

Psychiatric RESidential care Communities: Upgrading and Enhancing skills and competences for member of staff professional qualification”

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RESEARCH AND CONTEXT ANALYSIS NATIONAL REPORT – ABSTRACT

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The National Health Service (Servizio Sanitario Nazionale, **SSN**) is divided into three levels. The Ministry of Health; The Health Funds (Fondo Sanitario Nazionale, FSN); The Regional Administrations. The operative level of the health services is the Local Health Units (Unitarie Sanitarie Locali, USL). Classified as public enterprises (Azienda Sanitaria Locale, **ASL**). The Department of Mental Health (Dipartimento di Salute Mentale - **DSM**) is the cornerstone of public psychiatric care in Italy. It includes all public psychiatric facilities for adults in each of the 226 ASL of the 21 Italian regional districts.

A parallel psychiatric care system under private clinic management is also in place. A general difference is made between Cooperativa Sociale (Social oriented Firms) Type A and Type B. Type B supports the vocational re-integration of disadvantaged persons (disabled, sufferers of mental illness, sufferers of drug addiction disorders, youths with behavioural disorders).

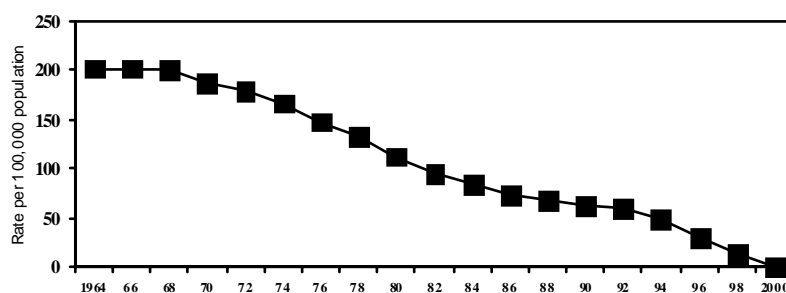
The social firms receive special tax reductions and the region authorities support the re-integration by way of a one-off payment to the co-operatives, with investments and through payments for material resources. In order to improve the working situations of disabled persons, public enterprises and private companies are obliged to occupy a minimum of 15% of all positions with “protected” employees.

The modern SSN was founded in 1978 (law. 833) and modeled on the British System. The reforms of 1992/1993 and 1999 effected a thorough decentralization of the Health Care Service. The political and financial responsibility was placed with the regional authorities, and the service providers and purchasers were granted more autonomy in the carrying out of their affairs.

An important movement of deinstitutionalization changed the situation during the period 1960-1978 (law 180/1978). The results have been a deep change in public attitudes. The main effects of that have been: 1) Prohibition of new admissions in Mental Hospitals; 2) Planning and building of new community based services, at a Regional level; 3) Dismantling of old Mental Hospitals; 4) Admission for acute care only in Psychiatric small wards in General Hospitals, for short-term periods.

Residents in Mental Hospital in Italy (1964-2000)

Rate per 100,000 population



In 1994-1996 the “**Progetto Obiettivo Tutela della salute mentale**” set as a priority the establishment of DSM in all the Local Health Units. The DSM structure is composed by: 1) Centres of Mental health (CSM); 2) Psichiatric Wards (SPDC); 3) Day hospitals and Day Centres (semi-residential facilities); 4) Residential facilities and Non Hospital Residential Facilities. The new “**Progetto Obiettivo Tutela della salute mentale (1998-2000)**” better defines

the DSM mission and focus on provision and response to severe mental diseases. It aims to the collaboration with family and user’s associations, NGOs, volunteers and other health and social services. The interventions also are aimed to: family’s involvement in the therapeutic/rehabilitation program; rehabilitation of severe users, so to reduce drop out and suicide’s rate; support the self-help groups and social oriented firms, especially that ones are aimed to the labor market enter; promote information toward the people about the severe mental diseases, aimed to reduce prejudice and increase solidarity.

Fig. 1 DSM organization

(Fonts: “Rilevazione 2001 del Personale e Strutture dei Dipartimenti di Salute Mentale” - Direzione Generale della Prevenzione Ufficio XI).

<p><i>Mental Health Centers and out-patients ambulatory</i></p> <p>OUT-PATIENT TREATMENT, HOME CARE AND COUNSELING</p>	<p><i>Psychiatric Wards and Day hospital</i></p> <p>In-patient treatment and care</p>
<p><i>Day Centers</i></p> <p>Social and rehabilitative treatments in semi-residential</p>	<p><i>Residential and Non-Residential facilities</i></p> <p>Therapeutic and rehabilitative treatments (subdivided in 3 typologies: 24h; 12h; less)</p>

The staff employed in DSM can be subdivided in two categories: 1) the first one includes all the vocational profiles foreseen by the Progetto obiettivo "Tutela della salute mentale" 1998-2000; 2) the second one refers to a wide variety of vocational profiles that are involved in the DSM.

Grafico 1 - Personale dei Dipartimenti di Salute Mentale a livello nazionale, 2001

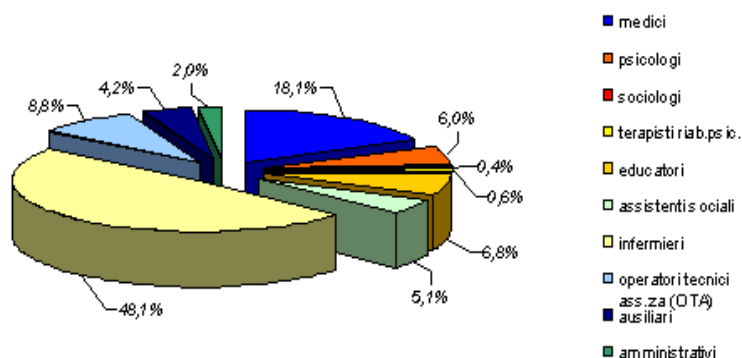
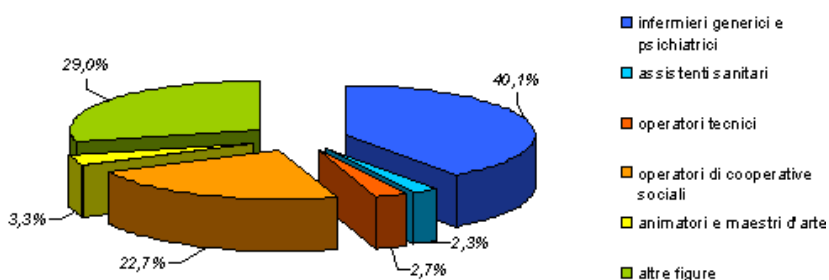


Grafico 2 - Altro personale dei Dipartimenti di Salute Mentale a livello nazionale, 2001



The total amount 34.446 workers, whose 30.711 belonging to the first group, 3.735 to the group "others". The rate is 0.80 per 1.500 inhabitants. This is lower than "Progetto obiettivo" standard (1/1.500), but it increased from 1998 (0.75). The voice "Other" (3.735 workers) is subdivided as follows: 1.496 generic nurses, (40,1%); 85 health assistants (2,3%); 99 technical workers (2,7%); 846 Social firms workers (22,7%); 125 entertainment organizer and art masters (3,3%); 1.084 others (29%).

Less or any information is available about the staff

Fonte: Ministero Salute, D.D.G.G. Prevenzione e Sistemi a Informativo e Statistico, rilevazione 30 giugno 2001
Elaborazione: C.Giordani, Redazione Ministerosalute.it - dicembre 2002

employed by private and social firms.

In accordance with the outcomes of the PROGRESS research the quantitative staff increase is not always correlated to best rehabilitative and treatment outcomes (especially when the staff lacks specific training). Professional nurses and generic health workers form the greater part of the staff. Several achieved a good level of competencies through the direct work experiences into the psychiatric services and often thought the updating courses promoted by the services themselves. Unfortunately, the PROGRESS research pointed out that the staff is often under-qualified. Also, the vocational profiles that should warrant the best performances in the psychosocial intervention are lacking: in fact, most of the residential facilities do not have in their staff any psychologist, neither psychiatric rehabilitation worker, even part-time.