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Pathways to mental health care in Italy: Results from a multicenter study

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Abstract

Background and aims: In Italy, the reform of the mental health system in 1978 should have drastically changed the provision of care and pathways of patients seeking to obtain it. The aim of this article is to examine the current pathways to psychiatric care in Italy.

Methods: We used a method developed in the World Health Organization international collaborative studies to investigate pathways to care in 15 Italian mental health centers. We recruited 420 patients with a psychiatric illness and explored the care pathways they took to reach to psychiatric services and the delays from the onset of illness to reaching psychiatric care.

Results: The majority of patients (33.8%) had direct access to mental health care, whereas the others arrived to a specialist in psychiatry through general hospitals (20.3%), general practitioners (33.0%) or private practitioners (9.8%). The main diagnosis for referral was neurotic disorder (36.6%), followed by affective disorder (35.4%) and psychotic disorder (11.5%). The delay from onset of illness to psychiatric care was greater for patients with psychotic disorders than for those with affective and neurotic disorders. The most frequently prescribed treatments were pharmacotherapy (56%), psychological support (8%), and psychotherapy (7.0%); 15% of the patients received no treatment.

Conclusions: Our multicenter study shows that although general practitioners and hospital doctors are still the main referral point for mental health care, a greater proportion of patients are first seen in private settings or directly reach mental health centers, compared to previous surveys conducted in Italy. However, a stronger collaboration of psychiatrists with general practitioners and psychologists is still needed.

Keywords

Pathways to care, psychiatric care in Italy, general practitioners, community mental health service, mental health systems, primary care

Introduction

Pathway studies have proven to be a quick, useful and inexpensive method of studying help-seeking behavior of people with chronic and severe illnesses (Campbell, Hotchkiss, Bradshaw, & Porteous, 1998; Rogler & Cortes, 1993; Singh & Grange, 2006). The evaluation of pathways to care in mental health is probably even more cogent than in other fields of medicine because of stigmatization by mental illness and consequent reluctance to seek care (Thornicroft et al., 2009).

Early studies on pathways to psychiatric care, carried out by the World Health Organization (WHO; Gater et al., 1991; Sartorius et al., 1986), demonstrated that pathways to care for mental disorders may significantly vary within and between different settings and countries and that such evaluations can provide valuable data about the functioning of mental health services.

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One of the first attempts to characterize psychiatric referrals was performed by Goldberg and Huxley (1980): the authors first described a '5-levels model', in which people with psychiatric problems start seeking care from general practitioners, who—through different levels and filters—refer them to community psychiatric facilities. Subsequently, many studies on pathways to care have been carried out in different countries of the world using the methodology originally developed by the WHO (Abiodun, 1995; Bekele, Flisher, Alem, & Baheretebeb, 2009; Fujisawa et al., 2008; Gater et al., 1991, 2005; Gater & Goldberg, 1991; Hashimoto et al., 2010; Kiliç, Rezaki, Ustün, & Gater, 1994; Kurihara, Kato, Reverger, & Tirta, 2006; Lahariya, Singhal, Gupta, & Mishra, 2010; Pawłowski & Kiejna, 2004; Steel et al., 2006; Vázquez-Barquero et al., 1993). On the whole, these studies revealed that the actual mental health seeking-care routes are often different from those planned or intended, and may vary significantly among different settings and regions, depending on various factors (including regional demographic characteristics, patients' diagnosis, the role of general practitioners, the structure of the mental health care system, the relationships between mental health professionals and other helping sources, and the accessibility to mental health facilities), which may greatly influence the pathways to care of people with mental disorders. Furthermore, specific help-seeking behaviors of individuals with first episode of a mental disorder may be influenced by numerous variables at the individual, organizational and systemic level, as well as by the interactions between these variables, as recently reported by studies investigating the Italian context (Carrà, Clerici, & Cazzullo, 2012; Carrà et al., 2011).

The Italian socio-cultural background and its mental health-care organization offer a unique opportunity to explore pathways to care of psychiatric patients. Indeed, Italy is one of the countries in which the reform of health system toward community-oriented services has been established in the whole country at once following the psychiatric reform law in 1978 (Piccinelli, Politi, & Barale, 2002). The so-called deinstitutionalization procedure, decreed by the law, implied a sudden shift from hospital-based models of care to community-oriented mental health services, strongly influencing pathways to mental health care. It is of particular interest to examine whether this reform has changed the pathways to care in Italy and whether they shaped pathways in a manner different from that in other European countries (De Girolamo et al., 2007; Luciano et al., 2012).

Pathways to psychiatric care in Italy have been explored in a previous study (Amaddeo, Zambello, Tansella, & Thornicroft, 2001; Balestrieri, Bon, Rodriguez-Sacristan, & Tansella, 1994). Authors found, in a sample of Verona residents telephonically interviewed, that the most common route to mental health services was via general practitioners (40%), followed by hospital doctors (26%) and self-referral (23%), with the median interval from onset to direct contact with psychiatric services (12 weeks) being shorter than those with other service providers (the median interval for contact with general practitioners and hospital doctors was 24 weeks). These results were obtained by non-standardized tools and in a specific Italian area and thus might not reflect the pathways to mental health care for the whole Italy.

This survey aimed to investigate the pathways to care of patients with mental disorders in a number of centers in Italy, with the methods previously used in a series of WHO studies (which may allow comparisons of Italian pathways to care with those of other countries).

Methods

Data collection

We examined pathways to care of people with mental illness in 15 Italian community mental health centers, using a semi-structured interview (Encounter Form) to record information about pathways to care (Gater et al., 1991). The English version of the Encounter Form was translated into Italian language by one of the authors (U.V.), revised and then translated back into English by another author (A.F.). The final English version was reviewed and approved by one of the authors of the original study (N.S.).

The Encounter Form allowed to record, for each enrolled patient, the basic socio-demographic characteristics, the main psychiatric problem(s) presented, the source/type of care received before seeing a mental health professional, as well as the interval from the onset of mental health problems to the contact with mental health professionals, at each step of care. For each patient, psychiatric diagnoses, according to International Classification of Diseases (ICD)-10 (World Health Organization (WHO), 1992), and the list of received treatments were also obtained.

The study was conducted under the auspices of the Early Career Psychiatrists Committee of the Italian Psychiatric Association. A total of 19 mental health centers (one per each Italian regional section of the Italian Association of Psychiatry) were asked to participate in the study and to recruit at least 20 patients per center. Of these, two centers declined the invitation to participate and other two centers were subsequently excluded because they failed to recruit the minimum number of patients. All participating centers were mental health centers, which are parts of the Italian National Health System, each of them being the main provider of psychiatric care for that area (although other psychiatric and emergency facilities as well as private practitioners were also present in the catchment areas and these could have been assessed retrospectively only).

All patients with any psychiatric disorder (either outpatients, emergency assessments, or newly referred patients for admission), who visited the 15 participating centers between 1 February and 1 March 2011, were included in the study. No exclusion criteria were applied and the only

conditions that had to be satisfied were that the patient had to be 'newly referred to the psychiatric facilities' (i.e. that he or she did not seek care from any mental health service within the last 12 months) and that he or she provided informed consent to participate in the study. All included centers interviewed patients with such characteristics until the target of 20 participants per center was achieved. Centers were allowed to recruit additionally referred patients during the study period of a month (on average, 24.6 patients were recruited in each center).

The study was approved by the Ethical Committee of the Coordinating Centre (University of Naples SUN, Italy), and all included subjects gave their written informed consent to participate in the study, after they had been provided with a complete description of the study aims and methods.

Data analysis

The routes taken by participants seeking mental health care were combined in a 'Pathway Diagram', which describes the steps needed to reach psychiatric care, from the onset of psychiatric disease onward. The proportion of patients taking each step on the pathway diagram is mapped onto the diagram, along with the time intervals occurring at each step. Delays were compared among major pathways, among different diagnostic groups, and among presenting problems. We obtained mean (±standard deviation (*SD*)) values for major variables, but when comparing delays, we provided median values, since the distribution of time intervals was significantly skewed. Categorical data were analyzed using the Chi-square test, while continuous variables were analyzed by means of the analyses of variance (ANOVAs). All analyses were performed with the SPSS software (version 18.0; SPSS Inc., Chicago, USA) and the level of significance was set at $p < 0.05$.

Results

Socio-demographic characteristics

A total of 418 patients were finally included in the study. Only two patients of the 420 who were initially approached refused to be interviewed, possibly due to the undemanding nature of the clinical information required by the WHO Encounter Form. There were no significant differences in terms of age, gender, and socio-economic status between subjects among the different centers. Their mean (±*SD*) age was 46.9 years (±17.9). The sample included approximately 60% women ($n = 249$), and nearly half of the patients were married (47%; $n = 197$). A simplified measure of the socio-economic status (a scale ranging from 1—*low* to 3—*high*) revealed that most of the patients were middle class (61.5%; $n = 257$), while 20.8% ($n = 87$) of them were in the lower and 17.7% ($n = 74$) of them in a higher socio-economic class.

Main problem presented and main diagnosis

The most frequent diagnosis for referral was neurotic disorders (F40-48; 36.6%; $n = 153$), followed by mood (F30-39; 35.4%); $n = 147$, psychotic (F20-29; 11.5%; $n = 48$), eating (F50; 4%; $n = 16$), and personality disorders (F60-69; 2%; $n = 9$); the remaining psychiatric syndromes were not sufficiently represented and were thus grouped into the 'other mental disorders' category (10.5%; n = 45).

The suggestion to first seek care most often came from the patients themselves (74%; $n = 309$). Roughly, in one-third of the cases (36%; $n = 109$), family members or friends suggested patients to ask for psychiatric care. However, patients with schizophrenia showed a significantly lower ($\chi^2 = 64{,}92$; $p < 0.001$) rate of self-referral (40.9%), when compared to patients with affective (73.57%), neurotic (87.85%), or eating disorders (81.25%).

The majority of patients (33.8%; $n = 141$) had a direct access to mental health care, whereas the others arrived to a psychiatric consultation through general hospital (20.3%; n = 85), general practitioners (33.0%; $n = 138$) or private doctors (9.8%; $n = 41$; of which, 42.13% were private psychiatrists, 31.57% neurologists, 15.78% nutritionists, 5.26% psychologists, and 5.26% endocrinologists). Only a minority of patients reached mental health care through police (1.2%; $n = 5$), other social/health professionals (0.2%; $n = 1$), homeopathic doctors (0.5%; $n = 2$), traditional (0.5%; $n = 2$) or spiritual healers (0.7%; $n = 3$). When reaching the recruiting centers, patients were assessed by a psychiatric carer (including psychiatrists, psychologists, and counselors; see Pingani et al., 2012) (Figure 1).

Treatments

At the study inclusion, treatment was offered by the current psychiatric carer to 85% ($n = 355$) of the new patients, usually in the form of psychotropic drugs (56%; $n = 234$), followed by psychological counseling (8%; $n = 33$) and psychotherapy (7%; $n = 29$); the rest received no formal treatment. Of these, 71% of patients ($n = 297$) considered the treatments they received by mental health professionals as 'useful'.

Delays

The greatest delay from onset of illness to psychiatric care was that of psychosis (*mean*±*SD* = 33.73±81.18; *median*: 18; *range*: 0–999 weeks), a value significantly higher ($F_{5,359} = 2{,}28$; $p < 0.03$) with respect to that of affective disorders (26.64±51.79; 31; 0–998), neurotic disorders (22.71±46.79; 17; 0–998), and eating disorders (5.21±2.70; 40; 8–60). The overall median symptoms' duration before contacts with mental health services for any diagnosis was 13 weeks. The median time needed to reach the first health professional was 4 weeks,

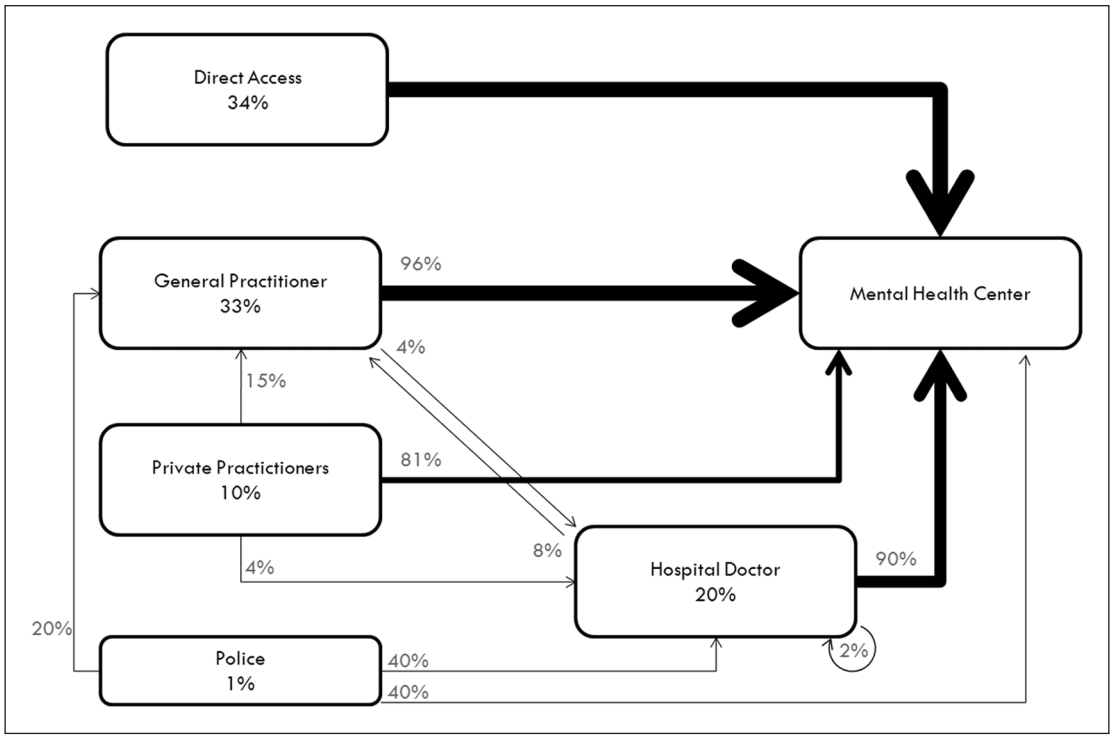

Figure 1. Pathways to care diagram.
In black are presented the first contact ratios, whereas in gray are provided the following steps of the pathways to mental health care. Curved arrows indicate 'recursive pathways' (i.e. patients had gone from one to another of the same type of carer).

but the time between first seeking care and arrival at the psychiatric unit (the so-called delay in mental health services) was 10 weeks. The mean (±*SD*) duration of journey to reach the mental health provider was 33.15 (±32.87) minutes.

Discussion

To our knowledge, this is the first multicenter study of pathways to care of patients with mental disorders seen in Italian mental health centers in almost all parts of Italy. The study was carried out with minimal resources and none of the participating physicians received an honorarium for their work. The methods used allowed comparison over time of pathways to care in Italy and with countries with different mental health care organization and background.

A high percentage of patients reached mental health care via direct access, while general practitioners seemed to have a less prominent gate-keeping role and hospital care was the first contact in 20% of the cases. This pathway-to-care model is different from that found in previous studies (Amaddeo et al., 2001; Balestrieri et al., 1994). The high proportion of patients who reach psychiatric services through self-referral may be connected to a greater knowledge about mental disorders of our patients and their carers, possibly as a consequence of more than 30 years of raising awareness about mental illnesses as well as of the achieved community mental health care. It is interesting also to note that our findings provide a representation of the Italian psychiatric referrals which is significantly different from that of recent reports on mental health services in Italy (Altamura & Goodwin, 2010), in that psychotic patients do not account for the great majority of the patients seen in mental health services in Italy.

Another relevant finding from our survey is that the delay from problem onset to first seek care is longer than those seen in other countries, although the total duration of untreated illness (i.e. the time between onset of symptoms and the first contact with a mental health carer) is shorter than that found in other studies (Gater et al., 1991; Gater et al., 2005; Hashimoto et al., 2010; Pawłowski & Kiejna, 2004). This is possibly due to the lack of knowledge of other health professionals about mental disorders, highlighting the need for a stronger collaboration of psychiatrists with general practitioners and psychologists, who still represent a significant first source of seeking psychiatric care in Italy.

Although general practitioners and hospital doctors are still the main referral for mental health care, about 10% of our patients are first seen in private settings. This result may be due to the fact that patients and their carers still stigmatize mental disorders and mental health centers, and prefer to use less stigmatizing professionals or settings (Magliano, Fiorillo, De Rosa, Malangone, & Maj, 2004). According to the critical period hypothesis (Birchwood & Fiorillo, 2000), such a delay in mental health care may have serious consequences on psychiatric care, with long delays and inappropriate treatments.

Table 1. Comparison of the main findings of Italian pathways to care studies.

	Amaddeo et al. (2001)	Present study
Routes to MHC		
General practitioners	40%	33%
Self-referral	23%	34%
Hospital doctors	26%	20%
Delay		
Median interval to reach MHC	12 weeks	10 weeks
Main problem presented		
Neurotic disorders	10%	36.6%
Affective disorders	41.9%	35.4%
Psychotic disorders	2.9%	11.5%
Personality disorders	4.1%	2.0%
Eating disorders	(not listed)	4.0%
Treatments received at MHC		
Pharmacotherapy	67%	56%
Psychotherapy or counseling	10%	15%

MHC: mental health center.
Percentages do not round to 100% since only ratios available in both studies, and thus directly comparable, are presented.

When comparing our results to that of the most recent previous study conducted in Italy to assess pathways to care (Amaddeo et al., 2001) several differences emerged (Table 1).

By diagnosis distribution our sample was similar to those of Japan, Croatia, Spain, and United Kingdom, with depression, anxiety, and eating disorders being the most represented. However, differently from those of other countries, our sample presented a lower ratio of organic symptoms, interpersonal problems, insomnia, and disturbed behaviors. This result may possibly imply that Italian patients refer to psychiatric services only in case of major mental disorders and only when referral is highly needed, leaving to other professionals, such as psychologists, general practitioners, and other physicians, the treatment of other less severe mental disorders. Of course, this interpretation must be taken with caution, due to its speculative nature and since it is based on descriptive statistics only, and other possible interpretation can be put forward. For example, this result may also reflect the excessive burden placed on Italian mental health centers, which are too often not adequately staffed, and are forced to treat only the 'most serious' patients. Another possible explanation may lie in the low awareness of the general population, who probably are still not familiar with the appropriate treatments they should receive in similar conditions, which underline the importance of public education about mental disorders, as well as about ways to deal with interpersonal problems, physical conditions due to mental disorders, and disruptive behaviors (Magliano et al., 2004; Semrau et al., 2011).

Finally, we have to acknowledge a further limitation since only three centers were from rural areas. In those areas pathways to care might be different than those in big cities, but after having controlled with statistical analysis for differences in urban and rural settings no substantial differences emerged.

Conclusions

In conclusion, our study showed that current pathways to care in Italy were characterized by a high proportion of patients reaching psychiatric services through direct access and with short delay. Pathways to care studies represent a valid and inexpensive tool to detect and monitor such changes, which should be probably performed systematically, in order to ensure the most efficient planning and delivery of mental health care.

Conflict of interest

Authors have no conflicts of interests relative to this article to be declared.

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