“Migranti e utilizzo dei servizi di salute mentale in Lombardia: una indagine epidemiologica”

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Le disuguaglianze etniche e culturali nei servizi psichiatrici

E’ ben documentato il sottoutilizzo dei servizi psichiatrici da parte di minoranze etniche e culturali [1][2][3][4][5]

E’ inoltro dimostrato:

- L’inappropriato delle terapie psicofarmacologiche [6][7][8]
- Il sottoutilizzo dei programmi di case management [9]
- Il sottoutilizzo dei trattamenti psicoterapici [10]
- Il più lunga durata degli episodi psicotici acuti non trattati [11]
- Biases diagnostici, problemi comunicativi tra operatori e pazienti, pregiudizio, discriminazione…[12][13]

Le disuguaglianze etniche e culturali nei servizi psichiatrici

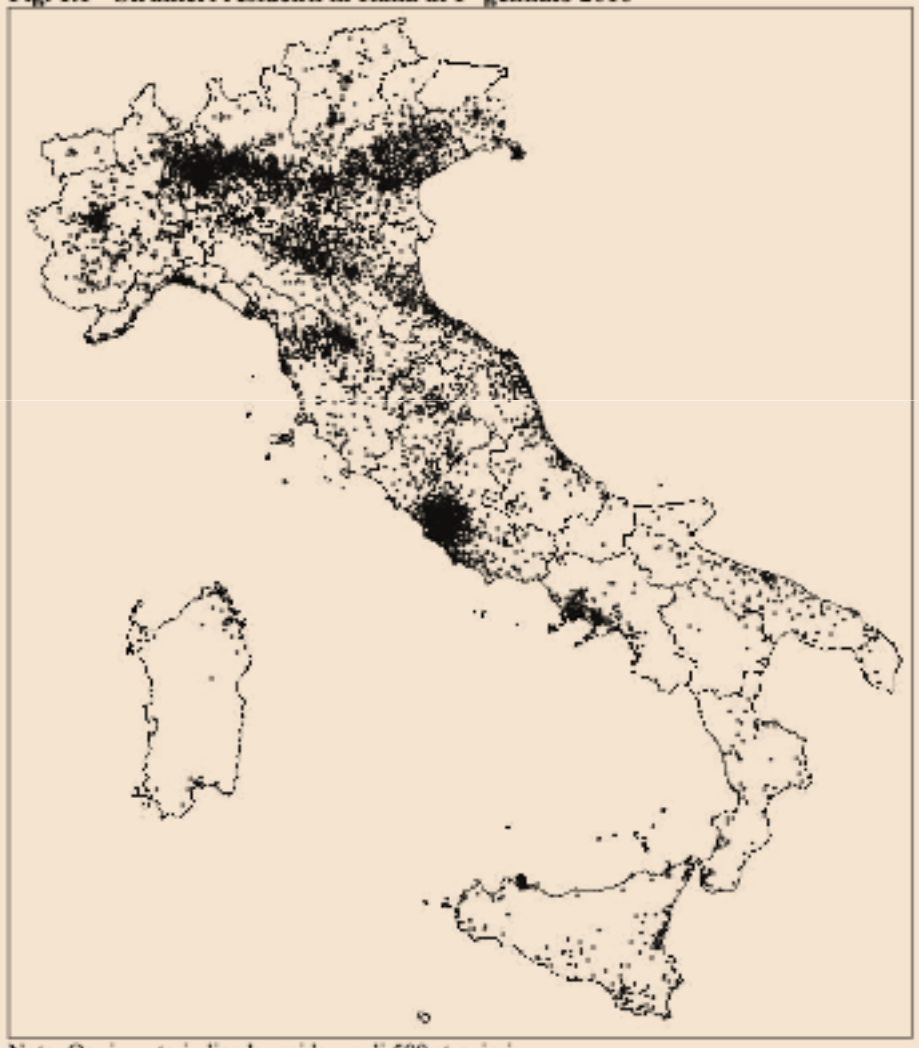
Più in generale la letteratura disponibile definisce tale disparità come conseguenza del divario tra il servizio erogabile e disponibile e il contesto culturale e sociale della comunità servita (Hernandez et al., 2009)

La competenza culturale è definita come un modello di comportamenti, attitudini e politiche attraverso cui i servizi (anche il singolo professionista) lavorano efficacemente in un contesto cross culturale

I servizi possono essere collocabili in 6 stadi: Distruttività Cultirale, Incapacità Culturale, Cecità Culturale, Pre competenza Culturale, Competenza Culturale e Abilità Culturale (APA, 2011)

Il quadro demografico di riferimento

Fig. 1.1 - Stranieri residenti in Italia al 1° gennaio 2010



Nota: Ogni punto indica la residenza di 500 stranieri.
Fonte: Istat

- Popolazione della Regione Lombardia nel 2010 9.917.114 abitanti
- Al 1 gennaio 2010 gli immigrati provenienti da PFPM residenti in Lombardia erano 1,185,000
- Il 23,2% degli stranieri presenti in Italia risiede in Lombardia
- I minori sono in forte crescita e rappresentano il 24.5% dei residenti

Fonte: ISMU

Il quadro demografico di riferimento

Tab. 2.1 - Stima del numero di stranieri provenienti da Paesi a forte pressione migratoria e presenti in Lombardia al 1° luglio 2010

Province	*Migliaia*	*V.%*	*Densità (per 1.000 abitanti)*[a]
Varese	74,3	6,3	84,8
Como	48,6	4,1	82,4
Sondrio	9,2	0,8	50,3
Milano	424,4	35,7	135,9
Capoluogo	*244,3*	*20,6*	*186,8*
Altri comuni	*180,1*	*15,2*	*99,2*
Monza-Brianza	71,0	6,0	84,4
Bergamo	137,9	11,6	126,8
Brescia	191,5	16,1	154,1
Pavia	62,2	5,2	114,3
Cremona	47,0	4,0	129,8
Mantova	62,1	5,2	150,6
Lecco	31,1	2,6	92,1
Lodi	29,2	2,5	129,4
Lombardia	*1.188,5*	*100,0*	*120,9*

Nota: (a) Rapporto tra il numero di stranieri presenti al 1° luglio 2010 e l'ammontare anagrafico di popolazione residente (prescindendo dalla cittadinanza) al 1° gennaio 2010.

Il quadro demografico di riferimento

Tab. 1.4 - Stranieri residenti in Lombardia al 1° gennaio 2010 per cittadinanza. Valori in migliaia di unità[a]

Paese	*V.A.*	*Paese*	*V.A.*	*Paese*	*V.A.*
Romania	129	Brasile	12	Russia	5
Marocco	105	Ghana	12	Bosnia-Erzegovina	5
Albania	96	Bulgaria	9	Algeria	5
Egitto	58	Serbia	9	Colombia	4
Filippine	44	Polonia	8	Burkina Faso	4
India	42	Macedonia	8	Cuba	4
Cina	41	Costa d'Avorio	8	Eritrea	3
Ecuador	39	*Francia*	8	Croazia	3
Perù	37	*Germania*	8	Kosovo	3
Ucraina	33	Nigeria	8	*Giappone*	3
Pakistan	28	Turchia	7	*Svizzera*	3
Senegal	28	Bolivia	6	Mauritius	3
Sri Lanka	25	El Salvador	6	*Stati Uniti*	2
Tunisia	22	*Regno Unito*	6	Argentina	2
Bangladesh	15	Rep. Dominicana	5	*Totale paesi*	*934*
Moldova	15	*Spagna*	5	*Tutti i paesi*	*982*

Nota: (a) In corsivo sono evidenziati i così detti "Paesi a sviluppo avanzato".
Fonte: elaborazioni su dati Istat

Il quadro demografico di riferimento

Tab. 2.6 - Distribuzione percentuale per area di provenienza degli immigrati stranieri presenti al 1° luglio 2010 in corrispondenza delle province lombarde

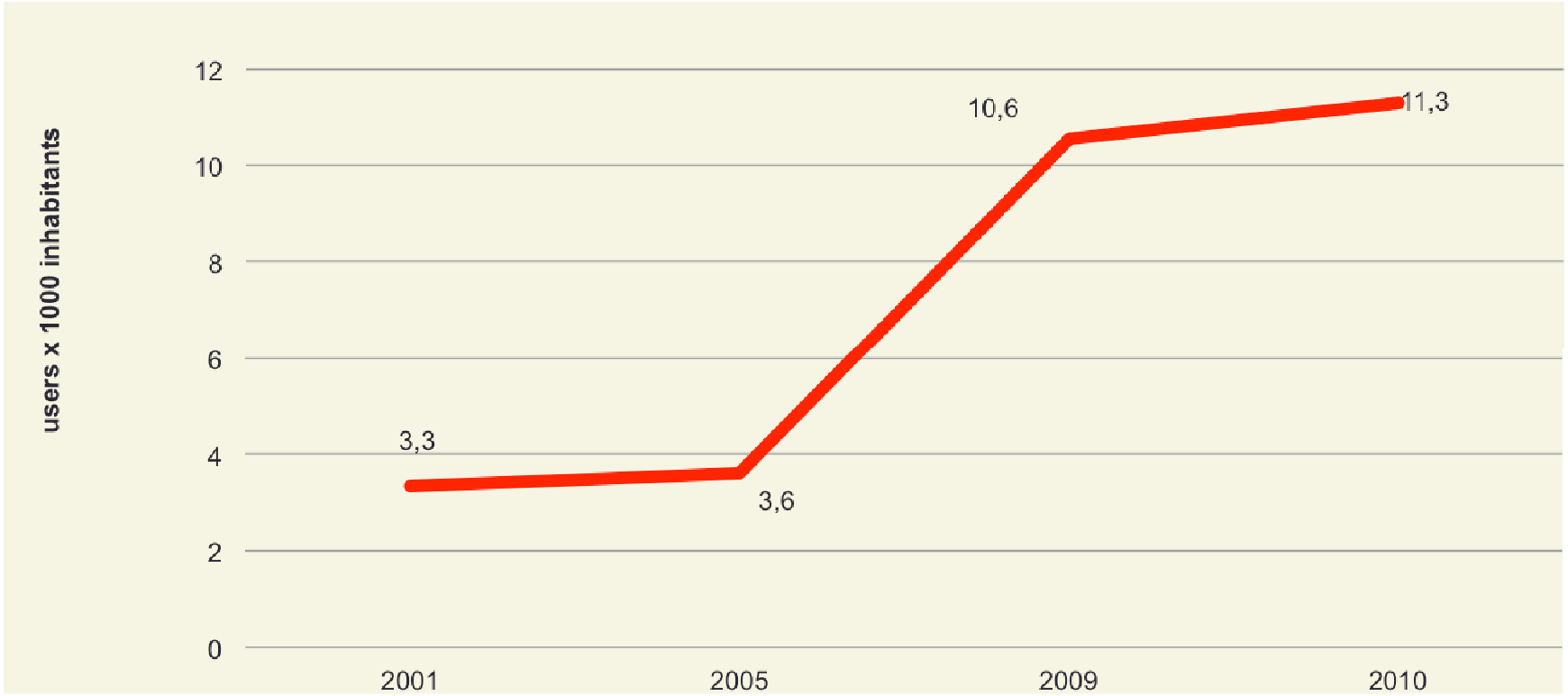
Province	*Area di provenienza*							
	Est Europa	di cui: *UE*	di cui: *extra-UE*	*Asia*	*Nord Africa*	*Altri Africa*	*Amer. Latina*	*Totale*
Varese	40,5	*14,1*	*26,5*	16,8	21,5	7,9	13,2	*100,0*
Como	34,4	*14,8*	*19,5*	23,7	21,7	10,1	10,1	*100,0*
Sondrio	45,4	*17,2*	*28,3*	13,4	28,2	4,4	8,6	*100,0*
Milano	26,1	*13,1*	*13,0*	29,5	18,9	4,9	20,6	*100,0*
Capoluogo	*16,4*	*8,0*	*8,4*	*36,7*	*19,6*	*4,9*	*20,4*	*100,0*
Altri comuni	39,3	*20,1*	*19,2*	*16,9*	*17,9*	*4,9*	20,9	*100,0*
Monza-Brianza	40,4	*21,1*	*19,3*	17,5	19,2	5,7	17,2	*100,0*
Bergamo	35,7	*14,2*	*21,5*	16,2	22,8	15,7	9,7	*100,0*
Brescia	40,2	*13,9*	*26,4*	25,2	18,9	12,6	3,1	*100,0*
Pavia	53,2	*30,3*	*22,9*	8,7	21,0	5,7	11,5	*100,0*
Cremona	42,3	*25,8*	*16,5*	22,8	22,4	7,6	4,9	*100,0*
Mantova	32,9	*15,1*	*17,7*	35,9	20,2	6,5	4,5	*100,0*
Lecco	38,3	*14,1*	*24,2*	9,9	21,6	20,9	9,4	*100,0*
Lodi	44,9	27,2	*17,7*	10,9	24,2	8,8	11,2	*100,0*
Lombardia	*34,9*	*15,9*	*19,0*	*23,4*	*20,2*	*8,6*	*12,9*	*100,0*

Utenti immigrati con almeno un contatto Regione Lombardia

	2001	2004	2009	2010
POPOLAZINE PFPM > 17 a	419.600	647.600	785.763	741.933
UTENTI PFPM	1.396	2.337	8.286	8.775

8.775 utenti

Utenti immigrati con almeno un contatto Regione Lombardia



Utilization rate of psychiatric services (x 1000 inhabitants) among CHMP migrants aged > 17 in Lombardy Region, Italy, 2001-2010

Utenti immigrati con almeno un contatto Regione Lombardia 2010

Rappresentano il 6.3% dell'utenza dei servizi psichiatrici

Gli immigrati il 9.3% della popolazione

Utenti immigrati con almeno un contatto Regione Lombardia 2010

L'età media (±SD) è piu alta nei nativi che per gli immigrati (50.4 anni ±19.9,versus 42.3 anni ± 23.0, p<0.0001). Questa differenza è più accentuata per gli utenti con disturbi affettivi (55.2 anni ± 21.1 nei nativi vs. 46.5 anni ± 22.0 negli immigrati, p<0.0001).

Utenti immigrati con almeno un contatto Regione Lombardia 2010

Il livello di scolarizzazione è più alto negli utenti immigrati (10.0 anni di scolarizzazione, SD 4.2) che per gli utenti nativi (9.03 anni, SD 4.0, $p<0.0001$).

Utenti immigrati con almeno un contatto Regione Lombardia 2010

La condizione famigliare. Gli utenti immigrati vivono con il proprio partner più spesso dei nativi (45.0% vs 42.0%, p<0.0001) e meno spesso vivono soli (11.4% vs 14.2%, p<0.0001) o vivono con i familiari (18.1% vs 28.0%.). Sono più spesso coniugati (43.1 vs 38.6%, p<0.0001) e ovviamente meno frequentemente vedovi (3.1 vs 6.0%, p<0.01).

Utenti immigrati con almeno un contatto Regione Lombardia 2010

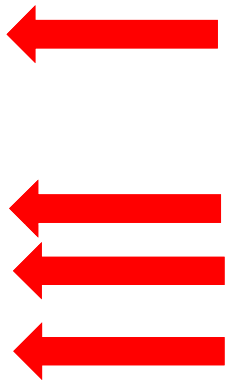
Non vi sono significative differenze nella ***condizione occupazionale***,(35.4% vs 35.8% occupati rispettivamente tra immigrati e nativi, p=0.3925)

Utenti immigrati con almeno un contatto Regione Lombardia 2010

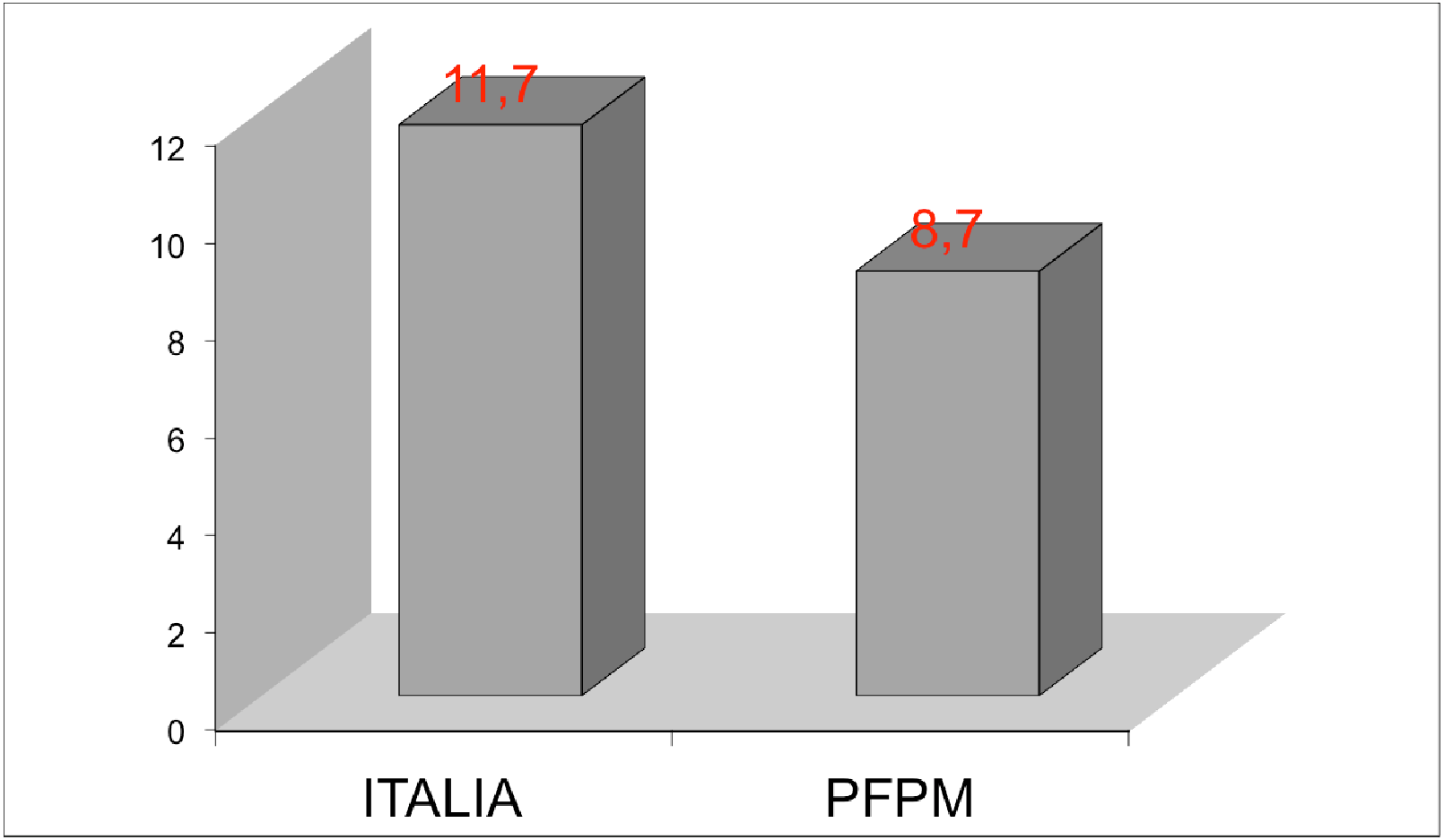
Il numero di ***utenti al primo contatto*** con i servizi psichiatrici della Regione Lombardia è più alto negli immigrati (5.5 vs 4.0 per 1,000 abitanti >17 $p<0.0001$).

Tipologia Interventi Regione Lombardia 2009

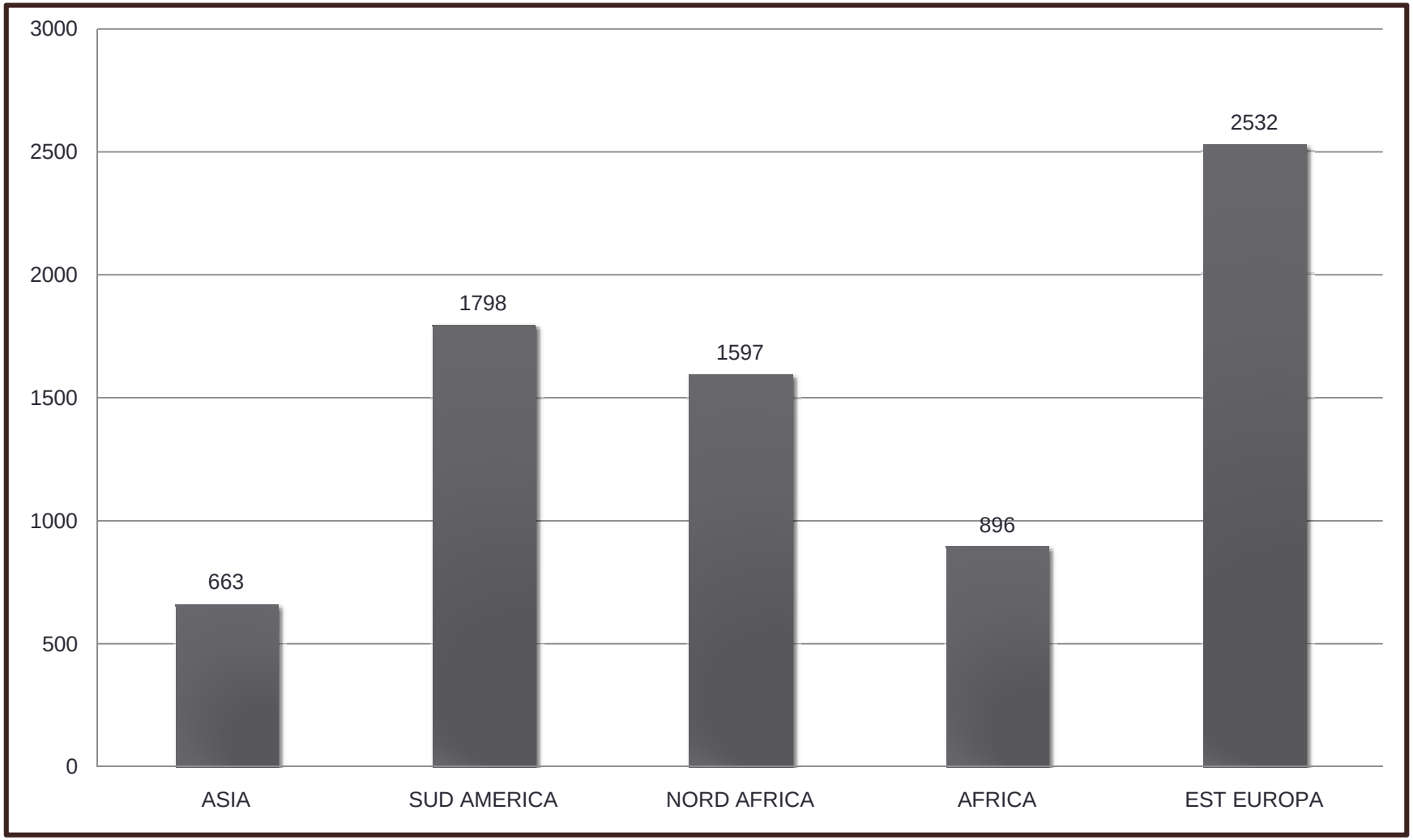
	ITALIA		PFPM	
TIPO_INTERVENTO	Frequenza	Percentuale	Frequenza	Percentuale
VISITA COLLOQUIO	108713	42,80%	6451	45,80%
SOMM FARMACI	15922	6,30%	780	5,50%
ATT VALUTAZIONE	4128	1,60%	240	1,70%
VISITA MED LEGALE	4148	1,60%	256	1,80%
PSICOTERAPIE	10258	4,10%	480	3,50%
COLLOQUIO FAMILIARI	28535	11,20%	1389	9,90%
RIUNIONE CASI UOP	25765	10,10%	1554	11,00%
RIUNIONE ALTRI ENTI	13682	5,40%	801	5,70%
RIUNIONE GRUPPI NON ISTITUZ	3410	1,30%	192	1,40%
INT INDIVIDUALE ABILITA' BASE	6823	2,70%	388	2,80%
SUPPORTO ATTIV QUOTID	5551	2,20%	243	1,70%
SUPPORTO SOCIALE	10087	4,00%	555	3,90%
ALTRO	17019	6,70%	759	5,30%



Frequenza Interventi Regione Lombardia 2010



Utenti anno 2010



Tassi specifici di utilizzo

Utilization rate of psychiatric services (x 1000 inhabitants)	Natives		Migrants CHMP	
Overall	17.0		11.3	
Gender specific	M	F	M	F
	15.5	18.3	9.1	13.5
M/F Ratio	0.85		0.68	

Utilization rate of psychiatric services (x 1000 inhabitants) Lombardy Region, Italy, 2010, age > 17.

Tassi specifici di utilizzo

Utilization rate of psychiatric services (x 1000 inhabitants)	Natives		Migrants CHMP		Asia		Sub-Saharan Africa		South America		North Africa		East Europe	
Overall	17.0		11.3		5.1		11.9		19.6		12.1		11.8	
Gender specific	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	15.5	18.3	9.1	13.5	4.6	5.6	8.4	17.3	3.7	23.(	12.1	12.1	8.0	15.4
M/F Ratio	0.85		0.68		0.82		0.48		0.58		1		0.5	

Utilization rate of psychiatric services (x 1000 inhabitants) Lombardy Region, Italy, 2010, age > 17.

Utenti anno 2010

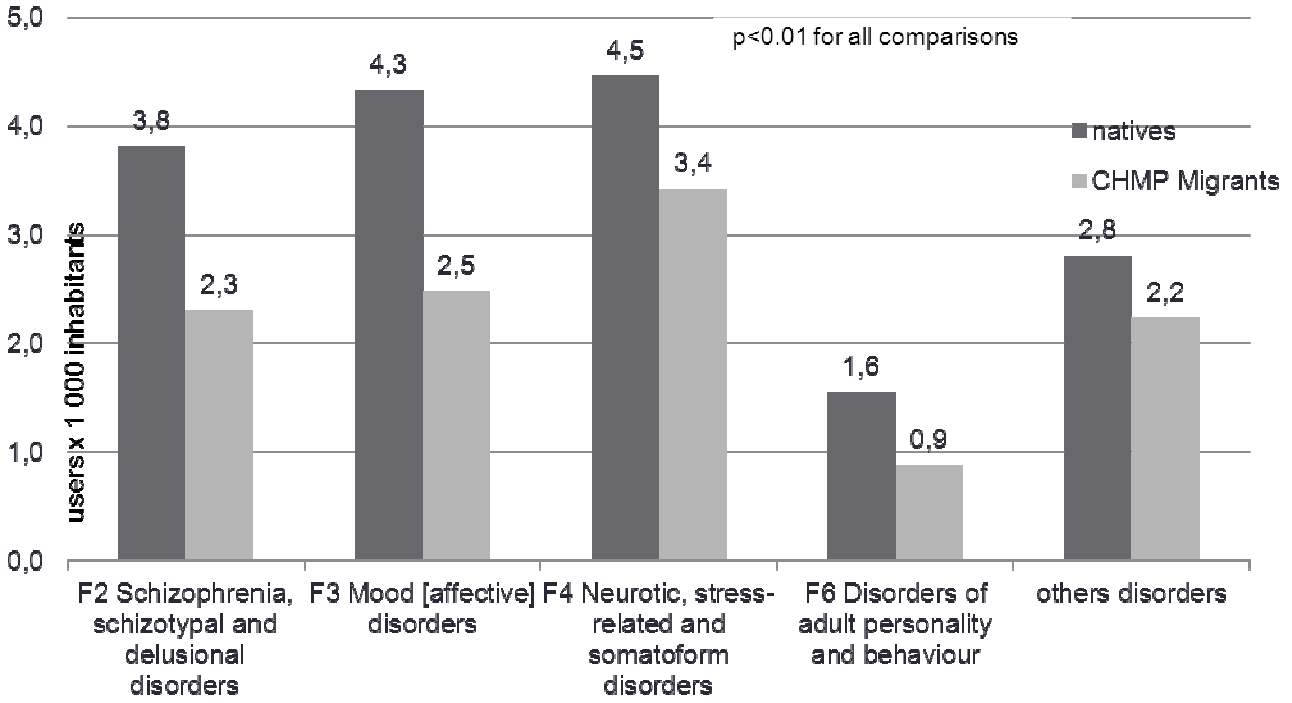
ASL	PROVINCIA	UTENTI	AFRICA	ASIA	EST EUROPA	NORD AFRICA	SUD AMERICA
301	BG	934	134	56	305	241	197
302/315	BS	1237	221	156	512	256	174
303	CO	323	25	37	116	75	73
304	CR	275	19	31	117	54	54
305	LECCO	194	30	14	72	58	30
306	LO	106	13	9	51	8	25
307	MN	322	16	47	125	70	55
308	MI CITTA	1550	146	247	380	284	293
309/310	MILANO PROV	891	72	68	52	158	219
311	MONZA	460	33	26	146	134	121
312	PV	286	19	15	115	43	84
313	SO	96	7	9	40	18	22
314	VA	549	60	3	42	15	17

Utenti per 1000 immigrati Regione Lombardia

Su base ISMU

ASL	PROVINCIA	UTENTI	IMMIGRATI	UTENTI PER 1000 IMMIGRATI
301	BG	934	83038	11,25
302/315	BS	1237	119065	10,39
303	CO	323	33746	9,57
304	CR	275	27525	9,99
305	LECCO	194	19585	9,91
306	LO	106	17509	6,05
307	MN	322	37327	8,63
308	MI CITTA	1550	156963	9,87
309/310	MILANO PROV	891	153159	5,82
311	MONZA	460	44983	10,23
312	PV	286	37488	7,63
313	SO	96	5902	16,27
314	VA	549	49569	11,08
	REGIONE	7223	785859	9.19

Principali diagnosi Regione Lombardia 2010



Principali diagnosi % Regione Lombardia 2010

Diagnosis	Natives	Migrants CHMP	Asia	Sub-Saharan Africa	South America	North Africa	East Europe
Schizophrenia, schizotypal and delusional disorders	22.5	20.3	28.5	37.9	15.2	17.9	18.3
Mood [affective] disorders	25.5	21.8	20.3	19.9	23.7	21.3	21.9
Neurotic, stress-related and somatoform disorders	26.3	30.1	22.6	21.6	31.3	29.9	33.8
Disorders of adult personality and behaviour	9.2	7.8	6.5	4.8	11.1	7.9	6.7
Other diagnosis	16.7	20.0	22.5	15.8	18.8	23.0	19.3

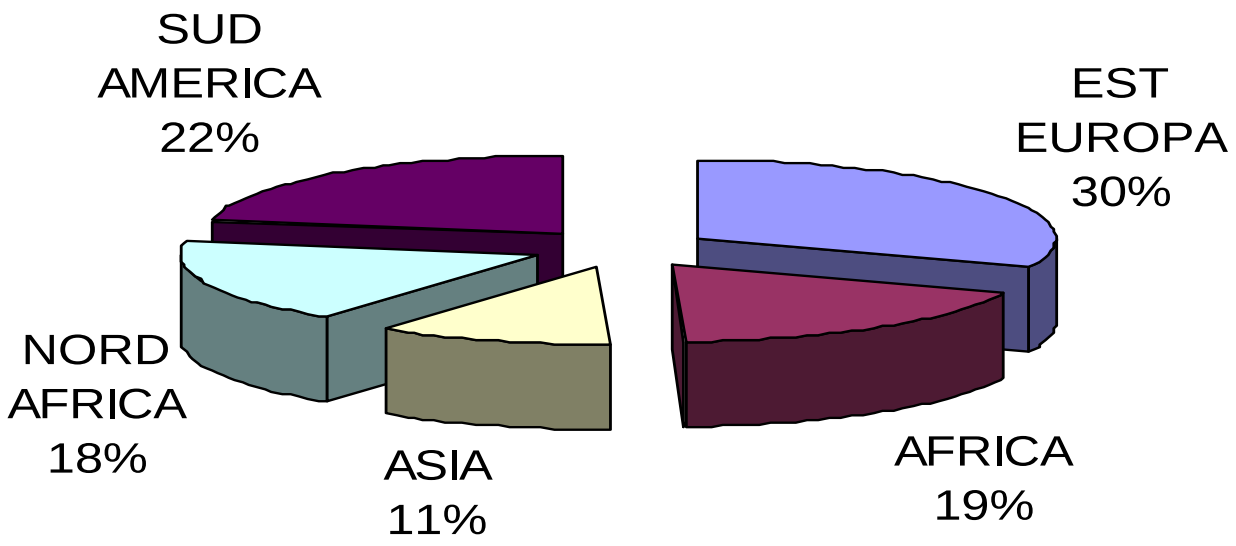
Ricoveri in SPDC Regione Lombardia 2010

Activity in acute psychiatric ward	CHMP Migrants	Natives	P*
Hospitalization (rate x 1000 inhabitants)	1,536 (2.0)	13,978 (1.9)	0.038
patients hospitalized (% on psychiatric user)	1,495 (17.1)	13,535 (0.7)	<0.01
patients with more than one hospitalization (%)	41 (2.7%)	443 (3.3%)	0.27
compulsory admission (%)	190 (12.4%)	1,620 (11.6%)	0.36
median length of hospitalization (days)	9	12	<0.01

based on z-score for rate comparison, chi-square test for percentage comparison, and Wilcoxon Rank Sum for median comparison

Hospital utilization data. Lombardy Region, Italy, 2010, age > 17.

Provenienze ricoveri SPDC Regione Lombardia 2010



CONSIDERAZIONI
gli utenti irregolari

- Non abbiamo dati disponibili sull'accesso ai servizi psichiatrici della Regione Lombardia
- Nel 2001 il 20,7% degli immigrati presenti in Lombardia era irregolare [17]
- Nel 2009 gli irregolari erano il 13%[17]
- Nel 2012 il 7.3%[18]
- Unico dato disponibile sono i ricoveri ospedalieri per il 2007; in questo anno sono stati il 0.7% di tutti i ricoveri psichiatrici e non [19]

CONSIDERAZIONI
l'accesso al Pronto Soccorso e i MMG

- Non abbiamo informazioni disponibili sull'accesso dei migranti alle prestazioni di Pronto Soccorso
- E' probabilmente più alto, in proporzione, rispetto alla popolazione nativa e questo potrebbe in parte spiegare il più facile accesso al ricovero
- Altro elemento da indagare per la più alta propensione al ricovero è la capacità da parte dei MMG di riconoscere e indirizzare ai servizi psichiatrici gli utenti immigrati con problemi psichiatrici [20]

CONSIDERAZIONI
densità etnica, isolamento sociale e disoccupazione

Variabili quali l'isolamento sociale, la disoccupazione, il vivere da soli e la densità etnica si collegano all'utilizzo dei servizi psichiatrici [8][21][22]

In modo particolare la densità etnica: quanto essa è maggiore tanto minore è l'accesso ai servizi psichiatrici, specie extra ospedalieri. Una bassa densità etnica è correlata sia a una maggiore frequenza che persistenza dei disturbi psichiatrici [22]. Questo potrebbe spiegare il basso utilizzo dei servizi psichiatrici da parte degli immigrati Asiatici concentrati a Milano (immigrati Cinesi e Filippini) e nel Sud della Lombardia (immigrati indiani).

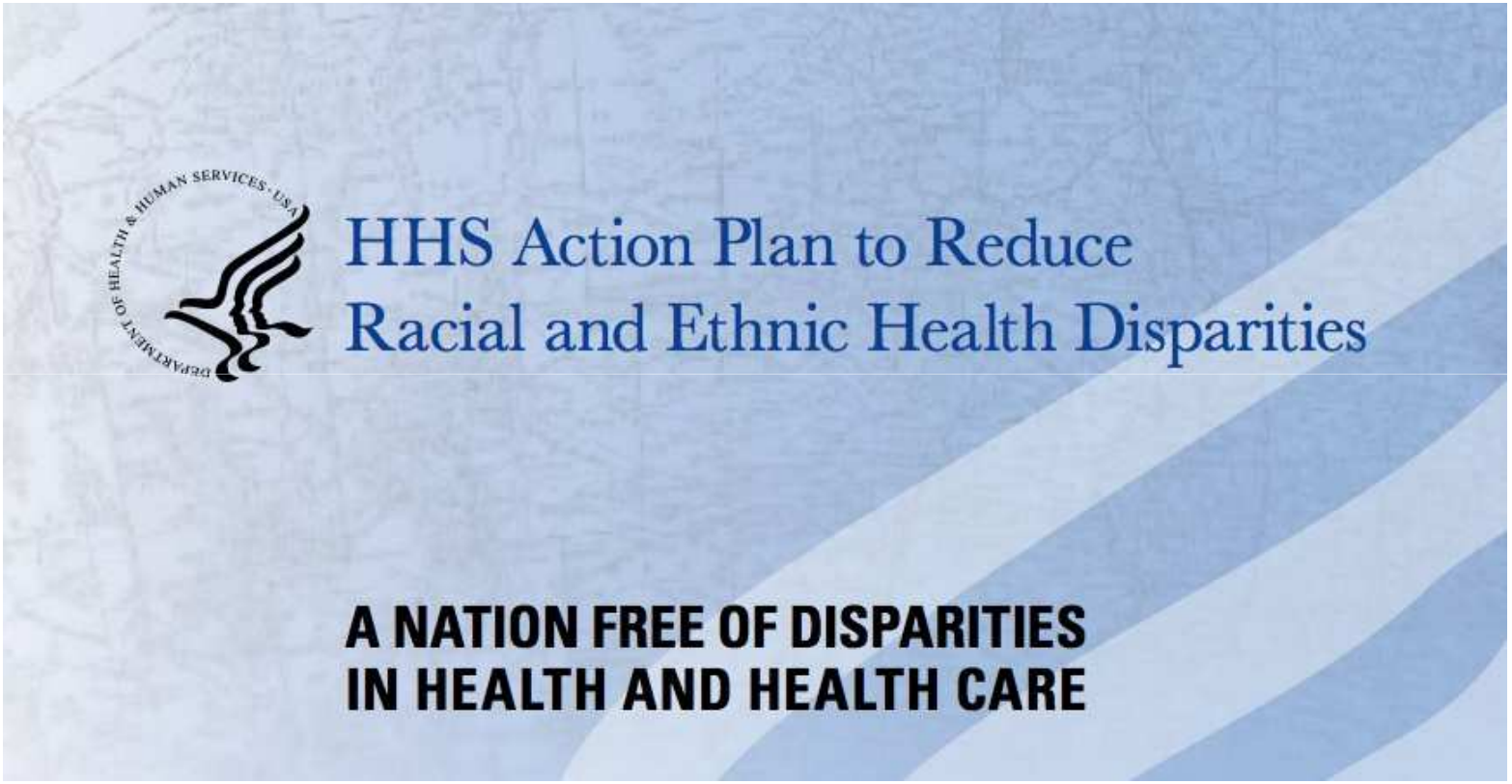
CONSIDERAZIONI
gli altri fattori di rischio e di protezione

- La densità etnica non è l'unico fattore che spiega il sottoutilizzo. I processi migratori sono estremamente complessi e non possono essere semplificatgi nel trasferimento da una nazione all'altra e sono correlate a diverse fasi in cui sono presenti sia fattori protettivi che di stress [23].
- Il miglioramento dell'accesso ai servizi passa attraverso la comprensione di tutti I fattori legati all'individuo ma anche all'organizzazione del servizio e a tutti I potenziali ostacoli di accesso a livello sociale [24].

CONSIDERAZIONI
le differenze di genere

- Le donne sono più spesso utenti dei servizi psichiatrici che gli uomini, anche se in maniera non omogenea con importanti differenze legate alla provenienza.
- Complessivamente I dati mostrano che la maggiore esposizione delle donne allo stresss migratorio non può essere ignotata.
- Tale stress è correlato alla ridefinizione dei ruoli e delle relazioni sia nella famiglia che nelnuovo contesto sociale. Situazioni queste che creano incertezze e ansia per il futuro e ambivalenze. Vi sono quindi specifici fattori di stress che devono essere presi in considerazione[27].

Le disuguaglianze etniche e culturali nei servizi psichiatrici



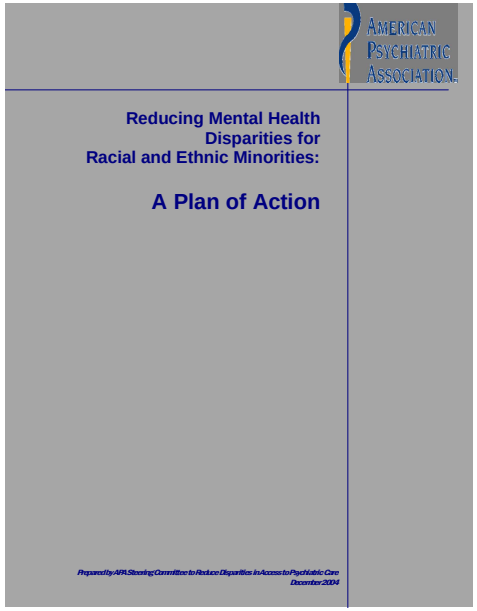
Le disuguaglianze etniche e culturali nei servizi psichiatrici

Commentary

APA's Efforts to Eliminate Disparities

Pedro Ruiz, M.D.
Annelle Primm, M.D., M.P.H.

PSYCHIATRIC SERVICES ♦ http://ps.psychiatryonline.org ♦ December 2005 Vol. 56 No. 12



Le disuguaglianze etniche e culturali nei servizi psichiatrici

National Action Plan on Integration
Abridged press version

Declaration of the Federal Government
Contribution of the German Länder
Contribution of the Federation of Local Government Associations

Competenza culturale e servizi psichiatrici

Cultural Competence: A Literature Review and Conceptual Model for Mental Health Services

Mario Hernandez, Ph.D.
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Debra Mowery, Ph.D.
Ignacio D. Acevedo-Polakovich, Ph.D.
Linda M. Callejas, M.A.

This article presents a conceptual model of organizational cultural competence for use in mental health services that resulted from a comprehensive review of the research literature. The model identifies four factors associated with cultural competence in mental health services (community context, cultural characteristics of local populations, organizational infrastructure, and direct service support) and redefines cultural competence as the degree of compatibility among these factors. A strength of this model of organizational cultural competence is that it facilitates future research and practice in psychiatric services settings and links culturally competent practices to service parity. (*Psychiatric Services* 60:1046–1050, 2009)

Among individuals who are in need of mental health services, members of many U.S. racial-ethnic minority groups face significant disparities compared with Americans with European origins (1). For instance, compared with European Americans with co-occurring depression and substance abuse, African Americans and Latinos with the same co-occurrence tend to have less access to selective serotonin reuptake inhibitors (2), which are often recommended as a first-line treatment for individuals with co-occurring depression and substance use disorder (3). Even when services are available to members of U.S. racial-ethnic minority groups, they often are not accessible to large subsets of those populations. For example, compared with their English-proficient counterparts, Asians, Pacific Islanders, and Latinos with a mental health need and limited English proficiency tend to be less likely to receive services (4). Given the limited English proficiency of a large proportion of Asians, Pacific Islanders, and Latinos, their limited ability to access mental health services may contribute to overall racial-ethnic disparities in mental health services (4).

It often has been suggested that increasing cultural competence in providing psychiatric services can contribute to the reduction of existing mental health service disparities (5,6). According to one popular definition, cultural competence in mental health services occurs when a set of congruent behaviors, attitudes, and policies come together in a system, an agency, or among professionals to enable effective cross-cultural work (7). Although the proposition that increased cultural competence in providing psychiatric services can reduce existing disparities is appealing, cultural competence lacks a clear means of operationalization that can direct research and practice (8–10).

This article summarizes a model for cultural competence in mental health services. The model has emerged from research that seeks to operationalize cultural competence in order to facilitate its understanding and implementation in behavioral health organizations (11). The model organizes the findings from a literature review that examined over 1,100 articles on the topic of cultural competence in mental health services for racially and ethnically diverse groups in the United States. The goal of the review was to identify and describe measurable factors associated with cultural competence in mental health services and the relations among these factors (11,12). This review was part of a larger study that focused on identifying organizational practices to operationalize cultural competence and reduce mental health service disparities by improving service accessibility (13). A full description of the study methodology can be obtained from source materials and by direct inquiry to the authors.

The model

The available literature suggests that disparities in delivery of mental health services are driven by incompatibility

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I.Contesto comunitario: i percorsi di cura sono influenzati, oltre che dai fattori organizzativi del servizio, dalla capacità della rete locale di farsi carico dei bisogni della persona e di fare riferimento al servizio

II: Caratteristiche culturali della popolazione locale: le differenze culturali influenzano i comportamenti di 'mental health help seeking', condiziona variabili come il riconoscimento del problema, la sua identificazione e la scelta del trattamento e del terapeuta. Condiziona anche i servizi (errori diagnostici, incomprensioni). Comprende lo status socio economico

Competenza culturale e servizi psichiatrici

Cultural Competence: A Literature Review and Conceptual Model for Mental Health Services

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The model

The available literature suggests that disparities in delivery of mental health services are driven by incompatibility

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III: L'infrastruttura organizzativa:

- *Valori* (mission, vision, codice etico)
- *Comunicazione*: sia diretta che tramite partner organizzativi
- *Partecipazione della comunità locale*
- *Governance:* definizione di strategie, politiche e obiettivi
- *Pianificazione e valutazione*
- *Risorse umane* (operatori e consulenti appartenenti al contesto culturale, formazione, ecc)
- *Utilizzo di risorse anche informali* per una adeguata risposta ai bisogni multiculturali
- *Supporto tecnico*

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IV. L'organizzazione del servizio:

- *Disponibilità*
- *Accessibilità*
- *Utilizzo*

La competenza culturale / efficacia

- *Studi metanalitici dimostrano che aumentando la competenza culturale del servizio migliora l'esito (Griner et al., 2006)*

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Competenza culturale: principali outcome

- A livello di organizzaione: tasso di accesso, durata della permanenza; persi di vista
- A livello della popolazione: tassi di utilizzo attesi ed effettivi; uso sproporzionato di specifici servizi
- A livello del servizio: soddisfazione degli utenti, esiti clinici, funzionamento sociale ed empowrment degli utenti

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Utilità dei servizi culturalmente competenti

- Facilità la competenza culturale in contesti dominati da un approccio culturale troppo allargato (minoranze etniche di piccole dimensioni o sottogruppi di gruppi etnici estesi)
- Consente a tutti i servi di essere culturalmente competenti, non solo quelli specificamente dedicati

Competenza culturale e servizi psichiatrici

WPA guidance on mental health and mental health care in migrants

Dinesh Bhugra[1], Susham Gupta[2], Kamaldeep Bhui[3], Tom Craig[1], Nisha Dogra[4], J. David Ingleby[5], James Kirkb ride[6], Driss Moussaoui[7], James Nazroo[8], Adil Qureshi[9], Thomas Stompe[10], Rachel Tribe[11]

(World Psychiatry 2011;10:2-10)

Policy makers

- Clear policies taking into account human rights of migrants, refugees and asylum seekers should be developed.

- Adequate resources should be made available according to the needs.

- Adequate resources for training, including cultural competency training, should be available.

- Different parts of the government (e.g., health, education, justice, home, external affairs) should be involved.

- Changes in admission criteria should be discussed with stakeholders, rather than being imposed arbitrarily.

- Public education and public mental health messages for refugees, asylum seekers and migrants should be carried out.

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Service providers

- Separate or joined up services should be made available, but it is essential that there are no barriers to help seeking.

- Services should be culturally sensitive, geographically accessible and emotionally appropriate.

- Cultural competence training must be provided and mandatory measures to achieve this should be considered.

- Other models, such as culture broker or cultural liaison, should be employed where indicated.

- Regular research into epidemiological factors, along with qualitative approaches, should be carried out in order to assess and monitor pathology.

- Regular audits into treatment accessibility, acceptability and usage must be conducted.

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Clinicians

- Clinicians must have access to resources informing them of specific cultural issues.

- Cultural awareness and competence training must be mandated and regular updates must form a part of this.

- Clinicians must provide culturally appropriate services related to language and other needs of migrants, refugees and asylum seekers. Children, the elderly and other special groups must have their needs met.

- Clinicians may wish to discuss and develop specific services, either condition based (e.g., trauma) or gender based.

- Wherever possible, mental health issues of migrants, refugees and asylum seekers should be part of the curriculum and training of clinicians.

- Cultural training is everyone's business and must be a part of training other health professionals, including primary care professionals.

Competenza culturale e servizi psichiatrici

APA Official Actions

Resource Document on Cultural Psychiatry as a Specific Field of Study Relevant to the Assessment and Care of All Patients

Culturally Appropriate Services

According to Cross (2), five essential elements contribute to an agency‘s ability to become more culturally competent. The culturally competent system: 1) values diversity; 2) has the capacity for cultural selfassessment; 3) is conscious of the dynamics inherent when cultures interact; 4) has institutionalized cultural knowledge; and 5) has developed adaptations to diversity. Each of these five elements must function at every level of the agency. Attitudes, policies, and practices must be congruent within all levels of the agency.

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Culturally-competent services incorporate the concept of equal and non-discriminatory services, but go beyond that to include the concept of responsive services matched to the client population. Four service models frequently appear: 1) mainstream agencies providing outreach services to minorities; 2) mainstream agencies supporting services by minorities within minority communities; 3) agencies providing bilingual/bicultural services; and 4) minority agencies providing services to minorities.

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In designing services, the following should be considered: *the concept of least restrictive alternatives*; *community-based approaches with strong outreach components*; *strong interagency collaboration*, including natural helpers and community systems; *early intervention and prevention*; *assessment and treatment processes that define "normal" in the context of the client's culture*; developing *adequate cross-cultural communication skills*; *the case management approach as a primary service modality*; and the *use of home-based services.*

CONCLUSIONI

- I dati analizzati, pur con le considerazioni e i limiti evidenziati, mostrano un rapido aumento degli utenti provenienti da paesi a forte pressione migratoria
- Nonostante ciò è evidente che I bisogni di salute mentale non sono completamente soddisfatti e che la crescita numerica non è omogenea per le diverse provenienze etniche e tende a favorire dei pattern di utilizzo ospedaliero piuttosto che comunitario
- I dati esposti inducono a rilanciare la necessità di costruire percorsi formativi e organizzativi per rendere i servizi psichiatrici culturalmente competenti.

Grazie per l’attenzione

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