The birth of child and adolescent neuropsychiatry: from rehabilitation and social inclusion of the mentally handicapped, to the care of mental health during development

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Summary. Child and adolescent neuropsychiatry services’ development is described from early deinstitutionalization, through to rehabilitation, intervention and social inclusion of children with disability. The issues that have changed the services in order to meet the growing mental health problem, and the protection of mental well-being through developmental years, are then dealt with in detail. Finally we draw a picture of the organization of child and adolescent neuropsychiatry services in Italy and in the different regional contexts.

Key words: childhood/adolescent, de-institutionalization, disability, psychological suffering, mental health.

INTRODUCTION

In treating this subject, I will focus on what I believe are the essential turning points, which have lead to the breakthrough in interventions offering an alternative to the institutionalization, and isolation of mentally handicapped children in the 1970’s, and the creation of those services we now call child and adolescent neuropsychiatry or mental health for childhood and adolescence. Those first interventions developed services in various territories and the coverage, which was originally concerned only with disabled children, has progressively extended it’s goals and intervention areas but has developed in a fragmented and differentiated way due to the lack of specific national and regional planning.

The turning points can be identified as:
- the first interventions towards the deinstitutionalization of children and school marginalization processes;
- school integration policies for children with disabilities; Law 104 for the inclusion of children with disability;
- development of child and adolescent psychopathology and the creation of child and adolescent neuropsychiatry services;
- approaching strategies for the protection of mental health in childhood and adolescence;
- state services. Various service organization nets and their configuration in regional plans.

“SPECIAL” ITALY AND THE MARGINALIZATION OF CHILDREN IN THE 1960’S

The Mental Homes Institution, was at the centre of the controversy, which called for a radical change in mental health treatment in Italy in the 1970’s; the Law 180 of 1978 “Assessments, and voluntary and compulsory sanitary treatment” introduced a fundamental change in the way in which mental illnesses were treated, and radically shifted, from the idea that patients should be treated in institutions, to the idea that patients benefit by living in their own environment, close to relatives and in their own social area. Those who worked at the time in this area know perfectly well that Basaglia’s cultural and
scientific elaborations concerning child psychiatry policies, didn’t primarily involve mental homes, but focused on other institutions which at the time represented the most evident sign of marginalization, and, unfortunately, of violence on children: social welfare homes for children and subsequently special school structures. The division of psychiatry policies, which in our country have developed into separate interventions for children and adults can clearly be seen in the first years of affirmation and renewal of mental health policies; for example, the Law 180 of 1978 doesn’t refer at all to under-aged children, even if their presence in mental homes was a considerable phenomenon. The relation between childhood and mental homes wasn’t considered in depth, or underlined, in those decades: information was poor and related scientific research was rare. The few publications which can be found, concerning this tragic side of the story of Italian mental homes; usually try to reconstruct the presence of children in mental homes by studying single mental homes, such as the one in Santa Maria della Pietà Hospital in Rome [1]. But the truth is that mental home’s experience in childhood has affected more deeply than we could think. Children with disabilities, not only intellectual, but also motor and sensory, including those labelled as “bad behaviour” were sent to mental homes; obviously children from poorer social classes were more likely to be institutionalized. Many authors, in the last few decades, have studied the story of mental homes in Italy and the development of psychiatric treatment; the great majority of their studies don’t even mention the presence of children in mental homes. “The silence that enfolds them is louder than their screaming. Victims of institution and sometimes of real tragedy, they don’t seem to exist, they’re often not even mentioned, and they appear even more isolated than adult “crazy” people. They are the ones who won’t be rehabilitated, they will die in a mental home in a few years or end up being chronic patients and moved to the adult wards, or transferred to other mental homes or institutes” [1; pag. 15].

Unlike the presence of children in mental homes, there was considerable social attention and request for change at national level for the de-institutionalization of children from children’s institutes, and subsequently for a change in childhood marginalization policies, lead by special schools and classes, the “different classes”. The 1960’s were defined by a massive children’s institutionalization and by the proliferation of special classes nationwide. These processes have been the base of our country’s social and welfare policies. On the 31 December 1960, the statistical year-book of welfare and social security (Istat data, [2]) showed that institutionalized children were:
- 112 956 in orphanages;
- 87 594 in “institutes for poor and abandoned children”;
- 61 402 in permanent colonies, that is “institutes that accommodate lymphatic, anaemic and TBC prone children etc.”. In reality children were almost always hospitalized for social/economic reasons;
- 18 464 in institutes for “other categories of patients”;
- 10 081 in institutes for “mentally disabled people”;
- 8699 in the new orphanages for “internal upbringing”, 3768 of these children weren’t acknowledged by their parents;
- 7624 in institutes for “sensory impaired”;
- 3506 in institutes for “physically impaired”.

This meant that, on 31 December 1960, there were 310 326 under-aged patients hospitalized in isolation institutes. The first reasons for institutionalization were poverty and abandon, but there was also a very strong trend towards the isolation of the disabled, sensory or intellectual; in fact institutionalization was the basic model for rehabilitation and recovery from any disability. We can’t even be sure of the number of functioning institutes because Istat’s data, on 31 December 1968, show 3871, while the National League for Maternity and Infants (ONMI) counted over 5000. Evidence of those days can be found in many court reports and related proceedings [3-5]. Two very sad and dramatic stories, emblematic of the level of violence that the institutional system had reached in those years, and events which had a deep impact on the public opinion at that time, showed the spreading of a system based on nepotistic tangles, economic interests and connivance inside of the institutional authorities who had completely abandoned any kind of control and supervision. In particular they also showed what was taking place inside the institutes for disabled children; two expressions of this are:
• the Maria Vergine Assunta in Cielo Institute in Prato, known as “Celestini’s Institute”; some of it’s executives and “educators” were sentenced, for serious acts of abuse on the hospitalized children, by the Florence Court on 3 December 1968. From the official records of the trial: “S. is ten years old, at the time of the events only seven. Testifying in front of the judge he had told of abuse, harassment by ... who had beaten him and hit him with a stick, had bathed him in cold water holding his head underwater and sometimes had made him lick dirt off the floor and other boy’s urine...”;
• the Santa Rita Institute in Grottaferrata headed by Maria Diletta Pagliuca, sentenced by the Corte d’Assise in Roma on 21 December 1971 also for “continual ill-treatment, and even worse, by the fact of having caused serious damage to 4 under-aged children and the death of 13 children in her care; with the further aggravation of having acted with purpose of profit”.

Violence, physical and psychical abuse, poor food, and a lack of basic hygienic conditions lead to the closure of both institutes and to a sentence for many of the accused.

It took a very long time to reach these sentences due to a very complex network of interests and cor-
ruption, which delayed and conditioned them. This network was called “assistance’s golden pasture” to underline how, economic and nepotistic aspects ruled and influenced assistance policies at the time. With regard to this we must remember how long it took to suspend and stop those savageries: it took 32 years to close the Celestini’s Institute and 18 for the Santa Rita in Grottaferrata, from the first reports of serious educational and structural deficiencies, and the violence which these children suffered, to the closure of these places, rightly defined “lager”. Another remarkable thing about these episodes is that the great majority of charges and accusations were made by private citizens, not by public, private or ecclesiastic authorities, which were directly responsible for the control and management of these institutes. The corrupt system had much more than just an economical interest; we won’t go into how the official scientific bodies (medical, psychological or pedagogical) allowed institutionalization with continuous scientific alibis, passing off institutes as the main method for rehabilitation in cases of disability and mental illness in children. In regard to this corruption we give only one example: in spite of the fact that many years have gone by, and we still can hardly believe how a violent and sadistic woman such as “doctor” Diletta Pagliuca, could have been so well thought, in fact she was invited to lecture at the Montessori’s followers congress in 1957 [6].

Along with this institutional system was also a consolidated school policy of marginalization and exclusion, through the diffusion of “different” classes and special schools. Basically all socially deprived children together with those with low and medium intellect or language deficiencies were placed in these special schools and classes.

**“SPECIAL” SCHOOLS IN ITALY**

**School year 1966/67**

In 1966/67 [7] in the Italian schools there were 40 573 pupils in “differentiated” classes and 60 490 pupils in “special” schools.

A total of more than 100 000 children were placed in special schools; but if these numbers reflect just how common special schools and classes were, we must also point out how hard the selection system must have been, as we can see by the high number of students repeating the year in 1966/67: more than 500 000. This situation was revealed after studying official reports, mainly the Istat’s yearbooks, but these sources, due to their fragmented survey system and partiality of considered situations and data, it is very difficult to evaluate the actual effect which these marginalization processes had on the territory. We can get a clearer picture from studies of smaller environments, where the documentation, not a priority at the time, gives us the chance to better understand the quality and quantity of the institutional children marginalization. One example is the survey that studied school and welfare institutions in the province of Modena [8; see Table 1].

It seems relevant, that the percentage of children in differentiated and special classes, reaches 4.1% of the total, especially if we compare it with today’s percentage of disabled children, that is now steadily set around 2% of the entire school population. It’s important to remember that in the province of Modena there were still more than 500 disabled children in institutes in 1972.

**THE GROWTH OF SERVICES AND INTERVENTIONS**

The reality of services today, shows an actual reinforcement in primary strategic planning in the interventions for the handicapped and disabled, but it is also an expression of how processes have strengthened, and changed, and how organisation and scientific development have grown in the last ten years. Some data may be considered representative of the latest development in interventions, which has become today’s “child and adolescent neuropsychiatry” or “mental health and rehabilitation during formative years”.

The first census carried out in Emilia Romagna regarding service quality, the rehabilitation of the handicapped and child neuropsychiatry, allow us not only to review the operative situation during the early 80’s but also confirm the rapid change in methods of intervention in a relatively short time since the 80’s [9; see Table 2].

From these results we have a clear picture of how the services were in the 70/80’s, where sensory impairments were strongly represented, along with physical and neurological pathologies, and the use of the service is mainly in the child and pre-adolescent age group: in fact in the 70’s the services co-

<table>
<thead>
<tr>
<th>Table 1</th>
<th>The special and institutional context in the Province of Modena (years 1970-1972)</th>
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<tbody>
<tr>
<td><strong>Year 1972</strong></td>
<td><strong>Year 1970</strong></td>
</tr>
<tr>
<td>Under-aged children with disabilities in segregating institutions</td>
<td>502</td>
</tr>
<tr>
<td>Pupils in “differentiated” classes</td>
<td>173</td>
</tr>
<tr>
<td>Pupil in “special” classes</td>
<td>520</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1195</strong></td>
</tr>
</tbody>
</table>

*Pupils in “differentiated” and “special” classes on the total of children attending school (1972)*
Table 2 | The users of child and adolescent neuropsychiatry services in the Emilia Romagna Region. Distribution of specific pathologies. Confrontation of years 1980-1994

<table>
<thead>
<tr>
<th></th>
<th>CENSUS 1980</th>
<th>Regional register 1994</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, neurological pathologies</td>
<td>38.2%</td>
<td>11.4%</td>
</tr>
<tr>
<td>Cognitive pathologies</td>
<td>26.4%</td>
<td>30.6%</td>
</tr>
<tr>
<td>Sensory pathologies</td>
<td>16.6%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Total</td>
<td>81.2%</td>
<td>44.9%</td>
</tr>
<tr>
<td>Relational and emotional problems</td>
<td></td>
<td>39.1%</td>
</tr>
</tbody>
</table>

...ed almost exclusively children with disabilities under the age of 14.

During two decades of use, these services have undergone substantial changes: the number of cases of physical and sensorial pathologies has dropped significantly; this is due to various factors which require only a brief referral in this article: the profound changes in social environment and population, the diffusion of various campaigns for widespread prevention of illnesses such as German measles, the improved care of mothers during pregnancy and of newborn babies, and vast reforms in the health service network. The fall in the number of cases of psychical and sensory disabilities through the last decade is difficult to assess due to the much more complex assessment methods and treatments used today. In fact today’s services are faced with the need to acquire not only more sophisticated skills, but also different models of intervention in a network in continual evolvement. Through the examination of recent data we find a greater stability in the activities related to language and learning difficulties, mental retardation and communication/social related problems, and the area defined as “mentally handicapped” in the past, is today more correctly referred to as part of the autistic range of symptoms.

Another important phenomenon which characterized the 80’s, through to the 90’s, was the involvement of health services in the child and adolescent psychological pathologies; this involved a larger number of interventions dealing with psychological and psychiatric problems and a growing number of adolescents making use of the services.

In brief the service’s register of Emilia Romagna’s users of child and adolescent neuropsychiatry shows that in 1998 1 in 2 users are in a condition of psychological distress, and in relation to year groups 1 in 4 is an adolescent.

THE EVOLUTION OF OPERATIVE STRATEGIES AND THE CONSOLIDATION OF SERVICES, REGIONAL DATA FOR Pиемонте AND EMILIA ROMAGNA

Ulterior elements to consider when valuating the services and the consolidation of their activities, can be seen by confronting the latest data emerging from the data processing systems, in use in regions such as Pиемонте and Emilia Romagna [10]. The data from these two systems make a perfect confrontation possible. The high percentage of patients in care in regards to the target 0/17 population (5.2% in Pиемонте and 5.9% in Emilia Romagna), show how deeply rooted these services have become for the children and adolescents in these areas.

The same results have emerged from all other areas where the services are structured and solid. The consistency, in the numbers of users, is an indication of the number of children under care, whose level of handicap is estimated as stated in the Law 104.

The percentage of disabled children is approximately 2% of all school age children (2.1% in Piemonte and 2.3% in Emilia Romagna), a valid example of the national average. But the disabled children as stated in the Law 104, now represents only 30% of service users regionally, confirming the tendency of using the services for situations motivated mainly by the presence of psychological problems. Studies reveal that the pre-adolescent and adolescent age group represent 40% of total patients.

STRATEGIES FOR THE PROMOTION OF MENTAL HEALTH IN CHILDHOOD AND ADOLESCENCE

Healthy means not only the absence of illness, but the sense of well being, the protection of this is not the exclusive concern only of the health service, nor can mental health be seen as the exclusive role for mental health specialists.

Mental health also becomes a general political objective, no longer the sole responsibility of the health service but a joint effort and network for interventions; actions taken require consideration for the promotion of mental health not only within this sector but throughout the public health service, and all political bodies who are responsible for mental health through every phase of life of individuals [11, 12].

Mental health in children and adolescents, cannot be considered apart from the contest of the child’s life (family, school, social environment) and so from interacting with the family, specialised health network, services in schools and education, social services and independent social bodies.

And so, if the contrasts, disparities and need of integration between social health and education, through preventive measures, become the central base for programming the activities for health in all areas, the mental health and “culture of childhood” aims for actions in contrast to poverty and conditions of psychological and emotional deprivation and confronting the problem of families at risk, early school abandon, child labour and immigration. A mental health program for children and adolescents requires a prevention and care analysis as early as possible in relation to psychological problems in children. For a long time this objective has been evident in the various national and international agencies for child...
health, but the operative strategies needed to reach this objective require a difficult and complex integration of the networks for child health services. Some data are already available to allow us to understand the dimensions and composition of the help needed, for example it could be useful to analyze data from the Rimini area, that keep together information from child and adolescent neuropsychiatry services and social services for minors [10].

By adding together data regarding the amount of patients using these two services we have a total percentage (12.1% of resident under-aged children) of patients in formative years that is very similar to the ones that national and international agencies have been showing in the last years.

User’s diagnosis underlines the diffusion and distribution of child and adolescent suffering (different expressions of distress, social and economical deprivation, situations that put development at risk) but also show how these needs have grown in the last few years.

Data give us the chance to notice some relevant aspects of this matter such as the growing number of young children living in difficult social and economical conditions. This has been acknowledged as one of the most common risk factors and with the worst consequences on children’s development. Between 2001 and 2005 the percentage of children admitted for economical difficulties has grown from 22% to 40% of the total of social service users.

Another relevant data is the growing number of immigrant children, coming from various countries, and of under-aged sent by the court to under-aged protection services (Table 3). On the total population of children from 0 to 17 we have a relevant percentage that are undergoing legal processes. Unfortunately we haven’t got many opportunities of confronting this data; it seems that this 1.2% of under-aged taken in charge because of legal processes can be considered representative of a much wider phenomenon if we think that the percentage of children with disability is 2% of the total population of under-aged (see Table 3).

There’s no doubt that neither single professionals nor specialized services can cope alone with such a huge number of children and adolescents suffering alone, what is required is a comprehensive political intervention, where national and regional governments, families and all health and educational services work together in defining goals, working out new strategies, monitoring results and organizing a rational use of suitable resources.

The intervention sphere is vast, so we must choose priority interventions, in relation to prevention, early diagnosis, and care, giving special attention to specified age groups. It seems reasonable to remind the goals shared by important internationally agency as the Department of Health and Human Services [13].

This National Agenda for Children’s Mental Health follows objectives written in the United States by the unified conference between the Department of Health and Human Services, the Department of Education and the Department of Justice; they call for objectives which take into consideration the amount of children suffering every day, due to the lack of a coordinated and integrated answer, to their emotional, behavioural and cognitive, needs from the system of services and working networks which were created for the exact purpose of taking care of them. These remarks lead to the following suggestions of priorities:

1. promote the acknowledgment of mental health as an essential part of children’s health;
2. integration mental health services for families, children and adolescents into the existing system for children and teenagers;
3. involve families and their views on children and teenagers, when scheduling the entire mental health care system;
4. develop and increase a private-public system able to support these efforts in an extensive way.

THE CONDITION OF CHILD AND ADOLESCENT NEUROPSYCHIATRY

The child and adolescent neuropsychiatry services have suffered for a long time now, in various regions, from organizational incongruities, and strong limitations in relation to financial and human resources.

For this reason the Italian Child and Adolescent Neuropsychiatry Society ran a survey in 2007 in order to ascertain the real existence and consistency of services in the 20 Italian Regions.

The results of this survey show that:

1. in 12 regions child and adolescent neuropsychiatry services have been formally created;
2. in 8 regions they have a clear and unequivocal denomination;
3. 7 have a specific plan for these services inside the region;
4. only 3 have fixed organization in operational units;
5. 9 have not been allocated a specific budget.

In relation to a departmental location of the child and adolescent neuropsychiatry services in the 20 regions, we have the following situation:

- 4 merge directly with the Mental Health Department;
- 4 merge directly with the Mother/Infant Department;
- the other 12 merges in various ways.

<table>
<thead>
<tr>
<th>Table 3</th>
<th>Under-aged protection service users. Data from Rimini’s National Health Local Unit, years 2001-2005</th>
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<tbody>
<tr>
<td></td>
<td>2001</td>
</tr>
<tr>
<td>Under-aged immigrant childrens</td>
<td>23.4%</td>
</tr>
<tr>
<td>Nationalities</td>
<td>40</td>
</tr>
<tr>
<td>Under-aged children sent by judiciary measures</td>
<td>305</td>
</tr>
<tr>
<td>% of under-aged under care of the service</td>
<td>18.3%</td>
</tr>
<tr>
<td>% of total population of under-aged children</td>
<td>1.1%</td>
</tr>
</tbody>
</table>
Regarding specific skills for integration at school – as stated in the Law 104:
- in 15 regions out of 20, the support for integration in school is provided by the child and adolescent neuropsychiatry services, alone, or in collaboration with commissioned rehabilitation services;
- in 10 regions there is still no sign of the enforcement of this Law of February 2006;
- in 7 regions they depend directly on the Disabled Commission.

Regarding the presence of different services in the 20 regions:
- child and adolescent neuropsychiatry medical specialists are in every service;
- there is a variable presence of psychologists;
- therapists are represented in a very fragmented and diversified way (we rarely find all therapists in the same service or in an homogeneous way in the region);
- we rarely find professional educators;
- there are many social workers in Southern regions but none in the Northern ones.

We have data from 10 regions concerning the total number of workers: it differs from 1 every 680 children to 1 every 10 000 children in the 0-17 age range.

As for rehabilitation it’s external to the service:
- less than 20% in 4 regions every 20;
- 20-40% in 7 regions every 20;
- 40-60% in 4 regions every 20;
- 60-80% in 4 regions every 20;
- more than 80% in 1 region every 20.

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References