General hospital psychiatry: the Italian experience

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It is not a case that Don Lipsitt, in his introductory paper, mentions the Italian experience, as well as the British, the Japanese and the German ones.

In the 1960s, psychiatric care in Italy was almost completely delivered in

psychiatric hospitals and private clinics. There were also University neuropsychiatric departments within general hospitals. In 1976, these were split into neurological and psychiatric departments.

The law 180 of the year 1978 radically changed the organization of psychiatric care in Italy (1). Two subsequent 'national target plans for mental health' underlined the importance of the mental health department as an organizing model aimed to prevention, care and rehabilitation of psychiatric disorders through the integration of activities done in different psychiatric services - community mental health centers (CMHCs), day centers, residences in the community, day hospitals, general hospital psychiatric wards (GHPWs) - and in other services such as the substance abuse services and the child psychiatry services.

The 320 GHPWs have no more than 16 beds each (about 1/10,000 inhabitants) (2). They are just a node in the service network, complementary to community facilities, and not vice versa, as in most European programs (3).

Compulsory admissions, which are aimed to address clinical needs rather than social dangerousness, are proposed by two physicians and decided by the administrative authority (the city mayor), rather than by legal authorities as in most other countries. They are requested initially for seven days. These admissions, representing 50% of total psychiatric admissions in 1975, dropped to 11.8% in 1997. The revolving door phenomenon is more frequent where community care is less efficient (4,5).

GHPWs also carry out consultation-liaison psychiatry (CLP) activities. In smaller hospitals, which do not have a GHPW, these activities are performed by psychiatrists of CMHCs. In some hospitals, mostly University ones, there are specific and independent CLP services, with a full time skilled staff.

Today CLP has several important tasks: to fight some negative tendencies of contemporary medicine (such as sectorialization and commercialization of health care), to maintain a holistic perspective, and to represent the way by which psychiatry introduces itself to hospital physicians and to primary care physicians (PCPs). Moreover, CLP allows psychiatrists to get in touch with many patients that they would not meet otherwise (alcohol abusers, borderline patients, patients with self-harm behaviors or eating disorders).

CLP for PCPs shares several features with the more traditional general hospital setting. In Italy, the recent creation of primary care departments (where groups of 15-20 PCPs work together) leads the way to new types of cooperation. For example, we can have a CL psychiatrist working with a PCP group to deal with complex clinical needs, representing a filter with respect to referral to CMHCs.

References

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