and psychologists from the italian NHS and 32 psychologists from management bodies belonging to CAS and SPRAR / SIPROIMI reception centers and third sector organizations)
- 83 social workers involved in the reception system and other services for forced migrants
- 86 migrants
- 6 institutional representatives (Municipality, Prefecture, Central Service)



1.1 The survey results

The available collected informations and data, with respect to the content provided by the interviews, brought to a first indication of the context which was intended to be analyzed. As expected, the public services response was overall less prompt than the third sector operators. Part of this delay is due to the need for public service operators to obtain formal authorizations before being able to give interviews and another certainly to the overload of commitments that affects the operators because of the known scarcity of human resources. However, from the first contact phase, it emerged that not all public mental health services have the same level of involvement with respect to the specific matter: some are particularly active, others declare that they have no experience in this regard.

Because of a comparison which was activated between operators with different cultures and sensitivities, in order to define the guidelines, we based ourselves on the shared positions and on the points on which there was a broad agreement among the interviewees: as we will be able to underline further on, the discussion launched within the project activities made it clear how

complex it is to find solutions to some specific problems of taking charge, especially in a as is context perceived by many interviewees as less favorable than in the past.

The survey itself seemed having a general delay in offering an integrated response to the mental health needs of forced migrants in the various territories affected by the project activities, within the specificity of each context. This delay, attributable to a large extent to a general fatigue of mental health services and welfare measures, both of which are subject to significant downsizing over the years, of course does not exclude that in some specific contexts, positive and effective collaborations may occur, informal or formalized, between the different actors involved in the reception, protection and care of forced migrants. These synergies lead to satisfactory results especially with regards to early emergence and prevention and, to a more limited extent, on shared management between multiple actors of social-health integration paths. Unfortunately, the sustainability of these interventions is still entrusted to the possibility of obtaining targeted financing. In all the survey affected territories, a significant part of the positive experiences and practices can be traced back to specific projects financed with European resources (especially the Migration and Integration Asylum Fund and, before year 2014, the European Refugee Fund), which involved public and private social bodies in experimental interventions for taking charge of applicants and holders of international protection in conditions of vulnerability. These projects have represented and continue to represent important opportunities, above all to draw on additional resources and to consolidate collaborations between territorial actors: on the other hand, however, the interventions are temporary and there is a difficulty in giving continuity in the ordinary programming intervention which have proven themselves, also in the light of long-term experiments, valid and even necessary to ensure the service (think for example of linguistic-cultural mediation).

The main critical issues, related to taking care of forced migrants mental health needs, emerged from the survey conducted by the Psychcare project, which are summarized in the following paragraphs according to an organization that distinguishes different areas of complexity, with the awareness that this is a classification affected by some approximations and the transversal nature of certain aspects typical of taking charge (eg the cultural appropriateness of the interventions).

Difficulties related to early emergence and prevention

The respondents agree on the fact that forced migrants mental health needs, emerge mainly in the form of acute situations. Against an extremely limited attendance of territorial mental health services by forced migrants (and, in some territories, by migrants in general), requests for TSO (Mandatory medical treatment) or hospitalization in SPDC (Psychiatric Service for diagnosis and treatment) for forced migrants who manifest crises of various kinds.

This phenomenon has been enhanced by the transformation of the reception system: the concentration of forced migrants in large structures, with an increasingly reduced availability of qualified operators, actually hinders the implementation of strategies for the early emergence of discomfort and prevention measures, which have also proved, and are still effective, where the reception has been able to maintain higher standards.

The negative impact of the changes that took place with the entry into force of the security decree (later Law 1 December 2018 / n.132) on the organization of the reception system and on the quality of the interaction of the managing bodies, appeared evident on all the territories with the various territorial services, including mental health services, to the point that a future partial revision of adopted measures is not excluded: the new specifications given to the CAS management, which despite the name, now become the centers for ordinary reception of asylum seekers, are particularly inadequate compared to the financial endowment of the type of services provided, although reduced to the essential ones. Even where a good level of collaboration and connection between the territorial mental health services and the CAS, such as in the case of Lombardy region, was established, today this collaboration is by far less easy, due to the fact that the reception facility teams have eliminated the psychologist figure, together with an overall reduction of resources. Furthermore, following the introduction of the new specifications, many managing bodies have chosen not to continue to manage CAS: this has led to the closure of many centers and the sudden redistribution of migrants in the area (in Sicily even from one province to another), with the consequent interruption of any path previously started.

Some psychologists and psychiatrists have also reported that part of the crises for which the operators of the reception centers ask for intervention, are in fact attributable to misunderstandings and conflicts, both between guests and operators and among guests of the same structure. In a context of tension, with a reduced availability of linguistic-cultural mediators, the possibilities of improperly considering pathological behaviors related to reactions of anger, pain, anxiety or frustration, are bound to increase. On the other hand, there is the risk of not detecting uncomfortable symptoms potentially as much if not more worrying, such as isolation and loss of interest in any activity, because, especially in a large structure, they go unnoticed.

More frequently than in the past, sending psychiatric and / or psychological insights to people with evident ailments, happens on the initiative of the Territorial Commissions for the recognition of international protection. On the one hand, this element testifies to an increased sensitivity of the Commissions; on the other hand, however, it is an additional element that returns a poor ability to bring out the vulnerability of asylum seekers early.

Inhomogeneity of responses from the services

Apart from some specific services that over the years have consolidated a specific competence in the mental health care of forced migrants, by virtue of clinical experiences gained over the years, through the constructive collaboration of different actors followed by constant reflection and study, there is still a widespread difficulty to provide adequate responses to the health needs of this specific target. Above all, the lack of work training with patients from other cultures, seems to lead to diagnostic and therapeutic errors, with a high risk of exacerbation and / or chronicization of pathologies.

For example, in Rome, as also revealed by the recent "Survey on the health and mental health needs of refugees and asylum seekers guests of the reception centers in the territory of Rome" (published in year 2019), on the capital area, the dedicated structures (both public and private) give adequate answers not only in terms of specific competence, but also in terms of promptness of taking charge, coordination with the reception structures, welcoming and empathetic staff, trained both with respect to transcultural psychopathology and with respect to the therapies of the traumatized , availability of cultural mediators. By contrast, general mental health services (CSM and SPDC) appear on average less adequate in all these respects.

In territories where mental health services record a particularly significant shortage of resources, such as Sicily and Campania regions[52], even when access to mental health services takes place, more than a few sporadic encounters cannot be ensured, there is no real responsibility for the user. This situation also applies to Italian citizens, even if migrants - like other fragile sections of the population - suffer it with even greater drama.

A complex and dynamic need for health

To a general difficulty of social and health integration and interventions, that are found to varying degrees on all territories, in the case of forced migrants, specific and complex elements of critical issues are also added. Reception service operators report a significant change in the mental health needs of the accepted migrants, partly linked to the lowering of the average age of the guests and the different migratory experience lived, both in transit countries and in Italy. In recent years, adults prevailed, who in some cases were carriers of serious and full-blown pathologies. Now instead the centers, especially in Sicily, mainly welcome new adults and very young people. In this case, the discomfort they manifest takes on typical forms of their age: the need to transgress, to experience the limit, use of substances and alcohol, behavior at risk in general. The recurring

[52] If on a national scale the percentage of use of resources on mental health is around 7%, in Naples this stands between 3 and 4%.

theme is addictions, even from social media, in some cases with a total subversion of the day-night cycle.

Generally speaking, the frequency of the so-called “double diagnosis” (addiction to alcohol, drugs or games associated with psychiatric symptoms) is recorded for forced migrants. In addition to the ordinary complexities of diagnosis in these cases, there is the additional difficulty of correctly assessing the patient's symptomatology in the specific cultural frame of reference. The SERTs (Addiction services) in many territories, find difficult to work effectively with people of foreign origin and, more generally, in how the service is structured, they have to deal effectively with physical dependence on heavy drugs: the psychological support pathways are very fragile and the staff, which is, again, reduced to a minimum, cannot imagine adequate answers to a different scenario.

Another element that has recurrently emerged, is what some interviewees have defined as "institutional re-traumatization" or "document disorder". In some cases, the unreasonable length of the procedures and the absolute lack of control over one's life induce processes that can become properly pathological. The elimination of the residence permit for humanitarian reasons had a particularly evident impact in Sicily, due to the concentration of new adults who owned it. The general climate and greater precariousness led in many circumstances, to the reactivation of post-traumatic symptoms and aroused concern, panic and sometimes real escapes, with the abandonment of integration paths and therapeutic paths that were proving to be effective.

Increased social fragility of forced migrants

The forced migrants’ social fragility, whom in most cases are deprived of means of subsistence, starting from home, and even without family and friends networks, makes the taking care of themselves particularly difficult, at the time of discharge of patients for whom hospitalization in SPDC had to be resorted to and it hinders the psycho-socio-rehabilitation pathways.

An additional difficulty is to be considered, relating to migrants in conditions of extreme social marginality since they have escaped, due to psychiatric pathology, from the reception system. The group includes people in whom the disease develops (or becomes slatent) because of the marginality in which they live and the repeated failures of any migration project. The recent regulatory changes have further accentuated this criticality, as there has been a massive leak of migrants, in many territories, registered from the reception system, people with no resources to manage their lives independently and in many cases even in conditions of irregular stay, subsequently refusal of international protection or because of the inability to convert the residence permit for humanitarian reasons. These migrants are particularly vulnerable due to the progressive precariousness of their existence after a long period that has seen them waiting to

know the outcome of their asylum request, because they are exposed to a frail process with the risk of psychological distress emerging as important. In these cases, the system's ability to intercept and intervene is particularly limited and unsatisfactory.

The social vulnerability of migrants in the area is evident because increased. As an example, from the activity of the street unit of the Municipality of Mantua city, among the homeless there is a proportion of 60% Italians and 40% foreigners, but it must be considered that foreigners represent just 14.1% of the resident population. The most serious cases of marginalization, often associated with problems of alcoholism and other addictions, depression and diagnosis of schizophrenia, are 85% of foreigners present for some time in the territory, who fell into a spiral of social exclusion after the dismantling of the reception system of the North Africa extraordinary emergency. Same stands for Rome, the estimate of the Social Operating Room of the capital, with respect to the incidence of foreign citizens among the homeless (about 70-80%) confirms this scenario.

2. Analysis and guidelines' first drafting

At the end of the first year of project activity, the emerged results were presented and discussed with a representative of the local stakeholders in a seminar held in Rome on 10th September 2019. After an initial analysis of what emerged during the assessment phase, we proceeded to group the results in three critical areas, in order to deepen the discussion and identify possible improvement strategies:

1. **Access** to mental health services
2. **Adequacy** of mental health services
3. The contribution of the **reception** system.

Three working documents were prepared, one for each of the identified critical areas, with a first proposal of guidelines which served as a starting point for a further and more targeted discussion with local stakeholders belonging to each territory.

The criteria adopted for drawing up the guidelines were the following:

- Do not subdivide the guidelines for professional areas (health, social), but rather formulate useful proposals for the system as a whole. This choice arose from the fact that we found a certain homogeneity in the detection of critical issues by all the stakeholders involved and an explicit consensus on the need to further promote interaction and synergy between different subjects.
- Try to work, articulating by areas, on the definition of the specific responsibilities of the actors involved: the indispensable prerequisite is access to services, to which all actors

must contribute, each with regard to their own competences; the second area, related to the adequacy of mental health services, affects directly the health system; the third area concerns more precisely the reception system organization.

- The issue of how to adequately reach forced migrants who have left the reception system remains largely open. In this area, even more than in others, it is clear that the issue of forced migrants is only a subset of the broader issue, which is, whether territorial services are able to enter into a relationship with those who live in conditions of extreme marginality and how this is accomplished.

3. Consensus building, strengthening of territorial networks and validation of guidelines

In the second phase of the Psychcare project, four multi-actor working tables were set up, one for each of the regions in which the project activities took place. Each of them was composed of about 15-20 participants, all representatives of the main stakeholders involved in the support services to forced migrants: Mental Health Departments and other services of the Health System, Prefectures and Local Authorities, organizations managing the reception services CAS and SPRAR/SIPROIMI, protection entities and other significant civil society organizations.

The working tables met between February and May 2020 with the aim of deepening the reflection starting from three working documents drawn up by the project team, which then brought together comments, corrections and additions as far as possible in the final draft of the guidelines, contained in the second part of this publication. The programming of the tables was partially interrupted by the health emergency and the consequent measures adopted throughout the country following the spread of the Covid-19 virus. The exchange and comparison work, already started in the territories, however continued through email exchanges between the participants. On most of the points dealt with, we received a broad consensus of the participants of the working tables, still recording the fact that on some aspects the discussion was animated and did not lead always to unequivocal conclusions.

Given, that some services have gained specific expertise in transcultural psychiatry and therefore it is appropriate they should become references for territorial services which have less experience, though there is no full agreement on the form this support should more appropriately take. Can you think of remote consultations? Is it desirable for each service to have a figure with specific

skills[53]? Is it better to think of other forms of networking, such as supervision, periodic training, coaching?

Similar questions arise with regards to cultural linguistic mediation topic. In the face of a broad consensus regarding the need for a less episodic involvement of the mediator and an effective investment in the professionalism of the people involved (which requires continuity in the resources used and less precariousness in the collaborations that are established), the organizational criticality is a given by the fact that forced migrations are by their very nature unpredictable therefore the linguistic and cultural skills required in the territories, can be different and vary with relative rapidity.

Finally, different positions and perceptions emerged regarding the use of drugs in therapy and the possible side effects they may have on this specific type of patient. Beyond specific assessments regarding the adequacy of treatment in some individual cases, it can certainly be said that cases of misdiagnosis are frequent in the treatment of forced migrants, plus the lack of work training released with patients coming from other cultures, combined with many elements which make compliance particularly complex, all of these elements can certainly lead to diagnostic and therapeutic errors.

Finally, the debate, underlying many of the comparisons and on several occasions made explicit, on what role psychiatry should take with respect to those that are configured as real social emergencies: on one hand, many specialists fear an excessive medicalization of the discomfort, imagining that we can end up attributing an improper, if not instrumental, value to social control to the therapeutic action. On the other hand, however, the correlation between marginality and mental health is very evident, especially in the case of forced migrants, subjects exposed repeatedly to trauma and extreme violence, social intervention in many cases needs to be supplemented by specific support related to mental health, under penalty of failure of the proposed routes. On the other hand, a reflection on the organization of social services intended specifically for forced migrants, starting from the reception system, could contribute significantly to that action to raise awareness and promote mental health which, although not the exclusive responsibility of the health system, however, is an integral part of care in a broad sense. The need for greater integration between health and social dimension is already recognized and formalized in some areas of intervention (for example, within the disability) and in various Italian regions the health budget financial tool, is being tested as an opportunity for the co-planning of individualized

[53] There is no full agreement among the specialists on what these specific skills should be, but it is a widely shared opinion that rather than a proper ethno-psychiatric approach, a cross-cultural clinical model is useful, which shall focus on communication and interaction between the patient's culture of origin and of the host country.

paths between health services and social services. An taking charge of forced migrants must certainly go in this direction.

The guidelines' version, contained in this publication can only give limited account to the richness of the discussion and should therefore not be understood as the conclusion of a path, but rather as a contribution and a drive to carry on, with other actors and in other territories. As stated in the introduction, the Psychcare project main goal is to achieve, at regional level, an increasingly broad consensus on service models concerning the protection of of migrants' health, and in particular mental health, which meet shared quality standards and are culturally appropriate; at national level the project aims to produce useful indications for improvement of the overall system; at European level, to offer a contribution to reflection on the main theme, starting from the specific Italian experience in the matter.

Annex 1

Trace of the semi-structured interviews, distinguished between which were addressed to operators and the ones relating to the interview with migrants.

Trace of Operator's interview

1. Can you briefly describe what your working experience is with migrants and in particular with forced migrants?
2. How many migrants do you meet during your working activity in a year (approximately)? How do they get to you in requesting this service?
3. Do you have collaboration agreements in this sense with the CAS or other reception facilities for asylum seekers and refugees?
4. How do you assess the adequacy of the Public Mental Health Service, for migrants as a whole? Is it accessible? In your opinion, which are the main problems that a migrant encounters on accessing mental health services?
5. What kind of collaboration exists between public and private social interventions on your territory?
6. Which sufferings, pathologies, major traumas are most found in patients?
7. What is your experience (if any) regarding drug therapies for migrant patients?
8. In your experience, is the addiction a relevant issue, in the treatment of migrant patients? Are the answers available and adequate?
9. In your experience, are there many acute cases in your area? How are they commonly addressed?
10. In your opinion, which are the most important critical issues on working with forced migrants (clinical, bureaucratic, linguistic, cultural…)? Have they changed over time?
11. In particular, did you find any differences after the regulatory changes introduced by the Safety Decree came into force (Legislative Decree no. 113. of 24/09/2018, then converted with amendments by Law 1 December 2018, no. 132)?
12. From your point of view, how could you improve mental health promotion service for forced migrants? Which changes should urgently be introduced?
13. Are you aware of good practices with regards to promoting the mental health of forced migrants that are carried out on your territory?
14. Our institute publishes a newsletter with updates and news about the PsychCare project, would you be interested in receiving it?
15. Would you like to add something?

Trace of interview with migrant

This trace is intended as indicative. The order of the questions can be rearranged according to the direction of the conversation. Precede the questions with a brief presentation of the purpose of the project to the interviewer together with presentation of the interviewed.

1. When did you arrive in Italy? Have you been / are you a guest in a reception facility?
2. Think back to the moment you arrived in Italy and the first period you spent in this country. Which were the biggest difficulties you encountered? Do you remember particular difficult moments? What or who helped you in those moments?
3. What do you like the most about life in Italy today? Is there something you enjoy doing, that makes you feel good?
4. Have you had life experiences in other Italian / European cities? In what ways was life better or worse there?
5. Do you know or have you met (in the reception centers, in the services you attended, etc ...) someone who had particular difficulties such as nightmares, insomnia, various crises? Did you find enough help? What kind of help? From whom? (in the case of operators / mediators with experience, you can try to deepen the discussion on the changes that have occurred in Italy over time and on the most recent evolutions of the context in which they live and operate)
6. Do you know or have you met (in the reception centers, in the services you attended, etc ...) someone who in Italy has started making excessive use of alcohol or drugs? Did you find sufficient help in your experience? What kind of help? From whom? (for operators / mediators see above)
7. Would you like to add something?

Annex 2

Trace of the questions used to conduct focus groups

Trace of focus groups with local operators

1. What kind of collaboration exists between the main (present) stakeholders?
2. In general, what is the impression you have regarding the mental health issue of migrants? Are there any particular acute cases, do you see an increase in specific pathologies etc?
3. Which impact did the Safety Decree have on the CAS, the ASP work, and the relationship between the parties with regards to the service rendered to patients (asylum seekers, refugees)? Are there any additional critical issues?
4. Given the state of the art, what should be improved? Which adaptations are needed?
5. How could these changes be made? Can we think of new protocols, or new forms of territorial collaboration? Which ones?

Trace of focus group with migrants

Suggestions for the facilitator

The interview guideline is evidently only indicative. Before starting (preferably in advance), it is important to know something about the participants profile: how long they have been in Italy, if they have been working (and in particular if they have been working in the reception, mediation system, etc.), with which language are they more comfortable. If the language used is Italian, take care to use short and well-defined sentences, avoiding too technical terms, without however taking an attitude of condescension. In short, speaking as we would, to a native English-speaking colleague speaking at a business meeting: not too quickly, without eating words.

1. The questions' order can be rearranged according to the direction of the conversation. It may be useful to stimulate all participants to act, but not concerning the question itself. 2: the sharing of personal experience, especially if problematic and potentially painful, must only be spontaneous.

The specific issue of mental health services should only be addressed explicitly if raised by the participants themselves. For example, if someone mentions among the things that have been useful to him/her for psychological interviews or drug therapies, at that point it is useful to ask for more information on how to access the service, on the duration and continuity of the therapy, on the language used, etc. But always without being too insistent. You may possibly reserve the right to deepen briefly with a private interview with the person, for greater confidentiality.

1. Presentation of those who conduct the focus and purpose of the meeting. Be careful not to generate unrealistic expectations. Explain that we are having this conversation to better understand the situation, do not emphasize the potential for change.
2. Think back on your arrival in Italy and the first period you spent in this country. Which were the biggest difficulties you encountered? Do you remember particular difficult moments? What or who helped you in those moments?
3. What do you like the most about life in Italy today? Is there anything you enjoy doing, that makes you feel good?
4. Do you know or have you met (in the reception centers, in the services you attended, etc ...) someone who had particular difficulties such as nightmares, insomnia, various crises? Did you find sufficient help in your experience? What kind of help? From whom?
5. Do you know or have you met (in the reception centers, in the services you attended, etc ...) someone who may started to make excessive use of alcohol or drugs since arrived here in Italy? Did you find sufficient help in your experience? What kind of help? From whom?

GUIDELINES

Access to Mental Health Services

PsychCare

PSYCHIATRIC SERVICES FOR REFUGEES

IPRS

Premises

Forced migrants are known to have different and specific care needs compared to the migrant population in general, due to the particularly traumatic experiences lived in the country of origin and in the countries of transit, but also for the living conditions they have to face after their arrival. In many respects, even with a view to protecting public health, through procedures that allow rapid activation of health services (in the phases immediately following arrival), early and systematic action is taken to identify and take care of possible diseases. In case of need, the first reception facilities take care of activating care paths for their guests in collaboration with the NHS. Similar attention, however, is not foreseen in the case of psychic suffering, which sees involved a very significant share of forced migrants. At national level, the Ministry of Health's guidelines, have been published for the planning of assistance and rehabilitation interventions as well as for treatment of mental disorders of the refugees and holders of subsidiary protection status who have suffered torture, rape or other forms of serious psychological, physical or sexual violence (22 March 2017). These Guidelines focus on the early identification of pre-migratory trauma (torture or extreme violence), which represent the outcomes in the phase immediately following the arrival, but even if these guidelines exist, they are largely not yet applied, also due to the current reorganization of the hospitality. Instead, the procedures provided for the long-term protection of psycho-social well-being, an indispensable prerequisite for any integration process, are not so precisely defined. The living conditions of forced migrants in Italy are in fact characterized by a sum of elements of fragility which are not only risk factors for mental health, but also represent strong elements of exclusion from the care systems. These are people who live in a condition of deep solitude characterized by distance from the family and with poor social relationships: they can therefore count on a very fragile support network, heavily dependent on services that ensure interventions which can hardly guarantee effective taking charge continuity. They are often welcomed into collective structures, which do not ensure an adequate level of privacy and do not even offer opportunities for real socialization. When they can't receive usual reception measures, they face serious forms of housing insecurity. They miss a solid working plan and in most cases they struggle to imagine their future, also due to the uncertainty deriving from the outcome of their application for international protection.

There are several reasons for mental health services not being so accessible, for forced migrants, than other health services. First, there is a greater difficulty, both on the part of the migrant and on the part of those who are responsible for taking care of him/her, to recognize the need for treatment in case of psychological suffering, unless it occurs in a particularly acute form. Self-diagnosis ability is generally lower, due to the lack of cultural tools for reading one's own

discomfort and a widespread prejudice that still drives mental health in many countries of the world.

Psychiatric care system knowledge, is much less widespread. From what emerged from the survey carried out during the Psychcare project, the intermediation of the general practitioner, when present, in most cases is not effective and is not always known to immigration service operators where to direct migrants who need assistance in this area. This means that forced migrants are often given access to territorial mental health services through emergency intervention following a failure: this emergency method consistently reduces the possibility of initiating adequate therapeutic courses.

There are also barriers to access the poor permeability of territorial services that are often overloaded, also intimidated by the difficulties which arise in the therapeutic relationship with a patient whose language and culture are unknown. There are often forms of discrimination manifested as objections of a bureaucratic nature or relating to the insufficiency or lack of specific skills of the existing services.

The organization of the first reception system has, so far, not substantially contributed on facilitating treatment courses. The managing bodies of the Extraordinary Reception Centers (CAS-Italian Acronymum), are extremely diversified in type and experience, they are not required to build an intervention network in the belonging area, on which their presence is sometimes limited to the mere provision of the basic service. Even when the role of the psychologist was in the team, its function was not clearly defined, neither within the center, nor in relation to the territorial mental health services. However, the presence of the psychologist contributes by ensuring a more careful and complete assessment of patients' needs and in many cases is a significant element for creating continuity of psycho-social management: it facilitates the reporting to the services of the most problematic cases and supports the center's team, in the internal management, of the psychological and relational dynamics between users. Unfortunately, in the most recent specifications, this profile is no longer envisaged in the CAS. Finally, it has never been clarified whether and how therapeutic responsibility should be shared between territorial services and reception operators. Access to mental health services is usually mediated by the family: in the case of forced migrants, this intermediation is completely missing and should in some way be supplied by the operators of the reception facilities or, in the case of people who do not use this measure, by service operators working on social marginality. In both cases, as for today, the interaction with territorial mental health services is not overall satisfactory or constructive.

Critical issues

- Lack of knowledge of mental health services by migrants and social workers and widespread prejudices in this regard;
- Resistance to access by the services: discrimination, real or alleged lack of access requirements, poorly transparent procedures;
- Language and cultural barriers;
- Lack of intermediation and facilitation between migrant and territorial care services;
- Increasing number of people excluded from the reception system who are not service oriented.

Guidelines

The loss of psycho-social well-being brings to the failure of migration project and integration processes of forced migrants. With a view to protecting health and preventing psychic suffering, while respecting the dignity and rights of the people involved, but also with the objective of reducing the possible associated social risks, a greater awareness of all the actors is necessary with respect to the their role and responsibility in this regard.

In particular:

- The reception facilities management organizations are responsible for establishing stable working practices with the territorial mental health services and, in collaboration with them, to ensure awareness of guests in the structures with respect to the protection of mental health. In the most appropriate forms, to promote the prevention of hardship and ensure interventions which allow migrants to recognize their suffering and communicate it in the most appropriate and consistent forms with respect to their culture of origin and sensitivity.
- The Prefectures are responsible for verifying that all the entities managing the reception services have established working practices, possibly formalized, with the territorial mental health services.
- The territorial health agencies are responsible for actively monitoring the adequacy of reception structures that insist on the territory with respect to promoting mental health of the received migrants and the operators involved, as well as activating the most appropriate interventions to raise awareness and train the structures' staff on the matter. Companies are also responsible for taking action by facilitating orientation and effective access to migrant services, even for those who do not use the reception

measures, who are equally present in various capacities in the area of competence, in collaboration with territorial social services.

Some indications for organization of services

- Provide stable economic resources for cultural mediation at the main access points of local health services (ASL, CSM, hospital facilities).
- Plan regular professional updating of front office operators with respect to the legal status of applicants and holders of international protection and their ownership of access to services.
- Making MHCs (CSM Italian Acronymum) more accessible to this type of user by adding post traumatic and dissociative disorders to "serious mental disorders", as priority areas for MHCs.
- Promote information and awareness-raising initiatives for potential users with respect to mental health services through group activities, laboratories, initiatives at reception facilities or at local services.
- Construction of solid working practices between territorial mental health services and potential "intermediaries" (reception structures' operators or services that deal with social marginality). Enter into formalized agreements between health institutions, local authorities, prefectures, managing bodies of reception centers and territorial social services to regulate mutual sending, the design of integrated socio-health paths.
- Organization of open clinics access, mobile units and other outreach activities relevant to specific territorial contexts.

GUIDELINES

Adequacy of mental health services

PsychCare

PSYCHIATRIC SERVICES FOR REFUGEES

IPRS

Premises

The territorial dimension of psychiatry implies effective networking, in which there are many places of treatment and must actually be in contact with each other in order to ensure integrated therapeutic paths. In the case of the autochthonous population, the connecting task of care actions and the places where they occur usually falls on the patient's family. In the case of migrants, and especially forced migrants, there is no one who can operate this type of connection: for this reason, in the absence of a solid and effective network, the paths are easily interrupted and the taking in charge, is lost, or does not take place at all. It is essential to strengthen the network in order for psychiatry to truly operate in an integrated way with social services, avoiding any opposition between the social and health dimension. If this does not happen, in fact, both the social integration processes of migrants and the care paths are destined to fail.

Socio-health integration in Italy has not been fully and homogeneously implemented on the national territory: the territorial psychiatric services have been poorly developed and financed insufficiently and in many territories, the available resources are not adequate to ensure socio-sustainable and accessible healthcare for all patients who need it. There is a chronic difficulty in working in a network with other territorial actors (public and voluntary). Frequent difficulties are encountered in working in a network with other territorial actors (public and voluntary). In addition, forced migrants in most cases use public reception services. The organization of these services in the last twenty years, without prejudice to some positive experiences of widespread reception and correctly integrated into territorial governance, has never been able to completely overcome an emergency logic. The most recent regulatory changes have further accentuated the situation, providing that all asylum seekers are welcomed in the Extraordinary Reception Centers (CAS), structures that in many cases are completely decentralized with respect to the logic of the services and provide standards of taking charge extremely low. Even in the case of the structures of the SIPROIMI system, which in any case today welcome a very small percentage of the forced migrants present in our country, collaborations with mental health services are not always structured and formalized.

The more psychiatry loses its territorial dimension, the more places assigned to treatment and therapeutic intervention become medicalized, with a twofold risk: seeking health responses to social distress and speculating, of not being able to activate effective cure. Most forced migrants come into contact with mental health services for the first time through hospitalization motivated by an acute crisis. There is a widespread difficulty in starting early taking in charge, but also in relocating the patient out of SPDC (psychiatric service diagnosis and treatment center) and to guarantee not only a reception place, but also post-acute care. This emergency and ineffective approach contributes on raising the risk of chronicization of migrants' psychological distress, with

important repercussions on the territories, both from a social and an economic point of view. In the absence of an intervention network, the work of the psychiatric services is tiring and fragmented.

Although the ability of health workers to intercept and assist immigrant patients has strengthened in recent years, also through specific training courses, this increase in skills has not yet spread sufficiently across all territories. The chronic shortage of staff certainly does not contribute to the quality of the service. It is often preferred to refer migrants to the few specialized services that have gained specific experience. However, this method of operating can lead to a removal of the place of care from the patient's habitual context of life, which in fact makes that proximity that is always recommended in the treatment path impossible.

Taking charge of forced migrants in mental health involves some clinical complexities that deserve proper consideration. In the case of forced migrant patients, for example, it is often difficult to reconstruct the clinical history, because it is inextricably connected to a very articulated life history and characterized by instability and precariousness. The language barrier represents a difficulty: it should however not be reduced to a mere technical question, which can be solved with on-call interpreting services. The use of cultural mediation services, still requires reflection on the role of the cultural mediator in a therapeutic setting and adequate training and supervision of the figures employed, when available. It would also be necessary to reflect on the methods, context and timing of communication with migrant patients and with all the actors involved in the process of taking charge: the poor care of these aspects can have a decisive influence on the effectiveness of the therapeutic path.

Finally, there is the problem of compliance, which is even more uncertain and incomplete during the social take-over, in the absence of precise coordination. This uncertain situation can generate a tendency to use, at a greater extent, long-acting antipsychotic therapies, than strictly necessary, or even lead to a risk of drug overdose.

Critical issues

- Poor integration between psychiatric and social services, self-referencing of services.
- Poor aptitude on reading emerging needs and reprogramming services.
- Difficulty in reconciling any sending to specialized services with the proximity dimension necessary for the treatment path.
- Insufficient availability and adequacy of cultural mediation service.
- Risk of diagnostic errors and consequent inadequate therapies.

Guidelines

In order to effectively make the care system, available in people's places of life -especially in consideration of the fact that an increasing number of migrant, who have a form of full-blown psychic discomfort, have left or will soon leave the reception system- there is an urgent need to intervene to consolidate existing networks and improve intervention quality, of all the territorial actors.

In particular:

- It is the ministries responsibility, which are directly involved (Internal, Health, Social Policies), to facilitate and enable formalized agreements between health institutions, local bodies and entities, managing reception facilities and territorial social services, including those operating in the extreme marginality of fields. It is their responsibility to regulate mutual dispatch, care for design of integrated socio-health paths and mutual updating in order to face the social, health and legal problems relating to forced migrants as a whole, with an integrated approach.
- It is up to the Regions to solicit, again through specific guidelines, mental health services and reference healthcare Agencies, in order to change the structure of their services, strengthening them if necessary, offer adequate responses to the treatment needs of forced migrants. In view of the fact that the presence and needs of this population are subject to relatively rapid and not fully foreseeable changes, it is necessary that policy work, is constant and supported by adequate monitoring.
- It is Healthcare Agencies' responsibility to take note of the need not only to strengthen but also to reprogram mental health services in the light of the most significant social transformations, including those connected with migratory phenomena. Taking note of the need not only to strengthen but also to reprogram mental health services in the light of the most significant social transformations, including those connected with migratory phenomena.

Some indications for the organization of services

- Proactively promote the creation of protocols between relevant territorial actors, including public and private, social and voluntary, to facilitate the launch of care pathways and the continuity of taking charge.
- To develop working methods which will allow to make use of specific expertise of specialized centers without renouncing the indispensable dimension of proximity of care services. Among the possible forms of collaboration, mention should be made of the use of

cross-cultural / ethno-psychiatric consultancy, even remotely, training and supervision of the staff of the territorial services, all of which to be assessed on the basis of the needs and characteristics of the territories.

- Regularly include modules, mental health related, in continuous education programs for healthcare professionals, dedicated to force migrants.
- Rethink and reprogram the services with respect to emerging needs, in close collaboration with the most relevant territorial actors.
- Adapt the care devices to the intervention of cultural mediators, consciously, starting from reflecting on the existing tension between the need to ensure the continuity and quality of services, which require a stable inclusion of mediators in the teams, and maintaining the necessary flexibility to respond to even sudden changes in the population that accesses the services themselves, in terms of number, language and characteristics.
- Improve communication quality with migrant patients by supporting nursing and medical staff by improving their skills and creating ways of accessing the service and settings to facilitate communication and relationships.
- Provide a time performance, compliant to the complexity of the therapeutic intervention, not basing the evaluation of the efficiency of the service, just on numeric performance indicator.

GUIDELINES

The reception system contribution

PsychCare

PSYCHIATRIC SERVICES FOR REFUGEES

IPRS

Premise

Italy mainly uses collective structures as reception of applicants and holders of international protection, and this method, despite the variety of types of centers and services provided, leads to some responsibilities to the management of these organizations, that are not always clearly defined, especially with regard to the role they must play with respect to the protection of the health of the people received. This indeterminacy of responsibility is particularly evident with respect to the issue of mental health. In this context, in fact, the recognition of the need for care is not easy, as the migrant is not always able to recognize it and make it explicit; the accessibility of services matter and continuity of treatments also arises, which in many cases risks conflict with the precariousness of life of migrants and with the temporary nature of the reception measures themselves.

The Italian psychiatric system, theoretically, has completely abandoned forms of residential treatment in favor of territorial psychiatry interventions. However, this reform has not been fully implemented in all territories and, in the absence of effective intervention networks, there is a growing tendency on the part of those who interact with psychiatric patients (families or social workers who are) to ask for activation or the strengthening of forms of residential intervention. This dynamic ends up further weakening the construction of integrated social-health paths. In the case of forced migrants, also the tendency to send specialized services with ethno-clinical skills, which are often distant from the patient's place of residence, contributes not ensuring the proximity response that the territorial psychiatry approach requires.

The only way to treat psychic distress, adequate and consistent with Italian regulatory provisions, is to provide for the activation of responses to care for the needs in people's places of life. For migrants these places often coincide with the reception facilities and for extended periods. Inevitably what follows is that those who manage these structures are called to assume responsibility in this regard and should therefore be placed in a position to exercise it appropriately.

Some experiences show that when networking with territorial services is solid and adequate support is ensured for operators, reception centers can carry out not only a significant preventive action, but also take on a support and facilitation function on therapeutic routes. Naturally, the delicate issue between balancing respect with individual freedom and the necessary action to guide and facilitate access to care for subjects who may have difficulty explaining a need for care, due to cultural barriers, also arises. Due to a condition of strong marginality which considerably complicates the reading of needs, both for migrants and social workers who interact with them.

Furthermore, even when the need for care is identified, relationship between reception and healthcare facilities needs to be clarified. A fully integrated approach would require that the

responsibility of the reception center is not limited to sending, but to provide forms of accompaniment along the care pathways and, at least to some extent, a sharing of the therapeutic alliance so that the conditions are created to guarantee a satisfactory therapeutic compliance, both with respect to taking medications and for the continuity of psychotherapy courses. This involvement must of course be prepared adequately through clear and transparent protocols and the acquisition of the patient's informed consent, also regarding the people to be involved in the different stages of his / her care path.

In any case, it is impossible for reception centers to adequately perform this function if they operate with insufficient resources. The lack of solid professional preparation and continuous training for operators, the excessive workload, the precariousness of contracts and the absence of regular supervision do not allow to face the multidimensionality and complexity of the needs of asylum seekers. Furthermore, all these factors expose operators to a high risk of work-related stress diseases, in particular with reference to burn-out syndrome and vicarious traumatization.

Critical issues

- Reception conditions which do not sufficiently protect the mental health of migrants or even aggravate psychological conditions of those admitted.
- Tendency by the reception facilities to refuse taking charge in the presence of any psychiatric disease.
- Confusion about the role of the reception operator with respect to therapeutic paths.
- Burn-out of the operators.

Guidelines

The forced migrants' reception, requires all the actors involved to be able to take an active role in promoting the psycho-social well-being of the people residing in the structures, an indispensable condition for the success of any inclusion path. A greater awareness of each of them is therefore necessary with regard to their role and responsibility in this regard.

In particular:

- The organizations related to the reception facilities are responsible for ensuring the necessary conditions to promote guests' mental health, starting from a timely identification of any inconvenience. This implies the development of stable working practices with the territorial mental health services, with a precise definition of the roles and responsibilities of the operators involved. In estimating the necessary financial and human resources to ensure a reception service, this responsibility cannot be overlooked.

- The Prefectures and Municipalities are responsible for verifying that all the entities managing the reception services establish working practices, possibly formalized, with territorial mental health services and facilitate the coordination and constant discussion between all the actors involved in the reception system, also through dedicated tables.
- Territorial Healthcare Agencies are responsible for recognizing and enhancing the role of local reception structures in the co-management of care paths, as well as proactively placing themselves in relation to the promotion of the mental health of the migrants accepted and the operators involved. Healthcare agencies are also required to taking action to support managing bodies, for example through operator training and supervision, awareness raising initiatives, experimental services that facilitate access to local services.

Some indications for organization of services

- Reception choice solutions which encourage the empowerment of the beneficiaries ensuring full synergy with the local social and health services.
- Creation of activities dedicated to the promotion of mental health in reception centers, which involve operators of care services and facilitate synergies between migrants, operators and territorial services.
- Implementation of strategies for the prevention and early emergence of vulnerability (training on how to recognize signs of psychic suffering in a timely manner so that an appropriate referral can be made to the competent CSM).
- Design of protocols that clearly define the roles of the involved actors within the territorial network.

SOME EXAMPLES OF GOOD PRACTICES

PsychCare
PSYCHIATRIC SERVICES FOR REFUGEES

IPRS

MILANESE NETWORK FOR VULBERABLE ASYLUM SEEKERS AND HOLDERS OF INTERNATIONAL PROTECTION

Milan

Starting from 2013 in Milan, as a consequence of the so-called refugee crisis, it was considered necessary to enhance networking and synergy between all the institutional and private social subjects involved in assisting the most vulnerable migrants. With a City Council resolution, a Memorandum of Understanding was therefore approved for the formalization of a network specifically dedicated to this issue, with the aim of building an integrated system of social health care, with actions and services in favor of refugees and asylum seekers living in the Milanese territory.

The protocol, valid for two years, was formally launched on 29th November 2013. It was renewed with a three-year validity in November 2016, with an expansion of the institutional partners involved. A further renewal is currently on the run.

Members of the network are: the Municipality of Milan, Niguarda Ca 'Granda Hospital, Casa della Carità Foundation "Angelo Abriani" Onlus (managing body of a SIPROIMI project for vulnerable cases), Farsi Prossimo Consortium, Development and Promotion Association, Terrenuove Cooperative, the University of Milan.

The Network is structured in:

- **Vulnerable cases table**, with the aim of stimulating interinstitutional co-responsibility, evaluating network activities and promoting co-planning between the participating entities and joint participation in calls for tenders.
- **SPRAR DM operating booth**, for the management of 8 reception places dedicated to forced migrants in vulnerable conditions (inclusion, multi-professional accompaniment and discharge).
- **Working table for complex cases**, with the aim of linking the various operational levels of social care (multipurpose center, different typologies of reception centers, ethno psychiatry service, job placement and training services).
- **Research and training area**, to promote scientific initiatives with international experts and collaborations with Italian and foreign universities.

This network model is positively evaluated by the various participating entities, because it combines an adequate level of formalization with an operational slenderness which makes the proposed activities sustainable for the participants. The long-term goal is to develop an inter-

institutional service culture among the partners of the Network to establish at a common definition of vulnerability and improve access to services and the adequacy of taking charge. Hopefully in occasion of the next renewal new stakeholders will be involved (including ATS, ASST and Prefecture). Lastly, thanks to the collaboration of the research organizations and universities involved, the Network proposes to define shared tools for the early diagnosis of vulnerabilities and to promote the widespread monitoring of integration indices and therefore the follow-up of the results of the interventions within the reception and effective access and use of the network of specialist services.

For further information

A. Armocida, M. Marzagalia, M. Andreani, F. Magli, C. Cattaneo, *Rifugiati nella rete: dall'accoglienza alla cura*, Franco Angeli 2020.

WORD GROUPS

Mantua

In the past four years Sol.Co. Mantua organized "speech groups" involving CAS operators and welcomed migrants. The concept from which this experience found its beginning, is related to protective factor with respect to physical and mental illness, with the participation of people in large and varied social networks, based on solidarity and reciprocity. The group offers an opportunity for mutual knowledge and understanding between the participants, but also for transformation: in the group, each one necessarily assumes responsibility for self-care and for the other, indeed for self-care through the other, practicing intentionally bonding and relationships, reciprocity. As Tobie Nathan puts it, [54] group work is particularly useful in the treatment of migrant patients. The patient can only be known through the deployment of a multidisciplinary cognitive arsenal and the mobilization of a plurality of subjects of different cultural ancestry and the group allows a discourse on the patient that does not fix him in a single diagnostic representation, but allows a "kaleidoscopic performance of the interpretations".
Word Groups organized by Sol.Co. Mantua have a three-week cadence. Professional psychologists of the cooperative, working in reception centers, carry out facilitation. Participation is completely free and spontaneous, open to men and women, and is based on some assumptions, shared by the participants:

- in the group all the participants are "experts", they are placed on a level playing field: those who lead make their psychology skills available, but all make their skills available (linguistic, cultural, emotional, direct experience ...);
- health is built together, in a group;
- the word group device is open to different strategies and methods, upon proposal coming from each of the participants. For example, if someone finds it necessary to pray, or to propose other strategies, the other participant are available to accept the suggestion. Integration means being available to accept everyone's way without hesitation or judgment.

The benefits found in recent years, based on the testimony of migrants, social workers (also with migratory backgrounds), mediators and doctors, have been remarkable. These meetings encourage the expression of needs, emotional suffering, in some cases even the first stories of trauma suffered, in a climate of total confidentiality on the part of those who are present. At the

[54] T. Nathan, *Fier de n'avoir ni pays, ni amis, quelle sottise c'etait. Principes d'ethnopsychanalyse*, 1993.

same time, sharing the needs is strongly linked to the common search for immediate solutions (for example through the orientation towards social-welfare services and social network resources) and for longer-term change (for example, introducing elements emerging from the discussion in the permanent training for social workers employed in reception centers).

For further information

L. Bianchera, G. Cavicchioli, A. R. Lovisatti (edited by), T*ransizioni e sconfinamenti: cambiamenti culturali nell'avventura delle migrazioni*, Sol.Co. Mantova 2018[55].

[55] The Training Papers are available and downloadable from the Sol.Co. Mantova's website: www.solcomantova.it

TRAINING OF LINGUISTIC-CULTURAL MEDIATORS

Palermo

Centro Penc, based at the Guarantor of Childhood and Adolescence of the Municipality of Palermo, has been carrying out systematic work on the training of mediators for years, in the belief that investing professionally in these figures is an indispensable step to ensure an adequate response to the health needs of forced migrants.

For the team of mediators, meetings are scheduled prior to each of the sessions in which they participate, in which the therapeutic plan is shared with them and, whenever possible, ideally including the plan for the specific session. When finished, the mediator lingers with the therapist for further discussion. In addition to these individual insights, team meetings are planned on a weekly basis. To a training part (on the interview techniques, for example), a terminological part follows which explains the most common terms used and, through a further open discussion that takes place between the mediators themselves, the group tries to better translate the concepts and the expressions which occur most often in therapeutic interviews. These terminological insights are also useful to introduce typical concepts belonging to the cultures of origin of the patients, so that the therapists' skills are also strengthened.

The meetings, both individual and group, also have the purpose of preventing vicarious trauma. In fact, mediators who work in the front line in the field of mental health, especially in contact with patients suffering from serious trauma, are often exposed to the same emotional and psychopathological risks that therapists run, with the substantial difference that the former, lack on adequate training to recognize the dangers of clinical interaction, and therefore even more difficult for therapists to take countermeasures to safeguard their psychic integrity.

In addition to internally organized training, Centro Penc offers mediators to participate in training events organized by other entities, for example in the context of funded projects. In order to make the participation of mediators in training activities sustainable, it is necessary not only to pay the expenses, but also to pay for training hours, including those of the weekly team meetings. Indeed, mediators generally work with temporary contracts and their work is poorly paid: if the training is not paid many of them would not be able to continue the journey.

For further information

Affronti M., Monti M. C. (edited by), Q*uale sguardo sui migranti forzati? L'esperienza dell'ambulatorio del Policlinico di Palermo*, ed. Pendragon 2015.

MENTAL HEALTH CENTER FOR VULNERABLE MIGRANTS AND SYLUM SEEKERS PASSI

Frosinone

The Mental Health Center for vulnerable migrants and asylum seekers PASSI was born within the Department of Mental Health and Addiction Pathologies of the ASL of Frosinone, as a response to the need to build a path of diagnosis, treatment and rehabilitation for asylum seekers, unaccompanied foreign minors and second generation, foreigners in marginal conditions and / or economic and social difficulties, with respect to mental distress and addictions with and without substances. The Center is the result of the collaboration of the Cooperatives belonging to the "La Casa Comune" Network (Cooperativa Ethica, Cooperativa Diaconia, Cooperativa La Speranza, Cooperativa Anthea, Cooperativa Eureka, Cooperativa Social Eureka and Cooperativa Crisalide), active on the territory of the province of Frosinone. The Center was born from the need to promote mental health in these population groups, subjected to considerable stress both for the physical and mental consequences for the journey from their country of origin up to us, and also for uncertain times, the difficulties of social and work integration, the condition of poverty, the very high risk of marginality. The center is open to collaboration with migrant communities, such as the local Nigerian community.

In consideration of the reduced possibilities in terms of staff and structures of the ASL and the increasingly limited resources of the entities managing the reception services, the PASSI Center wants to be a network as a response, through an attempt to co-manage mental distress. The Cooperatives, taking a first charge with the internal professional figures (psychologists, social workers and educators), through the PASSI Center indicating the need for psychiatric, psychological and social treatment by the ASL. Diagnosis and treatment become a tool for effective collaboration and for the identification of a rehabilitation path which involves the staff of the Cooperatives and the users themselves. All this can be guaranteed by a continuity of scientific and professional relations between Cooperatives and Center. The Center becomes an effective place of co-management of users, with the possibility of identifying shared care processes, therapeutic groups, territorial social animation initiatives.

In addition to the diagnosis and treatment of mental and substance dependence disorders and the certification of post-traumatic disorders, the PASSI Center acts as a reference for the outpatient treatment of specific disorders in connection with territorial CSM and SERD. It also ensures group supervision with the operators of the Cooperatives which manage the reception

centers and periodic meetings with the structures' managers, to promote specific training courses on mental illness for the operators and shared cultural events.

An important function of the Center is the social animation, aimed at building social integration paths for Italians and foreigners. The La Casa Comune network, within which the PASSI Center moves, contributes and supports the path, especially for the study and exploration of community empowerment processes and interventions to enhance the potential of the neighborhood, of local communities and of small cities.

PSYCHOANALYTIC INSTITUTE
FOR SOCIAL RESEARCH

PASSEGGIATA DI RIPETTA, 11 - ROME
TEL. 06.32652401 - IPRS@IPRS.IT
WWW.IPRS.IT

PROJECT SPONSORED BY OPEN SOCIETY FOUNDATIONS
WWW.OPENSOCIETYFOUNDATIONS.ORG
WITHIN THE MENTAL HEALTH PROGRAM