

Severe Chronic Mental Disorders: history of a denial

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Severe Chronic Mental Disorders: history of a denial

- **Asylum** the invented city
- **Dehospitalization** abandonment and family burden
- **Homelessness** the diffuse asylum
- **Transinstitutionalization** the imbroglio

Mental disorders are chronic conditions and require long term care

Why deinstitutionalization?

To avoid:

1. accumulation of deficit symptoms
2. geographical isolation
3. ill-treatment to patients
4. low cost-effectiveness

Also:

saving money (if no alternative are created)

But why institutionalization?

- a) long term protection
- b) long term care and assistance
- c) family relief
- d) easy solution of complex problems

Is this debate relevant to middle and low income countries? Myths to be dispelled

- Poor countries do not have many large asylums because they cost too much
- Rural areas in poor countries keep the severely mentally ill FREE in the villages or within the family because rural populations are more tolerant

Addressing Severe Chronic Mental Disorders

- Deinstitutionalization is not dehospitalization
- Moving Asylum Comprehensiveness to the Community
- Acknowledging the citizenship as an asset
- Building citizenship's abilities

Appropriate Comprehensive Long Term Care (ACLTC)

- *The limitations of Bio-Medical Model:* the social dimension dismissed
- *Comprehensiveness:* broad spectrum of "offers"
- *Continuity of human relationship*
- *Collegiality:* multiprofessional team + users
- *Capacity:* new skills for all

Deinstitutionalisation: evidence from Milano

- 1995-2000: 337 patients discharged
- 20% residential care units (less than 20 people each; 24 hours)
- 15% group homes (4-5 people; 12 hours)
- 14% supported flats (2-4 people; less than 8 hours)
- 14% homes for mentally retarded
- 10% homes for aged
- 9% nursing homes
- 18% died (over 70)

Milano: 3 year follow up

- 79% in the same place (residential stability)
- Acute admission: 21% admitted
- Mortality: 4,4 annual death rate but no suicide

The case of BRAZIL

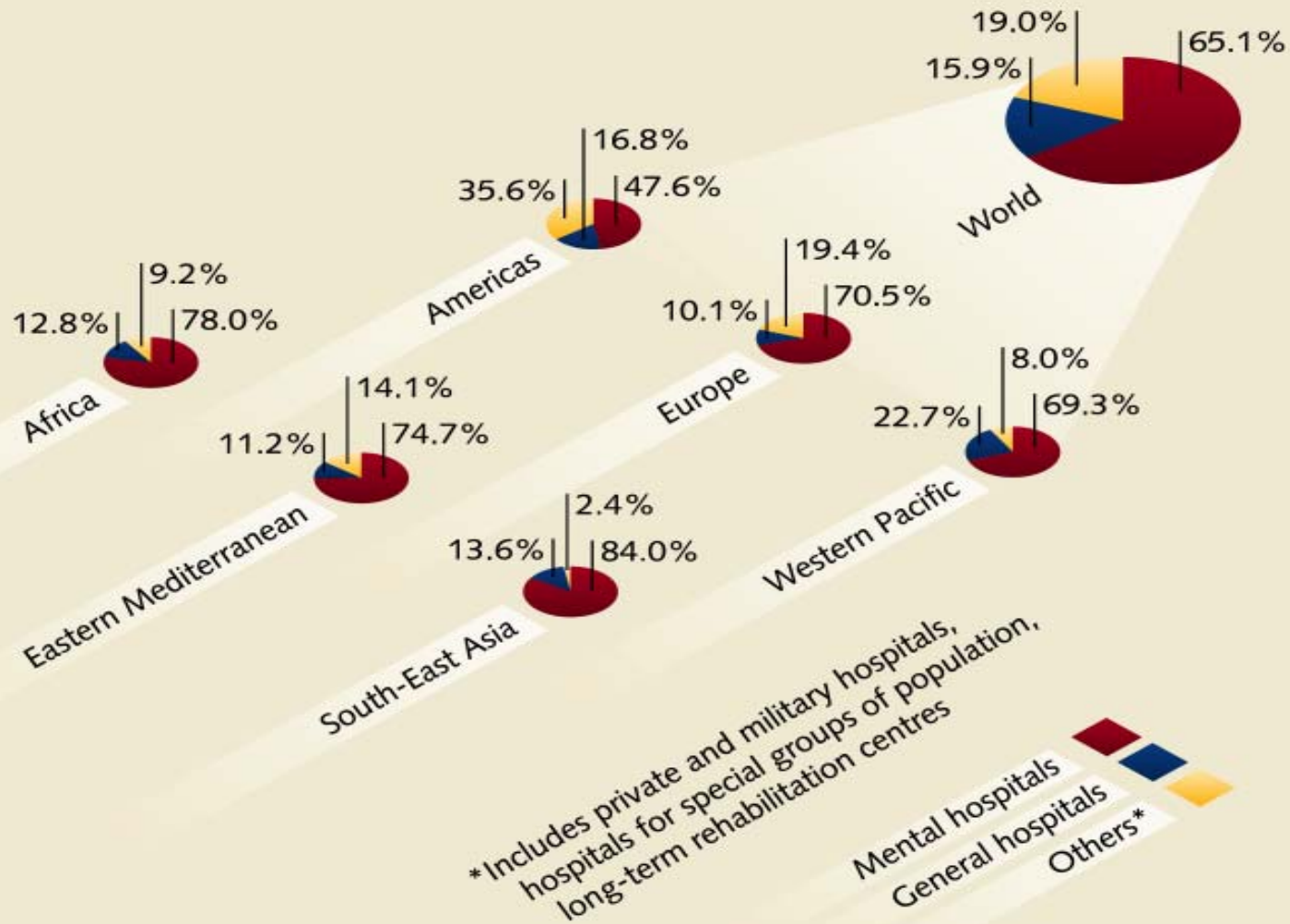
- BEDS: 73.000 in 1996 / 42.000 in 2005
- RESIDENTIAL FACILITIES (8 people): 2 in 1996 / 40 in 2000 / 357 in 2005
- Community Mental Health Centers: 92 in 1996 / 689 in 2005

➤ % expenditure:

Hospitals 93,14% in 1997 / 63,8 in 2004.

CMHC 6,86% in 1997 / 36,16 in 2004

Psychiatric beds in each WHO Region and the world (ATLAS Data, per 10,000 population)



Shifting Paradigms

- From Exclusion to Inclusion
(mentally ill or **citizens** suffering from mental disorders?)
- From bio medical to biopsychosocial approach
(social dimension as key component of treatment)
- From bed to setting
- From Hospital to Community
- From Short Term to Long Term Care
(rehabilitation)
- From Individual work to Team work
- From Treatment to Service



Negative Trends

- Human rights situation of mentally ill not improving sufficiently
- Predominance of acute and medical care with disregard to long-term and psychosocial needs
- Increasing influence of pharmaceutical industry



Positive Trends

- Development of newer and more effective interventions (pharmacological and psychosocial)
- Movement for community based services
- Awareness and involvement of user and family groups