

Psycho RES.C.U.E

Psychiatric RESidential Care communities
Upgrading and Enhancing skills and competences for
operators professional qualification

Dott. Antonio G. Maone



LEONARDO DA VINCI Programme II PHASE 2000-2006

Il progetto è stato finanziato con il sostegno della Comunità Europea.
Il contenuto del presente progetto non riflette necessariamente
la posizione della Comunità Europea o dell' Agenzia Nazionale
e non impegna in alcun modo la loro responsabilità.



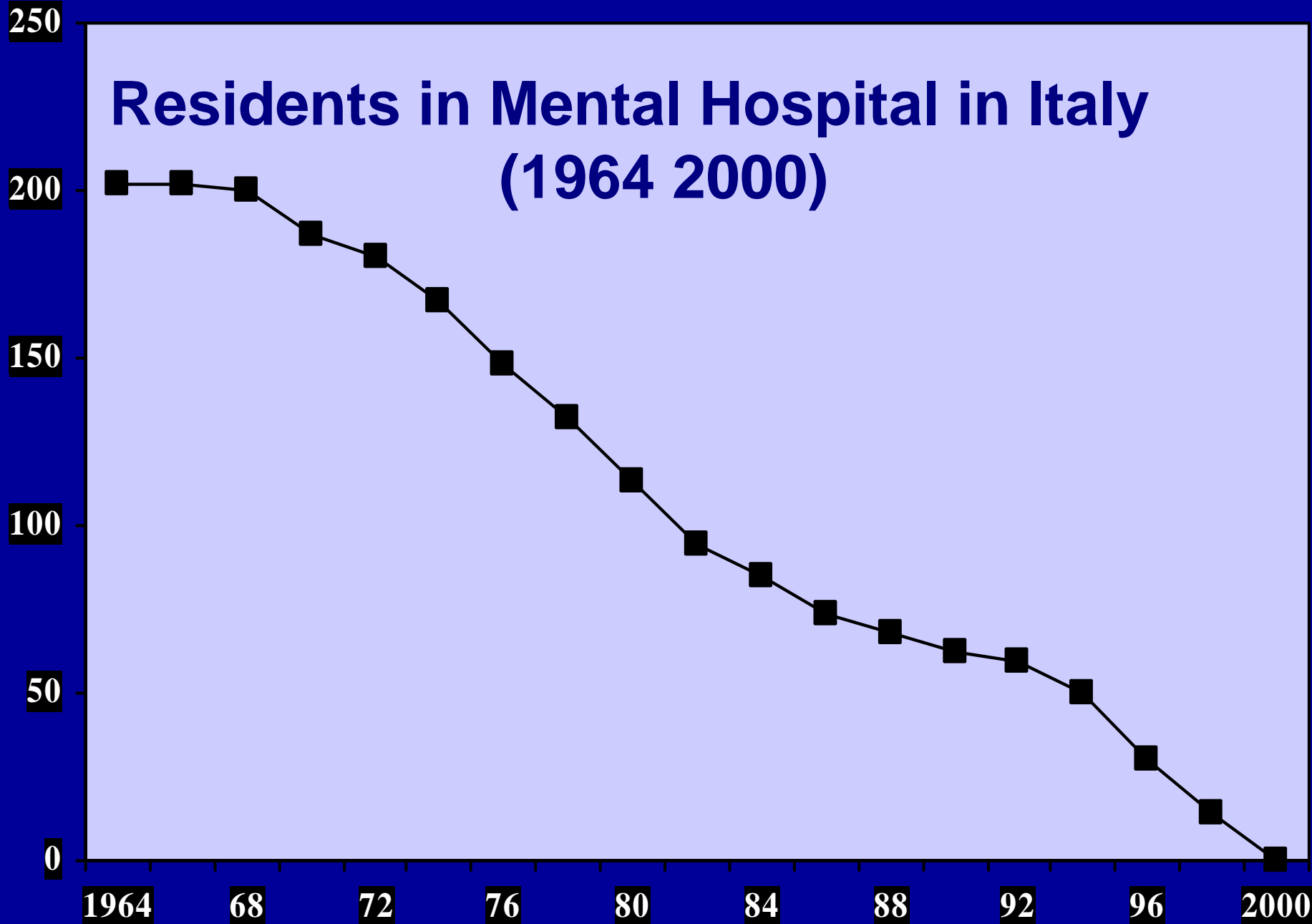
Competences of Community Facilities' Staff. A Mental Health System's Point of View

Partner:
Department of Mental Health,
Local Health Unit "Roma/A"

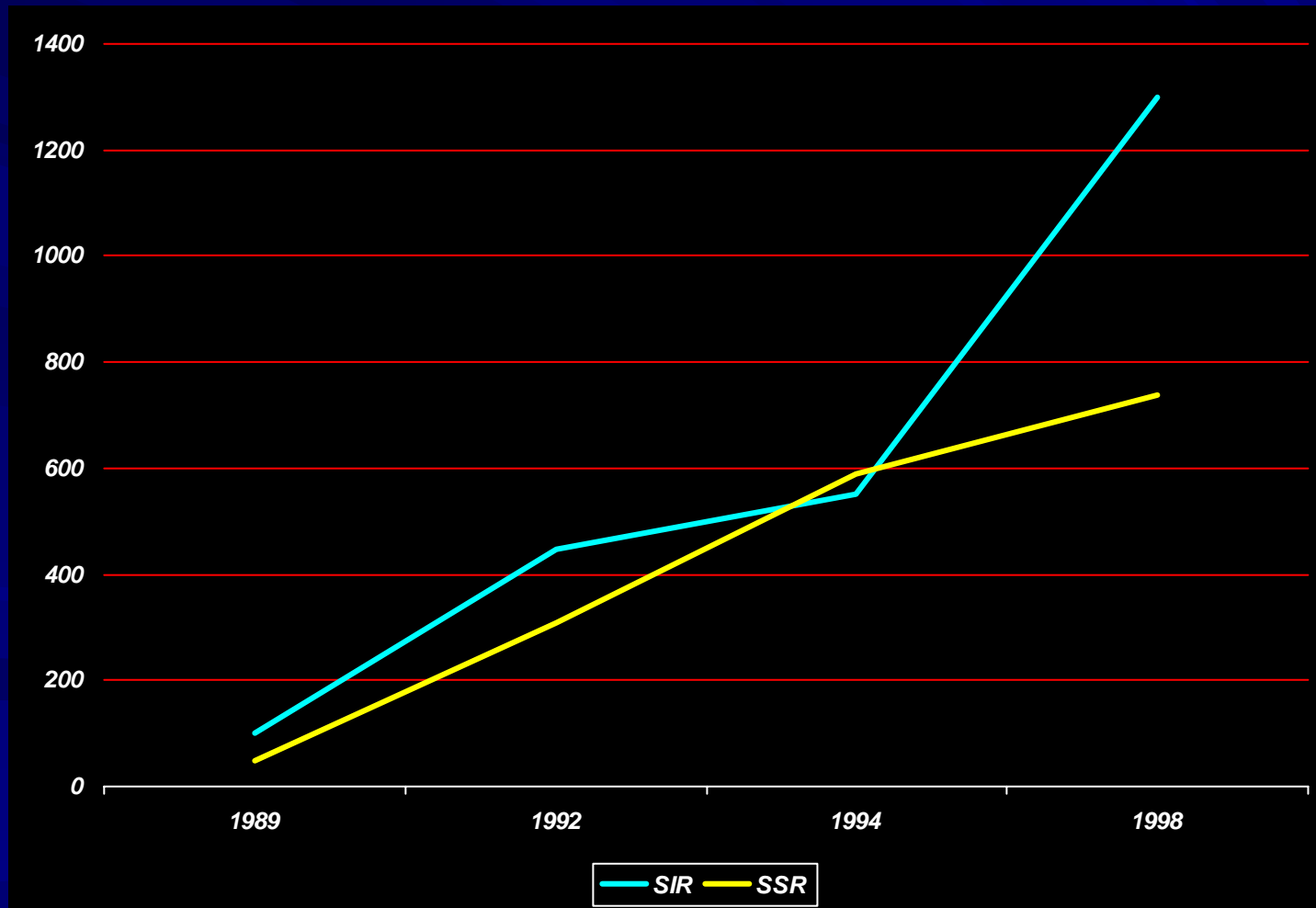
Rome, Italy *Dr. Antonio Maone, psychiatrist*

Rome, January 12 2006

Residents in Mental Hospital in Italy (1964 2000)



Intermediate Facilities in Italy (1989-1998)



Type of Intermediate Facilities in Italy

■ Nonhospital Residential Facilities

Therapeutic and Rehabilitative Communities
(24 h cover)

Group Homes, supervised apartments, ecc.
(<12 h cover)

• Day Centres

Staff in Intermediate Facilities

■ Psychiatrists	8.2
■ Psychologists	5.0
■ Nurses	50,3
■ Psychiatric rehabilitation Therapists	1.6
■ Occupational therapists	11.2
■ Socialworkers	4.4
■ Other qualified personnel	9.7
■ Other non-qualified personnel	9.6
■ Total full-time staff	60.2

Nurses are the most frequent

Nurses are not always trained for specific skills in mental health field

Staff-resident interactions

- Strong relationship between high levels of (high quality) staff-resident interaction and resident satisfaction (Shepherd *et al.*, 1996)
- What constitutes 'high quality' staff-resident interactions? Concept of 'Lo EE' staff (Ball, Moore & Kuipers, 1992).
- Strong relationship between good leadership and perceived autonomy and high levels of interaction (King, Raynes & Tizard, 1972)
- Hence: (a) select and train 'good' staff; (b) develop and support 'good' leaders Shepherd (2005)

“Good Staff”

- We need to make clear what “good interactions” and “good leadership” constitute:

“Staff in the community units would have attitudes that were **more client orientated** in management practices,

Would be **more optimistic** about client outcome,
and

Would feel **more involved** in the running of the unit than hospital staff” (Garety & Morris, 1984, Allen et al, 1989)

“Good Staff”

“Staff in the community settings would have **higher levels of interactions with their clients**, and these would be a **personal**, rather than an administrative **nature** compared with hospital staff” (*ibid*)

Staff in community facilities would use best practices.

Changing models of residential care in the community

- From small, 'institutions in the community' to integrated, 'mainstream' community housing
- From segregated, 'special housing', with staff on site (group homes, hostels, etc.) to ordinary housing, with flexible support, delivered as required
- From specialist 'clinical' providers (i.e. hospitals) to specialist housing providers
- From an emphasis on 'selection' and 'throughput' to an emphasis on 'choice' and 'security'

(Shepherd, 2005)

New Paradigm of Supported Housing

- Only by disentangling housing from services will it be possible to create a system in which services are designed to support the person in housing instead of developing housing programs to facilitate treatment or services (Hogan, 1996)

New Paradigm of Supported Housing

- Housing would be viewed as a place to live, not a place to be treated (Carling, 1993)

Changing models of residential care in the community

- Hence, we need to make clear competences and skills for the new trends in residential care and supported housing