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Community residential facilities in mental health services: A ten-year comparison in Lombardy

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ABSTRACT

Residential mental health services grew steadily since 2000 in Italy. A reorganisation of residential facilities was implemented in 2007 in Lombardy, introducing supported housing in addition to staffed facilities. We compare the provision and characteristics of residential facilities in the 2007 and 2016.

In 2007 there were 3462 beds (35.9/100,000 population) in 276 facilities. In 2016 beds were 4783 (47.8/100,000) in 520 facilities. The increase were unevenly distributed in the public and private sector, and the overall increase was due to a higher increase in the private sector. 72% of beds were in highly supervised facilities in 2007 and 66% in 2016.

The public sector managed more facilities with a rehabilitation goal, while the private sector more for long-term accommodation. Mean numbers of beds were higher in facilities managed by the private sector in both years.

The 2007 reorganisation and the stop to opening new facilities in the last years were not enough to correct the imbalance between highly supervised and flexible solutions. A wider and more diverse offer might have triggered off an increased demand, rather than a more rational use. Given the costs of highly staffed facilities, and the risk of reproducing custodial models, close evaluation of the use of residential facilities should inform policies.

1. Introduction

Mental health policies in most industrialized countries led in the last decades to the growth of a variety of community residential settings for people with mental disorders. Although the residences were originally developed to allow the discharge of long-stay patients from mental hospitals [1], they are now considered a key permanent component of mental health services [2]. Residence models, however, underwent considerable changes in last years and currently residences can serve a variety of functions: long-term care in alternative to mental hospitals [3], provision of time-limited rehabilitation services [4], accommodation for homeless with mental disorders [5], crisis intervention in alternative to acute inpatient admission [6], transition to independent life after short inpatient treatment [7], specialized setting for intensive treatment of some specific diagnostic groups, such as eating disorders [8] and borderline personality disorders [9], support to independent living for people with psychosocial disabilities [10]. It is worth noting that since the early 1990s supported or supportive housing has been presented as a model able to replace, at least to some extent, formal residential facilities [11].

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The picture of residential facilities is therefore quite complex and different mental health systems often present a mix of residential solutions for people with mental disorders, ranging from large traditional institutions to programs providing flexible need-led support to people living in their own accommodation. Moreover, it is well documented that in some countries a sizeable group of people with mental disorders are admitted to long-term residential care in settings for people with other types of disabilities, such as nursing homes, as shown by a recent analysis of the US mental health system [12]. Some authors went as far as to consider all residence models, including supported housing, as a new form of institutionalization, running the risk of reproducing some aspects of custodial care [13].

The development of a standardized methodology for residential facilities definition and classification encountered a number of difficulties, compounded by the fast pace of changes over time in residential models and organization. The World Health Organization Assessment Instrument for Mental Health Systems (AIMS) [14], introduced to gather valid and reliable information on care systems [15], defined residential services as non-hospital, community-based facilities, providing overnight residence to people with mental disorders, targeted to users with relatively stable mental conditions not requiring intensive medical interventions [14]. Under this heading a variety of settings were included: supervised housing; un-staffed group homes; group homes with residential or visiting staff; day staffed hostels; hostels and homes with day and night staff; halfway houses; therapeutic communities.

The European Service Mapping Schedule (ESMS), developed for measurement of service use [16], defined a residential service as a facility to provide beds overnight to patients for clinical and social management of their mental illness. Residential services were further divided into acute and non-acute, hospital and non-hospital. Seven categories of non-hospital residential services were identified: acute, non-acute time-limited (24-h support, daily support and lower support) and non-acute indefinite stay (24-h support, daily support and lower support).

However, notwithstanding remarkable efforts, the lack of international consensus on description of categories of residences in mental health care made comparison of service models a challenging task, not only across countries, but even across regions in the same country, thus hindering service research [17,18]. 'Community residential facility' is an umbrella term covering realities showing huge variations in goals, rules, size, location, staff level and characteristics, length of stay, environmental features, target population.

Few large scale surveys are available to provide information on this subject. A nationwide study assessed the provision of residential services in 2000 in Italy [19]. The authors identified 1370 residential facilities in the whole country, with a total of 17,138 beds (29.8 beds per 100,000 population), with marked variability between regions. The residences were small-sized (average 12.5 beds) and highly staffed. The low patients turnover showed a trend towards a long-stay. The closure of mental hospitals mandated by a law enacted in 1978 was then just completed [20]. The EPSILON study used the ESMS methodology to gather data on residential services in five areas of Netherlands, Denmark, England, Spain and Italy [21]. Huge variation in residential bed rates was observed from the highest rate of 250/100,000 in Denmark, to the lowest of 3.5 in Spain. No site offered the full range of residential solutions included in the ESMS schedule. The World Health Organization published in 2011 and 2014 information collected through AIMS about mental health services. Most countries, however, failed to provide data on residential services [22,23]. In Europe, only Austria, Finland, Greece, Iceland, Italy, Netherlands, Poland, Portugal, Slovakia and Slovenia reported data. Even this survey showed huge variations in bed rates, from the lowest in Portugal (6.3/100,000) to the highest in Slovakia (248.9/100,000). In a number of countries no residential facilities were available. The bed rate of 46.4 in Italy was considerably higher than the one found earlier in the previously mentioned nationwide survey, thus indicating a rise in the availability of residential facilities. An increase in residential bed occupancy has been subsequently reported in a number of European countries [13].

The sparse data available suggest that changes in the overall provision of residential services, probably coupled by an increase in their diversity, occurred in last years. However, few studies addressed this issue. Italy can provide a good standpoint for research on residential care for a number of reasons. First, as mentioned before, mental hospitals were closed in Italy more than fifteen years ago, thus leaving community residential facilities as the only setting for inpatient rehabilitation and long-term care. Second, available data on residential services in Italy were heavily influenced by the discharges of large numbers of mental hospital patients in the 1990s [24], and is therefore necessary to examine to what extent the system changed in relation to the characteristics of a population of users without a long experience of institutional life. Last, the facilities for people with mental disorders were included from the very beginning within the framework of the National Health Services and were therefore considered as health care facilities fully funded by the health budget and subject to a system of licence and registration. This allows their easy identification and classification [25]. In this paper we describe the evolution of the residential facilities network within the context of the largest Italian region over the last ten years.

2. Methods

Lombardy is the largest and the most affluent region in Italy, located in the North of the country. The Department of Mental Health (DMH) is the organization of the National Health Service providing in Lombardy, as in each region in Italy, mental health care to the population of a catchment area through a network of services, including outpatient clinics, outreach teams, hospital, day care and residential facilities. Care is delivered by multi-disciplinary teams led by consultant psychiatrists, and including doctors, psychologists, nurses, social workers, occupational therapists, rehabilitation counselors, auxiliary staff and, where available, peer-support workers. Each DMH should provide the