RegioneEmilia-Romagna

SERVIZIO SANITARIO REGIONALE
EMILIA-ROMAGNA

LINEE DI INDIRIZZO PER LA PROMOZIONE DELLA SALUTE E DEL BENESSERE NELLE PERSONE ALLA PRIMA MANIFESTAZIONE PSICOTICA O AD ALTO RISCHIO DI PSICOSI

Modulo 4

PRIMA MANIFESTAZIONE PSICOTICA O AD ALTO RISCHIO DI PSICOSI: POPOLAZIONI SPECIFICHE

25 Novembre 2025

Sala Palazzo della Regione
Via Aldo Moro 50, Bologna

30-9.00 Registrazione partecipanti e descrizione della giornata, *moderano Spyridon Zotos e Ilaria arricone*
00-10.00 **Approccio transculturale, bisogni specifici ed interventi a favore dei migranti,** *aria Tarricone*
0.00-11.00 **Disturbi gravi di personalità ed abuso di sostanze in persone alla prima anifestazione psicotica,** *Lorenzo Gammino e Luca Ghedini*
1.00-12.00 **Specificità di sesso e di genere nelle persone alla prima manifestazione psicotica,** *aria Ferrara*
2.00-13.00 **Telemedicina**, *Chiara Luongo, Luca Meregalli*
3.00-14.00 pausa
4.00-16.30 **Esperienze a confronto: discussione casi clinici, analisi dei bisogni e delle risorse,** *trodurrà Marianna Cavalli, Aurora Marchi, Giulia Zaffarami, Alice Onofrio.*
5.30-17.30 Discussione e conclusioni.

Responsabile Scientifico:
Dott. Musella
Segreteria Organizzativa:
AUSL Modena

Iscrizioni Portale WHR, codice 4177.1

Ilaria Tarricone, MD, PhD
Bologna Transcultural Psychosomatic Team BoTPT, Dipartimento di Scienze Mediche e Chirurgiche , UNIBO
Area Vulnerabili e Migranti, Dipartimento di Salute Mentale e DP, Ausl Bologna

APPROCCIO TRANSCULTURALE, BISOGNI SPECIFICI ED INTERVENTI A FAVORE DEI MIGRANTI*

*** Please , call them foreign citizens _ Perfavore, chiamiamoli cittadini stranieri**

Ilaria Tarricone, MD, PhD,
BoTPT, Dimec – UNIBO e DSM-DP Ausl Bologna
F. Lucchi, E. Leuci, O. Bettinardi, M. Belvederi Murri, A. Saponaro, F. Starace e gruppo di lavoro primo episodio psicotico RER

Outlines

- ✓ Il fenomeno migratorio e l'approccio transculturale
- ✓ Le evidenze relative a un eccesso di psicosi nei migranti e i loro bisogni specifici
- ✓ Gli interventi utili e la competenza culturale

Outlines

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The health of a world on the move

The Lancet Commissions

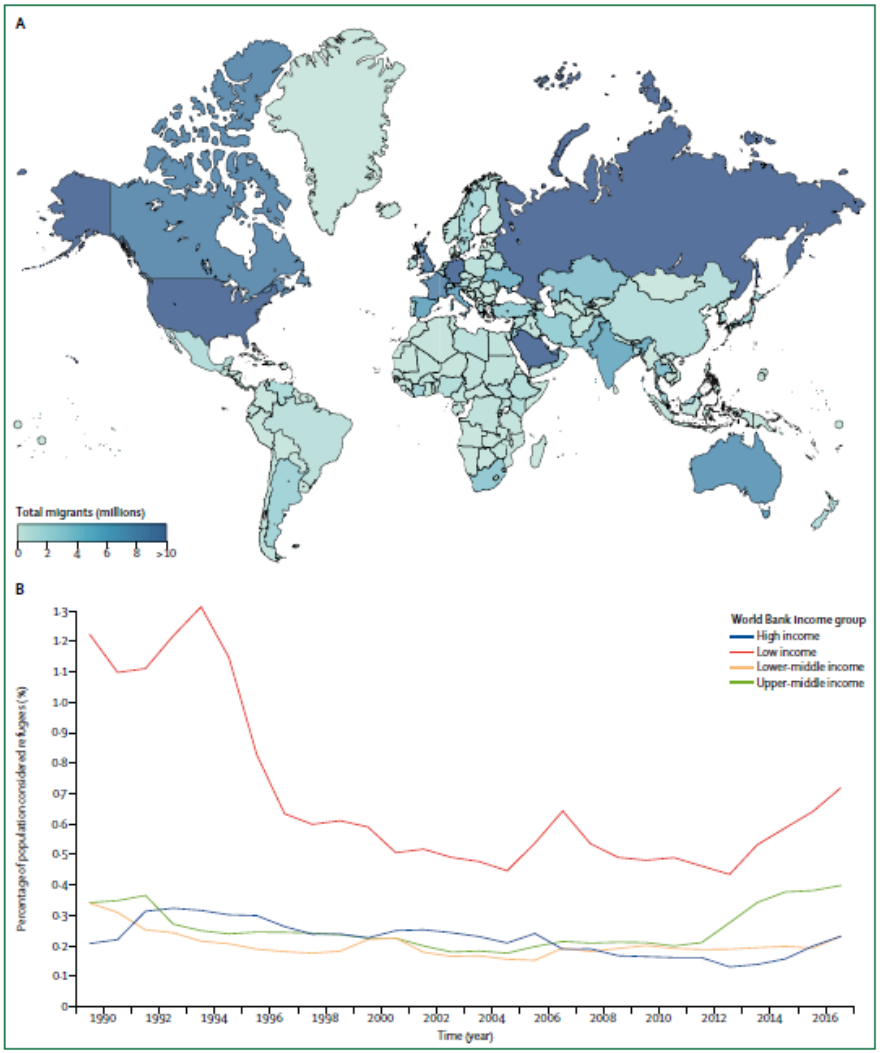


Figure 2: International migration globally[36]
(A) Global map of the total number of international migrants in 2015. (B) Percentage of population that were refugees by the World Bank Income group (1960-2017). Analysis done with data from the World Bank. Interactive online version available.[37]

The UCL–*Lancet* Commission on Migration and Health: the health of a world on the move

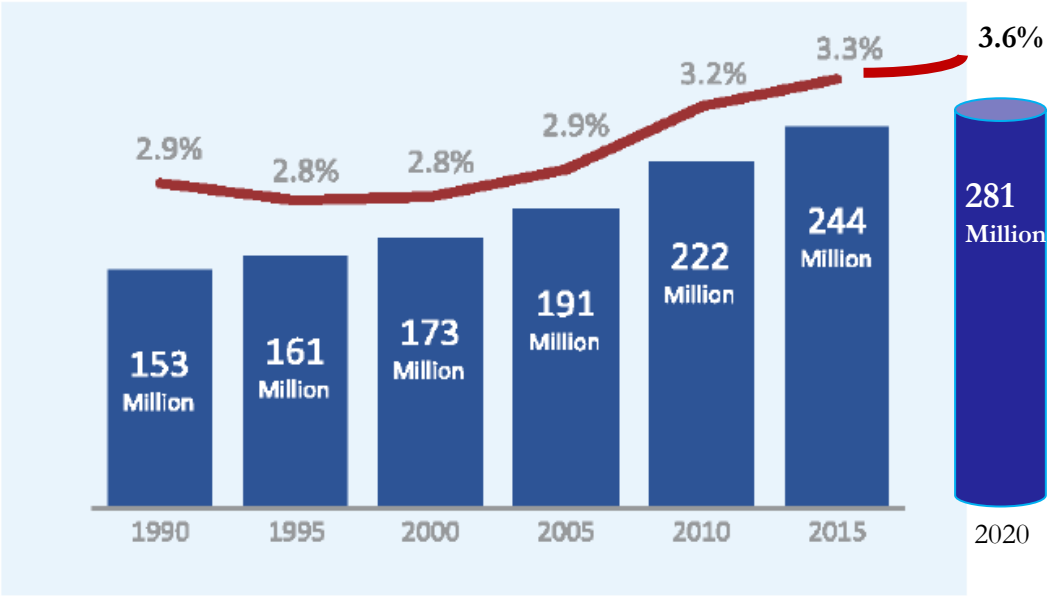
Ibrahim Abubakar, Robert W Aldridge*, Delan Devakumar*, Miriam Orcutt*, Rachel Burns, Mauricio L Barreto, Poonam Dhavan, Fouad M Fouad, Nora Groce, Yan Guo, Sally Hargreaves, Michael Knipper, J Jaime Miranda, Nyovani Madise, Bernadette Kumar, Davide Moscat†, Terry McGovern, Leonard Rubenstein, Peter Sammonds, Susan M Sawyer, Kabir Sheikh, Stephen Tollman, Paul Spiegel, Cathy Zimmerman*, on behalf of the UCL–Lancet Commission on Migration and Health‡*

- *"With one billion people on the move or having moved in 2018, migration is a global reality"*
- *"Although estimates indicate that the majority of global migration occurs within low-income and middle-income countries (LMICs), the most prominent dialogue focuses almost exclusively on migration from LMICs to high-income countries (HICs)"*
- **258 million international migrants (2017, IOM)**
- **740 million internal migrants (2009, UNDP)**

NEARLY ONE –SEVENTH OF THE WORLD'S POPULATION IS NOW LIVING IN A LOCATION DIFFERENT FROM THE ONE IN WICH THEY WERE BORN

SNAPSHOT OF INTERNATIONAL MIGRANTS

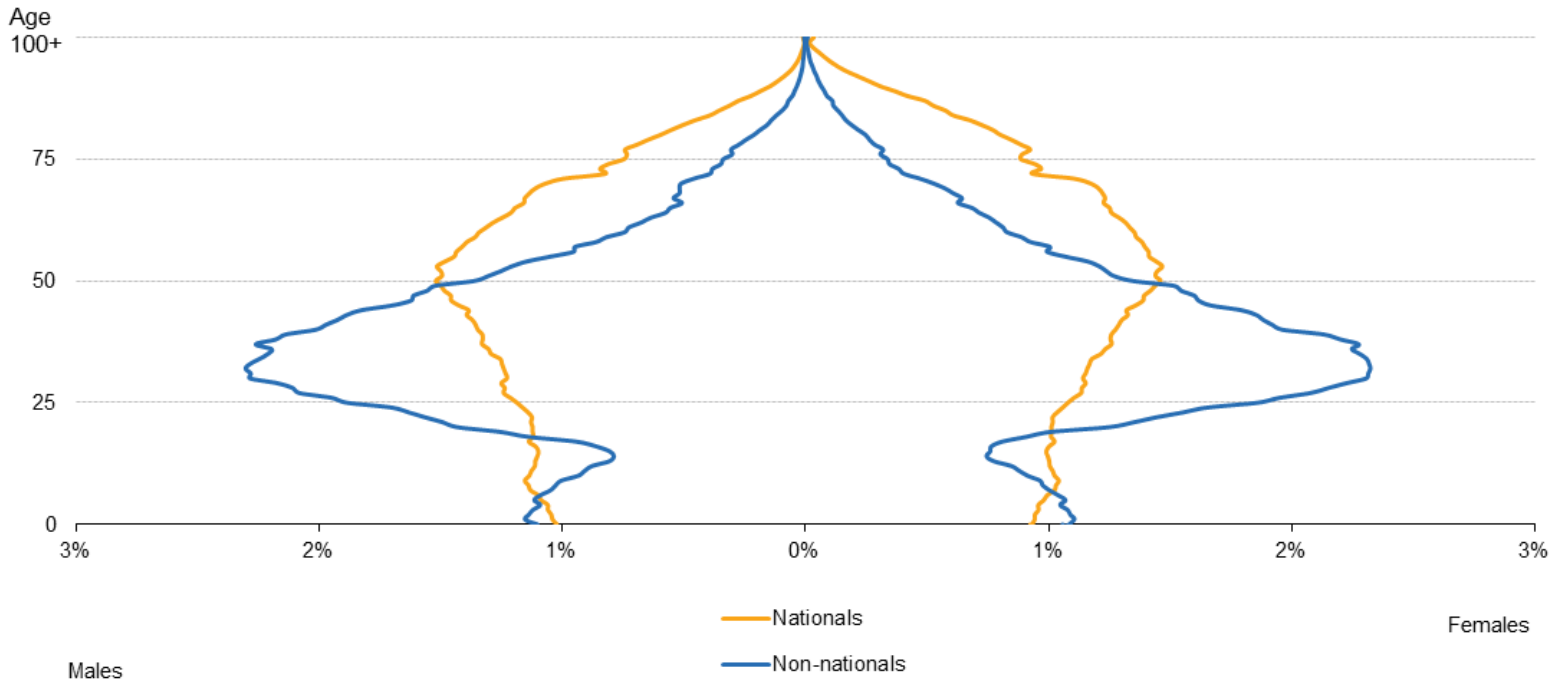
The international migrant population globally has increased in size but remained relatively stable as a proportion of the world's population.



What causes the migration phenomenon?

- ✓ Pushing factors in individuals - personal biography; pulling factors into the social context of the countries of arrival (first of all the aging structure of western countries' populations)
  - Demographic need
  - Climate change
  - Economic inequality
  - War and political persecution

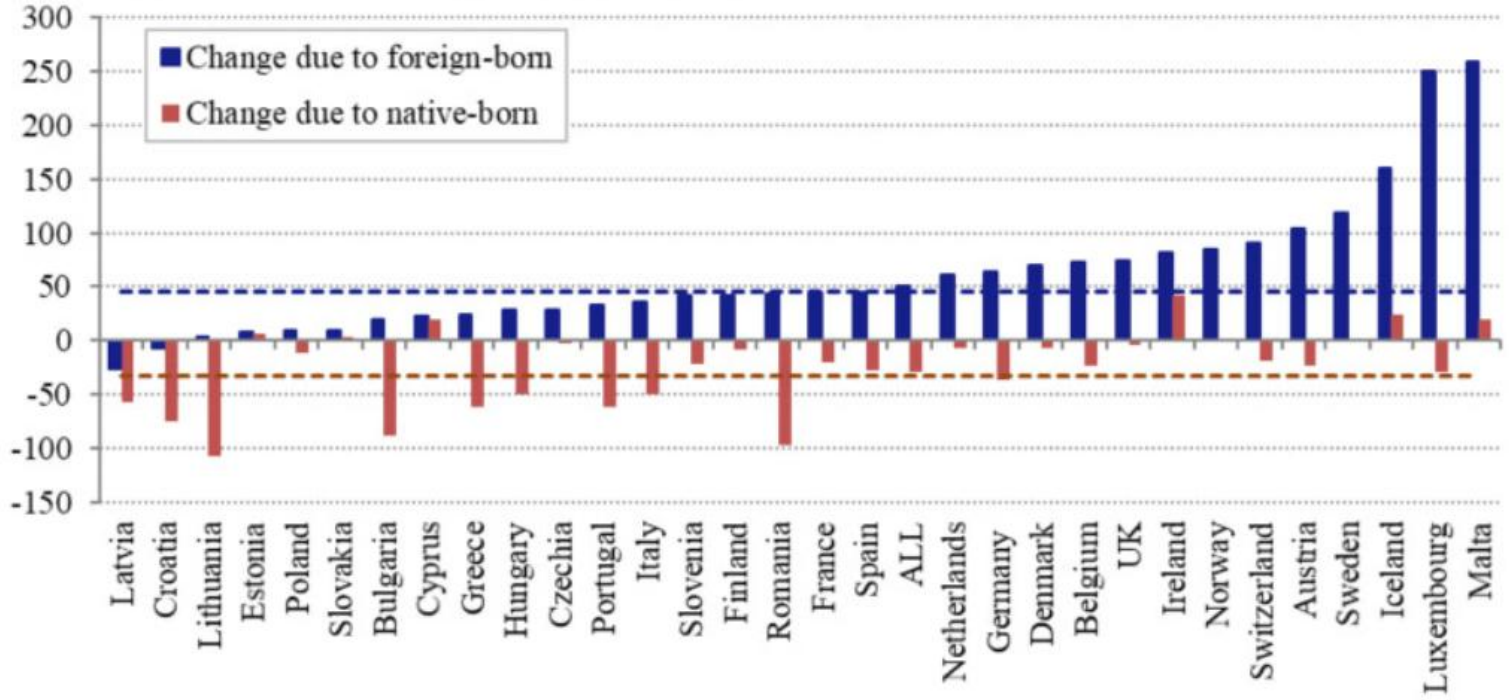
Age structure of the national and non-national populations, EU-28, 1 January 2018
(%)



Source: Eurostat (online data code: migr_pop2ctz)

eurostat

Figure 1. The contribution of foreign- and native-born populations to overall population change in Europe (annual average for the 2014-2019 period,[a] per 10,000)



[a] 2018–2019 for Germany and Switzerland, 2017–2019 for Ireland, 2014–2015 for Finland. Horizontal lines = EU-27.
Source: Bagavos (2022)

Climate change and migration

- **Environmental emergency migrants, Environmentally forced migrants and Environmentally motivated migrants**

- 2011, United Nations University, Institute for Environment and Human Security

http://www.green.it/cambiamenti-climatici-e-migrazioni/#prettyPhoto

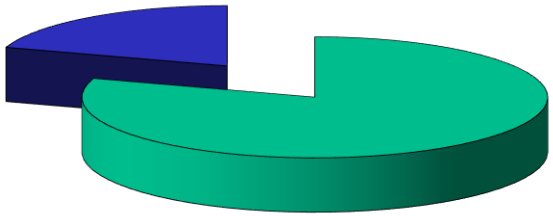
The fatal unbalance

"If you look at global economy from the point of view of the people, its greatest failure is the incapacity of creating enough job opportunities in their place of living"

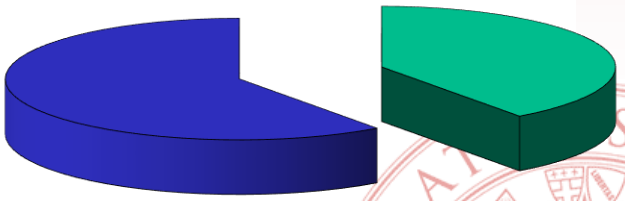
Juan Somavia, general manager ILO

«Our current global political economy is driven by HICs that draw on natural and human resources in LIMCs» Abubakar et al., 2018

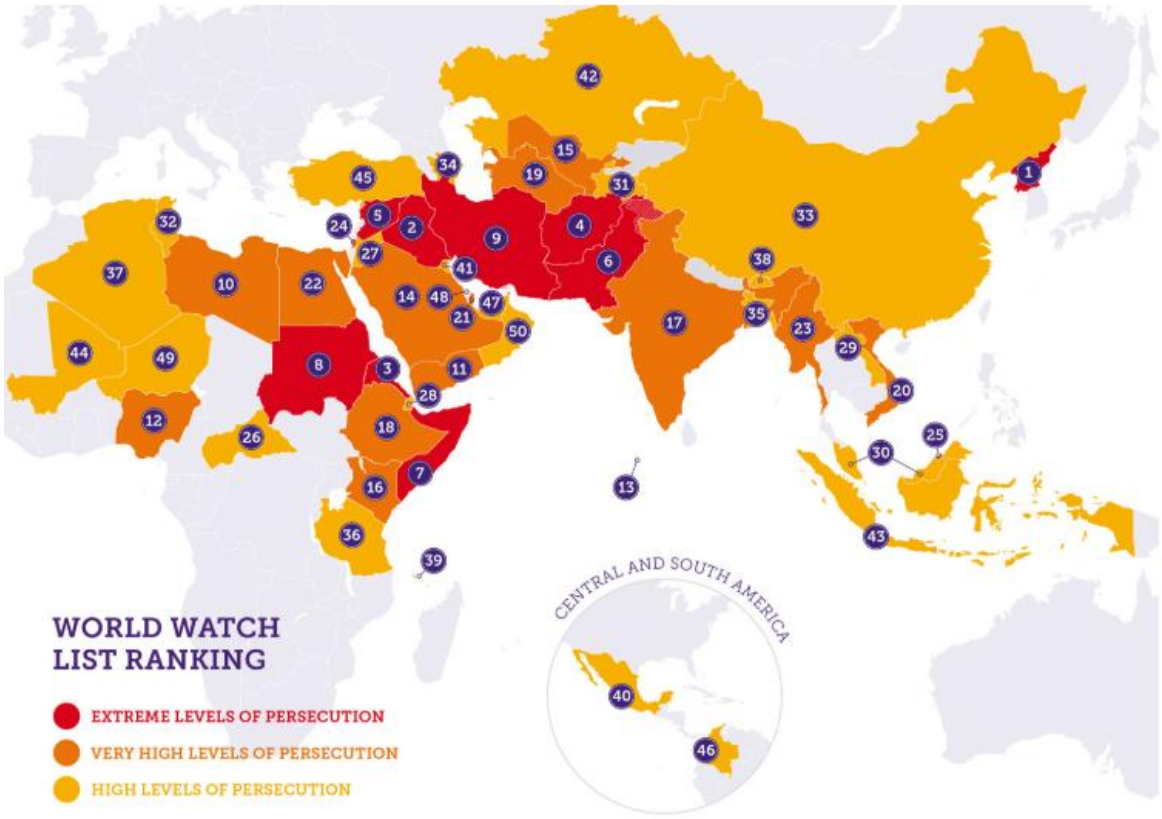
Distribution of population



Distribution of wealth



https://geoawesome.com/map-show-countries-people-face-persecution-believes/



Are migrants a burden on services?

- ✓ «Nowadays, rather than burdening systems, migrants in HICs are more likely to bolster services by providing medical care, teaching children, caring for older people, and supporting understaffed services.»
  - Abubakar et al., The UCL –Lancet commission on migration and health, 2018

L’immigrazione in Emilia-Romagna:

- ✓ L'Italia ha vissuto un aumento dell'immigrazione dagli anni '70, con un picco negli anni 2000.
- ✓ La crisi economica del 2008 e la pandemia del 2020 hanno causato una diminuzione dell'immigrazione.
- ✓ L'Emilia-Romagna è la regione italiana con la più alta percentuale di stranieri residenti (12%).
- ✓ I migranti in Emilia-Romagna rappresentano il 40% della popolazione under 40.

The transcultural (vs ethnic) characteristics of migrants: the migration history

1. Migration project
2. Culture
3. Migration process
4. Adaptation to new society

The boat people, Siracusa 08-08-2004

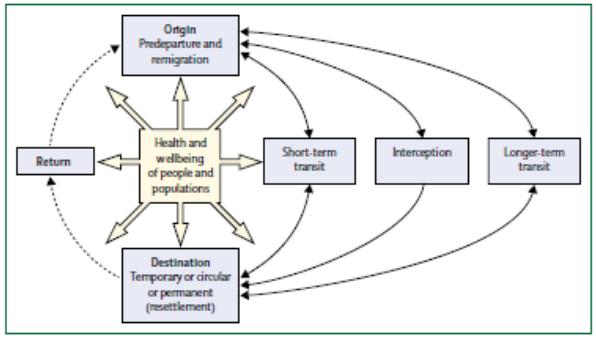


Figure 1: The migration cycle

Health throughout the migration process

«Migration trajectories involve various phases including ***pre-departure circumstances*** *at places of origin, short-term or long term* ***transit****, which might involve interception by authorities, non-governmental groups, or criminal gangs;* ***destination situation*** *of long term or short term stay; and* ***return*** *to places of origin for resettlement or for temporary visits before remigration.» (Abubakar et al, 2018)*

Women and children

"Women and children are especially at risk when they migrate without the protection of family or social networks. Unaccompanied girls and boys who move in ways that are not readily detected by potential support mechanisms are particularly vulnerable to neglect, trafficking, abuse, and sexual exploitation. Examples include unaccompanied and separated children who resort to sex work to survive and shelter in parks and makeshift camps in Greece.» (Abubakar et al., 2018)

Pertanto si raccomanda

Raccomandazione 89 di Livello A *- Attivare programmi di prevenzione indicata e cura delle psicosi per intervenire sui fattori avversi, potenzialmente modificabili tramite interventi sociosanitari, che tengano conto delle barriere linguistiche e delle diversità culturali.*

Outlines

- ✓ Il fenomeno migratorio e l'approccio transculturale
- ✓ Le evidenze relative a un eccesso di psicosi nei migranti e i loro bisogni specifici
- ✓ Gli interventi utili e la competenza culturale

Migration and psychosis

Psychological Medicine

cambridge.org/psm

Original Article

Cite this article: Selten J-P, van der Ven E, Termorshuizen F (2019). Migration and psychosis: a meta-analysis of incidence studies. *Psychological Medicine* 1–11. https://doi.org/10.1017/S0033291719000035

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Key words:
Bipolar disorder; depressive disorder; dopamine; ethnicity; migration; psychosis; race; schizophrenia; social exclusion; stress

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Migration and psychosis: a meta-analysis of incidence studies

Jean-Paul Selten[1,2], Els van der Ven[1,2] and Fabian Termorshuizen[2]

[1]School for Mental Health and Neuroscience, University of Maastricht, Maastricht, The Netherlands and [2]GGZ Rivierduinen, Institute for Mental Health, Leiden, The Netherlands

Abstract

Background. The aims of this meta-analysis are (i) to estimate the pooled relative risk (RR) of developing non-affective psychotic disorder (NAPD) and affective psychotic disorder (APD) among migrants and their children; (ii) to adjust these results for socioeconomic status (SES); (iii) to examine the sources of heterogeneity that underlie the risk of NAPD.

Methods. We included population-based incidence studies that reported an age-adjusted RR with 95% confidence interval (CI) published 1 January 1977–12 October 2017 and used a random-effects model.

Results. We retrieved studies performed in Europe ($n = 43$), Israel ($n = 3$), Canada ($n = 2$) and Australia ($n = 1$). The meta-analysis yielded a RR, adjusted for age and sex, of 2.13 (95% CI 1.99–2.27) for NAPD and 2.94 (95% CI 2.28–3.79) for APD. The RRs diminished, but persisted after adjustment for SES. With reference to NAPD: a personal or parental history of migration to Europe from countries outside Europe was associated with a higher RR (RR = 2.94, 95% CI 2.63–3.29) than migration within Europe (RR = 1.88, 95% 1.62–2.18). The corresponding RR was lower in Israel (RR = 1.22; 0.99–1.50) and Canada (RR = 1.21; 0.85–1.74). The RR was highest among individuals with a black skin colour (RR = 4.19, 95% CI 3.42–5.14). The evidence of a difference in risk between first and second generation was insufficient.

Conclusions. Positive selection may explain the low risk in Canada, while the change from exclusion to inclusion may do the same in Israel. Given the high risks among migrants from developing countries in Europe, social exclusion may have a pathogenic role.

-Most studies in EU
-RR NAPD2.13 , RR APD 2.94
-The RRs diminished but persist after adjustment for SES
-Extra EU, Black at higher risk (no first vs second generations)

Psychological Medicine (2012), **00**, 1–10. © Cambridge University Press 2012
doi:10.1017/S0033291712000335

ORIGINAL ARTICLE

First-episode psychosis at the West Bologna Community Mental Health Centre: results of an 8-year prospective study

I. Tarricone[1,2]*, S. Mimmi[3], A. Paparelli[4], E. Rossi[1], E. Mori[1], S. Panigada[1], G. Carchia[1], V. Bandieri[1], R. Michetti[2], G. Minenna[3], J. Boydell[4], C. Morgan[4] and D. Berardi[1,2]

[1] *Institute of Psychiatry, Bologna University, Italy*
[2] *West Bologna Mental Health Department, AUSL Bologna, Italy*
[3] *Public Health Department, Bologna University, Italy*
[4] *Institute of Psychiatry, King's College London, UK*

Median annual incidence rate of various psychoses x 100,000

Very similar to Bourque et al., (2011) median IRR

	Psychoses		Non affective psychoses (F20 – F 29)		Affective Psychoses (F30 – F33)		Substances Related Psychoses F10-19		Schizophrenia (F20 & F 25)	
	Rate (I.Q.R)	**IRR (95% C.I.)**	**Rate (I.Q.R)**	**IRR (95% C.I.)**	**Rate (I.Q.R)**	**IRR (95% C.I.)**	**Rate (I.Q.R)**	**IRR (95% C.I.)**	**Rate (I.Q.R)**	**IRR (95% C.I.)**
EM Group vs Native										
EM Group	38.8 (31 - 48.7)	**2.530 (2.170 - 2.890)**	33.9 (25.5 - 41.8)	**3.389 (2.985 - 3.794)**	0.0 (0.0 - 1.6)	-	0.0 (0.0 - 8.6)	-	26.3 (18.3 - 28.5)	**4.046 (3.558 - 4.534)**
Native	15.3 (12.8 - 15.9)	Ref.	10.0 (8.6 - 12.8)	Ref.	1.4 (1.0 - 2.8)	Ref.	2.4 (1.7 - 3.2)	Ref.	6.5 (3.9 - 8.1)	Ref.

COMPARISON OF IRR OF PSYCHOSIS IN FIRST GENERATION MIGRANTS IN EU

HOST COUNTRY	IRR	95% CI
ITALY (BOLOGNA)	2.5	2.2-2.9
THE NETHERLANDS*	2.5	2.0–3.2
SCANDINAVIA*	2.3	1.9- 2.7
UK*	2.8	2.2-3.5

*FROM BOURQUE ET AL, 2011

The psychosis incidence rate shows huge variations among places, but the IRR (migrants IR vs natives IR) is quite similar

Schizophrenia Research 173 (2016) 90–93

Contents lists available at ScienceDirect

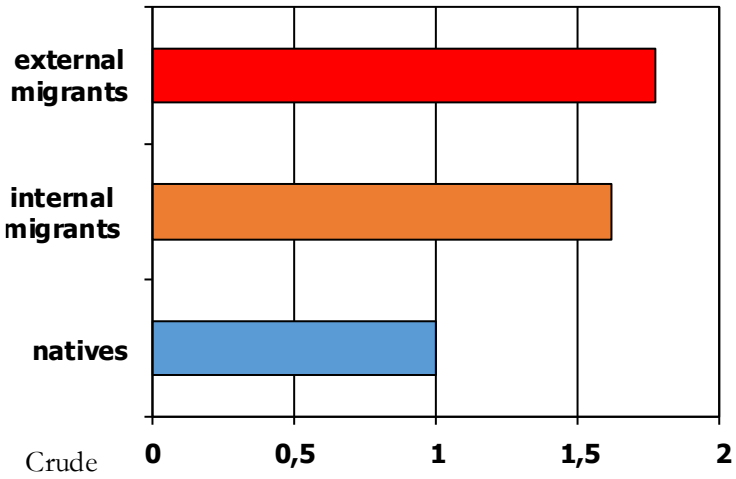
Schizophrenia Research

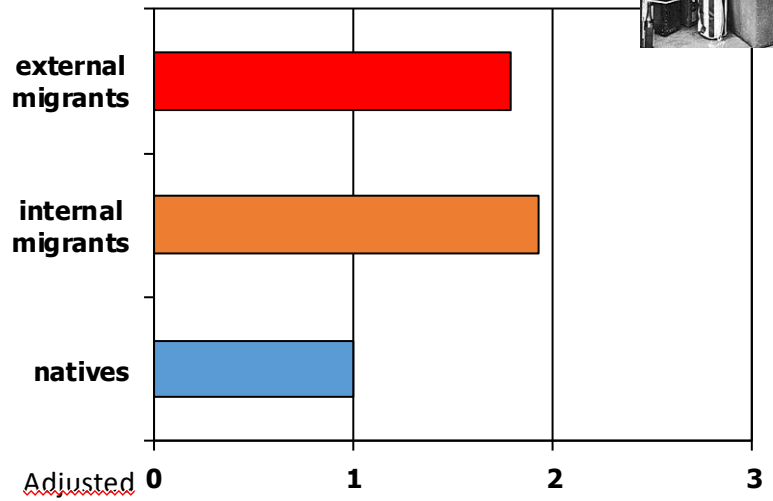
journal homepage: www.elsevier.com/locate/schres

Risk of psychosis and internal migration: Results from the Bologna First Episode Psychosis study

Ilaria Tarricone [a,b,c,*], Jane Boydell [c], Arnisa Kokona [a], Federico Triolo [a], Lisa Gamberini [a], Enrico Sutti [a], Michela Marchetta [a], Marco Menchetti [a,b], Marta. Di Forti [c], Robin M. Murray [c], Craig Morgan [c], Domenico Berardi [a,b]

[a] Bologna Transcultural Psychosomatic Team (BoTPT), Department of Medical and Surgical Sciences, Alma Mater Studiorum University of Bologna, Viale Pepoli 5, 40123 Bologna, Italy
[b] Department of Mental Health and Pathological Addictions, Bologna Local Health Trust, Viale C. Pepoli 5, Bologna, Italy
[c] Institute of Psychiatry, Psychology & Neuroscience, King's College London, 16 De Crespigny Park, London SE5 8AF, UK





Migration vs Ethnicity !

	IRR*	95% CI	p
NA	Ref.	Ref.	Ref
IM	1.93	[1.19 - 3.13]	0.007
EM	1.79	[1.06- 3.02]	0.03

***Age and sex adjusted**

- ✓ Which stress/ characteristics of migration history are related to psychosis vulnerability?

Table 1. 3 Risk Factors for FEP in migrants

	Evidence	Studies (AS= all setting; H= hospital record; GP= general practitioner)
Pre Migration Phase		
Individual level		
Selective migration	no	Selten et al, 2002 (H)
Genetic	no	Selten et al, 2008 (AS)
Neurological markers	no no	Dazzan et al, 2008(AS) Dean et al, 2007 (AS)
Area level		
Degree of development of country of origin	yes	Cantor-Graae 2005(AS)
Migration Phase		
Reason for migration: refugees	Yes yes	Norrendam 2009(H) Sundquist 2004 (H)
Early age of migration	Yes Yes yes	Veling 2011(AS) Harrison 1988(AS) Werbeloff 2012(H)
Past history of migration before age of 15	yes	Cantoor-Graae 2003(AS)
Post Migration phase		
Individual level		
Prenatal Determinant (II generation) Homocysteine levels Maternal BMI	 No No	 Brown 2007 (AS) Schaefer 2000(AS)
Parental separation before age 16	Yes Yes	Morgan 2007(AS) Mallet 2002 (only AC) (AS)
Unemployment	Yes Yes Yes yes	Reininghaus 2008(AS) Mallet 2004(AS) Mallet 2002(AS) Bhugra 1997(AS)
Living condition far from family alone	 Yes yes	 Cantoor-Graae 2007(AS) Mallet 2004(AS)
Low employment level	yes	Bebbington 1981(AS)
Low education	yes	Mallet 2004(AS)
Substance abuse	no	Harrison 1997(AS)
Skin colour	yes	Cantoor-Graae 2005(AS)
Loss of Cultural Identity	yes	Reininghaus 2010(AS) Bhugra 2010 (only AC)
Perceived discrimination	Yes Yes no	Cooper 2008(AS) Veling 2007(AS) Veling 2008b(GP)
Self-esteem and self-concept	yes	Cooper 2008(AS)
Mismatch between expectation and achievement	Yes yes	Reininghaus 2008(AS) Mallet 2004 (only Indians, no AC; only for housing) (AS)
Social defeat	Yes Yes yes	Morgan 2008(AS) Bresnahan 2007 (AS) Schofield 2001(GP)
Brain structure	yes	Morgan et al., 2009
Area level		
Low ethnic density	Yes Yes Yes yes	Kirkbride 2008(AS) Veling 2008(AS) Kirkbride 2007(AS) Boydell 2001(AS) Schofield 2001(GP)
Economic crisis and intolerance	yes	Smith 2006 (H)

Most studies conducted on post migration phase risk factors for psychosis

Psychotic symptoms and migration

International Journal of Social Psychiatry
http://isp.sagepub.com

Psychotic Symptoms and General Health in a Socially Disadvantaged Migrant Community in Bologna

Ilaria Tarricone, Anna Rita Atti, Federica Salvatori, Mauro Braca, Silvia Ferrari, Davide Malmusi and Domenico Berardi

Int J Soc Psychiatry 2009; 55; 203

- **57% (39) were above the 4 point GHQ-12 threshold**
- **19% (13) PSQ positive**
- **Factors associated with positive PSQ score:**
  - **–GENERAL HEALTH**
    - **Chronic disease** (OR 6.1, CI= 1.4–26.0),
    - **Health problems arising after migration to Italy** (OR 10.3, CI= 2.3– 45.8)
  - **–MIGRATION HISTORY VARIABLES:**
    - **Living with relatives** (OR 8.4, CI= 1.0-69.6),
    - **Less than 6 months in Italy** (OR 4.1, CI=1.1-15.5)
    - **Passive migration (following others)** (OR 9.6, CI= 1.1– 80.9)

EUGEI

EUropean network of national schizophrenia networks studying Gene-Environment Interactions

http://www.eu-gei.eu/

SEVENTH FRAMEWORK PROGRAMME

EUROPEAN COMMISSION

The project is funded by the European Community's Seventh Framework Programme under grant agreement No. HEALTH-F2-2010-241909 (Project EU-GEI).

Design

Directly comparable population based **incidence** and **case-sibling-control** studies of psychosis in 12 centres across 5 countries over a three-year period

http://www.eu-gei.eu/

SEVENTH FRAMEWORK PROGRAMME

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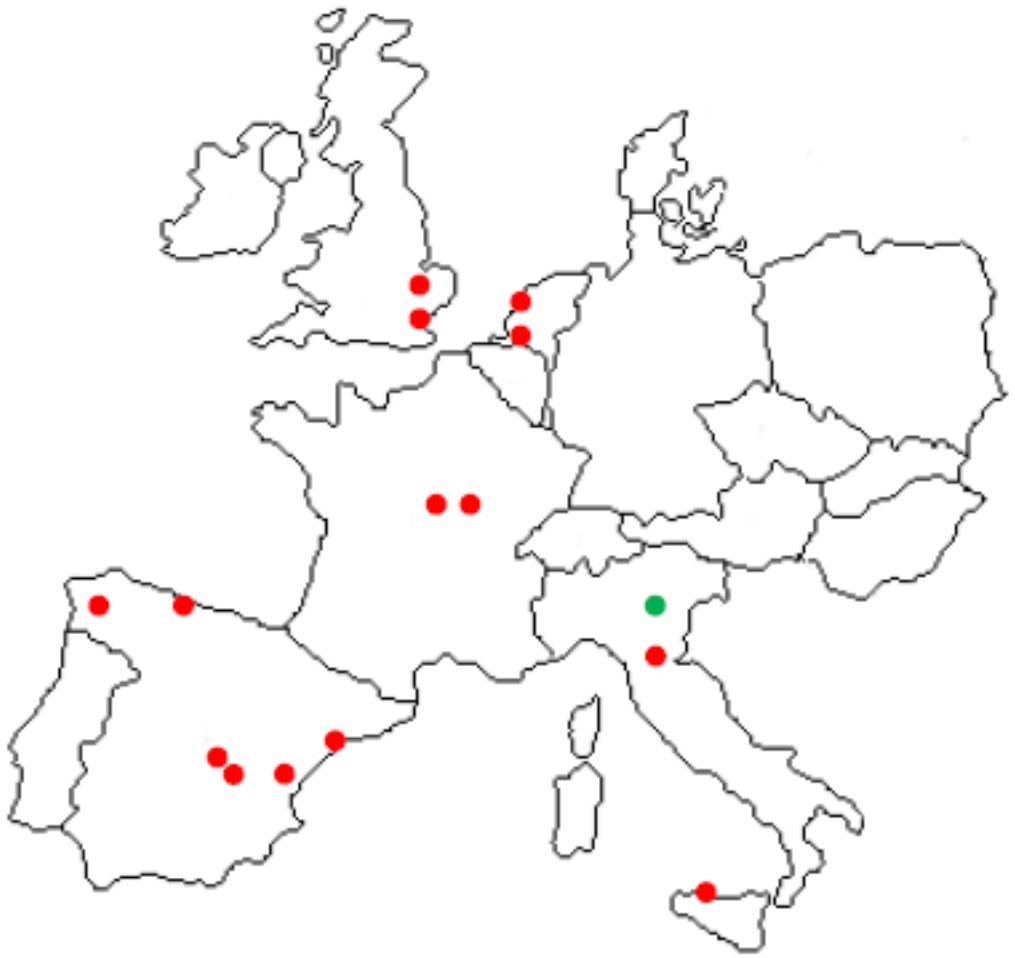
sites

15 in 5 countries

- UK
- Spain
- France
- Netherlands
- Italy



- Population at risk ...

  c. 4,800,000

sites

15 in 5 countries

- UK
- Spain
- France
- Netherlands
- Italy

- **Brazil**

  (Ribeirao Preto)

core assessments

Clinical	Social	Other
OPCRIT	**Schedules for Assessment of Social Experiences**	Neuro- and social cognition
Premorbid Adjustment		Substance use
Cannabis Experiences Questionnaire	**(sociodemographics; childhood trauma; list of threatening events; discrimination; neighbourhood)**	Family history
		DNA
	Migration history	

c. 3 hours to complete

Bologna Migration History and social integration quetionnaire

BOLOGNA MIGRATION HISTORY AND SOCIAL INTEGRATION
(FOR FIRST GENERATION MIGRANTS) CORE Interview

ETUDE: EU GEI — Date de naissan
Numéro du sujet: |_|_|_|_| - |_|_|_|_|_| — |_|_|-|_|_|-|1

Intervalle de temps: — Période – Version
Investigateur: ..... — Date |_|_|-|_|_|-|_|

A – Avant la migration

1. Avec qui viviez-vous dans votre pays d'origine, juste avant de migrer?
O1 Seul — O2 Seul, avec enfants — O3 partenaire/Epoux(se) — O4 partenaire/épouse, a
O5 Parents — O6 Autre famille — O7 amis — O8 autre (spécifiez): ...

BOLOGNA MIGRATIE GESCHIEDENIS EN SOCIALE INTEGRATIE
(VOOR EERSTE GENERATIE MIGRANTEN) *Diepte -interview*

STUDIE: EU GEI — Geboorte
Subjectnummer: |_|EU|_|_|-|_|_|_|_| — |_|_|-|_|

Time interval: — Periode– R
Interviewer: ..... — Datum |_|

A – Voor migratie

1. In wat voor type accommodatie woonde u voordat u migreerde?
O1 Koopwoning (eigen) — O4 Gehuurd (overhead)
O2 Koopwoning (familie) — O5 Andes, specificeer
O3 Gehuurd (particulier)

BOLOGNA MIGRATION HISTORY AND SOCIAL INTEGRATION
(FOR FIRST GENERATION MIGRANTS) *Intervista-core*

STUDIO: EU GEI — Data di Nascita
Numero del soggetto: |_|_|_|_| - |_|_|_|_|_| — |_|_|-|_|_|-|1|9|_|_|

Periodo di tempo: — Periodo – Replicat |0|_|-|0|_|
Intervistatore: ..... — Data |_|_|-|_|_|-|2|0|_|_|

A - Prima della migrazione

1. Con chi viveva nel Paese di origine immediatamente prima di partire?
O1 Solo — O2 solo, con bambini — O3 con partner/coniuge — O4 con partner/coniuge e bambini
O5 con genitori — O6 presso altri familiari — O7 con amici — O8 altro (specificare): .....

2. Ha mai lavorato nel Paese di origine? O0 No O1 Si

3. Che lavoro faceva nel Paese di origine, immediatamente prima di partire?
O1. Disoccupato — O7. Studente
O2 Economicamente inattivo: — O8 Occupato
O3 casalingo — O9 lavoro part-time
O4 disabile — O10 lavoro a tempo pieno
O5 pensionato — O11 lavoro in proprio
O6 badante

4. Classe sociale
(fornire solo descrizioni) — Principale (nel paese di origine)
a. Titolo di lavoro _____
b. Cosa faceva principalmente? _____
c. Cosa faceva la sua organizzazione? _____

O1 Professionista, di livello più alto — O2 Professionista, di livello più basso
O3 Occupazione intermedia — O4 Piccolo imprenditore e lavoratore autonomo
O5 Lavoratore autonomo — O6 Supervisore e occupazione tecnica di basso livello
O7 Servizi di basso livello, venditore, impiegato — O8 Occupazione tecnica di basso livello
O9 Occupazione di routine — O10 Mai lavorato e disoccupato da lungo tempo

Migration history and Social Integration Core Interview, Italian EU GEI, 4-D, May 2010, Page 1

OGNA MIGRATIE GESCHIEDENIS EN SOCIALE INTEGRATIE
OR EERSTE GENERATIE MIGRANTEN) *Kern interview*

EU GEI — Geboortedatum
ummer: |_|EU|_|_|-|_|_|_|_| — |_|_|-|_|_|-|1|9|_|_|

rval: — Periode – Replicat |0|_|-|0|_|
er: ..... — Datum |_|_|-|_|_|-|2|0|_|_|

nigratie

fet wie heeft u gewoond in uw land van herkomst, voorafgaand aan de migratie?

)1 Alleen — O2 Alleen, met kinderen — O3 Partner/Echtgenoot — O4 Partner/Echtgenoot met kinderen
)5 Ouders — O6 Overige familieleden — O7 Vrienden — O8 Anders (Specificeer) .....

HISTORIA DE LA EMIGRACION E INTEGRACION SOCIAL DE BOLONIA
(PARA LOS EMIGRANTES de primera generación) CORE Interview

STUDIE: EU GEI — Fecha de nacimiento
Código del sujeto: |_|_|_|_| - |_|_|_|_|_| — |_|_|-|_|_|-|1|9|_|_|

Intervalo de tiempo: Presente — Periodo – Replicat|0|_|-|0|_|
Entrevistador: ..... — Fecha |_|_|-|_|_|-|2|0|_|_|

A – Antes de la emigración

1. ¿Con quién vivías en tu país de origen, inmediatamente antes de la emigración?

O1 Solo — O2 Solo con hijos — O3 Pareja / Cónyuge — O4 Pareja / Cónyuge con hijos
O5 Padres — O6 Otra familia — O7 Amigos — O8 Otros (especificar).....

BoMH interview:
Structure and contents

- ✓ **2 parts**: core interview (5 minutes) and in depth interview (15 minutes)
  - Firstly use core section; secondly, carry out in depth section (NB the 2 parts contain different items!)
- ✓ **3 sections** :
  - *before migration*
    - Socio-economic status, satisfaction with life, preparation of migration
  - *migration process*
    - Reason for migration, debt, migration travel, intention to stay in the new country, detention
  - *post migration*
    - Socio-economic status, legal status, social integration, social network, expectation achieved

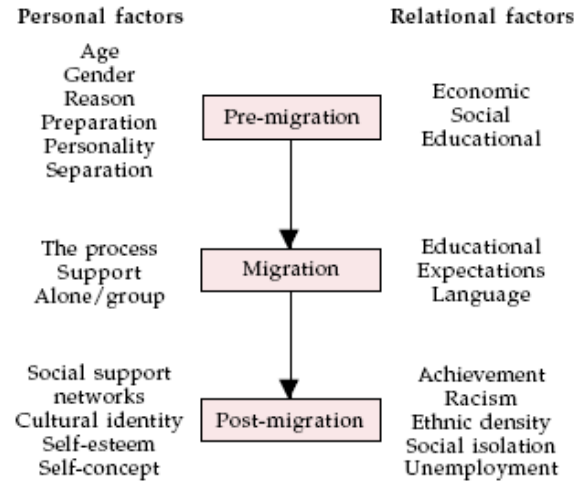


Fig. 2 Factors in migration and psychological distress

APT (2001), vol. 7, p. 220 — Bhugra & Jones/Lipsedge

From: **Treated Incidence of Psychotic Disorders in the Multinational EU-GEI Study**

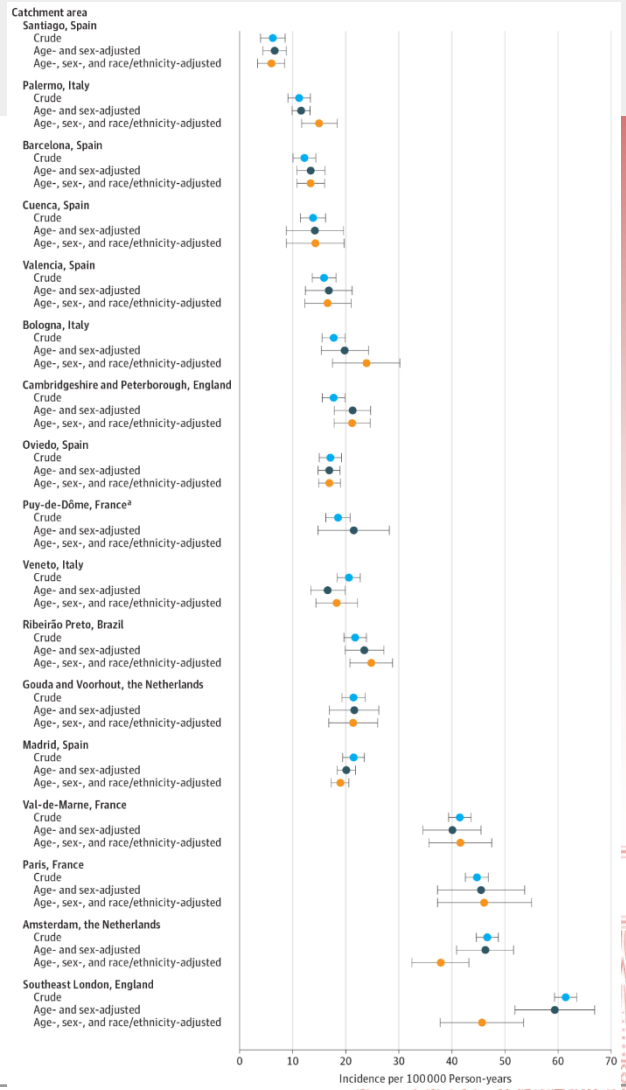
JAMA Psychiatry. 2018;75(1):36-46. doi:10.1001/jamapsychiatry.2017.3554

Figure Legend:

Crude Age- and Sex-Standardized and Age-, Sex-, and Race/Ethnicity-Standardized **Incidence Rates per Catchment Area**

Crude incidence rates vary 10-fold between catchment areas, and age-, sex-, and race/ethnicity-adjusted rates vary 8-fold.

Error bars indicate 95% CIs.



Date of download: 3/3/2018

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- 249 cases and 219 controls were assessed.
- **Pre-migration** (OR 1.61, 95% CI 1.06–2.44, p = 0.027) and **post-migration social disadvantages** (OR 1.89, 95% CI 1.02–3.51, p = 0.044), along with **expectations/achievements mismatch** (OR 1.14, 95% CI 1.03–1.26, p = 0.014) were all significantly associated with psychosis.

Psychological Medicine

cambridge.org/psm

Original Article

Cite this article: Tarricone I *et al.* (2021). Migration history and risk of psychosis: results from the multinational EU-GEI study. *Psychological Medicine* 1–13. https://doi.org/10.1017/S003329172000495X

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Key words:
First-episode psychosis; first-generation migrants; migration adversities; migration history; psychosis risk; social disadvantages

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Migration history and risk of psychosis: results from the multinational EU-GEI study

Ilaria Tarricone[1,2], Giuseppe D'Andrea[1,3], Hannah E. Jongsma[4,5], Sarah Tosato[6], Charlotte Gayer-Anderson[7], Simona A. Stilo[8,9], Federico Suprani[1], Conrad Iyegbe[9], Els van der Ven[10,11], Diego Quattrone[12], Marta di Forti[12], Eva Velthorst[13,14], Paulo Rossi Menezes[15], Celso Arango[16], Mara Parellada[16], Antonio Lasalvia[6], Caterina La Cascia[17], Laura Ferraro[17], Julio Bobes[18], Miguel Bernardo[19], Iulio Sanjuán[20], Jose Luis Santos[21], Manuel Arrojo[22], Cristina Marta Del-Ben[23], Giada Tripoli[9,24], Pierre-Michel Llorca[25], Lieuwe de Haan[13], Jean-Paul Selten[11], Andrea Tortelli[26], Andrei Szöke[27], Roberto Muratori[2], Bart P. Rutten[11], Jim van Os[9,11,28], Peter B. Jones[5,29], James B. Kirkbride[4], Domenico Berardi[3], Robin M. Murray[9] and Craig Morgan[7]

Abstract

Background. Psychosis rates are higher among some migrant groups. We hypothesized that psychosis in migrants is associated with cumulative social disadvantage during different phases of migration.

Methods. We used data from the EUropean Network of National Schizophrenia Networks study-

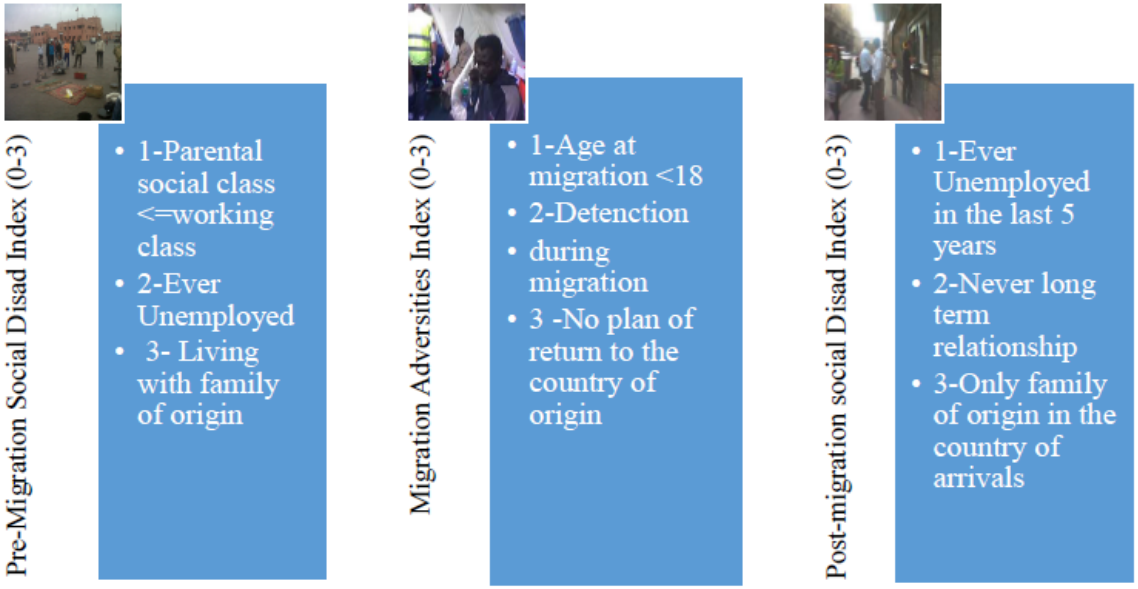
Table 3. Unadjusted and adjusted odds ratios for first-episode psychosis

	OR	OR[A]	OR[B]
Pre-migration disadvantages	**1.61 (1.19–2.17) (*p* = 0.002)**	1.55 (0.99–2.41) (*p* = 0.051)	**1.61 (1.06–2.44) (*p* = 0.027)**
Migration adversities	**1.78 (1.31–2.41) (*p* < 0.001)**	**1.53 (1.05–2.25) (*p* = 0.028)**	1.18 (0.672–2.06) (*p* = 0.568)
Post-migration disadvantages	**1.94 (1.19–3.15) (*p* = 0.008)**	**2.06 (1.13–3.73) (*p* = 0.018)**	**1.89 (1.02–3.51) (*p* = 0.044)**
Expectations/achievements mismatch	**1.61 (1.38–1.87) (*p* < 0.001)**	**1.81 (1.07–1.29) (*p* = 0.001)**	**1.14 (1.03–1.26) (*p* = 0.014)**

OR = unadjusted.
OR[A] = adjusted for site, age, gender, ethnicity, education, family history of psychosis, childhood trauma, cannabis use, language fluency, years after migration.
OR[B] = adjusted for all above variables plus pre-migration and post-migration disadvantages, migration adversities and expectations/achievements mismatch.
ORs in **bold** are significant (*p* < 0.05).

Migration Social disadvantages and adversities index

Supplemental Figure 1. Social disadvantages and adversities indexes during the 3 phases of the migration history.



- We found a **dose–response effect** between the number of adversities across all phases and odds of psychosis
- (**⩾6: OR 14.09**, 95% CI 2.06–96.47, p = 0.007).

Table 4. Dose–response effect of cumulative exposure to disadvantages/adversities

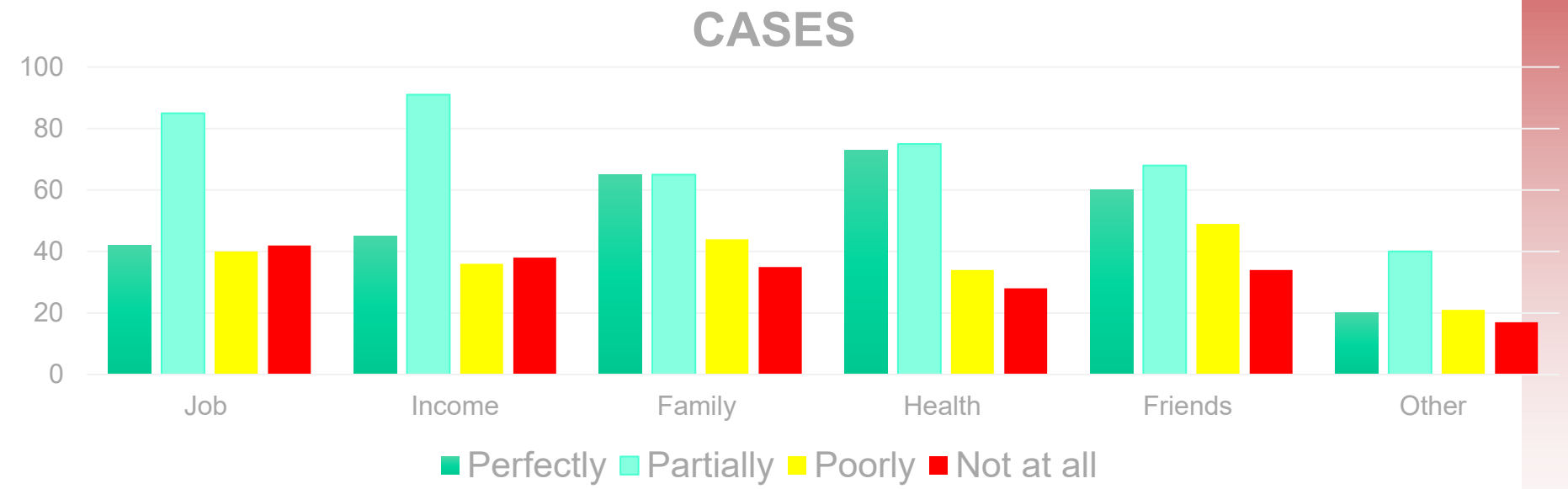
N. of disadvantages/adversities (% cases *v.* % controls)	OR (95% CI)	OR^{A} (95% CI)
0 (2.6% *v.* 11.7%)	1.00 (–)	1.00 (–)
1 (6.4% *v.* 21.1%)	1.36 (0.433–4.25) ($p = 0.601$)	1.21 (0.308–4.72) ($p = 0.788$)
2 (13.1% *v.* 17.9%)	**3.29 (1.12–9.72) ($p = 0.031$)**	2.28 (0.578–9.03) ($p = 0.239$)
3 (14.0% *v.* 15.7%)	**3.99 (1.37–11.65) ($p = 0.011$)**	2.92 (0.701–12.16) ($p = 0.141$)
4 (18.7% *v.* 15.5%)	**5.50 (1.85–16.40) ($p = 0.002$)**	**5.94 (1.19–29.42) ($p = 0.029$)**
5 (21.7% *v.* 9.9%)	**9.97 (3.22–30.26) ($p < 0.001$)**	**9.24 (1.73–49.47) ($p = 0.01$)**
⩾6 (23.5% *v.* 8.2%)	**14.05 (3.86–51.08) ($p < 0.001$)**	**14.09 (2.06–96.47) ($p = 0.007$)**

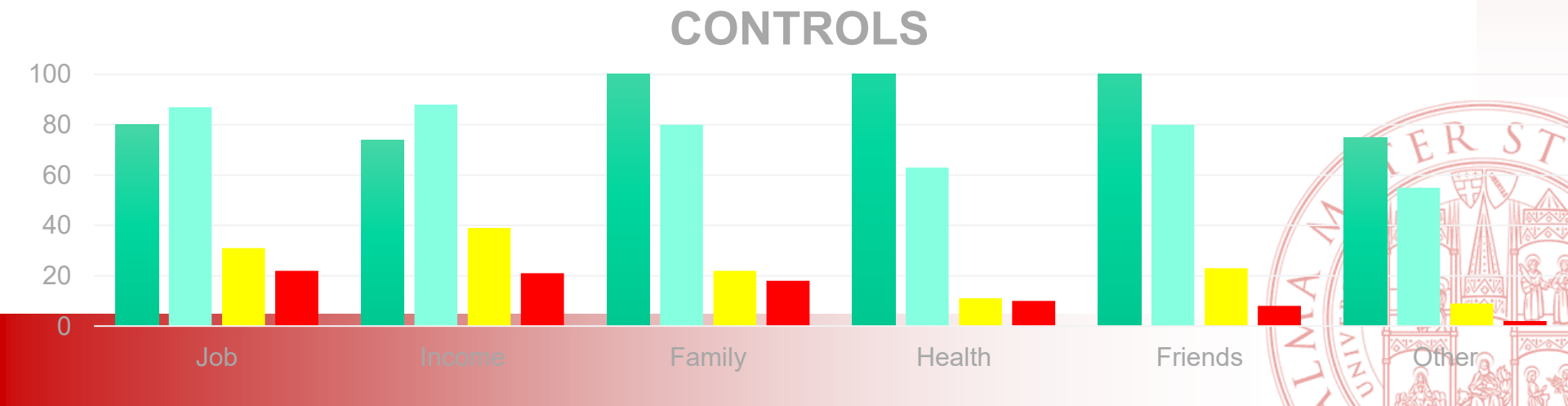
OR^{A} = adjusted for site, age, gender, ethnicity, education, family history of psychosis, childhood trauma, cannabis use, fluency, years after migration, and achievements/expectations mismatch.
ORs in **bold** are significant ($p < 0.05$).

Before migration: satisfaction with life

48 % (n 45) cases vs 71 % (n 61) controls where satisfied in all domains of life before migration (p= 0.02)

After migration: mismatch expectations-accomplishment





Higher exposure to Child Maltreatment (CA) accounted for a greater proportion of incident FEP cases among migrants

- We examined 849 FEP cases and 1142 controls.
- CM prevalence was higher among migrants, their descendants and migrants of non-Western heritage.
- Migrant status, classified by generation (likelihood test ratio:$\chi 2 = 11.3$, $p = 0.004$) or by region of origin (likelihood test ratio:$\chi 2 = 11.4$, $p = 0.003$), attenuated the association between CM and FEP.
- PAFs for CM were higher among all migrant groups compared with the reference populations.

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Original Article

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Child maltreatment, migration and risk of first-episode psychosis: results from the multinational EU-GEI study

Giuseppe D'Andrea[1,2], Jatin Lal[1], Sarah Tosato[3], Charlotte Gayer-Anderson[4], Hannah E. Jongsma[5,6], Simona A. Stilo[7,8], Els van der Ven[9], Diego Quattrone[10], Eva Velthorst[11,12], Domenico Berardi[13], Paulo Rossi Menezes[14], Celso Arango[15], Mara Parellada[15], Antonio Lasalvia[3], Caterina La Cascia[16], Laura Ferraro[16], Daniele La Barbera[16], Lucia Sideli[17], Julio Bobes[18], Miguel Bernardo[19], Julio Sanjuán[20], Jose Luis Santos[21], Manuel Arrojo[22], Cristina Marta Del-Ben[23], Giada Tripoli[8,16,24], Pierre-Michel Llorca[25], Lieuwe de Haan[26], Jean-Paul Selten[27], Andrea Tortelli[28], Andrei Szöke[29], Roberto Muratori[30], Bart P. Rutten[31], Jim van Os[8,31], Peter B. Jones[32], James B. Kirkbride[33], Robin M. Murray[8], Marta di Forti[10], Ilaria Tarricone[1,30] and Craig Morgan[4]

Abstract

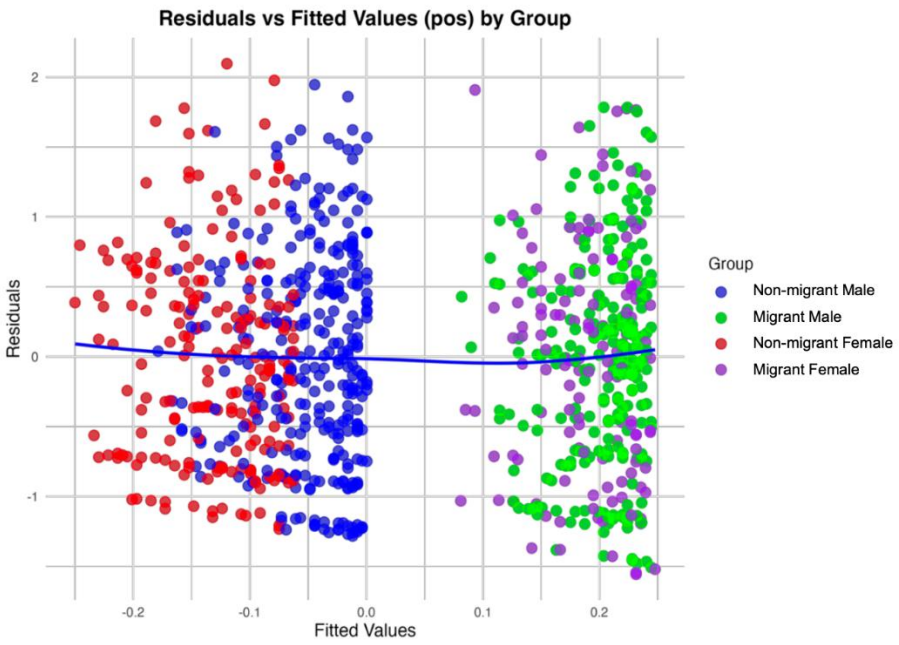
Background. Child maltreatment (CM) and migrant status are independently associated with psychosis. We examined prevalence of CM by migrant status and tested whether migrant status moderated the association between CM and first-episode psychosis (FEP). We further explored whether differences in CM exposure contributed to variations in the incidence rates of FEP by migrant status.

Methods. We included FEP patients aged 18–64 years in 14 European sites and recruited controls representative of the local populations. Migrant status was operationalized according to generation (first/further) and region of origin (Western/non-Western countries). The reference population was composed by individuals of host country's ethnicity. CM was assessed with Childhood Trauma Questionnaire. Prevalence ratios of CM were estimated using Poisson regression. We examined the moderation effect of migrant status on the odds of FEP by CM fitting adjusted logistic regressions with interaction terms. Finally, we calculated the population attributable fractions (PAFs) for CM by migrant status.

Results. We examined 849 FEP cases and 1142 controls. CM prevalence was higher among migrants, their descendants and migrants of non-Western heritage. Migrant status, classified by generation (likelihood test ratio:$\chi^2 = 11.3$, $p = 0.004$) or by region of origin (likelihood test ratio:$\chi^2 = 11.4$, $p = 0.003$), attenuated the association between CM and FEP. PAFs for CM were higher among all migrant groups compared with the reference populations.

Conclusions. The higher exposure to CM, despite a smaller effect on the odds of FEP, accounted for a greater proportion of incident FEP cases among migrants. Policies aimed at reducing CM should consider the increased vulnerability of specific subpopulations.

Different psychopathological presentation at FEP by sex and migrant status



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Positive dimension (delusion , allucinations)

Linear multivariate regression model (male non migrant ref category)

Positive dimension				
Predictors	Estimates std. Beta	p	I.C. 2.5%	I.C. 97.5%
(Intercept)	0.078	0.357	-0.089	0.246
Migrant Male	0.243	<0.001***	0.118	0.369
Non-migrant Female	-0.062	0.368	-0.198	0.073
Migrant Female	0.247	0.001**	0.096	0.399
Age at first contact	-0.004	0.086	-0.009	0.001
Observation 942 R^2/R^2 adjusted 0.036 / 0.032				

Striatal stress-induced dopamine release elevated in migrants

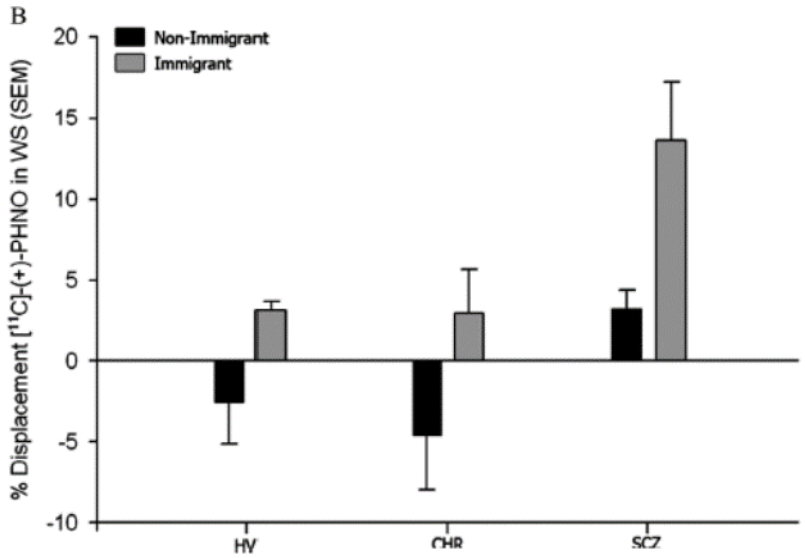
Schizophrenia Bulletin vol. 43 no. 2 pp. 293–301, 2017
doi:10.1093/schbul/sbw181
Advance Access publication January 5, 2017

Elevated Striatal Dopamine Function in Immigrants and Their Children: A Risk Mechanism for Psychosis

Alice Egerton[1,10], Oliver D. Howes[1,10], Sylvain Houle[2,3,4,10], Kwame McKenzie[2,4], Lucia R. Valmaggia[1], Michael R. Bagby[3,4,5], Huai-Hsuan Tseng[1,2], Michael A. P. Bloomfield[1,6,7], Miran Kenk[2], Sagnik Bhattacharyya[1], Ivonne Suridjan[2], Chistopher A. Chaddock[1], Toby T. Winton-Brown[1], Paul Allen[1,8], Pablo Rusjan[2,4], Gary Remington[3,4], Andreas Meyer-Lindenberg[9], Philip K. McGuire[1,11], and Romina Mizrahi*[2,3,4,11]

[1]Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK; [2]Research Imaging Center, CAMH, PET Centre, Toronto, ON, Canada; [3]Department of Psychiatry, Faculty of Medicine, University of Toronto, Toronto, ON, Canada; [4]Campbell Family Mental Health Research Institute, Centre for Addiction and Mental Health, Toronto, Ontario, Canada; [5]Department of Psychology, University of Toronto; [6]Division of Psychiatry, University College London, London, UK; [7]Psychiatric Imaging Group, MRC Clinical Sciences Centre, Hammersmith Hospital, London, UK; [8]Department of Psychology, Whitelands College, University of Roehampton, London, UK; [9]Central Institute of Mental Health, University of Heidelberg/Medical Faculty Mannheim, Mannheim, Germany

[10]These authors are joint first authors.



Migration is a major risk factor for schizophrenia but the neurochemical processes involved are unknown. One candidate mechanism is through elevations in striatal dopamine synthesis and release. The objective of this research was to determine whether striatal dopamine function is elevated in immigrants compared to nonimmigrants and the relationship with psychosis. Two complementary case–control studies of in vivo dopamine function (stress-induced dopamine release and dopamine synthesis capacity) in immigrants compared to nonimmigrants were performed in Canada and the United Kingdom. The Canadian dopamine release study included 25 immigrant and 31 nonmigrant Canadians. These groups included 23 clinical high risk (CHR) subjects, 9 antipsychotic naïve patients with schizophrenia, and 24 healthy volunteers. The UK dopamine synthesis study included 32 immigrants and 44 nonimmigrant British. These groups included 50 CHR subjects and 26 healthy volunteers. Both striatal stress-induced dopamine release and dopamine synthesis capacity were significantly elevated in immigrants compared to nonimmigrants, independent of clinical status. These data provide the first evidence that the effect of migration on the risk of developing psychosis may be mediated by an elevation in brain dopamine function.

Migration and Psychosis: what the evidence tells us

- ✓ High rates of first episode psychosis (FEP) in migrants and ethnic minorities (Shen et al, 1998; Fossion et al, 2002; Carta et al, 2002; Dembling et al, 2002; Cantor-Graae et al, 2003; Cantor-Graae & Selten, 2005; Selten et al., 2019)
  - Studies had mostly been conducted in the UK and northern Europe.
  - Despite huge variations of psychosis IR , IRR (migrants IR/natives IR) is quite similar among places
- ✓ Risk persists in second generations migrants (Selten et al. 2019) and higher risk found also in internal migrants (Tarricone et al., 2016)
- ✓ Evidence of cumulative effect of social adversities and disadvantages during migration history (Tarricone et al., 2021), childhood maltreatment (D'andrea et al. 2022), and elevated stress induced dopamine release in migrants (Egerton et al., 2017)

Is it time to think about history of migration and psychosocial intervention in countries of arrivals

Pertanto si raccomanda

Raccomandazione 90 di Livello A

- *Prestare attenzione alla **narrazione della storia migratoria e personale**, raccogliendo informazioni relative a difficoltà dell'adattamento prima, durante e dopo la migrazione e alla esposizione al **trauma**, in considerazione della più elevata frequenza di PTSD nella popolazione migrante; si possono utilizzare a tale scopo interviste quali la "Bologna Migration history and social integration interview», già implementata nel progetto europeo EU-Gei e disponibile in italiano (Tarricone et al., 2022). La consultazione dei documenti citati è disponibile sul sito https://centri.unibo.it/bo-tpt/it/innovazione/servizi-per-enti-e-imprese*
- *Assicurare adeguata **mediazione linguistica e culturale** in tutte le fasi della cura, da quella di valutazione a quella di implementazione degli interventi sopra descritti per la popolazione generale;*
- *Rafforzare la **presa in carico sociale**, mediante il coinvolgimento, accanto al case-manager di area sanitaria, dell'operatore sociale;*
- *Implementare gruppi di auto-mutuo aiuto per gestire lo stress ed i fattori di rischio*

Outlines

- ✓ Il fenomeno migratorio e l'approccio transculturale
- ✓ Le evidenze relative a un eccesso di psicosi nei migranti e i loro bisogni specifici
- ✓ **Gli interventi utili e la competenza culturale**

Cittadini stranieri «irregolari» in Italia:

- Hanno diritto alle cure ambulatoriali ed ospedaliere urgenti o comunque essenziali, anche se continuative.
- Possono accedere ai programmi di medicina preventiva.
- L'accesso alle cure non comporta alcuna segnalazione alle autorità.

Legge italiana:

- Garantisce il diritto alla salute per tutti, indipendentemente dalla regolarità del soggiorno.
- Promuove la salute individuale e collettiva.

Fonte:

- Circolare del Ministero della Salute del 24 marzo 2000, n. 5

La competenza culturale

Il problema:

Le persone con psicosi che provengono da contesti culturali diversi possono avere difficoltà ad accedere e aderire ai programmi di trattamento.

La soluzione:

Rafforzare la "cultural competence" nei servizi di salute mentale e nei programmi di trattamento delle psicosi.

Obiettivi:

- Rendere il sistema di cure visibile e accessibile a tutti.
- Rafforzare l'aderenza al programma di cura.

Come fare:

- Mediazione linguistica e culturale:
  - Il mediatore linguistico aiuta il clinico a comprendere meglio il paziente e la sua cultura.
  - Il mediatore aiuta il paziente a comprendere il sistema di cure e il programma di trattamento.
- Coinvolgimento dell'operatore sociale:
  - L'operatore sociale facilita i rapporti con le associazioni cittadine.
  - L'operatore sociale favorisce l'integrazione sociale del paziente.

Benefici:

- Migliore comunicazione tra paziente e clinico.
- Maggiore fiducia nel sistema di cure.
- Aumento dell'aderenza al programma di cura.
- Migliore outcome del trattamento.

Fonti:

- Schouler-Ocak et al. (2015; 2025 in press)

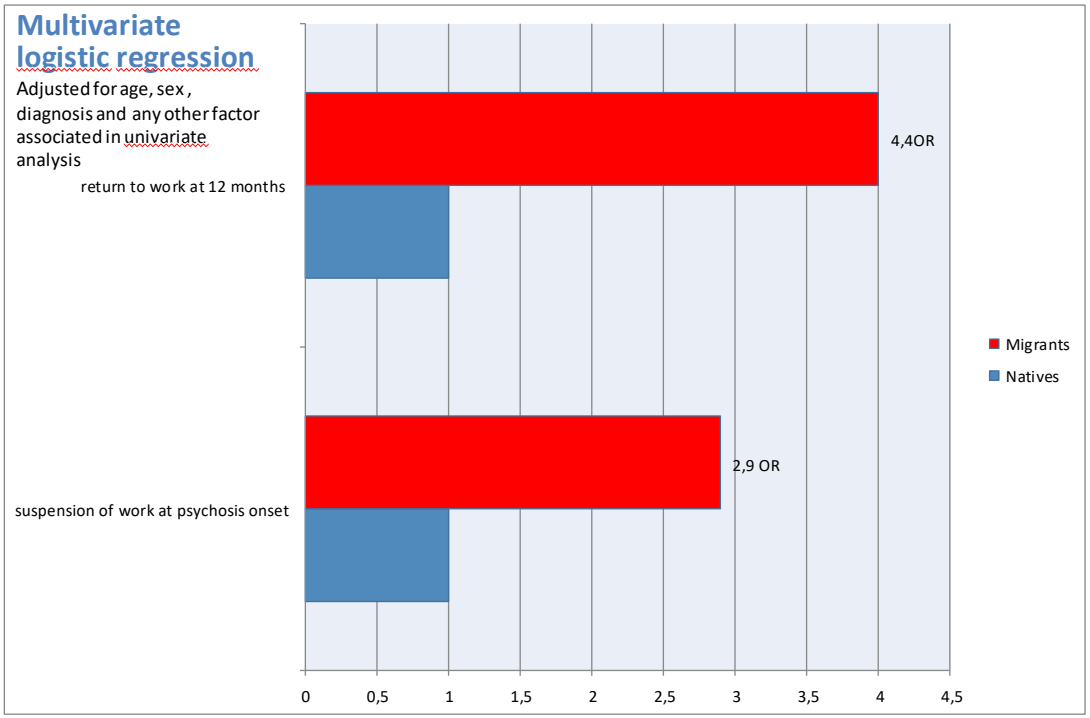
Functional Outcomes : first generation migrants vs Italian natives

Early Intervention IN PSYCHIATRY
First Impact Factor released in June 2010 and now listed in MEDLINE!
Early Intervention in Psychiatry 2016; ••: ••–••
doi: 10.1111/eip.12325

Brief Report

Occupation and first episode psychosis in Northern Italy: better outcomes for migrants

Ilaria Tarricone,[1,2,3]* Craig Morgan,[3] Jane Boydell,[3] Serena Panigada,[1] Raffaele Morigi,[1] Mauro Braca,[1,2] Enrico Sutti,[1] Pierluigi Boldri,[2] Marta Di Forti,[3] Robin M Murray[3] and Domenico Berardi[1,2]



The better social course of FEP migrants (as the higher rate of work resumption) could possibly imply that their FEP has a larger “psycho-social causation” compared with FEP in native Italians

Importanza dell'intervento sociale sugli esiti clinici

International Journal of Social Psychiatry
http://isp.sagepub.com/

Migrants referring to the Bologna Transcultural Psychiatric Team: Reasons for drop-out

Ilaria Tarricone, Anna Rita Atti, Mauro Braca, Graziano Pompei, Michela Morri, Francesca Poggi, Saverio Melega, Elisa Stivanello, Lorenza Tonti, Maria Nolet and Domenico Berardi

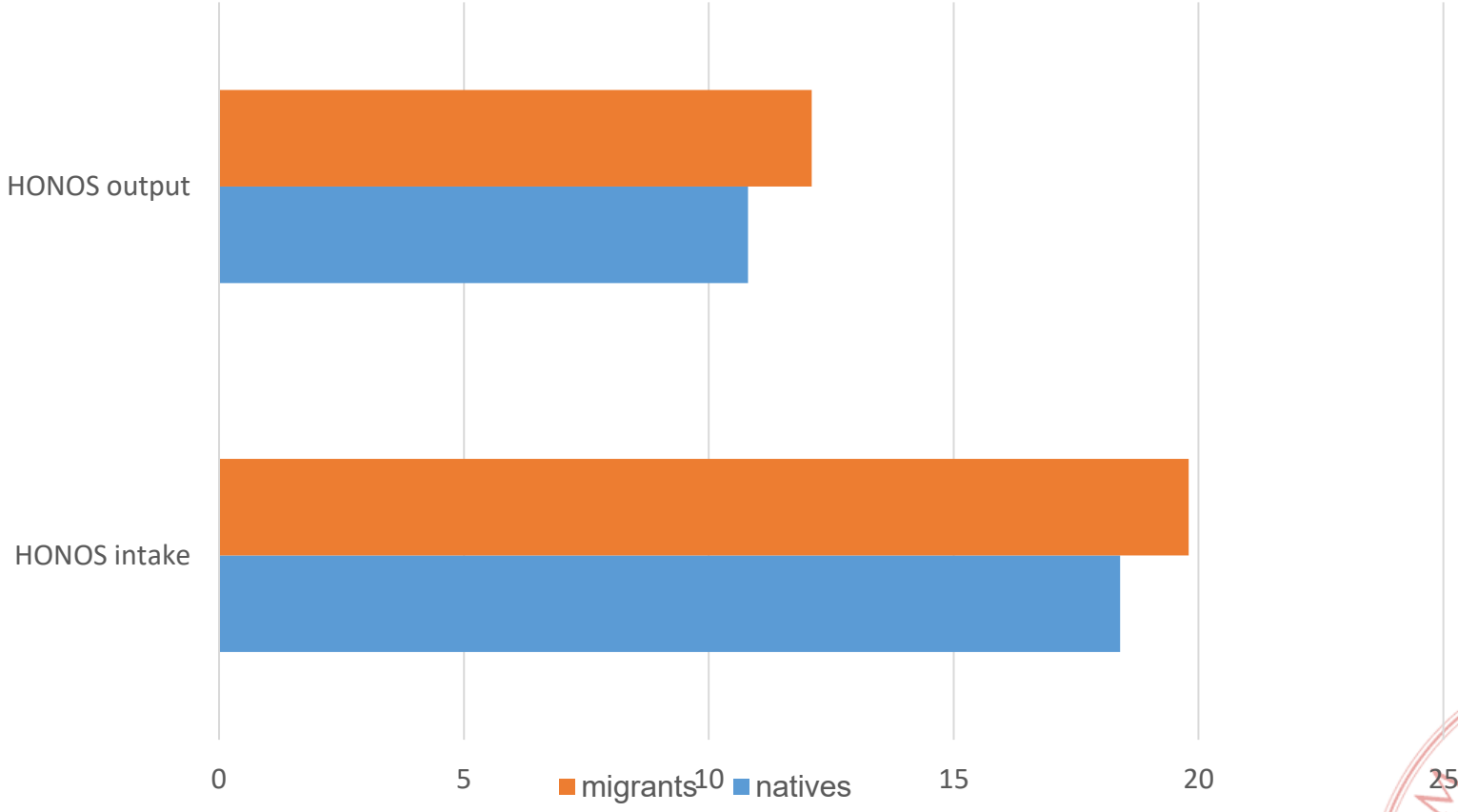
Int J Soc Psychiatry published online 17 September 2010
DOI: 10.1177/0020764010382368

The online version of this article can be found at:
http://isp.sagepub.com/content/early/2010/09/16/0020764010382368

Table 1. Sociodemographic and clinical variables related to drop out at six-month follow-up

	χ^2	p	OR (95% CI)
Sociodemographic variables			
Younger than 26 years old	4.4	0.04	2.4 (1.0–5.3)
Asian origin	8.1	0.004	0.1 (0.01–0.7)
Having lived in Italy for a period shorter than five years	8.6	0.004	3.4 (1.5–7.9)
Clinical variables			
Being affected by mood disorders	4.5	0.04	0.3 (0.08–0.97)
Receiving social intervention	5.2	0.02	0.7 (0.71–0.85)
Receiving cultural mediator-intervention	2.2	0.1	0.3 (0.07–1.49)

Storia migratoria e scala HONOS (877 cittadini italiani , 208 cittadini stranieiri, dati RER programma primi episodi psicotici)



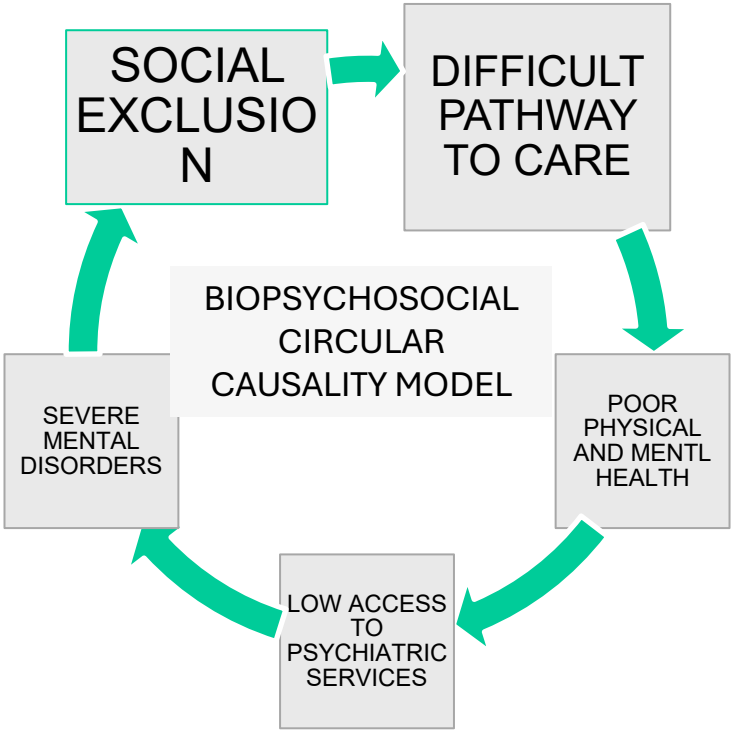
Variabili esplicative cliniche

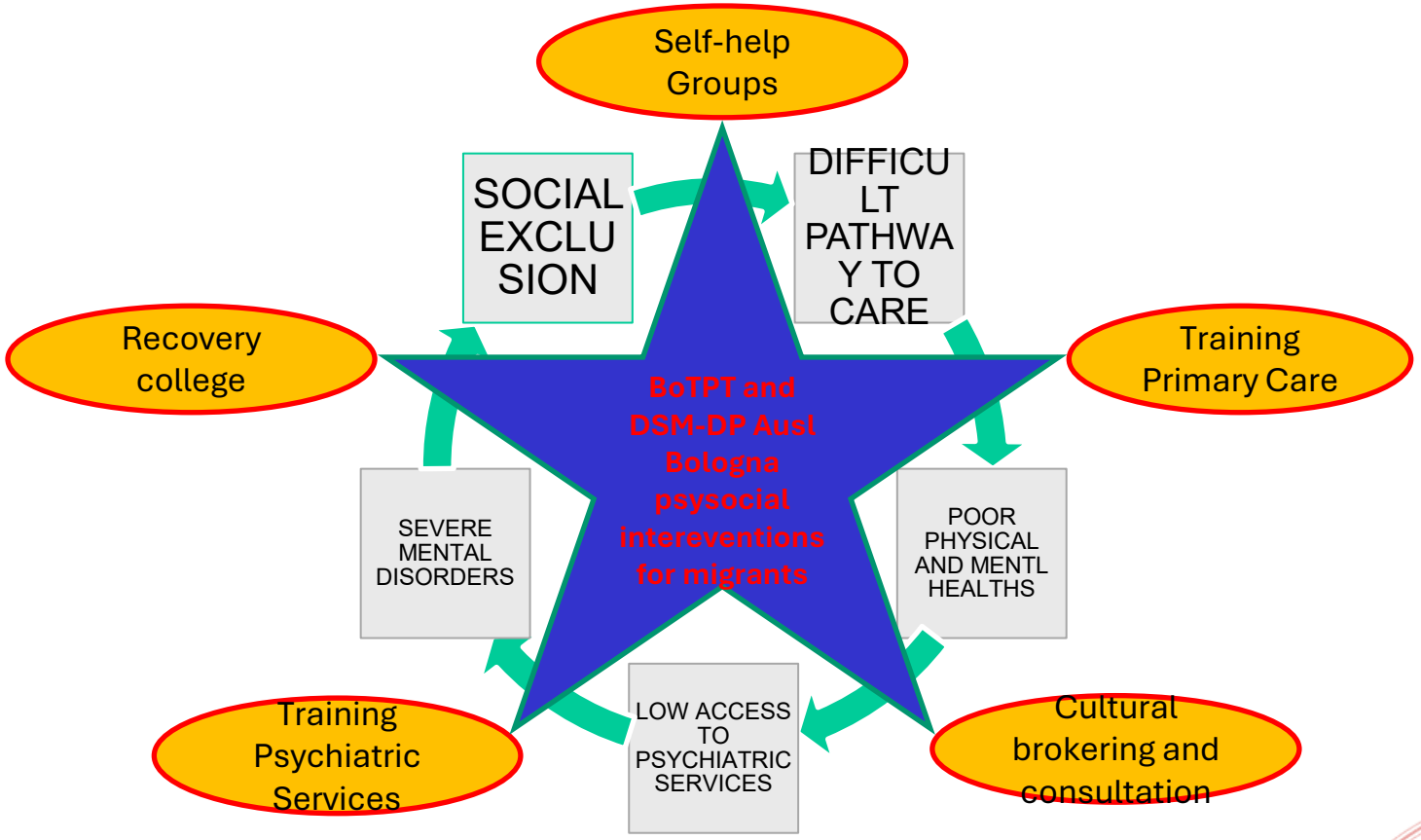
- ✓ Numero di **ricoveri**,
- ✓ Numero totale di interventi ricevuti,
- ✓ numero di **interventi diretti (DI)** (cioè gli interventi che implicano interventi diretti e significative tra i partecipanti e gli operatori – medici, infermieri, assistenti sociali, altri utenti – partecipanti),
- ✓ Numero di **interventi specifici (SI)** (cioè gli interventi specifici per FEP come la psicoeducazione e la CBT, (RER-FEP recommendations, 2024)
- ✓ Numero di **interventi Indiretti (II)** (cioè che non coinvolgono gli utenti direttamente, come le supervisioni dei casi clinici)

Miglioramento significativo della Honos alla analisi multivariata

✓ **DUP < 9 mesi (**p = 0.003**), uso di sostanze all'intake** (p=0.01) e **numero di interventi specifici maggiore della media di 36 (**p = 0.005) sono gli unici fattori che restano predittori indipendenti di miglioramento Honos (**recovery**) nella analisi multivariata.

Biopsychosocial circular causality model




Self-help Groups
SOCIAL EXCLUSION
DIFFICULT PATHWAY TO CARE
Recovery college
Training Primary Care
BoTPT and DSM-DP Ausl Bologna psysocial intereventions for migrants
SEVERE MENTAL DISORDERS
POOR PHYSICAL AND MENTL HEALTHS
Training Psychiatric Services
LOW ACCESS TO PSYCHIATRIC SERVICES
Cultural brokering and consultation

Pertanto si raccomanda

Raccomandazione 91 a cura del GLR *- Prevedere nelle equpe di cura nei servizi di salute mentale dedicati ai programmi di trattamento delle psicosi le figure del mediatore culturale e dell'operatore sociale.*

Inoltre il Gruppo Regionale raccomanda

Raccomandazione 92 a cura del GLR *- Prevedere nei servizi di salute mentale dedicati ai programmi di trattamento delle psicosi progetti a "bassa-soglia", che prevedono un coordinamento sovra-territoriale della presa in carico dei migranti privi di residenza o stabile domicilio, in stretta collaborazione con i servizi sociali del Comune, per facilitarne l'erogazione e la continuità delle cure.*

Organizzazione del lavoro della U. Centro Casa dell'Area Vulnerabili e Migranti del DSM-DP Ausl Bo

INVIANTI :
SERVIZI AUSL :DSM.DP (CSM , SPDC, NPIA), DCI, DCP, OSPEDALE GENERALE E PS; TAVOLO SICUREZZA CAS/ PREFETTURA; CARCERE; BASSA SOGLIA; SERVIZI SOCIALI TERRITORIALI; TERZO SETTORE; SERVIZIO DISABILITA' E SAP UNIBO

INFORMATIZZAZIONE E TRIAGE

PERSONE RICHIEDENTI ASILO E/O CON STORIA DI TRAUMA

PERSONE CON GRAVE EMARGINAZIONE E SOCIO SANITARIA

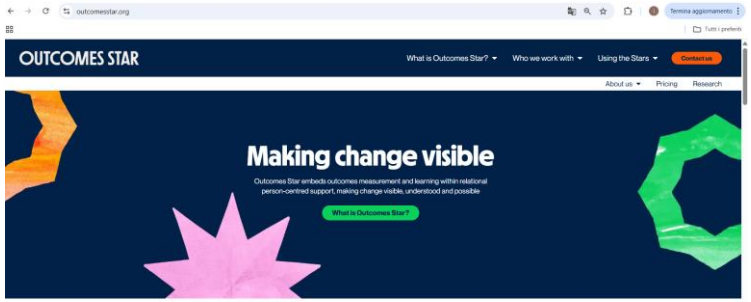
DISCUSSIONE CASI

INTERVENTI BREVI E CONSULENZA (1°livello)

CASI COMPLESSI (2° livello)

INVIO DIRETTO AI SERVIZI

PERCORSI DI AGGANCIO



The Journey of Change has no shortcuts

OUTCOMES STAR

What is Outcomes Star? | Who we work with | Using the Stars | Contact us

How does the Integration Star work?

The Integration Star covers eight key outcome areas to help refugees who need support to integrate into their new country and to build a life there. It assesses their progress towards each outcome area following a five-stage Journey of Change.

You and the people you support will fill out the Star together, and use it to better identify where their strengths lie and where they might need more help, and to make plans for moving forward along the journey.

Using the Stars

Outcome areas

- Housing
- Money
- Practical English
- Education and work
- Family and children
- Community and connections
- Laws, systems and services
- Health and well-being

Integration Star and Recovery College Diverse Population

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- Dr Ralph Nisbet
- Bologna Transcultural Psychosomatic Team – DIMEC UNIBO and EUGEI Consortium : Dr Giuseppe D'Andrea , Dr Margherita Alfieri

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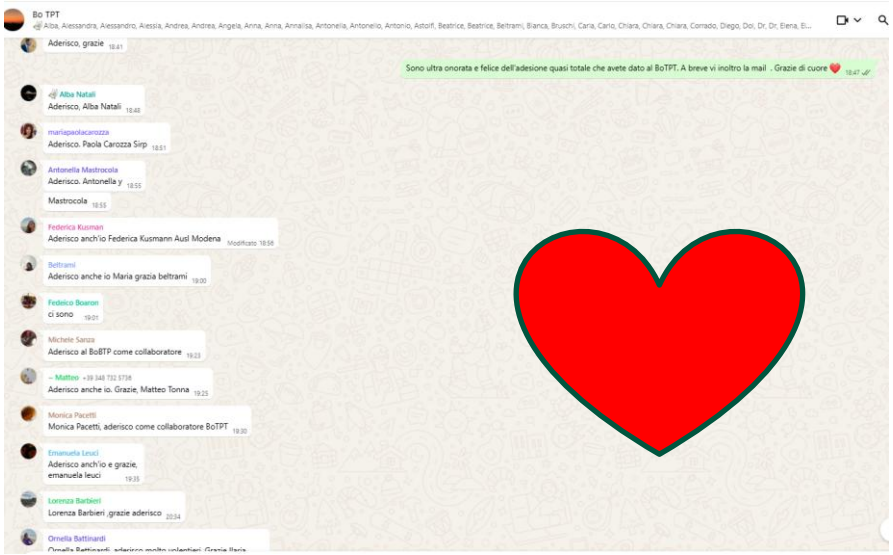
Grazie !

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