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University psychiatry in Italy. Organisation and integration of university clinics and the National Health Service

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Abstract
Introduction. In the Italian psychiatric system, community-based care has become increasingly important and widespread since the national reform of 1978. This report aims to provide an overview of the involvement of university medical schools in this process, considering their responsibility for teaching and training specialist practitioners and professionals.
Methods. The study was carried out between early 2010 and February 2011. An 18-items, self-administered, questionnaire was designed to investigate the number of faculty members that are responsible both for running a clinical ward and for providing community-based healthcare.
Results. Nine out of 53 faculty members (17%) manage a Mental Health Department, 9 (17%) manage a University Department, and 2 (3.8%) manage both types of department. Less than half of the teachers have full responsibility (hospital and community); however the percentage reaches 73.2% if we include the hospital wards open to the community emergencies. The remaining 26.8% have no responsibility for community psychiatry. Moreover there were undoubtedly still too many universities with specialisation schools that are without an appropriate network of facilities enabling them to offer complex psychiatric training.
Discussion. As expected, there were several types of healthcare management that were not uniformly distributed throughout Italy and there were also marked differences between mental health care provision in the North, Centre, and South of Italy. The university involvement in clinical responsibility was great, but at the management level there was a lack of equality in terms of clinical care, which risks being reflected also on the institutional functions of teaching and research.

Key words
- mental health services
- university
- psychiatry
- teaching hospital
- medical school

INTRODUCTION

The Italian situation has undergone a significant transformation process that began when Laws no. 180 and no. 833 came into force in 1978 [1, 2]. These laws decreed the start of a deinstitutionalisation process, prohibiting the use of psychiatric hospitals, transferring the diagnosis and treatment of mental illnesses into general hospitals, and transferring care of and responsibility for those suffering from psychiatric illnesses to the community and to the patient's socio-environmental context [3]. The rationale underlying this process was that individual, environmental, and social projects would be set up for clinical care and treatment, within a "tightly woven" network of services [4].

However, decisions about ways and means to implement this process were delegated to the Regional Governments, which on average took about ten years to issue appropriate laws. From the mid-1990s, two National Mental Health Projects (NMHP) for mental health were drawn up [5, 6], which contributed to establishing operative parameters and minimum standards for staff and structures [7], but gave few indications concerning the universities' participation in the process of deinstitutionalising mental healthcare and transferring it to the community. The difficulty of attributing specific responsibilities was immediately obvious, and the speed or otherwise of local application of the NMHP depended greatly on the specific situation obtaining in the region's public health service [8, 9]. This lack of uniformity often lead to preconceived ideas, one of the commonest concerning the protracted absence of academia from the psychiatric reform [10].

This report presents a detailed and in-depth de-

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scription of the clinical care provided by Italy's university psychiatry institutions, considering that, in the psychiatric field, this activity is carried out in different types of health structure:

a) hospital services, that includes General Hospital Psychiatric Wards (GHPW) [11], University Clinical Wards (UCW) and Other Hospital Services (OHS): outpatient services, day hospitals and consultation-liaison psychiatry services);

b) territorial services, that include Mental Health Centres and day centres (MHC), Residential Facilities (RF), with types A and B residential facilities, housing communities, accommodation units (ranging from supported to minimal care), crisis centres, and thus several other initiatives (*i.e.*, Therapeutic Foster Family Care Services, professional training and job placement, psychotherapy groups, and activities with associations of family members) [12].

The complexity of these activities, and the non-uniform attribution of healthcare responsibilities in general [13] and especially in Italy (due to both the independence of Regional Authorities on questions of public health, as well as the independence of universities with regard to their specific duties [14]) have made this survey necessary. It was completed in February 2011, and aims to provide an overview of the training provided by universities, as a function of the structures available for students' clinical practice [15, 16].

The data reported here thus fulfil the aim to show how, and to what extent, university psychiatry is today interpenetrated with the hospital and community-care frameworks, also taking into account the need for an ever-increasing integration between universities and the National Health Service (NHS), as recently pointed out in Law no. 240/2010 [17].

METHODS

In order to investigate the degree of interpenetration between the universities and the NHS, those universities in which there was at least one Faculty of Medicine, where Scientific Disciplinary Sector (SDS) MED/25-Psychiatry was taught, were selected from among the 98 Italian public and private universities. A total of 38 universities were eligible (36 state universities, 2 non-state universities) with 39 Faculties of Medicine at which SDS MED/25 was taught (both at the Rome Biomedical Campus and at the Salerno University psychiatry is not taught, and thus, were not included in this survey).

For the 39 Faculties included in the study, the university psychiatrists were first determined who, at least on the basis of Law 582/80 [18] (known as "Lodo Papaldo" [19], dictating specific regional conventions) should be in charge of a University-Managed Complex Structure (UMCS) because they were Full Professors (FP) – for whom teaching and research duties are indivisible from the requirement to provide clinical care – or alternatively because they were Associate Professors (AP) or University Researchers (UR) occupying teaching posts in the absence of a FP, or anyhow in charge of a UMCS. Applying the following methods, 53 university psychiatrists were included in the study. As first step, all FPs were included; to these were added the APs and UR occupying teaching posts in Psychiatry where there was no FP, or in charge of a UMCS (which occurred in some very large universities). Clinical psychology wards and simple health structures were excluded even where they were managed by a MED/25 professor (as for example occurs at Turin Molinette). In all, 42 FPs, 10 APs and 1 UR were thus selected, together with 50 UMCS.

The investigation began in early 2010, and was carried out by means of self-administered individual questionnaires sent by e-mail, and comprising 18 items. Some of these had two-way replies (yes/no) while others were open questions, in which the assignment of care-giving responsibilities and any peculiarities could be described in detail. The yes/no items related to management responsibilities of the structures included in the NMHP, whereas the open-reply questions concerned the legal and regulatory framework, the relationship between university structures and the community, in particular with regard to the types of clinical responsibilities, the teaching post and the role played by the specialisation schools, and lastly the presence, if any, of a clinical psychology course. Given their complexity, these last questions are not included in this report.

In order to ensure the highest-possible response rate, the questionnaires were sent repeatedly; some items were also explored in greater depth in telephone interviews with the structure heads (this was also necessary because of the marked diversity in the provision of clinical facilities, caused by the regionalisation of the NHS).

By February 2011, 100% of questionnaires had been returned, completed and in many cases integrated by direct interview. Subsequently, in order to guarantee the accuracy of the information collected, a summary was sent to all structure heads for confirmation that the situation described corresponded at that point in time to the existing one. Confirmation was received in 100% of cases.

The information flow and data processing were handled by the Mental Health Care Department, "San Luigi Gonzaga" Faculty of Medicine and Surgery, Turin University.

The medical care responsibilities of the 53 university faculty members considered were analysed by two criteria: the first, relating to the individual members and to the type of structure; the second, subdividing the structures by independent educational seat or faculty (*e.g.* Milan), to determine the availability of healthcare facilities to the discipline. For example, Bologna and Chieti Faculties of Medicine attribute GHPW responsibilities to a FP, and community-care responsibilities to another FP. If the description were limited to each individual faculty member, the structure might appear to possess responsibilities for certain sectors, whereas the university structure overall provides complete care that is consistent with the indications of the NMHP.

RESULTS

The study includes 53 faculty members and 50 UMCS, because 3 university professors (2 FP; 1 AP) do not have II level managerial status *(Table 1)*.

Table 1 shows the geographical distribution by macro-areas of the universities that include a faculty of medicine and also complex psychiatry structures under university management. In the north of Italy, for 17 universities and 18 faculties, there are 23 psychiatry UMCS; in central Italy, for 11 universities and 11 faculties there are 14 UMCS; in southern Italy, Sardinia and Sicily, for 10 universities and 10 faculties there are 13 UMCS. Thus, of the three macro-areas, psychiatry UMCS, as well as universities and faculties, are more numerous in the north (46%) than they are in the centre (28%) or South (26%) of the country.

University Management of Departments of Mental Health and of University Departments

Considering the management responsibilities of university MED/25-Psychiatry staff, both at the academic level and in terms of medical care, 9 out of 53 faculty members (17%) manage a Mental Health Department (MHD), 9 (17%) manage a University Department (UD), and 2 (3.8%) manage both types of department *(Table 2)*. Two also hold the post of Faculty Dean.

University management of MHD, *i.e.* the prevalence of healthcare responsibilities, is particularly concentrated in four regions of northern Italy (7 university-managed MHD), while there is only one in central Italy and one in the south. The distribution of UD management is more uniform. The two faculty deanships are in the north: Turin San Luigi Gonzaga and Verona.

Healthcare facilities under university management

In the analysis of the management of UMCS, data were subdivided by type: hospital and/or community-based context (*Table 3*). Thus the types of structures relate to those provided for by NMHPs, with the addition of University Clinical Ward (UCW) whose existence within the Italian psychiatric care situation is the result of the pre-existing university institutions, which have maintained the setup of extended-area and exclusively voluntary hospitalisations.

The UMCS total 50; two FPs and one AP are not responsible for clinical management, despite the first-tier university posts of the FPs and the fact that the AP is, alone, responsible for teaching within the degree course of Medicine and Surgery.

39 faculty members out of 53 (73.6%) are in charge of at least one hospital ward (GHPW and/or UCW): 24 (45.3% of the total) manage a GHPW and, of these, 2 also manage a UCW. A further 15 (28.3%) are in charge of a UCW.

15 (28.3%) are responsible not only for a hospital ward (12 GHPW; 3 UCW) but also for at least one community-based unit. In particular, at Turin Molinette the management of the PDTS ward is not in the hands of the university, which is however in charge of the MHD to which that ward is attached, and thus, it was preferred to consider Turin Molinette among the structures with clinical ward and community-care unit, since the healthcare responsibility of the Director of the MHD over the PDTS ward is limited.

Lastly, 24 (45.3% of the total) manage a hospital ward but are not responsible for community-based care (12 GHPW; 12 UCW).

Analysing these data starting from the provision of community-based healthcare, 20 of the 53 faculty members (37.7%) are responsible for a complex community-based unit and, of these, 5 (9.4%) do not have hospital wards. Lastly, 3 (6%) are not responsible for managing complex medical care structures.

The allocation of medical care responsibilities described above relates to the universities considered, taking into account the non-divisibility of their responsibilities (teaching, providing medical care, research). However, in many universities, the role of MED/25 Psychiatry teaching is covered by more than one faculty member; these persons are often involved in teaching various courses of the degree in medicine, as well as those of other health-related degree courses. Considering the attribution of responsibilities for providing community-based care, subdivided by university or by faculty, rather than by individual MED/25 lecturer, in some universities more than one faculty member is in charge of a complex structure, with diversified responsibilities. For example, the universities of Turin, Bologna, Chieti and Verona appear twice each in *Table 3*: as seat with hospital ward without community-based responsibilities ($\text{Turin}_{\text{MOL}}$2, Bologna1, Chieti1) and as seat with no ward and only with community-based responsibilities (Bologna2, Chieti2). Verona appears both as seat with GHPW ward (Verona1) plus community-based responsibilities, and as seat without any healthcare responsibilities (Verona2). Similarly, Messina appears as being without care-giving responsibility, while it is present as UCW. In actuality, the Turin and Bologna seats in-

Table 1
Geographical distribution of universities, faculties and UMCS by macro-area

Macro-Area	University	Faculty	UMCS
North	17 (44.7%)	18 (46.1%)	23 (46%)
Centre	11* (28.9%)	11 (28.2%)	14 (28%)
South	10** (26.3%)	10 (25.6%)	13 (26%)
Total	38 (100%)	39 (100%)	50 (100%)

*Of which 1 non-state (Milan San Raffaele). **Of which 1 non-state (Rome Catholic University: this has its effective academic headquarters in Rome, at the Gemelli Polyclinic, although the administrative offices are in Milan).

Table 2
Regional subdivision of universities and faculty seats, showing the local number of faculty members with leadership healthcare responsibilities, the number of integrated university-hospital facilities, the number of University Department Deanships and/or Mental Health Department Deanships, the presence of hospital wards and/or community-based structures

REGION	UNIVERSITY		FACULTY SEAT	FACULTY MEMBERS (N)	UNIVERSITY HOSPITAL	MANAGEMENT UD	MANAGEMENT MHD	HOSPITAL WARD STRUCTURES	COMMUNITY-BASED STRUCTURES
Piedmont	Turin University	Turin	$Turin_{MOL}1$ $Turin_{MOL}2$	2	x	x	x	UCW UCW (DCA)	MHC
		Orbassano	$Turin_{SLG}$	1	x		x	GHPW	MHC/RF /CC
	Eastern Piedmont University	Novara	Novara	1	x			GHPW	
Lombardy	Milan University	Milan	$Milan_{POL}$ $Milan_{SP}$ $Milan_{SAC}$	3	x x		x x	UCW Polyclinic UCW S. Paolo --- Sacco	MHC/RF MHC/RF MHC/RF
	Vita Salute S. Raffaele University	Milan	$Milan_{SR}$	2	x			UCW UCW	MHC
	Milan-Bicocca University	Monza	$Milan_{BIC}$	1				GHPW	MHC/RF
	Pavia University	Pavia	Pavia	1	x	x		GHPW	MHC/RF
	Insubria University	Varese	Varese	1			x	GHPW	MHC/RF
	Brescia University	Brescia	Brescia	1			x	GHPW	MHC/RF
Veneto	Verona University	Verona	Verona1 Verona2	2			x	GHPW	MHC/RF
	Padua University	Padua	Padua	1				GHPW	MHC/RF
Friuli-Venezia-Giulia	Udine University	Udine	Udine	1	x				
	Trieste University	Trieste	Trieste	1					
Liguria	Genoa University	Genoa	Genoa	1	x			UCW	
Emilia Romagna	Modena and Reggio Emilia University	Modena	Modena	1	x			GHPW	
	Parma University	Parma	Parma	1	x			UCW	MHC/RF
	Bologna University	Bologna	Bologna1 Bologna2	2	x	x		GHPW	MHC/RF
	Ferrara University	Ferrara	Ferrara	1	x	x		GHPW	MHC/RF
Tuscany	Pisa University	Pisa	Pisa	1				GHPW UCW	
	Florence University	Florence	Florence	1	x			UCW	
	Siena University	Siena	Siena	1	x			UCW	
Umbria	Perugia University	Terni Perugia	Perugia	1		x	x		MHC
Marche	Le Marche Polytechnic University	Ancona	Ancona	1	x			GHPW	
Latium	Rome La Sapienza University	Rome	$Rome_{SAP}1$ $Rome_{SAP}2$ $Rome_{SAP}3$	3	x x	x x		GHPW UCW Polyclinic GHPW S. Andrea	RF
	Sacro Cuore Catholic University	Rome	$Rome_{cat}$	1					
	Rome Tor Vergata University	Rome	$Rome_{TV}$	1	x			UCW	

(continues)

Table 2 (continued)

REGION	UNIVERSITY	FACULTY SEAT		FACULTY MEMBERS (N)	UNIVERSITY HOSPITAL	MANAGEMENT UD	MANAGEMENT MHD	HOSPITAL WARD STRUCTURES	COMMUNITY-BASED STRUCTURES
Abruzzo	L'Aquila University	L'Aquila	L'Aquila1 L'Aquila2	2	x			GHPW UCW	
	G. D'Annunzio Chieti-Pescara University	Chieti	Chieti1 Chieti2	2				GHPW	MHC
Molise	Molise University	Campobasso	Campo-Basso	1					
Campania	Naples Federico II University	Naples	$\text{Naples}_{\text{FED}}$	1	x			GHPW	
	Naples Second University	Naples Caserta	$\text{Naples}_{\text{SUN}}1$ $\text{Naples}_{\text{SUN}}2$	2	x	x		GHPW UCW	
Puglia	Bari Aldo Moro University	Bari	Bari1 Bari2	2		x		GHPW UCW	
	Foggia University	Foggia	Foggia	1	x		x	GHPW	MHC/RF
Calabria	Magna Graecia Catanzaro University	Catanzaro	Catanzaro	1					
Sicily	Palermo University	Caltanissetta Palermo		1	x			UCW	
	Catania University	Catania	Palermo	2	x			UCW GHPW	
	Messina University	Messina	Messina1 Messina2	2				UCW	
Sardinia	Sassari University	Sassari	Sassari	1					
	Cagliari University	Cagliari	Cagliari	1					MHC/RF
TOTAL	**38**	**39**		**53**	**25**	**9**	**9**		

UD = University Department; MHD = Mental Health Department; GHPW = General Hospital Psychiatric Wards; UCW = University Clinical Wards; MHC = Mental Health Centres and/or day centres; RF = Residential Facilities and/or crisis centres.

clude community-based care responsibilities that are attributed to other FPs, and the Chieti seat includes ward responsibility with one GHPW for one FP. One FP at Verona has no healthcare responsibilities, since the seat holds community-based and hospital-ward responsibilities that are covered by another FP.

Considered in this light, some cases change the previous percentage breakdown, whereas others do not cause any such changes. The seats of Bari, Rome La Sapienza (Polyclinic and S. Andrea) and Naples each appear twice, since more than one FP is responsible for clinical care. However, since the FPs in question have no community-based responsibilities, or because they are affiliated to the same university but to two different hospitals (as in the case of the Polyclinic and S. Andrea), no percentage changes are produced. Lastly, Milan University comprises three complex structures (directed by three different FPs) of which two (Polyclinic and San Paolo) have GHPW wards and community-care units, while the third (Sacco Hospital) has no hospital wards, but does have an intra-hospital day centre and a community-based healthcare unit.

Thus the percentage data change somewhat if they are subdivided by independent educational seat rather than by the healthcare responsibilities attributed to individual faculty members (*Table 4*). In this breakdown, there are 41 independent educational seats: the number carrying out both ward and community-based activities increases, compared to the breakdown by individual faculty member, from 15 to 17 (41.4% of the total). There are 16 seats (39%) with no community-based responsibility but with hospital wards, of which 5 have GHPW and UCW, 5 have GHPW alone, and 6 have UCW alone.

Lastly, from the operative standpoint the presence of a GHPW ward generates community-based responsibilities in any case, since the ward is charged with hospitalising patients depending on the needs of non-hospital structures. It is thus reasonable to assume that the 9 university structures responsible for GHPW, even if they do not hold community-based responsibilities directly, may nevertheless be considered to have marked significance within the community. In this way, the overall number of structures with hospi-

Table 3
Type of healthcare leadership responsibilities of the 53 university faculty members included in the study, indicating the seats of the UMCS

GHPW	UCW	OHS	MHC	RF	N	LOCATION
■	■	■		■	1	Rome$_{SAP}$1
■	■	■			1	Pisa
■		■	■	■	8	Milan$_{POL}$; Turin$_{SLG}$; Brescia; Padua; Milan$_{SP}$; Verona1; Milan$_{BIC}$; Foggia
■		■	■	■	1	Ferrara
■		■			8	Bologna1; Modena; Novara; L'Aquila1; Rome$_{SAP}$2; Catania1; Naples$_{FED}$; Bari1
■			■	■	2	Varese; Pavia
■					3	Naples$_{SUN}$1; Chieti1; Ancona
	■	■	■	■	1	Parma
	■	■	■		2	Turin$_{MOL}$1; Milan$_{SR}$1
	■	■			12	Milan$_{SR}$2 ; Turin$_{MOL}$2 ; Genoa; Catania2; L'Aquila2 ; Florence; Rome$_{TV}$; Messina; Palermo; Naples$_{SUN}$2; Bari2; Siena
		■	■	■	2	Milan$_{SAC}$; Cagliari
		■	■		1	Perugia
		■			6	Udine; Trieste; Rome$_{CAT}$; Rome$_{SAP}$3; Catanzaro; Sassari
			■	■	1	Bologna2
			■		1	Chieti2
					3	Campobasso; Verona2; Messina

GHPW = General Hospital Psychiatric Wards; UCW = University Clinical Wards; OHS = Other Hospital Services; MHC = Mental Health Centres and/or day centres; RF = Residential Facilities and/or crisis centre.

talisation facilities that collaborate with the community is 27 out of 41 (65.9%). To this should be added 3 (Milan$_{SAC}$, Cagliari and Perugia) which, though without wards, have community-based responsibilities. Thus the total number of structures that have some relationship with the community is 30 (73.2%).

Of the remaining 11 (26.8%) with no clinical relationship with the community, 6 (14.6%) have no direct community-based responsibilities, being limited to an UCW, and 5 (12.2%) only have out-patient or intra-hospital consultancy functions.

DISCUSSION AND CONCLUSIONS

The first significant point to emerge *(Table 1)* is the progressive reduction, from north to south, of the number of psychiatric structures under university management. This only partially reflects the north-south decrease in the number of universities, since there is also a progressive decrease in both the complexity of psychiatric structures, and the extent of university management of departments: these are numerous in the north, but in central-southern Italy such a structure is only present at Perugia.

A discussion of the data and of the more detailed critical aspects should be subdivided according to the two breakdowns proposed above: by course-holders combined with the management of clinical care facilities, and from a more overall viewpoint, by aggregate structures. The two different breakdowns are justified because each faculty member is independent with regard to questions concerning teaching: for the clinical training of medical degree students and those of other health-related degrees, the type of structure employed is at the faculty member's discretion (although this selection is made collegially). The breakdown by independent educational seats is also useful because the regional public health system generally enters into agreements with these structures, rather than with individual faculty members.

Table 4
Breakdown of independent educational seats by hospital-ward and by community structures

	Structure	Independent training seats	N (%)	
Community-based responsibility 30 (73.2%)	CBS	Cagliari; Milan$_{SAC}$; Perugia	3 (7.3%)	CBS ALONE 3 (7.3%)
	UCW + CBS	Milan$_{SR}$1-2; Parma; Turin$_{MOL}$1-2	3 (7.3%)	RHF + CBS 17 (41.4%)
	GHPW + CBS	Bologna1-2; Brescia; Chieti1-2; Milan$_{BIC}$; Milan$_{SP}$; Milan$_{POL}$; Ferrara; Foggia; Padua; Pavia; Turin$_{SLG}$; Varese; Verona1-2	13 (31.7%)	
	GHPW + UCW + CBS	Rome$_{SAP}$1	1 (2.4%)	
	GHPW + UCW	Bari1-2; Catania1-2; L'Aquila2; Pisa; Naples$_{SUN}$1-2; Pisa	5 (12.2%)	RHF alone 16 (39.0%)
	GHPW	Ancona; Modena; Naples$_{FED}$; Novara; Rome$_{SAP}$2	5 (12.2%)	
No community-based responsibility 11 (26.8%)	UCW	Florence; Genoa; Messina; Palermo; Rome$_{TV;}$ Siena	6 (14.6%)	
	OHS	Catanzaro; Rome$_{CAT;}$ Sassari; Trieste; Udine	5 (12.2%)	NO RHF, NO CBS 5 (12.2%)
	Total		**41 (100%)**	

GHPW = General Hospital Psychiatric Wards; UCW = University Clinical Wards; OHS = Other Hospital Services; CBS = Community-Based Services (*i.e.,* Mental Health Centres and/or day centres, Residential Facilities and/or crisis centres); RHF = Residential Hospital Facilities (*i.e.,* GHPW and/or UCW). (The one structure with no healthcare responsibilities is not listed: Campobasso).

The study points up that there are different types of healthcare management that are not uniformly distributed throughout Italy (*Table 3*). These range from the management of departments that offer a broad spectrum of care to structures that offer only outpatient care or in-hospital consultancy, or only community-based activities. Thus, already at the management level there is a lack equality in terms of clinical care, which risks being reflected also on the institutional functions of teaching and research.

Areas where the university plays a role in providing healthcare both in the hospital ward setting and in the community are chiefly in the North: there is only one such structure in central Italy (Rome La Sapienza) and one in the South (Foggia).

Management of GHPW wards, independently of community responsibilities, appears to be distributed more uniformly (although missing in Liguria and, in Tuscany, only present in Pisa). Central Italy is well covered, but in the South, Basilicata, Calabria, Sicily and Sardinia are without such facilities. With regard to university management of a UCW, the situation is somewhat different, the geographical distribution being substantially uniform: 8 in the north, 7 in the centre and 5 in the South.

Responsibility towards the community, whether or not combined with responsibility for a hospital ward, is poor overall to the south of Rome, being present only at Rome La Sapienza, Chieti, Foggia and Cagliari (in this latter seat without ward facilities).

If clinical responsibility for a GHPW ward is included within the community responsibility breakdown, it emerges that university involvement is greater, reaching an overall percentage above 73% (*Table 4*). Universities at which activities are distributed and differentiated among more than one faculty member also contribute to achieving a satisfactory percentage of involvement in community-based care (for example Turin Molinette, Milan San Raffaele, Bologna, Chieti), but there are undoubtedly still too many universities with specialisation schools that are without an appropriate network of facilities enabling them to offer complex psychiatric training.

The presence of a UCW alone, but with a community-based unit (Milan$_{SR}$, Parma), though not provided for in the NMHP, nevertheless can rightly be considered as university participation in the Italian psychiatric model. Thus the situations that do not include a GHPW, but possess a hospital ward and community-based structures, are undoubtedly working in line with today's psychiatric organisation model. It may be debatable whether the lack of a GHPW, and that is of a structure able to tackle emergencies and to programme hospitalisation, may lead to critical issues from the teaching standpoint, as well as causing interruptions in patients' therapeutic course.

Another criticism that might be made against the current psychiatric system is the lack of hospitalisation facilities for illnesses that are less closely linked to emergency situations or to the manifestation of frankly psychotic behaviour. Taking into account the complexity of mental illnesses, and in consequence the difficulty of teaching them, it is to be hoped that the types of clinical department could be maintained and extended to other pathological situations that are not well suited to the GHPW (to give a few examples: alcoholism, post-traumatic disorders, behavioural disorders, eating disorders, and illnesses with elevated risk of suicide).

However, the fact that 11 universities have no community-based healthcare involvement is a marked anomaly in terms of the clinical facilities that can be assigned for higher and specialised university training (an anomaly that is particularly evident in central and

southern Italy). Hence the need for regional programming, capable of drawing up guidelines and directives, that would thus not be left to individual local initiatives.

Furthermore, given the increase in global costs of mental illness [20] and the concomitant decline of the national funds dedicated to mental health (in the wake of hiring freeze, repayment plans, spending review and more), future studies could aim to investigate whether and how local mental health financing affects the degree of interpenetration between the universities and the NHS.

Conflict of interest statement

The Authors declare that they have no conflict of interest.

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