JA ImpleMENTAL

Joint Action on Implementation of Best Practices in the area of Mental Health

Joint Action ImpleMENTAL: from the European project to the pilot implementation of Lombardy Region

Regione Lombardia

Sistema Socio Sanitario
Regione Lombardia
ASST Lecco

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Aknowledgements

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A final thanks, very heartfelt, to **the professionals of the Implementation Teams of the Lombardy DMHs**, without whom this project would never have been born or reached the results obtained.

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Abbreviations

ARIA: Regional Innovation and Purchasing Company

ASST: Local Health Authority

BP: Best Practice

BPD: Borderline Personality Disorder

CMHC: Community Mental Health Centre

DP: Personality Disorders

DMH : Department of Mental Health

EI : Local Implementation Team

JA : Joint Action

M: month

MHIS: Mental Health Information System

PAP: Pilot Action Plan

ITP: Individual Treatment Plans

SANA: Situation Analysis Needs Assessment

ToC: Theory of Change

WP: Work Package

Figures

1. THE EUROPEAN PROJECT *JOINT ACTION IMPLEMENTAL*

The ***Joint Action ImpleMENTAL*** is a three-year project funded by the European Union, aimed at **improving the mental health** of the population through innovative **and sustainable changes in the mental health system** and based on the transfer and **pilot implementation of two pre-selected Good Practices (BPs):**

- the **Belgian Reform BP,** aimed at improving the mental health system at community level, to which 14 countries have adhered (developed by **Work-package 5 - WP5**).
- the **Austrian BP SUPRA** to develop a multilevel suicide prevention strategy involving 17 countries (developed by **WP6**).

In the JA, WP5 and WP6 represent two "technical" WPs, in charge of implementing the two BPs and are part of a system of other transversal WPs listed below, which support the activity of the two "technical" WPs, and where the WP1 coordinate the whole JA.

Figure 1. Articulation of the Work Packages

WP1 Coordination

WP2 Dissemination

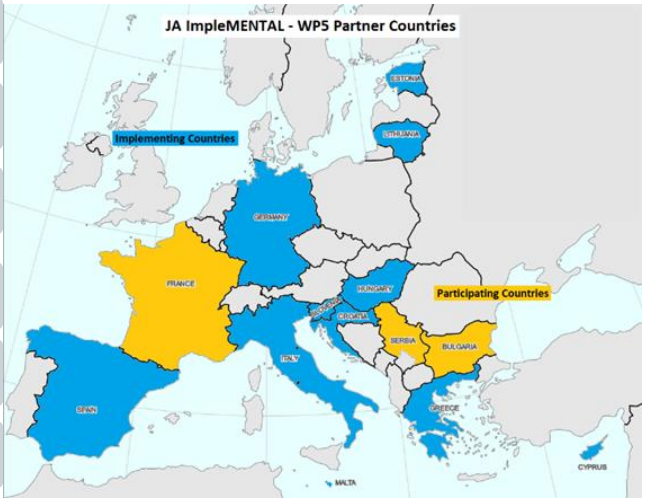
WP3 Evaluation

WP4 Sustainibility

WP5 Belgian Best Practice

WP6 SUPRA Best Practice

Figure 2. WP5 Participating Countries



WP5 was managed under the leadership of the *Bundeszentrale für gesundheitliche Aufklärung (BZgA)* (Institute for German Health Prevention and Promotion**)** in co-direction with the DG Welfare of the Lombardy Region, which participated as a representative of Italy**.**

WP5 has continued the implementation **of improvement actions aimed at the development of community care in the participating countries**, through **actions carried out at international, regional and local level**:

- the **coordination of the process of identification and implementation of pilot projects to be implemented** in the participating countries.
- the **training to the participating countries,** aimed at supporting the implementation of the pilot projects, was conducted at international level by the Mario Negri Institute for Pharmacological Research in Milan in order to support and guide the implementation of BPs and the models identified by the various partner countries for the pilot implementation. The training sessions, which took place *online* and *on-site*, also contributed to developing the

overall objectives of the JA centred on deinstitutionalization, cross-sectoral network building, and user and family participation.

- the **development of a dashboard of indicators** to monitor the activity of mental health services in the participating countries and to assess their quality (University of Milano-Bicocca and Politecnico di Milano).

Below are the contents of the BPs of the countries implementing the Belgian Reform BP.

Figure 3. Content of the Best Practice for the individual participating countries

COUNTRY	BEST PRACTICE CONTENT
CROATIA	Activation of multidisciplinary mobile teams.
CYPRUS	Transition between child and adolescent mental health services and adult services.
GERMANY	Supporting children and adolescents of parents with psychiatric disorders.
GREECE	Support the creation and coordination of community-based mental health networks and the establishment of standardized care pathways.
HUNGARY	Promote employment for people with severe psychiatric disorders, adaITPng the *Individual Placement and Support model*.
ITALY	**Improvement of the quality of care provided to young adults with Borderline Personality Disorder (BPD) through the implementation of evidence-based psychosocial interventions and the activation of a process of social inclusion and *recovery* in adult mental health services.**
LITHUANIA	Community-based case management services for patients with severe mental disorders.
MALTA	Improve collaboration with experienced users and develop the transition from hospital to community care.
SLOVENIA	Creation of a cross-sectoral mental health network that includes patients and family members along with other significant stakeholders.
SPAIN	Integrated territorial care for people with severe mental disorder through the development of Life Projects and greater integration with the social sector.
ESTONIA	Activation of mobile mental health services at the territorial level for patients with serious mental disorders.

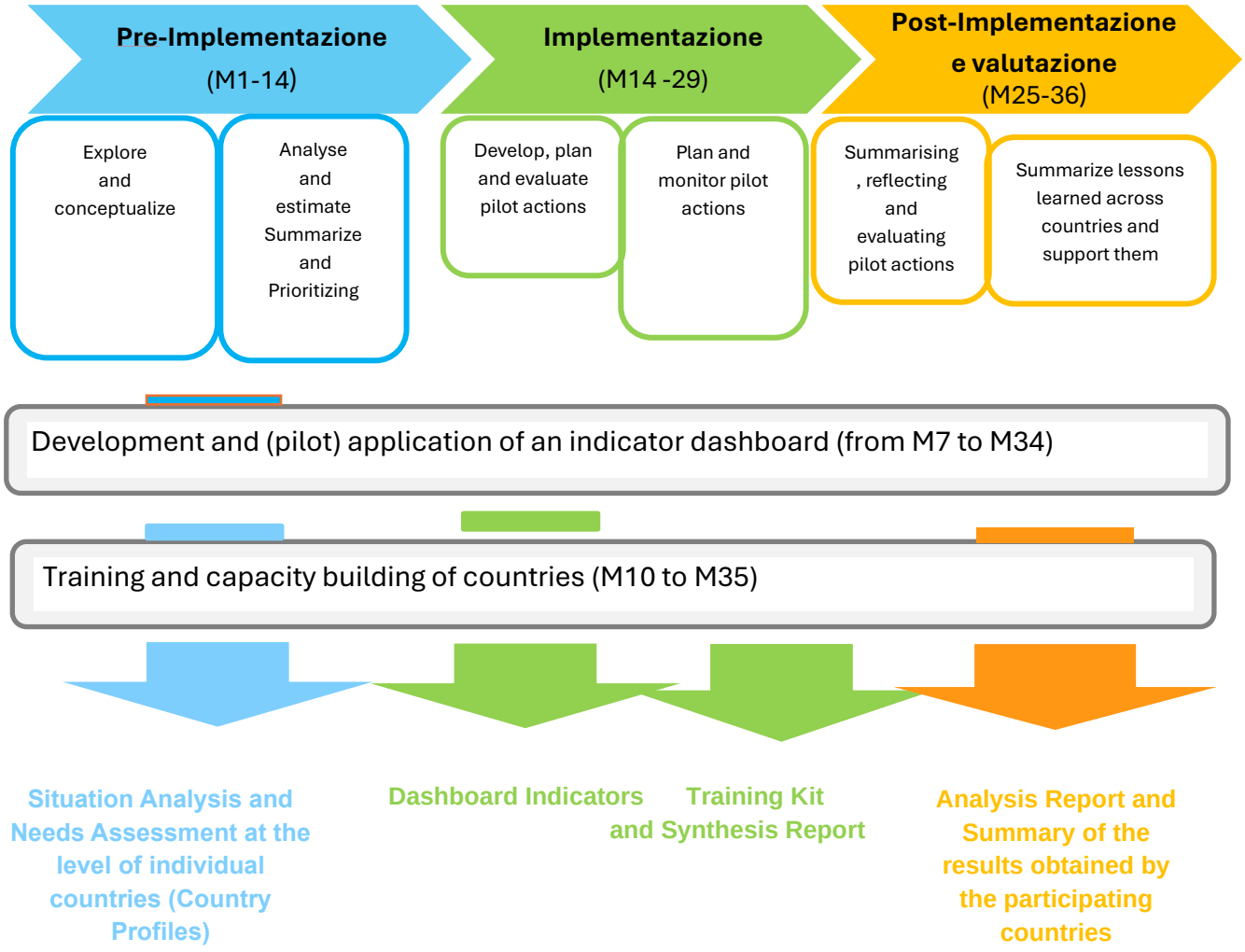
To achieve the overall objective of implementing BP in the participating countries, the work of WP5 has been divided into **three distinct phases** depending on the relevant processes activated, the tools used and the results to be achieved.

a. The **preparatory phase (pre-implementation**) aimed to establish structures of collaboration between countries and to define the contents of the WP5 action, exploring the principles of *community care* and the Belgian reform model, as well as to develop the tools for the analysis and assessment of the specific situation of the participating countries.

b. The results of this phase formed the basis for the development of the pilot actions in the participating countries in the **implementation phase**. They were provided with continuous support by BZgA and the Lombardy Region during the pre-implementation and implementation phase through training and regular meetings with countries in the framework of *online* and face-to-face meetings.

c. During the **post-implementation (and evaluation) phase,** a method and model were developed to systematically summarize the results that countries have achieved in the implementation process and to foster the sustainability of BP even after the conclusion of the JA.

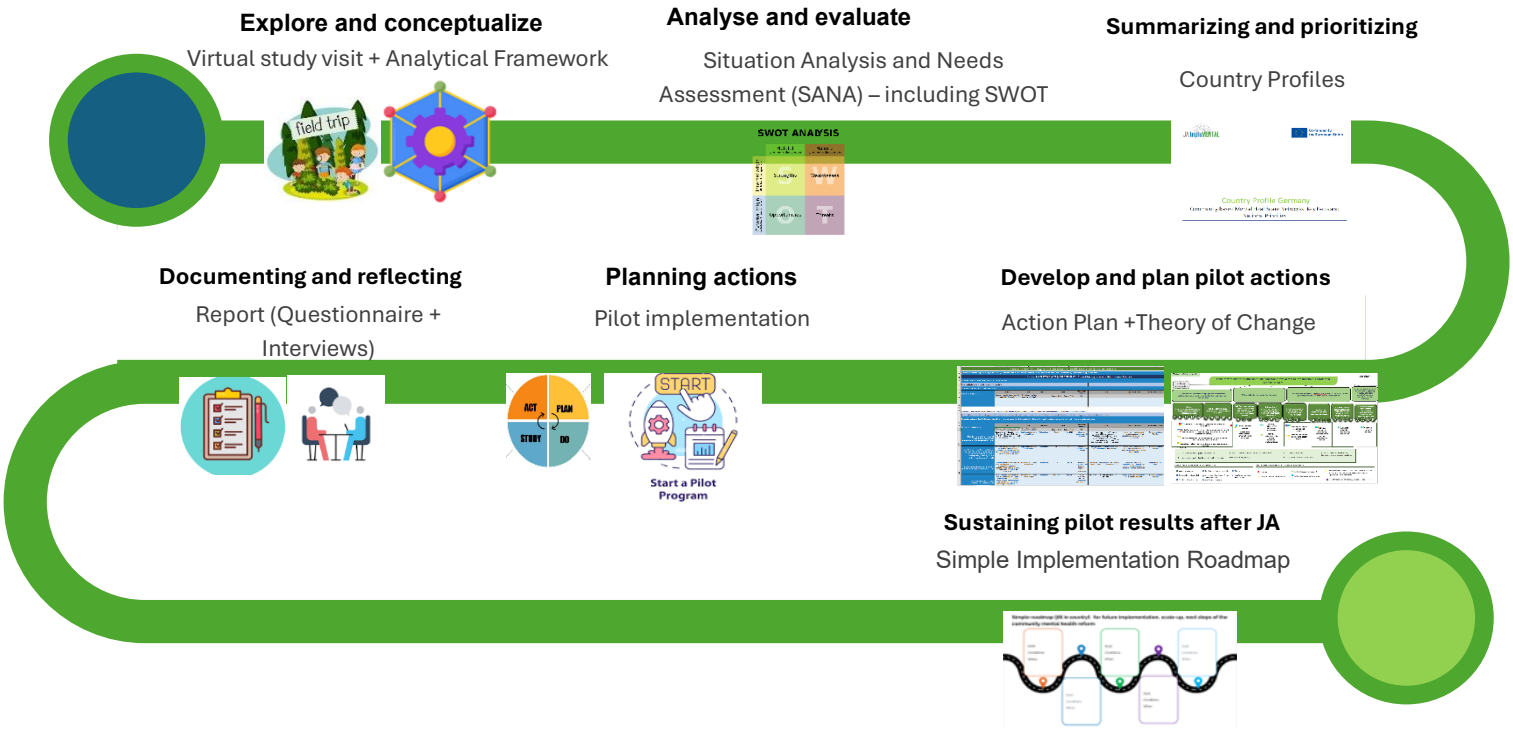
Figure 4. WP5 framework according to the phases of the JA



2. *JA IMPLEMENTAL:* THE LOMBARD PILOT PROJECT

The Lombard project aimed to **improve the quality of care in young adults with Borderline Personality Disorder (BPD),** following the same phases and subphases of the other European projects, reported below.

Figure 5. Overview of processes and tools



2.1 THE PRE-IMPLEMENTATION PHASE

To define the objective of improvement actions in Lombardy, the results of the QUADIM research project (2016-2019) were used, which evaluated the quality of mental health care provided to patients with personality disorders in four Italian regions, including Lombardy, the Region that coordinated the project[1]. This project has shown that the quality of the care provided in Lombardy in 2015 to young patients aged between 18 and 24 with personality disorder at onset had to be radically improved. Only one-sixth of the young patients had been assessed in a structured way in the early stages of treatment, while one-third had not received any psychosocial intervention, specifically indicated for this type of disorder, and only one-third of family members had received specific interventions.

[1] Sanza M, Monzio Compagnoni M, Caggiu G, Allevi L, Barbato A, Campa J, Carle F, D'avanzo B, Di Fiandra T, Ferrara L, Gaddini A, Saponaro A, Scondotto S, Tozzi VD, Lorusso S, Giordani C, Corrao G, Lora A. *Assessing the quality of the care offered for people with personality disorders in Italy: the QUADIM project. A multicentre research based on the database of use of Mental Health services.* Int J Ment Health Syst. 2023 Oct 13; 17(1):31. doi: 10.1186/s13033-023-00603-9. PMID: 37833745; PMCID: PMC10571410.

2.1.1 SANA and the *Country Profile*

The results of the above project have been valuable elements in the drafting of the *Country Profile*, which describes the key elements of the national and regional mental health system and summarizes the results of the **Situation Analysis and Needs Assessment (SANA**).

SANA was developed to allow participating countries to have an overview of the national mental health system and in the area of the pilot implementation and to support countries in choosing the BPs to be implemented, starting from an analysis of existing data on care in the area of mental health. The tool consists of two parts (SANA I and II). **Part I of SANA** provided a **general overview of the mental health system at national level**: 61 indicators were derived from international data collections, covering 10 thematic areas (primary health care system, demography, policy and legislative framework, funding, availability/use of mental health services for adults and children/adolescents, staff present and mental health information system). **SANA II** used the structure and indicators of SANA I but focused on local **characteristics at the level of the area chosen by each country for the implementation of BP, be it national, regional or local**. Starting from the results obtained in SANA, a **Country Profile** was compiled by each country, divided into two parts: the first relating to the national mental health system, the second relating to the local mental health system, where the implementation of BP, Lombardy Region in our case, was planned.

2.1.2 SWOT analysis

After the collection of data for SANA and during the compilation of the *Country Profile*, the countries conducted a **SWOT analysis** to assess the strengths and weaknesses of the territorial mental health system at the pilot area level. The SWOT was **completed at the regional level** in March-April 2023 and made it possible to identify and categorize **significant internal** factors (strengths and weaknesses) **and external** factors (opportunities and threats) related to the implementation of BP at the Lombardy level, as follows.

Figure 6. SWOT analysis at regional level

Strengths	Weaknesses
1. Well-structured network of mental health services 2. Presence in some ASSTs of teams specialized in the treatment of young patients 3. Mental health information system capable of tracking implementation activities 4. Previous investment in training 5. Professionals involved in training and implementation with permanent employment contracts	1. Shortage of mental health workers 2. Few experiences in mental health projects that include structured implementation processes 3. Assessment of clinical and psychosocial needs in patients with infrequent BPD and lack of specificity of the related care pathways 4. Family members not always involved 5. Organization of medical-centric mental health services

Opportunity	Threats
1. More attention after the COVID-19 pandemic to the mental health of the young age group 2. Improved cooperation with Child and Adolescent MH Services 3. JA as an opportunity to learn implementation 4. Awareness of the need for integration between clinical and social aspects 5. Associations of users and family members interested in being involved	1. Stigma related to young adults with behavioural problems and substance use 2. Limited cross-sectoral collaboration between mental health and social services 3. Limited economic resources for mental health services

The **SWOT analysis** conducted at the level of the Lombardy Region was then **replicated at the local level** by the local Implementation Teams (EIs). Based on the matrices compiled by almost all the EIs of the participating ASSTs, some **significant common factors were detected**. The **staff** plays a fundamental role, both as a strength for multidisciplinarity and as a critical point for the scarcity of professionals with a recurring absence in the teams of the professional figures of the social worker and the nurse. However, the **presence of professionals, permanently employed and not hired on a fixed-term basis for the project,** is decisive in ensuring the continuity of the interventions provided, as well as the availability of hours that can be dedicated to the project. The **presence of patients already in charge** of the services facilitates the recruitment of the expected number of patients. The **intersectoral collaboration already in place with the internal network (e.g. Child and Adolescent MH Services)** facilitates referrals in transition or coming from other services, where the presence of pre-existing teams dedicated to patients at the onset argues in favour of already established procedures. The **external network** is also affected by previous integration, with particular reference to family associations, although not always dedicated to this type of user (young patients at onset). The **specific training** of the staff involved, both previously provided or received through the JA, is of particular importance with respect to the possibility of being able to implement specific treatment pathways, from the assessment of patients to the provision of evidence-based psychosocial interventions.

The **ease of access to IT communication tools** makes it easier to manage meetings and interviews remotely. The **interested involvement of the Director of the DMH** and the **channel opened with the Communication Office** seem to favour the dissemination of the project inside and outside the health network.

2.1.3 The *Theory of Change model*[2]

The **Theory of Change (ToC)** ***model*** was used as a first step in the design and planning process of pilot actions, as well as in the final phase of evaluation. It requires the **formulation of measurable objectives** and **the identification of useful indicators.** The ToC allows to localize

[2] Elements of the ToC for the Belgian Best Practice: https://youtu.be/O5JWzJQrDRc

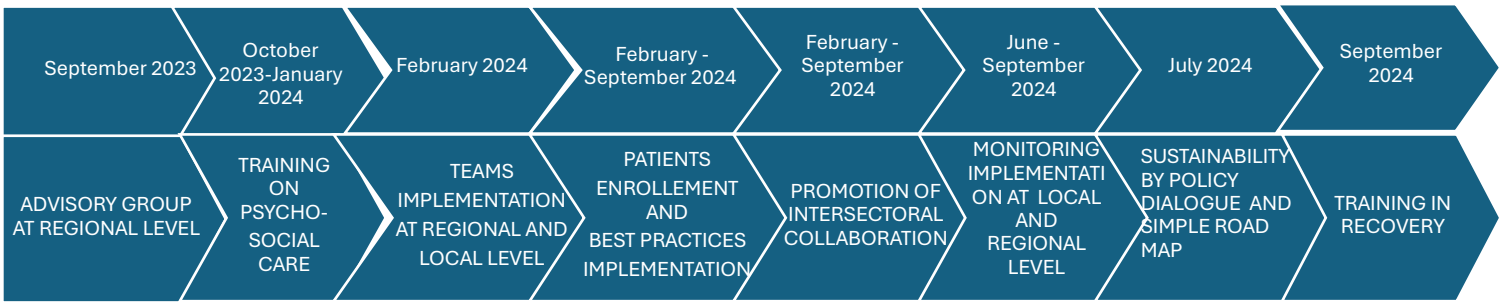
the effects of the planned activities at different levels: the ***output*** refers to the results obtained by differentiating themselves from the expected results **(*outcomes*),** both of which can be measured using appropriate indicators, while the **impact** is localized at a level that goes beyond the responsibility of the activities and the possibilities of evaluation in the medium term. **AssumITPons** qualify as necessary conditions for the achievement of *outputs* and *outcomes* and can become **risks** that compromise them.
The ToC model led to the development of a flowchart that provides an overview of the change process. It has defined at the level of the Lombardy Region the overall impact, the *outcomes* corresponding to the expected results and the *outputs* to be measured, linked to the planned activities (inputs), and the hypotheses on how to achieve them, thus allowing a visualization of the main pillars of the planned actions. In this sense, the ToC model functioned as a bridge between the analysis of the *Country Profile* and SANA and the planning of the activities to be conducted in the Action Plan.

2.2 THE IMPLEMENTATION PHASE

2.2.1 Pilot Action Plans

To guide and further support countries in the process of implementing their pilot projects, **Action Plans (PAPs)** have been developed for each of them.
This tool helped countries to identify and **translate the essential elements of the BP into priority activities for their pilot implementation at national, regional and/or local level.** The elements have been grouped into five **strategic areas**, which in turn are differentiated into sub-strategic areas. The PAP model required countries to plan the activities to be implemented, the actors responsible, the timing of the planned activities, the stakeholders involved, the target population and the final beneficiaries, **starting from the outcomes, outputs and inputs identified in the ToC model**.
The PAPs were used to plan the BP and monitor the implementation process and as far as the Lombardy situation is concerned, the PA was **compiled both at the regional level and at the local level** of the individual DMH.
Below is the BP timeline developed in the implementation phase in Lombardy in its most important stages.

Figure 7. Regional BP timeline



2.2.2 The activation of the Regional Implementation Group and the Action Plan

The first step was the activation of the **Regional Implementation Group** in charge of coordinating and monitoring the implementation of BP at regional and local level. Alongside the Regional Implementation Group, the Project Advisory Group was created in September 2023 , which included representatives of key stakeholders (DG Welfare, professional groups, user and family associations, project trainers and experts in the DBP area).

The Regional Implementation Group:

Dr. Antonio Lora, former Director DMH ASST Lecco, regional coordinator of the JA, participated as co-leader of WP5 in the activities of the Joint Action and in the general coordination of the project. At the level of the Lombardy Region, he coordinated the working group, which included the *regional Affiliated Entities* (ASST Lecco, IRCSS Istituto Mario Negri and Fatebenefratelli San Giovanni di Dio, Bicocca University and Polytechnic) that developed actions in the Joint Action, the implementation group and the consultation group.

Dr. Teresa Di Fiandra, former head of the mental health area of the Ministry of Health, consultant of the Lombardy Region, participated as co-leader of WP5 in the activities of the Joint Action, with particular reference to the general coordination of the project.

Dr. Simonetta Martini and **Dr. Stefania Pollice** of ASST Lecco, coordinated and monitored the local implementation process of the individual member of the local Implementation Teams. Dr. Pollice also developed the final reports of the project.

The Regional Implementation Group also included the TAV **Cluster team**, with **Dr. Marco Sacco, Dr. Stefania Palumbo** and **Dr. Chloé Lefevre**, who provided support to the general management of the project, managed the dissemination and communication activities (poster design, meeting invitations or video content creation) and assisted in the organization of three key events in the institutional headquarters of the Lombardy Region: the WP5 conference with the participating countries on 8-9 April 2024, the regional conference on 9 May 2024 with the main stakeholders (from EI to User and Family Associations) and finally the *Policy Dialogue* on 22 July 2024.

2.2.3 Training

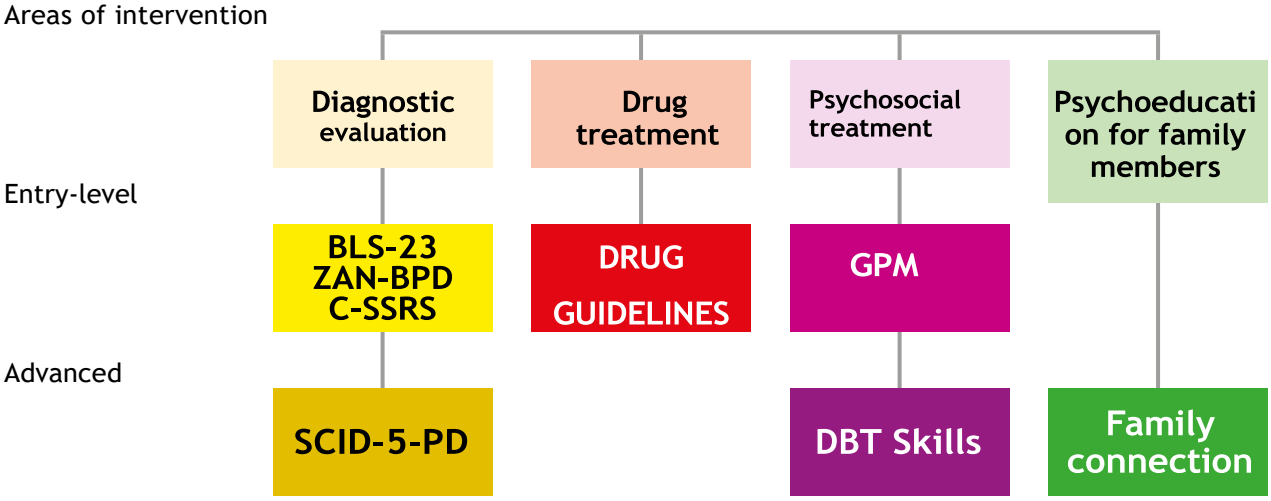
It was provided at regional level by the **Fatebenefratelli Institute of Brescia** with regard to **evidence-based** psychosocial interventions and by the **Mario Negri Institute of Milan** with regard to the **recovery *process***.

Concerning the training on psychosocial interventions, the following training focuses were proposed for the treatment of young people with Borderline Personality Disorder as part of an intensive course (56 hours in presence):

- definition of diagnostic and evaluation pathways.
- recommendations for non-pharmacological treatment according to the *Good Psychiatric Management* (GPM) model.
- recommendations for pharmacological treatment.
- the *Dialectical Behavior Therapy* (DBT) model.
- the *Family Connection model*.

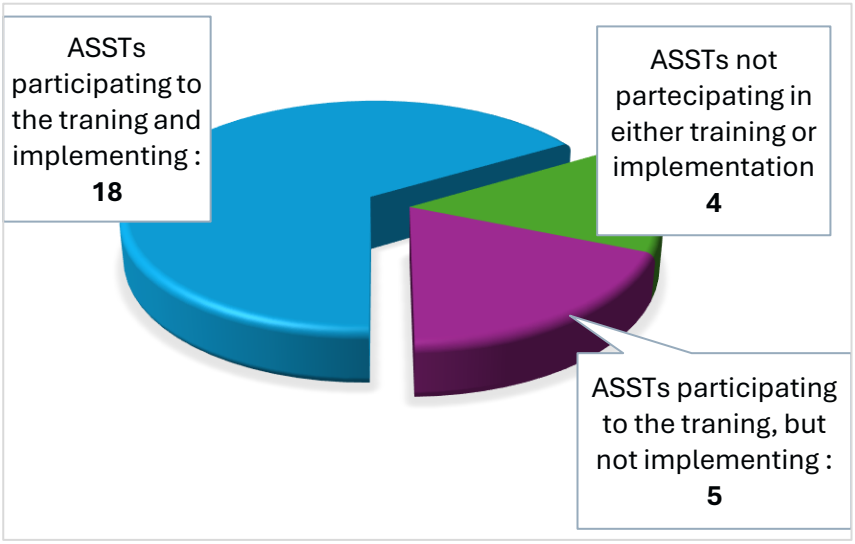
The **proposed general intervention model** was based on the principle of ***stepped* care**, which provides for a **basic level of** diagnostic evaluation and treatment addressed to all patients, starting with the *Good Psychiatric Management* proposed by John Gunderson, and for an **advanced level**, reserved for patients with particular complexities in terms of clinical care, which involves longer training and includes the involvement of family members. The training scored a positive receITPon from the professionals : almost all of the participants completed the training cycle and nine out of ten considered the topics covered "very relevant" for their updating needs, assessing the quality of the content as "good/excellent".

Figure 8. The phased training course



On **12 September 2024**, an online training on the topic of **Recovery** for EIs of the ASST members of the JA was offered and extended to the relevant stakeholders. The proposal met with the support of **42 participants. The Recovery Paradigm was presented to adapt it to the treatment and experience of BPD** with the aim of integrating training on psychosocial interventions with a focus on the person's life context and experience.

Figure 9. ASSTs between training and implementation

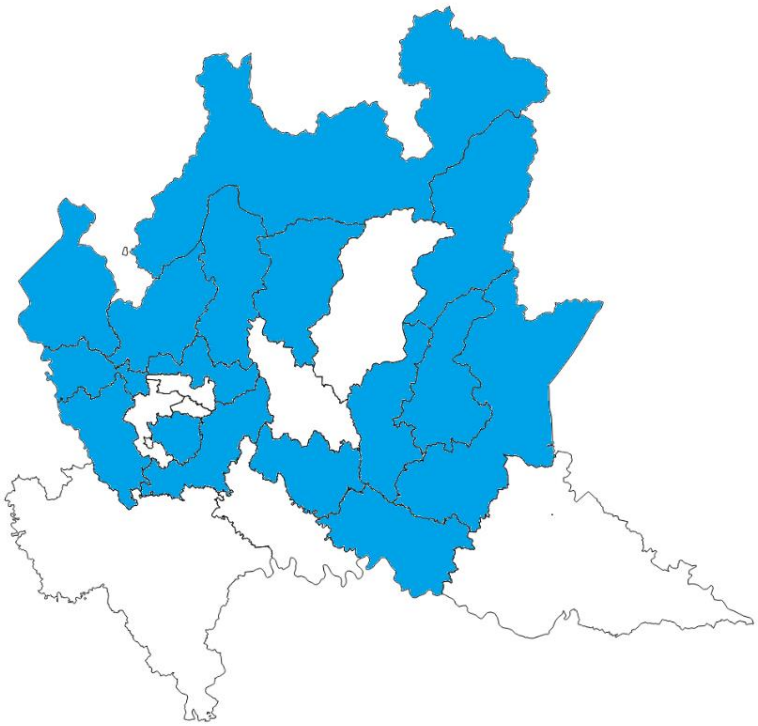


298 professionals **from** 23 Lombardy ASSTs **joined the training on psychosocial interventions**: in 18 ASSTs the training was followed by implementation, while 5 ASSTs received training, but did not then implement the project.

2.2.4 Activation of the implementation team and the action plan at local level

18 DMHs belonging to the ASST indicated in the list and on the map have joined the implementation process:

Figure 10. Regional map of the participating ASSTs

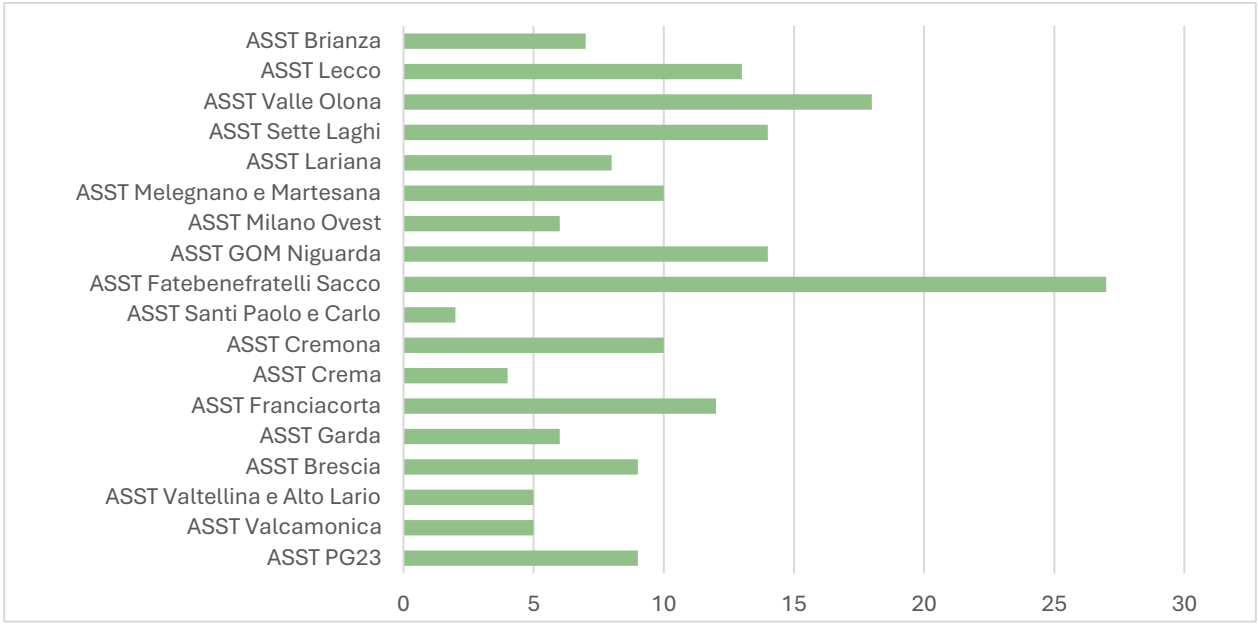


ASST Valle Olona
ASST Sette Laghi
ASST Lariana
ASST Milano Ovest
ASST Melegnano and Martesana
ASST GOM Niguarda
ASST Fatebenefratelli Sacco
ASST Santi Paolo Carlo
ASST Brianza
ASST Lecco
ASST Papa Giovanni XXIII
ASST Valtellina and Alto Lario
ASST Valcamonica
ASST Brescia
ASST Garda
ASST Franciacorta ASST Cream
ASST Cremona

The involvement of the individual ASSTs was accompanied by the presentation of the project by the Regional Implementation Group, in parallel with the training course (December 2023), and by some subsequent online meetings aimed at clarifying the contents of the implementation (January 2024). For each EI, a Coordinator was identified who carried out with

the rest of the professionals the task of proceeding with the **local SWOT analysis** and drafting the related **Action Plan,** according to the guidance of materials sent by the Regional Implementation Group. The EIs relating to the individual participating ASSTs are shown below, broken down by number of participating professionals and by professional profiles present.
179 professionals **were involved in the EIs**, with a **median of 9 professionals for each ASST** participating in the project. A heterogeneous distribution should be noted, both in numerical terms and in terms of type of professionals involved. The differentiation also concerns the location of the pilot: there are cases of multiple EIs within the same DMH, as well as ASSTs that have implemented in a single facility. If the presence of a double EI within the same DMH is attributable to the geographical distance and the territorial diversification of the services available, the partial/centralized implementation mostly refers to the difficulty of activating staff in certain territories (lack of training, criticalities of the network...). As regards the implementation in the metropolitan area of Milan, in some cases the EIs have been significantly enriched with previously trained personnel, to allow the BP to be extended to the entire territory of relevance. The identification of the coordinator was not immediate for all the participating ASSTs, representing for some of them a real obstacle to the take-off of the implementation.

Figure 11. EIs and number of professionals involved



More than half of the professionals who participated in the training did not really take part in the implementation process This gap is largely due to the withdrawal, after the training, by 5 ASSTs. In addition to the 124 professionals trained and involved in the training, 55 professionals were added who, although not included in the training process, were active in the implementation having in many cases received specific previous training.

Figure 12. Professionals involved in the training and implementation process.

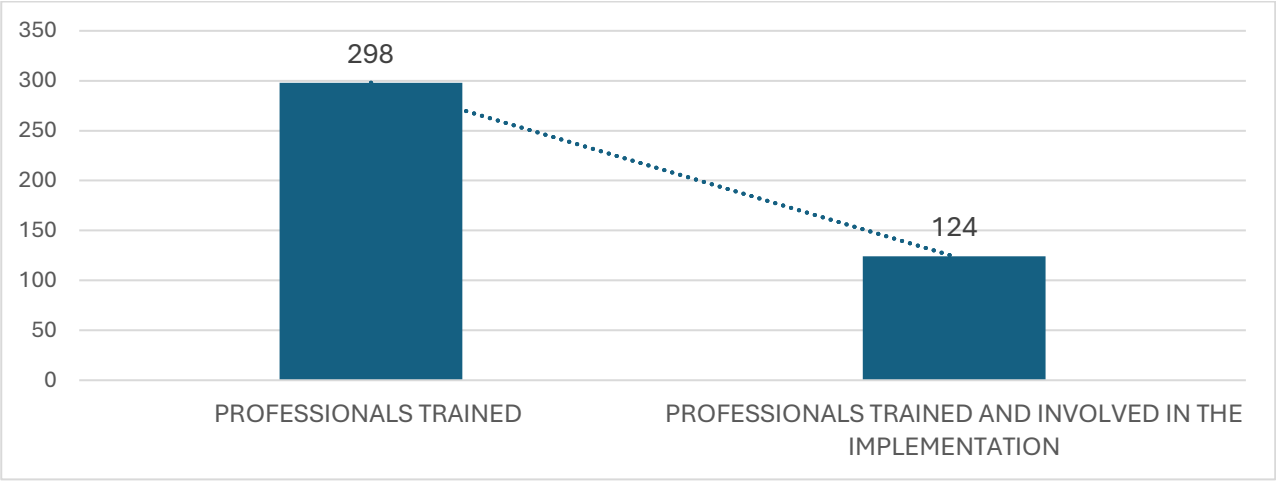
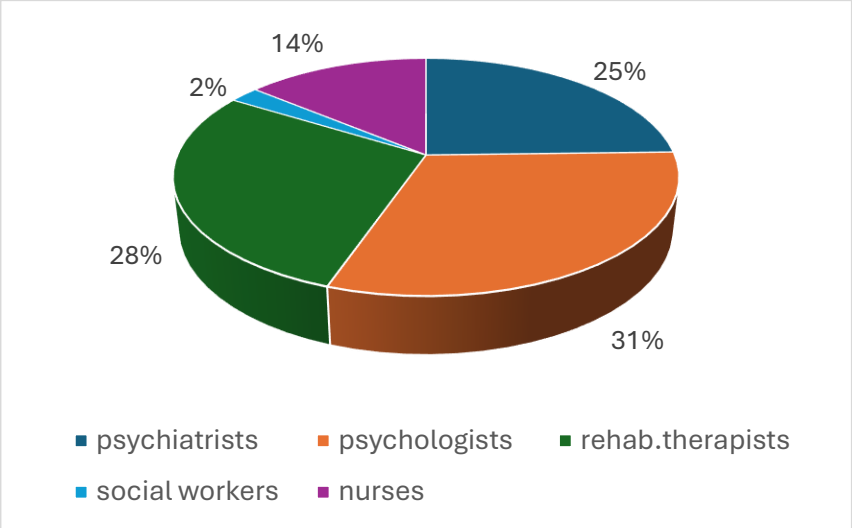


Figure 13. EI and professional profiles.



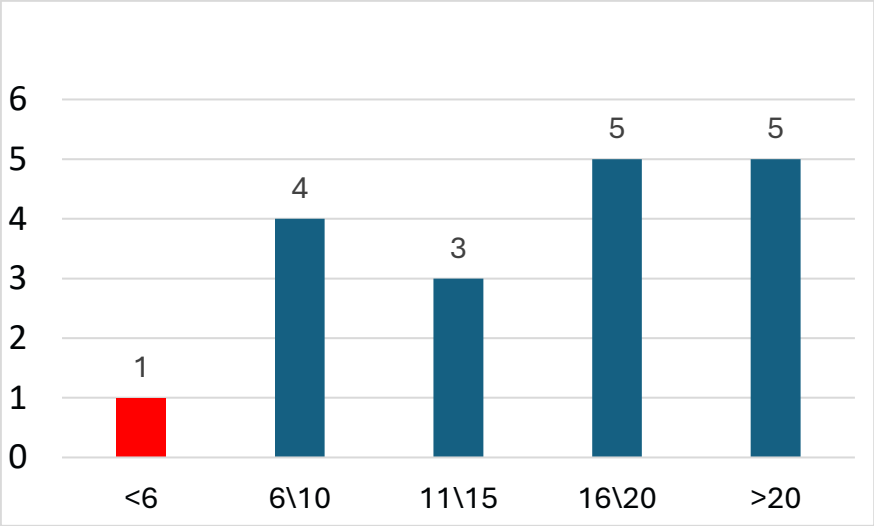
The prevalence of Psychologists, Rehabilitation therapists and Doctors compared to Nurses and Social Workers is immediately detectable, partly related to the profiles involved in the training and partly to the difficulty of involving these professionals in the implementation, as already noted by the local SWOTs.

A series of **19 online meetings** were held with the **individual ASSTs** which made it possible to get to know the coordinators and to share both the tasks of the SWOT and the PA. In a subsequent phase, a new series of **8 online meetings was carried out in** which the coordinators themselves participated with their **EIs grouped by ATS to which they belonged**: in addition to an update on the implementation in progress, a comparison between neighbouring territorial realities and the first exploration of future trajectories were encouraged.

2.2.5 Patient enrolment, psychosocial interventions and networking

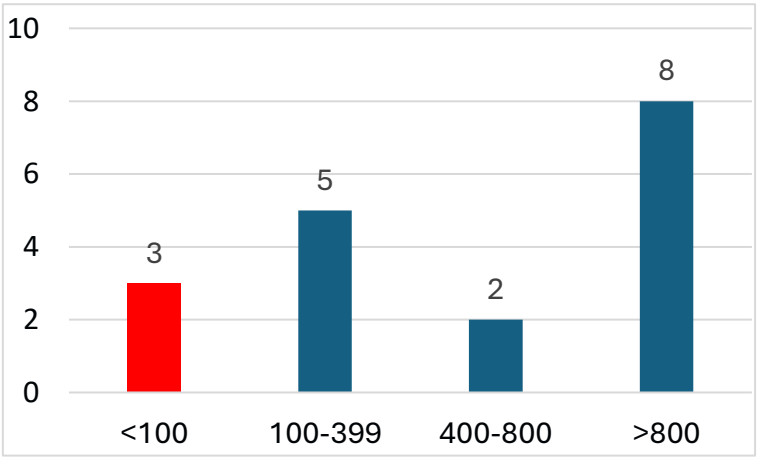
In the Lombardy pilot project, alongside the **enrolment of patients** and the activation of **psychosocial interventions**, particular attention was given to **intersectoral collaboration with social services and associations of family members and users** and to the centrality of the **recovery *and social inclusion* process**. Last but not least, the focus was not only on **communication** inside DMHs and the ASSTs, but also on communication with the stakeholders involved and with the general population.

Figure 14. ASSTs by number of patients enrolled.



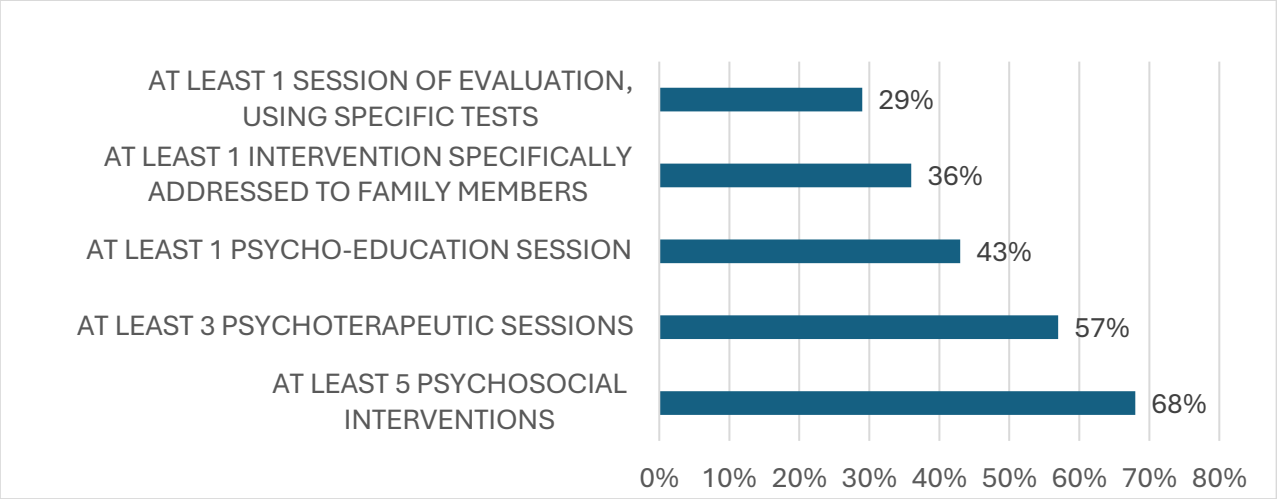
The implementation provided for the **enrolment for each ASST of at least 15 patients, aged between 18 and 30 years with BPD, with priority given to patients at first contact with the service.** A total **of 314 patients were recruited, with an average of 17.5 patients per ASST.** While more than half of the ASSTs exceeded the expected number, some ASSTs, which remained below the threshold, showed difficulties in enrolling patients in the recommended age group and/or at their first contact. The **characteristics of the patients enrolled** in the project complied with the indications given: 77% of patients are aged between 17-24 years and 18% between 25-30 years; 56% came into contact with DMHs in 2023/24, while 28% in 2021/22 and only 17% earlier. Nine out of ten patients are female: this figure reflects the greater difficulty in taking care of young male patients. As far as diagnosis is concerned, the matter is more complex: eight out of ten patients have the diagnosis of borderline personality disorder as their main diagnosis (78%) or more rarely as a secondary diagnosis (2%), but two out of ten of the patients have diagnoses other than BPD. This figure is probably linked to a lack of updating of diagnoses and not to the enrolment of patients with different diagnosis.

Figure 15. ASSTs by number of individual and group interventions delivered.



Inside the pilot about 24,000 interventions **were delivered**, of which 11,400 were psychosocial ones. The **median of interventions delivered per ASST is approximately 800 interventions**, while the **median of psychosocial interventions delivered per patient** over the implementation period **is 17**.

*Figure 16. Patients and family members according to psychosocial interventions delivered **in the first three months of care**.*



PSYCHOSOCIAL INTERVENTIONS

- Individual and group psychoeducational interventions
- Individual and group interventions on basic, interpersonal and social skills
- Individual and group psychotherapeutic interventions
- Interventions aimed at family members and group of family members
- Assessment interventions
- Job placement interventions
- Social support interventions

It should be emphasized that one of the major objectives of the project, to ensure an adequate intensity of psychosocial care in the first months of care, has been achieved, as evidenced by the indicator relating to the percentage of patients (68%) who have received at least five psychosocial interventions in the first three months of taking charge treatment. While the initial diagnostic and psychosocial assessment with structured tools involved about a third of the patients, as well as the activity aimed specifically at family members, the percentages of patients who received psychoeducational (43%) and psychotherapeutic/psychological (57%) interventions are significantly higher. With respect to the application of training contents in daily practice, EIs have generally **implemented the use of tests alongside the clinical interview**. In the choice of the same, the majority of ASSTs have progressively implemented the *SCID5 PD* (Structured Clinical Interview for the DSM5 for Personality Disorders) together with **faster administered tools** (*ZAN -BPD- Zanarini Rating Scale for Borderline Personality Disorder* and *Borderline Symptom List 23*). From direct information provided by EI professionals , it emerges that they use the SCID, either as a second-level tool for cases of diagnostic doubt or because there is already a tradition in its use within the service to which they belong. The *Columbia Suicide Risk Scale* is used less frequently.

Figure 17. ASST by frequency of use of initial patient assessment tools

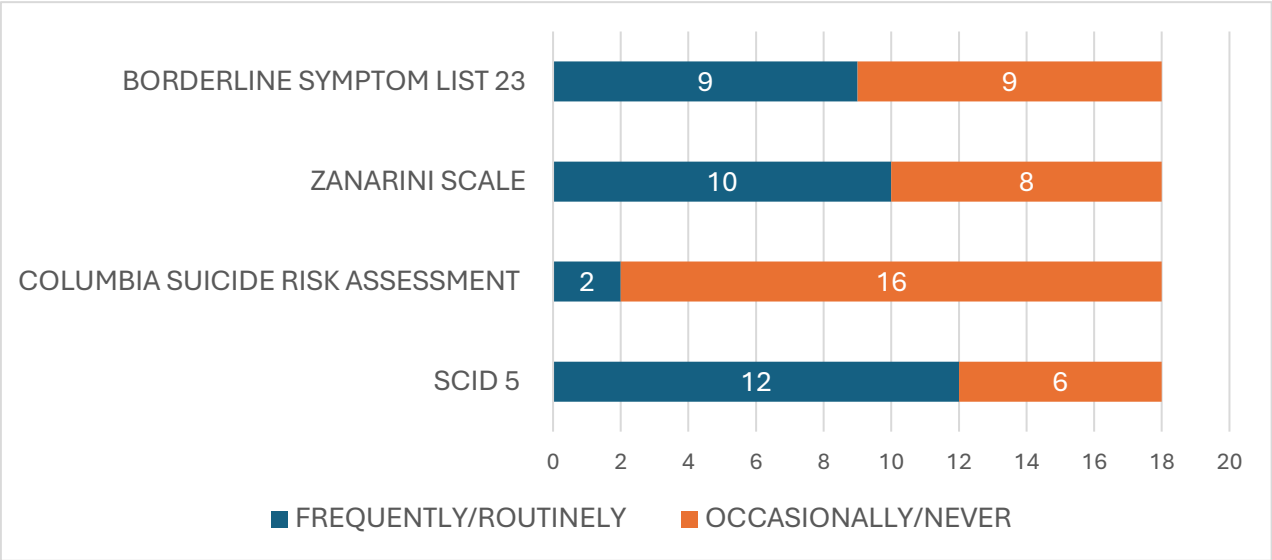
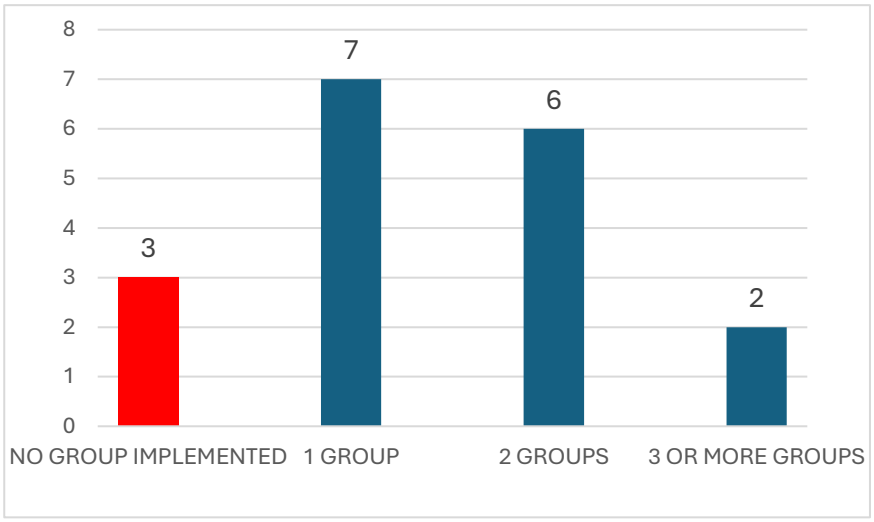
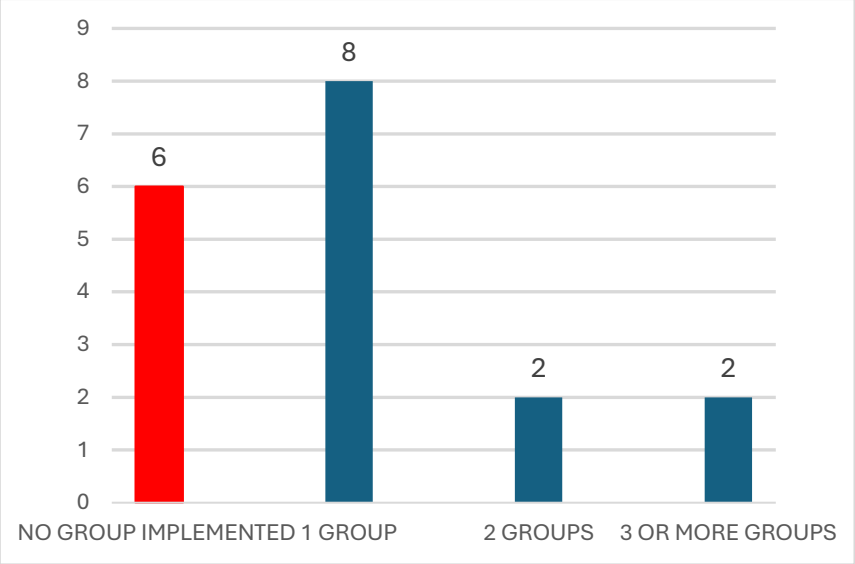


Figure 18. ASSTs by number of social skills groups implemented.



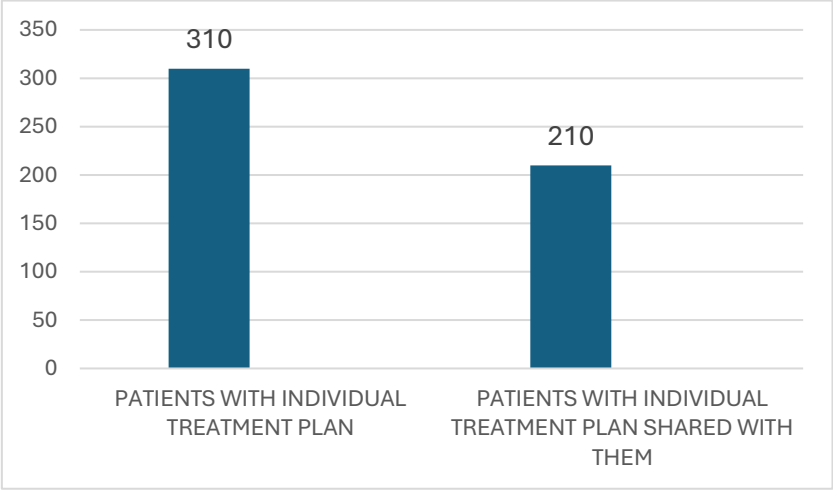
During the training the trainees were stimulated to activate two groups: the *DBT social skills training group*, addressed to the young patients and the *Family Connections group*, addressed to the family members. Regarding the ***DBT social skills training groups***, most ASSTs were able to activate one or two groups: in several cases it was a matter of continuing a pre-JA implementation process, while in others the JA acted as a driving force for activation. In any case, direct discussion with EI professionals shows a flexible use of the same groups, with the inclusion also of patients who were not initially planned to be enrolled (i.e. over 30 years old and/or not at the first contact with mental health services).

Figure 19. ASSTs by number of Family Connection groups implemented.



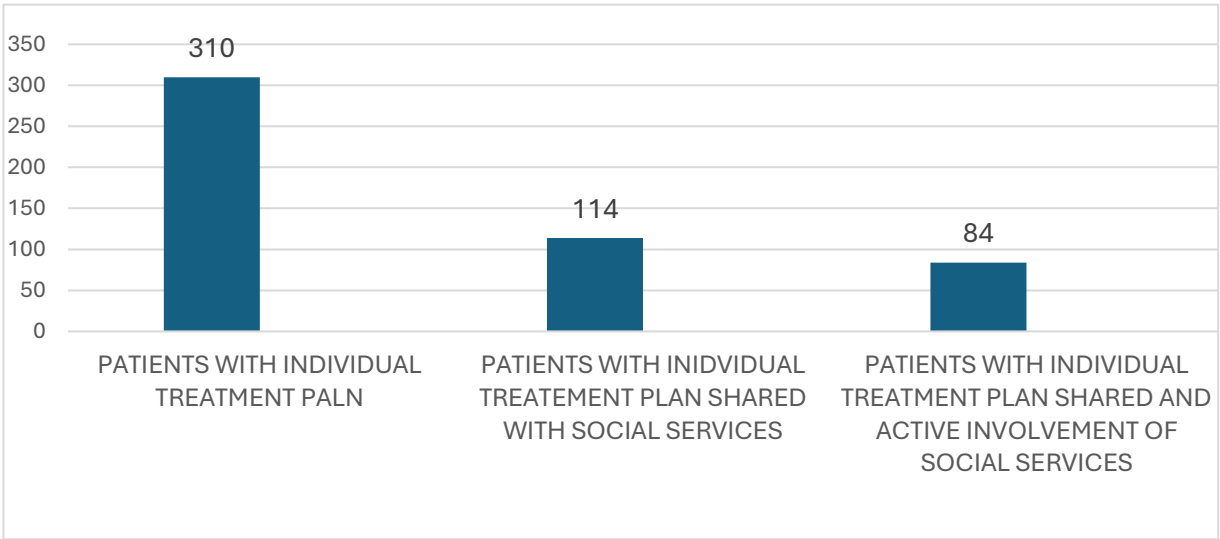
Regarding ***Family Connection groups***, two-thirds of EIs have activated at least one of them. For the remaining third, not active on this front, direct discussion with the professionals showed the precise choice to postpone the activation of these groups, preferring to start with those dedicated to patients and only later arriving at those focused on family members.

Figure 20. Individual Treatment Plans and Patients



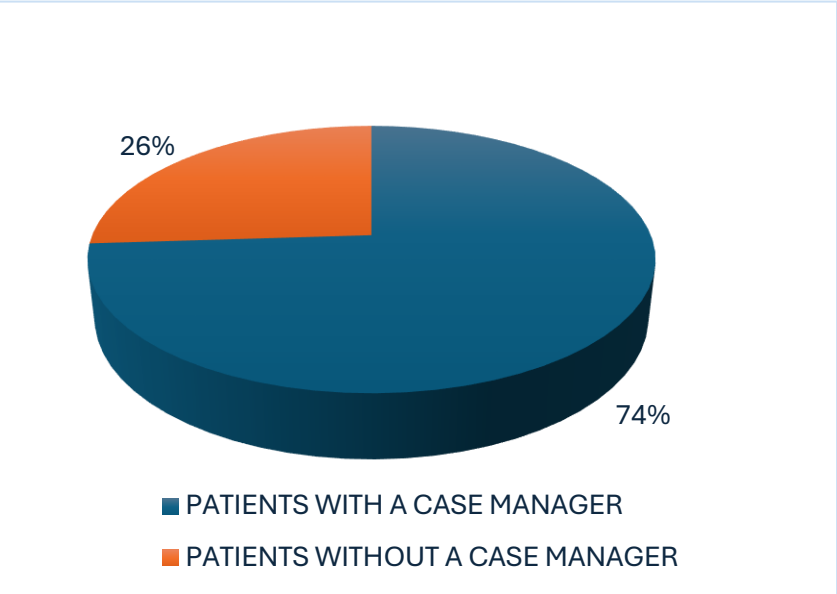
There is a gap between activated ***Individual Treatment Plans*** and those shared and signed by the patient (about two-thirds of the total). From the direct confrontation with the EI professionals , the gap between the desired sharing with the patient in the presence of the team and the real difficulty of carrying it out emerges.

Figure 21. Individual Treatment Plans and their integration with other local services



With respect to the **integration of the *Individual Treatment Plans with the other services in the area*** (social services, third sector), it is clear that almost all of those activated do not correspond to the number of those shared with the Social Services and the Services for social and work inclusion and to an even lesser extent with the interventions actually carried out, an element that makes us reflect on the difficulties of the relationship with Social services and the risk of considering the ITP as an administrative compliance rather than a good practice, also aimed at social inclusion.

Figure 22. Patients and Case Managers



Case management deserves a separate discussion which, even if it covers three quarters of patients, is limited not only by the scarcity of staff, but also by the different interpretations attributed by individual EIs. In some cases, it is seen as a function attributed exclusively to the Medical Doctor or Psychologist, in others also to the Rehabilitation Therapist and in others to the entire team.

These results, together with the elements collected during the video meetings with EIs, show the **great difficulty of networking in the transition from health to social sector** observed in the September 2024 survey**,** despite the increase in the project of the intersectoral collaboration with social services and services for social inclusion. While in the processes of collaboration within the ASST the EIs can start from **transition procedures already shared with the Child and Adolescent MH Services**, adaITPng them to the specificity of the target users of the JA, in the external one there are frequent difficulties in interfacing with the **Social Services** and the related Planning Offices. Referring to Family **Associations**, there is a difficulty linked to the fact that the latter had not until now played an active role in a homogeneous way towards a new emerging psychopathology (BPD) and in the young adult group. Nevertheless, the implementation of *Family Connection* groups has also allowed family members to participate in training, and therefore the activation of associations on this front. The mediation of U.R.A.Sa.M, which intercepted EIs and facilitated the involvement of local associations, proved to be even more effective.

The **U.R.A.Sa.M Association,** as a second-level association in defence of the rights of patients and family members for mental health, has contributed to the JA, facilitating the network of EIs with local first-level associations. The objective was to make a trained family member available to Family *Connection* groups and on the other hand to facilitate the organization of mutual self-help groups. The response of the EIs has shown marked variability, from territory to territory, but in general the activation times of these interventions with the Family Associations have gone in parallel with the activation of the Family Connection groups.

2.2.6 Communication

During the online meetings with the individual local areas, it was highlighted that forms of direct communication inside the Department of Mental Health (e.g. with the Director, with other MH facilities) were activated in almost all EIs**.** The same process took place, albeit in a slower and more difficult way with **the social services network,** while the **dissemination of the project's results** with respect **to the population** was almost absent. The latter seems to be linked to the absence of a communication strategy towards the population and in some cases also to the EI's concern in promoting a service, without the guarantee of being able to manage the extent of the consequent possible/probable new accesses.

With respect to the dissemination of the JA on a regional scale, the activities of the **Regional Implementation Group** have been designed with the aim of **informing the different recipients**, ensuring wide visibility and involvement among the key stakeholders of the Region, and to **promote the sustainability of the project** even beyond its conclusion.
Among the activities carried out by the TAV Cluster are the publication of **articles, newsletters and posts on social media** to reach a wider audience. Emphasis was given to **the collaboration with the Progetto Itaca Foundation** which, with its 17 active offices nationwide, represents an important Association of Family Members engaged in the promotion of mental health in Italy. Together with the Foundation, communications have been activated on social media (**Linkedin).** In spring 2024, the **Regional Implementation Group** wanted to take stock of the **implementation process activated in the Lombardy ASSTs participating in the project,** through a regional conference held on 9 May 2024 at the institutional headquarters of the Lombardy Region, Palazzo Lombardia. The Conference was attended by professionals of Mental Health Services and Family Associations. Alternating with the **plenary sessions,** interactive sessions **were proposed** to investigate with the participants the difficulties encountered in the implementation process and the solutions found to overcome them. In one session, a representative of the user association discussed the **positive aspects that this improvement action can bring to young people with BPD**. During **round tables**, two fundamental aspects for the implementation process were discussed with the main stakeholders in Lombardy (representatives of DG Welfare, ASST, ATS, Psychiatry SC Directors, project trainers and family associations): on the one hand, the importance of the fidelity of the implementation with respect to the training received, and on the other hand the future sustainability of the JA after its conclusion.

2.2.7 Monitoring of the project through the Social and Health Information System and the Questionnaire on the progress of the pilot implementation

To evaluate the implementation of the pilot, using the parameters of the ToC model, in a second phase **key indicators were identified to monitor the achievement of the outputs (activities) planned for the implementation of the pilot**. Taking into account that an evaluation of the *outcomes* within the project timeframe was not considered feasible, the focus of the development of the indicators was on the level of achievement of the outputs *of* the ToC model.

At Regional level, the indicators identified were included in a **Questionnaire on the level of progress of the pilot implementation** that the individual EIs filled in electronically during the implementation phase and at the end of it. Alongside the indicators collected through the questionnaire, others were collected through the **regional Mental Health Information System**. Specifically, indicators, relating to patient enrolment and delivery of interventions conducted within BP, monitored several times during the implementation process and updated at the end of September 2024.

2.2.8 The point of view of the professionals of the Implementation Teams

Discussions with the professionals involved in the implementation process show that:

- The **JA** represented a **push and a framework of reference for the ASSTs to think and plan** about the areas to be implemented.
- The **training** facilitated implementation and was an **incentive to use the most appropriate care pathways with BPD.**
- The **SWOT and PAP** have been found to be useful tools for greater awareness of the **context in which to implement and its strengths and weaknesses.**
- The **difficulty of enrolling patients at first contact** (with the consequent enrolment of patients already followed by Child and Adolescent MH Services or already in charge of the CMHC) and the **waiting lists compared to the visits of the Psychiatrist and the Psychologist** had a significant negative impact on the initial phase of the project.
- **The enrolment of patients, the delivery of interventions and internal communication within the DMH** were **more easily implemented** than the construction of intersectoral networks and external communication with Social Services and Associations.
- The **difficulty of communication and sharing between the Director of DMH and professionals** with respect to the objectives of the JA and BP has conditioned the implementation process, where present.

2.2.9 The point of view of Family Associations

The regional associations of family members have highlighted how:

- the level **of involvement of DMHs** on the issue of collaboration with **Family Associations** was **heterogeneous, facilitating or hindering intersectoral collaboration with associations at local level.**
- it is important to encourage **intersectoral collaboration between DMHs and local Family Associations** to share mutual resources**.** It is desirable not only to activate *Family Connection groups* for family members of patients undergoing treatment, but also for family members of patients who do not adhere to treatment (patients who struggle to access or refuse to access the treatment paths offered by local services or patients who are placed in residential facilities or prisoners).

2.3 SUSTAINABILITY (POST-IMPLEMENTATION PHASE)

Sustainability refers to the opportunity to **ensure the activity of the project beyond the end of the JA**. Among the actions aimed at this end**, the Consultation Group was activated,** involving the main regional stakeholders: representatives of Lombardy Region and of the main professional categories working in the Lombardy DMHs, representatives of family members and user associations, trainers of the regional implementation process and experts in the treatment of BPD. This group represented in the last months of 2023 and at the beginning of 2024 an embryo of what would be later activated in the ***Policy Dialogue meeting*.**

On 22 **July 2024** at the Lombardy Region Palace, the **Regional Implementation Group** activated a ***Policy Dialogue session*** bringing together experts, politicians, and stakeholders from various sectors to share knowledge, experiences and proposals on **the sustainability of the implemented action** after the end of the JA, starting from the intermediate results of the **implementation process in the Lombardy ASSTs participating in the project.**

In addition to the ***Policy Dialogue***, the other tool used for the identification of objectives for the consolidation and/or extension of the pilot actions after the end of the JA was a **simple *Implementation Roadmap***. This easy-to-apply tool can be used as a strategic plan to define the **objectives** corresponding to the desired results, the **conditions** for achieving them and the related **expected timeframes**. Within the JA, each country has drawn up its own map, starting from a common model.

The Lombardy Region Roadmap shows the result of the trajectories identified at the level of the Regional Implementation Group based on the elements acquired through the monitoring meetings at local level. A couple of sample ASSTs drew up their Roadmap, piloting the task that was later also delivered to the remaining ASSTs, together with a special compilation guide. At the ASST level, 14 Roadmaps were finally compiled out of a total of 18 planned. The Regional Roadmap and the two sample local Roadmaps were presented during the *Policy Dialogue* meeting mentioned above, together with a descriITPon of the implementation process in the 2 ASSTs.

3. JOINT ACTION ImpleMENTAL: LESSONS LEARNED

The extension of BP to two-thirds of Lombardy ASSTs and **the improvement of the quality of care** for patients included in the project were the main results of this implementation, since the enrolled patients received early and intensive psychosocial interventions more frequently. These results, both in terms of territorial extension and in terms of activities aimed at patients and family members, have been achieved not only thanks to the adhesion and motivation of the DMH staff but also through the ability of the DMH, as an organization, to welcome innovation and work to consolidate it, even in a moment of crisis like the current one.
The role of the regional mental health system in achieving these results has been decisive. Compared to the other countries that participated in the JA, the Lombardy Region and Italy had a significant advantage: a Mental Health System developed for forty years with a rich network of community services. The structure of the Lombard system, focused on the community, has allowed the extension of this project to two-thirds of the Lombardy ASST and the support of its implementation. Alongside the regional system, the pre-existing system at the local level has also exerted a strong influence, often facilitating, and sometimes hindering implementation. The tradition of Lombardy services of attention to patients at onset, the expertise in certain types of treatments, the involvement of staff already in service in the CMHC have proved to be a strength, while the lack of human resources in the CMHC, the difficulty in building intersectoral networks, the lack of attention from the Directors at the DMH level have instead negatively affected, sometimes significantly, the implementation process.
But the interest in this process goes beyond the results obtained in terms of the activity provided. Other results derive from the lessons learned along the way: the experience of the JA can be useful in identifying the factors and obstacles for future projects, both at local and regional level. Below we summarize the **lessons learned** during the implementation at the regional level, **accompanied by useful recommendations** to ensure the sustainability of the current improvement action and to make future projects in the field of mental health more effective.

- **The staff of the Department of Mental Health** represents a strength. These are staff who were not hired specifically for the project, but who were already present in the services with a permanent or freelance contract and will remain in the coming years. This has made it possible to look at the sustainability process of this improvement action in a more oITPmistic way. These staff were sensitive to the issue of early interventions in young people with severe mental disorder and, in some cases, had also already received training on the psychosocial treatment of BPD.
    - ***Recommendation.*** *Consolidate and strengthen the specialist teams dedicated to young people within the CMHC.*

- **The training** was decisive in activating the implementation process: the quality of the training days and the satisfaction of the professionals were certainly the strengths of this

project. The extension of training to other staff and the activation of supervision of clinical content was requested. However, training alone does not magically guarantee implementation. Without structured attention to how to transfer training contents into the real world of services, professionals often fail to implement it. One thing to think about is the fact that, in the transition from training to implementation, more than half of the trained staff did not participate in the implementation process. The cause is that in five cases the DMHs, despite having sent the professionals to the training sessions, did not actually activate the implementation process, while in other cases the trained staff were not working in community facilities capable of implementing. In regional projects it is necessary to precede or accompany the training with planning activities tailored on the DMH level, which clearly indicate the professionals and facilities that will be engaged after the training in the implementation process.

Recommendations.

- *Extend the training process to other professionals /structures, accompanying it with forms of supervision and implementing a regional connection network between the different ASSTs, to allow an exchange of experiences, including organizational ones*.
- *Identify at DMH level, before the start of the training, the personnel who will participate in the training and the facilities that will be activated, with the aim of facilitating the rapid application of the training contents in the practices of the services*.

- It was useful within the JA to devote targeted attention to the implementation process through the use **of specific planning tools**: starting from the analysis of the initial situation and needs (*SANA* and *SWOT Analysis*) and the definition of objectives (*Theory of Change*), to arrive at an evaluation of the results, based on indicators, through the translation of the same into actions to be implemented (*Action Plan*).
    - ***Recommendation.*** *To include specific tools for needs analysis, goal setting and activity planning in all implementation projects*.

- **Coordination at the regional level** has been a great resource: the capillary monitoring of the local situations of the ASST, their networking in a regional connection system and the continuous stimulation of planning and evaluation activities have made it possible to support the work of the individual EIs at the local level, favouring the implementation process.
    - ***Recommendation.*** *Always provide for regional coordination within the regional projects, which guarantees continuous contact with the implementation units and the monitoring of the progress of the project*.

- Within the implementation process, the areas of greatest difficulty for EI concerned **cross-sectoral collaboration** with stakeholders outside the health network, such as social

services. The crisis linked to the lack of human resources, but not only to those, has certainly made the activity of services at the level of intersectoral collaboration less incisive.

- ***Recommendation.*** *To consolidate cross-sectoral institutional collaboration in the treatment of young people with BPD both at the level of the Lombardy Region and Local Health Units and to include this objective within the Local Health Unit planning.*

- In the face of the lack of homogeneous care pathways at the community level for young people with BPD, the need to structure a **regional care pathway** that networks the different EIs has emerged. However, this path cannot be exhausted within the health sector, but must be integrated with the sector, as well as with user and family associations in order to promote social inclusion and *recovery*.
    - ***Recommendation.*** *Activate a treatment pathway at the regional level to improve the quality of care provided and promote the process of social inclusion and recovery for young people with BPD.*

- If the focus of the clinical activity aimed at young patients with BPD is on psychosocial treatments, particular attention, especially considering the present crisis of human resources in DMHs, must be paid to the spectrum of potential providers of such interventions. It is necessary to promote **task sharing *processes*** within the Departments that support a full use of the human resources already present, favouring the provision of structured psychosocial interventions by non-clinical professionals (nurses, educators, rehabilitation therapists) and their role as *case manager*. In some cases, the difficulty of the services in engaging in the implementation process was linked precisely to the choice of an important involvement of medical staff, which was not then sustainable, compared to the possibility to delegate to other professional figures.
    - ***Recommendation.*** *To promote and monitor task-sharing and task-shifting processes in the treatment of young people with BPD, both within the regional care pathway and at the level of individual DMHs.*

- The JA was also useful to take stock of the value and application of some procedures, such as **the sharing of the ITP with the patient or the assignment of the function of case manager**, which despite having been adopted for years in MH services, seem to have partly lost their meaning as "good practices" aimed at promoting the patient's recovery process, and run the risk of remaining confined to administrative obligations. As for the failure to appoint the case manager, the cause can often be sought in the scarcity of staff present in the EI.
    - ***Recommendation.*** *Disseminate the criteria for sharing the ITP with the patient and for the attribution of the role of case manager and monitor their effective use as a tool in the patient's recovery process.*

- A separate discussion concerns **the activity aimed at family members and the collaboration with user and family associations**. The activation of psychosocial interventions specifically aimed at the relatives involved only a third of them and about a third of the ASSTs were unable to start the *Family Connection* groups, specifically addressed to family members and conveyed by the training. It is clear how staff shortages affect these results, but there is also a non-homogeneous ability of DMHs to involve and get involved with associations of family members and users, who can instead collaborate in the provision of psychosocial interventions and become valuable allies. The same associations of family members and users are moving from a focus on the problems of chronicity to a broader and more inclusive one, also aimed at young people at the onset of a serious mental disorder.
    - ***Recommendation***. *Ensure in all DMHs a stable link with user and family associations to involve them in the delivery of psychosocial interventions, and as allies in the recovery process*.

- As already mentioned, in terms of service culture, the JA has re-proposed the themes of **intersectoral collaboration, social inclusion and recovery**, which are strongly sponsored by both the European Commission and the European Office of the World Health Organization. These issues are already an integral part of the culture of Lombardy MH services, but without continuous reinforcement in service practices, they risk not to be really affecting the quality of care.

    Recommendations.
    - *Integrate the issues of recovery and social inclusion within the regional care pathway and define them through measurable actions*.
    - *At the local level, involve the patient in the definition of his/her treatment program and activate the collaboration of user and family associations, the third sector and the social services of the municipalities, monitoring the results*.

- **Dissemination of results and communication,** both to other stakeholders and to the population, remain a challenge for DMHs, which are more focused on implementing innovative interventions internally than on externally aimed communication activities to inform a wider audience about their work.
    - ***Recommendation.*** *Develop, within projects, a closer relationship with the Office of the Local Health Unit dedicated to communication to promote information to the population on the innovative activities promoted by the DMH*.

- **Finally, monitoring and evaluation** are indispensable tools for the development of projects and for the analysis of their results. In recent years, the Lombardy Region has acquired considerable *expertise* in the use of information systems not only to monitor the activities provided, but also to assess their quality. From the comparison with the other countries participating in the JA, it became clear that a mental health information system, such as the

regional and national one, represents an asset and a strength of the mental health system in Italy. However, it requires a continuous maintenance of the quality of the data entered, in particular with regard to the completeness and updating of diagnoses and socio-demographic variables. In addition to this analytical capacity, already used during the JA, the need to evaluate the outcomes of the implemented treatments at patient level has been reported by several parties, especially by family associations.

Recommendations.

- *Routinely use the regional mental health information system to monitor the activities provided within projects and to assess their quality.*
- *Improve the quality of the data entered in the regional information system, for example by periodically updating diagnoses, to improve the appropriateness of interventions.*
- *Monitoring should also be accompanied by an evaluation of the outcome of practices and treatments at patient level.*