Approccio clinico e riabilitativo nel budget di salute

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Seminario AVEC

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Rappresentazioni della psichiatria

- Neuroscienze
- Pratica sociale
- Abissi psicoanalitici
- Pratiche new age
- Repressione della devianza
- ……

Un «oggetto molto singolare»

- Non è nato con una teoria
- Ha ed ha avuto molte teorie in competizione tra loro (inconsistenza – explanatory pluralism)
- Non è (principalmente) una disciplina intellettuale

Un «oggetto molto singolare»

- Si è formata a partire dalle malattie che «ha preso in consegna»
- E’ una avventura umana
- E’ una istituzione in perenne evoluzione

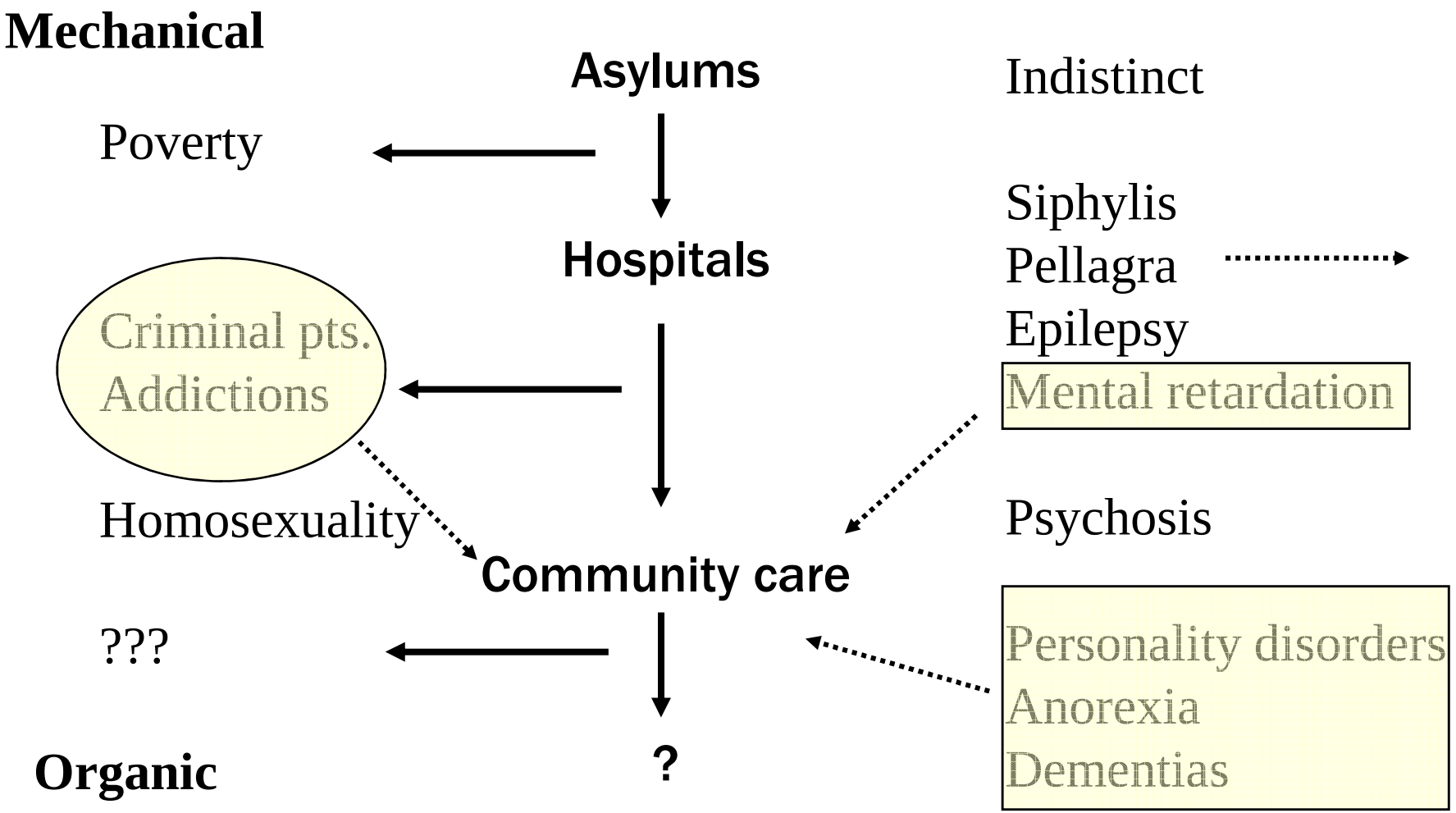
M. Douglas,
How institutions think, 1986

- Social nature of individual thought
- Analogy
- Conferring identity
- Collective memory
- Shared classification
- Decisions on life and death

Un «oggetto molto singolare»

- Ha un ruolo rilevante nei sistemi sanitari nazionali
  - UK: 20 % spesa sanitaria
  - Italia: 5%
    - Bologna: circa 10% personale AUSL
    - Circa 1600 operatori

Two centuries of psychiatry



Che cosa è la malattia mentale?

- Le m.m. esistono tra le persone
- Esperienze e comportamenti che acquistano significato se sono dirette a, o sono osservate da altri
- La stessa diagnosi è basata su di una interazione sociale che offre opportunità di relazione

La psichiatria

- «Preminently a moral enterprise involved with the application of social meanings to segments of everyday life». Andrew Scull
- «Madness is the most solitary of afflictions to people who experience it, but the most social of maladies to those who observe it». Michael Mc Donald

La malattia mentale

- Facile da riconoscere intuitivamente, difficile da definire
- Natura interpersonale
- Diversità/alienità
- Dagli altri / dal se stesso usuale

La psichiatria

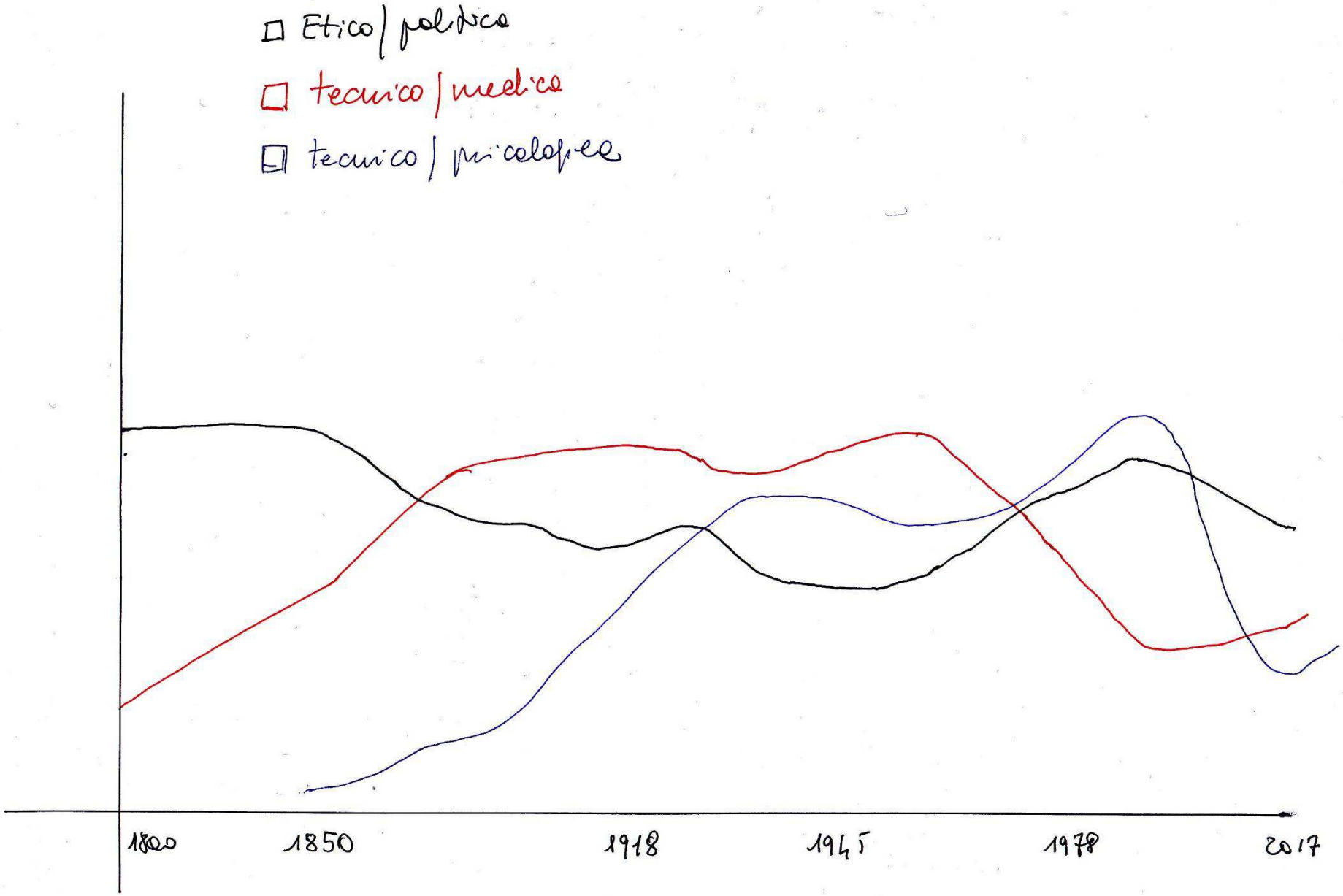
- Comprendere e trattare questa diversità/alienità?
- Perché?
- Forte spinta sociale a farlo
- Natura sociale del pensiero umano
- Conoscere e comprendere le intenzioni altrui
- Soccorrere ed aiutare chi è in difficoltà

Gli operatori di salute mentale

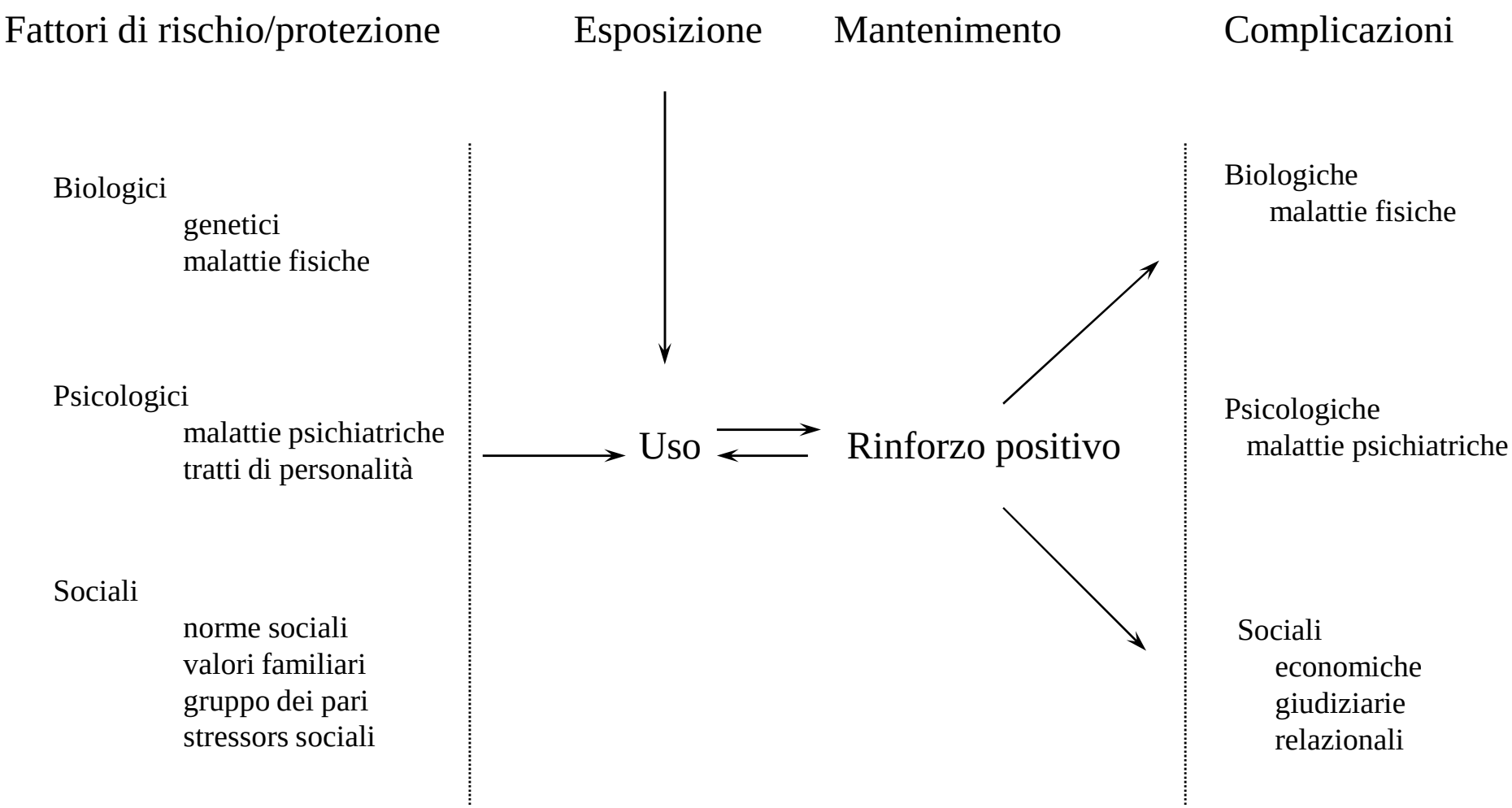
- Dovrebbero essere persone che hanno sviluppato capacità di:
  - Capire gli altri riflettendo su se stessi (psicopatologia descrittiva, fenomenologia empatia guidata dalla unicità)
  - Spiegare cosa avviene nell'altro (psichiatria scientifica, osservazione e classificazione, oggettivazione)

La psichiatria

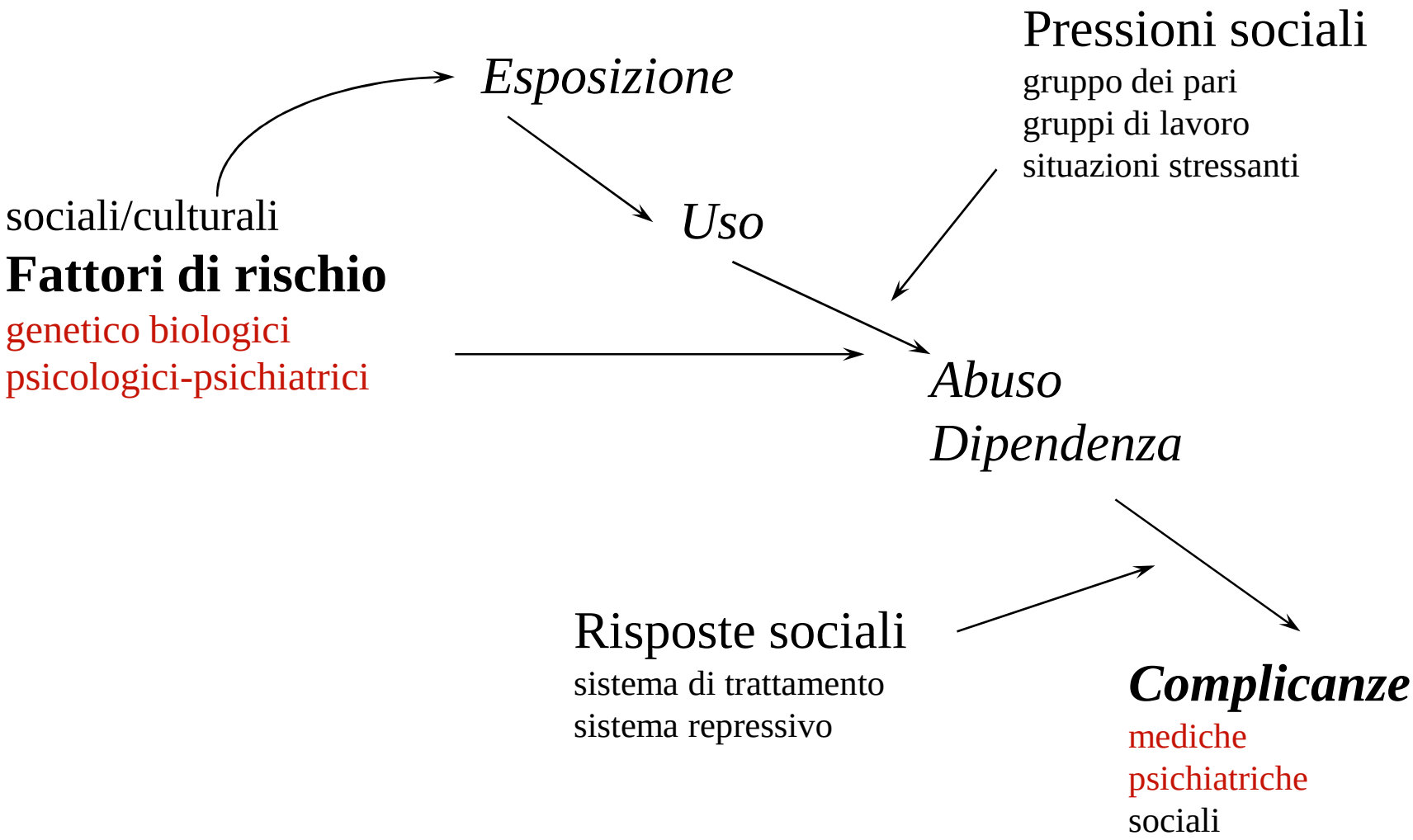
- Tre radici ben distinte, tutte affondate nella filosofia
  - Etico-politica
  - Tecnico-medica
  - Tecnico-psicologica


Etico/politico
tecnico/medico
tecnico/micologico
1800
1850
1918
1945
1978
2017

Il Modello Biopsicosociale delle Dipendenze



Uso, abuso e dipendenza da sostanze: influenze sociali



In conclusione

- La psichiatria riguarda le aree della vita con le quali ci sentiamo a maggior disagio
- Deve costantemente essere sottoposta a critica
  - Per migliorare
  - Per comprendere meglio questa nostra «ombra necessaria»
- Attenzione ai sogni di onnipotenza

Oggi e domani?

- Neuroscienze
- Psicologia cognitiva e comportamentale
- Empowerment
- Recovery

- Mental Health Gap

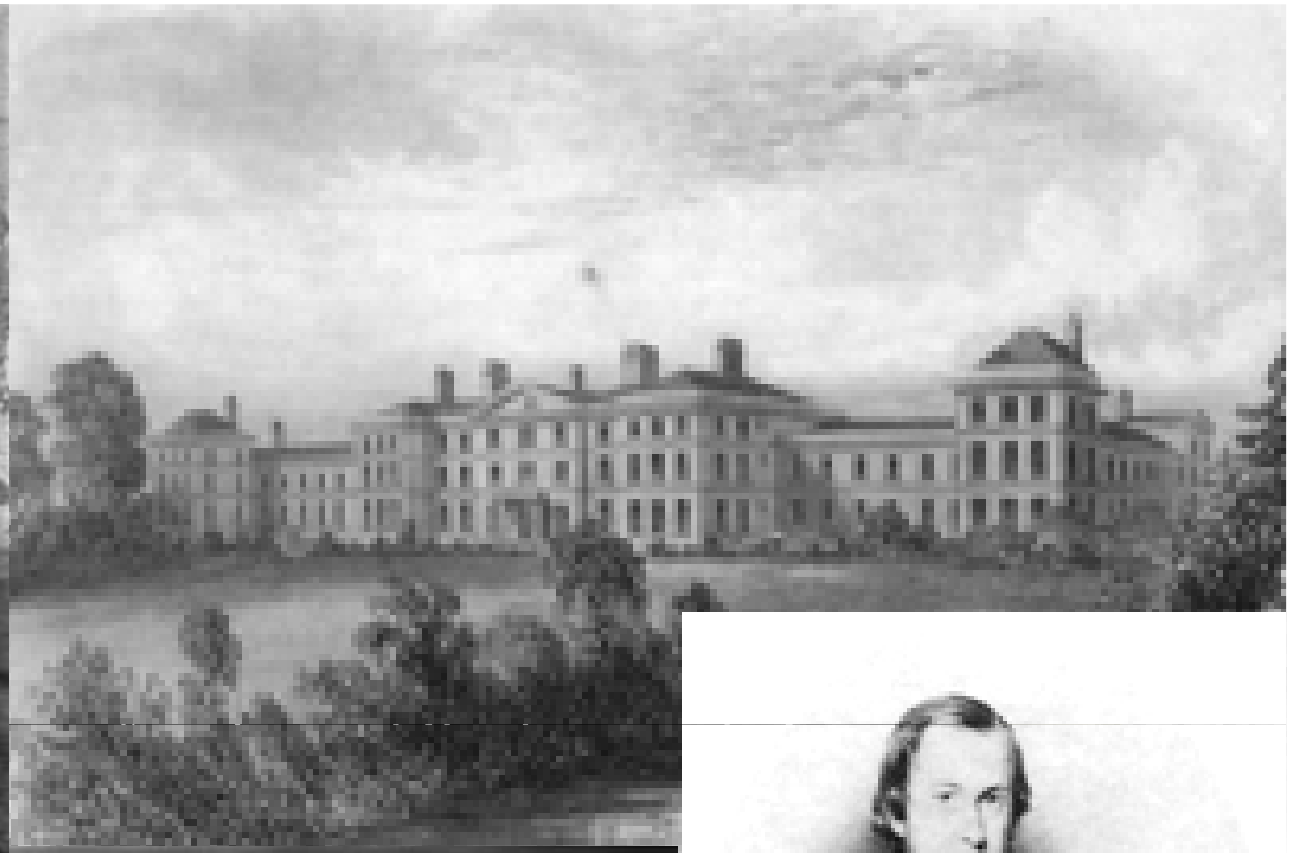
Grazie per
l’attenzione

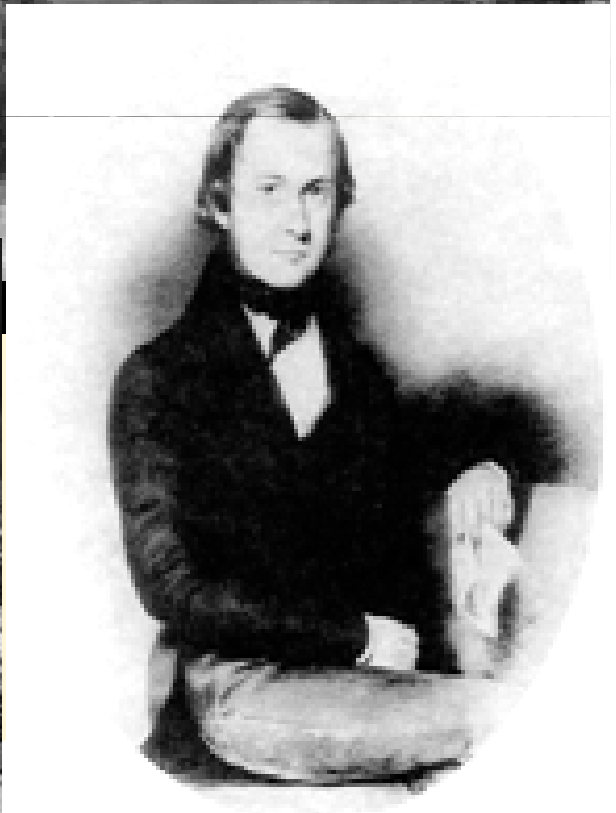
What before?

- Foucault: *Histoire de la folie à l'age classique*, 1972
- Middle age and renaissance
- Attitude between tolerance, curiosity, literature and repression

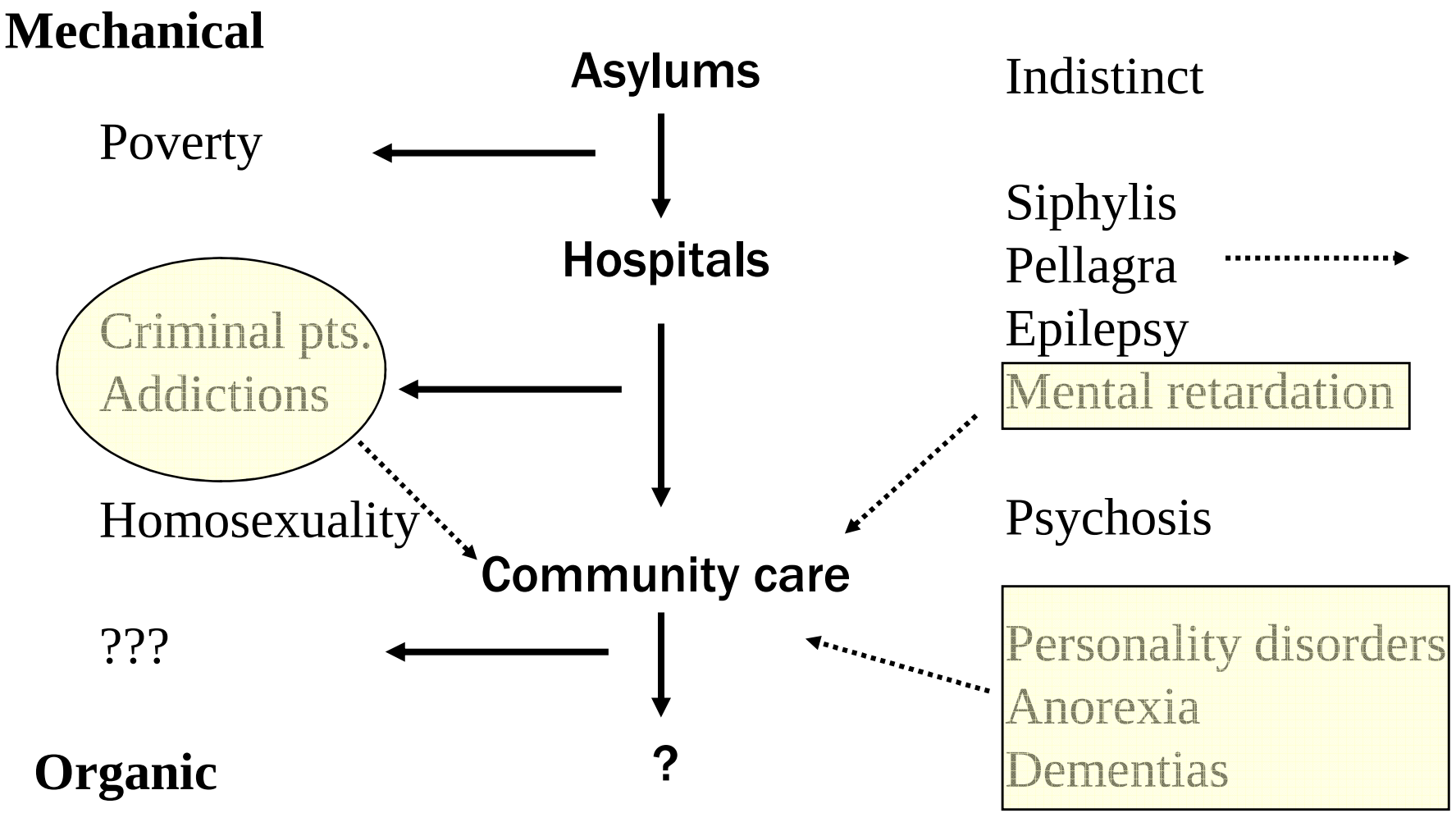
E. Durkheim
La division sociale du travail, 1893

- ***Conscience collective***
- Mechanic solidarity
  - All behaviours are social
  - Use of coercion for non social behaviours
- Organic solidarity
  - Most behaviours are individual
  - Use of negotiation





Two centuries of psychiatry



A long-standing legal framework

Loi sur les aliénés n° 7443 du 30 juin 1838

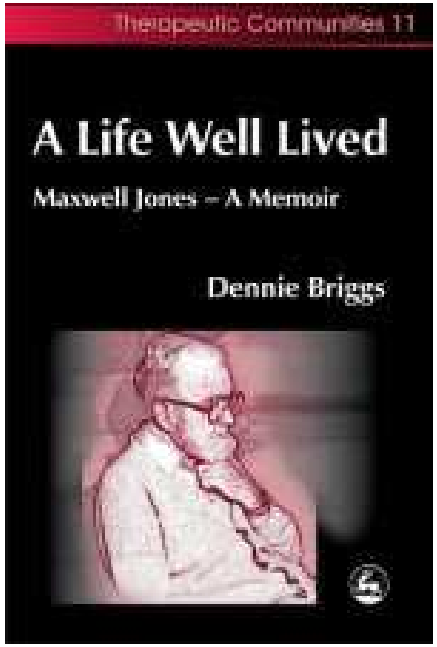
Loi n. 90-527 du 27 juin 1990 relative aux droits et à la protection des personnes hospitalisèes en raison de troubles mentaux et à leur conditions d'hospitalisation

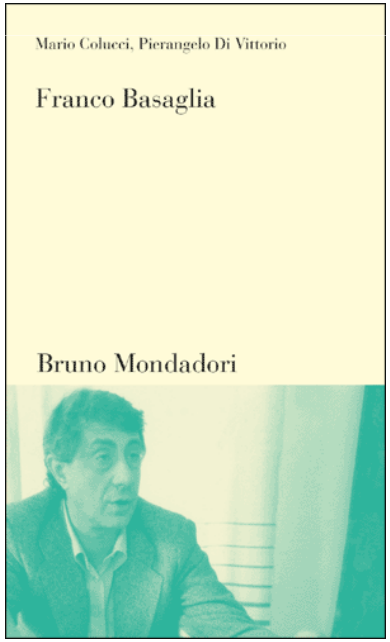
Law & Mental Health

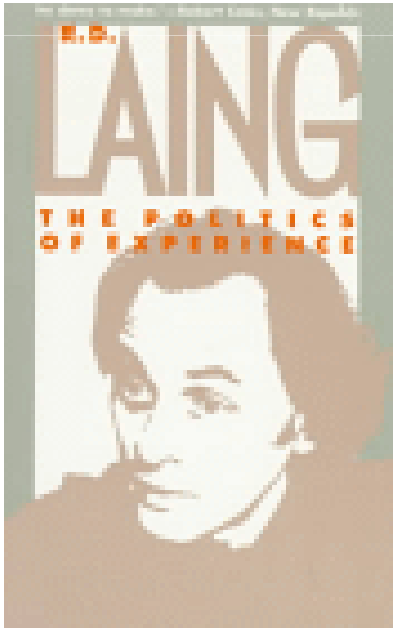
- Traditional legal frameworks are based on the regulation of coercion:
  - Criteria for admission (dangerousness vs. need)
  - Legal Procedures and roles (medical vs. legal systems)
  - Duration of detention
  - Reviewing systems
  - Management of properties
  - Administration of treatments
  - Rights

Two centuries of psychiatry & law

- Medical paternalism and humanization
- Anti-institutional psychiatry







Legal frameworks

- To what extent legal and mental health systems are consistent?
- Can legal changes promote new mental health systems?
- Can a European mental health law ever exist?
- New principles for changing mental health frameworks

Consistency

- Increasing unsatisfaction about the regulatory function of law:
  - More sources (criminal, civil, administrative, regional, local)
  - Rapid turn-over of laws about comp. treatments
  - Changes in terminology
  - New (and more) places and treatments
  - Detailed and longer laws
  - More complex regulation of rights
  - Medical vs. legal model

Role of laws in changing MH systems

- Different cultural and legal traditions:
  - Practice ⇒ Law (UK)
  - Law ⇒ Practice (ITA, D)
- Italian law 180
  - 20-year process of adjustement
- UK MH Bill
  - 10-year process of revision

Europe as a vision

- Global rights and values
- Local policies and solutions

Review of European laws, 2000

Treatment & Placement of MDOs: a European collaborative Project

- Coordinating Center: ZISG, Mannheim (D) – Dr. Hans Joachim Salize & Harald Dressing
- Participating experts:
  - Hans Schanda (Austria), Paul Cosyns (Belgium) , Roell Verellen (Belgium), Peter Kramp (Denmark), Riitakerttu Kaltiala-Heino (Finland), Frédéric Meunier (France), Bernd Dimmek (Germany), Dermot Walsh (Ireland), Angelo Fioritti, Caty de Kogel (The Netherlands), Miguel Xavier (Portugal), Helena Silferhielm (Sweden) David James (United Kingdom)

Treatment & Placement of MDOs: global rights and values

- Position of citizen vs. penal law
- Special status of MDOs within the penal system
- Public safety interest
- Coercive measures
- Balance between punishment and care
- Human and civil rights
- Right to health care

Evolving legal frameworks

1. Avoid unnecessary special legislation
2. Integration with health systems
3. Right to treatment and right to health
4. Support
5. Empowerment & Representativeness
6. Equality
7. Shortness and integration of textes

Changing legal frameworks

Empirical research

- History of compliance
- Studies on coercion
- Studies on services provision
- Others

A brief history of compliance

Jean Delay,
1907-1989
The era of efficacy

The ’70s:
Discovering (non)compliance

- Van Putten, AGP, 1974: *“Why do schizophrenic patients refuse to take their drugs?”*
- Rifkin et al., AGP, 1977: *FLU-Dec vs. FLU vs. PLA.*
- Quitkin, AGP, 1978: *FLU-Dec vs. FLU-inj, double-blind, 1 yr. Follow-up*
- *Hogarty et al., AGP, 1979: FLU-Dec vs. FLU-inj, double blind, 2 yrs follow-up.* [Social Therapy!]

The ’80s: *Investigating compliance*

- Kane, JClinPsychiat, 1983: “*Problems of Noncompliance in the Outpatient Treatment of Schizophrenia”*
  - Complex therapeutic regimens
  - Side effects (subclinical EPS e sexual)
  - Conceptions of illness
  - Difficult to accept *preventive therapy*
  - Difficult to llink withdrawal and relapse
  - Psychodynamic aspects

The ’80s:
Strategies for *compliance*

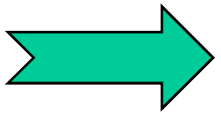
- Minimum effective dosage
- Depot medication

- Information
- Investigate reasons for noncompliance
- Motivational interviewing
- Non-judgemental approach

The ’90s: compliance as key criterion for choosing medication

Ayuso-Gutierrez et al., SchizRes, 1993:

- 73% of relapses due to NC
- Four types of NC
  - Pharmachological
  - Cognitive
  - Substance Misuse [!]
  - Psychosocial [Adherence]



Atipical Antipsychotics

Murphy & Coster, Drugs, 1997

- Responsability for compliance is shared between the clinician and the patient:
  - Involving patient
  - Information about difefrent options
  - Monitoring medication
  - Overcome cognitive deficits
  - Motivational Interviewing

The 2000s: compliance as link btw. biology and psychology

Factors Associated With Noncompliance With Psychiatric Outpatient Visits

Franca Centorrino, M.D.
Miguel A. Hernán, M.D., Dr.P.H.
Giuseppa Drago-Ferrante, M.D.
Melanie Rendall, M.S.
Anthony Apicella, B.A.
Gabriela Längar, B.A.
Ross J. Baldessarini, M.D.

Adherence to recommended services is essential for long-term effectiveness of ambulatory treatment programs, but factors associated with such adherence are not securely established. We evaluat-

school education, and those living alone. Adherence was also higher when visits were routinely scheduled, when the intervisit interval was shorter, and when the visit entailed psychotherapy rather than

tensive than research on medication compliance (8).

Fenton and colleagues (1) found that treatment noncompliance may be associated with demographic, clinical, and environmental factors; the

Chronicity, low education, living alone;
Long intervals btw. visits,
Only pharmacological management

History of compliance

- Coercion
- Information
- Education
- Persuasion
- Motivation
- Adherence
- Concordance

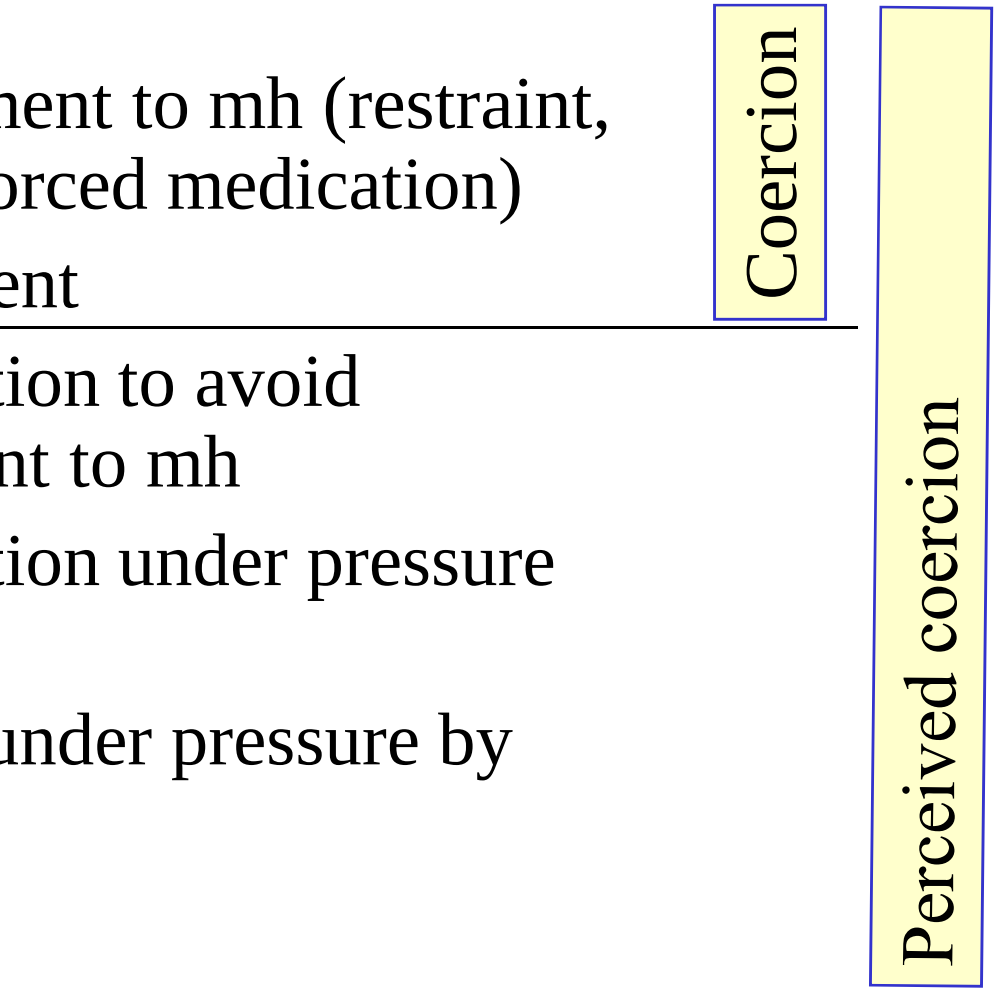
A brief history of studies on coercion

- 1966-1995: 346 studies
- 1996-2005: 234 studies

- Involuntary admissions
- Outpatient committment
- Perceived coercion
- Ethics

Definition of coercion

- Involuntary committment to mh (restraint, seclusion, isolation, forced medication)
- Outpatient committment
- Voluntary hospitalization to avoid imminent committment to mh
- Voluntary hospitalization under pressure by others
- Outpatient treatment under pressure by others



Fischer WA, AJP, 1994

Restraint and seclusion: a review of the literature

- Seclusion and restraint efficacious in preventing injury and reducing agitation
- Nearly impossible to operate without
- Deleterious physical and psychological effects emphasized by consumers/survivors
- Demographic and clinical factors have limited influence on rates of restraint and seclusion

Fischer WA, AJP, 1994

Restraint and seclusion: a review of the literature

- Nonclinical factors greater influence on rates:
  - cultural biases
  - staff role perceptions
  - attitude of the hospital administration
- Training valuable in reducing rates:
  - prediction and prevention of violence
  - self-defense
  - implementation of restraint and/or seclusion
- Studies comparing well-defined training programs have potential usefulness.

Involuntary admissions

- EUNOMIA

EU – collaborative ZISG

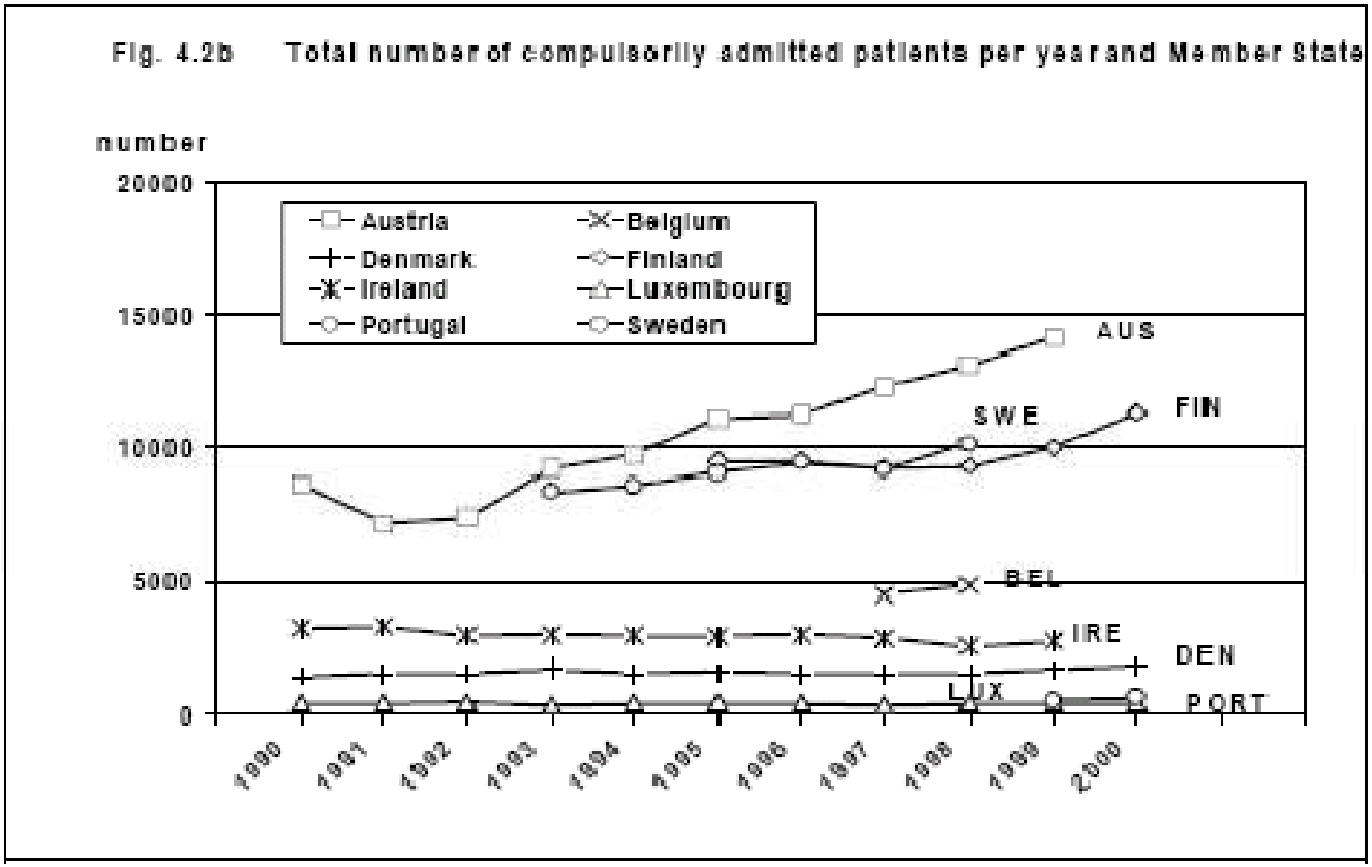
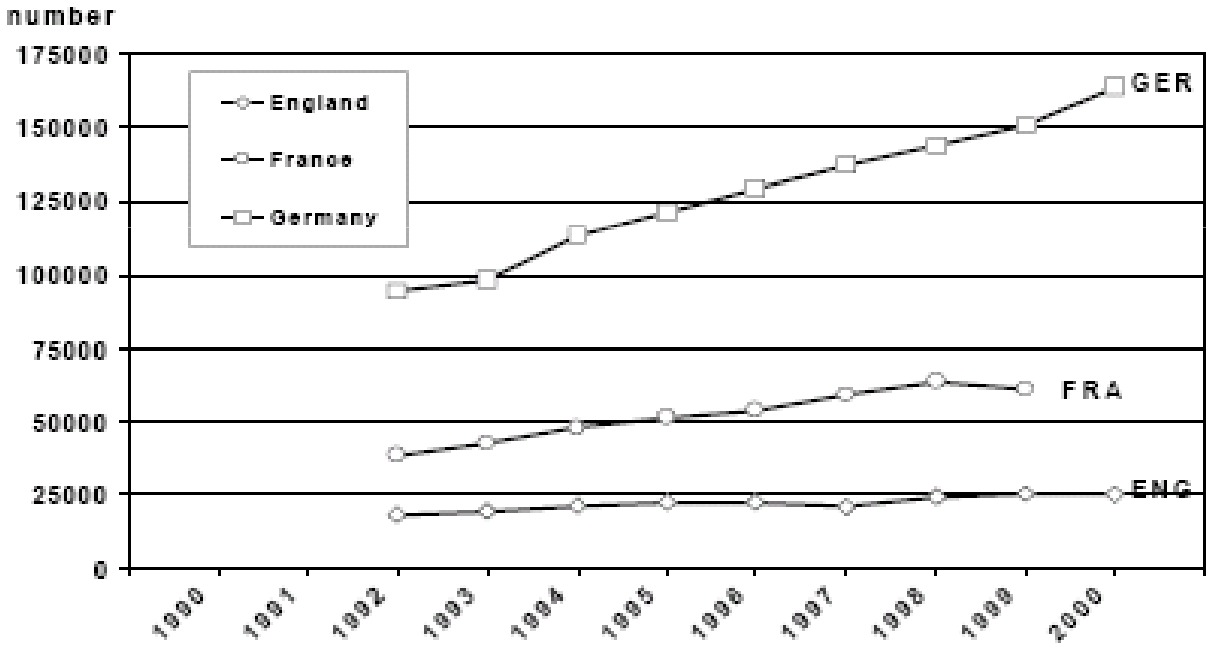


Fig. 4.2a Total number of compulsorily admitted patients per year and Member State



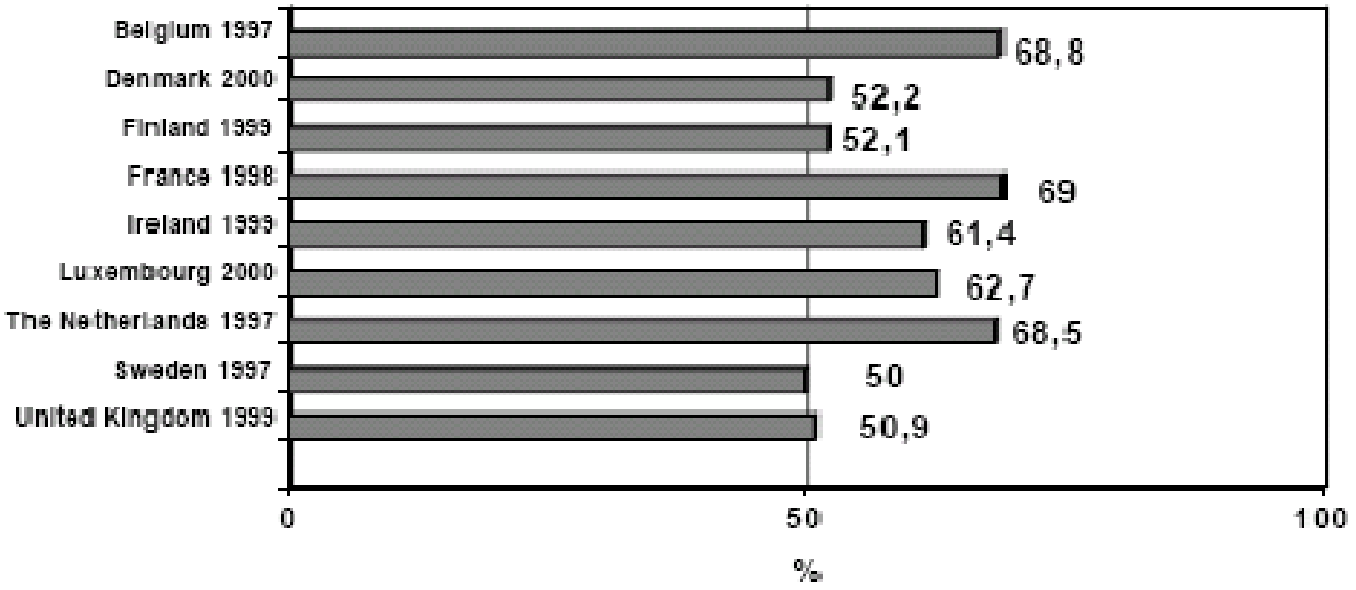
4.2 Frequency of involuntary placements / percentage of involuntary placements of all inpatient episodes / involuntary placements per 100,000 population

	year	*number*	*percentage (of all inpatient episodes)*	*involuntary placements per 100,000 population*
Austria	1999	14,122	18	175
Belgium	1998	4,799*	5.8*	47
Denmark	2000	1,792	4.6	34
Finland	2000	11,270	21.6	218
France	1999	61,063	12.5	11
Germany	2000	163,561*	17.7*	175*
Greece		not available	not available	not available
Ireland	1999	2,729	10.9	74
Italy		not available	12.1*	not available
Luxembourg	2000	396	not available	93
The Netherlands	1999	7,000	13.2	44
Portugal	2000	618	3.2	6
Spain		not available	not available	not available
Sweden	1998	10 104	30*	114
United Kingdom	1998 1999	46,300* 23,822*	13.5	93* 48*

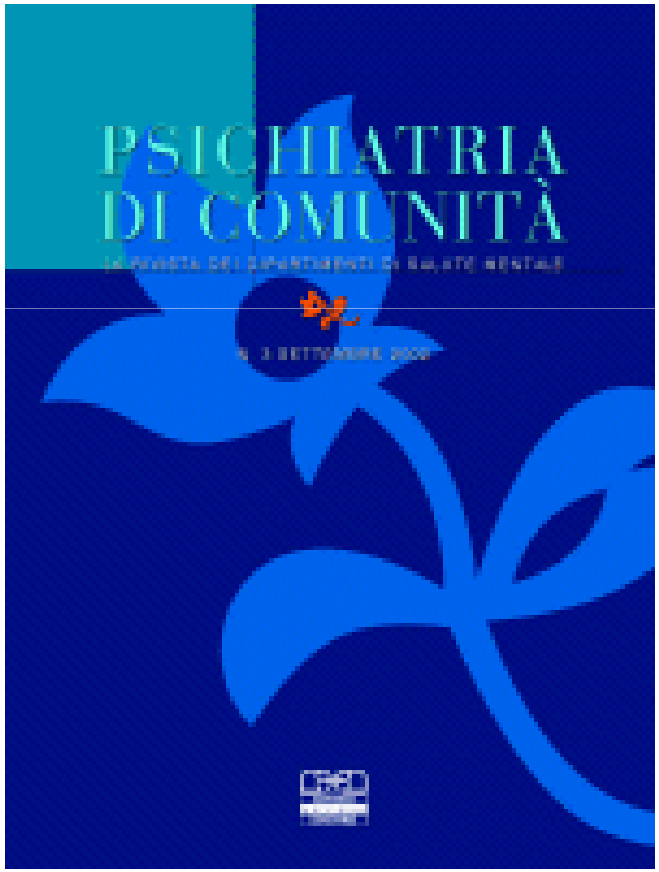
4.1 Number of psychiatric beds per 1,000 population, mean length of stay of all psychiatric inpatient admissions (voluntary *and* involuntary)

	year	*beds per 1,000 population*	*mean length of stay*
Austria	1999	0.51	17.6 days
Belgium	1999	1.2*	not available
Denmark	2000	0.77*	36 days *
Finland	1999	1.0*	46 days
France	1998	1.14	35.7 days*
Germany	1997	0.70	26.9 days*
Greece		not available	not available
Ireland	1999	.91	130 days
Italy	1998	0.1	13.4 days*
Luxembourg	2000	1.0	not available
The Netherlands	2000	1.7	not available
Portugal	2000	0.3	not available
Spain	1999	0.43	18 days
Sweden	1998	0.67	28 days
United Kingdom	1999	0.69*	52 days*

Fig. 4.5 Percentage of male patients among all involuntary placements (most recent year availabe)



Priebe & Fioritti, 2004 (3) 137-144



- Definizione di DI/RI
- Estensione della DI
- Trasformazioni sociali e DI
- Trasformazioni dei servizi sanitari e DI/RI
- Indizi di RI

bmj.com

2005 (330), 123-126

Reinstitutionalisation in mental health care: comparison of data on service provision from six European countries

Stefan Priebe, Alli Badesconyi, Angelo Fioritti, Lars Hansson, Reinhold Kilian, Francisco Torres-Gonzales, Trevor Turner, Durk Wiersma

- Dati da 6 paesi europei (UK, I, NL, S, E, D)
  - ✓Letti ospedalieri
  - ✓Letti in residenze psichiatriche
  - ✓Letti in strutture forensi
  - ✓Ricoveri obbligatori
  - ✓Popolazione carceraria

Number of forensic beds, involuntary hospital admissions, places in residential care or supported housing, psychiatric hospital beds, and prison population in six countries in 1990-1 and 2002-3. Values are numbers per 100 000 population unless stated otherwise

Service provision	England	Germany	Italy	Netherlands	Spain	Sweden
Forensic beds:						
1990	1.3 (1991)	4.6	2.0	4.7 (1991)	1.2 (1992)	9.8 (1993)
2002	1.8* (2001)	7.8	2.2 (2001)	11.4 (2001)	1.5	14.3 (2001)
Change (%)	+38	+70	+10	+143	+25	+46
Involuntary admissions:						
1990	40.5 (1991)	114.4 (1992)	20.51	16.4	33.8	39.0 (1992)
2001	50.3	190.5	18.14†	19.1‡ (1999)	31.8§ (2000)	32.4¶
Change (%)	+24	+67	−12	+16	−6	−17
Places in supported housing:						
1990	15.9 (1997)	8.9	8.8 (1992)	24.8 (1992)	5.1 (1994)	76.0 (1997)
2002	22.3	17.9 (1996)	31.6† (2000)	43.8 (2001)	12.7§	88.1
Change (%)	+40	+101	+259	+77	+149	+15
Psychiatric hospital beds:						
1990	131.8	141.7	4.5 (1992)	159.2	59.5 (1991)	168.6
2001	62.8	128.2 (2000)	5.3† (2000)	135.5	43.0 (1999)	58.3
Change (%)	−52	−10	+18	−15	−28	−65
Prison population:						
1992	90	71	81	49	90	63
2002	141 (2003)	98 (2003)	100	100	136 (2003)	73
Change (%)	+57	+38	+23	+104	+51	+16

See bmj.com for data sources.

*Data refer to restricted patients admitted to all (high security and other) hospitals.

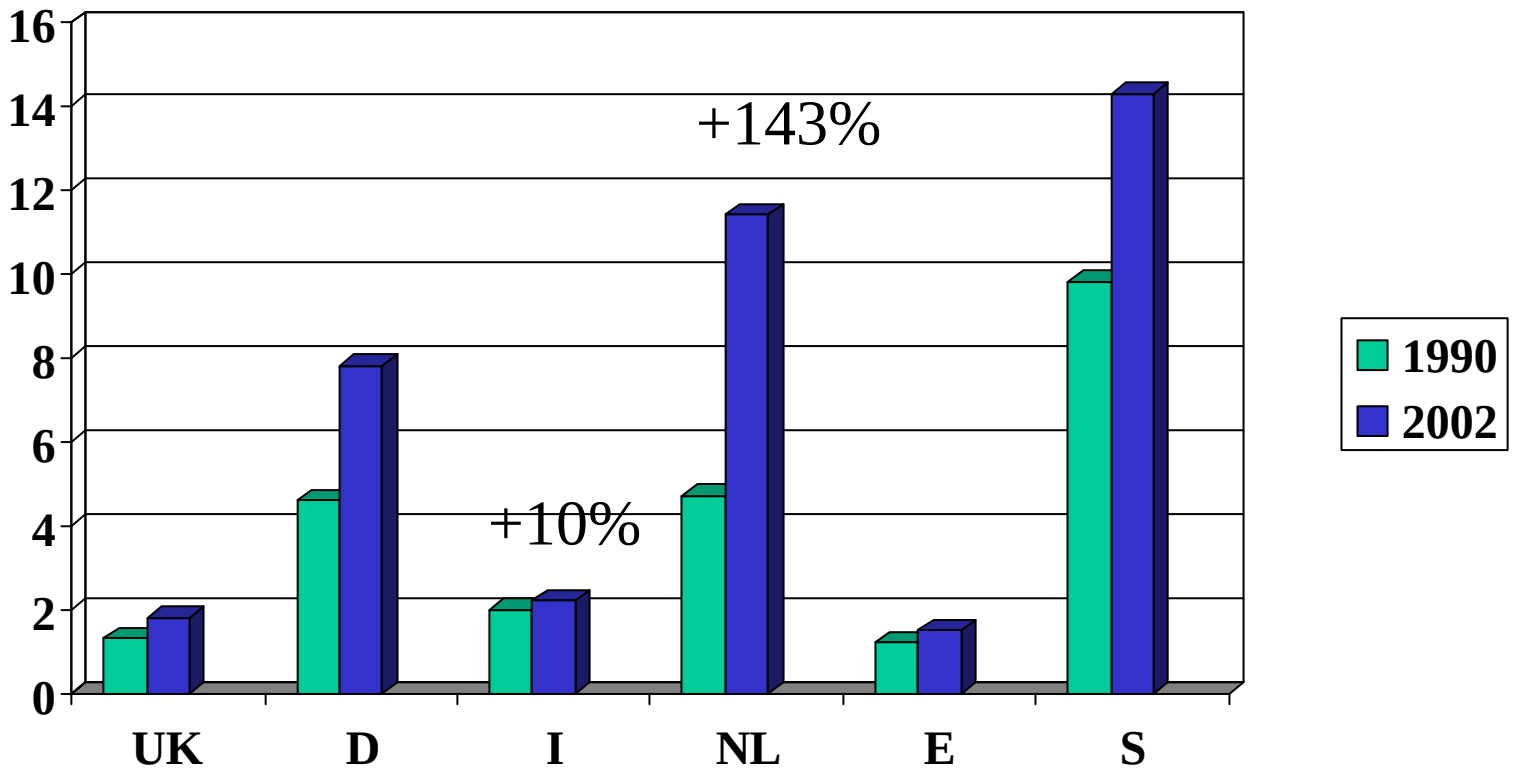
†Data for Emilia-Romagna, a region in northern Italy with a population of 4 million.

‡Data for Drenthe, a rural area with 450 000 inhabitants.

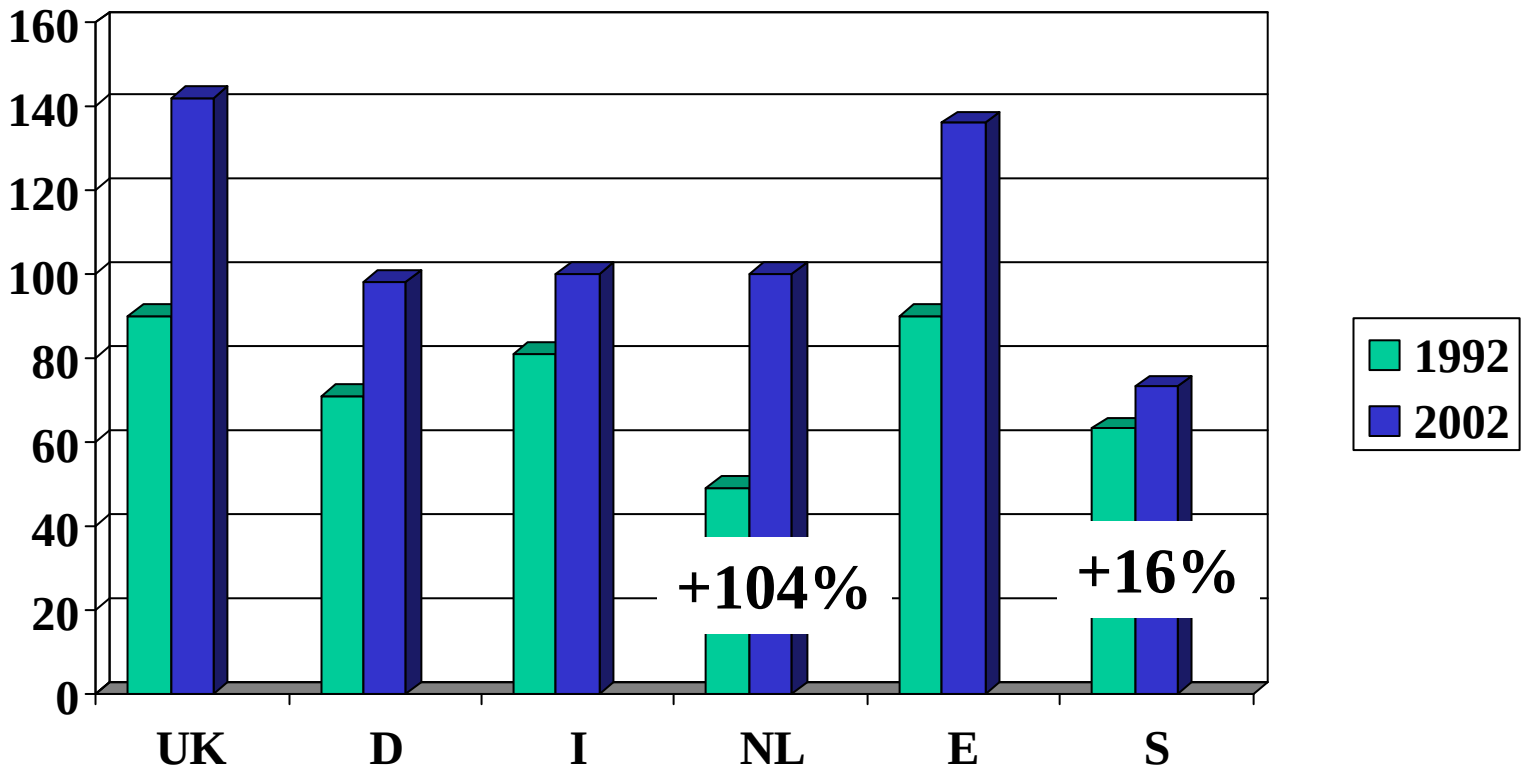
§Data for Andalucia, the second largest region in Spain, with a population of 7 million.

¶Discharges from treatment under the Compulsory Care Act during a six month period.

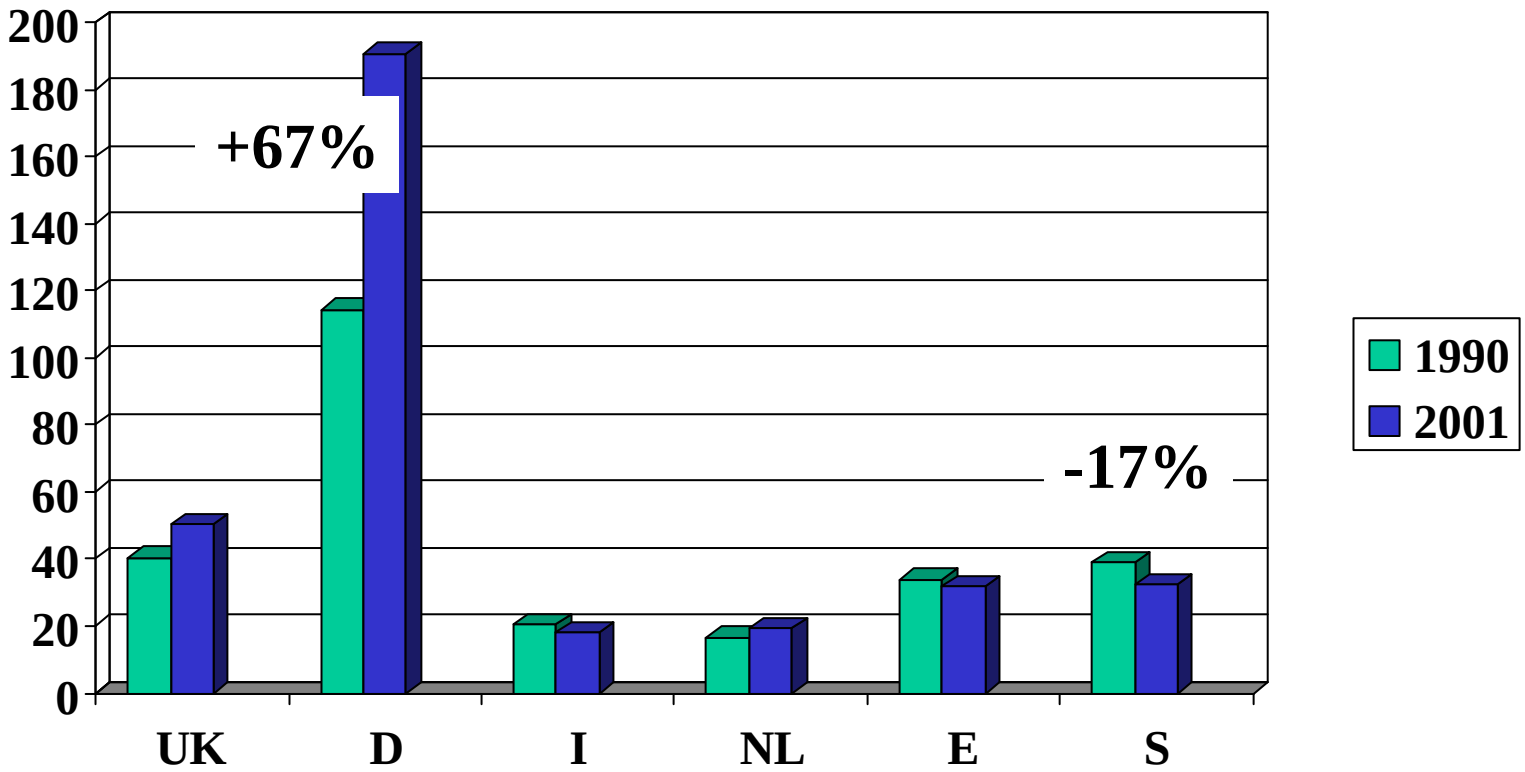
Forensic beds



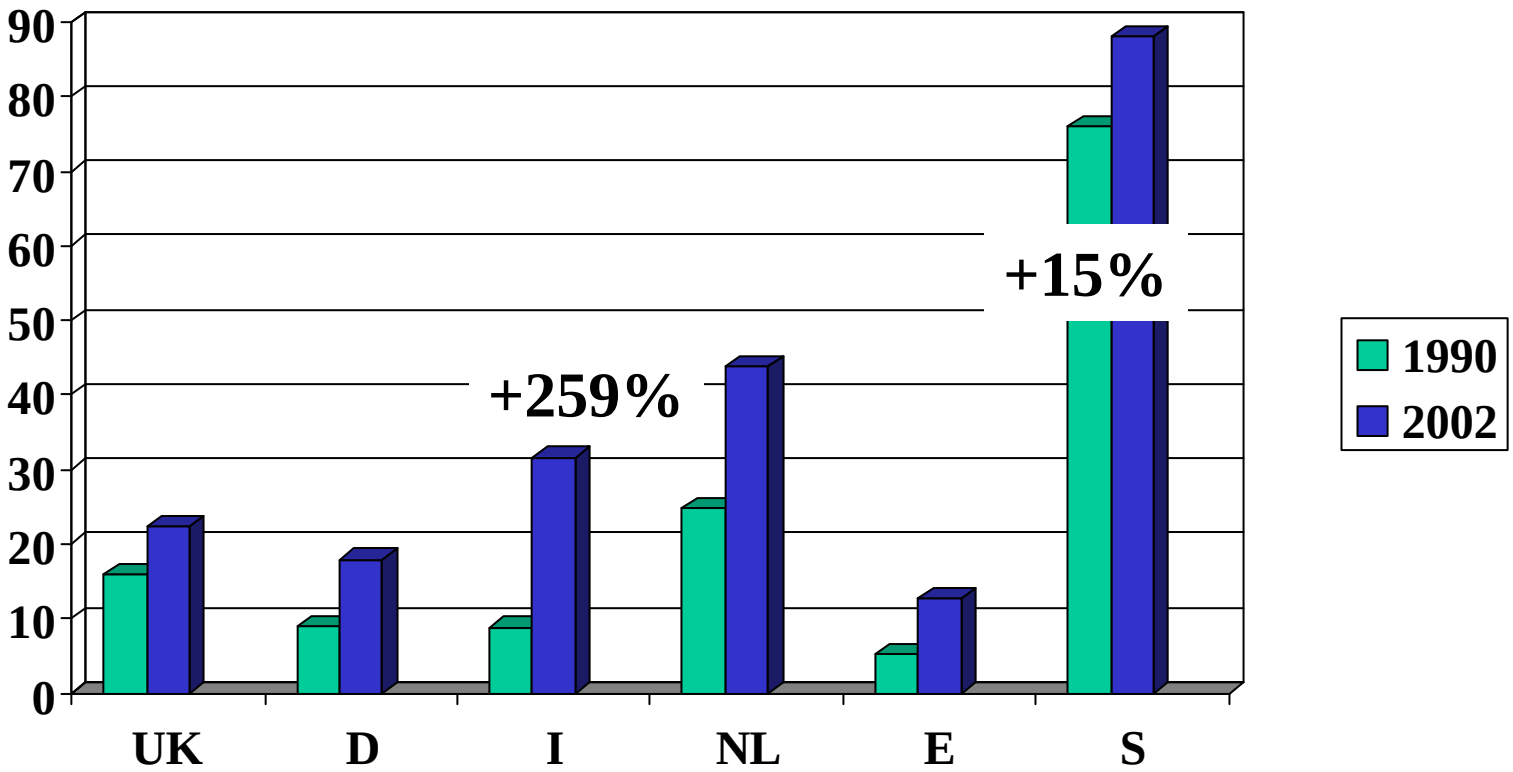
Prison population



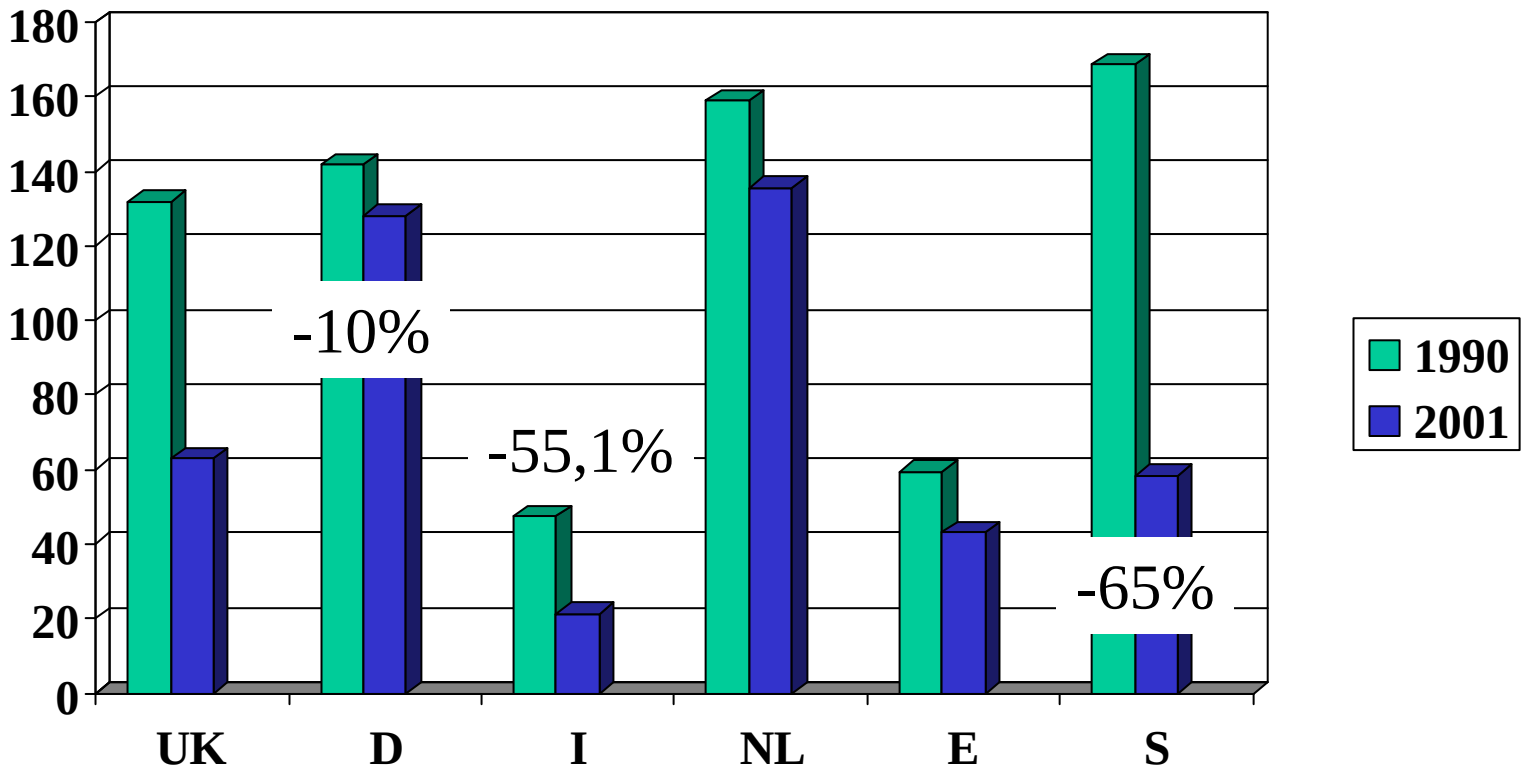
Compulsory admissions



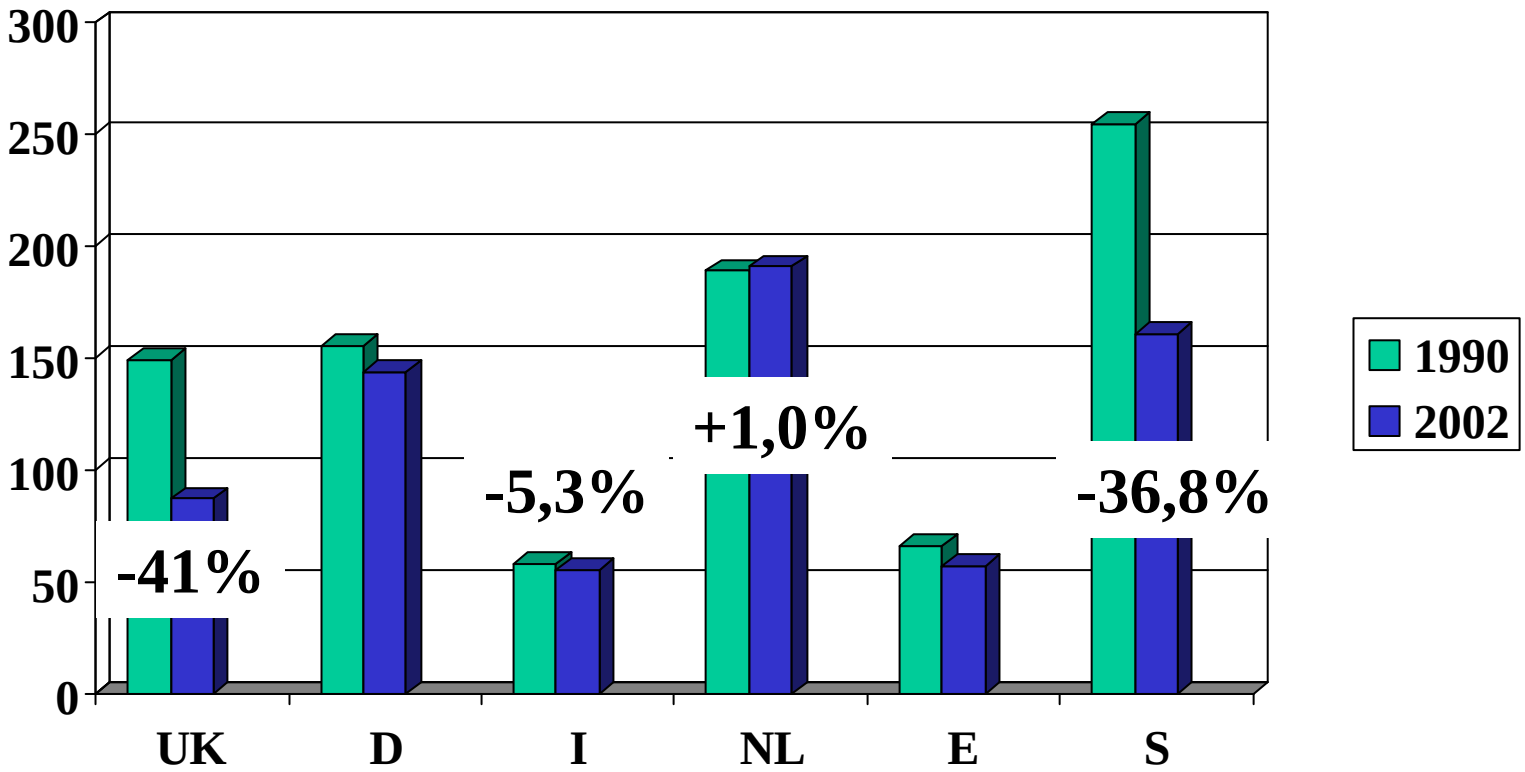
Supported housing



Hospital beds



Forensic+hospital+supp.housing



Fioritti, Burns et al. (IJMH 2003)

	Bologna	Londra
Protetto	12.1	6.8
Solo	32.8	61.2
Fam. Origine	36.2	19.4
Coniuge	19.0	7.8
Shared acc.	0	4.9

London-Bologna, 2003

	London, UK		Bologna, Italy	
Diagnosis	**# 103**	**(%)**	**# 58**	**(%)**
Schizophrenia	**68**	**66.0**	**21**	**36.2**
Delusional dis.	**8**	**7.8**	**7**	**12.1**
Bipolar	**25**	**24.3**	**11**	**19.0**
Personality dis.	**0**	**0**	**9**	**15.5**
Other	**2**	**1.9**	**10**	**17.2**

London-Bologna: use of beds

	Bologna	London	P
Total admissions	1.75	1.24	NS
Mean days of stay	79.35	55.56	NS
Under sections	0.36	0.67	NS
Mean days of stay	3.77	44.4	0.001

The Mc Arthur Foundation study on coercion (1988-2001)

- Does coercion “work”?
- Therapeutic and non-therapeutic outcomes

Lidz, Monahan, Mulvey, Gardner & Hoge

The Mc Arthur Foundation study on coercion (1988-2001)

Three studies

- Assessing experience of coercion in 157 adult pts
- Assessing experience of coercion in:
  - 433 pts,
  - their family members,
  - their clinicians,
  - “factual account”
- Adding the **Perceived Coercion Scale** to assessment of 1,136 pts in the Mac Arthur Risk Assessment Study

The Mc Arthur Foundation study on coercion (1988-2001)

- Legal status is a blunt index
- Patient accounts are reliable
- Patient views about the need for hospitalization may change (50% acknowledgement of need)
- Negative pressures (threats, force) affect individual experience of coercion
- Positive (persuasion, indicement) do not

The Mc Arthur Foundation study on coercion (1988-2001)

- The amount of PC not related to demographics and voluntariness of treatment
- It is related to pt's belief about the justice of process:
  - Genuine concern
  - Respect and good faith
  - Chance to explain reasons

The Mc Arthur Foundation study on coercion (1988-2001)

- Now replicated in USA, England, Australia, Scandinavia and ISC
- Experimental design with intervention in order to reduce experience of coercion by enhancing the degree of “procedural justice”.

Bonsack & Borgeat, IJLMH 2005

- 87 patients voluntary & unvoluntary
  - 74% felt pressured
  - 70% acknowledged need
  - Positive pressure more related with acknowledgement of need

Huss & Zeit, IJLMH 2005

- You have the right not to have a hearing:
- Evaluation of the impact of fully advising civilly committed patients on their rights
- Reducing the adversarial nature of the treatment process.

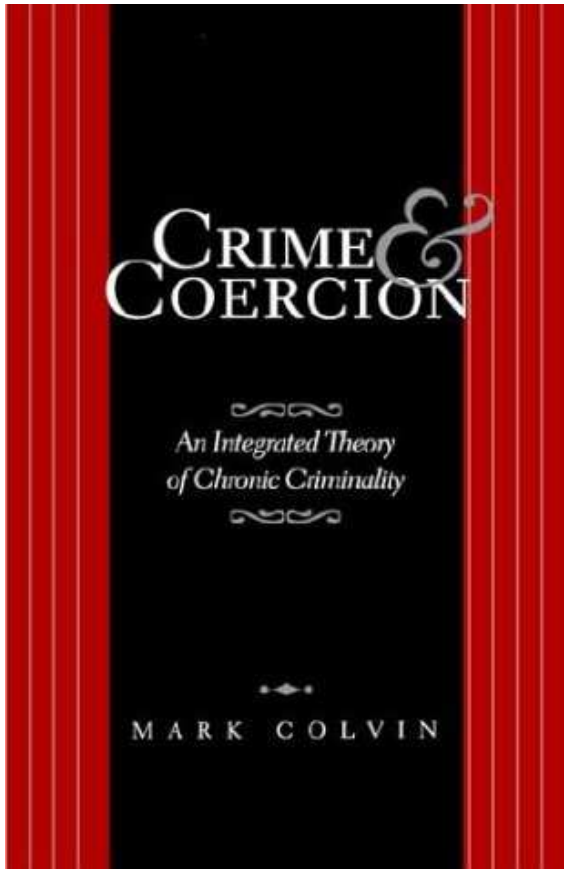
Bindman, Reid & al., SPPE 2005

- PC at admission and engagement with follow-up (10 mths)
- 118 pts, 100 interviewed
  - Compulsory pts had more PC
  - 1/3 voluntary pts high PC, 2/3 not sure they can leave hospital
  - Age, poor insight and non-white ass. with PC
  - PC does not predict engagement at FU

Forthcoming issues

- Carney T., *Coercion in the treatment of anorexia nervosa*, Medicine & Law, 2005
- Clark et al., *Coercion in the treatment with co-occurring disorders and histories of abuse*, JBHS&R, 2005
- Janssens M., *Pressure and coercion in the care for the addicted*, Ethical perspectives, J Med Ethics, 2004

Forthcoming issues



- Parental coercion
- Peer coercion
- School coercion
- Neighborhood coercion

- Social psychological deficits

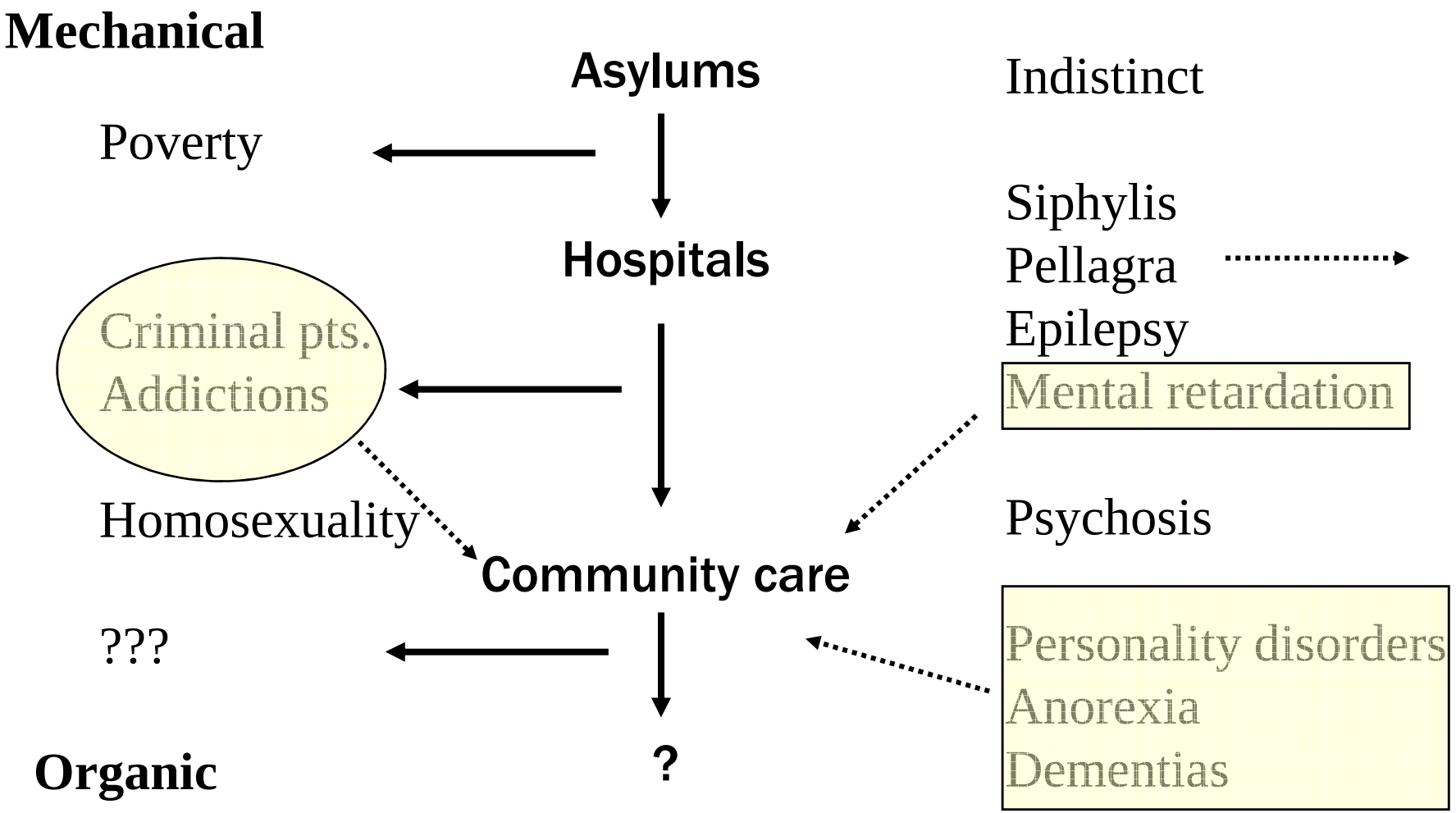
- Crime

Conclusions

- No substantial evidence of increase in coercion in European and USA psychiatry
- Developing interes in empirical research
- Developing specific intervention to minimise perceived coercion

- Unlilkely that psychotic patients will experience a higher degree of coercion in the next future.

Two centuries of psychiatry



Conclusions

- Societies are pressuring psychiatry to take care of conditions for which evidence of effectiveness is poor:
  - Severe drug addiction
  - Personality disorders
  - Antisocial personality disorders
  - Behavioural disorders

- Very likely that these conditions will imply an increase in the use of coercion by our systems.