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The relationship between deinstitutionalization and quality of care in longer-term psychiatric and social care facilities in Europe: A cross-sectional study

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ABSTRACT

Background: The process of deinstitutionalization (community-based care) has been shown to be associated with better quality of life for those with longer-term mental health problems compared to long stay hospitals. This project aimed to investigate the relationship between national progress towards deinstitutionalization and (1) quality of longer-term mental health care (2) service users' ratings of that care in nine European countries.
Methods: Quality of care was assessed in 193 longer-term hospital- and community-based facilities in Bulgaria, Germany, Greece, Italy, the Netherlands, Poland, Portugal, Spain and the UK. Data on users' ratings of care were collected from 1579 users of these services. Country level variables were compiled from publicly available data. Multilevel models were fit to assess associations with quality of care and service user experiences of care.
Results: Significant positive associations were found between deinstitutionalization and (1) five of seven quality of care domains; and (2) service user autonomy. A 10% increase in expenditure was associated with projected clinically important improvements in quality of care.
Conclusions: Greater deinstitutionalization of mental health mental health services is associated with higher quality of care and better service user autonomy.

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1. Introduction

Deinstitutionalization is the movement of the locus of mental health care from hospitals to the community. It includes not only closing down mental hospitals but ensuring the availability of mental health services within the community to address service user needs through policy, legislation and human and financial resources. Evidence from the literature suggests that although mental health service users in receipt of community-based care show no significant difference in symptoms compared to those cared for in hospital [1], they are more likely to have better social relationships, higher quality of life [2], fewer needs [3] and better overall functioning [4] than those in hospital.

Although deinstitutionalization is a goal of many mental health policies, the majority of the world's psychiatric beds are still located in mental hospitals or other institutional settings [5,6]. Critiques of deinstitutionalization include high numbers of individuals with mental health problems who are homeless or incarcerated, cycle of discharge and readmission (the "revolving door") and instances of service user abuse and neglect in community-based settings [7].

Much of the evidence used to support or oppose deinstitutionalization have largely focused on comparisons of hospital and community facilities or the outcomes of service users relocated to the community following the closure of a large mental hospital. Large-scale, country level evaluations of the impact of deinstitutionalization are necessary to determine whether this type of

service configuration results in positive outcomes for service users. The aim of this study was to evaluate the relationship between the deinstitutionalization of mental health care at the country level and: (1) the quality of care provided in longer-term psychiatric and social care facilities; (2) service user ratings of this care.

2. Methods

2.1. Participants and procedures

Hospital and community-based residential facilities for people with longer-term mental health were recruited in ten European countries (Bulgaria, Czech Republic, Germany, Greece, Italy, the Netherlands, Poland, Portugal, Spain and the UK) participating in the development of a European measure of best practice for people with longer-term mental illness in institutional care (DEMoBinc) project [8]. Facilities providing care exclusively to specific subgroups of service users (e.g. older people, individuals with learning disabilities, forensic patients) were excluded. Facility managers participated in a face-to-face interview with a DEMoBinc researcher. Between 5 and 13 service users were randomly selected from each facility to complete a face-to-face research interview. Prior to participation, facility managers and service users provided written informed consent. Service users were excluded only if they were not present at the time of recruitment, lacked mental capacity to provide informed consent or were unable to complete the interview. A detailed description of the sampling process is provided by Killaspy et al. [8]. The DEMoBinc project was approved by the relevant ethics committee in each country.

2.2. Variables

Quality of care was assessed using the Quality Indicator for Rehabilitative Care (QuIRC) [9]. Quality scores for each of the seven domains assessed (Living Environment; Therapeutic Environment; Treatments and Interventions; Self-management and Autonomy; Social Interface; Human Rights; Recovery-based Practice) are presented as a percentage derived from the ratings from facility managers' responses to 88 items. Higher percentage scores indicate better quality of care in the relevant domain.

Service users' experiences of care were measured using standardised instruments of quality of life (Manchester Short Assessment of Quality of Life) [10], autonomy (Resident Choice Scale) [11], experiences of care (Your Treatment and Care) [12], and the therapeutic milieu of the facility (Good Milieu Index) [13]. For all measures, higher scores indicated a more positive experience of care. Demographic information including age, gender, diagnosis and date of admission, was also sought from the service user and corroborated from case notes.

The degree of deinstitutionalization in each country was determined using the Mental Health Services Deinstitutionalization Measure (MENDit) [14]. The MENDit consists of five items which assess the closure of mental hospitals, availability of mental health care in primary care settings, availability of community residential care, presence of a national mental health budget and numbers of mental health professionals. Each item has a maximum score of one and the sum of scores for all items provides the country's MENDit score (range: 0–5); higher scores indicate greater progress towards deinstitutionalization. The tool was developed to be completed using publicly available data. Scores for all countries were based on country reports published within the WHO Mental Health Atlas 2005, a regular report of existing mental health care legislation, policy and provision within United Nation member states [15]. Details of the development and items of the MENDit have been previously published by the authors [14].

Potential confounding variables (based on the findings of studies conducted in similar user groups and treatment settings) at both facility and country level were also measured.

Facility level variables were restricted to those collected as part of the DEMoBinc project. They included facility type (hospital or community residential mental health facilities), full-time equivalent (FTE) staff to service user ratio (above or below the sample mean) and whether the facility had an expected maximum length of stay (yes or no).

Country level variables were limited to publicly available data:

- we used country level data on stigma associated with schizophrenia from a pan-European study by Thornicroft et al. [16]. The Discrimination and Stigma Scale (DISC) is a 36-item scale scored from 0 to 32 where increasing scores indicate greater stigma related to schizophrenia;
- the number of years to 2011 (the year the analysis was conducted) since the introduction of mental health policy was obtained by country reports published in the WHO Mental Health Atlas 2005.

2.3. Statistical analysis

Multilevel models were used as they allow for effects attributed to data clustering at the facility and country levels to be taken into consideration when examining the variation between outcomes (Luke, 2004).

In order to examine the association between deinstitutionalization and the quality of care, four two-level models were developed:

- model A: QuIRC domain scores (living environment; therapeutic environment; treatments and interventions, self-management & autonomy; social interface; human rights; recovery-based practice) were included separately as dependent variables at the facility level (level 1). Progress towards deinstitutionalization was included as an independent, country level (level 2) variable;
- model B: the independent variables facility type, FTE staff to service user ratio and having an expected maximum length of stay were added to the model as level 1 fixed effects;
- model C: the degree of national stigma and the number of years since the introduction of mental health policies were added as fixed effect, independent variables to level 2 in model A;
- model D: both facility and country independent variables were added to model A as fixed effects.

Four, three-level models were developed to examine the association between deinstitutionalization and service user ratings of care:

- model E: the service user ratings of quality of life, autonomy, experiences of care and therapeutic milieu were included as dependent variables at the service user level (level 1). Deinstitutionalization score was included as a fixed effect at the country level (level 3);
- model F: the independent variables facility type, FTE staff to service user ratio and having an expected maximum length of stay were added to the model as facility level (level 2) fixed effects;
- model G: the degree of national stigma associated with schizophrenia and years since development of mental health policy were added to model E as level 3 fixed effect, independent variables;
- model H: both facility and country variables were added to model F as fixed effects.