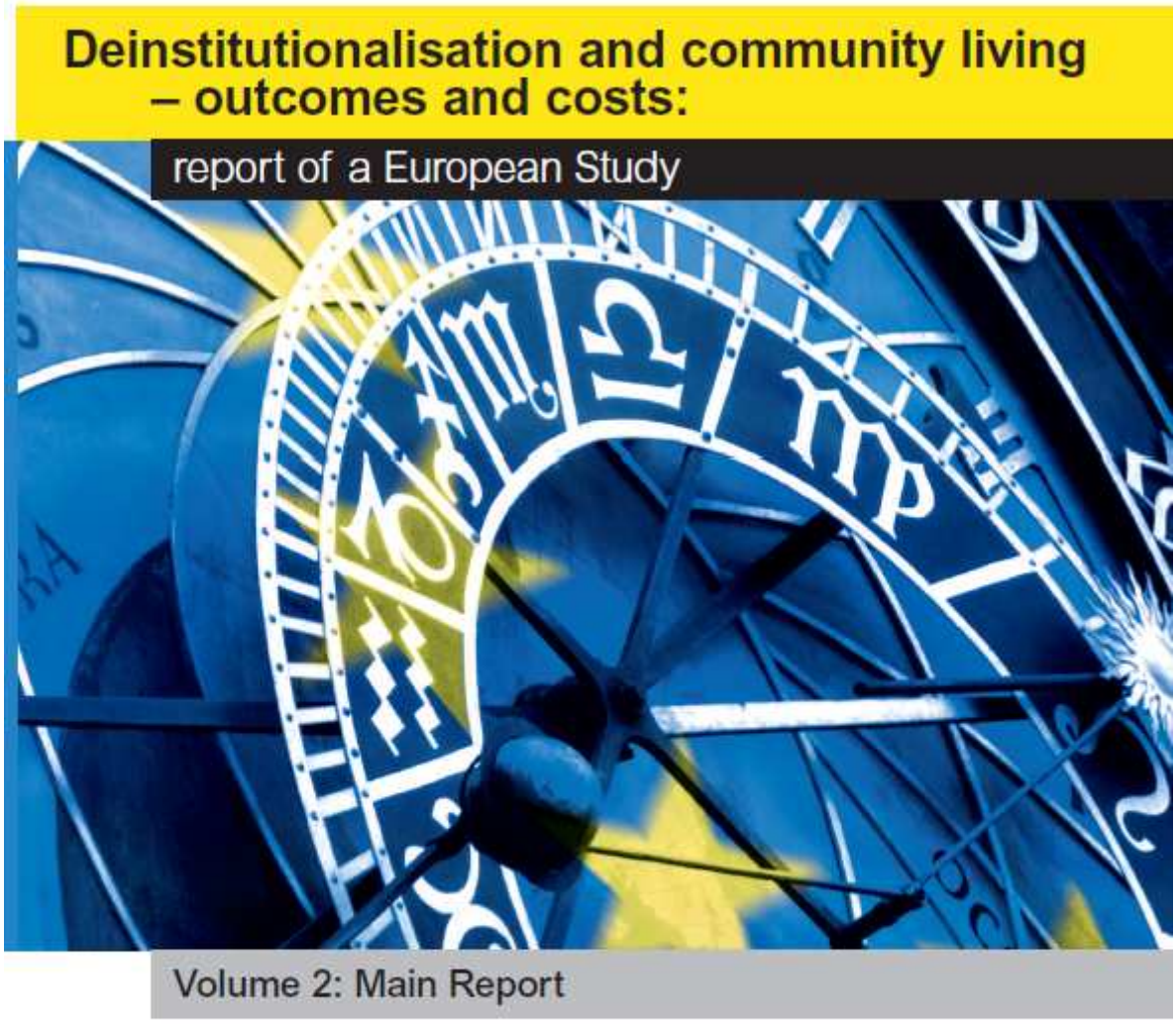
SERVICE DEVELOPMENT IN ITALY

Abstract from:



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Italy

The main area of service development in Italy has been the reform of mental health services. In 1978, Law 180 legislated for the closure of psychiatric hospitals, a network of new mental health facilities on a regional basis, with the person at the centre of care. The prohibition of new admissions led to a decrease in hospital beds from 60,000 in 1978 to 2,500 in 1998. New mental health structures were created including outpatient clinics, new departments in general hospitals, mental health centres, and residential settings designed to provide differentiated kinds of treatment aimed at reducing the need for hospitalisation, and reducing the duration of time spent in treatment. The last 15,000 patients living in the 57 mental hospitals are officially resettled to residential facilities and family groups (1992). However, some hospitals remain partially open and district-based services have been slow to develop. Three general patterns seem to be emerging regarding the pace and spread of reforms, although there has been increased momentum in recent years:

- In small/medium sized towns in the north and centre – full implementation of reforms
- In large urban areas – new community-based services, but no running down of existing facilities: diversification of services, little co-ordination
- In the south – no change, little reform[19].

The administrative decentralisation of Italy favoured local initiatives but provided an obstacle to the implementation of the new law – at local and regional level, partly due to the politicised situation, it was difficult to agree national standards. The wide disparities in resources, levels of institutional provision, professional staffing, degrees of dependency on charity or private initiatives, political cultures between North to Centre to South and the islands of Sicily and Sardinia make it hard to judge the full impact. For example of the 95 provinces in Italy, only 52 were directly responsible in 1979 for managing all psychiatric services in their area – the others depended on varying degrees on contracting out of services to, in particular, Church-sponsored psychiatric hospitals[19]. Most of the provinces dependent upon the private sector are concentrated in the South and Lazio, the region around Roma.

The trend of decline in hospital numbers began before 1978; the Law then accelerated the fall. By 1983 there were about 43,000 beds (76 per 100,000) from a peak in 20 years earlier of 98,000. With a decline in public beds there has not been a corresponding rise in private beds, which have declined from 26,000 in 1972. Private beds continue to play a role, especially in the South and Lazio region.

The new in-patient facilities were small 15-bedded units in general hospitals. As of 1984 there were 236 units with just over 3000 beds (5.5/100,000 population). There was a great deal of variation in the level of provision across different regions ranging from high rates in the Veneto region (11 beds per 100,000) to Lazio (1.4:100,000). This might conceal either poor implementation or general scarcity of facilities (as in Roma) or a well-developed network of community services that were working well and required little in-patient facilities (Emilia–Romagna).

Residential facilities largely replaced mental hospitals for long-term residential care of people with mental health problems. These include boarding houses, halfway houses, unsupervised hostels or apartments and intermediate facilities. Referrals are made by local departments of mental health that pay for residential care. There is only limited information about the characteristics of these facilities, the environment and staff[20]. These services usually have a home-like atmosphere, but restrict the behaviour of clients. Length of stay is indefinite and turnover is low. In 2000, there were 1,370 services with four or more beds in Italy, with 117,138 residents at a ratio of 29 per 100,000 population. Half had been set up between 1997-2000 and large proportions were privately owned (although all expenses were covered by the National Health Service). The amount of residential provision varied tenfold between the regions. Most have 24 hour staffing, although a substantial proportion of staff had no specific mental health training. Services located in the northern regions tend to be less restrictive and often cluster style. They are not supposed to have more than 20 beds, although 16 (5.7%) did and one had 60 beds. Private facilities had a higher number of beds than state –provided services (ratios 14.9:11.6).

A random sample of 265 psychiatric residential services[21] found that most were independent buildings located in urban or suburban areas. The median number of residents was 10. Those with more than 20 beds have a higher rate of drop-outs and absconding. Usually there are two residents to a bedroom with an average of one bathroom for 2.5 residents. Most establishments have two or more common rooms, although less than half had a private room where residents could meet visitors. Only two thirds prepare all meals inside the facility, the remainder use a catering service. More than half had architectural barriers that made it difficult for physically disabled residents. Most facilities have a garden and are located within walking distance of shopping centres or recreational facilities, though in 30% of services residents were not allowed out alone. 75% have 24 hour staff coverage.