INTRODUCTION

The Compulsory Health Treatment (TSO) is an action applicable in case of justified need and clinic emergency, in presence of the refusal to Health Treatment Volunteer (TSV) in a subject suffering from specific illnesses, among which there are severe psychiatric illnesses. It’s widely discussed throughout the Country, since it violates – even if for a limited period of time (7 days, renewable and with the ability for the person to appeal it to the surveillance judge) – the free will of the Person. It’s a procedure justified by the impossibility of applying alternative practices that ensure a speedy recovery to the subject of his psychic integrity, consistent with the need of the person and her/his social-affective system.

The 4 CMHC (CSM) of the 4 catchment areas, in the system built by the Mental Health Department (MHD), have a direct responsibility in the proposal and management of the TSO. The Emergency Unit don’t have the task of a “take-in-charge” of the therapeutic plan, but acts for brief periods of time dealing with the competent CMHC.

The MHD has the goal to limit the use of the TSO tool, trying to shrink its use by strengthening the take-in-charge of the CMHC, facilitating the communication between the two institutions and promoting individual plans for each person while still admitted to the Emergency Unit.

MATERIAL AND METHODS

71 people were submitted to 74 TSOs in the Province of Trieste in the period 2011-2013. 22 were females, 49 were males. This retrospective study analysed gender, diagnosis (ICD-X), duration of TSO, frequency and variation of the number of TSO in the Province of Trieste during the years 2011, 2012 and 2013.

RESULTS

The number of people under TSO was the same in the three years, with a counterrtrend of gender (decrease of 30% of women; increase of 46% of men).

The number of days of TSO have decreased from 2011 (n=251) to 2012 (n=233), with a variation of -7.1%. These data has shown an inversion between 2012 and 2013 (n=334), with a new increase of 43.3%; the increase between 2011 and 2013 was 33%

Unevenly, in the observation period there’s been a decrease in the total number of days of TSO spent in one of the 4 CMHC (n=163 in 2011; n=140 in 2013, variation of – 14,1%), while this showed a strong increase for those days spent in the emergency Unit (2011 n=88, 2013 n=194, variation=120,4%).

CONCLUSIONS

During the observed period, among the considered diagnoses the F20-F29 ones have constantly been the most represented (2011 n=12, 67%; 2012 n= 24, 71%; 2013 n=22, 69%), while the range of diagnoses has been extended (no TSO in 2011 for psychic conditions related to drugs misuse, 9% in 2012 and 13% in 2013). A lower rate of appearance of mood disorders took place, showing a growing trend of psychopathological complexity.

A high prevalence of people under TSO with a F20-F29 diagnosis may explain why males are over-represented in 2012 and 2013. The rate of people under TSO in the province of Trieste is extremely low (0,01%), but the number of days of TSO admittance has grown in the period 2011-2013 (+33%), because of longer mean length of them. This may be caused by two factors: at first, more complicated psychopathological situations may have shown; in second hand, TSO’s role is to ensure a greater and truer participation of the subject, planning an individualized therapeutic path and having a strong, catchment CSM and Agencies’ take-in-charge of her/him.

More studies that could assess cultural and socio-demographic variables, CSM’s equipe and perceived sanitary, cultural and ethic value of TSO. A new study of the phenomenon of longer periods of TSO in the Emergency Unit should be done in the last period, where a new protocol has been applied.

It’s necessary to implement practices that promote good cooperation from the subject, to establish a contractuality which allows to limit TSO only for time strictly necessary.

BIBLIOGRAPHY

Law number 833/1978.