

school performance according to the expectations of parents and teachers. Such prescriptions for children with academic or behavioural difficulties may serve to hide the responsibilities of parents, schools and the public for the child's problems. Besides inadequate educational conditions, having a small number of child psychiatrists can make it harder to plan rational medication use in ADHD. On the other hand, many children whose symptoms are severe enough for a diagnosis of ADHD have difficulties in obtaining psychiatric care.

Conclusion

There are limited data regarding the prevalence, comorbidity, effects of treatment modalities, useful diagnostic procedures or diagnostic criteria for ADHD in Turkey. In order to receive the correct diagnosis and to find appropriate treatment, these data are very important in a country like Turkey, whose population is culturally different from those of most higher-income countries (Rohde, 2002). The evaluation and the treatment phase should take account of cultural and socio-economic variables. Unlike in some higher-income countries with better measures of education and health, it is not realistic to expect the psychosocial and behavioural problems of Turkish children to be resolved by prescribing pills. Education and health policies that take into account current debates in the world on ADHD also need to be implemented in Turkey.

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SPECIAL PAPER

Intellectual disability: an Italian perspective

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Italy is a country that has a very long tradition, dating back to the Middle Ages, of offering assistance to people with all kinds of disabilities. The approach taken to intellectual disability in recent times can be divided into two periods: before and after the enactment of Law 180 in 1978. That law set in train a profound reform of Italy's public sector psychiatric care, which principally involved the closure of the psychiatric hospitals and the establishment of a system of community care.

Before this law, people with intellectual disabilities were generally admitted to psychiatric hospitals, not only because of their pathology but also because they were considered 'deviant'. After the closure of the psychiatric hospitals, Italian psychiatry seemed to lose any interest in the care adults with intellectual disabilities and that still seems to be true of the discipline today.

Definitions of disability

Under Law 104 of 1992, 'disability' is defined as a loss of the ability of the person to perform basic daily activities unaided. However, this is just a legal definition and differs in its parameters from the eligibility criteria that are used to determine whether an individual is able to receive state assistance in the form of services and benefits. For the latter purpose, 'invalidity' gives the right to receive financial benefits when an intellectual disability is a consequence of biological damage. That is, there is no reference to general self-sufficiency. In fact, an individual's 'disability' is rarely used as a criterion for the receipt of social care or benefit; indeed, the individual's social insurance status is much more often the determining factor, as opposed to any functional limitation (such as intellectual disability, psychiatric disorder or dementia).

The lack of national indicators

There are no official data regarding the prevalence of intellectual disabilities, for either children or adults. There are several reasons for this:

- as indicated above, there is no universal definition of intellectual disability
- the recognition of intellectual disability depends on the type of assessment
- assessment is required for both people with intellectual disability living in institutions and those living with their families
- there is no certification system for intellectual disability and no computerised network (ISTAT, 2001).

There is similarly a lack of national indicators of mental health problems among the population with intellectual disability (La Malfa *et al.*, 2005).

Policy framework and legislation

In Italy there is no policy guidance from government that relates specifically to people with intellectual disability, although general proposals relating to health and welfare may have direct effects on that population. There is some policy support for the integration of children with intellectual disability in mainstream schools but for adults, especially those with severe degrees of intellectual disability, resort is often made to segregation.

Because the national political climate emphasises devolution and deregulation, policy is developing unevenly in the different regions. An online survey has been carried out on the health plans adopted by Italy's regional governments. This used the key words 'psychiatric disability', 'mental retardation' and 'intellectual disability'. Only four regional health plans (those of Toscana, Lazio, Umbria and Basilicata) included at least one of these key words. This confirms that specific attention to intellectual disability is rare. Moreover, there was nearly a total absence of interest in the coexistence of intellectual disability and mental health problems.

Residential service provision

Despite the deinstitutionalisation seen from the late 1970s onwards, the emphasis of policy for people with severe intellectual disability is very much on institutional provision. In fact, there is still a strong tradition of non-state institutional provision in Italy, run by religious and other organisations. Alternative solutions to care (family houses, small community-based residential placements, etc.) are often restricted to those with mild or moderate disability.

Funding is a mixture of individual entitlement and discretionary awards. Central government usually funds pension systems, while residential care and newer forms of care are funded at a regional or local level. Funding structures are

offered mainly on the basis of politically decided subsidies. The ideal of care packages being tailored to the individual is rarely seen.

The non-state institutional provision mentioned above is run through corporate arrangements with the regional governments. Residential homes and similar facilities are run by the private sector and public sector. In both cases, however, the autonomy of service providers is low.

There is a trend of increasing qualitative and quantitative demand while, paradoxically, available funds are reduced. Individual and family support schemes and more efficient service delivery could help to bridge the existing gaps but there is little sign of such developments. There has, though, been an increase in the provision of community-based social care services (e.g. group homes, professional training).

The involvement of the families of people with intellectual disability in the planning and provision of services is low, although there are a few family associations involved in local policy-making.

Emerging trends

There are some pilot schemes for individuals with intellectual disability and mental health problems, including training for mental health professionals in a number of Italian universities. The Società Italiana per lo studio del Ritardo Mentale (SIRM; the Italian Society for the study of Mental Retardation) is currently undertaking a survey to 'map' the different types of provision and training activities.

Conclusions

Despite the shift from institutional care to community care started with Law 180 in 1978, the care of adults with intellectual disability, and especially of those with severe disability or with mental health problems, has been largely institutional and marked by indifference at a political and administrative level. On the other hand, the education of children with intellectual disabilities does prioritise individual care, although families are still not really involved in service planning.

Acknowledgements

The author thanks professor Eugenio Aguglia, President of the Italian Society of Psychiatry, for comments on an earlier draft of this article, and Ms Chiara Giganti was invaluable in editing assistance.

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