THE MENTAL HEALTH SYSTEM IN ITALY: AN OVERVIEW FOCUSED ON REGIONAL EXPERIENCES

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Italian-Mexican Workshop on
"Health Promotion and Healthy Lifestyles"
Rome, 23-24 January 2012

- Mental health needs in the community
- Mental disorders treated at primary care and mental health services level
- Quality of care for severe mental illness
- Which agenda is feasible for the mental health system in Italy?

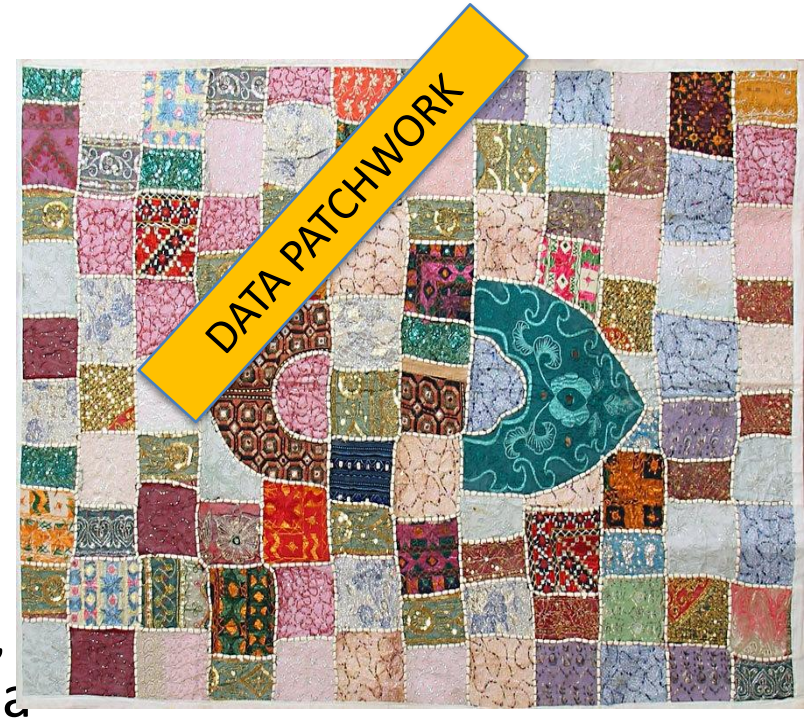
ONLY PSYCHIATRIC CARE FOR ADULTS

GOVERNANCE

- the 1978 national legislation (“Legge 180”) devolved to Italian regions the responsibility of managing the transition towards community psychiatric care.
- Recent legislation emphasizes the role of the regions in planning, coordination and delivery of healthcare services (including MH services).
- regional implementation process caused wide variation across the 20 Italian regions
- each Italian region set up its own mental health system
- limited monitoring of this dramatic change

MAIN DATA SOURCES

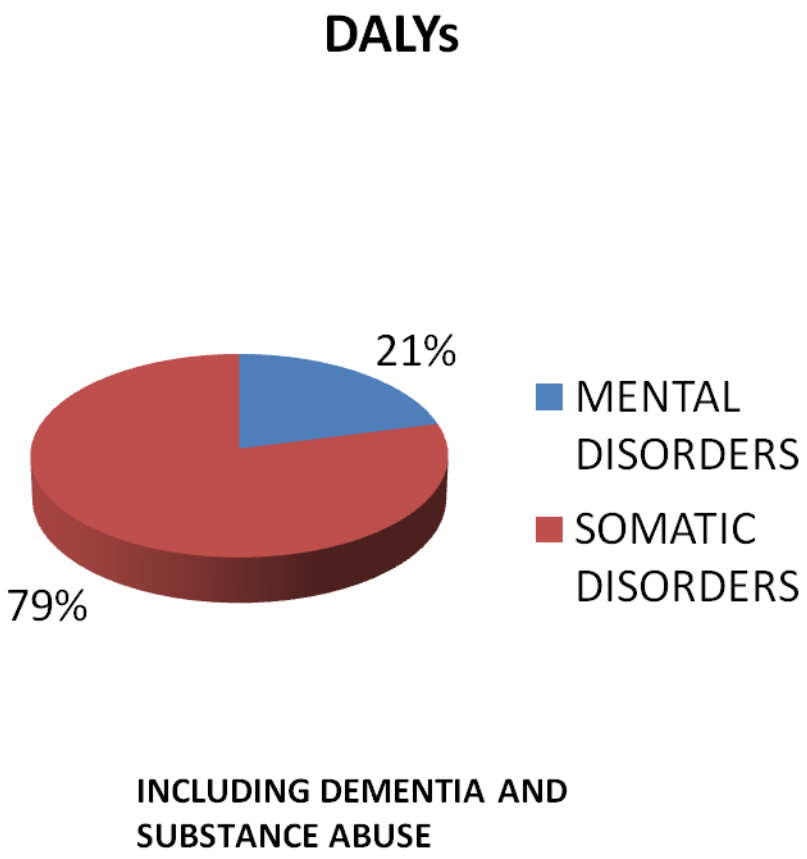
- 1 national survey on the prevalence of mental disorders in the community (ESEMeD: European Study of Epidemiology of Mental disorders, 2000)
- 3 national surveys on Residential Facilities (PROGRES, 2000), Psychiatric Wards in General Hospital (PROGRES Acuti 2002-2003) and Community Health Centers (PROGRES CSM 2005-2006)
- Data from 5 Regions (2009): Lombardy, Emilia Romagna, Friuli, Lazio and Liguria
- Data from Ministry of Health (2009)
- Data from Lombardy, a Region where a regional case register is working from 1999.



MENTAL HEALTH NEEDS IN THE COMMUNITY

BURDEN DUE TO MENTAL DISORDERS

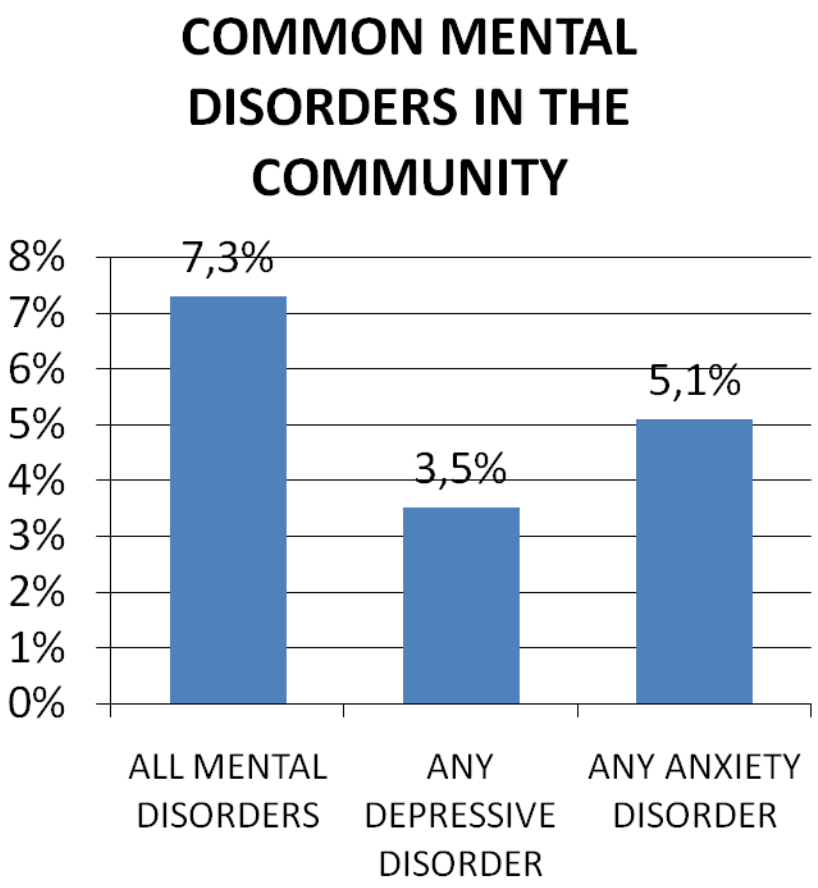
- In Italy **21%** of the global burden of disease measured in Disability Adjusted Life-Years (DALYs) can be attributed to mental and substance use disorders



	DALYs
DEPRESSION	7%
BIPOLAR DISORDERS	1%
SCHIZOPHRENIA	1%
OBSESSIVE-COMPULSIVE DISORDER,	1%
PANIC DISORDER	1%
ALCOHOL ABUSE	3%
DRUG USE	2%
DEMENTIA	4%

PREVALENCE OF MENTAL DISORDERS AT COMMUNITY LEVEL

- **ESEMED survey** in 2001-2003 interviewed a sample of 4712 Italian citizens
- The **annual prevalence** for common mental disorders was **7.3%**, The most common mental disorders were major depression (3%) and specific phobia (2.7%).
- the **use of health services** is relatively **scarce**. Only one sixth (16.9%) used health services (20.7% of those with mood disorder and 17.3% with anxiety disorder).



DEPRESSIVE SYMPTOMS IN ITALY *(PASSI, 2010)*

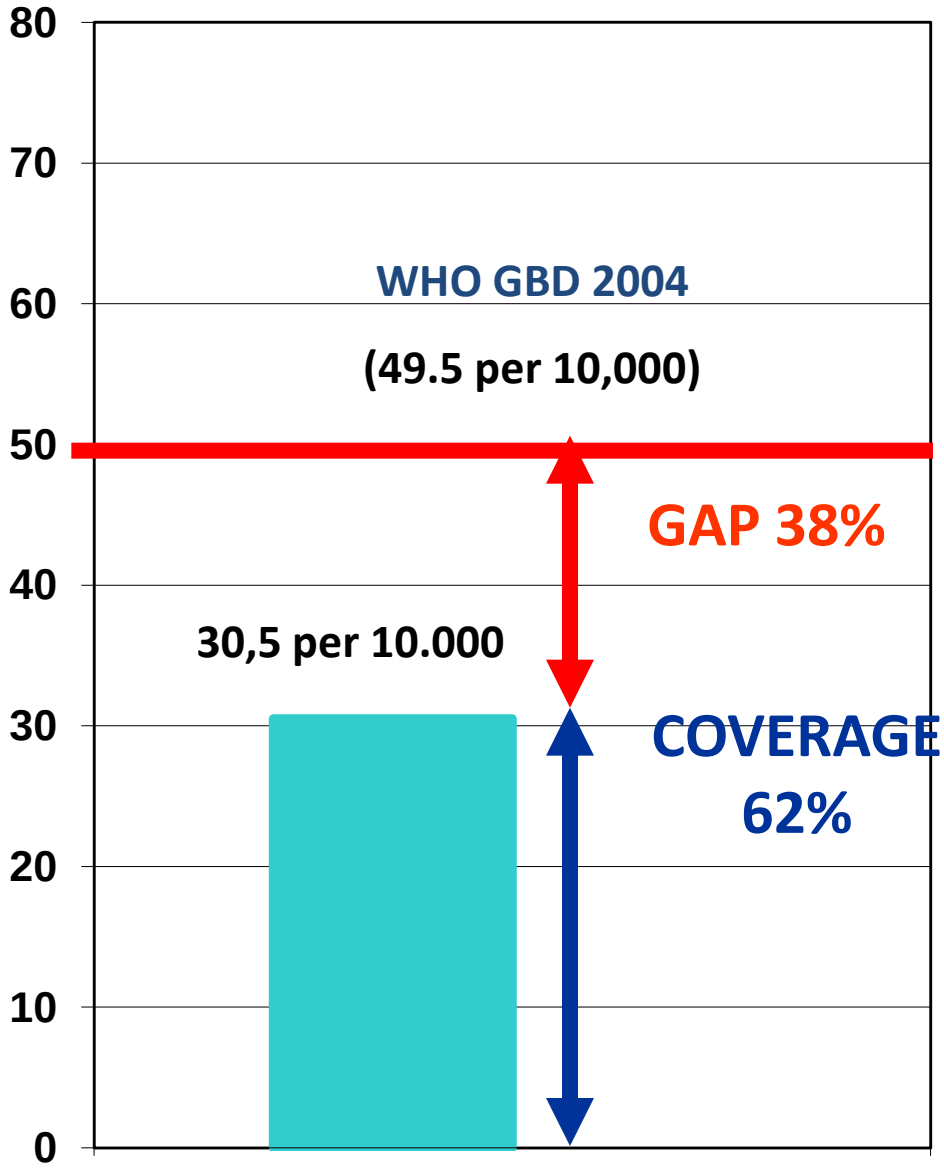
- PASSI (2007): national survey promoted by MoH
- about 20.000 phone interviews
- Depressive symptoms **6.4%** (men: 4%; women: 9%)

To whom do people with depression call for help?
People with depression call for help from :
- doctors (34%)
- family members (19%)
- both (7%)

TREATMENT GAP IN SCHIZOPHRENIC DISORDERS

the treatment gap as the absolute difference between the true prevalence of a disorder and the treated proportion of individuals affected by the disorder.

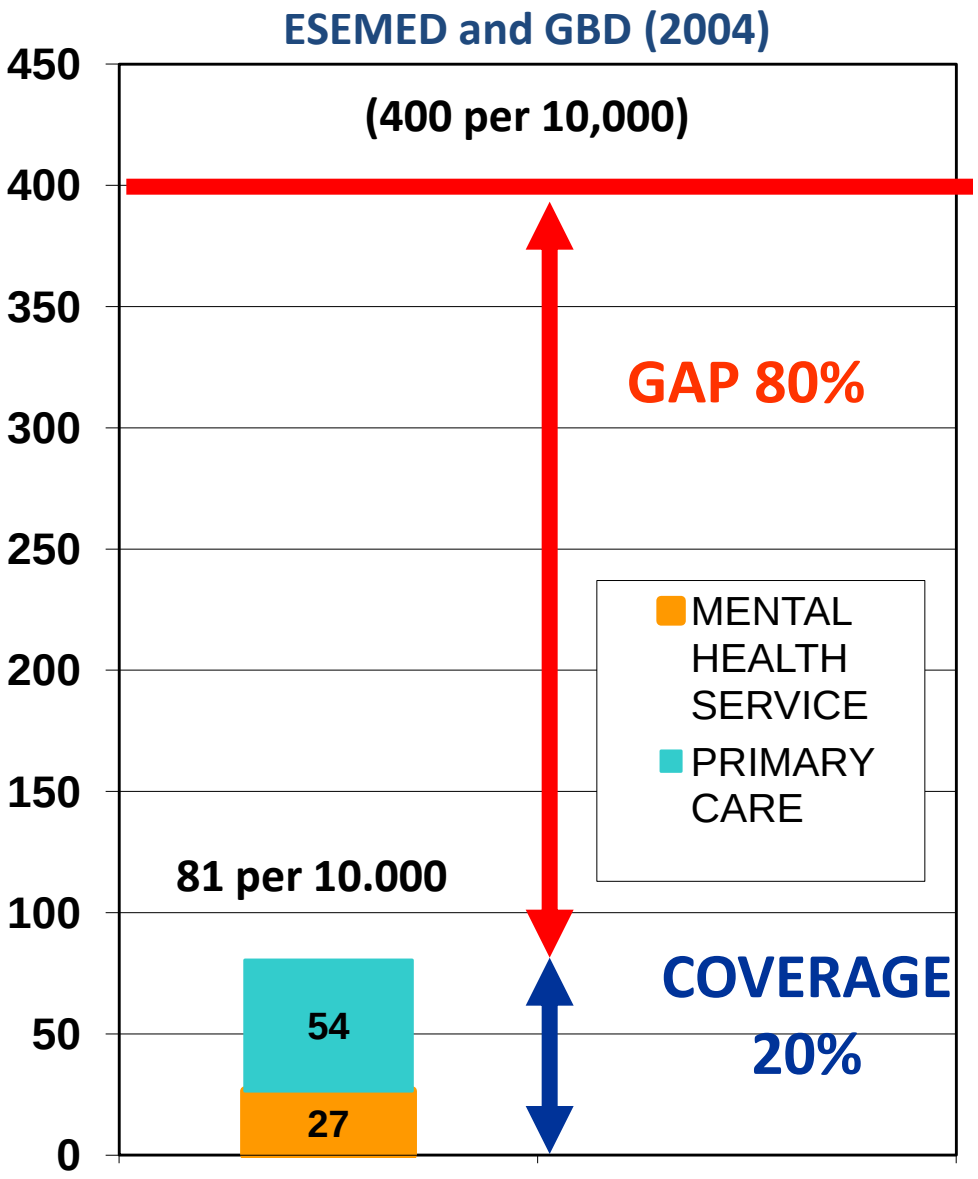
Public Departments of Mental Health in 5 Regions (2009)



TREATMENT GAP IN AFFECTIVE DISORDERS

Both unipolar (3.5%) and bipolar affective disorders (0.5%)

Data on service utilization for primary care from *ESEMeD* (54 per 10.000) and for mental health services (27 per 10.000) from *5 Regions*



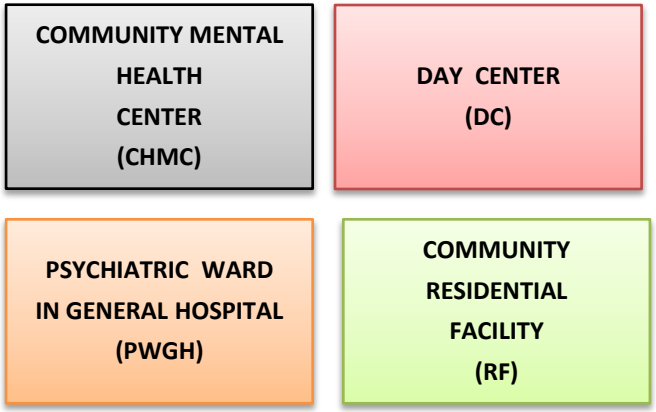
MENTAL HEALTH DISORDERS TREATED IN PRIMARY CARE AND MENTAL HEALTH SERVICES

PRIMARY CARE

- About **12%** of patients attending primary care service are suffering of a common mental disorder
- Referral and back referral with mental health services are common in Italy, but they are not structured
- only few Regions improved at system level this collaboration

DEPARTMENTS OF MENTAL HEALTH (DMH)

- **208 Departments of Mental Health** are the public health organizations responsible of the planning and management of all medical and social resources related to prevention, treatment, and rehabilitation in mental health
- defined **catchment area** (about **240.000 residents**)
- More than half of the DMHs included not only mental health services for adults, but also services for substance abuse, child and adolescent psychiatry, and clinical psychology services.

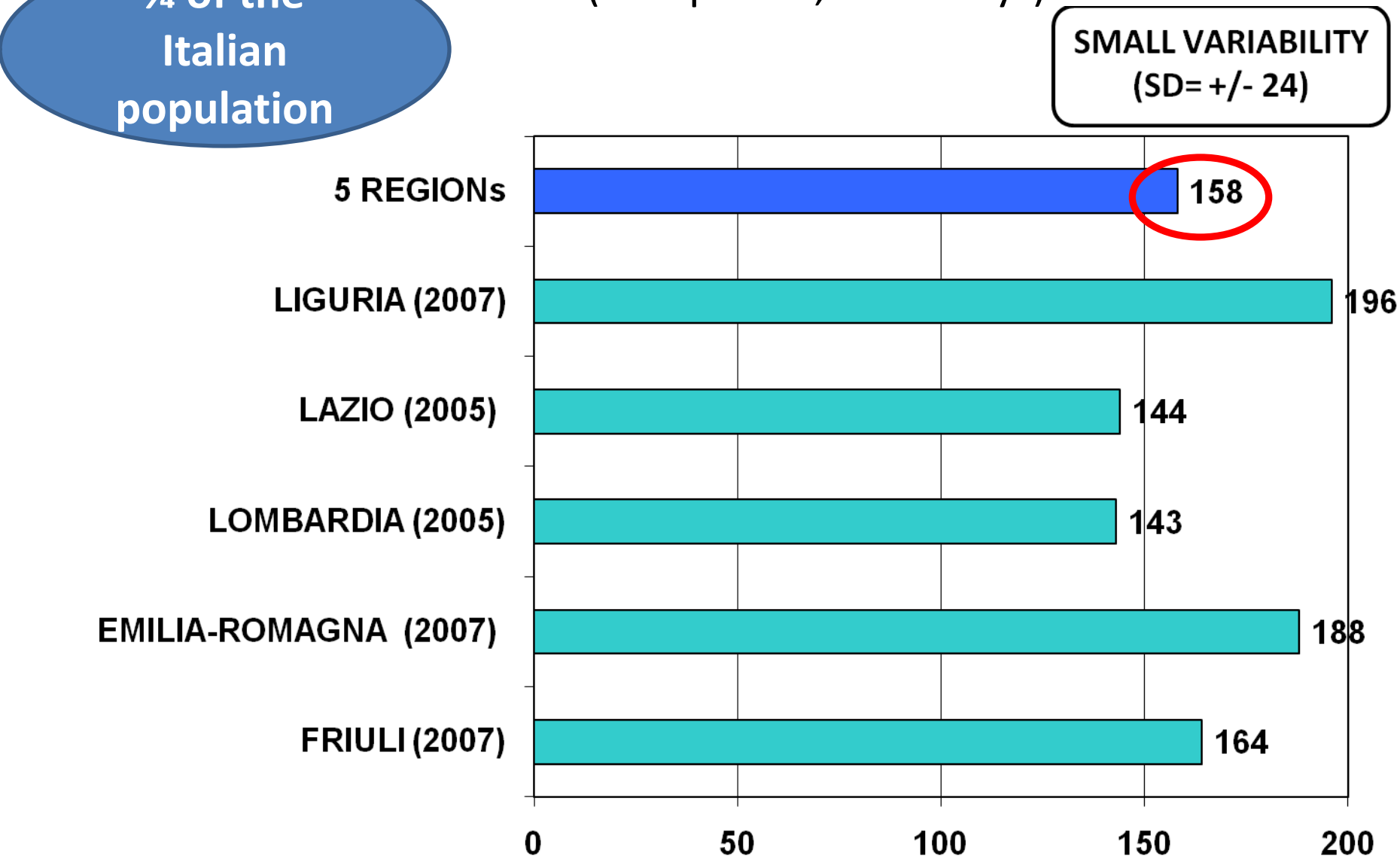


Concerning the **availability of the whole network of mental health facilities**, about eight DMHs out of ten included Residential Facilities or Day Care Facilities , almost all had Psychiatric Wards in General Hospitals and all had Community Mental Health Centers

DEPARTMENTS OF MENTAL HEALTH: ONE YEAR PREVALENCE

(rate per 10,000 > 17yr)

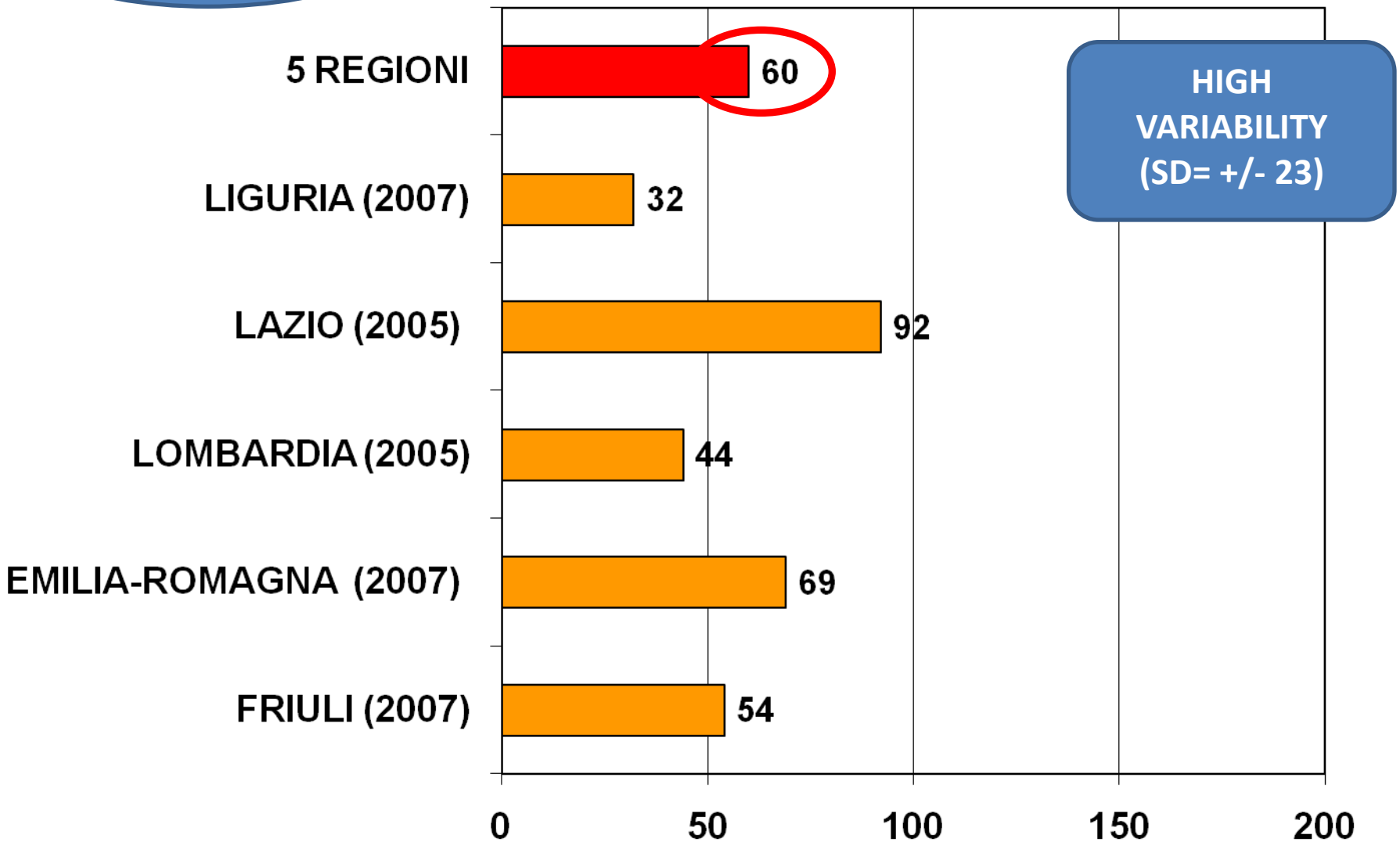
¼ of the Italian population



¼ of the Italian population

DEPARTMENTS OF MENTAL HEALTH: NEW CASES

(rate per 10,000 > 17yr)



HIGH VARIABILITY (SD= +/- 23)

TREATED PREVALENCE AND NEW CASES: DIAGNOSTIC BEAKDOWN IN 3 REGIONS

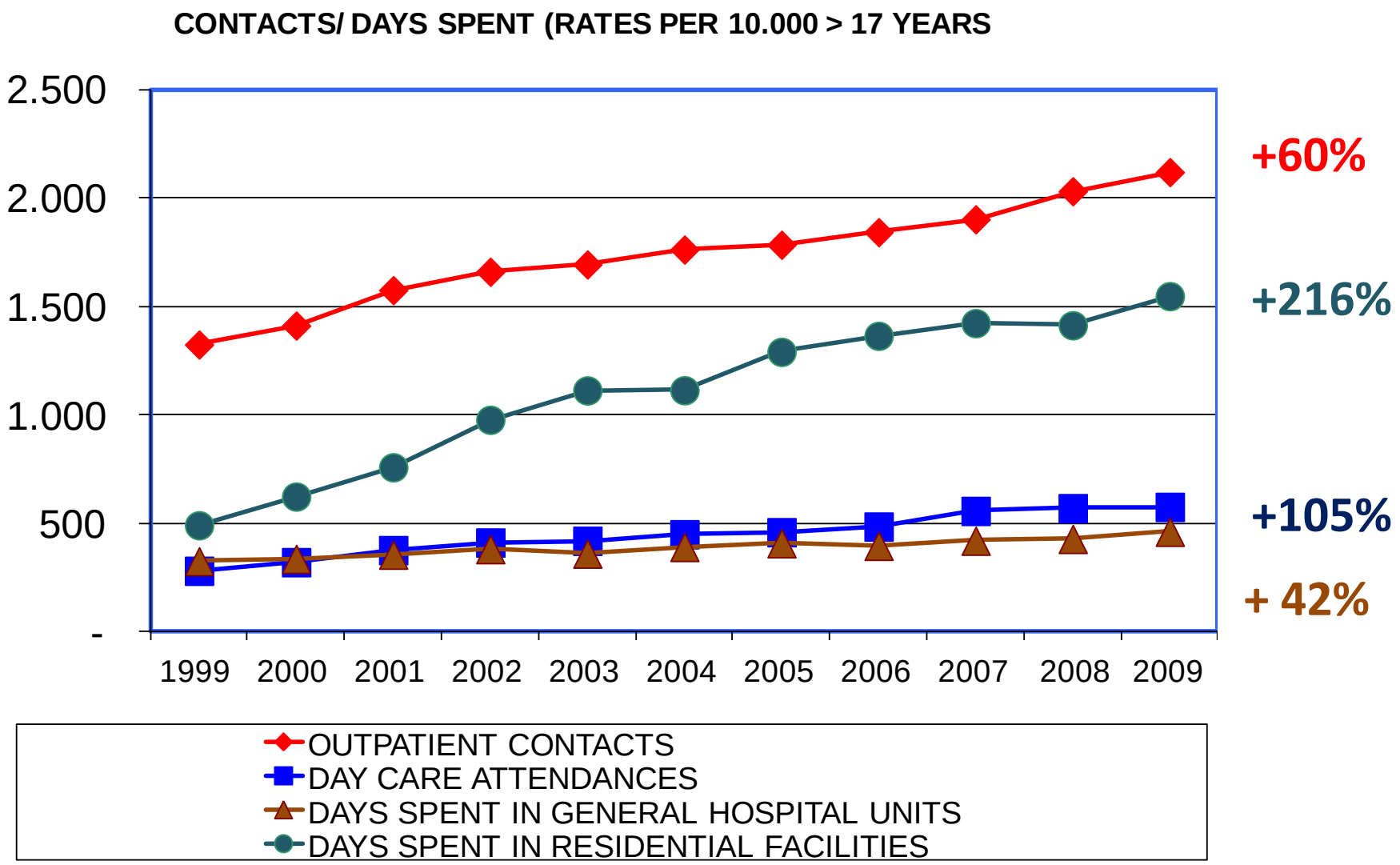
TREATED PREVALENCE

	FRIULI V.G. (2007)	EMILIA – ROMAGNA (2007)	LOMBARDIA (2005)
SCHIZOPHRENIC DISORDERS	30,9%	24,9%	30,7%
MOOD DISORDERS	25,5%	17,2%	20,7%
NEUROTIC DISORDERS	19,2%	33,8%	20,6%
ORGANIC MENTAL DISORDERS	7,3%	3,7%	3,5%
PERSONALITY DISORDERS	6,5%	11,8%	11,6%
DISORDERS DUE TO SUBSTANCE ABUSE	2,9%	2,1%	2,6%
OTHERS	7,8%	6,4%	7,9%

NEW CASES

	FRIULI V.G. (2007)	EMILIA – ROMAGNA (2007)	LOMBARDIA (2005)
SCHIZOPHRENIC DISORDERS	12,1%	8,8%	9,9%
MOOD DISORDERS	25,8%	13,4%	27,0%
NEUROTIC DISORDERS	28,5%	54,8%	37,5%
ORGANIC MENTAL DISORDERS	13,8%	6,9%	5,0%
PERSONALITY DISORDERS	3,7%	9,0%	7,3%
DISORDERS DUE TO SUBSTANCE ABUSE	3,7%	3,5%	1,0%
OTHERS	12,4%	3,5%	10,4%

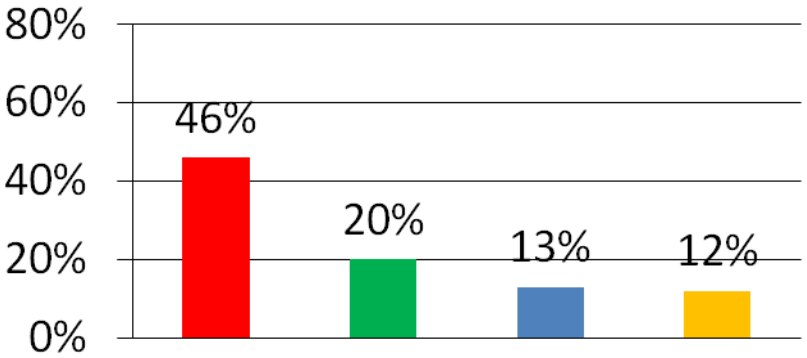
CARE DELIVERY (Lombardy 1999-2009)



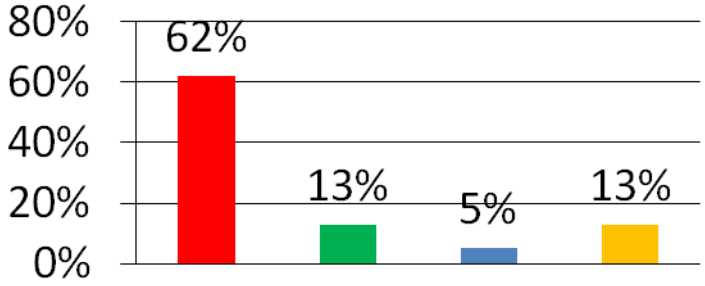
DELIVERED CARE BY DIAGNOSIS (Lombardy 2009)

SCHIZOPHRENIC DIS0RDERS
MOOD DISORDERS
NEUROTIC DISORDERS
PERSONALITY DISORDERS

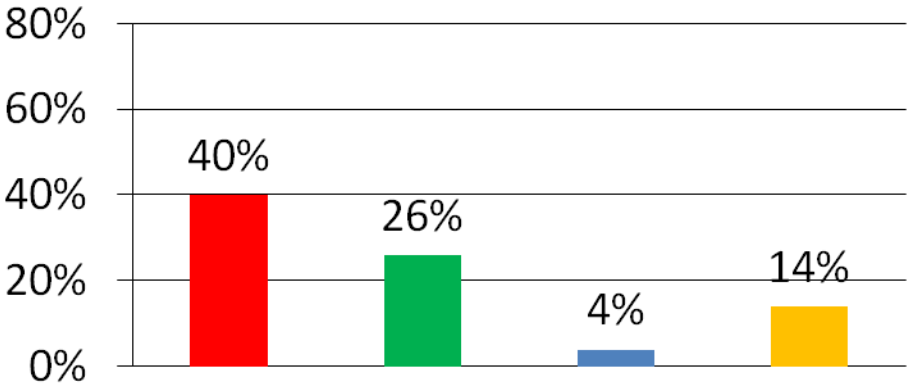
CONTACTS IN CMHC



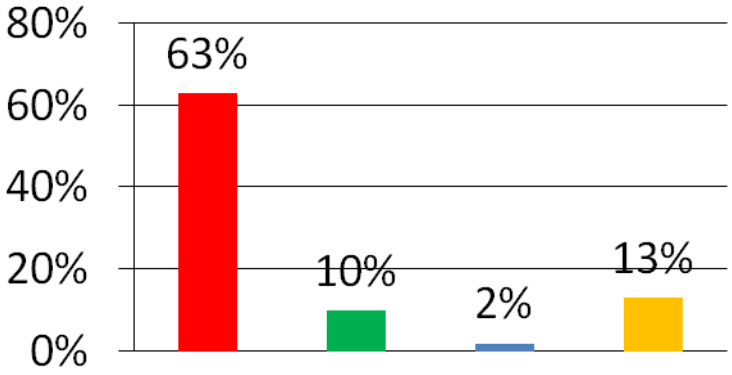
DAY CARE ATTENDANCES



DAYS SPENT IN PWGH

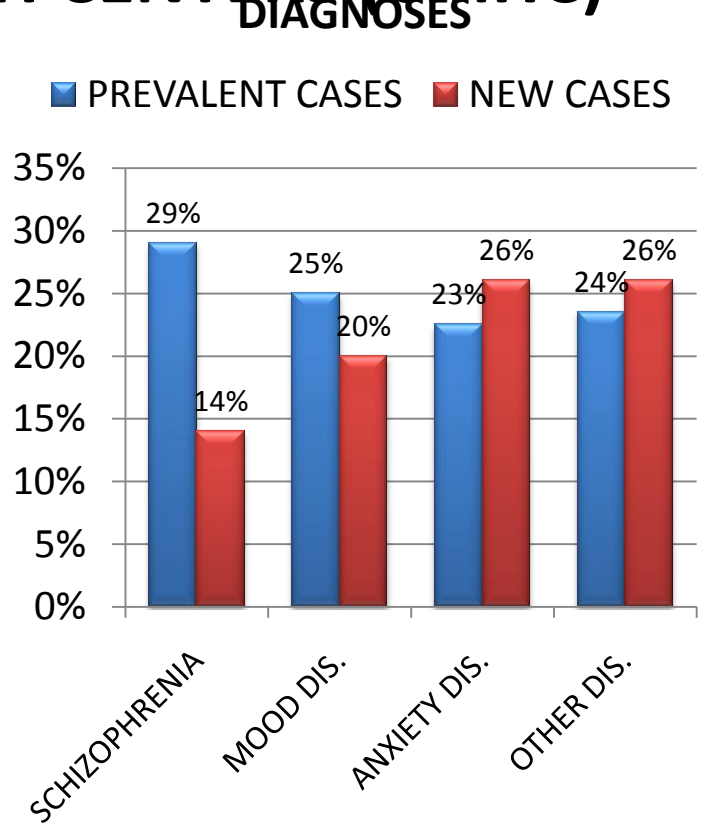


DAYS SPENT IN RF



COMMUNITY MENTAL HEALTH CENTERS (CMHC)

- CMHCs are the **core of the community-based system**: 95% of DMH patients are in contact with CMCHs.
- CMHCs cover all activities pertaining to adult psychiatry in outpatient settings, and coordinate activities delivered by day care and residential facilities.
- About 700 CHMCs: **1 facility per 80 460 inhabitants.**
- The rate of professionals working in CMHCs was quite homogeneous in Italy,
- ¼ of all interventios outside the CMHC (home visits, etc.) .



CMHCs are **highly accessible, also for patients with severe mental disorders** (in Lombardia about two thirds of the patients with schizophrenic disorders were treated solely by CMHCs)

DELIVERED ACTIVITIES IN CMHCs

ACTIVITIES PROVIDED BY CMHCs
(percentages)

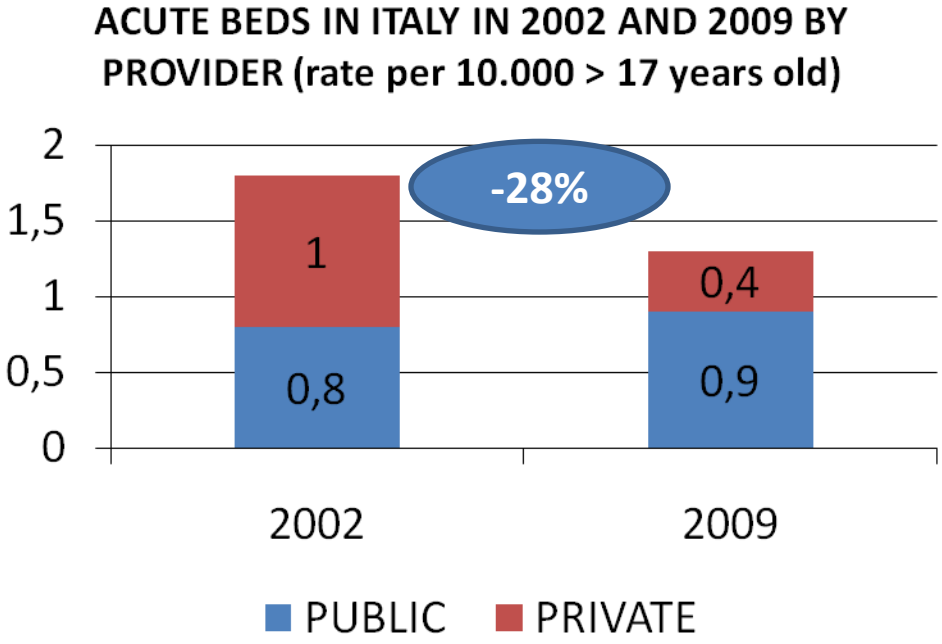
ACTIVITIES	TOTAL
CLINICAL PSYCHIATRISTS' ACTIVITY	29%
PSYCHO THERAPEUTIC ACTIVITY	8%
NURSES' ACTIVITIES	31%
ACTIVITY ADDRESSED TO FAMILIES	4%
CARE COORDINATION ACTIVITY	6%
REHABILITATIVE AND SOCIALIZING ACTIVITY	9%
SOCIAL SUPPORT ACTIVITY	4%

PATIENTS TREATED AND INTERVENTIONS PROVIDED YEARLY BY CMHCs PER REGION
(rates per 10.000 > 14 years old)

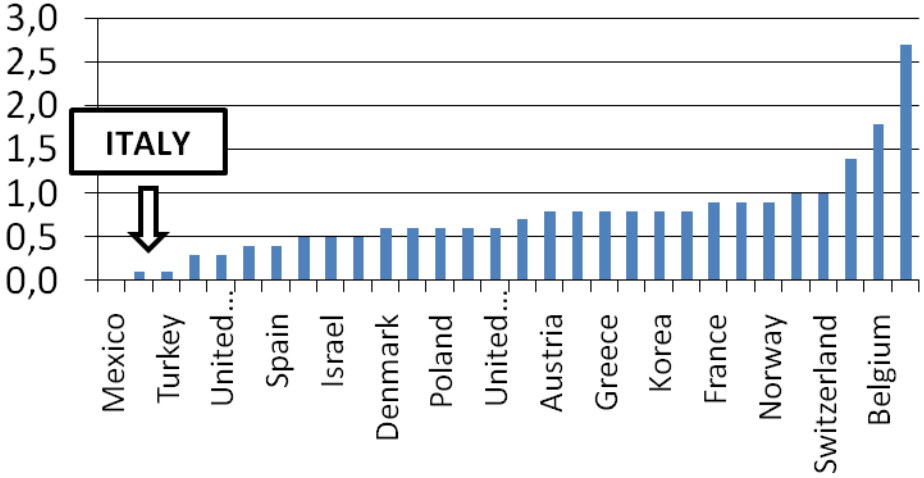
	PATIENTS	INTERVENTIONS
FRIULI V.G. (2007)	159	3,848
EMILIA-ROMAGNA (2007)	179	4,339
LOMBARDY (2005)	133	1,731
LAZIO (2005)	138	1,709

One year outpatient rate in CMHCs of 4 Regions was 148 per 10 000 > 14 years old, while intervention rates was 2402 per 10 000.

ACUTE PSYCHIATRIC BEDS



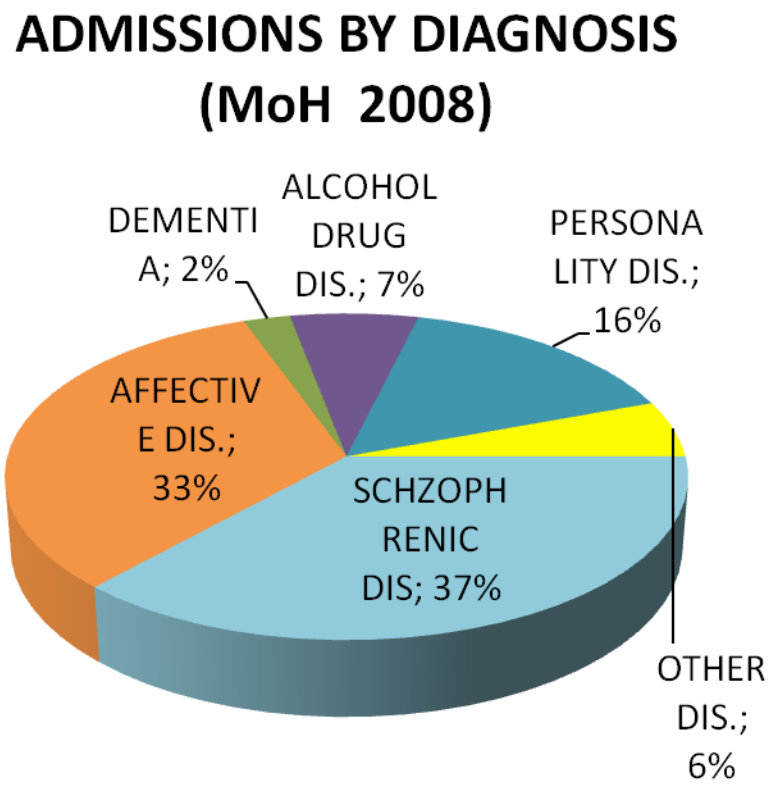
RATE OF ACUTE PSYCHIATRIC BEDS BY GEOGRAPHICAL AREA (rate per 10,000 > 17years old) (Ministry of Health 2009)



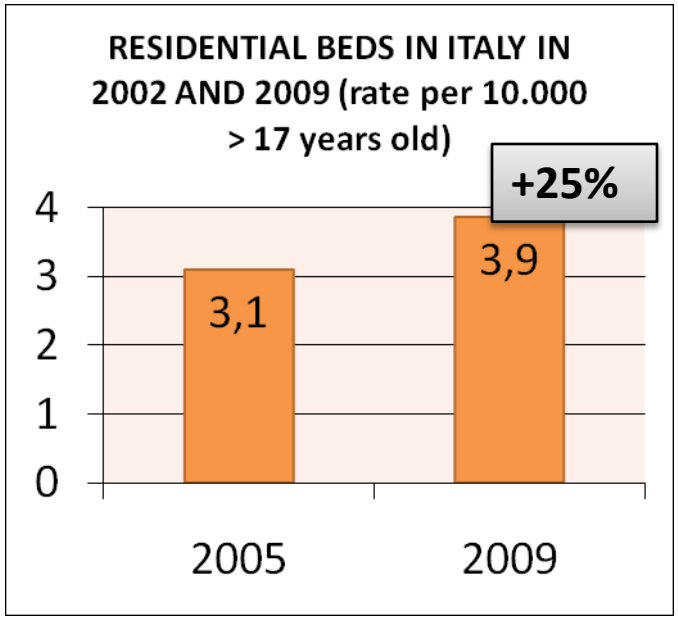
	PUBLIC BEDS	PRIVATE BEDs	TOTAL
NORTHEN ITALY	1,2	0,8	1,6
CENTRAL ITALY	0,8	0,3	1,0
SOUTHERN ITALY	0,9	0,3	1,0

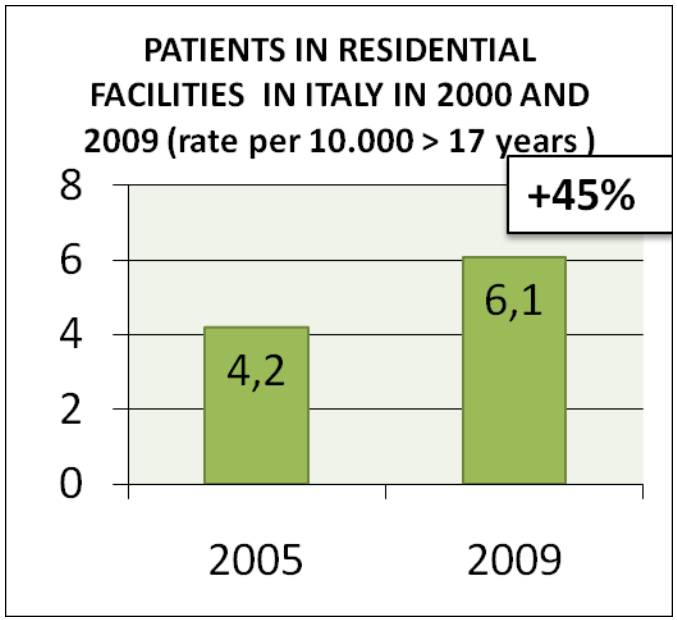
ACUTE PSYCHIATRIC BEDS

- In 2008 admission in acute psychiatric beds were 26.3 admissions per 10.000 > 17 yr
- The percentage of the **compulsory admissions** on the total (private + public sector) was **4.6%** in 2008
- **Multiple admissions** for the same patients were 30.4%
- The **lenght of stay** in PWGHs was 11.2, in other public wards 12.3, while in private facilities was 30.6



COMMUNITY RESIDENTIAL FACILTIES (RF)





BEDS BY GEOGRAPHICAL AREAS (rate per 10.000 >17 years)	
NORTHEN ITALY	43
CENTRAL ITALY	33
SOUTHERN ITALY	36

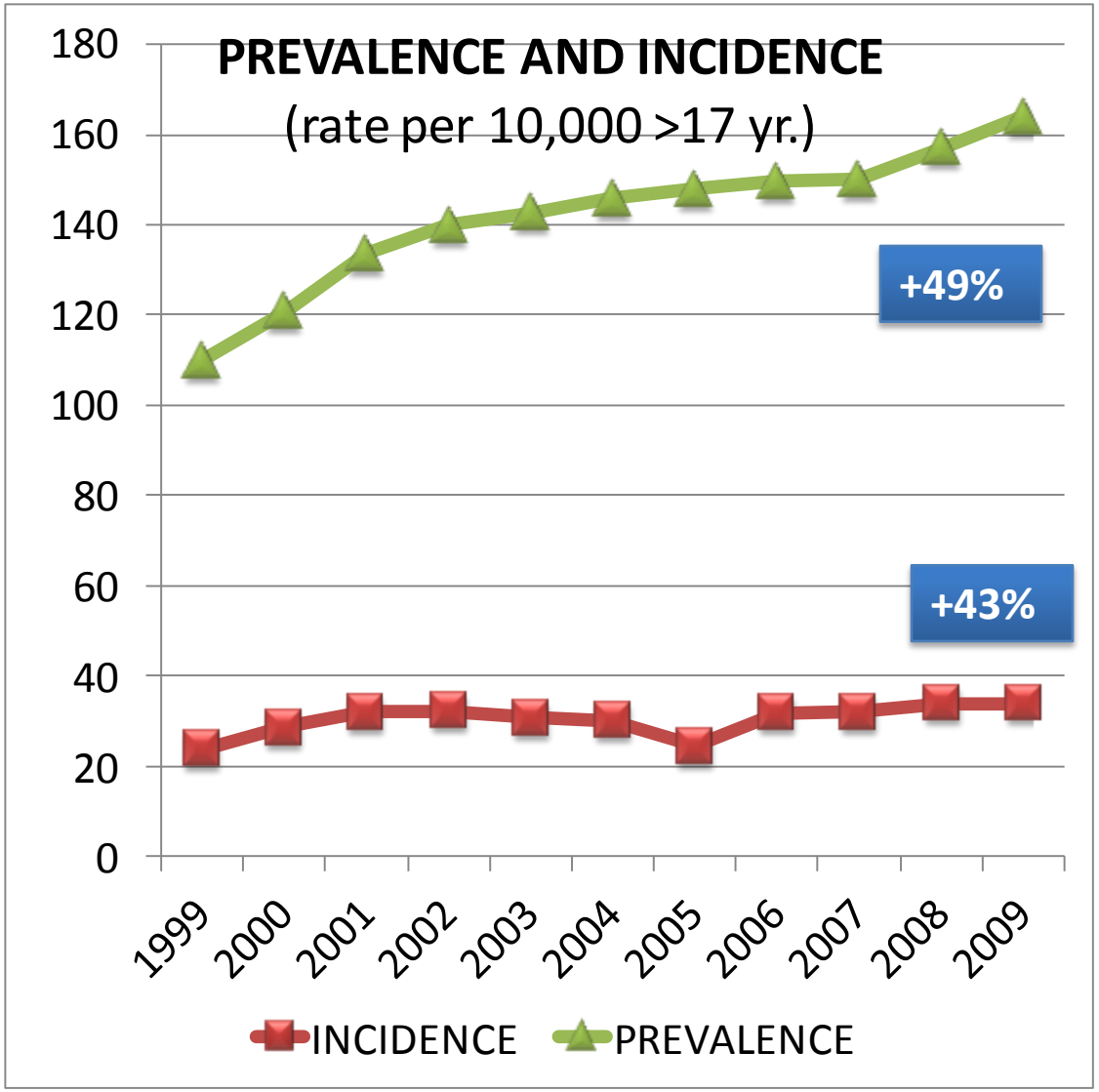
- the historical gap in the mental health system of the 80s, *i.e. the lack of RFs in the community,* has been now filled.
- The lenght of stay has been shortened in the last years from 222 days in 2005 to 187 days in 2009

COMMUNITY RESIDENTIAL FACILTIES

- For many chronic,disabled patients, RFs represent ‘‘a home for life’’, rather than a transitional facility.
- The environmental characteristics are relatively good: residential units are small (an average of 12.5 beds each), residents generally living in twin-bed rooms
- Most were males (63.2%) who had never married, and more than 70% were over 40 years of age;
- Two thirds suffering of schizophrenic disorders
- Mental illness had been long-lasting and severe: for seven out of ten patients the severe mental problems had begun more than fifteen years earlier,
- In 2000 the majority the total sample of RF residents (58.5%) had never been admitted to a mental hospital or a forensic mental hospital;
- Leisure and socializing activities, psychomotor and creative interventions prevailed on rehabilitative interventions

QUALITY OF CARE FOR SEVERE MENTAL ILLNESS (ACCESSIBILITY, CONTINUITY OF CARE AND APPROPRIATENESS)

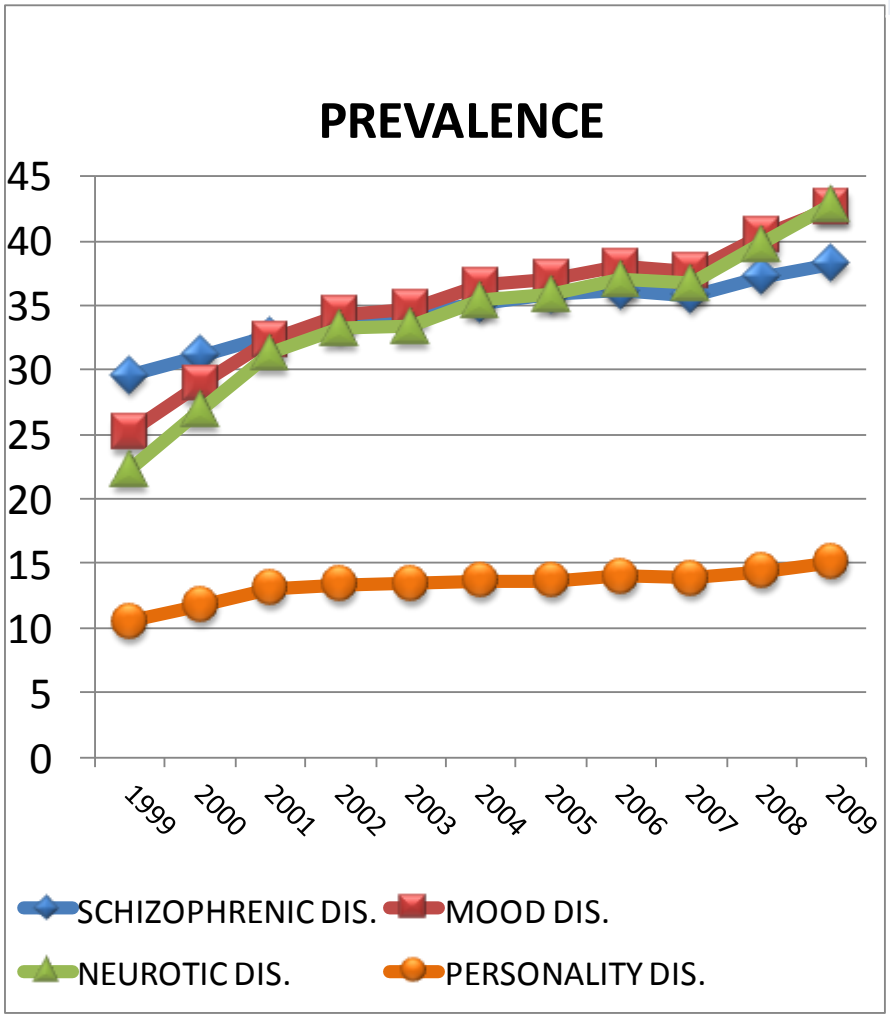
ACCESSIBILITY :
TREATED PREVALENCE AND INCIDENCE
(Lombardy 2009)

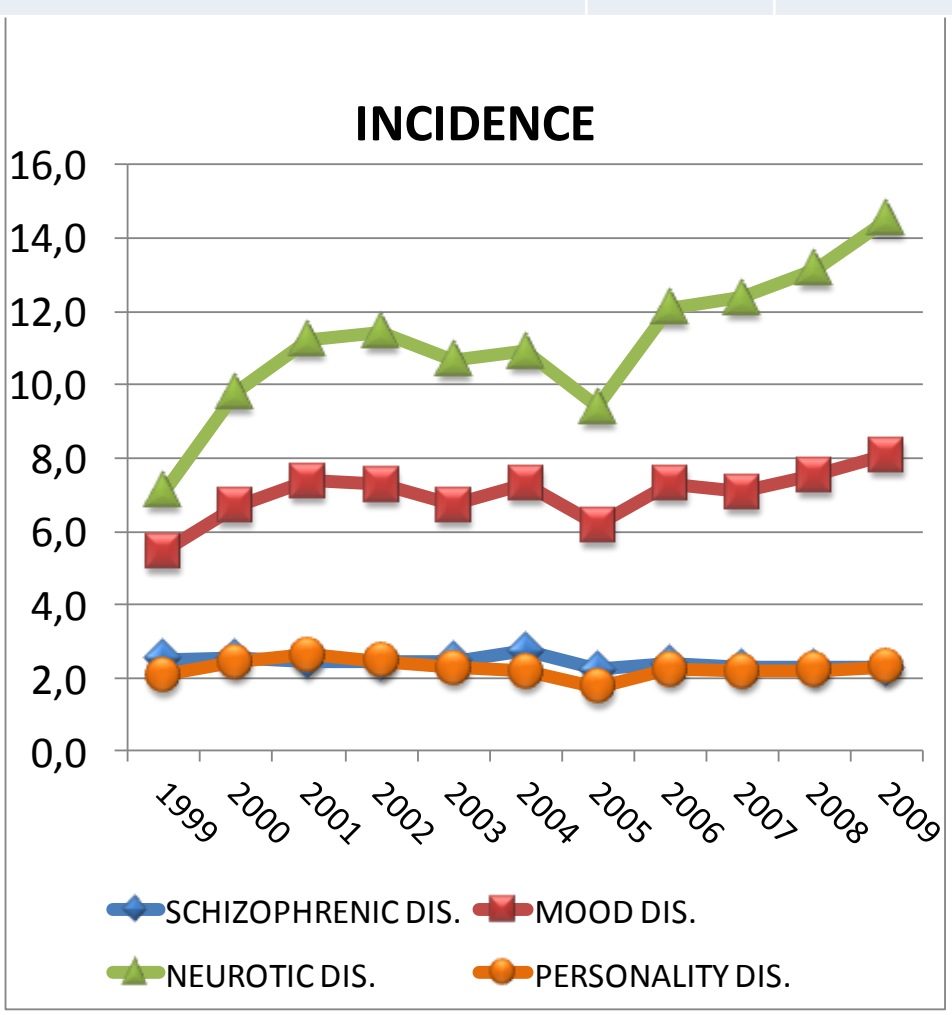


- In Lombardy from 1999 to 2009 the prevalence rate in DMHs increased of **49%** ,while the incidence rate of **43%**
- The users are prevalently female over 45 years old
- Frequently users are married and are working and as far as new cases have high level of education

ACCESSIBILITY : TREATED PREVALENCE AND INCIDENCE BY DIAGNOSIS (Lombardy 2009)

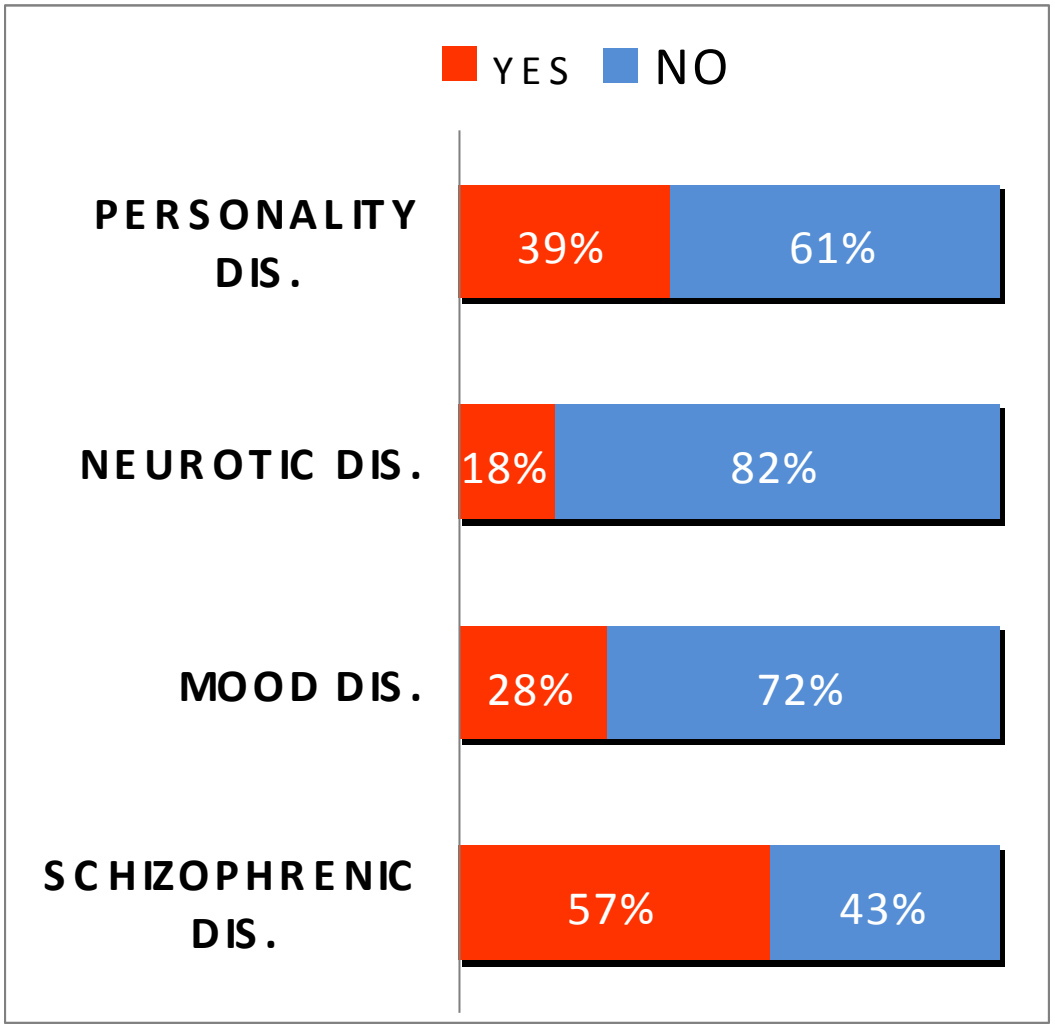
INCREASE 1999/2009	PREV	INC
SCHIZOPHRENIC DIS	+29%	-3%
MOOD DIS	+69%	+46%
NEUROTIC DIS	+92%	+95%
PERSONALITY DIS	+44%	+11%





CONTINUITY OF CARE

(Lombardy 2008)



CONTINUITY OF CARE:
At least one contact every 90 days in the 365 days after the first contact in the year

- Continuity of care is assured to severe mental illness (schizophrenic and personality disorders)

ADEQUACY OF CARE – 1
(Lombardy 2007)

MINIMALLY ADEQUATE TREATMENT

(Wang et al. 2007)

.. At least two months of treatment with specific psychotropic drugs

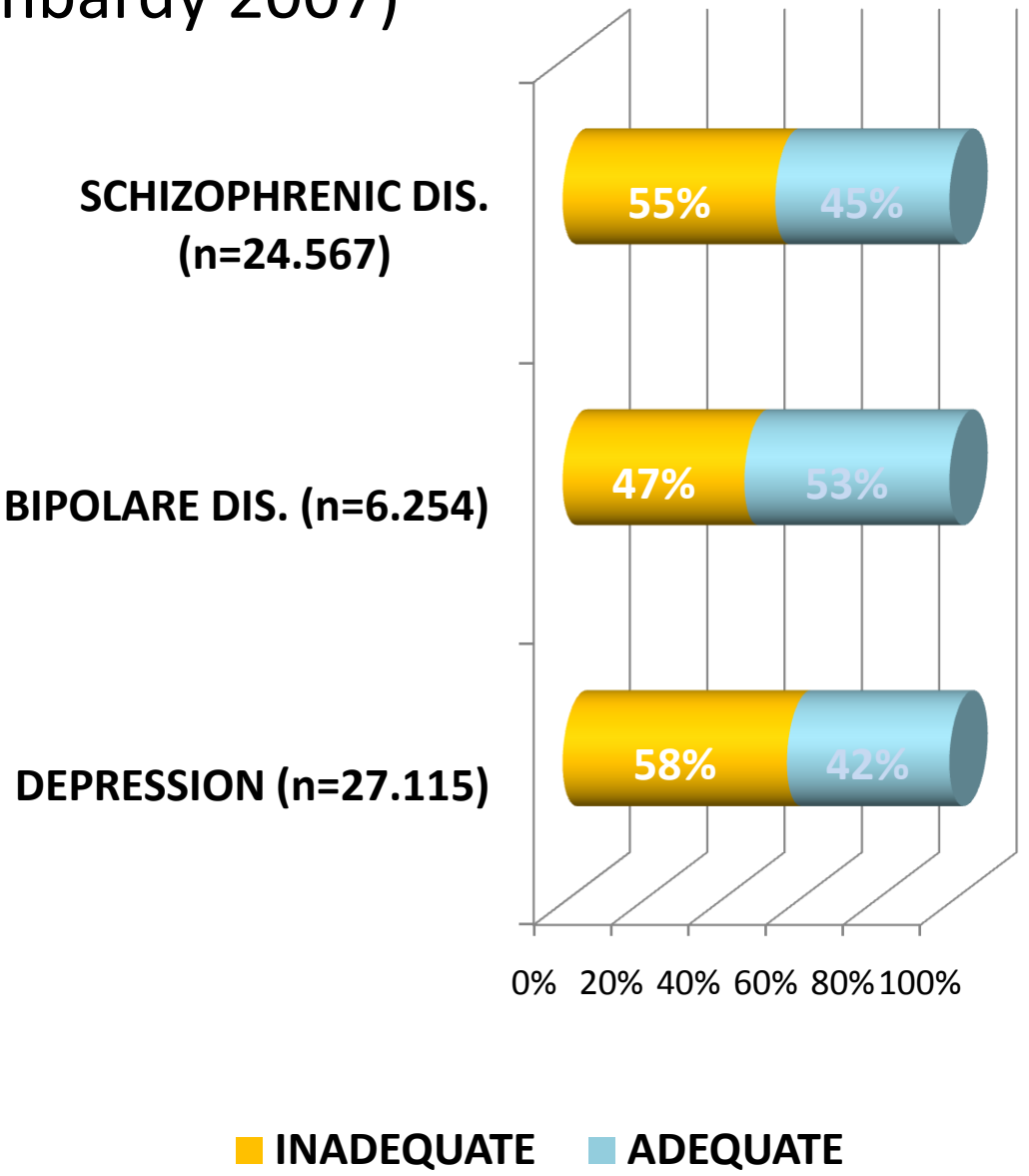
+

4 visits with psychiatrist

OR

8 psychotherapeutic sessions

(only for depression)



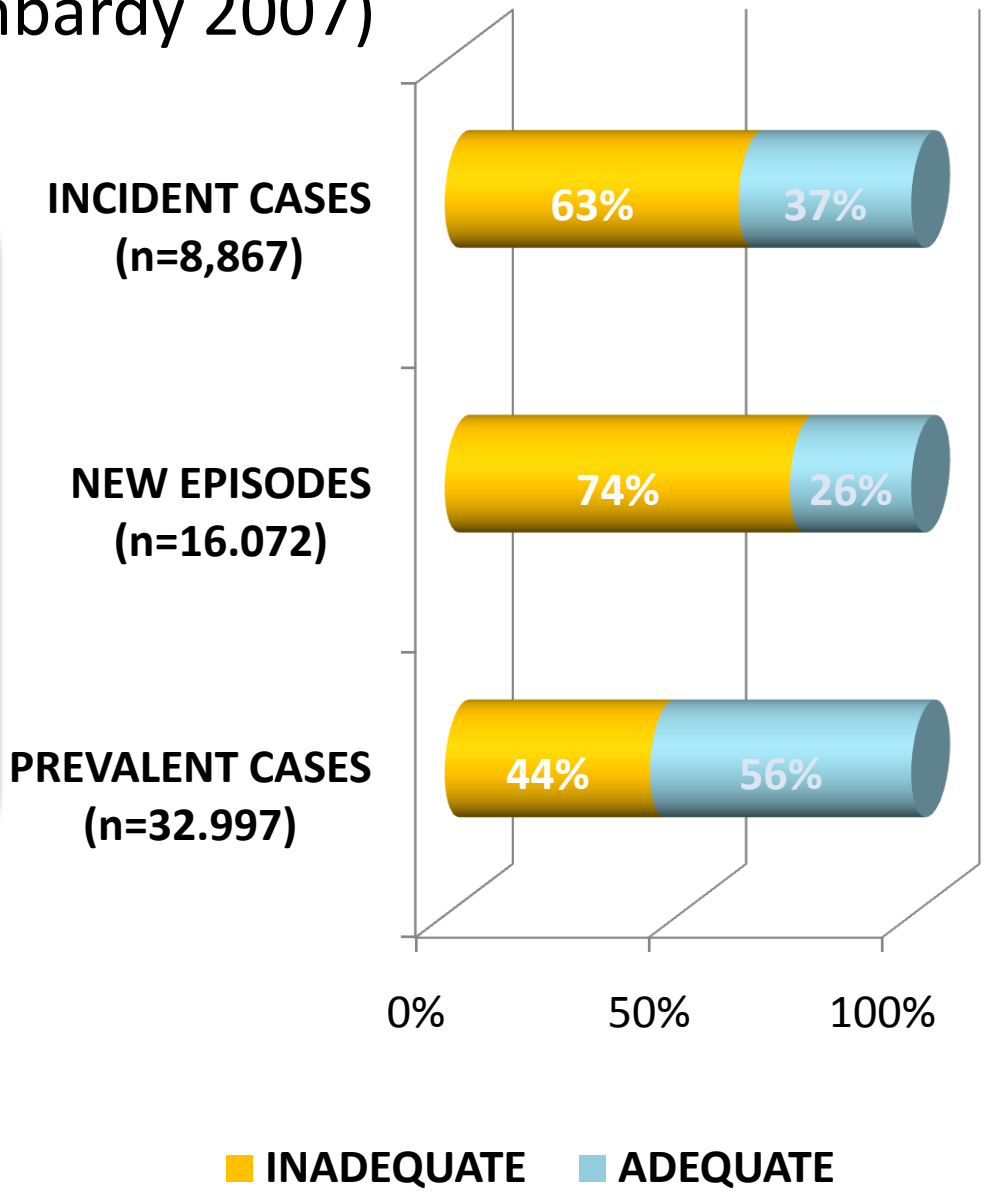
ADEQUACY OF CARE- 2

(Lombardy 2007)

PREVALENT CASES : patients already treated in 2006

NEW EPISODES: patients already treated before, but without contacts in 2006

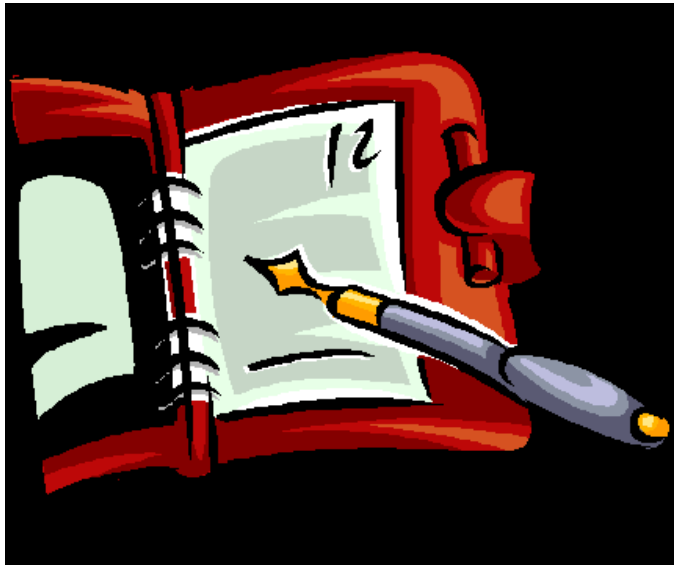
INCIDENT CASES: patients at first contact in 2007



AN AGENDA FOR CHANGING THE MENTAL HEALTH SYSTEM

MONITORING MENTAL HEALTH SERVICES

- At regional level in 7 Regions **regional MH information systems** are actually working
- MoH is now implementing **national MH information system**:
  - The model is psychiatric case register,
  - collecting data from all the facilities of DMH and
  - focused on the patient
- **Merging data** from different information flows (e.g MH and pharmaceutic data) we can assess quality of delivered care
- A **glossary of community interventions** has been stated
- **A "dashboard" of MH indicators** for monitoring MH system has been defined



- The **mental health system** in Italy in the last 30 years is grown and is more complex.
- The **network of MH facilities** seems complete, especially as far as concerns RFs, CMHCs and, partly, GHPUs, though a relevant variability still remains among the Regions
- **CMHCs** should increase psychosocial activities (e.g. working with families, community rehabilitation, social support, supported employement)
- **RF** should improve care effectiveness and coordination within the Departments of Mental Health.
- further RF expansion could hamper, in terms of competition for resources, the provision of intensive and innovative community care by CMHCs

- **The treatment of common mental disorders in primary care** is needed to bridge the treatment gap in common mental disorder.
- **Prevention and promotion activities** addressed to the general population are not common
- The **early treatment of psychosis** in young people is frequently implemented in DMHs
- Departments of Mental Health treat prevantely SMI, but now an increasing number of patients with common mental disorders is entering in the MH system.
- The **dilemma** is to ensure both accessibility for common mental disorders and continuity/ appropriateness of care for SMI

QUALITY OF INFORMATION WILL DETERMINE QUALITY OF CARE

Decision Support 2000+

(*Substance Abuse and Mental Health Services Administration* – SAMHSA)