

UNIVERSITÀ DEGLI STUDI DI VERONA

DIPARTIMENTO DI SANITÀ PUBBLICA E MEDICINA DI COMUNITÀ
SCUOLA DI DOTTORATO DI SCIENZE, INGEGNERIA, MEDICINA
DOTTORATO DI RICERCA IN SCIENZE PSICOLOGICHE E PSICHIATRICHE
CICLO XXVII / 2012

PhD Thesis

QUALITY ASSESSMENT OF MENTAL HEALTH AND SOCIAL CARE SERVICES

FINDINGS FROM THE EUROPEAN REFINEMENT PROJECT AND AN ITALIAN
MULTICENTRE STUDY

S.S.D. MED/25

Coordinator: Prof.ssa Mirella Ruggeri

Tutor: Prof. Francesco Amaddeo

PhD candidate: Dott.ssa Gaia Cetrano

ACKNOWLEDGMENTS

I wish to express my grateful thanks to my supervisor, Professor Francesco Amaddeo, for his expert guidance and advice through the PhD process. Special thanks are also given to Professor Giorgio Gosetti, with whom a fruitful collaboration in developing one of the research projects in the thesis was developed. I would also like to thank colleague Laura Rabbi: from the very beginning of this work, she has provided me with invaluable support. Many thanks to Dr Federico Tedeschi for his precious help with statistics and to all members of the Research Unit Psychiatric Register, Economics and Geography of Mental Health for their friendly support. A special thanks to the Social Care Workforce Research Unit at King's College London for hosting my visiting research in 2014. Especially, I would like to thank Professor Jill Manthorpe, the Unit director, and Jess Harris, who provided brilliant comments and suggestions on an earlier version of the thesis.

INDEX

ACKNOWLEDGMENTS	3
INDEX	5
LIST OF TABLES.....	7
LIST OF FIGURES.....	8
INTRODUCTION	9
1. RESEARCH BACKGROUND	13
1.1 POLICY AND ORGANIZATIONAL CONTEXT	14
1.1.1 <i>Mental health care system</i>	14
1.1.2 <i>Welfare state and social services</i>	16
1.2 MENTAL HEALTH SOCIAL CARE AND SOCIAL WORK.....	20
1.2.1 <i>What are social care and social work</i>	20
1.2.2 <i>The role of the social worker in adult mental health services</i>	21
1.2.3 <i>Challenges and future perspectives for mental health social work</i>	22
1.3 EXPLORING THE QUALITY OF MENTAL HEALTH CARE.....	24
1.3.1 <i>Preliminary remarks: definitions of quality of care</i>	24
1.3.2 <i>Measuring the quality of mental health care: why and how?</i>	26
1.3.3 <i>Key elements of quality of mental health care: staff wellbeing and quality of working life</i>	30
1.4 MEASURING QUALITY IN SOCIAL CARE SERVICES	34
1.4.1 <i>What are the challenges for measuring the quality of social care?</i>	34
1.4.2 <i>What is high quality social care?</i>	35
1.4.3 <i>Measuring social care outcomes</i>	36
2. METHODOLOGY	40
2.1 OBJECTIVES	40
2.2 THE EUROPEAN REFINEMENT PROJECT.....	41
2.2.1 <i>Areas of study</i>	42
2.2.2 <i>Mapping of mental health and social care services</i>	44
2.2.3 <i>Literature review on quality of mental health and social care services</i>	50
2.3 THE ITALIAN MULTICENTRE STUDY	53
2.3.1 <i>Areas of study</i>	53
2.3.2 <i>Overview of methods and instruments</i>	55
2.3.3 <i>Survey on quality of professional life</i>	55
2.3.4 <i>Interviews with service users</i>	58
2.3.5 <i>Analysis of data from Mental Health Information Systems</i>	63
2.3.6 <i>Ethical approval</i>	64
3. THE REFINEMENT PROJECT	66
3.1 MENTAL HEALTH CARE PROVISION IN EIGHT EUROPEAN STUDY AREAS.....	66
3.1.1 <i>A new taxonomy to analyze health vs. non-health care services</i>	69
3.1.2 <i>Discussion</i>	74
3.2 QUALITY OF MENTAL HEALTH AND SOCIAL CARE SERVICES.....	78
3.2.1 <i>Literature review on quality of mental health and social care</i>	78
3.2.2 <i>The REFINEMENT Quality of Care Tool - REQUALIT</i>	82
3.2.3 <i>Examples of social care quality indicators</i>	84
3.2.4 <i>Discussion</i>	90

4.	THE ITALIAN MULTICENTRE STUDY: THE QUALITY OF PROFESSIONAL LIFE	95
4.1	AREAS OF STUDY	95
4.2	PROFILE OF MENTAL HEALTH STAFF	101
4.3	INDICATORS OF QUALITY OF WORKING LIFE	105
4.4	UNIVARIATE ANALYSIS: FACTORS ASSOCIATED WITH COMPASSION SATISFACTION, COMPASSION FATIGUE, AND BURNOUT	109
4.4.1	<i>Mean values of CS, CF, and BO.....</i>	<i>109</i>
4.4.2	<i>CS, CF, and BO scores above cut-off points</i>	<i>115</i>
4.4.3	<i>Correlations between quality of working life indicators and CS, CF, and BO</i>	<i>123</i>
4.5	MULTIVARIATE ANALYSIS: PREDICTORS OF COMPASSION SATISFACTION, COMPASSION FATIGUE, AND BURNOUT.....	126
4.6	DISCUSSION	129
5.	THE ITALIAN MULTICENTRE STUDY: QUALITY FROM THE PERSPECTIVE OF SERVICE USERS.....	135
5.1	SOCIO-DEMOGRAPHIC PROFILE OF SERVICE USERS	135
5.2	UTILIZATION OF MENTAL HEALTH AND SOCIAL SERVICES	139
5.3	SERVICE USERS' PERSPECTIVES ON CONTINUITY OF CARE	143
5.3.1	<i>Importance, experience and satisfaction with continuity of care</i>	<i>143</i>
5.3.2	<i>Correlations between importance, experience and satisfaction</i>	<i>146</i>
5.4	SOCIAL CARE RELATED QUALITY OF LIFE.....	147
5.5	CORRELATIONS BETWEEN CONTINU-UM AND ASCOT SCORES.....	152
5.6	PREDICTORS OF CONTINU-UM AND ASCOT SCORES.....	153
5.7	DISCUSSION	156
	CONCLUSIONS.....	161
	BIBLIOGRAPHY.....	165
	APPENDICES.....	I
	APPENDIX 1: PROQOL III QUESTIONNAIRE.....	I
	APPENDIX 2: QUALITY OF WORKING LIFE QUESTIONNAIRE	III
	APPENDIX 3: SOCIO-DEMOGRAPHIC INFORMATION SHEET	XI
	APPENDIX 4: CONTINU-UM QUESTIONNAIRE	XV
	APPENDIX 5: ASCOT INT-4 QUESTIONNAIRE	XXVI
	APPENDIX 6: DATA FROM MENTAL HEALTH INFORMATION SYSTEMS	XXXVII

LIST OF TABLES

Table 1. Quality of working life: Framework of analysis	33
Table 2. REFINEMENT project work packages.....	42
Table 3. Study areas of eight REFINEMENT project countries	43
Table 4. REMAST: Content and data sources	44
Table 5. Units of analysis used in DESDE-LTC	49
Table 6. Literature review on quality of mental health care: Search terms	50
Table 7. Literature review: Exclusion and inclusion criteria	51
Table 8. Methods and instruments adopted in the Multicentre study	55
Table 9. Instruments and variables collected during interviews with service users	62
Table 10. Mapping of mental health services in eight European study areas	68
Table 11. Taxonomy of health and non-health care services	71
Table 12. Staff in health and non-health care services per 100,000 capita (18+ years)	73
Table 13. Provision of residential services in REFINEMENT study areas.....	74
Table 14. REFINEMENT project: Results of grey literature search	79
Table 15. REQUALIT: Summary of main topics/indicators.....	84
Table 16. Indicators of quality of social care included in REQUALIT	85
Table 17. Employment legislation in the REFINEMENT countries.....	88
Table 18. Multicentre study: Socio-demographic characteristics of the three areas	95
Table 19. Staff, users treated, and activities delivered in the three centres.....	100
Table 20. Staff survey: Response rates in the three centres	101
Table 21. Multicentre study: Socio-demographic profile of mental health staff	102
Table 22. Multicentre study: Occupational characteristics of mental health staff	104
Table 23. Staff variables included in the Multicentre study.....	105
Table 24. Indicators of quality of working life	106
Table 25. Mean values of CS, CF, and BO among mental health staff.....	112
Table 26. Mental health staff scoring above cut-offs in CS, CF, and BO	117
Table 27. Staff scoring above and below cut-offs in CS, CF, and BO (continuous variables)	122
Table 28. Correlations between indicators of quality of working life and CS, CF, and BO	125
Table 29. Stepwise regression analysis using CS score as dependent variable	127
Table 30. Stepwise regression analysis using CF score as dependent variable	128
Table 31. Stepwise regression analysis using BO score as dependent variable	128
Table 32. Multicentre study: Socio-demographic characteristics of service users	137
Table 33. Socio-demographic characteristics of service users (continued)	138
Table 34. Utilization of mental health services by service users in previous 12 months	139
Table 35. Utilization of mental health services in previous 12 months (continued)	141
Table 36. Utilization of health and social services in previous 12 months	142
Table 37. CONTINU-UM: Importance descriptive statistics	144
Table 38. CONTINU-UM: Experience descriptive statistics	145
Table 39. CONTINU-UM: Satisfaction descriptive statistics	145
Table 40. Correlations between CONTINU-UM items.....	146
Table 41. Definitions of ASCOT scores	147
Table 42. Multicentre study: Overall ASCOT scores (weighted).....	150
Table 43. Correlations between CONTINU-UM and ASCOT scores	152

LIST OF FIGURES

Figure 1. DESDE-LTC Mapping tree	46
Figure 2. Geographical location of selected areas in the Multicentre study	54
Figure 3. Health vs. non health care services in the REFINEMENT study areas	70
Figure 4. Collection and screening of quality indicators in the REFINEMENT project	81
Figure 5. Social workers in mental health services of REFINEMENT study areas.....	87
Figure 6. Geographical location of Lecco MHD	96
Figure 7. Geographical location of Legnago MHD	97
Figure 8. Geographical location of South Verona CMHS.....	98
Figure 9. Social care related quality of life (unweighted)	150
Figure 10. Current SCRQoL by domain (unweighted)	151
Figure 11. Expected SCRQoL by domain (unweighted).....	151

INTRODUCTION

The last two decades have witnessed an increasing emphasis on performance and quality assessment of health and social care services. Understanding how mental health systems are designed and how they can best function has become especially crucial, given the impact of poor mental health on the morbidity of the population, as measured by the WHO Global Burden of Disease (GBD). Recent studies showed that worldwide mental health and substance abuse disorders accounted for 7.4% of total disease burden, making mental health and substance use disorders the fifth leading disorder category of Disability Adjusted Life Years (DALYs) (Whiteford *et al.*, 2013). Moreover, mental health remains a key health policy priority, as demonstrated by the attention the World Health Organization (WHO) has paid to mental health issues in a range of background policy documents (WHO, 2003, 2009, 2013a). Despite this, worldwide many individuals with mental health problems remain untreated although effective treatments exist. In many lower and middle-income countries, three-quarters of people with mental health problems do not have access to mainstream mental health services. Even in developed countries, the figure ranges from 35% to 50% (WHO, 2013a). Moreover, research studies have documented wide variations in the quality of care, including gaps between clinical practice and evidence-based guideline recommendations (Hermann *et al.*, 2006; Ruggeri *et al.*, 2008). For such reasons, the issue of performance and quality assessment of mental health care systems is crucial. One prerequisite to better delivery of mental health services is the systematic and standardized collection of information to describe and assess the performance of mental health systems.

This thesis is developed within the context illustrated above, the overarching aim being the development of a framework to analyse the quality of mental health and social care services from different perspectives covering the quality domains of input, process and outcome.

Social care and its interfaces with mental health care is given special emphasis since mental health services are not solely funded and delivered within the health care system, being carried out also by other organizations, such as social services, education, employment, judicial, and housing services (Jacobs & McDaid, 2009).

In the last decade, with the spread of the concept of ‘recovery-oriented’ approaches in mental health, the relevance of social care provided to users with mental health problems has become crucial. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the adverse effects of mental illness (Anthony, 1993). This means helping each person to live well and to achieve their individual recovery goals - getting a job, making new friends, or learning a new skill, for example. Since social care plays a key role in supporting personal recovery, it is important to develop a methodology to assess the quality, and the outcomes, of social care interventions. However, the contribution of social science in general and social care research in particular is very limited compared with the volume of research undertaken within medical psychiatry. This imbalance contributes to the disparities between the two disciplines, resulting in much more influence played by the medical counterpart. Moreover, development of social care research in mental health is needed for a number of reasons. Through research the social work profession can evaluate the effectiveness of social care services in meeting people’s needs, demonstrate the benefits of social services, assess the needs and resources of people in their environments, and advance professional education in light of changing contexts for practice. Another aim of this thesis is therefore to enhance the contribution of social care to mental health research knowledge and thus develop a scientific methodology to approach mental health social care issues.

The first chapter illustrates the research background of this thesis. The core questions that led the development of the research objectives are addressed. The definition of ‘quality of care’ is explored in order to further analyse the state of art in quality and performance assessment of

mental health services internationally. Moreover, since the focus of this thesis is on mental health social care, the role of social care provided to people with mental health problems is described. Specific emphasis is given to the definition of quality of social care and to social care outcomes as a key area of quality assessment.

The second chapter specifies the thesis objectives and defines the methods applied to achieve them. The methodology of two different research projects is illustrated: an EU funded Project (REFINEMENT) and an Italian multicentre study.

The third chapter illustrates the major findings of the REFINEMENT project: the results of a mapping analysis of mental health and social care services in eight European study areas. Additionally, the results of a literature review on quality of mental health and social care are presented.

Finally, the results of the Italian Multicentre study are illustrated in chapters four and five. Chapter four discusses findings of the survey on quality of professional life, while chapter five illustrates findings of interviews with service users in order to appraise their experiences of continuity of care and perceptions of social care related quality of life.

It should be noted that the focus of this thesis is on the working age adult population, thus services targeted at children, adolescents and elderly people are not considered here. Furthermore, especially in chapter one there is mention of services' organization in England and references to literature from the same area. This is because a substantial number of publications, especially on social care, come from the Anglo-Saxon context. In addition, the present author accessed such literature and explored mental health services in England during a seven month visiting scholarship in 2014 at the Social Care Workforce Research Unit, at King's College London.

1. RESEARCH BACKGROUND

In this first chapter, the core questions that led the development of the research objectives of this thesis will be addressed. In order to contextualize the research project, the policy and organizational features of both mental health and social services in Italy will be initially discussed (Section 1.1). The aim of this section is to describe the major developments of mental health and welfare policies in order to appraise the current situation and contextualize the circumstances in which the assessment of quality - which is the objective of this thesis - takes place. The definitions of social care and social work will be provided in Section 1.2, with a specific emphasis on the role of the social worker within adult mental health services. In Section 1.3 the definition of 'quality of care' will be explored in order to further analyse the state of art in quality and performance assessment of mental health services internationally. Finally, since the focus of this thesis is on mental health social care, specific emphasis will be given to the definition of quality of social care, the challenges of measuring it, and the different actors involved in the process of quality assessment (Section 1.4). In the same section, specific attention will be dedicated to social care outcomes as a key area of quality assessment.

1.1 POLICY AND ORGANIZATIONAL CONTEXT

1.1.1 Mental health care system

Mental health care in Italy was radically reformed in 1978 by the so called ‘Law 180’. This reform law was a milestone in transforming mental health care from a hospital-based model to one of community psychiatry. The main principle of Law 180 was that people with mental health problems have the right to be equally treated as patients with other diseases and only voluntary treatment is allowed, with compulsory treatments being exceptional and strictly regulated (Amaddeo *et al.*, 2012). The Law enabled the closure of long stay mental hospitals and their replacement with a new network of community-based mental health services. Hospitalisation, both voluntary and compulsory, hereafter had to take place in small acute psychiatric wards with a maximum 15 beds, located in General Hospital Psychiatric Units (GHPUs). This new system was set up to promote prevention, care and rehabilitation of people with mental health problems in an integrated and comprehensive way. In addition to the reforms in the acute sector, reformed mental health services were to be located within the community and in geographically defined catchment areas in order to assure accessibility and continuity of care (Piccinelli *et al.*, 2002).

Later in 1978 the reform law was incorporated into more comprehensive legislation establishing the National Health Service (NHS). Currently, the NHS is organized through 21 Regional Health Authorities (RHAs) and approximately 200 Local Health Authorities (LHAs), which serve defined geographical areas, ranging from approximately 200,000 to 800,000 populations (Fioritti & Amaddeo, 2014). Together, they are responsible for ensuring the delivery of healthcare services through a composite system of public and private accredited hospitals and other facilities. Each LHA has a Mental Health Department (MHD), which is in charge of the planning and management of all medical and social resources

related to prevention, treatment, and rehabilitation in mental health within a defined catchment area (Lo Scalzo *et al.*, 2009). Although current regional disparities are marked, the minimum set of services required by national policy regulations is available in all regions and includes:

- Community Mental Health Centres (CMHCs);
- Day-hospital/daycare rehabilitation centres;
- General Hospital Psychiatric Units (GHPUs); and
- Non-hospital, residential, medium- and long- term facilities (Fioritti & Amaddeo, 2014).

However, the reform's implementation followed neither a linear nor a homogeneous process. It was left to the responsibility of the regions, which in most cases did not have the financial resources to set up the new system. The closure of mental hospitals became realized only in late 1990s (Lora, 2009). Three studies - PROGRES, PROGRES-Acute, and PROGRES-CSM (de Girolamo *et al.*, 2002, 2007; Munizza *et al.*, 2011) - provided detailed nationwide data about the characteristics of (acute and non-acute) residential and outpatient facilities after the enactment of Law 180. These three studies confirmed that the process of replacing former mental hospitals with modern residential facilities has been gradually concluded (Picardi *et al.*, 2014). However, they also showed distinct nationwide variation in the provision of mental health care, confirming that further efforts are needed to improve quality. More particularly, PROGRES study showed an imbalance in the concentration of public and private beds among regions, that is, regions with the lowest public acute inpatient bed rate showed the highest concentration of private inpatient beds. Also, the overall availability of inpatient beds (public and private) widely varied across regions (Amaddeo *et al.*, 2012). Moreover, the main finding of the PROGRES survey of non-acute residential facilities was the low turnover of patients, and the infrequent discharge to independent living.

These and other findings shed light on future challenges for both policymakers and practitioners. Among these, is the need for community mental health services to develop and implement innovative ways of treatment that take into account the societal changes that Italy has experienced in the last decades. Service development is required to meet the needs of the most vulnerable and increasingly poorly served subgroups of patients, such as adolescents and older people, as well as immigrants (Amaddeo *et al.*, 2012). Also, implementing evidence-based and cost-effective interventions is a key priority in mental health care, both in Italy and in the international context (Thornicroft & Tansella, 2014). This is especially important in times of economic constraints. Other two areas that were insufficiently developed after the Italian reform law are support and services for carers and user and carer involvement in the planning and evaluation of mental health services. Two recent reviews (Casacchia & Roncone, 2014; Barbato *et al.*, 2014) summarize experiences in these two areas, suggesting that a reshaping of Italian mental health services is required to pass from a medical and somewhat ‘paternalistic’ framework to a more patient-centered, collaborative and responsive organization of care.

1.1.2 Welfare state and social services

The origins of the modern Italian welfare state date back to 1898, when a system of compulsory insurance for accidents at work was introduced for certain categories of industrial workers (Costamagna, 2013). In the same year the National Insurance Fund for Invalidity and Ageing was established, a voluntary insurance scheme financed by the State, employers and workers. In 1919 this type of insurance became compulsory for all employed workers and later on was renamed as the National Institute for Social Insurance (INPS). Between the First and Second World War, the Italian welfare system underwent the ‘consolidation phase’ (Ferrera, 2006) with the introduction of additional forms of insurance, such as unemployment

insurance, tuberculosis benefits, widow pensions and family grants, as well as the first forms of redundancy funds. However, the system was extremely fragmented and scattered amongst a number of bodies. Healthcare and social assistance were provided by private organizations, mainly religious, together with the *Istituzioni Pubbliche di Assistenza e Beneficienza* (IPAB) created in 1890 by the ‘Legge Crispi’. After the Second World War, with the birth of the new Republican State the restructuring of the welfare system became a priority and efforts were made to reform it on a universal basis. However, economic, social and political factors prevented this from happening. Subsequently, in the 1950s, 1960s and early 1970s, the welfare system underwent unprecedented expansion. Social insurance was made compulsory for all employed workers and new insurance schemes were created for other categories. A social pension for deprived citizens aged 65 years and older was introduced. Another important achievement was the establishment of the aforementioned NHS in 1978. These major reforms, together with that of the pensions system in 1995, have contributed to the mixed nature of the Italian welfare system: the occupational feature of a Bismarckian model is mitigated by universalistic-selective measures (Franzini & Raitano, 2007).

Social care has historically played a residual role compared to social security schemes and health care. Social care policy in Italy was undefined for more than a century before a comprehensive reform was undertaken in 2000 by Law 328. Until this reform, a comprehensive system of social services available to all citizens had never been defined. The Framework Law 328 “for the realisation of an integrated system of social interventions and services” replaced legislation dating from 1890 (the ‘Legge Crispi’). A major change in social assistance policies had occurred during the 1970s when a decentralization process was initiated. The newly established regions were conferred some normative competences in the social sector and duties to provide social services were gradually passed to local authorities (i.e., municipalities). However, these new tasks were not integrated into a national law that

would establish policy principles and strategies, and the long-lasting absence of a framework law encouraged the development of geographically differentiated welfare programmes. The main objective of Law 328 was to ensure that all individuals and families residing in Italy, including immigrant families, had access to an integrated system of social services to prevent, reduce or eliminate situations of deprivation, poverty and deficiency through assistance activities coordinated with active labour market policies, education and healthcare policies. The reform law 328 adopted a new model defined as ‘selective universalism’, which entitled all citizens and families regularly resident in Italy to benefit from social services. However, priority was given to: people living in poverty or with limited income; people with a partial or total incapacity to provide for their own needs due to physical or mental disability; people who face difficulties in entering active life or the labour market; and people subject to judiciary measures that call for social assistance. The law defined the role of the institutions involved and gave greater planning and management responsibilities to the regions and to local actors. The reform promoted a new model of planning services, more participatory and open to the active involvement of citizens. The integrated system established by the law attributed a key role to the third (not for profit) sector, not only in the delivery of social services but also in their planning (Costamagna, 2013).

At the time of its enactment, Law 328 aimed to provide a comprehensive regulation of the sector, which had been previously fragmented and subject to overlapping legislation. However, the regulatory framework defined by the law was destined to fail with the approval of the Constitutional Law n. 3 of 2001 which endorsed the transition of the Italian State towards federalism. Regions were given an exclusive legislative power in the sector of social services and so Regional Governments hereafter could decide whether or not their social service systems should comply with the principles of Law 328. In this new system the only role left to central government was the definition of the ‘essential levels of assistance’ (*Livelli*

Essenziali di Assistenza) that should be provided across the whole Nation to guarantee territorial homogeneity. The enactment of Law 328 prompted Regional Governments to reform their social services systems and most of them produced new Regional Plans to implement the reform. However, the regions advanced at different speeds and different models of governance were adopted, also in light of the new powers regions were attributed by the Constitutional Law of 2001.

The situation today is one of significant territorial disparities and lack of support from central government for the development of a homogeneous system of social care policies. Although the definition of the 'essential levels of assistance' was prescribed both by Law 328/2000 and Constitutional Law 3/2001 they have never been outlined. Disparities are especially identifiable in the economic resources that municipalities invest in order to fund the service provision. The fracture between the North and the South of the Country is evident and, paradoxically, the distribution of expenditures moves in the opposite direction with respect to needs. In 2011, the Italian municipalities spent on average € 115.7 per-capita, but in the North-East this value reached a high of € 159.4 while in the South it was barely around € 50 (www.istat.it). At the same time, while in North-Central regions the percentage of families living below the threshold of poverty is lower than 10%, in the South (excluding Abruzzo and Sardinia) this figure rises to around 20%, and in Sicily closer to 30% (Pizzuti, 2008).

1.2 MENTAL HEALTH SOCIAL CARE AND SOCIAL WORK

1.2.1 What are social care and social work

Social care is a generic term that refers to all those non-medical services provided to people who are in need of support due to illness, disability, old age or poverty (Morgan, 2007). The White Paper *Our Health, Our Care, Our Say* published by the Department of Health in England defined social care as “the wide range of services designed to support people to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and manage complex relationships” (DH, 2006). The social care workforce encompasses a variety of job titles, mainly differing in relation to the level of qualification and responsibility. Social workers are those professionals that typically undertake a systematic set of graduate or post-graduate training and qualifications that are distinct from those of other social care workers, such as care assistants, support workers, personal assistants, and care workers.

Social services and interventions for people with mental health problems include: befriending schemes; community day services; direct payments and personal budgets; vocational rehabilitation, employment projects and supported employment; home help and meals on wheels; housing with care and support; hostels; residential care homes; carer support; self-help and peer support groups; information, advice, advocacy; and social service support (Morgan, 2007). Social care for people with mental health problems is generally provided both by health and care sectors. In Italy, as well as in England, the health and social sectors have historically differed for institutional and professional structures, as well as diverging approaches to the provision of services. In England health care is the responsibility of the National Health Service (NHS), while social care is the preserve of local authorities. The structural separation between the NHS and local authority services is problematic, especially

in such conditions that combine health and social aspects (mental health problems, long term conditions, and disabilities). In Italy, levels of health and social services integration vary nationwide, with some regions traditionally developing more integrated models and other regions where the health and care sectors have historically been separated. An example of the former are the Health Societies in Tuscany, which are non-profit public bodies constituted, by voluntary membership, of municipalities and local health authorities for the exercise of integrated health and social services activities in the same locality (Burgalassi, 2007).

1.2.2 The role of the social worker in adult mental health services

Both in Italy and England some mental health care is provided by multidisciplinary teams based in the NHS (including community mental health, crisis care, home treatment, assertive outreach, and rehabilitation teams) in which health and social care professionals, including social workers, work together to deliver a service to people with mental health needs in a more integrated manner. Social workers have been described as an essential part of multidisciplinary teams as they bring a unique perspective to the work that places the individual in the wider context of their personal, family, cultural, and socio-economic circumstances (Evans *et al.*, 2006). Social work also plays a significant part in multiagency working, in working across different organizations and alongside professionals in health, housing, employment and other sectors, to deliver services that effectively respond to the complex needs of service users (Allen, 2014). Literature on mental health teams' composition, although quite limited, shows evidence of the positive impact of multidisciplinary teams and the integration of health and social care staff on symptom severity, functioning, employment, and housing of people with severe mental illness, in comparison with traditional services (Franx *et al.*, 2008). A research briefing by the Social Care Institute of Excellence (Ray *et al.*, 2008) reports a substantial body of evidence of the

significant role of mental health social work in promoting the involvement of people using services, as well as developing holistic approaches that combine practical and emotional support, reducing isolation, promoting independence and self-directed support, advocating and helping people to access services (see also Watters, 2001; Orel *et al.*, 2003 Carpenter *et al.*, 2004; Foster, 2005; Newbigging *et al.*, 2008).

1.2.3 Challenges and future perspectives for mental health social work

As a connecting profession, social work does not always occupy a secure position as part of the multidisciplinary team. Part of the difficulties social workers face in achieving effective teamwork is concerned with interdisciplinary tensions, which may result in social workers feeling undervalued and left isolated by their medical colleagues (Evans *et al.*, 2006). Professional barriers may derive from differences in perspectives, as well as professional stereotypes, cultural differences, different professional philosophies, lack of trust, respect and control, and the absence of joint training and team-building (Cameron *et al.*, 2012). Relatedly, there is evidence showing higher rates of stress and emotional exhaustion among social workers in multidisciplinary teams in comparison with other professionals (Evans *et al.*, 2006; Lasalvia *et al.*, 2009). The main reason behind these high rates of stress and exhaustion seem to be high levels of job demand and feelings of not being appreciated for the work. Other important determinants of stress are the number of worked hours, the caseload, and decision latitude (Evans *et al.*, 2006). These factors might exacerbate recruitment and retention problems. High vacancy and turnover rates can contribute to staff shortages, excessive workloads and reliance on temporary staff, making social work practice increasingly difficult (Eborall & Garmeson, 2001).

‘De-professionalization’ is another risk mental health social workers encounter (Clifton & Thorley, 2014). There is sometimes a tendency for social work methods to lose their richness

and potential values. For example, care management may become an administrative exercise, concerned largely with procedural assessments rather than use of professional judgement and expertise (Bland & Renouf, 2001). Moreover, the job has become increasingly 'bureaucratised' with social workers processing high volumes of cases and navigating complex resource allocation systems. The bureaucratic demands of the job are such that social workers describe spending too little time delivering effective interventions with families and individuals (Clifton & Thorley, 2014).

The question of how social work can play a greater part in improving adult mental health services and achieve better service user, family and community outcomes is not easy to answer. In England, the College of Social Work's recent report, *The Role of the Social Worker in Adult Mental Health Services* (Allen, 2014), provides a helpful framework for defining and strengthening the role of mental health social workers. It outlines five key areas of practice that should provide the framework for social workers' learning and development in integrated mental health teams. These include enabling citizens to access the statutory social care and social work services, promoting recovery and social inclusion, showing professional leadership and skill in highly complex situations, discharging legal duties and meeting the personalisation agenda, and working with service users to support increasingly resilient and engaged communities (Allen, 2014). These themes may assist social workers, educators, employers, managers, commissioners of mental health services, and policy makers to identify ways social work may support the delivery of mental health services that are more personalised, preventative, and focused on recovery.

1.3 EXPLORING THE QUALITY OF MENTAL HEALTH CARE

1.3.1 Preliminary remarks: definitions of quality of care

Defining ‘quality of care’ is not straightforward. The literature contains a multitude of definitions, many elaborated in the health care context. In 1990 the Institute of Medicine (IOM) in the United States defined quality of care as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (IOM, 1990). This definition has received wide acceptance and marked the flourishing of work to develop operational definitions and measures to assess quality of care. Other definitions of quality of care frequently cited in the quality literature are those by the American Medical Association (AMA, 1986), by Donabedian (1979), Steffen (1988), and more recently by the Agency for Healthcare Research and Quality (AHRQ, 2005).

These definitions helpfully shed some light on the notion of quality of care. However, there is still lack of clarity around this concept. The terminology of quality of care is often uncritically assumed and generally referred to for its persuasive appeal. Goldenberg (2012) discussed the difficulty surrounding the task of defining quality of care. She argued that although the language of quality is ubiquitous there is limited consensus on the terminology in the quality literature. The various attempts to define quality of care are constrained by some limitations. One of these has been called ‘the catalogue approach’, which refers to the process of not defining quality of care but instead indicating the attributes and the components of quality (Goldenberg, 2012). There are a number of examples in the writing on quality on this regard. For instance, the IOM defined six attributes or goals for improving the quality of health care, such as safety, effectiveness, patient-centeredness, efficiency, timeliness, equity (IOM, 2001). Other common quality components cited in the quality

literature are appropriateness, continuity, coordination, accessibility, responsiveness, timeliness, and acceptability (Arah *et al.*, 2006). The interpretation of these dimensions can be confusing if not guided by detailed justification for the chosen criteria and the exclusion of others. Furthermore, these catalogues of components often lack guidance on how to mediate the conflicts that may arise between different traits: how for example the principle of patient-centeredness fit with that of efficiency?

The complexities not only concern the definition of quality of care, but also the process of measuring it. In fact, the definition of quality of care and how it is measured largely depends on who assesses it and for what reasons. As Donabedian (1988) points out “several formulations are both possible and legitimate, depending on where we are located in the system of care and on what the nature and extent of our responsibilities are”. Different groups such as regulators, providers, practitioners, and service users can have very different reasons for measuring quality and hence different measurement criteria and emphasis. Practitioners, for instance, regard quality to be a measure of the excellence of the services they provide and may emphasise the quality of the interactions with patients or service users. Service users want to feel better and improve their life circumstances. They might more likely value features such as compassionate care, warmth, shared-decision making (Beresford & Branfield, 2006; TLAP, 2013). Organizations might emphasize the degree to which the product/service is adequately delivered in terms of staff proficiency, efficiency and cost-effectiveness (IOM, 2001).

Donabedian (1980) makes a distinction between *structure*, *process*, and *outcome* in the measurement of quality of care. More specifically, *structure* refers to the characteristics of the setting in which care takes place. Structure measures might include the physical facility, equipment, and human resources, as well as organizational characteristics such as legal and policy framework and staff training. *Processes* represent actions applied in the provision of

care and include technical and interpersonal components of care (e.g., treatment with dignity, appropriate care, and evidence-based practice). *Outcome* contains all the effects of healthcare on patients or populations, including changes to health status, behaviour, or knowledge as well as patient satisfaction and health-related quality of life. Outcomes are the most important indicators of quality, as the primary goal of healthcare is to improve patient health status.

This thesis was framed within the Donabedian model, aiming at detecting the interconnections that occur among the three domains. As illustrated below, exploring the three components as integrated and interdependent is especially important in mental health care, given the complex nature of mental disorders and of the mental health care system.

1.3.2 Measuring the quality of mental health care: why and how?

The last two decades have witnessed an increasing emphasis on performance and quality assessment of health and social services. This is partly due to central government attempts to ensure value for money and to contain expenditure, but variations in the types, quality, costs of care, demands of transparency, as well as failures to protect vulnerable individuals have also been significant concerns.

Understanding how mental health systems are designed and how they can best function has become especially crucial, given the impact of poor mental health on the morbidity of the population, as measured by the ‘global burden of disease’. In the findings of the Global Burden of Disease 2010 study (GBD 2010), worldwide mental and substance abuse disorders accounted for 7.4% of total disease burden, making mental health and substance use disorders the fifth leading disorder category of Disability Adjusted Life Years (DALYs) (Whiteford *et al.*, 2013). DALYs is the number of years of life lost due to illness, disability or early death. Moreover, the mental health system worldwide is challenged by the mental health ‘treatment gap’ (Kohn *et al.*, 2004). Many individuals with mental health problems remain untreated

although effective treatments exist. In many lower and middle-income countries, three-quarters of people with mental health problems do not have access to mainstream mental health services. Even in developed countries the figure ranges from 35% to 50% (WHO, 2013a). Moreover, research studies have documented wide variations in the quality of care including gaps between clinical practice and evidence-based guideline recommendations (Hermann *et al.*, 2006; Ruggeri *et al.*, 2008). These findings have led to increased attention to improving the quality of mental health care. Providing adequate and competent mental health care globally is a key health policy priority and it is with this objective that the World Health Organization (WHO) has published a range of background policy documents on mental health care in the last two decades (WHO, 2003, 2009, 2013a). Mental health has also received increasing attention in the European Union, as demonstrated by the recent endorsement by the WHO European Region member states of the European Mental Health Action Plan (WHO, 2013b).

One prerequisite to better delivery of mental health services is the systematic and standardized collection of information to describe and assess the performance of mental health systems. In order to provide effective services it is important to be able to assess the extent to which the existing mix of services in any region or country is performing on different objectives, including the effect on health status, the efficiency and fairness of services, the responsiveness of services to service users' needs, as well as the protection of dignity and human rights. However, the analysis of quality of mental health care becomes challenging if comparisons between different countries are undertaken. Variability of mental health care systems between countries is considerable, even within the European Union (Becker *et al.*, 2002). This disparity can be attributed to historical and political factors, as well as to differences in funding, financing and organizational patterns. These factors, along with terminological inconsistencies (services with the same name carry out different activities

in different areas, and vice versa), and the lack of a standardized classification system to facilitate description of services across different settings, are obstacles in the development of quality research in an international perspective (Salvador-Carulla *et al.*, 2013). In the last two decades there have been attempts to standardize the description of health services. For example, the *Description and Evaluation of Services and Directories in Europe for Long Term Care* (DESDE-LTC) (Salvador-Carulla *et al.*, 2013). DESDE-LTC is an extension of the European Service Mapping Schedule (ESMS) for the evaluation of services in mental health (Johnson *et al.*, 2000), and related instruments for the evaluation of services for older people and services for disabilities, including acute care (Salvador-Carulla *et al.*, 2006). The ESMS/DESDE system was designed to facilitate territorial like-with-like comparisons and provide a classification based on the main activity provided by the minimum organisational units identified in every service. This classification is adopted in this thesis for its potential to overcome the traditional distinction based on the governance/management agency, which is clearly limited by the high geographical variation across mental health services in Europe. Indeed, similar community residential services or day care/rehabilitation services are classified as part of the social sector in one area whilst they are part of the health sector in another.

Information on the structural characteristics of services, obtainable by using DESDE-LTC, need to be integrated and complemented with process and outcome measures. In fact, quality should be assured in all the three areas of input-process-outcome and a balance across the three is shown to improve quality of care (Amaddeo & Tansella, 2013). Various authors have described quality of care using a vast number of dimensions and indicators. A comprehensive analysis of all measures available in the literature is beyond the scope of this thesis. Here, the focus is specifically on the concept of *continuity of care*, as it represents a significant ingredient of quality of care. This concept is analysed in order to capture aspects related to

individual pathways to and through mental health services. This is especially important since the core of this thesis is on the interfaces between health and social services.

In the mental health literature, as well as the general health literature, there is lack of consensus on the definition of ‘continuity’. In broad terms it can be regarded as “the extent to which health care for specified users, over time, is smoothly organized within providers and institutions” (Arah *et al.*, 2006). Over years various definitions of continuity have been proposed, however, as Freeman and colleagues point out (2000), continuity has been often described from the provider perspective with little attention on users’ perceptions and experiences. Including service users’ perspectives is crucial in order to add key information to what is already known from a provider perspective. The only measure in the mental health literature completely developed from the service user perspective is *CONTINUity of care User Measure* (CONTINU-UM). CONTINU-UM was employed as a measure of ‘experienced continuity’ in a larger research programme in England called the ECHO study (Experiences of Continuity of care and Health and social Outcomes) (Burns *et al.*, 2009). Experienced continuity is described as the “experience of a smooth progression of care from the user’s point of view” (Freeman *et al.*, 2000). The measure was generated using focus groups and expert panels, a consultation exercise and a feasibility study (Rose *et al.*, 2009). The study demonstrated that it is possible and valid to construct outcome measures in mental health entirely from the user perspective (Rose *et al.*, 2009). It also showed that some components of continuity of care were redefined from the perspective of receiving rather than delivering services, while others were not found elsewhere in the pre-existing continuity literature (Sweeney *et al.*, 2012). This thesis has adopted the instrument CONTINU-UM in order to better understand service users’ experiences. This helps to place service users at the centre of service evaluation. Finally, having a user-defined measure of continuity of care adds a key missing piece to the mainstream knowledge, thus offering multiple study approaches.

1.3.3 Key elements of quality of mental health care: staff wellbeing and quality of working life

When assessing quality of mental health care the *wellbeing of staff* needs to be taken into consideration since it can significantly affect the quality of services delivered. This issue is especially important for people working in mental health services as they represent one of the categories of health workers at highest risk of burnout and work stress (Pines & Maslach, 1978; Bressi *et al.*, 2009; Lasalvia *et al.*, 2009; Pedrini *et al.*, 2009).

In this thesis the impact of working in mental health services on staff wellbeing is assessed in terms of Burnout (BO), Compassion Fatigue (CF), and, more positively, in relation to Compassion Satisfaction (CS). These three elements are analysed together with a broader concept of *quality of working life*, as outlined below. CF has been described as an occupational hazard specific to clinical work (Figley, 1995). It is defined as the practitioner's reduced capacity of, or interest in, being empathic or "bearing the suffering of clients" (Figley, 1995, 2002a, 2002b). CF is likely to result in problems such as misjudgements, clinical errors and poor treatment planning, all serious issues for effective care (Figley, 2002a; Bride *et al.*, 2007; Adams *et al.*, 2008). CF and BO differ in some key aspects. BO, which is defined as "a state of physical, emotional, and mental exhaustion caused by long term involvement in emotionally demanding situations" (Pines & Aronson, 1988), is not directly related to the exposure to traumatic material (Adams *et al.*, 2008). The onset of BO is gradual and cumulative, while CF has a faster onset of symptoms and may result from the exposure to a single traumatic event (Figley, 2002a). Staff who care for mental health patients are not subject only to negative consequences. CS refers to the satisfaction derived from being able to help other people (Stamm, 2002).

The concept of *quality of working life* describes the broader job-related experience an individual has. Over time, various definitions of quality of working life have been proposed,

depending on the theoretical stance of researchers and the different combinations of factors considered. In this thesis a multidimensional approach is applied to the study of quality of working life, which is similar to the one developed by the European Foundation for the Improvement of Living and Working Conditions (EUROFOUND). Within this framework, two constitutive areas are recognized as characterizing quality of working life. These are the *intrinsic quality of work* and the *quality of work-life balance* (Gosetti, 2012).

The *intrinsic quality of work* derives from the relations between the worker's needs and the intrinsic characteristics of the organization of work. As reported in Table 1, Gosetti (2012) recognizes six major dimensions for the analysis of the intrinsic quality of work. Wage is a core element of the *economic dimension* and reflects the basic need of individuals to sustain themselves. The *ergonomic dimension* is concerned with working conditions in both physical and psychological terms. The *complexity dimension* is about the content of work and relates to personal commitment and professional growth, as well as with relational aspects. *Autonomy* refers to the level of discretion and freedom the individual can exercise while working. *Control* is both about the influence that employees could exercise over their immediate work tasks and the organizational participation or the influence that employees can exert over work organization. The *symbolic dimension*, more recently added in the study of quality of working life, is concerned with the needs of appreciation, visibility and social utility of one's work. It is related to the need the individual feels to construct a work-related identity.

Moreover, *quality of work-life balance* is about reconciling working life and life outside work. This is an essential condition both for encouraging entry into the labour market and for enabling people to remain at work. A number of elements need to be taken into consideration when the quality of work-life balance is analysed. These are concerned with circumstances including the household situation (e.g., the work situation of a partner, the presence of

children), the organization of work (e.g., working time arrangements), as well as cultural traditions (for example, the mother staying at home to take care of children or other dependants), social infrastructure (e.g., afterschool care), and the social protection system. All these elements have an impact on the work-life balance of men and women. The combination of all these elements determines whether men and women do have a real choice and what people are effectively able to do and to be (EUROFOUND, 2012).

To conclude, the theory underlying this thesis is that the wellbeing of staff and their working life experience play a crucial role in determining the quality of care. Moreover, while mental health professionals are subjected to similar organizational stressors as other workers - concerned for example with workload, job role, work demands, and work environment - there are also intrinsic characteristics of mental health work that constitute further stress factors. Mental health professionals face additional emotional strain by the very nature of their professions in dealing with troubled persons, often over extended periods. Thus, they are particularly vulnerable to negative consequences such as CF and BO. The framework described above will help analyse all these aspects, as well as their interconnections.

Table 1. Quality of working life: Framework of analysis

DIMENSIONS OF QUALITY OF WORKING LIFE		
PERSPECTIVES	<i>Intrinsic quality of work</i>	<i>Quality of work-life balance</i>
<i>SUBJECTIVE</i>	(1) Economic (Sustenance, economic security, etc.)	(7) Work-life balance (Compatibility between choices in work and life, etc.)
a) Satisfaction	(2) Ergonomic	(8) Social protection
b) Self-evaluation	(Psychological and physical wellbeing, etc.)	(Work accessibility, continuity of work, work safety, etc.)
<i>OBJECTIVE</i>	(3) Complexity (Commitment, prospects, experience, etc.)	(9) Social participation (Participation to social life, social involvement, etc.)
a) Behaviours	(4) Autonomy (Discretion)	
b) Conditions	(5) Control (Control over work conditions, etc.)	
	(6) Symbolic (Appreciation, social utility, visibility, etc.)	
(10) Discriminant factors (Person's profile, organization's profile, macro system factors)		

Source: Gosetti, 2012.

1.4 MEASURING QUALITY IN SOCIAL CARE SERVICES

1.4.1 What are the challenges for measuring the quality of social care?

The discussion of quality in social care has historically differed from that in the health sector. While medicine has long been engaged with issues of quality, the contribution of social care, both as a discipline and a profession, in quality research has been limited in comparison (Megivern *et al.*, 2005). Health priorities have dominated and so data on the processes and outcomes of social care services to people with mental health problems have been slow to develop (Clarkson & Challis, 2002). This is also due to the specific conceptual and analytical challenges that measuring the quality of social care encompasses. Malley and Fernández (2010) explain that identifying good quality indicators in social care is a complex task because of three main difficulties. First, social services are best described as ‘performances’, because their products are intangible and thus difficult to quantify and measure. Second, social care services are ‘labour intensive’, this meaning that service performance can be extremely heterogeneous and can vary from producer to producer as well as from consumer to consumer, and from day to day also with the same producer and consumer. Thirdly, since services are consumed and produced simultaneously it is difficult to distinguish the providers’ impact on service quality from that of users. Overall, these three characteristics of social care make it challenging to identify specific ‘search properties’ that can be easily measured and verified.

Despite these challenges, measuring quality of social care is of great importance in order to promote improvements. Good quality measurement plays a key part in improving services through informed decision-making. Quality improvement is likely to bring about a multitude of benefits, including improvements in service user health and social care outcomes, such as morbidity, mortality, employment and housing outcomes. Quality improvements are thus

likely to enhance service effectiveness and increase social wellbeing. Services are effective when they prevent both patient/service user harm and the use of more expensive interventions (e.g., hospital care). Finally, by improving processes and outcomes relevant to high-priority social and health needs, an organization improves efficiency, reducing waste and the costs associated with system failures and errors.

1.4.2 What is high quality social care?

In an era of increasing privatization and diversification in the provision of services, quality assessment involves a growing number of stakeholders. Nowadays, due also to the crisis of the welfare state and increased demand for care services, more direct provision of services is by private and non-profit organizations. Thus, quality measures need to be available at different levels, including at the commissioner level, to aid decisions about purchasing and monitoring the performance of services, at the provider level, and at the micro level of individual practitioners and teams (Clarkson & Challis, 2002). Moreover, new forms of consumer-directed support (such as direct payments and personal budget in England) are profoundly changing ways of delivering social services and, consequently, assessing their quality. In England, for example, personalisation policy promotes a system where service users have greater choice and control about what they receive, by acting as direct purchasers (DH, 2006). This implies that quality information is also needed “to inform service users in their role as purchasers, by providing evidence about the quality of the different services available” (Malley & Fernández, 2010).

Thus, the presence of different stakeholders conveying different priorities and perspectives does not allow for a ‘one size fits all’ definition of what is quality of social care. However, some factors have been cited as necessary components of high quality of care. A document from the improvement agency funded by the Department of Health in England, Think Local

Act Personal (2013), summarises research evidence about which factors service users, commissioners, providers, and practitioners regard as important. They are condensed in three concepts: quality is about assuring effective service delivery, having a positive care experience meeting personal needs and aspirations, and putting in place processes that keep people safe and recognize choice and control. The definition of ‘excellence’ provided by the Social Care Institute of Excellence (SCIE, 2010), another improvement agency funded by the Department of Health in England, is built around similar themes. The definition identifies four essential components of excellence. Three of these are related to improvements in people’s lives as outcomes of service use. The fourth element is about the organisational and service factors which need to be in place to achieve these outcomes. The three outcome-related factors can be summarized under the themes of ‘voice, choice and control’, ‘good relationships’, and ‘spending time purposefully and enjoyably’. Service and organizational factors include the leadership by managers, and the values, policies and culture of an organization. All these factors affect how well the organization functions and the services it delivers. The notion of social care outcomes and how these can be measured will be discussed in more detail in the next pages.

1.4.3 Measuring social care outcomes

The two definitions by Think Local Act Personal (2013) and the Social Care Institute of Excellence (2010) reported above highlight the importance of outcomes, that is, the impact services have on individuals and their carers. In recent years, the discussion on quality of social care has increasingly emphasized the importance of measuring outcomes. Indeed, measuring outcomes is crucial for a number of reasons. First, in order to achieve quality of care it is essential to measure the effectiveness of interventions. Focusing on outcomes will enable the identification of effective practices, informing decisions about activities to

continue and build upon as well as practices that need improvement. Moreover, outcome measurement is critical to support policy analysis and strategic decision-making. Finally, the interest in outcomes reflects “a shift away from service-led systems, where people are fitted into the pattern of provision that has developed historically, to user-led or user-centred services” (Beresford & Branfield, 2006).

Outcomes are not just defined in terms of the positive (or negative) impact of services, but also in terms of the value of the impact. They are therefore indicative of the benefit resulted from the intervention (Malley & Fernández, 2010). As Netten and colleagues (2012a) outlined, the ultimate aim of social care services is improvement in people’s quality of life. Quality of life is defined by the World Health Organization as the “individuals’ perceptions of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns” (WHO, 1997). This definition reflects the subjective point of view as an inherent aspect of quality of life, and hence, the best person to assess quality of life is the individual himself.

One of the objectives of this thesis is to measure the impact social services have on people’s quality of life. However, measuring the extent to which a change (positive or negative) in people’s quality of life is dependent upon the service delivered is far from straightforward. Indeed, quality of life can be quite independent of the standard of care an individual receives, so that a person may be receiving a high standard of care, but experience a poor quality of life, and vice versa. Also, social care interventions are low in ‘change’ outcomes, which aim is to reduce the person’s level of impairment, and high in ‘maintenance’ outcomes, where the aim is to maintain the person’s quality of life or physical and mental functioning (Malley & Fernández, 2010). This makes it more difficult to identify the outcome when the aim of the service is to maintain a certain situation. Moreover, social care services are often provided on a regular basis and for a long period of time and this characteristic makes it more challenging

to assess the ‘before and after’ the intervention. Again, social care is often provided by a mixture of actors, both formal and informal, including family members, neighbours and friends. Thus, the role of social services excluding other (informal) sources of support is not easy to capture. All these issues need to be taken into consideration when designing research projects that aim to measure social care outcomes. It is crucial that the measures of outcome used are valid, reliable and sensitive to the impact of social care (Netten *et al.*, 2011). In the literature, various measures and frameworks have been developed to measure social care outcomes (for more details see SCIE, 2010). This thesis focuses on the *Adult Social Care Outcomes Toolkit* (ASCOT) (Netten *et al.*, 2011), which aims to measure *Social care-related quality of life* (SCRQoL). ‘Quality of life’ in this context is defined by the following eight domains:

1. Control over daily life
2. Personal cleanliness and comfort
3. Food and drink
4. Personal safety
5. Social participation and involvement
6. Occupation
7. Accommodation cleanliness and comfort
8. Dignity (Netten *et al.*, 2011).

ASCOT was selected for this thesis for its strength to establish the effect that a social care intervention has on a person’s quality of life. Moreover, ASCOT is the only measure able to measure SCRQoL across the full range of users groups and care settings. ASCOT domains were identified through extensive work, including consultation and focus groups with service users, experts and policy makers (Netten *et al.*, 2009). This work demonstrated that ASCOT

domains capture aspects of social care-related quality of life that are valued by people who use services.

2. METHODOLOGY

This chapter specifies the thesis objectives and defines the methods applied to achieve them. More precisely, the two research projects within which the thesis objectives were developed will be described in terms of their methods. The following aspects will be reported: the study design, the areas of study, the procedures, the instruments and measures, the samples, and ethical approval.

2.1 OBJECTIVES

The overarching aim of this thesis was to develop a framework to analyse the quality of mental health and social care services from different perspectives covering the three quality domains of input, process and outcome. More specifically, this thesis had five core scientific objectives:

1. To identify existing and develop new indicators of quality of mental health and social care provided to people with mental health problems;
2. To assess the quality of working life amongst mental health staff and investigate how this might affect the quality of care;
3. To investigate and describe the quality of mental health and social care using a measure of service users' continuity of care;
4. To investigate and describe the quality of social care services using a measure of social care-related quality of life; and
5. To assess the relationships between social care-related quality of life, continuity of care, and utilization of mental health and social care services.

The stated aims were developed within the framework of two different research projects: an EU funded Project (REFINEMENT) and an Italian multicentre study.

2.2 THE EUROPEAN REFINEMENT PROJECT

The REFINEMENT (REsearch on FINancing systems' Effect on the quality of MENT-al health care) project had its genesis in the wish to compare and standardize the different and elaborate systems of both financing and performance assessment of mental health care in Europe, in order to promote knowledge of how financial systems can be used to support the development of good quality and efficient services. The overarching aim of the REFINEMENT project was to explore the relationship between different models of health care financing and the extent to which mental health care services could meet the goals of high quality, equity, efficiency and better long-term health outcomes. In order to achieve this goal an experienced team of health economists, mental health service researchers and public health specialists worked collaboratively from:

- Austria (Ludwig Boltzmann Gesellschaft)
- England (London School of Economics and Political Science)
- Estonia (University of Tartu)
- Finland (Terveyden ja Hyvinvoinnin Laitos)
- France (Université Paris XII – Val de Marne)
- Italy (University of Verona - project coordinator)
- Norway (Stiftelsen Sintef)
- Romania (Institutul de Prognostica Economica)
- Spain (Asociacion Cientifica Psicost).

The REFINEMENT project was organized into nine work packages (Table 2). The project was financed for three years by the European Commission within the 7th Framework Programme and started in January 2011. A legacy of the project was a suite of tools that can be used across other European countries for mental health system analysis and adapted to examine issues concerning other aspects of the health care system.

Table 2. REFINEMENT project work packages

Mandatory
WP1 Management
WP2 Evaluation
WP3 Dissemination

Technical
WP4 Analysis of the financing of health and social care systems
WP5 Functional and dysfunctional financial incentives
WP6 Service mapping for mental health care
WP7 Pathways of care
WP8 Quality of mental health care and met/unmet needs
WP9 Building of best practice models of mental health care financing

Part of the aims of this thesis were developed within the framework of work packages 6 and 8. Particularly, the first aim of this study was to describe all services (general health, mental health and social services) available for people with mental health problems in nine European countries and analyse the organizational models adopted in each country. Secondly, this study was aimed at identifying indicators of performance and quality of both mental health and social care services and developing a strategy for the collection of such information in the nine European countries.

2.2.1 Areas of study

Most of the data in the REFINEMENT project were not collected for whole countries but for selected ‘study areas’. Nine study areas were selected across the nine participatory countries encompassing sizes of populations between 200,000 and 1,500,000 inhabitants, preferably covering a health district served by a defined range of health services. Additional characteristics considered in the selection of study areas were the availability of appropriate

sources of information on the local mental health system, previous knowledge of the datasets, and cooperation with local, regional and national health officers.

The study areas selected were: Industrieviertel (Austria); Hampshire, including Portsmouth and Southampton Unitary Authorities (England); Tallin municipality (Estonia); Helsinki and Uusimaa Hospital District (Finland); Loiret Department with seven sectors of psychiatry of the Georges Daumézon hospital (France); Verona Mental Health Department (Veneto, Italy); Trøndelag (Norway); Jud Suceava (Romania); and Girona Health District (Catalonia, Spain). Geographical size varied from 1,061 km² in Italy to 18,856 km² in Norway. The main characteristics of the selected study areas are described in Table 3 and more details are available at the REFINEMENT webpage (www.refinementproject.eu).

Table 3. Study areas of eight REFINEMENT project countries

Country	Study Area	Population > 18 years	Land Area (km²)
Austria	Industrieviertel	445,748	3,921
England	Hampshire (including Portsmouth and Southampton Unitary Authorities)	1,364,799	3,769
Finland	Helsinki and Uusimaa Hospital District	1,206,446	8,751
France	7 sectors of psychiatry of the Georges Daumézon hospital in the département “Loiret” of the region “Centre”	422,853	5,626
Italy	ULSS20 - Verona	393,402	1,061
Norway	Sør-Trøndelag	225,081	18,856
Romania	Jud Suceava	484,212	8,553
Spain	Girona Area	599,473	5,585

2.2.2 Mapping of mental health and social care services

The REFINEMENT Mapping Services Tool (REMAST) was used to map all mental health and social services in the nine study areas. REMAST was one of the project legacy tools and allowed for detailed description of the key features of mental health service provision, including those provided by primary and social care services, within a selected study area.

REMAST covers information on mental health policy and characteristics of the study area in terms of the demographic, socioeconomic and geographical environment. The tool can be used by researchers, service planners and policy makers in different regions, countries and at the European level to understand the complexity of the mental health system in specific areas and to compare the availability of resources and the care capacity across the different regions. More specifically, as shown in Table 4, REMAST consists of three main sections each focusing on different sources of data to be collected.

Table 4. REMAST: Content and data sources

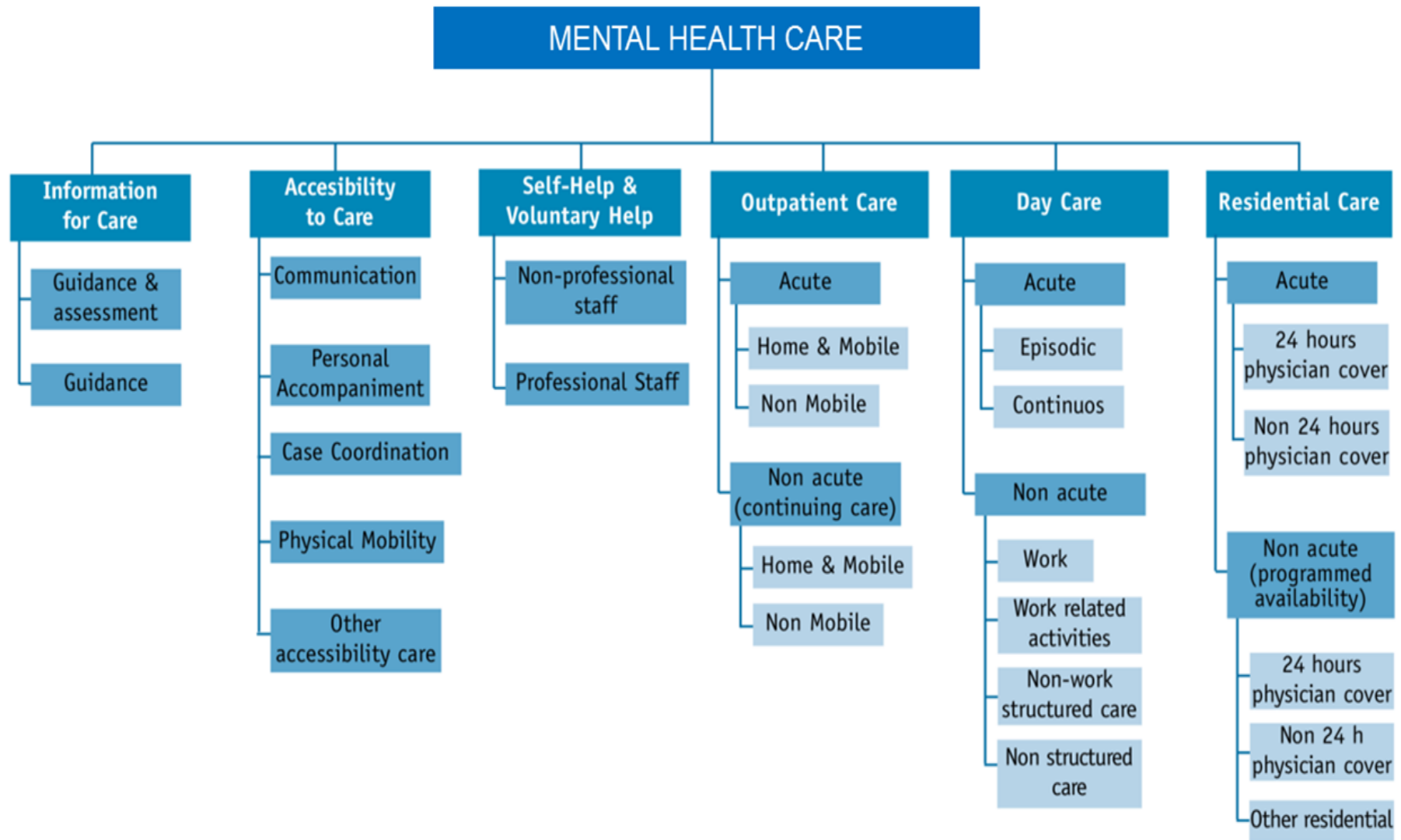
Content	Data sources
<i>Mental Health Systems Checklist</i> <ul style="list-style-type: none">• Policies and legislative framework	Data from different public sources and/or interviews with system representatives.
<i>The Ecological Setting of the Study Area</i>	<ul style="list-style-type: none">• Population data by age and gender• Socio-Economic Status (SES)• Geographical data
<i>Service Inventory File (SIF)</i> <ul style="list-style-type: none">• Mapping all health and social services directed towards, or used by, working-age population with mental health needs located in the study area.	Instrument based on the Description and Evaluation of Service and Directories in Europe for Long Term Care (DESDE-LTC) (Salvador-Carulla <i>et al.</i> , 2011).

This thesis will focus in more detail on the Services Inventory File (SIF), one of the sections of REMAST aimed at describing all mental health care services in each study area providing health and social care to people with mental health problems.

The core of the SIF is represented by a validated tool on its own, the Description and Evaluation of Services and Directories in Europe for Long-Term Care (DESDE-LTC) that provides the information needed to complete the Services Inventory. DESDE-LTC is the extended version of the European Service Mapping Schedule (ESMS-I) for the assessment of services in adult mental health care (Johnson *et al.*, 2000). The feasibility, reliability and validity of both ESMS-I and DESDE-LTC have been previously described (Johnson *et al.*, 2000; Salvador-Carulla *et al.*, 2000; Salvador-Carulla *et al.*, 2006; Salvador-Carulla *et al.*, 2013). These instruments have been used in over 13 countries to provide regional, national and international comparisons of mental health systems and long-term care (Salvador-Carulla *et al.*, 2013). DESDE-LTC uses a tree system for the classification of services in a defined catchment area according to the main care structure/activity offered, as well as their level of availability and utilization. The tree structure, as shown in Figure 1, distinguishes the following categories of services, called ‘branches’ (see Table 5 for detailed definitions):

- Accessibility to care
- Information on care
- Self-help and voluntary care
- Outpatient care
- Day care
- Residential care.

Figure 1. DESDE-LTC Mapping tree



DESDE-LTC also adopts the operational definitions of Basic Stable Input of Care (BSIC) and Main Type of Care (MTC) in order to classify services and compare like-with-like (Salvador-Carulla *et al.*, 2013). See Table 5 for detailed definitions.

SIF data collection **included** all public and private mental health services aimed at caring for adults 18+ years old with mental health problems and their families. The reference years were 2010-2012, each country providing the best available data within this timeframe. The following types of services were **excluded**:

- 1) All services especially dedicated to the treatment of individuals with organic mental disorders, and/or mental and behavioural disorders due to psychoactive substance use, and/or intellectual disability (e.g. specific rehabilitation centres for alcohol and drug withdrawal, memory clinics, facilities for individuals with intellectual disabilities etc.);
- 2) All services especially dedicated to the treatment of older people (e.g. nursing homes, mobile home nursing services, etc.), unless they provided care especially for people with mental disorders;
- 3) Forensic services; and
- 4) Services exclusively for children and adolescents.

SIF data collection followed a number of steps. First, a list of primary, mental health and social services (BSICs) providing care for people with mental health problems aged 18 years and older living in each of the nine study areas was prepared. The list was prepared through the review of service catalogs and databases, as well as contacting services' managers or team leaders. Second, one or more MTC was assigned to the listed BSICs and for each MTC a detailed set of information was collected. These included:

- a. Service basic information (e.g., identification number, name);

- b. Location and geographical information about the service (e.g., address, served geographical area, size of served population);
- c. Information and contact details (e.g., local definition of the service, telephone, website);
- d. Service data (e.g., opening days, opening hours, staffing, management, legal system, economic information);
- e. DESDE-LTC coding section (see below); and
- f. Evaluator information (name and contacts of reference source and evaluator, observations).

The DESDE-LTC coding section was the most substantial and through it a detailed description of the services emerged. For the compilation of this section, the DESDE-LTC manual instructions were followed (Salvador-Carulla *et al.*, 2011). In summary, each MTC listed in the SIF was attributed a specific DESDE-LTC code according to the type of care provided (i.e., accessibility, information, self-help, residential, outpatient, day care), the health status of the user (acute/non acute), the typology of care (home and mobile/non-mobile, physician/non-physician cover), the intensity, and other specifications of the care activity. Additional information in this section included: the service user profile (e.g. age, gender), the number of users, number of contacts or admissions, number of days in hospital or residential structure, number of available beds or places, and links with other services.

Each of the six sections above included specific questions to answer with numbers, acronyms or short sentences. A web-based platform was created for the compilation of SIF. Once SIF was compiled by all countries, the data were unified in one single file to be analyzed.

Table 5. Units of analysis used in DESDE-LTC

Unit of analysis	Definition
Basic Stable Inputs of Care (BSIC)	Minimal unit of production of care characterized by a set of inputs with temporal continuity and organisational stability for delivering health related care to a defined group of users in a specific location. It is usually composed of an administrative unit with an organised set of structures and professionals.
Main Type of Care (MTC)	Major descriptor of the BSIC in relation to its more relevant “generic care function”. The generic care function typically describes the principal activity carried out in the BSIC (e.g. the user stays overnight in a setting where a physician is available 24 hours a day). It is important to note that one BSIC can be described by more than one MTC.
Accessibility to care	Type of care aimed at providing accessibility aids to users.
Information on care	Type of care aimed at providing information and assessment to users. This care does not entail a subsequent monitoring/follow-up of the user.
Self-help and voluntary care	Its main aim is to provide users with self-help or contact, with unpaid staff that offers accessibility, information, day, outpatient and residential care (as described in other branches).
Day care	Type of care: <ul style="list-style-type: none"> i. Normally available to several users at a time (rather than delivering services to individuals one at a time). ii. Providing some combination of treatment for problems related to long-term care needs (e.g. structured activity, social contact and/or support). iii. With regular opening hours and users staying at the facilities not only for the time they have face-to-face contact with staff.
Outpatient care	Type of care typically: <ul style="list-style-type: none"> i. Involving contact between staff and users for some purpose related to management of their condition and its associated clinical and social difficulties. ii. Not provided as part of delivery of residential or day services.
Residential care	Care provision of beds overnight for patients for a purpose related to the clinical and social management of their care needs.

2.2.3 Literature review on quality of mental health and social care services

In the framework of work package 8 of the REFINEMENT project ‘Quality of mental health care and met/unmet needs’, the existing literature on indicators of quality of mental health care was reviewed. The following research questions guided the search:

- i. What are the principal topics of quality of care of mental health services studied and which are the gaps?
- ii. What are the principal indicators used in the international literature?

The literature review was based on two distinguished methodologies:

1. A literature review for published papers using a mapping approach (Gough & Elbourne, 2002); and
2. A hand search of grey literature on portals and organizational websites on quality of care in mental health.

The following electronic databases were searched for published material: Medline, Cinhal, Psycarticles, Psycinfo. Only studies reporting both **mental health** and **quality of care** terms were included. Table 6 reports the search terms.

Table 6. Literature review on quality of mental health care: Search terms

(TI (Mental health OR Mental health service* OR Community Mental Health Service* OR Mental disorder* OR Psychiatric Diagnos* OR Behavior Disorder* OR Behaviour Disorder* OR Mental* illness OR Mentally Ill Person OR Mentally Ill Persons OR Mentally Ill OR Mental Patients OR Psychiatry OR Psychiatric service*) OR SU (Mental health OR Mental health service* OR Community Mental Health Service* OR Mental disorder* OR Psychiatric Diagnos* OR Behavior Disorder* OR Behaviour Disorder* OR Mental* illness OR Mentally Ill Person OR Mentally Ill Persons OR Mentally Ill OR Mental Patients OR Psychiatry OR Psychiatric service*))
AND
(TI (Quality of health care OR Health Care Quality OR Quality of Healthcare OR Healthcare Evaluation OR Healthcare Quality OR Standard of care OR Quality Indicator* OR Process Assessment OR Process Measure* OR Quality Improvement OR Benchmarking OR Best Practice Analysis OR Health Care Benchmarking OR Performance indicator* OR Performance measure* OR Health Care Quality Assurance OR Healthcare Quality Assessment) OR SU (Quality of health care OR Health Care Quality OR Quality of Healthcare OR Healthcare Evaluation OR Healthcare Quality OR Standard of care OR Quality Indicator* OR Process Assessment OR Process Measure* OR Quality Improvement OR Benchmarking OR Best Practice Analysis OR Health Care Benchmarking OR Performance indicator* OR Performance measure* OR Health Care Quality Assurance OR Healthcare Quality Assessment))

Publications were selected according to specific **inclusion** and **exclusion** criteria, as reported in Table 7.

Table 7. Literature review: Exclusion and inclusion criteria

Criteria	Inclusion and exclusion criteria
Time frame	Included only studies published from 2000 until the end of 2011 (14 November 2011).
Geographical areas	Geographical coverage was limited to OECD countries or in the European Economic Area (EEA).
Language	Included only publications in English.
Publication type	Included all relevant publications reporting abstracts or chapter summaries, including full articles, books or book chapters, and grey literature. Excluded materials without abstracts.
Population	Included only adult population (18 - 65 years old) with psychiatric disorders. Excluded publications dealing exclusively with child or adolescent or with people more than 65 years old.
Diagnosis	Included psychiatric disorders as defined by ICD-10 or DSM-IV classifications. Excluded: <ul style="list-style-type: none"> i. Organic mental health disorders (ICD-10: F0). ii. Substance use disorders (ICD-10: F1). iii. Mental health retardation (ICD-10: F7). iv. Physical disorders only (ICD-10: non-F).
Type of service	Mental health services providing care to adults (18 - 65 years old) with psychiatric disorders were included. Excluded: <ul style="list-style-type: none"> i. Services especially dedicated to the treatment of individuals with F0- and/or F1- and/or F7-diagnoses (as per ICD-10), e.g. specific rehabilitation centers for alcohol and drug withdrawal, memory clinics, institutions for individuals with intellectual disabilities. ii. Services exclusively for older people 65+ years old (e.g. nursing homes, mobile home nursing services, etc.). iii. Services exclusively for children and adolescents or their carers/families. iv. Forensic services or military services.

Two pairs of reviewers, including the present author, independently assessed each paper looking at the titles and abstracts. Full papers meeting initial inclusion criteria were retrieved and a final consensus-based assessment was made. From each selected publication the indicators of quality of mental health care were extracted and inserted in an Excel database. The following information were collected:

1. Source (references);
2. Country;
3. Type of service (e.g., inpatient unit, day care centre, employment service, etc.);
4. Name of the indicator;
5. Level of quality (input, process, outcome);
6. Dimension of quality (accessibility, continuity, effectiveness, sustainability, etc.);
7. Rationale;
8. Standards or benchmarking (if available);
9. Definition of the indicator; and
10. Type of measurement (numerator, denominator, rate, percentage, etc.).

The sources for grey literature review were selected based on the expertise of the REFINEMENT research team and were representative of the principal international organizations on evaluation of quality of care. Indicators selected from the grey literature search were catalogued and merged with those collected from the literature review. The final database was double-checked for duplicates, which were excluded.

2.3 THE ITALIAN MULTICENTRE STUDY

In order to further analyse the results obtained in the REFINEMENT project as well as integrate the data collection with measures at staff and service user level, a different project was designed and carried out in the Italian context.

The study was coordinated by the Research Unit Psychiatric Register, Economics and Geography of Mental Health at the University of Verona. It started in January 2013 and involved three centres in Italy: Lecco Mental Health Department (MHD), Legnago MHD, and South Verona Community Mental Health Service (CMHS). Both staff and mental health service users from the three sites were involved in the study. The research team in South Verona was coordinated by Professor Francesco Amaddeo and included Professor Giorgio Gosetti (Professor of Sociology), Laura Rabbi (Social Worker and Researcher), Dr Federico Tedeschi (Statistician), and the present author. Antonio Lora, Psychiatrist and Director of Lecco MHD, coordinated the study in this site with the collaboration of one psychologist and one administrative assistant. Dario Lamonaca, Psychiatrist, coordinated the project in Legnago MHD. He was assisted by three rehabilitation therapists and one nurse who carried out the interviews.

2.3.1 Areas of study

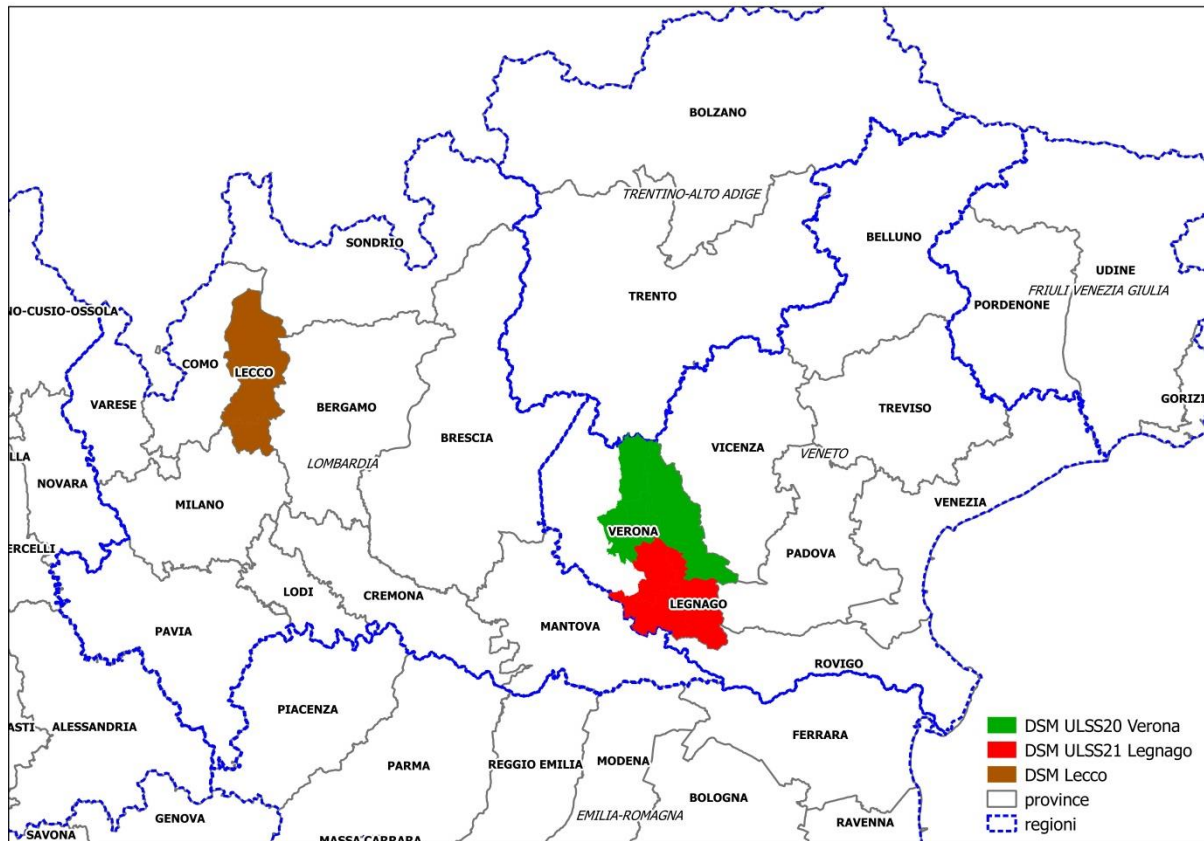
Three centres in Northern Italy were selected for the Multicentre study:

1. Lecco Mental Health Department (MHD);
2. Legnago MHD; and
3. South Verona Community Mental Health Service (CMHS).

Both Legnago and Verona are in the Veneto Region, whereas Lecco is in Lombardy. The geographical location of the three areas is illustrated in Figure 2, while further socio-

demographic characteristics of the areas and the features of mental health services in the three centres will be described in Chapter 4.

Figure 2. Geographical location of selected areas in the Multicentre study



2.3.2 Overview of methods and instruments

Data collection comprised a mixed methods approach involving a staff survey, individual interviews with service users, and analysis of data from the Mental Health Information Systems (MHISs). Table 8 summarizes the methods and instruments used.

Table 8. Methods and instruments adopted in the Multicentre study

Method	Instruments
Survey on quality of professional life	Professional Quality of Life Scale - ProQOL III
	Quality of Working Life Questionnaire
Interviews with service users	Socio-demographic Information Sheet
	CONTINUity of care User Measure - CONTINU-UM
	Adult Social Care Outcomes Toolkit - ASCOT
Analysis of data from Mental Health Information Systems	Clinical variables
	Services utilization variables

2.3.3 Survey on quality of professional life

The survey on quality of professional life was comprised of two instruments:

1. Professional Quality of Life Scale (ProQOL III)
2. Quality of Working Life Questionnaire.

ProQOL III focused on three conceptual domains: Burnout (BO), Compassion Fatigue (CF), and Compassion Satisfaction (CS). The Italian version of the instrument (see Appendix 1) has been validated in a study involving 939 subjects where the theoretical three dimensional structures have been confirmed (Palestini *et al.*, 2009). The ProQOL III is composed of 30 items corresponding to three sub-scales: BO Scale, CF Scale, and the CS Scale. Respondents

were asked to indicate how often (0=never, 5=very often), during the last 30 days, each item was experienced (Stamm, 2005). The pre-established threshold values were 32.0 for CS, 28.0 for BO, and 17.0 for CF. These cut-off values were based on the scores corresponding to the lowest quartile for CS and the highest quartile for BO and CF as reported in the ProQOL Manual (Stamm, 2005). That is, a score of 32.0 or below on the CS scale might predict job dissatisfaction, while scores above 28.0 on the BO scale might suggest negative feelings about one's effectiveness in one's position. Regarding the CF scale, scores above 17.0 might suggest the presence of a potential problem in this domain (Stamm, 2005).

The Quality of Working Life Questionnaire was developed for this study in collaboration with Professor Giorgio Gosetti, based on other questionnaires previously used in other work settings (Gosetti, 2014). The dimensions and perspectives captured by the questionnaire are shown in Table 1, while the whole questionnaire is attached in Appendix 2. The questionnaire underwent several revisions by the research group and was pre-tested on a sample of 16 staff members in the South Verona CMHS. Participants were representative of the different occupational categories employed by the service, i.e. psychiatrists, psychiatrists in training, nurses, psychologists, professional educators, social workers, and support workers. Professor Gosetti and the present author conducted the group. Participants were first invited to complete the questionnaire and afterwards to discuss the items one by one. Thanks to the suggestions of the group, it was then possible to develop the final version of the instrument.

The data collection started by organizing a meeting in each of the three sites to present the research project to managers and staff members. At these meetings the study protocol, tools and the procedure for filling the survey were explained and discussed. The data collection started in November 2013 and was completed by August 2014.

All staff working in the three centres of Lecco, Legnago and South Verona were asked to complete anonymously the two questionnaires mentioned above. They were in charge of

either clinical, research or administrative activities and were psychiatrists, psychologists, psychiatric nurses, social workers, rehabilitation therapists, support workers, psychiatrists in training, researchers, and administrative staff. No distinction was made on the type of contract or the organization they belonged to, that is, both staff members employed by the public sector and by private and non-profit organizations contracted with the MHDs in Lecco and Legnago and the CMHS in South Verona were involved.

Each member of staff received an envelope containing the two questionnaires (ProQOL III and Quality of Working Life Questionnaire) to be filled in, the study information sheet, the informed consent form and an unmarked envelope in which to place and seal the completed questionnaires. The compilation of the instruments and informed consent form took approximately 20 minutes. In each site a nominated person was responsible for collecting the questionnaires. The two centres of Lecco and Legnago delivered the questionnaires to the Verona centre, which was responsible for collecting all materials and entering the data into a single database.

2.3.4 Interviews with service users

Through the Mental Health Information Systems (MHISs) in the three sites it was possible to identify patients to be invited to participate in the study. Each site selected the first 100 patients that in the first three months from the commencement of the study have had either inpatient or outpatient (including day care and rehabilitation activities) contacts with the services. The recruitment was based on the following **inclusion criteria**:

- i) Being in contact with the mental health service for at least two years;
- ii) Having had at least one contact with the mental health service during the last two years; and
- iii) Being aged between 18 and 65 years old.

The three centres provided the complete list of patients who both have had contacts with the service in the considered timeframe and met the inclusion criteria illustrated above. As for Legnago MHD and Verona CMHS, a systematic sampling method was used to select the sample of 100 patients. Whereas for selecting patients at Lecco MHD a stratified sampling strategy (with simple random sampling within each stratum) was used. Here, members of the population were divided into three homogeneous subgroups before the sampling, corresponding to users of community mental health services, residential facilities, and general hospital psychiatric units respectively. The stratified sampling strategy allowed sampling each subpopulation (stratum) independently, thus improving the representativeness of the sample by reducing sampling error. Moreover, in each centre a group of additional 100 patients was created; these were substitutes to be contacted in case there would be refusals by people in the original sample. The additional groups were randomly ranked and such rankings were followed in getting in contact with people (e.g.: in case of 10 refusals, the first 10 patients of the additional list were contacted).

The selected sample was then invited to complete the research questionnaires. The instruments administered were the following:

1. Socio-demographic Information Sheet
2. CONTINUity of care User Measure (CONTINU-UM)
3. Adult Social Care Outcomes Toolkit (ASCOT).

The Socio-demographic Information Sheet (see Appendix 3) was adapted from the Client Socio-Demographic and Service Receipt Inventory (CSSRI – EU; Chisholm *et al.*, 2000) and was used to collect relevant socio-demographic characteristics, as detailed in Table 9.

CONTINU-UM is a measure of continuity of care produced from the perspectives of service users (Burns *et al.*, 2009; Rose *et al.*, 2009). The final measure, as reported in Table 9, consisted of 16 domains. Each domain was split into four items:

- a) The importance of the domain to the respondent;
- b) Whether the respondent had received the domain in the last 12 months;
- c) Whether the respondent was satisfied with their experience; and
- d) Further comments (free text).

Questions a) to c) were scored on a five-point adjectival Likert scale. Three of the b) domains were reverse scored: staff changes, repeating your life history, and waiting. There were two types of missing data: first, when there was no response at all and second, when a respondent ticked ‘not applicable’. This measure has been shown to be psychometrically robust (Rose *et al.*, 2009). The English version was translated into Italian for the purposes of this study. A collaboration was established with the authors of CONTINU-UM, Dr Angela Sweeney and Professor Diana Rose, in order to translate and adapt the instrument to the Italian context. The translation underwent several revisions and was preliminarily submitted to a sample of 20 service users who were involved in focus groups to discuss experiences of continuity of care

as well as to pre-test the instrument. For the Italian version of CONTINU-UM see Appendix 4.

ASCOT is a collection of tools for measuring an individual's Social Care-Related Quality of Life (SCRQoL) (Netten *et al.*, 2011). In this study we adopted the four-level interview tool (INT4), which is designed for use with people living in community settings. The questionnaire covered eight domains which reflect outcomes of social care activities, as reported in Table 9. The measure included 23 questions from which current SCRQoL and expected SCRQoL can be calculated. In addition to a question asking about a person's current status within each domain, there was also a 'hypothetical question' asking people to rate what their quality of life would be like in the absence of services. ASCOT was translated into Italian following the guidelines provided by the ASCOT team from the Personal Social Services Research Unit at the University of Kent (England). The forward translation was carried out by the present author, after attending two days of ASCOT training in London. The instrument was translated back to English by an independent translator, whose mother tongue was English and who had no knowledge of the questionnaire. The English version of the questionnaire was then submitted to the ASCOT group main researcher (Dr Juliette Malley) for review. During this phase some linguistic discrepancies were found and corrected. Some terms in the Italian version were changed as they slightly modified the sense of the original text. For example, the term *affect* in the question "Do the support and services that you get from <<example>> affect how much control you have over your daily life?" was firstly translated into Italian as *help*, which wrongly implied a positive effect. In addition, the fact that people are asked not to make any assumptions about any additional help/care that may step in to help them if they had no formal services needed further clarification. Moreover, the two questions on dignity underwent several revisions, as they were complex to translate into Italian in a clear and concise way. At first, the difference between the two questions was

difficult to make. After these revisions, the final version of the instrument was sent to the ASCOT group at PSSRU and finally approved. The instrument is attached in Appendix 5.

In Lecco one psychologist was in charge of organizing and carrying out the interviews. She directly phoned the selected service users to introduce the research and establish their willingness to be interviewed. In Legnago four members of staff (three rehabilitation therapists and one nurse) were responsible for the interviews. Before starting the data collection the interviewers in Lecco and Legnago were trained by colleague Laura Rabbi and the present author on the instruments and the interview structure. During the data collection phase we remained in constant contact with the other interviewers and organized Skype meetings on a regular basis to monitor progress. In South Verona, colleague Laura Rabbi and the present author contacted the service users through their case manager (usually a psychiatrist or psychologist). The service user was first invited to take part in the research by their case manager, who explained the purpose of the study and established their willingness to meet the research team at the end of the next programmed visit. When it was more convenient for the person, we also gave the opportunity to arrange another appointment for the interview. In all three sites most of the interviews took place in the mental health facilities. The interview lasted about one hour. The interviewee was first given the information sheet and the consent form. After signing the consent form, the Socio-demographic Information Sheet was completed. CONTINU-UM was offered as either self-complete or interview, while ASCOT was interview-based.

Table 9. Instruments and variables collected during interviews with service users

Instrument	Variables
Socio-demographic Information Sheet	<ol style="list-style-type: none"> 1. Gender 2. Marital status 3. Nationality 4. Education 5. Living situation 6. Accommodation 7. Employment 8. Income 9. Receipt of social welfare benefits 10. Utilization of health and social services
CONTINUity of care User Measure (CONTINU-UM)	<ol style="list-style-type: none"> 1. Access 2. Range 3. Waiting 4. Out of hours support 5. Hospital discharge 6. Staff changes 7. Information 8. Flexibility 9. Individual progress 10. Day centres 11. Care plans 12. Crisis 13. Staff communication 14. Peer support 15. Life histories 16. Avoiding services
Adult Social Care Outcomes Toolkit (ASCOT)	<ol style="list-style-type: none"> 1. Control over daily life 2. Personal cleanliness and comfort 3. Food and drink 4. Personal safety 5. Social participation and involvement 6. Occupation 7. Accommodation cleanliness and comfort 8. Dignity

2.3.5 Analysis of data from Mental Health Information Systems

Clinical and Services Utilization variables were obtained from the Mental Health Information Systems (MHISs) in Lecco, Legnago and South Verona. MHISs gather information region-wide from all Mental Health Departments and from private day care and residential facilities contracted with the public sector. The MHISs provide a complete description of service activities, as well as monitoring the interventions provided. The information system collects demographic information and ICD-10 (WHO, 1992) diagnoses on any user of mental health services, as well as recording all users' care episodes in any setting (outpatient and home contacts, day-care attendance, admissions to general hospital and residential facilities).

Diagnosis, as classified by the ICD-10 system (WHO, 1992), was collected as the clinical variable. The variables measuring utilization of services, as shown in Appendix 6, were:

- a) Date of first contact with the psychiatric service;
 - b) Number of admissions and days hospitalized in acute psychiatric wards in the last 12 months;
 - c) Day care contacts (including day care, rehabilitation, socialization and work-related activities) in the last 12 months;
 - d) Number of domiciliary visits (visits at patient's home to provide crisis intervention in response to emergency calls, or visits planned in advance to provide assessment and treatment; visits made by such mental health workers as psychiatrists, psychologists, social workers, occupational therapists and psychiatric nurses) in the last 12 months;
 - e) Number of outpatient contacts (consultations and therapies) in the last 12 months;
 - f) Number of contacts with different members of staff (i.e., psychiatrists, psychologists, nurses, social workers, occupational therapists, and other staff) in the last 12 months;
- and

- g) Breaks in contacts with the community psychiatric service for more than six months in the last two years.

2.3.6 Ethical approval

The Ethics Committee for Clinical Trials in Verona (Comitato Etico per la Sperimentazione Clinica delle Province di Verona e Rovigo) reviewed and approved the study protocol. This was subsequently approved by the Ethics Committees in the two centres of Legnago and Lecco.

Both staff and service users were informed that taking part in the research was voluntary and that choosing not to take part would not disadvantage them in any way. An information sheet was provided to explain why the research was conducted and what participation involved. It was explained that the collected data would be managed according to privacy regulation (D.Lgs. 196/2003) and that all data would remain anonymous. Participants were told they might withdraw from the research, without giving a reason, at any time during the study.

For service users, a procedure of pseudoanonymization was adopted to render the data records less identifiable. The most identifying field within the Mental Health Information Systems (MHISs) was the ‘case register number’, a unique patient identifier by which the Information Systems match the person to his/her health records. This field was replaced by one pseudonym from which the identities of individuals could not be intrinsically inferred. The pseudonym was a sequential alphanumeric code where the alphabetic characters identified the centre (i.e., “LC” for Lecco, “LG” for Legnago, and “VR” for South Verona) and the number the temporal succession of interviews. Pseudonyms linked to the person’s identifier were kept in a separate secure file under the responsibility of one researcher per centre. This allowed tracking back of data to its origins as well as linking data obtained from the MHISs with those collected through the interviews. Service users were informed that they

would be attributed a code and that only one authorized researcher in each centre would be able to link this code to their names. Service users were also given the possibility to inform their General Practitioner (GP) about their participation in the research if they wished to. An Information Sheet for the GP was prepared and handed to the participant during the interview.

3. THE REFINEMENT PROJECT

This chapter illustrates the major findings of the REFINEMENT project. Section 3.1 presents the results of SIF data collection on mental health care provision in eight European study areas. Data from Estonia could not be double-checked and were incomplete so they were excluded from the analysis. In Section 3.2 the results of the literature review on quality of mental health care will be presented. As a result of this review a tool called REQUALIT (REfinement QUALity of care Tool) for collecting information on the performance and outcomes of mental health and social care in Europe was created. The detailed characteristics of REQUALIT will be presented. Finally, a few examples of the information collected using the tool in the eight REFINEMENT areas will be illustrated. Especially, examples of indicators of social care quality included in REQUALIT will be presented.

3.1 MENTAL HEALTH CARE PROVISION IN EIGHT EUROPEAN STUDY AREAS

As explained above, SIF constituted an integral part of REMAST and thus data related to it and other sections of REMAST were collected simultaneously. Each research group in the eight European countries identified two or three people responsible for the REMAST data collection. The University of Verona was the task leader and assisted the other research groups throughout the data collection process. The Verona research team worked in partnership with the Spanish research team based at PSICOST in double-checking and refining the SIF data. The REMAST data collection started in January 2012 and finished by September 2013. In September 2012 a Report was completed of the preliminary results of the REMAST data (REFINEMENT group, 2012).

SIF data collection allowed analyzing the provision of mental health care in eight European study areas. Data regarding services available in each area and their characteristics are reported in Table 10. The analysis focused on the Main Types of Care (MTCs, see Table 5 for definition) identified in every area. As shown in Table 10, the total number of MTCs in the eight study areas was 1270. The number of residential MTCs was 361, while 704 were outpatient MTCs, and 205 were day care services. As for outpatient care, in Industrieviertel [AUT], Loiret [FRA], and Jud Suceava [ROM] single-handed psychiatrists and psychologists were a dominant organizational structure in health care provision to people with mental health problems. This organizational structure was infrequent in Helsinki and Uusimaa [FIN], Verona [ITA] and Girona [SPA], and was absent in Hampshire [ENG]. Looking at the user group variable, 1018 were MTCs working exclusively with people with mental health problems, while 252 were for generic healthcare users that, to some extent, were accessed also by mental health service users. Services belonging to the health sector were predominant (N=1106), followed by services in the social care sector (N=112).

Table 10. Mapping of mental health services in eight European study areas

	Type of care (Number of MTCs)			Users group (Number of MTCs)		Sector (Number of MTCs)					
	Residential	Outpatient	Day care	Mental health	General health	Health	Social	Work	Education	Justice	Other
Industrieviertel [AUT]	25	126	16	156	11	141	11	10	0	0	5
Hampshire [ENG]	29	63	17	108	1	106	3	0	0	0	0
Helsinki and Uusimaa [FIN]	151	63	42	256	0	240	3	12	1	0	0
Loiret [FRA]	58	169	37	202	62	232	19	13	0	0	0
Verona [ITA]	46	77	24	71	76	99	45	2	0	1	0
Sør-Trøndelag [NOR]	17	169	50	149	87	226	5	0	0	0	5
Jud Suceava [ROM]	13	21	2	36	0	28	8	0	0	0	0
Girona [SPA]	22	16	17	40	15	34	18	0	0	0	3
Total	361	704	205	1018	252	1106	112	37	1	1	13

3.1.1 A new taxonomy to analyze health vs. non-health care services

The distinction between health and, for example, social (care), education, and work sectors, as shown in Table 10, was based on the agency/department responsible for the oversight and governance of such specific functions. However, this classification proved problematic when comparing different areas in different countries. This is due to the high geographical variation across mental health services in Europe, where, for instance, similar community residential services and day care/rehabilitation services might be run from the social (care) sector in one catchment area but be run by the health sector in another.

In order to compare groups of services referring to similar activities and provided in similar settings, and thus to facilitate territorial comparisons of like-with-like, in this study a new taxonomy based on DESDE-LTC was created. As shown in Table 11, this taxonomy enabled distinctions to be made between health and non-health care activities. In general terms, ‘health care’ refers here to services whose main aim is explicitly direct clinical treatment of diseases (in this case mental disorders); and that is usually provided by healthcare professionals, typically with over three years of training in health sciences (physicians, nurses, psychologists, physiotherapists). ‘Non-health care’ is typically provided by other staff and its main aim is not direct clinical treatment. It typically includes caring, housing, training, promotion of independence, development of autonomy, personal, interpersonal, work placement and support and social skills; and integration, inclusion, social participation, and encouragement of mental as well as social capital within communities (McDaid *et al.*, 2007; Morgan, 2007).

Overall, 820 MTCs (65%) were identified as providing health care and 450 (35%) non-health care. This indicates that over one third of the specific care provision for mental health was non-health related. As shown in Figure 3, this proportion varied across the eight areas, with

Verona [ITA] showing the highest proportion of non-health related services (49%) and Industrieviertel [AUT] and Hampshire [ENG] the lowest (23% and 24% respectively).

Figure 3. Health vs. non health care services in the REFINEMENT study areas

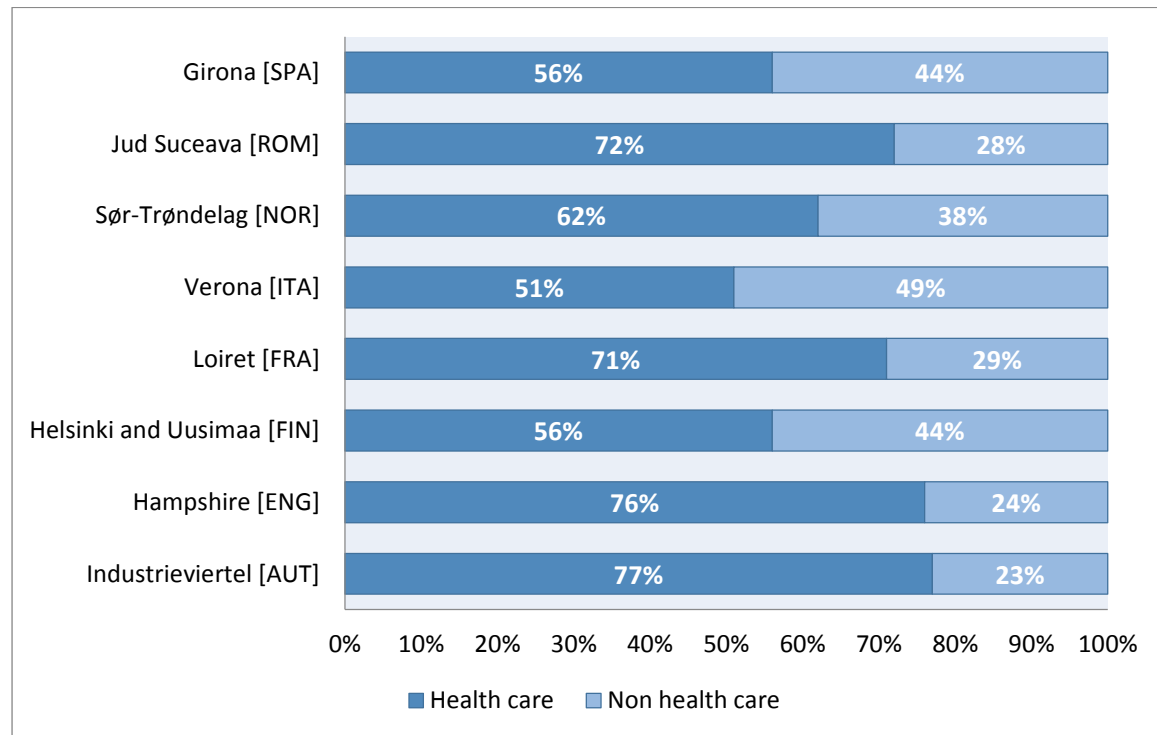


Table 11. Taxonomy of health and non-health care services

MAIN ACTIVITY	TYPE OF CARE	DEFINITION	DESDE-LTC CODE	EXAMPLES
HEALTH CARE	RESIDENTIAL CARE	Acute, 24 h physician cover	R0, R1, R2	Units from general hospitals, psychiatric hospitals, other specialist hospitals
		Acute, non 24 h physician cover	R3.0, R3.1.1	Some acute wards at specialised psychiatric hospitals without 24-h medical cover
		Non-acute, 24 h physician cover	R4, R5, R6, R7	Units for rehabilitation, community therapeutic programmes, nursing homes
	OUTPATIENT CARE	Acute, health related care*	O1.1, O2.1, O3.1, 04.1	Emergency units in general hospitals, home & mobile teams providing crisis treatment
		Non-acute, health related care*	O5.1, O6.1, O7.1, O8.1, O9.1, O10.1	Community mental health teams, Outpatient psychiatric clinics
	DAY CARE	Acute	D1.1, D1.2	Day hospitals
Non-acute, non-work structured, health related care*		D4.1, D8.1	Day care centres	
NON-HEALTH CARE	RESIDENTIAL CARE	Non-acute, non 24 h physician cover	R8, R9, R10, R11, R12, R13, R14	Residences, houses for groups, therapeutic communities with various levels of support from staff
	OUTPATIENT CARE	Acute, not meeting the criteria for health related care	O1.2, O2.2, O3.2, 04.2	Emergency units providing crisis intervention, non-health related
		Non-acute, not meeting the criteria for health related care	O5.2, O6.2, O7.2, O8.2, O9.2, O10.2	Home care for daily activities (e.g., cleaning, grooming, cooking, toileting and dressing)
	DAY CARE	Non-acute, work	D2, D6	Sheltered work services or opportunities on the open labour market
		Non-acute, work-related care	D3, D7	Occupational centres, workshops
		Non-acute, non-work structured, education, social, cultural, or other	D4.2, D4.3, D4.4, D8.2, D8.3, D8.4	Creative activities, art, music, group work
		Non-acute, non-structured care	D5, D9	Social contact, practical advice and/or support

* Main goal is the specific clinical care and at least 20% of the staff is qualified health care professionals.

‘Availability’ not only relates to the number of services in an area, but also to the capacity of each service. Staff numbers and beds availability were considered in the analysis as indicators of capacity. Table 12 shows the distribution of full-time equivalent personnel in health and non-health care services in the eight study areas. Looking at total staff numbers, 79% of staff worked in health care services and 21% in non-health ones.

Beginning with health related services, Sør-Trøndelag [NOR] stood out showing the highest number per 100,000 adult population when considering both the total staff (359.8) and the single categories of staff. In non-health care this rate ranged from 2.6 in Hampshire [ENG] to 99.4 in Jud Suceava [ROM]. However, it must be noted that information on staff was lacking for some services. Hence, the staff level shown for some study areas may be too low. This is especially the case for the study area in England, where about 30% of services had missing data on staff.

Focusing on beds availability, Table 13 shows a major diversity among European areas in provision of residential care for people with mental health problems. Totally, 45% of beds were found in health care services and 55% in non-health services. As far as health care services are concerned, the average number of beds per residential unit ranged from 13.9 in Verona [ITA] to 75 in Jud Suceava [ROM]. In non-health services this average ranged from 3.4 in Loiret [FRA] to 106.4 in Jud Suceava [ROM]. Furthermore, the highest rates of health care beds per 100,000 adult inhabitants were found in Helsinki and Uusimaa [FIN] and Sør-Trøndelag [NOR]. In non-health services the highest rates of beds were found in Helsinki and Uusimaa [FIN] and Jud Suceava [ROM].

Table 12. Staff in health and non-health care services per 100,000 capita (18+ years)

	Total*	Psychiatrists/Other doctors	Psychologists	Nurses	Social workers	Occupational therapists	Other staff
Industrieviertel [AUT]							
Health care	63.7	23.2	10.5	21.3	4.7	1.9	2.2
Non health care	22.2	0.03	3.3	7.3	1.0	0.7	9.9
Hampshire [ENG]							
Health care	128.1	11.5	9.7	79.3	10.4	8.6	8.6
Non health care	2.6	0.1	0.0	0.0	0.1	0.1	2.3
Helsinki and Uusimaa [FIN]							
Health care	184.4	23.9	11.5	88.5	9.3	6.6	44.6
Non health care	63.5	0.4	0.2	9.5	0.8	0.4	52.2
Loiret [FRA]							
Health care	155.7	18.7	22.1	72.5	4.1	0.1	38.2
Non health care	6.5	0.1	0.1	5.0	0.1	0.0	1.1
Verona [ITA]							
Health care	118.3	18.5	5.2	44.3	3.8	0.0	46.5
Non health care	37.6	2.5	2.1	2.4	0.9	0.0	29.7
Sør-Trøndelag [NOR]							
Health care	359.8	35.6	69.5	146.3	20.1	16.0	72.3
Non health care	73.0	0.1	0.7	13.2	19.9	1.7	37.3
Jud Suceava [ROM]							
Health care	35.8	9.0	5.4	18.0	1.7	1.7	0.2
Non health care	99.4	5.8	2.3	29.4	2.3	16.1	43.6
Girona Area [SPA]							
Health care	29.4	9.3	2.2	6.5	2.8	0.5	8.0
Non health care	6.7	0.1	0.7	0.03	0.7	0.2	5.1

* Only services exclusively for people with mental health problems were included here (N = 1018).

Table 13. Provision of residential services in REFINEMENT study areas

	Average number of beds per Residential Service * (Min – Max)	Total beds per 100,000 adult inhabitants in the Study Area
Industrieviertel [AUT]		
Health care	52 (44-60)	23.3
Non health care	13.8 (2-46)	37.0
Hampshire [ENG]		
Health care	18.4 (4-75)	33.7
Non health care	25.5 (11-43)	7.5
Helsinki and Uusimaa [FIN]		
Health care	16.7 (3-56)	91.3
Non health care	24.4 (6-91)	172.2
Loiret [FRA]		
Health care	29.8 (17-77)	63.4
Non health care	3.4 (1-5)	11.4
Verona [ITA]		
Health care	13.9 (10-25)	42.5
Non health care	6.4 (1-20)	35.8
Sør-Trøndelag [NOR]		
Health care	15.9 (5-41)	105.7
Non health care	10 (10-10)	8.9
Jud Suceava [ROM]		
Health care	75 (40-160)	77.4
Non health care	106.4 (10-420)	175.7
Girona Area [SPA]		
Health care	44.7 (42-50)	22.4
Non health care	11.8 (4-58)	21.7

* Only services exclusively for people with mental health problems were included here (N = 1018).

3.1.2 Discussion

In line with previous reports (WHO, 2008, 2011), the mapping of mental health services showed the huge diversity in the provision of mental health care across Europe. As McDaid and colleagues (2007) point out, these findings demonstrate that a substantial share of responsibility and funding for mental health care is found in non-medical support services. In fact, a considerable part of mental health care resources in Europe were found in non-health services as defined in the taxonomy developed for this study.

The data also indicate that non-health services play a different role in different countries, this resulting in different configurations of the balance of care across Europe. Generally, day and residential care seemed to be the main areas of non-health care provision. However, in Hampshire [ENG] residential services providing non-health care were infrequent. In Verona [ITA] and Sør-Trøndelag [NOR] outpatient services (more specifically, municipalities in Norway and local social services in Italy) also played a substantial role in providing non-health care to people with mental health problems. However, it should be noted that such services do operate also in the other areas although they were not mapped, in many cases due to lack of information. In Helsinki and Uusimaa [FIN] the major area of non-health care was represented by residential services. In this area the bed rates in non-health related services were much higher than in the other countries. The majority of non-health beds were found in nursing homes with 24-hour staffing providing permanent care for people with severe mental disorders. The rest were mainly beds in nursing homes with daily support. These categories of beds have been rapidly increasing in Helsinki and Uusimaa, and represent trans-institutionalization (a shift from hospitals to other institutions) (Fackhoury & Priebe, 2007), as well as private entrepreneurship (the majority of these nursing homes are private for-profit under public contract and highly profitable). Furthermore, Jud Suceava [ROM] had a high number of both health and non-health beds (mostly indefinite stay beds with daily support), a majority of these being found in extremely large units. However, all these data must be interpreted with caution due to the fragmentation of the mental health system in Romania which might have led to substantial inconsistencies in data collection (Junjan *et al.*, 2009). In addition, in Romania there is no catchment area organization (i.e., ‘sectorization’) and mental health services usually serve the whole country population. Thus, data adjusted for the study area population might not be realistic. Future studies are warranted to further analyze the pattern of the balance of care including service availability and capacity in eastern European

countries with a particular focus on the deinstitutionalization process and the mental health care reform in these countries.

Interestingly, the new taxonomy developed in this study did not match with the traditional classification based on sector (i.e., health, social, work, education). Indeed, almost two thirds of non-health care related activities were found in the health sector. This adds further evidence to the importance of distinguishing services by their main activity in order to appraise their actual functions and patterns of care. Also, this study identified some ‘grey zones’ that were more difficult to be analyzed. These refer for example to day care/rehabilitation activities and supported housing.

This analysis offers a well-structured procedure for international collection of overall mental health services in Europe. It involved the use of an internationally standardised instrument for service assessment (DESDE-LTC), on-line training material, a brief face-to-face training course and monitoring of the data collection by the coordinating group. However, the large number of researchers collecting data across the eight partner countries, the different levels of information availability and databases across the eight countries, the practicality of the assessment tool, and the complexity of the assessment of mental health systems may have led to data inconsistencies. The identification of the minimal units of production of care (BSICs) at every specialized service required a considerable time effort and revision of the information gathered in each study area. In addition, missing information was identified in several countries particularly in non-health care services. Therefore, the results of this research require confirmation in future studies of managerial epidemiology that should be carried out by a limited number of highly trained raters. Even though this could be a better alternative when comparing two countries (Salvador-Carulla *et al.*, 2008) or services within a single region (Tibaldi *et al.*, 2005), it is not practical in larger international comparisons. Alternatively, on-line tools could be developed to produce automatic codes and mapping of

the service systems. Using such tools can be useful also for longitudinal monitoring of service changes within an area. Paradoxically enough, a huge public investment has been made to improve utilization databases whilst little effort has been made to provide a standard coding of the care services themselves. There is an urgent need to develop IT tools that may facilitate the identification of services and their coding by care function. Indeed, this taxonomy is a useful tool that can apply to other areas of integrated care, such as geriatric care.

Some limitations of the study should be acknowledged. First, there is a limitation in the terminology itself. The term ‘non-health care’ is very broad and services have been reported in this category to a varying degree. Although the DESDE system allowed distinguishing quite precisely non-health care provision, a ‘negative’ definition is not the best alternative in terminology and taxonomy. Also, caution must be used in comparing data, especially in relation to indicators such as staff and beds availability. The comparison of bed rates illustrates the challenge in making international comparisons of mental health care services. The definition of (type of) service and how beds are reported may differ between countries. Differences may arise both related to how services are organized and funded and how they are reported in national statistics. Finally, a bottom-up approach was missing in this study. In some instances the only way to obtain the information on the individual non-health care services would be by contacting mental health advocacy groups and/or service user groups. Hence, in future studies a triangulation of the relevant stakeholder groups including service users and carers is recommended.

3.2 QUALITY OF MENTAL HEALTH AND SOCIAL CARE SERVICES

One of the challenges in assessing quality in a mental health system has been a lack of agreement on the dimensions and measures which should be used as indicators of quality of care in mental health (Hermann *et al.*, 2006). In part, this may be due to differences in the organization of health care systems, policy priorities and data sources available in different countries. The REFINEMENT work package 8 ‘Quality of mental health care and met/unmet needs’ aimed to address these issues. As presented below, an extensive literature search for indicators on quality was conducted. As a result of this literature review the instrument REQUALIT was developed and piloted in the eight REFINEMENT countries.

3.2.1 Literature review on quality of mental health and social care

Here the findings of both the literature review and the grey literature search are reported. Beginning with the literature review, a total of 1210 papers resulted from this search (see 2.2.3 for details on the methodology used in this process). As shown in Figure 4, the **first review phase** was based on title and abstract review. 625 of the papers were excluded from this phase as it was clear they did not meet the inclusion criteria (i.e., time frame, geographical areas, language, publication type, population, diagnosis, type of service). The **second review phase** was based on the full text analysis and resulted in an additional 177 papers being excluded because they did not meet the inclusion criteria. 446 indicators were extracted from the papers. In the **third review phase**, the 446 indicators were compared one by one with the indicators extracted from the grey literature search (approximately 540) in order to identify and remove identical or very similar indicators. A final number of 830 candidate indicators resulted from the literature review and the grey literature review. The results of the grey literature search are presented in Table 14. The sources were selected on

the basis of the expertise of the REFINEMENT partners and were representative of the principal international organizations on quality of health and social care evaluation.

Table 14. REFINEMENT project: Results of grey literature search

Organisation	Country	Number of indicators
Australian Council of Healthcare Standards	Australia	34
Danish National Indicator Project	Denmark	43
Canadian Institute for Health Information	Canada	5
Key performance indicators for Australian public mental health services	Australia	12
Center for Quality Assessment and Improvement in Mental Health	USA	206
National Centre for Health Outcome Development	United Kingdom	32
Mental health information and determinants for the European level (MINDFUL)	Finland	18
Società Italiana di Epidemiologia Psichiatrica - Quality Indicators in Severe Mental Illness project (QuISMI)	Italy	45
The OECD Health Care Quality Indicators project	Europe	11
Swedish Health Care	Sweden	7
Canadian Mental Health Association	Canada	107
Personal Social Services Research Unit, University of Kent	United Kingdom	16
The Joint Commission	USA	7
Total		543

The **fourth review phase** was carried out by the two main investigators of work package 8 (Dr Valeria Donisi and Professor Francesco Amaddeo, project coordinator). In this phase a substantial number of indicators was excluded in order to limit the number of indicators that comprise the final tool, as well as assuring that the main aspects of quality of mental health and social care would be represented. The following types of indicators were excluded:

1. Indicators related to financial aspects (e.g., costs, budget allocation), as they were part of the REFINEMENT work package 4.

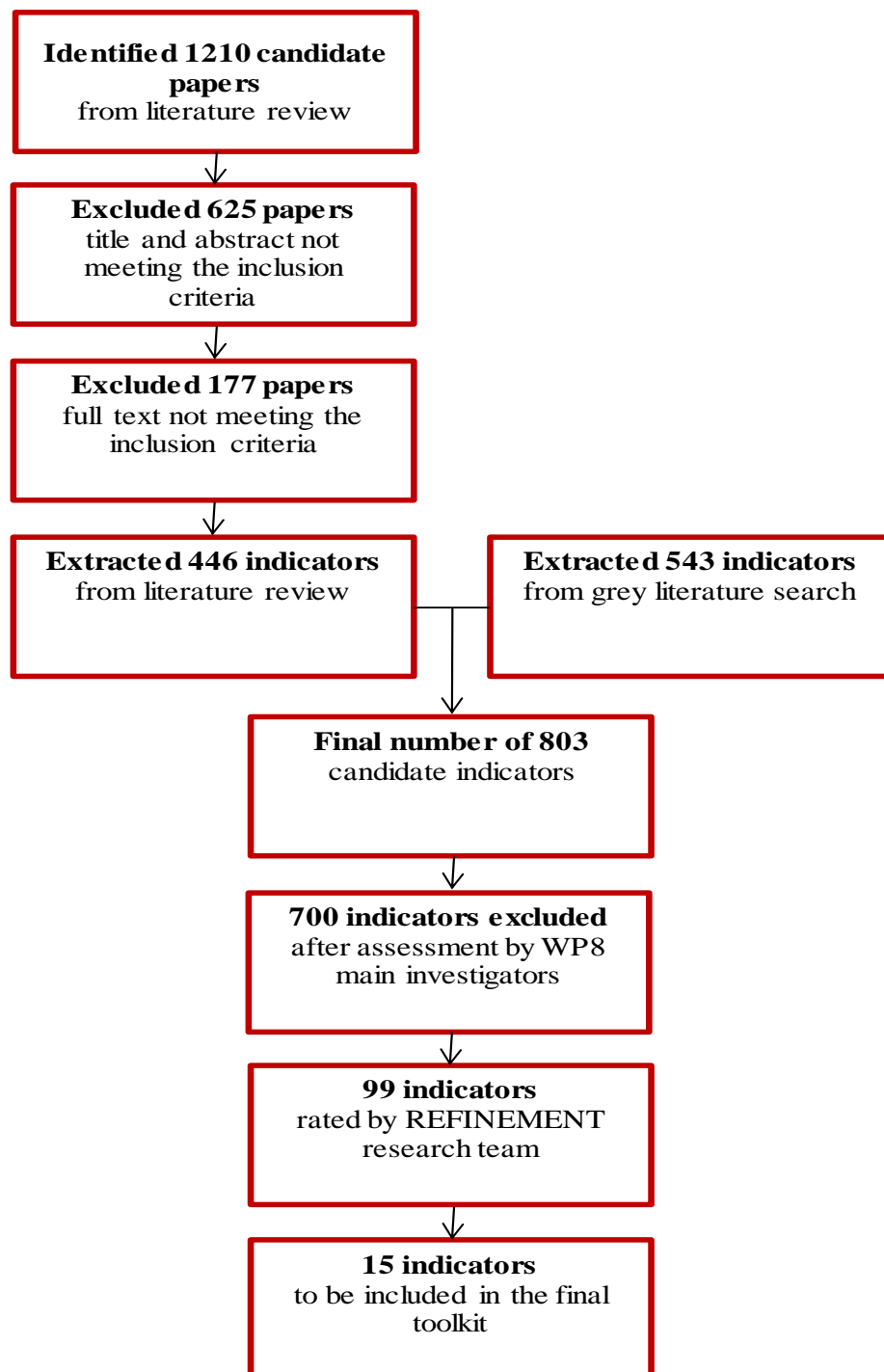
2. Indicators representing subcategories of broader indicators. In this case only one indicator for each main category (e.g., hospital readmission, community tenure, assessment of needs, etc.) was included.
3. Indicators related to specific diagnostic groups when the same indicator existed for all diagnostic groups. In this case more general and comprehensive indicators were preferred to specific ones.

The indicators resulting from this screening were 99. In the **fifth review phase** nine experts, one from each REFINEMENT research team, were asked to rate the 99 indicators on numerical scales according to three criteria:

1. Relevance
2. Scientific soundness
3. Feasibility (Hermann *et al.*, 2004).

Each indicator was rated anonymously. For the criteria of relevance and scientific soundness, a 7-point Likert scale was used on a continuum from *strongly agree* to *strongly disagree*. For feasibility, the experts were asked to assess whether each indicator was *likely*, *possibly* or *unlikely* to be feasible, based on the feasibility of data collection in their country. As the aim is that the REQUALIT is used in a comparable international way, the indicators needed to be based as far as possible on data routinely collected or easily available, and for this reason the feasibility of data represented the most important selection criteria. An indicator was considered feasible if rated *likely* or *possibly feasible* in at least four countries. Starting from this criterion, the most relevant and scientifically sound indicators were evaluated and finally included in the tool. The resulting indicators were 15: each of them was discussed at different meetings with REFINEMENT partners to further be refined or defined and maximize agreement among countries.

Figure 4. Collection and screening of quality indicators in the REFINEMENT project



3.2.2 The REFINEMENT Quality of Care Tool - REQUALIT

Based on the procedures illustrated above, a tool called REFINEMENT Quality of Care Tool (REQUALIT) was created for collecting information on the performance and outcomes of health and social care for people with mental health needs. The data collected with REQUALIT, as indicated in Table 15, contained a broad set of indicators which represented a combination of different elements that can be summarized as follows:

- Domain (e.g., input, process, outcome);
- Quality dimension (e.g., effectiveness, efficiency, appropriateness, patient centeredness, responsiveness, continuity, coordination, accessibility, equity, safety, capability and sustainability); and
- Type of setting (e.g., whole system, inpatient care, community care, etc.).

The instrument considered indicators of quality of care that can apply across all mental health services, however for pragmatic reasons focused specifically on services that can be mapped using the REMAST tool: primary care, outpatient services, community care and inpatient services. Specific indicators for general hospitals, forensic hospitals and services for vulnerable population groups were not included. REQUALIT included three sections: A, B, and C. **Section A** included the 15 indicators resulted from the literature review. These were mainly statistical indicators to be obtained by using administrative data systems. **Section B** included quality measures dependent on surveys or interviews. Some information on services infrastructure and organization was retrieved from the REMAST tool (see 2.2.2) and used in REQUALIT as quality measures (**Section C**). REQUALIT included *input* indicators related to the structural characteristics of the system, including staff mix, professional experience and qualifications, financial resources, legal and policy frameworks and the mix of services provided (Thorncroft & Tansella, 2009). Examples of these indicators were: does a country have an appropriate human resources policy for mental health? What structures are in place

for continuing education, training and supervision? What is the balance of expenditure between hospital and community services? Another key area of analysis was the *process* of care, including service user interaction with mental health professionals and services, as well as their level of involvement in treatment decisions. An important process issue was individuals' pathways to and through mental health services; the term is connected to accessibility and continuity domains of quality of care. *Outcome* measures were also considered and included, for instance analysis of service user satisfaction, quality of life, functioning, and employment status.

REQUALIT was piloted in the eight European countries. Data collection started in November 2012 and finished by the end of January 2013. Results of this data collection are reported elsewhere (Donisi *et al.*, 2013). In this work only aspects related to the quality of **social care** provided to people with mental health problems will be analysed and discussed.

Table 15. REQUALIT: Summary of main topics/indicators

Section A Statistical indicators, mainly based on administrative data.	Section B Review of empirical findings, official documents and expert interviews.	Section C Variables based on REMAST data.
<ul style="list-style-type: none"> •Suicide •Length of stay •Emergency visits •Involuntary committal •Seclusion •Documented diagnosis •Documented discharge plans •Treatment •Involvement of users •Benefit •Employment •Housing •Continuity •Readmission •Community tenure 	<ul style="list-style-type: none"> •Needs •Symptoms •Functioning/living skills •Quality of life •Satisfaction •Physical health •Employment •Housing •Stigma and discrimination •Adherence and concordance •Dual diagnosis •Early intervention •Case management •Psychoeducational interventions •Decision making •Self-help organizations •Equity and cultural sensitivity •Coordination •Staff morale and training •Best practice •Assessment and monitoring mechanism 	<ul style="list-style-type: none"> •Balance •Integration •Policies •Accessibility and equity

Source: REQUALIT Tool (www.refinementproject.eu).

3.2.3 Examples of social care quality indicators

REQUALIT included specific indicators of quality of social care provided to people with mental health problems. These indicators were based on the results of the literature review presented above as well as resulted from discussions at project meetings between the present author and researchers from the partner countries. Table 16 presents an overview of the indicators of quality of social care included in REQUALIT. Part of the indicators was concerned with structural characteristics of services (e.g., services availability, staff composition). This data was collected in REMAST (see 2.2.2 for further details on the tool) and used in REQUALIT as quality measures. Other indicators covered the areas considered as most pertinent to social care provided to individuals with mental health problems. These

included aspects such as housing, employment, disability benefits, and service users' involvement.

Table 16. Indicators of quality of social care included in REQUALIT

Topic	Indicator	Source
Day care services	Types and characteristics of mental health day care centers.	REMAST
Social workers in mental health services	Presence of social workers in mental health services.	REMAST
Multidisciplinary teams	Presence of multidisciplinary teams in mental health services (composed by at least one doctor, one psychologist, one nurse, and one social worker/occupational therapist).	REMAST
Housing legislation	Existence of legislative provisions to help individuals with mental health problems exercise their rights to live at home (e.g., help with costs, safeguards in tenancy agreements, protection of accommodation rights while having an inpatient stay).	REQUALIT
Supported housing	Number of people with severe mental illness receiving supported housing programs.	REQUALIT
Assessment of housing situation	Number of people with mental health problems that have the quality of their housing situation routinely assessed by a trained professional (e.g., social worker, visiting nurse, health visitor, etc.).	REQUALIT
Housing outcomes	Number of people with mental health problems experiencing homelessness.	REQUALIT
Employment legislation	Existence of legislative provisions concerning a legal obligation for employers to hire a certain percentage of employees that are disabled.	REQUALIT
Supported employment	Number of people with severe mental illness receiving supported employment programs.	REQUALIT
Employment outcomes	Number of people with mental health problems attaining competitive (paid) employment.	REQUALIT
Disability benefits	Number of people receiving disability pensions due to mental disorders in one year.	REQUALIT
Service users' involvement	Existence of mechanisms/programs to promote participation of users in self-help organizations.	REQUALIT
Service users' involvement	Existence of facilities/services directly managed or led by service users with mental health problems.	REQUALIT

Indicators illustrated in Table 16 - except those collected in REMAST - were collected using the following two methods:

- 1. Collection and review of available empirical findings.** Each partner group was asked to collect and review findings from all studies, evaluation reports, websites, etc., which might contribute to the assessment of the specific situation in their country/region or selected study area. All references and data sources were reported when filling the tool.
- 2. Interviews with relevant stakeholders and experts.** Expert interviews were conducted when empirical findings were not available or to compound empirical findings with further details. The aim of the interview was to obtain information as much as possible objective, thus individual opinions were not explored. The range of stakeholders included: professionals, other service provider groups (e.g., non-governmental organizations), policy makers, advocacy groups, planners, associations of service users and carers.

In this work the presentation will focus on the results of a sub-sample of the indicators reported in Table 16, more specifically data on availability of social workers in mental health services and employment legislation for people with mental health problems will be illustrated.

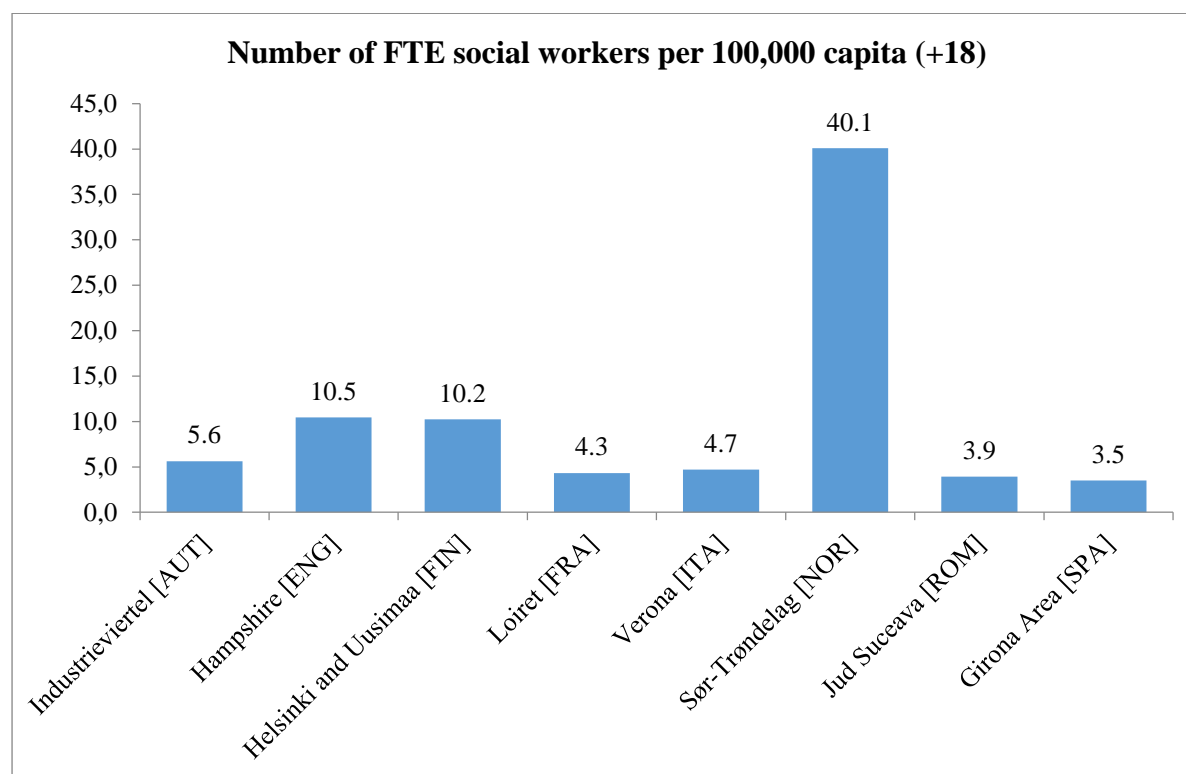
Social workers in mental health services. This indicator was calculated as follows:

- The number of full-time equivalent social workers employed in mental health services per 100,000 adult inhabitants.

This is a proxy indicator of a comprehensive approach to mental health care. The presence of various professional profiles (i.e, social workers, occupational therapists, care workers) in the multi-professional teams of mental health services is likely to indicate services that are

oriented towards rehabilitation and recovery. The services included were those mapped in the study areas selected for REMAST data collection.

Figure 5. Social workers in mental health services of REFINEMENT study areas



As shown in Figure 5, in all REFINEMENT study areas there were social workers employed in mental health services. However, substantial differences in numbers were reported. The number of social workers in mental health services per 100,000 adult inhabitants ranged from 3.9 in Jud Suceava [ROM] to 40.1 in Sør-Trøndelag [NOR]. Jud Suceava [ROM] and Girona [SPA] had the lowest rate.

Employment legislation. This indicator included the following questions:

- Do legislative provisions exist concerning a legal obligation for employers to hire a certain percentage of employees that are disabled?
- Does the legislation differentiate by type of disability or mental health problem?

- Is there any penalty if a quota is not met?

It was required to consider only legislation that included individuals with mental health problems (i.e., either a specific legislation pertaining to mental health problems, or a legislation on disabilities including mental health problems). Table 17 reports the results of this indicator.

Table 17. Employment legislation in the REFINEMENT countries

	Do legislative provisions exist concerning a legal obligation for employers to hire a certain percentage of employees that are disabled?	Does the law differentiate by type of disability?	Is there any penalty if a quota is not met?
Austria	Yes and are enforced	No	Yes
England	No	x	x
Finland	No	x	X
France	Yes and are enforced	No	Yes
Italy	Yes and are enforced	No	Yes
Norway	No	x	x
Romania	Yes but not enforced	No	Yes
Spain	Yes and are enforced	No	N/k

As shown, in all countries except England, Finland and Norway there was a legislation concerning a legal obligation for employers to hire a certain percentage of employees that are disabled. However, in Romania this legislation was not enforced. None of the legislations differentiated by type of disability, thus any difference was made whether somebody suffered from a physical or mental disability.

In Austria, the law prescribes to employ a person with disability (above 50% degree of disability) per 25 other employees. In case the quota is not met employers have to pay at least 226 €/per month and not employed disabled person. In Finland, pilot projects at national level are currently being implemented. In France, the disability Law of 11 February 2005 provides

an obligation for public services and private companies with more than 20 employees to hire at least 6% of people recognized as suffering from disabilities, including people with mental health related disabilities. If this obligation is not met, companies have to pay an annual contribution to the association managing the fund for the professional integration of disabled people (*Association de gestion du fonds pour l'insertion professionnelle des personnes handicapées* (AGEFIPH)). This contribution amounts to 600 times the minimum hourly wage per non employed disabled people. It may reach 1500 times the minimum hourly wage for companies that have not taken action to employ disabled people within three years.

In Italy, the Law on the employment of disabled people (Law n. 68 of 12 March 1999, Regulations on the right to employment for persons with disabilities) is the main legislation concerning disability employment in Italy. Based on the size of their workforce, both private and public sector employers are required to hire a certain percentage of disabled workers: (a) employers with more than 50 employees must meet a 7% disability employment quota; (b) at least 2 disabled workers must be hired in workplaces of 36 to 50 employees; and (c) workplaces of 15 to 35 employees must hire at least 1 disabled worker if they operate new intake. Disabled workers hired on temporary contracts for a period of less than 9 months cannot be included in the percentage, in other words employers must hire disabled workers for longer periods to meet the legal requirement.

In Romania, according to law 448/2006, companies (public and private) with more than 50 employees must employ up to 4% persons with disabilities (physical and mental) of the total number of their employees. Alternatively, either (a) they have to pay to the state budget, on a monthly basis, 50% of the minimum wage multiplied by the number of positions not occupied by persons with disabilities; or (b) they have to buy products or serviced offered by protected units (units where at least 30% of the workforce are persons with disabilities) up to the level of taxes described under point a).

In Spain, the reserve quota is of 2% for companies with more than 50 workers. There are also other legal instruments to promote labor integration of people with disabilities. For example, employers can receive a subsidy of up to 3,906.5 € for every person with disabilities they take on indefinitely. In addition, there is a company tax subsidy for such employers of 4,808 € for each additional person with disabilities they employ.

3.2.4 Discussion

In this sub-section the discussion will focus on the results of the REFINEMENT work package 8 ‘Quality of mental health care and met/unmet needs’ illustrated above. Various elements need to be discussed concerning the findings from the literature review on quality of mental health and social care. These include the following issues:

- Definition of quality
- Measurement
- Gaps in the literature
- Future developments.

The results of the literature review helped to shed some light on the definition of quality of care. More specifically, the work illustrated above showed that ‘quality’ is both a multidimensional and complex concept. This is especially true in the mental health sector. The vast majority of papers reviewed described quality in disaggregated ways, defining quality according to several dimensions or components (Gaebel *et al.*, 2012). In the literature, the most frequently analysed dimension of quality was effectiveness, which was defined as “the degree of achieving desirable outcomes, given the correct provision of evidence-based health care services to all who could benefit but not to those who would not benefit” (Arah *et al.*, 2006). Thus, there seems to be extensive work in the research field on establishing what services/interventions improve outcomes. This is reassuring as it seems to express an ongoing

commitment towards improvement of mental health care. However, defining and consequently measuring quality of mental health care is a complex task. Indeed, many mental disorders are long-term, relapsing and remitting conditions and thus do not easily fit the classical input-process-outcome structure (Thornicroft & Tansella, 2009). Moreover, mental health care encompasses several modalities of treatment, including medication management, psychotherapy, and case management and takes place in different settings, such as inpatient and outpatient, hospital, prisons, and community-based settings (Hermann *et al.*, 2000). A number of professions are thus involved in the field of mental health care. This is of course enriching as the integration of different disciplines and perspectives allows framing mental health problems within a bio-psycho-social model. However, the presence of diverse professions brings about specific challenges, e.g. the differences in roles and power among professional categories. Again, mental health systems include services that may or may not be funded and delivered within the health care system, being carried out by, for example, social services, education, employment, judicial, and housing services (Jacobs & McDaid, 2009). Even more so, the power imbalance between providers and users is greater in mental health than in other health sectors. All these issues need to be taken into account when considering the second point of this discussion: measurement. The literature review showed a plethora of methods to measure the quality of mental health care. Mostly, quality was assessed through indicators. Indicators are defined as “explicitly defined and measurable items which act as building blocks in the assessment of healthcare” (Gaebel *et al.*, 2012). The literature abounded with indicators and measures to assess the structure, process, or outcomes of mental health care. However, the majority of indicators were found to measure the process dimension. It should also be noted that not always the methods of measurement and the constitutive elements of the indicators (e.g., definition, numerator, denominator) were sufficiently clarified within the papers. In various instances the indicators were constructed

specifically for the purpose of the paper. This raised significant issues when the generalizability of results was considered. Furthermore, a great use of questionnaires was observed. Questionnaires were generally used to assess the outcome of services. These were largely analyzed through aspects such as quality of life, global functioning, symptoms, health status, and satisfaction. Extensive use of validated scales was found but also of questionnaires developed purposefully for the studies.

These considerations help us introduce the analysis of the gaps identified in the literature review. Precisely, the review showed that some areas are much researched: examples are hospital care, pharmacological treatment, and severe mental health problems such as schizophrenia. Other areas, such as social care, dementia care, psychotherapy, were less represented. Here the discussion will concentrate on social care, the main topic of this thesis.

Measures of quality of social care provided to adult people with mental health problems were limited. This is partly because it is difficult to distinguish social care from other components of mental health care. In fact, adult mental health services are more and more organized in multidisciplinary teams where members of the various disciplines coordinate their activity in order to achieve a comprehensive, holistic view of the service user's needs. However, there are specific areas of expertise that social care staff brings to mental health. These were identified in the REFINEMENT project and included family support, supported employment, supported housing, community treatment, service users' involvement, and peer support. Moreover, the REFINEMENT project allowed developing indicators of quality social care and establishing their feasibility in eight European countries. However, comparability of data among the partner countries was problematic. In fact, the collection of the aforementioned indicators was based on existing material since a brand new data collection was not viable due to time and resource constraints. The results of this data collection showed some areas where information was limited, while in other cases information existed within the countries

but was difficult to be used in international comparisons. For example, it was difficult to retrieve estimates of prevalence of homelessness among people with mental health problems. Other kind of information was generally available within the partner countries but the comparability of this information among them was low. Examples of this phenomenon are statistics on people with mental health problems attaining competitive employment or statistics on people with mental health problems living independently. Information on outcomes of social interventions, such as supported employment or supported housing programs, was generally reported in small scale studies or evaluations, thus making it challenging to generalize and compare results.

To conclude, the importance of measuring quality of mental health care is widely recognized (Gaebel *et al.*, 2012; Amaddeo & Tansella, 2013). However, there is still lack of consensus on the dimensions and measures which should be used as indicators of quality of care. There is need to develop a core set of standardized measures to assess the efficacy and efficiency of mental health services. This would be in line with the work undertaken by OECD, who identified a core set of twelve quality indicators of structures, processes and outcomes of mental health care (Hermann *et al.*, 2004). The adoption of core sets by a wide range of organizations will allow collecting comparable data and lead to the development of benchmarks to be used at various levels: regional, national, and international (Hermann *et al.*, 2000). The development of standardized measures was also the central focus in the REFINEMENT project. The project identified some of the key questions that need to be asked in order to assess performance, and in particular how the financing and funding of a mental health system may be correlated with its organizational structure, pathways of care and quality. The tools developed within the project (here only REMAST and REQUALIT were presented, but other key tools were FINCENTO¹ and REPATO²) constitute a step by

¹ Financing and INCENTive Tool (REFINEMENT group, www.refinementproject.eu).

step guide to developing questions, collecting information and then interpreting findings. The next step would be to further develop European studies comparing different models of mental healthcare services in order to identify European recommendations for mental health care. This would finally allow building a system for quality improvement.

² REfinement PAthways Tool (REFINEMENT group, www.refinementproject.eu).

4. THE ITALIAN MULTICENTRE STUDY: THE QUALITY OF PROFESSIONAL LIFE

For clarity purposes, the presentation of the Italian Multicentre study has been divided into two chapters, number 4 and 5. The present chapter reports findings of the survey on quality of professional life (see 2.3.3 for details on the methodology). Before presenting the results of the survey in Section 4.2, the three study areas will be described (Section 4.1) looking at the socio-demographic characteristics of the areas and the organizational features of mental health services in each area. Finally, the main findings will be presented and discussed in Sections from 4.3 to 4.6.

4.1 AREAS OF STUDY

The three centres selected for the Multicentre study were:

1. Lecco Mental Health Department (MHD);
2. Legnago MHD; and
3. South Verona Community Mental Health Service (CMHS).

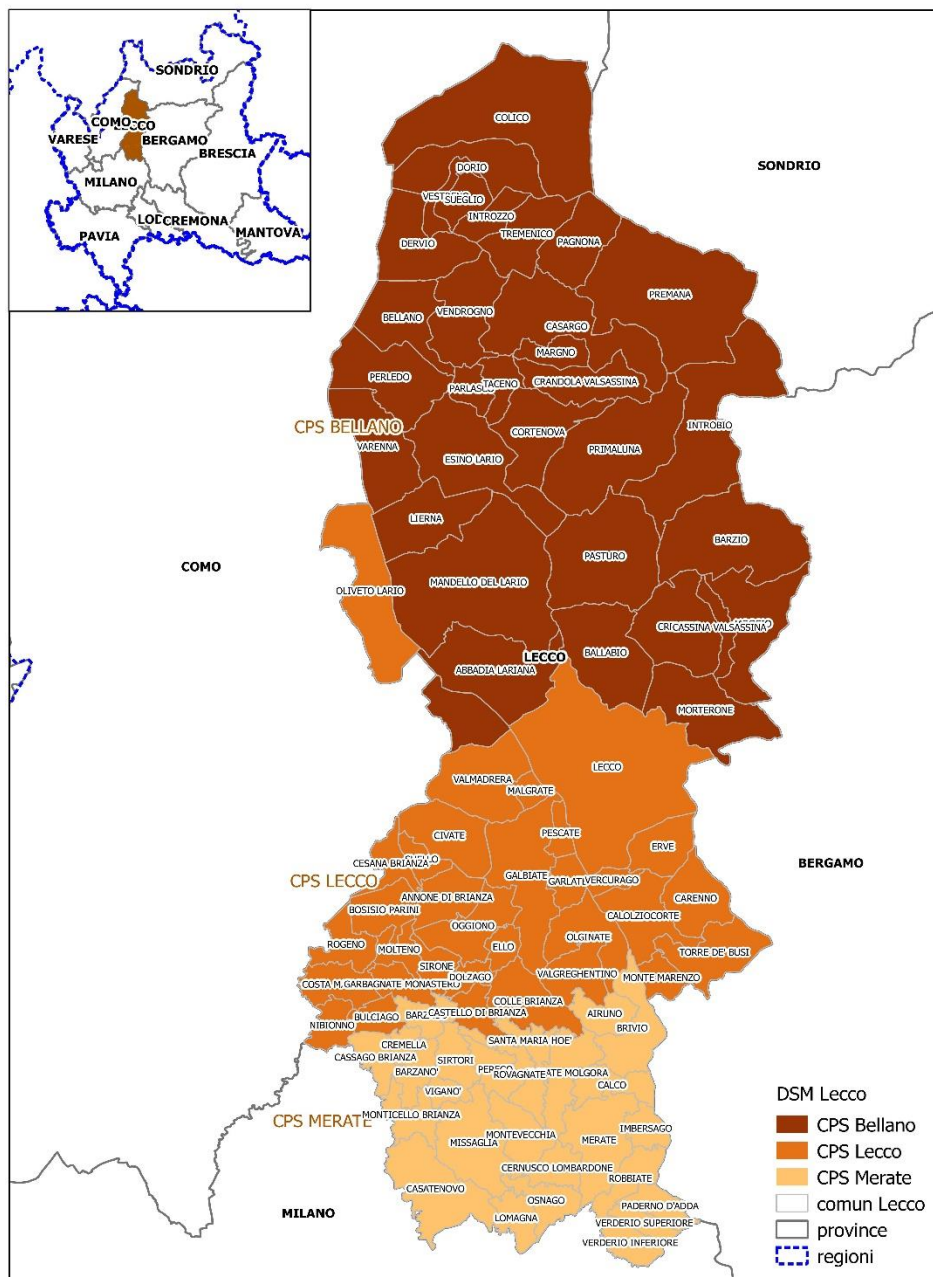
Table 18 reports the main socio-demographic characteristics of the three areas.

Table 18. Multicentre study: Socio-demographic characteristics of the three areas

Reference year: 2012	Lecco MHD	Legnago MHD	South Verona CMHS
Area (km²)	814.59	809.77	94.50
Municipalities (<i>Comuni</i>)	89	26	4
Population	336,127	154,015	108,421
Density (pop./km²)	413	190	1147

Lecco MHD serves a population of 336,127 inhabitants and is responsible for planning and coordinating all mental health services in the Province of Lecco. Figure 6 illustrates the geographical location of Lecco MHD. The MHD is divided into three catchment areas: Bellano, Merate, and Lecco.

Figure 6. Geographical location of Lecco MHD



Legnago MHD belongs to Local Health Authority n. 21 (ULSS 21). It covers the southern part of Province of Verona and serves a population of 154,015 inhabitants. The MHD is divided into three catchment areas, as illustrated in Figure 7: Bovolone-Zevio, Legnago, and Nogara-Cerea.

Figure 7. Geographical location of Legnago MHD

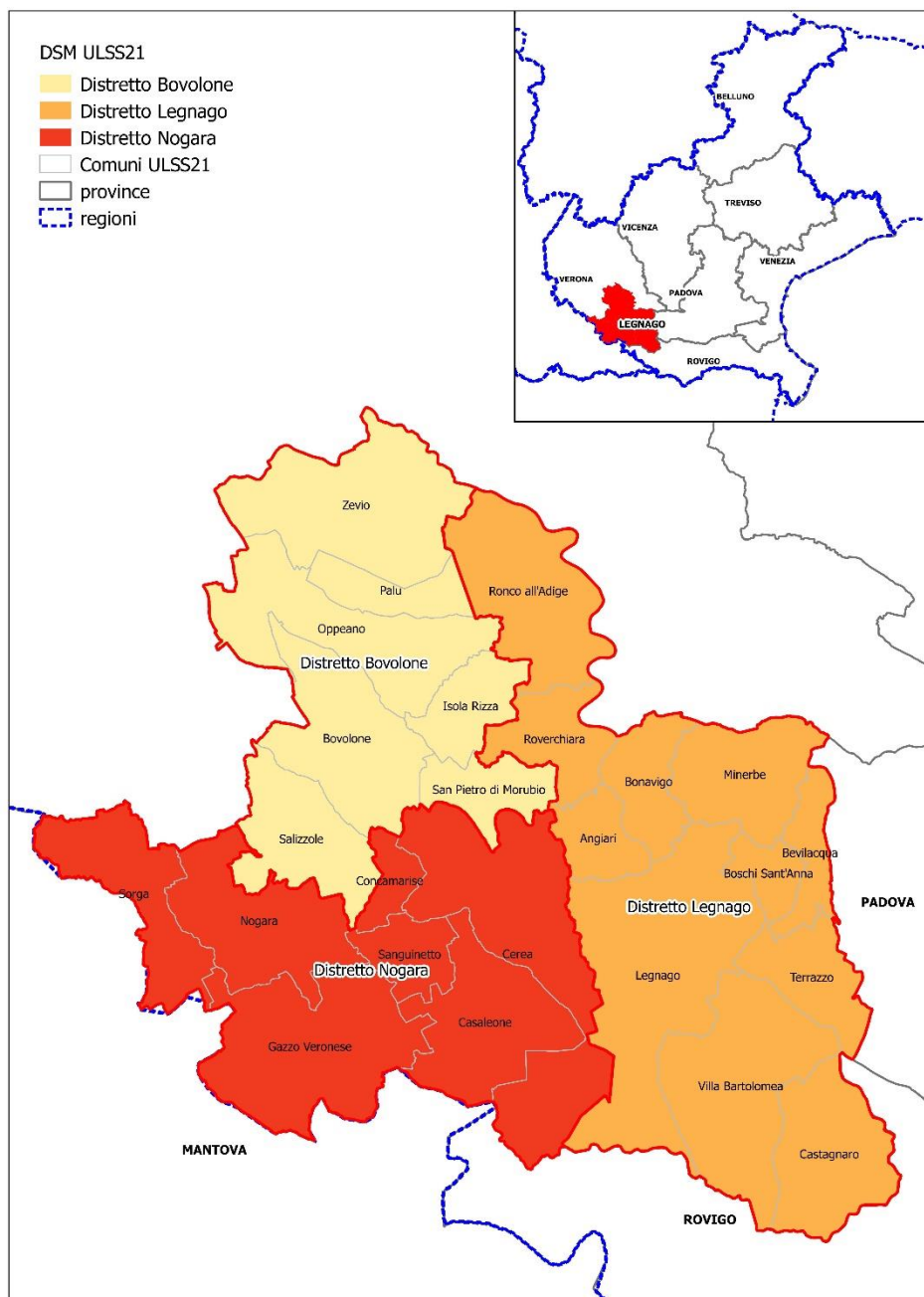


Figure 8. Geographical location of South Verona CMHS



Table 19 illustrates information about mental health staff, users treated, and activities delivered in the three centres (reference year: 2013). The staff composition was similar in Lecco and Legnago MHDs, while Verona CMHS showed a greater number of psychiatrists, psychologists, nurses, and social workers. The number of users in Community Mental Health Centres (CMHCs) was higher in Legnago, whereas the number of users in Day Care Centres (DCCs) was greater in Verona. The number of users admitted to General Health Psychiatric Units (GHPUs) - as well as the number of days of hospitalization - was higher in Verona than in the other two centres. The number of users admitted to Residential Facilities (RFs) in Verona was twice as high as in the other two centres. However, in Legnago only information on public facilities was available. Finally, the prevalence of users treated and the incidence of new cases was greater in Verona.

Table 19. Staff, users treated, and activities delivered in the three centres

Reference year: 2013	Lecco MHD	Legnago MHD	South Verona CMHS
Population 18 years or older ⁺	277,987	127,957	90,845
Year of the last regional MH plan/policy	2004	2012	2012
MH professionals (full-time equivalent professional) ^{1,2}	5.0	3.9	9.3
Psychiatrists	0.9	0.8	1.1
Psychologists	0.2	0.1	0.7
Nurses	2.2	2.4	3.5
Social Workers	0.2	0.2	0.6
Rehabilitation therapists/Educators	0.4	0.0	0.4
Other professionals	1.0	0.4	0.7
Community Mental Health Centres (CMHCs), <i>n</i>	2	1	1
Opening times of CMHCs	8.00-18.00	8.00-20.00	8.00-20.00
Users treated in CMHCs ¹	151.1	198.7	155.5
Contacts in CMHCs ¹	2270.2	2376.6	2372.7
Day Care Centres (DCCs), <i>n</i>	2	3	1
Places in DCCs ¹	1.3	4.7	4.4
Users treated in DCCs ¹	3.3	6.6	20.5
Attendances in DCCs ¹	307.5	719.8	880.1
Day Hospitals, <i>n</i>	0	0	2
Places in Day Hospitals ¹	0	0	1.9
General Hospital Psychiatric Units (GHPUs), <i>n</i>	2	1	1
Beds in GHPUs ¹	0.9	1.3	1.7
Users admitted to GHPUs ¹	13.8	19.9	19.9
Days spent in GHPUs ¹	351.3	260.9	540.0
Users admitted to Residential Facilities (RFs) ^{1,3}	4.7	4.3 ⁴	8.8
Days spent in RFs ^{1,3}	1084.2	178.0 ⁴	2687.1
Treatment prevalence ¹	151.1	189.8	253.6
Users 17-34 years old, %	17.6	6.0	20.5
Users with ICD-10 F2 schizophrenic disorder, %	24.4	9.4	15.4
Users with ICD-10 F3 affective disorder, %	20.9	23.5	34.2
Users with ICD-10 F4 neurotic disorder, %	30.8	44.2	16.3
Users with ICD-10 F6 personality disorder, %	12.4	8.4	5.9
Users with other ICD-10 disorders, %	11.5	8.4	28.5
New cases ¹	33.9	71.9	126.6
Users 17-34 years old, %	32.4	n/k	23.7
Users with ICD-10 F2 schizophrenic disorder, %	3.8	n/k	5.0
Users with ICD-10 F3 affective disorder, %	13.2	n/k	33.7
Users with ICD-10 F4 neurotic disorder, %	58.0	n/k	18.0
Users with ICD-10 F6 personality disorder, %	6.9	n/k	4.1
Users with other ICD-10 disorders, %	18.2	n/k	39.2

⁺ Reference year: 2012.

¹ Rate per 10,000 older than 18 years.

² Only public sector, excluding accredited private sector.

³ Public sector and accredited private sector.

⁴ For Legnago MHD, only information on public sector was available.

4.2 PROFILE OF MENTAL HEALTH STAFF

The survey on quality of professional life involved 508 mental health workers in the three centres. As shown in Table 20, 443 people returned completed questionnaires, with a response rate of 87%.

Table 20. Staff survey: Response rates in the three centres

	Initial sample	Returned completed questionnaires	Response rate (%)
Lecco MHD	239	215	90
Legnago MHD	79	69	87
South Verona CMHS	190	159	84
Total	508	443	87

Table 21 reports the socio-demographic characteristics of the sample in the three sites. The whole sample was composed of 103 males (24%) and 332 females (76%). The majority (33%) of respondents were within the age bracket of 40-49 years, with 9% aged 18-29, 27% aged 30-39, another 27% aged 50-59, and finally 4% older than 60 years. Sixty-one percent of the sample was married, 29% of people were single, and 10% separated, divorced or widowed. The vast majority (81%) of respondents lived with somebody (partner, family, or others), while the remaining 19% lived alone. The educational level was high: the majority of staff (55%) had a University diploma or degree, of which 23% also had a Master, a PhD or a Specialization.

Table 21. Multicentre study: Socio-demographic profile of mental health staff

		Lecco MHD		Legnago MHD		South Verona CMHS		Total	
		N	%	N	%	N	%	N	%
Age									
	18-29 yrs	10	5	1	1	28	18	39	9
	30-39 yrs	53	26	15	22	48	30	116	27
	40-49 yrs	70	34	24	35	51	32	145	33
	50-59 yrs	66	32	24	35	26	16	116	27
	>60 yrs	8	4	4	6	6	4	18	4
Gender									
	Male	43	21	16	24	44	28	103	24
	Female	165	79	52	76	115	72	332	76
Marital status									
	Single	47	23	11	16	66	42	124	29
	Married/Partnered	139	67	47	69	78	50	264	61
	Separated, Divorced, Widowed	20	10	10	15	13	8	43	10
Living Situation									
	Alone	33	16	8	12	40	25	81	19
	With partner or family or other	174	84	60	88	118	75	352	81
Educational level									
	Up to middle school	10	5	6	9	8	5	24	5
	Secondary school	78	37	35	51	58	36	171	39
	University degree	72	34	12	18	57	36	141	32
	Master/Phd/Specialization	51	24	15	22	36	23	102	23

Table 22 reports the occupational characteristics of respondents. Looking at occupational status, nurses was the most represented category (29%). They were followed by healthcare support workers (20%) and psychiatrists (18%). It should be noted that in the latter group also psychiatrists in training (N=32) were included. Ten percent of respondents were educators, 8% psychologists, 5% rehabilitation therapists, and 4% social workers.

Sixty percent of staff reported they had worked in the mental health service up to ten years. The other 40% had an experience of more than 10 years. When asked whether they had previously worked in other health or social services, 64% of people answered they had and 36% stated they had not.

More than half of the sample (59%) was employed by the Local health authority or the Hospital trust, whereas 27% of staff belonged to non-for profit organizations, and 15% was employed by the University. These were found in the South Verona CMHS, which belongs to a multi-agency department including the University of Verona. Moreover, the vast majority of staff (81%) had an open-ended contract. People with a fixed-term contract were the 7%, while the remaining 13% included employees with temporary contracts, fellowships or scholarships.

The survey also asked to report the percentage of time dedicated to the following activities in the week: clinical and care work, research, teaching, and administration. Generally, 72% of time was dedicated to clinical and care work, 16% to administration, 7% to research, and finally 5% to teaching activities. Again, most research activities were carried out in South Verona CMHS for the reason explained above. Finally (not reported in the table), when asked whether they had attended training events in the past 24 months, 95% of staff answered they had.

Table 22. Multicentre study: Occupational characteristics of mental health staff

	Lecco MHD		Legnago MHD		Verona CMHS		Total	
	N	%	N	%	N	%	N	%
Occupational status								
Psychiatrist/Psychiatrist in training	31	15	7	10	41	26	79	18
Psychologist	15	7	4	6	15	9	34	8
Nurse	67	32	26	38	33	21	126	29
Social worker	9	4	3	4	6	4	18	4
Rehabilitation therapist	20	9	0	0	2	1	22	5
Educator	31	15	9	13	6	4	46	10
Healthcare support worker	32	15	19	28	39	25	90	20
Other	7	3	1	1	17	11	25	6
N. of previous years worked in the mental health service								
< 10	119	55	37	54	110	69	266	60
>10	96	45	32	46	49	31	177	40
Worked in other health or social services								
Yes	57	27	20	30	76	51	271	64
No	151	73	47	70	73	49	153	36
Organization								
Local health authority/Hospital trust	161	75	46	67	52	33	259	59
University	0	0	1	1	64	41	65	15
Non for profit organization	53	25	22	32	42	27	117	27
Type of contract								
Open-ended contract	199	93	62	90	96	60	357	81
Fixed-term contract	9	4	5	7	16	10	30	7
Temporary contract/ Fellow/Scholar	7	3	2	3	47	30	56	13
Average % of time dedicated to the following activities in the week								
Clinical and care work	72%	-	79%	-	64%	-	72%	-
Research	4%	-	2%	-	14%	-	7%	-
Teaching	6%	-	3%	-	7%	-	5%	-
Administration	19%	-	17%	-	14%	-	16%	-

4.3 INDICATORS OF QUALITY OF WORKING LIFE

The Quality of Working Life Questionnaire (see 2.3.3 for details) allowed for the analysis of socio-demographic characteristics, occupational variables and indicators of quality of working life among a sample of 443 mental health staff, as reported in Table 23. Detailed descriptions of the indicators of quality of working life are reported in Table 24.

Table 23. Staff variables included in the Multicentre study

Socio-demographic variables	1. Age
	2. Gender
	3. Marital status
	4. Living situation
	5. Extra income in the family
	6. Educational level
Occupational variables	1. Centre
	2. Number of previous years worked in the psychiatric service
	3. Number of previous years worked in other health or social services
	4. Occupational status
	5. Organization
	6. Type of contract
	7. Contract with required availability
	8. Receiving variable component of pay
	9. Attended teaching/training events in the past 24 months
	10. Perceived need of attending teaching/training events
	11. Average percentage of time dedicated to clinical and care work
Indicators of quality of working life	1. Opinion on current pay
	2. Ergonomic problems
	3. Job complexity
	4. Trust
	5. Autonomy
	6. Participation
	7. Utility of meetings
	8. Organizational commitment
	9. Conditioning of work on life
	10. Conditioning of life on work
	11. Job satisfaction
	12. Perceived risks for the future
	13. Organizational changes
	14. Importance attributed to stability
	15. Importance attributed to relations/autonomy

Table 24. Indicators of quality of working life

Indicator	Description
1. Opinion on current pay	How do you assess your current pay?
2. Ergonomic problems	<ul style="list-style-type: none"> - Hot or cold temperatures - Excessive or insufficient light levels - Inappropriate workspace - Poor hygiene - Shortage of personal protective equipment - Lifting, pushing or pulling heavy loads - Time pressures (work pace and intensity) - Long periods of time at computer - Risk of assaults
3. Job complexity	<ul style="list-style-type: none"> - Different tasks to be carried out - Unexpected situations and problems to solve - Tasks requiring experience - Tasks with high levels of responsibility - Job rotation with colleagues - Coordination of other people's work
4. Trust	<ul style="list-style-type: none"> - The manager knows well my tasks - I am free in the work and little controlled - The manager helps me when I have problems - The colleagues help me when I have problems - The manager trusts me
5. Autonomy	<ul style="list-style-type: none"> - I can decide to have breaks during work - I can decide how to do the work - I have autonomy in solving an organizational problem - I can decide the timing of my work - I can decide the paucity and intensity of my work - I can choose the tasks to carry out - I can make weekly or monthly plans - I can decide the quality level of my work

Indicator	Description
6. Participation	<p>In the previous 12 months, participated in meetings to:</p> <ul style="list-style-type: none"> - Discuss the service organization - Define methods, technologies, and techniques - Plan and verify the activities of the service - Decide projects and services to be realized
7. Utility of meetings	<p>Meetings give me the opportunity to:</p> <ul style="list-style-type: none"> - Discuss interesting issues - Bring my contribution - Be appreciated for my contribution - Influence the decisions of the group - Adequately deal with problems - Receive emotional support
8. Organizational commitment	<p>The group:</p> <ul style="list-style-type: none"> - Has a clear idea of the mission of the service - Feels the mission of the service as its own - Is involved in the achievement of the objectives - Critically reflects on its work - Receives support from managers in the development of its own ideas and projects
9. Conditioning of work on life	<p>How work influences:</p> <ul style="list-style-type: none"> - One's caregiving role (taking care of children, parents, etc.) - One's home duties (housekeeping, etc.) - One's hobbies and interests (friends, sport, etc.) - One's political, social and religious activities
10. Conditioning of life on work	<p>How life influences:</p> <ul style="list-style-type: none"> - One's career opportunities - One's professional growth - One's opportunity to accept extra duties - One's opportunity to change job

Indicator	Description
11. Job satisfaction	<p>Satisfaction on the following aspects:</p> <ul style="list-style-type: none"> - Social utility - Job stability - Job content - Colleagues - Job autonomy - Working hours - Proximity to home - Managers - Expressing capabilities - Physical environment - Work organization - Appreciation for the work done - Pace of work and workload - Decision latitude - Pay conditions
12. Perceived risks for the future	<p>Perceived risk for the future of:</p> <ul style="list-style-type: none"> - Losing job - Having an inadequate work competence - Being unable to maintain one's family - Being unable to sustain a substantial expense - Not receiving an adequate pension
13. Organizational changes	<p>In the previous 12 months, the service:</p> <ul style="list-style-type: none"> - Underwent organizational changes - Introduced technological innovations - Increased/decreased the number of employees - Increased/decreased the activities - Developed innovative projects

Indicator	Description
14. Importance of relations/autonomy	<p>Importance attributed to the following aspects:</p> <ul style="list-style-type: none"> - Social utility - Job content - Colleagues - Job autonomy - Managers - Expressing capabilities - Work organization - Appreciation for the work done - Decision latitude
15. Importance of stability	<p>Importance attributed to the following aspects:</p> <ul style="list-style-type: none"> - Job stability - Working hours - Proximity to home - Physical environment - Work organization - Pay conditions - Pace of work and workload

The indicators illustrated in Table 24 were calculated as follows:

- Ergonomic problems, job complexity, trust, autonomy, utility of meetings, organizational commitment (five-level Likert scale from 1 'never' to 5 'always').
- Participation (three-level Likert scale from 1 'never' to 3 'often').
- Conditioning of work on life, conditioning of life on work, job satisfaction, importance of relations/autonomy, and importance of stability (five-point Likert scale from 1 'not at all' to 5 'very much').
- Perceived risks for the future and organizational changes (ordinal scale, i.e., no = zero yes responses out of five; some = 1 or 2 yes responses out of five; many = 3, 4 or 5 yes responses out of five).

For all indicators reported in Table 24 (except perceived risks for the future and organizational changes that were on an ordinal scale), a final score was calculated as the mean value of all items' responses. Cronbach's α coefficient of internal consistency reliability was calculated for all indicators, except for opinion on current pay since this indicator was made up by just one item. The coefficients were good in most cases and acceptable in a few ones, ranging from 0.62 (organizational changes) to 0.88 (relative importance attributed to relations/autonomy). Only perceived risks for the future had a lower Cronbach's α (0.59). However, the result is still acceptable since the items included in this indicator were not meant to measure a single unidimensional construct.

4.4 UNIVARIATE ANALYSIS: FACTORS ASSOCIATED WITH COMPASSION SATISFACTION, COMPASSION FATIGUE, AND BURNOUT

The aim of this section is to analyze factors associated with levels of Compassion Satisfaction (CS), Compassion Fatigue (CF), and Burnout (BO) among a sample of 427 mental health professionals. These three dimensions were analyzed through the Professional Quality of Life Scale (ProQOL III). Although the total sample included 443 people, only staff engaged in clinical and care activities was asked to complete ProQOL III. The tables below report findings for socio-demographic, occupational characteristics, and the aforementioned indicators of quality of working life. Table 25 and Table 26 report data for categorical variables, while Table 27 and Table 28 for continuous variables.

Records with more than 15 missing values (out of 30) were eliminated; in all other instances, missing values were imputed by using Corrected Item Mean Substitution method (Huisman, 1999), i.e. the item mean across the sample weighted by the person's mean of filled items. In all analyses using CF, CS and BO as continuous variables, observations were weighted proportionally to their percentage of non-missing items. As for results related to cut-off scores, only observations whose status (being above the cut-off or not) did not depend on missing values were considered.

4.4.1 Mean values of CS, CF, and BO

In this sub-section the associations between categorical variables and CS, CF, and BO are investigated. Table 25 reports frequencies (number and percentage), mean values, standard errors of the mean (S.E.M.), and the result of Kruskal-Wallis test for CS, CF, and BO. Kruskal-Wallis test is a non-parametric method for testing whether samples originate from the same distribution. Kruskal-Wallis is used for comparing two or more samples that are independent, and that may have different sample sizes, and extends the Mann–Whitney U test

to more than two groups. Beginning with CS, four variables were significantly related to this outcome. These were marital status, type of contract, the need of attending teaching/training events, and perceived risks for the future. More specifically, separated, divorced and widowed people had a mean value of CS significantly higher than married and single ones ($p\text{-value} = 0.046$). Moreover, staff with a fixed-term contract had higher levels of CS than people with an open-ended contract ($p\text{-value} = 0.002$). Again, workers who did express the need for training were also those with higher levels of CS compared with workers who did not report such need ($p\text{-value} = 0.008$). Finally, people not worried about incurring risks in the future were also those with higher levels of CS ($p\text{-value} = 0.006$).

As for CF, significant differences were found for organizational changes and risks for the future. Staff who did not report any organizational change in the previous year showed higher levels of CF than people reporting some or many changes ($p\text{-value} = 0.04$). Furthermore, staff who did not perceive risks for the future scored significantly lower than staff who did so ($p\text{-value} = 0.045$). Moreover, although not statistically significant, looking at the mean values psychiatrists seemed to experience CF more than other workers.

The last column of Table 25 refers to BO. The present outcome was significantly associated with the following variables: centre, work experience in other health or social services, organization, type of contract, perceived risks for the future, and opinion on current pay. Mental health staff working in Lecco MHD seemed to experience BO more than staff in the other two centres ($p\text{-value} = 0.005$). Furthermore, professionals who had worked more than 10 years in other services had a mean value in the BO score higher than people with shorter previous experience ($p\text{-value} = 0.01$). Also, workers employed by the Local Health Authority or the Hospital Trust showed higher levels of BO compared with Non for Profit Organization's and especially University employees ($p\text{-value} = 0.01$). Respondents with an open-ended contract had mean values in the BO score higher than people with a fixed-term

contract ($p\text{-value} < 0.001$). Moreover, significantly lower BO scores were detected for people who did not perceive risks for the future, compared with those who perceived some or many risks ($p\text{-value} = 0.001$). Finally, staff who considered their pay insufficient showed higher levels of BO ($p\text{-value} = 0.006$).

Table 25. Mean values of CS, CF, and BO among mental health staff

		N (%)	Compassion Satisfaction		Compassion Fatigue		Burnout	
			Mean (S.E.M.)	Test value	Mean (S.E.M.)	Test value	Mean (S.E.M.)	Test value
Age								
	18-29 yrs	38 (9.2)	32.8 (0.8)	3.7 (0.45)	15.2 (0.6)	5.5 (0.24)	22.7 (0.6)	4.6 (0.33)
	30-39 yrs	112 (27.1)	33.6 (0.6)		14.1 (0.3)		22.2 (0.4)	
	40-49 yrs	138 (33.3)	32.2 (0.6)		14.1 (0.3)		23.0 (0.4)	
	50-59 yrs	108 (26.1)	32.0 (0.7)		14.8 (0.5)		23.3 (0.5)	
	>60 yrs	18 (4.3)	34.1 (2.1)		14.4 (1.2)		22.1 (1.2)	
Gender								
	Male	97 (23.4)	32.6 (0.7)	0.001 (0.97)	14.7 (0.5)	0.5 (0.48)	22.5 (0.46)	0.67 (0.41)
	Female	318 (76.6)	32.7 (0.4)		14.3 (0.2)		22.8 (0.25)	
Marital status								
	Single	118 (28.6)	31.6 (0.7)	6.1 (0.046)*	14.3 (0.4)	0.1 (0.96)	22.3 (0.4)	2.5(0.29)
	Married	252 (61.2)	32.8 (0.4)		14.4 (0.3)		23.1 (0.3)	
	Separated, Divorced, Widowed	42 (10.2)	34.9 (1.1)		14.1 (0.5)		22.1 (0.7)	
Living Situation								
	Alone	79 (19.1)	32.6 (0.8)	0.05 (0.82)	14.7 (0.5)	1.3 (0.23)	22.7 (0.5)	<0.01 (0.99)
	With partner or family or other	335 (80.9)	32.7 (0.4)		14.3 (0.2)		22.8 (0.2)	
Educational level								
	None/Primary/Lower Secondary school	20 (4.8)	31.8 (2.0)	7.2 (0.06)	13.8 (0.8)	1.7 (0.63)	22.8 (1.2)	0.5 (0.91)
	Professional qualification/High school diploma	162 (38.8)	31.7 (0.6)		14.4 (0.4)		22.7 (0.4)	
	University diploma or degree	139 (33.3)	33.5 (0.5)		14.4 (0.3)		22.7 (0.3)	
	Master/Phd/Specialization	96 (23.0)	33.4 (0.7)		14.3 (0.4)		23.2 (0.5)	
Existence of extra income in the family								
	Yes	282 (67.6)	32.6 (0.4)	0.08 (0.78)	14.4 (0.2)	1.9 (0.16)	22.8 (0.3)	0.02 (0.88)
	No	135 (32.4)	32.9 (0.6)		14.3 (0.4)		22.9 (0.4)	
Centre								
	Lecco MHD	211 (49.4)	32.3 (0.5)	0.4 (0.82)	14.6 (0.3)	0.4 (0.82)	23.6 (0.3)	10.6 (0.005)**
	Legnago MHD	68 (15.9)	33.2 (0.9)		13.8 (0.4)		22.5 (0.5)	
	South Verona CMHS	148 (34.7)	33.0 (0.6)		14.2 (0.3)		21.8 (0.3)	

Table 25. (continued)

	N (%)	Compassion Satisfaction Mean (S.E.M.) Test value		Compassion Fatigue Mean (S.E.M.) Test value		Burnout Mean (S.E.M.) Test value	
N. of previous years worked in the psychiatric service							
Up to 10	255 (60.3)	32.9 (0.4)	1.9 (0.17)	14.4 (0.3)	0.3 (0.56)	22.7 (0.3)	0.7 (0.41)
More than 10	168 (39.7)	32.2 (0.6)		14.3 (0.3)		23.1 (0.4)	
Worked in other health or social services							
No	139 (39.4) ⁺	32.7 (0.6)	0.3 (0.88)	14.2 (0.3)	4.3 (0.12)	22.1 (0.4)	8.5 (0.01)*
Up to 10 years	162 (45.9)	32.7 (0.6)		14.2 (0.3)		23.4 (0.4)	
More than 10 years	52 (14.7)	32.1 (1.0)		15.9 (0.8)		24.0 (0.7)	
Occupational status							
Psychiatrist/Psychiatrist in training	79 (18.8)	33.1 (0.7)	10.6 (0.10)	15.3 (0.5)	7.9 (0.25)	23.2 (0.6)	6.7 (0.35)
Psychologist	33 (7.9)	35.3 (1.0)		13.5 (0.5)		21.6 (0.5)	
Nurse	123 (29.3)	31.5 (0.7)		14.5 (0.4)		22.8 (0.4)	
Social worker	18 (4.3)	33.0 (1.6)		14.1 (0.9)		23.3 (0.9)	
Rehabilitation therapist	22 (5.2)	34.3 (1.3)		14.1 (0.8)		23.6 (0.8)	
Educator/Healthcare support worker	133 (31.7)	32.4 (0.6)		14.0 (0.3)		22.7 (0.4)	
Other	12 (2.9)	32.8 (2.5)		14.4 (1.5)		23.1 (1.5)	
Organization							
Local health authority/Hospital trust	250 (59.2)	32.0 (0.5)	4.0 (0.14)	14.5 (0.3)	1.4 (0.50)	23.3 (0.3)	9.3(0.01)**
University	56 (13.3)	33.9 (0.8)		14.4 (0.4)		21.5 (0.4)	
Non for profit organization	116 (27.5)	33.2 (0.7)		14.0 (0.3)		22.5 (0.4)	
Type of contract							
Open-ended contract	344 (81.3)	32.1 (0.4)	9.9 (0.002)**	14.3 (0.2)	1.9 (0.17)	23.2 (0.3)	11.7 (<0.001)**
Fixed-term contract	79 (18.7)	34.9 (0.6)		14.5 (0.4)		21.4 (0.4)	
Contract with required availability							
Yes	119 (28.3)	33.4 (0.6)	1.0 (0.31)	14.8 (0.4)	2.5 (0.11)	22.8 (0.4)	0.004 (0.95)
No	302 (71.7)	32.3 (0.4)		14.2 (0.2)		22.8 (0.3)	
Receiving variable component of pay							
Yes	267 (65.6)	32.7 (0.6)	0.01 (0.98)	14.4 (0.4)	0.04 (0.85)	23.1 (0.3)	0.7 (0.41)
No	140 (34.4)	32.6 (0.4)		14.4 (0.3)		22.7 (0.3)	

⁺ Respondents who did not report the number of years worked in other services were considered missing; real % of people who did not work in other services was 34.4%.

Table 25. (continued)

	N (%)	Compassion Satisfaction		Compassion Fatigue		Burnout	
		Mean (S.E.M.)	Test value	Mean (S.E.M.)	Test value	Mean (S.E.M.)	Test value
Attended teaching/training events in the past 24 months							
Yes	406 (96.9)	32.6 (0.3)	0.7 (0.41)	14.4 (0.2)	0.2 (0.64)	22.8 (0.2)	0.01 (0.94)
No	13 (3.1)	29.7 (2.3)		14.1 (1.3)		23.4 (1.7)	
Perceived need of attending teaching/training events							
Yes	388 (92.4)	32.9 (0.3)	7.0 (0.008)**	14.4 (0.2)	0.1 (0.72)	22.8 (0.2)	0.5 (0.50)
No	32 (7.6)	28.9 (1.6)		14.4 (0.8)		23.6 (1.0)	
Organizational changes							
No change	11 (2.6)	31.5 (2.7)	0.5 (0.76)	14.8 (2.2)	6.3 (0.04)*	23.9 (2.0)	0.2 (0.90)
Some changes	191 (45.4)	32.7 (0.5)		14.1 (0.3)		22.7 (0.3)	
Many changes	219 (52.0)	32.6 (0.5)		14.6 (0.3)		22.9 (0.3)	
Perceived risks for the future							
No risk	38 (9.0)	35.9 (0.8)	10.3 (0.006) **	12.8 (0.4)	6.2 (0.045) *	20.5 (0.5)	13.6 (0.001) **
Some risks	186 (44.3)	32.3 (0.5)		14.4 (0.3)		22.7 (0.3)	
Many risks	196 (46.7)	32.2 (0.5)		14.6 (0.3)		23.5 (0.3)	
Opinion on current pay							
Insufficient	96 (22.7)	31.4 (0.8)	5.2 (0.07)	14.0 (0.4)	1.2 (0.55)	23.7 (0.5)	10.2 (0.006)**
Sufficient	228 (54.0)	32.9 (0.5)		14.6 (0.3)		23.0 (0.3)	
Good	98 (23.2)	33.3 (0.6)		14.1 (0.4)		21.5 (0.4)	

* Significant at the 5% level.

** Significant at the 1% level.

4.4.2 CS, CF, and BO scores above cut-off points

Table 26 presents the percentages of respondents scoring above the pre-established threshold scores for CS, CF and BO for each value of the categorical variables³. A chi-square test was performed in order to assess the association between categorical variables on one side and CS, CF and BO (as binomial indicators for being either above or below the cut-off points) on the other side. In ordinal variables (i.e., age, educational level, worked in other health or social services, perceived risks for the future, opinion on current pay, and organizational changes) a test for trend was calculated. This was used to test for a monotonic relationship between predictors (the ordinal variables) and outcomes (the probability of scoring above the cut-off points).

The first column presents the results for CS. Significant differences appeared in the following variables: age, type of contract, perceived need of attending teaching/training events, and perceived risks for the future. These differences, except for age, were significant also when analyzing the whole distribution of CS (see Table 25 for details). As for age, younger workers (18-29 years old) had higher levels above the cut-off than older employees (p-value = 0.049). Also, 70.6% of professionals with a fixed-term contract scored above the cut-off line, while only 49.5% with an open-ended contract showed scores above the cut-off (p-value = 0.001). People who reported the need of attending teaching/training events were those with higher levels of satisfaction: 54.7% of this subgroup reported CS values above the cut-off, while only 33.3% of people who did not report training needs scored above the cut-off (p-value = 0.03). Finally, 85.7% of people who did not perceive risks for the future scored above the cut-off point in CS, while the same figure was around 50% in staff who perceived some or many risks (p-value = 0.004).

³ Cut-off values are reported in 2.3.3.

As for CF, the only significant variable was perceived risks for the future. More specifically, 20.5% of workers who perceived many risks for the future seemed to be exposed at higher risk of fatigue ($p\text{-value} = 0.03$). This percentage was 2.7% in people who did not perceive such risks. Moreover, although not statistically significant, younger staff (between 18 and 29 years old) seemed to be more fatigued. Interestingly, as outlined above, the same subgroup of people had also higher levels of CS.

Finally, significant variables in the BO model were the following: centre, previous work in other services, organization, type of contract, perceived risks for the future, and opinion on current pay. More specifically, 15.8% of staff in Lecco scored above the cut-off in the BO dimension ($p\text{-value} = 0.001$). Intriguingly, levels of BO were higher in Legnago MHD than in South Verona CMHS: in Legnago 9.7% of staff scored above the cut-off, compared with 3.6% in Verona. The opposite happened for CF: there were found higher levels in Verona (16.8%) than in Legnago (8.1%). Furthermore, the longer the career in other services was, the higher the percentage above the cut-off resulted. More specifically, only 7.8% of people who did not report previous experience in other services scored above the cut-off point in BO, while the number reached 12.1% in staff with an experience of 10 years or less and 18.75% among people with a previous career longer than 10 years ($p\text{-value} = 0.04$). Mental health staff employed by the Local health authority or the Hospital trust reported higher percentages above the cut-off point, while none from the University reported scores above the cut-off ($p\text{-value} = 0.02$). In addition, staff with an open-ended contract reported higher percentages above the cut-off point ($p\text{-value} = 0.003$). Interestingly, people who did not perceive risks for the future always scored below the cut-off point, while 13.9% of professionals who perceived many risks scored above the cut-off ($p\text{-value} = 0.01$). Finally, 16.3% of people who considered their pay insufficient seemed to be at higher risk of BO. Not surprisingly, this figure was very low (1.05%) among staff who rated their pay as good ($p\text{-value} < 0.001$).

Table 26. Mental health staff scoring above cut-offs in CS, CF, and BO

	Compassion Satisfaction			Compassion Fatigue			Burnout		
	N (%)	% above cut-off	Test value	N (%)	% above cut-off	Test value	N (%)	% above cut-off	Test value
Age									
18-29 yrs	37 (9.6)	62.2	3.9 (0.049)*	37 (9.25)	29.7	<0.01 (0.96)	37 (9.4)	8.1	2.2 (0.14)
30-39 yrs	103 (26.6)	60.2		108 (27.0)	13.9		105 (26.6)	4.8	
40-49 yrs	130 (33.6)	50.0		133 (33.25)	15.8		132 (33.5)	13.6	
50-59 yrs	100 (25.8)	49.0		104 (26.0)	20.2		102 (25.9)	13.7	
>60 yrs	17 (4.4)	47.1		18 (4.5)	22.2		18 (4.6)	5.6	
Gender									
Male	93 (24.0)	60.2	2.2 (0.14)	95 (23.7)	16.8	0.1 (0.80)	94 (23.8)	8.5	0.4 (0.55)
Female	294 (76.0)	51.4		306 (76.3)	18.0		301 (76.2)	10.6	
Marital status									
Single	110 (28.6)	50.0	5.0 (0.08)	113 (28.4)	15.0	0.9 (9.62)	111 (28.2)	7.2	1.3 (0.5)
Married	235 (61.0)	52.8		243 (61.1)	17.7		240 (61.1)	10.8	
Separated, Divorced, Widowed	40 (10.4)	70.0		42 (10.6)	21.4		42 (10.7)	11.9	
Living Situation									
Alone	74 (19.2)	56.8	0.3 (0.58)	77 (19.25)	22.1	1.4 (0.24)	75 (19.0)	8.0	0.4 (0.54)
With partner or family or other	312 (80.8)	53.2		323 (80.75)	16.4		319 (81.0)	10.3	
Educational level									
None/Primary/Lower Secondary school	18 (4.6)	50.0	2.7 (0.10)	20 (5.0)	15.0	0.75 (0.39)	18 (4.5)	11.1	0.5 (0.47)
Professional qualification/High school diploma	147 (37.8)	46.9		156 (38.7)	19.2		153 (38.5)	12.4	
University diploma or degree	132 (33.9)	59.8		133 (33.0)	20.3		133 (33.5)	9.0	
Master/Phd/Specialization	92 (23.7)	56.5		94 (23.3)	12.8		93 (23.4)	9.7	
Existence of extra income in the family									
Yes	262 (67.5)	52.7	0.7 (0.41)	272 (67.7)	16.5	0.4 (0.51)	269 (67.9)	10.0	0.3 (0.59)
No	126 (32.5)	57.1		130 (32.3)	19.2		127 (32.1)	11.8	
Centre									
Lecco MHD	200 (50.5)	53.0	0.3 (0.88)	206 (50.1)	20.9	5.5 (0.06)	203 (50.1)	15.8	13.0 (0.001)**
Legnago MHD	61 (15.4)	52.5		62 (15.1)	8.1		62 (15.3)	9.7	
South Verona CMHS	135 (34.1)	55.6		143 (34.8)	16.8		140 (34.6)	3.6	

Table 26. (continued)

	Compassion Satisfaction			Compassion Fatigue			Burnout		
	N (%)	% above cut-off	Test value	N (%)	% above cut-off	Test value	N (%)	% above cut-off	Test value
N. of previous years worked in the psychiatric service									
Up to 10	234 (59.4)	57.3	3.2 (0.07)	247 (60.5)	17.4	0.02 (0.88)	240 (59.7)	10.4	0.05 (0.825)
More than 10	160 (49.6)	48.1		161 (39.5)	18.0		162 (40.3)	11.1	
Worked in other health or social services									
No	129 (39.3)	56.6	0.3 (0.60)	135 (39.7)	18.5	0.2 (0.66)	129 (38.6)	7.8	4.2 (0.04) *
Up to 10 years	153 (46.6)	51.6		156 (45.9)	17.9		157 (47.0)	12.1	
More than 10 years	46 (14.0)	54.3		49 (14.1)	22.4		48 (14.4)	18.75	
Occupational status									
Psychiatrist/Psychiatrist in training	76 (19.5)	59.2	4.7 (0.58)	79 (19.6)	20.3	5.4 (0.50)	77 (19.3)	13.0	5.1 (0.53)
Psychologist	32 (8.2)	65.6		32 (7.9)	9.4		32 (8.0)	0	
Nurse	115 (29.5)	48.7		116 (28.7)	19.8		116 (29.1)	11.2	
Social worker	17 (4.4)	50.0		17 (4.2)	27.8		16 (4.0)	5.9	
Rehabilitation therapist	21 (5.4)	52.4		21 (5.2)	19.0		21 (5.3)	9.5	
Educator/Healthcare support worker	120 (30.8)	51.7		127 (31.4)	14.2		127 (31.9)	12.6	
Other	9 (2.3)	66.7		12 (3.0)	25.0		9 (2.3)	11.1	
Organization									
Local health authority/Hospital trust	233 (59.4)	49.4	5.2 (0.07)	237 (58.5)	18.8	1.3 (0.52)	235 (58.9)	12.7	7.8 (0.02)*
University	55 (14.0)	65.5		56 (13.8)	19.6		55 (13.8)	0	
Non for profit organization	104 (26.5)	56.7		112 (27.7)	14.3		109 (27.3)	11.9	
Type of contract									
Open-ended contract	319 (81.0)	49.5	10.9 (0.001)**	330 (80.9)	17.3	0.2 (0.68)	325 (80.8)	12.9	8.8 (0.003)**
Fixed-term contract	75 (19.0)	70.6		78 (19.1)	19.2		77 (19.2)	1.3	
Contract with required availability									
Yes	113 (28.8)	57.5	1.1 (0.30)	118 (29.0)	18.6	0.1 (0.75)	116 (28.9)	11.2	0.04 (0.84)
No	280 (71.2)	51.8		289 (71.0)	17.3		285 (71.1)	10.5	
Receiving variable component of pay									
Yes	136 (35.9)	51.5	0.3 (0.59)	139 (35.4)	15.8	0.7 (0.39)	138 (35.8)	11.6	0.2 (0.64)
No	243 (64.1)	54.3		254 (64.3)	19.3		248 (64.2)	10.1	

Table 26. (continued)

	Compassion Satisfaction			Compassion Fatigue			Burnout		
	N (%)	% above cut-off	Test value	N (%)	% above cut-off	Test value	N (%)	% above cut-off	Test value
Attended teaching/training events in the past 24 months									
Yes	379 (97.2)	53.0	0.01 (0.92)	392 (97.0)	17.6	0.01 (0.93)	12 (3.0)	10.6	0.4 (0.51)
No	11 (2.8)	54.5		12 (3.0)	16.7		386 (97.0)	16.7	
Perceived need of attending teaching/training events									
Yes	364 (93.1)	54.7	4.6 (0.03)*	375 (92.6)	17.6	0.1 (0.74)	28 (7.0)	10.2	1.6 (0.21)
No	27 (6.9)	33.3		30 (7.4)	20.0		371 (93.0)	17.9	
Organizational changes									
No change	10 (2.6)	50.0	0.3 (0.58)	11 (2.7)	9.1	1.6 (0.21)	11 (2.75)	9.1	0.01 (0.93)
Some changes	175 (44.6)	55.4		183 (45.2)	15.8		180 (45.0)	11.1	
Many changes	207 (52.8)	51.7		212 (52.2)	19.8		209 (52.25)	10.5	
Perceived risks for the future									
No risk	35 (8.9)	85.7	8.4 (0.004) **	37 (9.1)	2.7	4.8 (0.03) *	37 (9.25)	0	6.0 (0.01) *
Some risks	173 (44.1)	50.9		179 (44.1)	17.9		176 (44.0)	9.7	
Many risks	184 (46.9)	49.5		190 (46.8)	20.5		187 (46.75)	13.9	
Opinion on current pay									
Insufficient	90 (22.8)	45.6	3.6 (0.06)	92 (22.6)	17.4	0.13 (0.72)	92 (22.9)	16.3	11.4 (<0.001)**
Sufficient	210 (53.3)	54.3		218 (53.6)	18.8		214 (53.4)	12.6	
Good	94 (23.9)	59.6		97 (23.8)	15.5		95 (23.7)	1.05	

* Significant at the 5% level.

** Significant at the 1% level.

Table 27 presents statistics about the relationship between CS, CF, and BO levels on one side and continuous variables on the other side. For each collected variable, the table reports levels of continuous variables corresponding to values of CS, CF, and BO above and below, respectively, the cut-off points. Mean values, standard deviations, and the results of Kruskal-Wallis test for each variable are illustrated.

As for CS, significant differences were detected for the following variables: trust, autonomy, participation, utility of meetings, organizational commitment, job satisfaction, and importance attributed to relations/autonomy. More specifically, people scoring above the cut-off in CS (i.e., more satisfied) had also higher levels of trust (p-value = 0.001), autonomy (p-value = 0.003), participation (p-value = 0.048), perceived meetings as more useful (p-value < 0.001), and reported a greater commitment to their organization (p-value < 0.001). Finally, not surprisingly, people scoring above the cut-off in CS reported higher levels of job satisfaction (p-value < 0.001) and attributed greater importance to aspects of relations/autonomy (p-value < 0.001).

In the CF model, the score distribution was rather unbalanced: only 72 were the workers scoring above the cut-off, while 336 were those below the cut-off line. Significant differences were found for the following aspects: ergonomic problems, utility of meetings, conditioning of work on life, conditioning of life on work, and job satisfaction. Precisely, staff above the cut-off – i.e. showing higher levels of fatigue – perceived more ergonomic problems (p-value < 0.001) and reported less utility of team meetings (p-value = 0.002). Moreover, staff above the cut-off in CF reported higher levels of conditioning of work on life (p-value < 0.001) as well as of life on work (p-value < 0.001). Not unexpectedly, people above the cut-off showed lower levels of job satisfaction (p-value = 0.04).

Finally, significant differences in the BO model were found for a substantial number of variables. These can be summarized as follows: time dedicated to clinical and care work,

ergonomic problems, trust, autonomy, utility of meetings, organizational commitment, conditioning of work on life, conditioning of life on work, and job satisfaction. More specifically, staff with levels of BO exceeding the cut-off were those who dedicated more time to clinical and care work during the week (p-value = 0.03). Staff reporting higher levels of BO also perceived more ergonomic problems (p-value < 0.001), as well as reported lower levels of trust (p-value < 0.001) and autonomy (p-value < 0.001). Moreover, workers above the cut-off point were also those who perceived meetings as less useful (p-value < 0.001) and the team as scarcely committed to the organization (p-value < 0.001). Again, as in the CF model, staff above the cut-off in BO reported higher levels of conditioning of work on life (p-value = 0.003) and conditioning of life on work (p-value = 0.04). Finally, people above the cut-off showed lower levels of job satisfaction (p-value < 0.001).

Table 27. Staff scoring above and below cut-offs in CS, CF, and BO (continuous variables)

	Compassion Satisfaction			Compassion Fatigue			Burnout		
	Mean (S.D.) of workers> cutoff (N=211)	Mean (S.D.) of workers< cutoff (N=183)	Test value	Mean (S.D.) of workers> cutoff (N=72)	Mean (S.D.) of workers< cutoff (N=336)	Test value	Mean (S.D.) of workers> cutoff (N=43)	Mean (S.D.) of workers< cutoff (N=359)	Test value
Average % of time dedicated to clinical and care work	74.5 (26.4)	74.2 (27.7)	0.001 (0.97)	73.8 (26.1)	74.3 (27.4)	0.2 (0.63)	82.0 (24.5)	73.7 (27.1)	4.9 (0.03)*
Ergonomic problems	2.2 (0.5)	2.3 (0.6)	2.5 (0.11)	2.6 (0.6)	2.2 (0.5)	30.5 (<0.001)**	2.7 (0.7)	2.2 (0.5)	20.0 (<0.001)**
Job complexity	3.5 (0.6)	3.5 (0.6)	0.03 (0.86)	3.6 (0.5)	3.5 (0.6)	3.0 (0.08)	3.6 (0.6)	3.5 (0.6)	0.2 (0.64)
Trust	3.7 (0.6)	3.4 (0.7)	10.5 (<0.001)**	3.5 (0.7)	3.6 (0.7)	2.3 (0.13)	3.2 (0.6)	3.6 (0.7)	18.7 (<0.001)**
Autonomy	3.2 (0.7)	3.0 (0.7)	9.1 (0.003)**	3.0 (0.7)	3.2 (0.7)	2.7 (0.10)	2.7 (0.7)	3.2 (0.6)	15.4 (<0.001)**
Participation	2.3 (0.6)	2.1 (0.5)	3.9 (0.048)*	2.2 (0.5)	2.2 (0.6)	0.04 (0.85)	2.1 (0.6)	2.2 (0.6)	2.0 (0.16)
Utility of meetings	3.3 (0.6)	2.9 (0.7)	20.5 (<0.001)**	2.9 (0.7)	3.2 (0.7)	9.9 (0.002)**	2.8 (0.7)	3.2 (0.7)	14.4 (<0.001)**
Organizational commitment	3.3 (0.6)	3.0 (0.6)	23.5 (<0.001)**	3.1 (0.7)	3.2 (0.7)	0.9 (0.33)	2.9 (0.6)	3.2 (0.7)	11.3 (<0.001)**
Conditioning of work on life	2.9 (0.9)	3.0 (0.9)	0.2 (0.62)	3.3 (0.8)	2.8 (0.9)	19.1 (<0.001)**	3.3 (1.0)	2.9 (0.9)	8.8 (0.003) **
Conditioning of life on work	2.4 (0.9)	2.4 (1.0)	0.2 (0.67)	2.7 (0.9)	2.3 (0.9)	13.9 (<0.001) **	2.6 (1.0)	2.3 (0.9)	4.1 (0.04)*
Job satisfaction	3.3 (0.5)	3.0 (0.5)	36.35 (<0.001)**	3.1 (0.6)	3.2 (0.5)	4.3 (0.04)*	2.7 (0.4)	3.2 (0.5)	41.0 (<0.001) **
Importance of stability	3.8 (0.6)	3.8 (0.6)	0.15 (0.70)	3.8 (0.6)	3.8 (0.6)	0.04 (0.85)	3.9 (0.5)	3.8 (0.6)	2.3 (0.13)
Importance of relations/autonomy	4.1 (0.5)	3.9 (0.5)	15.9 (<0.001)**	4.0 (0.6)	4.0 (0.5)	0.001 (0.98)	4.0 (0.5)	4.0 (0.5)	1.0 (0.31)

*Significant at the 5% level.

**Significant at the 1% level.

4.4.3 Correlations between quality of working life indicators and CS, CF, and BO

The analysis presented above highlighted the relationship between the dimensions of CS, CF, and BO, and the indicators of quality of working life. In order to further analyze whether compassion (both in its positive and negative terms) and burnout were correlated with quality of working life, a correlation analysis was performed. Table 28 presents the Pearson's correlation coefficients between indicators of quality of working life and, respectively, CS, CF, and BO. Pearson's correlation coefficients is a measure of the linear correlation (dependence) between two variables X and Y, giving a value between -1 and +1 inclusive, where 1 is total positive correlation, 0 is no correlation, and -1 is total negative correlation.

As for CS, most variables were positively correlated with this outcome. Ergonomic problems was the only significant negative correlation (coefficient = -0.12; p-value = 0.01), while conditioning of life on work showed a null correlation. As concerning CF, significant positive correlations were found with the following variables: ergonomic problems (coefficient = 0.28; p-value < 0.001); job complexity (coefficient = 0.16; p-value < 0.001); conditioning of work on life (coefficient = 0.24; p-value < 0.001); and conditioning of life on work (coefficient = 0.19; p-value < 0.001). Interestingly, job complexity was positively correlated with CS as well. Moreover, CF was negatively correlated with the following: trust (coefficient = -0.14; p-value = 0.005); autonomy (coefficient = -0.10; p-value = 0.04); utility of meetings (coefficient = -0.17; p-value < 0.001); and job satisfaction (coefficient = -0.17; p-value < 0.001). Conversely, these variables were positively correlated with CS.

Finally, BO showed the same positive correlations as CF, except for the indicator of participation. The latter was significantly and negatively correlated with BO (coefficient = -0.10; p-value = 0.04), while it did not show significant correlations with CF. BO showed two additional significant correlations. These were organizational commitment and importance of

relations/autonomy. More specifically, the higher the organizational commitment was rated, the lower the level of BO (coefficient = -0.29; p-value < 0.001). Likewise, staff that gave more emphasis to aspects of autonomy/relations was less likely to experience BO (coefficient = -0.11; p-value = 0.03).

Table 28. Correlations between indicators of quality of working life and CS, CF, and BO

	Compassion Satisfaction		Compassion Fatigue		Burnout	
	Coeff.	p-value	Coeff.	p-value	Coeff.	p-value
Ergonomic problems	-0.12	0.01 *	0.28	<0.001 **	0.32	<0.001 **
Job complexity	0.10	0.04 *	0.16	0.001 **	0.04	0.46
Trust	0.22	<0.001 **	-0.14	0.005 **	-0.30	<0.001 **
Autonomy	0.19	<0.001 **	-0.10	0.04 *	-0.18	<0.001 **
Participation	0.14	0.005 **	0.06	0.25	-0.10	0.04 *
Utility of meetings	0.29	<0.001 **	-0.17	<0.001 **	-0.29	<0.001 **
Organizational commitment	0.29	<0.001 **	-0.05	0.28	-0.24	<0.001 **
Conditioning of work on life	-0.09	0.07	0.24	<0.001 **	0.17	<0.001 **
Conditioning of life on work	0.00	1.00	0.19	<0.001 **	0.08	0.09
Job satisfaction	0.41	<0.001 **	-0.17	<0.001 **	-0.41	<0.001 **
Importance of stability	0.01	0.86	-0.05	0.29	0.03	0.54
Importance of relations /autonomy	0.26	<0.001 **	-0.03	0.61	-0.11	0.03 *

*Significant at the 5% level.

**Significant at the 1% level.

4.5 MULTIVARIATE ANALYSIS: PREDICTORS OF COMPASSION SATISFACTION, COMPASSION FATIGUE, AND BURNOUT

Finally, a linear multivariate regression analysis was performed in order to further estimate the relationships between the variables discussed so far. Linear regression is an approach for estimating the relationship between a scalar dependent variable *Y* and one or more explanatory variables (or independent variable) denoted as *X*. More specifically, three regression models were run using CS, CF, and BO as outcomes and factors presented in Table 23 (i.e., socio-demographics, occupational variables, and indicators of quality of working life) as independent variables. In all three models, the stepwise regression method was used. In the stepwise regression, the choice of predictive variables is carried out by an automatic procedure. In the present analysis, the approach of backward elimination was chosen. This involved starting with all variables significant at the 5% level in univariate analysis (results not showed here), and then removing the variable that was least significant, and repeating this process until all had a p-value of 0.1. The results of this analysis are reported in Table 29, Table 30, and Table 31, where regression coefficients, p-values, and confidence intervals (C.I.) are presented. As for continuous variables, the regression coefficient represents the rate of change of CS, CF, and BO as a function of one point increase in the independent variable; in categorical variables, the same coefficient expresses the rate of change of CS, CF, and BO as a function of change in the possible values of the independent variable.

As illustrated in the three tables, some variables recurred in the models. For example, perceived risks for the future was an important covariate in both CS and BO models. People who perceived many risks seemed to be less satisfied compared with people who did not perceive such risks (coefficient = -3.2). Conversely, perceiving many risks for the future showed to increase the BO score (coefficient = 1.8). Moreover, staff who reported a greater utility of meetings seemed to be more satisfied (coefficient = 1.4) and less fatigued

(coefficient = -0.7). Again, staff who attributed greater importance to aspects of relations/autonomy both seemed to be more fulfilled at work (coefficient = 3.0) and had lower levels of BO (coefficient = -0.9). People with a previous occupation in other health or social services of more than 10 years showed higher levels of both CF and BO (coefficient = 1.8 in both cases) than those without previous experience in other services. Furthermore, ergonomic problems were significant in both the CF and the BO models: experiencing ergonomic problems turned out to increase both levels of, respectively, 1.5 and 1.4 points. Finally, people reporting a greater influence of work on life had higher levels of both CF and BO. It showed to increase both scores of, respectively, 0.9 and 0.6 points.

Finally, in order to evaluate the robustness of results of the three stepwise regressions, three multiple linear regression analyses were run. Such multiple regressions included all predictors that turned out to be significant in univariate analyses. The three models showed very similar results to those of the stepwise regressions, the only relevant exception being the variable utility of meetings, which turned out as non-significant in the regression to predict CF.

Table 29. Stepwise regression analysis using CS score as dependent variable

Compassion Satisfaction (N=368)					
Adj R ² = 0.2783					
		Coeff.	p-value	C.I. (95%)	
Marital status					
Married vs. Single		1.882	0.010**	0.452	3.313
Separated, Divorced, Widowed vs. Single		4.629	<0.001***	2.314	6.945
Type of contract					
Fixed-term contract vs. Open-ended contract		4.535	<0.001***	2.931	6.138
Perceived need of attending teaching/training events					
Yes vs. No		3.460	0.010**	0.815	6.104
Perceived risks for the future					
Some risks vs. No risk		-3.036	0.007***	-5.245	-0.827
Many risks vs. No risk		-3.191	0.005***	-5.438	-0.945
Utility of meetings		1.413	0.009***	0.351	2.474
Job satisfaction		4.158	<0.001***	2.585	5.731
Importance of relations/autonomy		2.999	<0.001***	1.638	4.360

*Significant at the 10% level.

**Significant at the 5% level.

***Significant at the 1% level.

Table 30. Stepwise regression analysis using CF score as dependent variable

Compassion Fatigue (N=323)				
Adj R ² = 0.1475				
	Coeff.	p-value	C.I. (95%)	
Worked in other health or social services				
Up to 10 years vs. No	-0.280	0.554	-1.212	0.651
More than 10 years vs. No	1.844	0.006***	0.521	3.167
Ergonomic problems	1.511	<0.001***	0.713	2.309
Job complexity	0.753	0.082*	-0.097	1.603
Utility of meetings	-0.689	0.045**	-1.361	-0.017
Conditioning of work on life	0.931	<0.001***	0.443	1.418

*Significant at the 10% level.

**Significant at the 5% level.

***Significant at the 1% level.

Table 31. Stepwise regression analysis using BO score as dependent variable

Burnout (N=347)				
Adj R ² = 0.2635				
	Coeff.	p-value	C.I. (95%)	
Centre				
Legnago MHD vs. Lecco MHD	-0.295	0.633	-1.511	0.920
Verona CMHS vs. Lecco MHD	-1.603	0.001***	-2.569	-0.637
Worked in other health or social services				
Up to 10 years vs. No	0.754	0.115	-0.186	1.694
More than 10 years vs. No	1.787	0.007***	0.493	3.082
Perceived risks for the future				
Some risks vs. No risk	1.270	0.113	-0.304	2.844
Many risks vs. No risk	1.780	0.028**	0.198	3.361
Ergonomic problems	1.414	0.001***	0.619	2.210
Conditioning of work on life	0.631	0.012**	0.143	1.120
Job satisfaction	-2.837	<0.001***	-3.758	-1.917
Importance of relations/autonomy	-0.939	0.052*	-1.888	0.010

*Significant at the 10% level.

**Significant at the 5% level.

***Significant at the 1% level.

4.6 DISCUSSION

While mental health professionals are subjected to similar organizational stressors as other workers – e.g. workload, job role, work demands, and work environment – there are also intrinsic characteristics of mental health work that constitute further stress factors. Mental health professionals face additional emotional strain by the very nature of their professions in dealing with troubled persons, often over extended periods. Such risk factors have been analyzed in this thesis in terms of Compassion Satisfaction (CS), Compassion Fatigue (CF) and Burnout (BO). Before discussing the results, the strengths and limitations of this study should be acknowledged.

The main strength of the study is the large sample size (N=443) and the representativeness of different types of mental health professionals. Moreover, the generalizability of the study is likely to be high, as it was conducted in three different Italian mental health departments and included staff working in different settings such as general hospital psychiatric units, outpatient, day, and residential services. In addition, the response rate was very high (87%). Another strength of the study is the inclusion of a large set of variables measuring both socio-demographics, occupational characteristics and a core set of indicators of quality of working life. The latter made it possible to capture the subjective experience and perceptions of mental health staff.

Some limitations of the study should be taken into account. First, the cross-sectional nature of the survey did not allow for the determination of causality. Since the theoretical models frame compassion fatigue and burnout within long-term processes, the development of longitudinal designs is warranted. This would allow assessing the casual relationships among the number of factors investigated above. Moreover, because this study emphasized the role of organizational and environmental factors other significant variables were not included in the survey. For example, individual coping strategies to face work-related stresses were not

considered, although extensive literature demonstrates their crucial role in tackling difficult situations at work (Radey & Figley, 2007; Zeidner *et al.*, 2013; Montero-Marín *et al.*, 2014). When performing the multivariate analysis, the most significant predicting factors for CS, CF and BO were the aforementioned indicators of quality of working life. In addition, a few significant results were found for socio-demographic and occupational variables. More specifically, marital status was significant in the CS model. Being married (vs. single) increased the level of CS of 1.9 points and, intriguingly, also being separated, divorced or widowed predicted higher levels of CS than being single. These findings are consistent with previous research in showing that single individuals are more prone to experience work-related negative outcomes (Maslach, 2003; Adams *et al.*, 2008; Rossi *et al.*, 2012). As for CS, other two significant occupational characteristics were type of contract and perceived need of attending training events. People with a fixed-term contract seemed to be more satisfied compared with staff with an open-ended contract. This result is in line with previous research and seems to indicate that flexible contracts do not always necessarily bring about negative consequences (Rossi *et al.*, 2012). It can be speculated that people with fixed-term contracts experience more satisfaction because they are more motivated. Also, knowing that your work position will be the same for the rest of your life might elicit feelings of ‘being trapped’ and thus reduce the possibility of experiencing satisfaction. Moreover, people who perceived the need of attending teaching/training events were more prone to experience CS. It might be that staff that requests more training is more committed and invests more energies in work than people indifferent to training. This seems to have a positive effect on the satisfaction derived from helping other people. However, the casual ordering of such phenomena could not be established within this survey. As for the indicators of quality of working life, an interesting variable that was significant both in the CS and the BO models was that of perceived risks for the future. The more the respondents perceived risks for the future (e.g., losing job, having an

inadequate work competence, being unable to maintain one's family, being unable to sustain a substantial expense), the less they were likely to experience CS and the more were prone to BO. The present survey also investigated the utility of meetings as perceived by staff, that is, whether the respondent perceived meetings as an opportunity to bring his/her contribution, to be appreciated for his/her work, to influence the decisions of the group, to adequately deal with problems as well as receive emotional support. Utility of meetings was an important covariate in both the CS and the CF model. Moreover, although not significant in multivariate analysis, utility of meetings was found significantly and negatively correlated with BO in correlation analysis. Not surprisingly, job satisfaction showed to increase of 4.1 points the level of CS and decrease of 2.8 points the BO score. In correlation analysis, job satisfaction also showed a significant and negative correlation with CF. Finally, this survey investigated the importance attributed to specific aspects of work and its influence on CF, CS, and BO. Interestingly, professionals that emphasized aspects of relations/autonomy (colleagues, managers, social utility, job content, job autonomy, decision latitude) had higher levels of CS and lower levels of BO. These aspects may be seen as intrinsic job factors and differentiate from extrinsic factors which include tangible aspects of the work, such as salary, working hours, proximity to home, physical environment (Klopper *et al.*, 2012). This result seems to show that intrinsic factors have a stronger impact than extrinsic ones (analyzed with the variable 'importance of stability') on levels of CS and BO.

As for CF, people who had previously worked in other health or social services for more than 10 years had significant higher CF scores than people without previous experience in these services. The same pattern was found in the BO model, where a career of more than 10 years in other services predicted a 1.8 point increase in the BO score. If looking at the number of respondents scoring above the cut-off points, although not statistically significant, it should be noted that also staff with a longer career in the mental health service scored higher in the CF

and BO measures. In general, this seems to confirm what is called the ‘cumulative effect’ (Montero-Marin *et al.*, 2011; Czaja *et al.*, 2012). That is, stressful experiences are more likely to be recurring over time and thus a longer career exposes to higher levels of CF and BO. However, the fact that only work in other health or social services was statistically significant in multivariate models can be explained referring to specialized training, which has been described as protective against CF and BO (Sprang *et al.*, 2007). Although such indicator was not investigated in this survey, it can be argued that people that arrive at the mental health service after a long experience in other services are less prepared to effectively deal with mental health patients and thus more exposed to CF and BO.

Moreover, the experience of ergonomic problems significantly increased the levels of both CF and BO. Ergonomic problems were also significantly and positively correlated with CS. It can be argued that the presence of additional strains in the environment (e.g., inappropriate workspace, poor hygiene, time pressures, etc.) has a negative impact on the ability to help other people, thus reducing the likelihood of feeling satisfied with one’s caring role and exacerbating levels of CF and BO. This is consistent with previous research. Abu-Bader (2000) found that higher satisfaction, lower burnout and lower turnover were a function of adequate working conditions.

When two indicators of work-life balance (i.e., conditioning of work on life and conditioning of life on work) were analyzed, the results showed that higher levels of conditioning of work on life predicted higher BO and CF scores. Conditioning of life on work did not predict significant differences, although in correlation analysis it was significantly and positively correlated with CF. These findings demonstrate that work-life balance is essential in preventing work-related negative outcomes, as various authors illustrate (Figley, 2002b; Hesse, 2002). The finding that the impact of work on life had a stronger effect on CF and BO than conditioning of life on work seems to show that people are more concerned about the

interference of work with their personal life than the opposite. Finally, staff working at Lecco MHD had significantly higher levels of BO than those in the other two centres. It can be argued that age influences this result. Indeed, staff in Lecco MHD was older than in Legnago and Verona. However, this finding requires further investigation.

The findings illustrated above are encouraging in that they demonstrate that the indicators of quality of working life identified in this study play a significant role in predicting CS, CF and BO. Results of correlation analyses corroborate this observation. Indeed, results showed that all indicators of quality of working life considered here had significant correlations with CS, CF, and BO. Discounting the indicators already mentioned, the indicator of job complexity showed an interesting pattern: it was positively correlated with all three dimensions of CS, CF and BO, although not significantly with the last one. It is expected that the more the job is complex the more the individual is exposed to fatigue and burnout, however once a complex task is successfully completed it is likely that a person will derive far more satisfaction from it. On this regard, Evans and colleagues (2006) reported high job demand as a major predictor of stress and emotional exhaustion. However, this finding is also in line with Stamm (2002) who suggested that a professional might experience simultaneously CS and CF. As expected, trust was significantly and positively correlated with CS and significantly and negatively correlated with CF and BO. This indicator describes the extent to which the manager and colleagues are perceived supportive. This result is in line with research demonstrating that support and trust received from manager and coworkers are critical in protecting against CF and BO (Prosser *et al.*, 1997; Galeazzi *et al.*, 2004; Hunsaker *et al.*, 2014). The same pattern as for trust was found when analyzing autonomy. Autonomy in the workplace refers to how much freedom employees have while working and to the level of control over work. This result substantiates previous studies in demonstrating that a sense of autonomy and control protects staff from negative consequences (Abu-Bader, 2000; Maslach, 2003). When

analyzing the indicator of participation, a significant and positive correlation was found with CS, while a significant and negative correlation appeared with BO. The notion of participation is similar to that of ‘decision latitude’, whose lack was found to contribute to poor job satisfaction and the most aspects of burnout (Evans *et al.*, 2006). When correlating organizational commitment with CS, CF and BO, results showed a significant and positive correlation with CS and significant and negative correlation with BO. Li and colleagues (2014) investigated a similar indicator. The authors found that the individual’s identification with and involvement in the organization’s goals and values was related to job satisfaction and compassion satisfaction.

In conclusion, these findings are useful for health managers and team leaders to identify factors affecting the ability of being compassionate and the risk of burnout. It is widely recognized that lack of satisfaction, compassion fatigue and burnout have adverse consequences on work performance and quality of services. Compassion fatigue is likely to result in problems such as misjudgments, clinical errors, poor treatment planning, all serious issues for effective care (Figley, 2002a; Bride *et al.*, 2007; Adams *et al.*, 2008). Therefore, in order to provide adequate mental health and social services for people in need, managers and administrators need to provide their employees with adequate ergonomic conditions, support and trust, encourage staff to be committed towards the organization’s goals as well as to act independently. Lastly, to positively influence the life of their clients, managers, administrators, and professionals themselves need to consider strategies to reduce work-life conflicts.

5. THE ITALIAN MULTICENTRE STUDY: QUALITY FROM THE PERSPECTIVE OF SERVICE USERS

Sections from 5.1 to 5.6 will illustrate the findings from interviews with service users. More specifically, the following aspects will be analyzed: socio-demographic characteristics of the sample; utilization of mental health and social care services; service users' perspectives on continuity of care; and social care related quality of life. Finally, all findings will be discussed in Section 5.7.

5.1 SOCIO-DEMOGRAPHIC PROFILE OF SERVICE USERS

Socio-demographic characteristics of service users participating in the Multicentre study are presented in Table 32 and Table 33 below. The total sample included 220 people, comprising 60 users in Lecco, 60 in Verona, and 100 in Legnago.

Females and males were equally represented. The majority of participants (44%) were between 36 and 50 years old, followed by people aged between 51 and 65 years (41%) and those between 18 and 25 years (15%). Sixty-two percent of service users were single, while only 22% were married or partnered. Ninety-six of participants were Italian, whereas other nationalities were scarcely represented. The majority of participants (52%) had an elementary or middle school degree, followed by secondary school diploma (45%) and university degree (3%).

Significant differences between the three centres were found for diagnosis. The vast majority (71%) of participants in Legnago MHD had an ICD-10 diagnosis of schizophrenic disorder, while the same figure was 47% in Lecco MHD and 32% in South Verona CMHS. Moreover, in Legnago the percentage of respondents with a diagnosis of personality disorder was

substantially low (5%) compared with the other two centres. This data did not seem to match with information on the one-year prevalence in the year before the data collection that have been presented in Table 19. In addition, neurotic and somatoform disorders did not seem to be well represented in the study sample if compared with the usual one-year prevalence. This percentage was very low in the sample, ranging from 3 (Lecco MHD) to 10 percent (South Verona CMHS). However, the one-year prevalence (Table 19) shows a prevalence of such disorders between 16 (South Verona CMHS) and 44 percent (Legnago MHD).

Seventy-one percent of respondents owned their house, while 19% of people were in rented houses (including those who privately rented the house and who rented from local authority/municipality or housing services). The sample included 19 people (9%) living in overnight residential facilities. Moreover, only one quarter of respondents were employed, while inactive people (i.e., retired, students, looking after family, people unable to work) were 37% of respondents and unemployed another 21%. Users in sheltered employment or training programs represented the 17% of the sample. In addition, a substantial number of people (46%) reported their primary source of income was the disability allowance, while only 26% of participants could count on their salary or wage. Another 13% declared their income came from family support. Data on monthly personal income confirmed an unfavorable situation: about half of respondents answered their income was less than 500 € per month.

Table 32. Multicentre study: Socio-demographic characteristics of service users

		Lecco MHD		Legnago MHD		South Verona CMHS		Total	
		N	%	N	%	N	%	N	%
Age									
	20-35 years old	8	14	14	14	11	18	33	15
	36-50 years old	28	47	45	45	23	38	96	44
	51-65 years old	23	39	41	41	26	43	90	41
Gender									
	Male	31	52	52	52	27	45	110	50
	Female	29	48	48	48	33	55	110	50
Marital status									
	Single	34	57	62	62	41	68	137	62
	Married/Partnered	13	22	22	22	14	23	49	22
	Separated, Divorced, Widowed	13	22	16	16	5	8	34	15
Nationality									
	Italian	58	97	97	97	57	95	212	96
	Other	2	3	3	3	3	5	8	4
Education									
	Up to middle school	30	50	60	60	25	42	115	52
	Secondary school	29	48	37	37	32	53	98	45
	University	1	2	3	3	3	5	7	3
Living situation									
	Alone	14	23	22	22	8	13	44	20
	With others	46	77	78	78	52	87	176	80
Diagnosis (ICD-10)									
	Schizophrenic disorders	28	47	71	71	19	32	118	54
	Affective disorders	16	27	18	18	17	28	51	23
	Neurotic and somatoform disorders	2	3	4	4	6	10	12	5
	Personality disorders	12	20	5	5	10	17	27	12
	Other diagnosis	2	3	2	2	8	13	12	5

Table 33. Socio-demographic characteristics of service users (continued)

	Lecco MHD		Legnago MHD		South Verona CMHS		Total	
	N	%	N	%	N	%	N	%
Accommodation								
Owner occupied flat or house	40	67	76	76	41	68	157	71
Privately rented flat or house	12	20	11	11	7	12	30	14
Rented from local authority/municipality or housing services	0	0	6	6	4	7	10	5
Overnight facility, 24-hour staffed	5	8	1	1	5	8	11	5
Overnight facility, staffed (not 24-hour)	2	3	4	4	2	3	8	4
Other	1	2	2	2	1	2	4	2
Employment status								
Paid or self employed	15	25	21	21	20	33	56	25
Sheltered employment/Training	10	17	21	21	6	10	37	17
Unemployed/Redundancy fund	16	27	12	12	17	29	46	21
Unable to work/Retired/Housewife/Student/Voluntary employed	19	32	46	46	17	28	81	37
Primary source of income								
Salary/wage	15	25	20	20	23	38	58	26
Work pension	5	8	10	10	7	12	22	10
Disability allowance	32	53	54	55	14	23	100	46
Family support	6	10	13	13	10	17	29	13
Other	2	3	2	2	6	10	10	5
Personal gross income from all sources (monthly)								
Less than 300 €	11	20	32	34	17	29	60	29
From 300 to 500 €	8	14	19	20	11	19	38	18
From 501 to 1.000 €	20	36	27	28	16	28	63	30
From 1.001 to 2000 €	14	25	17	18	12	21	43	21
More than 2.000 €	3	5	0	0	2	3	5	2

5.2 UTILIZATION OF MENTAL HEALTH AND SOCIAL SERVICES

As illustrated in Chapter 2, information on utilization of mental health and social services by service users participating in the study was collected via both interviews and analyzing Mental Health Information Systems. Table 34 reports data on utilization of mental health services retrieved from Mental Health Information Systems in the three centres. This information refers to the last 12 months before the start of the study. More specifically, numbers and duration of acute psychiatric admissions and numbers of outpatient, day hospital, day care contacts, and domiciliary visits are illustrated. The number of people who were admitted to the acute psychiatric unit in the last 12 months was similar in the three centres. However, in Lecco MHD a shorter length of stay was reported. The number of outpatient visits was similar in Lecco and South Verona but lower in Legnago MHD. However, in Legnago MHD a higher number of day care contacts were registered. Lecco MHD differentiated from the other two centres in the number of domiciliary visits, much higher than in the other two centres.

Table 34. Utilization of mental health services by service users in previous 12 months

	Lecco MHD N	Legnago MHD N	Verona CMHS N
Acute psychiatric admissions	10	27	11
Min-Max	0-5	0-5	0-2
Length of stay (n. of days) on acute psychiatric wards	102	493	241
Min-Max	0-26	0-188	0-63
Outpatient visits	2037	1730	2006
Min-Max	1-189	1-156	1-255
Day hospital contacts	-	145	131
Min-Max	-	0-40	0-43
Day care contacts	1543	5078	1229
Min-Max	0-250	0-287	0-300
Domiciliary visits	939	257	41
Min-Max	0-269	0-60	0-9

Table 35 reports additional information on utilization of mental health services by interviewees. More specifically, information on duration of care, breaks in contacts, and contacts with different professionals working in the mental health services (i.e., psychiatrist, psychologist, nurse, social worker, rehabilitation therapist, and support worker) are presented. Table 35 illustrates the number of years that service users had been in contact with the mental health service. The time participants had been in treatment ranged from 2 to 43 years (being on the caseload for at least two years was one of the inclusion criteria). The average number of years was 13, ranging from 11 in Legnago MHD to 16 years in Lecco MHD.

When analyzing breaks in care, i.e. interruptions in contacts of more than six months in the last two years, data reported that they occurred in 10 percent of cases. This figure ranged from 8% in Lecco MHD and 15% in South Verona CMHS. Almost all participants (96%) had at least one contact with their psychiatrist in the last 12 months. The number of people who had contact with a psychologist in the last year was around 30%. As for contacts with nurses, different situations were found: in Legnago MHD the vast majority (88%) of interviewees had contact with a nurse, this number ranging between 48 and 53 percent in, respectively, Lecco MHD and South Verona CMHS. Moreover, contacts with social workers happened in 37% of cases on average, with Lecco MHD reporting a percentage of 58%. Finally, around one third of service users had contacts with rehabilitation therapists or support workers in the last 12 months.

Table 35. Utilization of mental health services in previous 12 months (continued)

	Lecco MHD		Legnago MHD		Verona CMHS		Total	
	N	%	N	%	N	%	N	%
N. of years from first contact								
2-7 years	10	17	40	40	20	33	70	32
8-15 years	25	42	33	33	21	35	79	36
16-43 years	25	42	27	27	19	32	71	32
Breaks in contacts (more than 6 months in the last 2 years)								
Yes	6	10	8	8	9	15	23	10
No	54	90	92	92	51	85	197	90
Contact with psychiatrist								
Yes	60	100	99	99	57	95	216	98
No	0	0	1	1	3	5	4	2
Contact with psychologist								
Yes	16	27	28	28	20	33	64	29
No	44	73	72	72	40	67	156	71
Contact with nurse								
Yes	29	48	88	88	32	53	149	68
No	31	52	12	12	28	47	71	32
Contact with social worker								
Yes	35	58	29	29	18	30	82	37
No	25	42	71	71	42	70	138	63
Contact with rehabilitation therapist/support worker								
Yes	21	35	38	38	15	25	74	34
No	39	65	62	62	45	75	146	66

Table 36 presents information on utilization of health and social services by participants in the previous 12 months. These data were collected directly from participants during interviews. Most of the respondents (92%) reported at least one contact with the General Practitioner (GP). One third of participants had contacts with municipal social services, although this percentage was around 48% in Lecco MHD. As for contacts with employment services, the percentage of people who had such contacts ranged between 12% in Verona CMHS and 21% in Legnago MHD. Contacts with self-help, third and voluntary sector organizations were reported in 19% of cases. When asked whether they had received support from social services (regardless the type of social service organization), 39% of people stated they had. Finally, service users were asked whether they had received a welfare benefit in the last 12 months (e.g., disability allowance, redundancy fund, income support, benefits for families). Most of

the respondents (63%) answered they had received welfare benefits; while 37% answered they had not. This is in line with what people declared about their primary source of income, which for 46% was the disability allowance.

Table 36. Utilization of health and social services in previous 12 months

	Lecco MHD		Legnago MHD		Verona CMHS		Total	
	N	%	N	%	N	%	N	%
Contact with GP								
Yes	54	90	93	93	55	92	202	92
No	6	10	7	7	5	8	18	8
Contact with municipal social services								
Yes	29	48	23	23	14	23	66	30
No	31	52	77	77	46	77	154	70
Contact with employment services								
Yes	11	18	21	21	7	12	39	18
No	49	82	79	79	53	88	181	82
Contact with self-help, third and voluntary sector								
Yes	17	28	11	11	13	22	41	19
No	43	72	89	89	47	78	179	81
Received support from social services								
Yes	27	45	35	35	24	40	86	39
No	33	55	65	65	36	60	134	61
Received a welfare benefit								
Yes	41	68	68	68	29	48	138	63
No	19	32	32	32	31	52	82	37

5.3 SERVICE USERS' PERSPECTIVES ON CONTINUITY OF CARE

The aim of this section is to analyze responses to CONTINUity of care User Measure (CONTINU-UM) in order to systematically explore users' experiences and satisfaction with user-defined continuity.

5.3.1 Importance, experience and satisfaction with continuity of care

Table 37 provides descriptive statistics for the 16 importance items. These items were scored on a five-point Likert scale from 'very unimportant' (1) to 'very important' (5). The single mean scores showed that all the dimensions were considered fairly important. A weighted mean of 4.17 (S.D. = 0.45) was found (using weights proportional to the percentage of valid responses on the total number of applicable items). The two final columns show number of respondents who rated the items as 'not important' (points 1 and 2) and 'important' (points 4 and 5). Value 'sometimes important/sometimes not' (3) was not considered. Looking at the final column, 11 items out of 16 were rated as 'very important' or 'important' by at least 86% of respondents. Information, individual progress, care plans, access, and range were most strongly endorsed, with ratings from 94 to 98%. Items with the lowest importance ratings were out of hours support, life histories, peer support and avoiding services, with the last item the least endorsed.

The descriptive statistics for the experience items are shown in Table 38. All items were scored on a five-point Likert scale from 'never' (1) to 'definitely' (5), although in staff changes and repeating life histories values of 1 and 5 were 'never' and 'very often'. In experience scores there was far greater variability in responses than importance items, with typically lower means and higher standard deviations. Experiences of elements were typically fairly positive, with a general weighted mean of 3.82 (S.D. = 0.57). Access, range and hospital discharge elicited more positive responses, with a proportion of respondents between

84 and 89 percent reporting they had continuity. Conversely, aspects with lower scores were out of hours support, peer support, day centres, and avoiding services.

Descriptive statistics for the satisfaction items can be found in Table 39. Responses were scored on a five-point Likert scale from ‘very dissatisfied’ (1) to ‘very satisfied’ (5). Responses to satisfaction items displayed far less variability than experience items. Satisfaction with elements of continuity were typically fairly positive, with a general weighted mean of 4.03 (S.D. = 0.54). Items where people showed higher mean levels of satisfaction were access, range, information and day centres. The dimensions where people seemed to be less satisfied were peer support, out of hours support, life histories and hospital discharge.

Table 37. CONTINU-UM: Importance descriptive statistics

Importance	N.	Mean	Standard deviation	Not important (% valid for points 1 and 2)	Important (% valid for points 4 and 5)
Access	220	4.53	0.63	0	94
Range	220	4.53	0.60	0	95
Waiting	220	4.31	0.80	4	88
Out of hours support	213	3.81	1.12	20	67
Hospital discharge	33	4.33	0.82	6	91
Staff changes	219	4.28	0.98	8	86
Information	220	4.53	0.54	0	98
Flexibility	218	4.44	0.66	2	95
Individual progress	220	4.65	0.59	1	97
Day centres	129	3.83	1.29	19	74
Care plans	198	4.55	0.63	2	96
Crisis	210	4.49	0.78	4	94
Staff communication	219	4.46	0.71	2	95
Peer support	206	3.42	1.19	24	55
Life histories	218	3.44	1.37	31	56
Avoiding services	216	3.09	1.33	39	46

Table 38. CONTINU-UM: Experience descriptive statistics

Experience	N	Mean	Standard deviation	Does not have continuity (% valid for points 1 and 2)	Does have continuity (% valid for points 4 and 5)
Access	217	4.45	0.87	4	89
Range	219	4.27	0.98	8	87
Waiting	219	4.09	1.18	9	68
Out of hours support	175	2.03	1.43	69	18
Hospital discharge	32	4.25	1.19	13	84
Staff changes	219	4.07	1.09	11	70
Information	219	4.20	0.98	6	83
Flexibility	212	3.78	1.28	16	71
Individual progress	218	4.07	1.14	11	76
Day centres	110	3.15	1.78	39	58
Care plans	199	4.15	1.16	13	82
Crisis	195	3.71	1.36	18	71
Staff communication	207	4.09	1.16	12	79
Peer support	174	2.47	1.45	50	29
Life histories	209	4.10	1.08	10	68
Avoiding services	185	3.53	1.32	22	59

Table 39. CONTINU-UM: Satisfaction descriptive statistics

Satisfaction	N	Mean	Standard deviation	Dissatisfied (% valid for points 1 and 2)	Satisfied (% valid for points 4 and 5)
Access	218	4.19	0.75	2	84
Range	218	4.16	0.82	4	83
Waiting	219	4.00	0.78	4	81
Out of hours support	175	3.85	0.97	11	77
Hospital discharge	32	3.97	1.09	13	75
Staff changes	218	4.00	0.89	8	78
Information	218	4.15	0.75	3	86
Flexibility	212	4.14	0.73	2	87
Individual progress	218	4.11	0.85	4	82
Day centres	110	4.15	0.70	2	88
Care plans	199	4.11	0.88	5	85
Crisis	195	4.05	0.90	8	81
Staff communication	206	4.04	0.86	6	83
Peer support	174	3.65	0.89	13	67
Life histories	209	3.87	0.88	9	77
Avoiding services	185	4.05	0.70	3	85

5.3.2 Correlations between importance, experience and satisfaction

Pearson's correlations were performed in order to investigate the relationships among the items of importance, experience and satisfaction. The results (Table 40) showed a statistically significant and positive correlation between importance and experience, as well as between importance and satisfaction and experience and satisfaction.

Table 40. Correlations between CONTINU-UM items

	Importance	Experience	Satisfaction
Importance	1		
Experience	0.2262**	1	
Satisfaction	0.2212**	0.6901**	1

**Correlation is significant at the 1% level.

5.4 SOCIAL CARE RELATED QUALITY OF LIFE

The data collected with INT4 version of Adult Social Care Outcomes Toolkit (ASCOT) were used to produce a current social care-related quality of life (SCRQoL) score as well as an expected SCRQoL score and a measure of SCRQoL gain. Scores have been analyzed using the data entry tool provided by the ASCOT group at the Personal Social Services Research Unit at the University of Kent, which automatically calculated final scores. Definitions of scores are reported in Table 41.

Table 41. Definitions of ASCOT scores

Current SCRQoL	The current SCRQoL score measures social care-related quality of life (SCRQoL) as it currently stands. In most uses of ASCOT, this would usually mean SCRQoL the person is receiving services and support. The only exception may be when you use ASCOT to measure baseline social care-related quality of life before somebody starts to use a service.
Expected SCRQoL	The expected SCRQoL score measures what we would expect somebody's SCRQoL to be in the absence of services and support. Depending upon the context in which you are using ASCOT, this could be all services or a specific one.
SCRQoL gain	<p>SCRQoL gain is a score that measures the impact of a service(s) on SCRQoL as the difference between current SCRQoL and expected SCRQoL. So, for example, if a person had a current SCRQoL score of 0.97 and an expected SCRQoL score of 0.67, SCRQoL gain would be 0.30.</p> <p>Where the expected SCRQoL score is higher than the current SCRQoL score, a negative SCRQoL gain score will be produced, suggesting that services are having a negative impact on SCRQoL. Negative SCRQoL gain scores can reflect the lack of impact of services in any domain, or/and a loss of dignity associated with the way the support is provided.</p>

Source: Netten *et al.*, 2011.

Each of the eight ASCOT domains had four response options, which were aimed to reflect the following situations:

1. *Ideal state*: the desirable situation, where needs are fully met.
2. *No needs*: needs are met, but not to the ideal level.
3. *Some needs*: there are needs, but these do not have longer-term health implications.
4. *High needs*: there are needs and these are distinguished from *some needs* by having mental health or physical health implications (Netten *et al.*, 2011).

The outcome measure was SCRQoL gain, intended to capture the impact of the care provided on service users SCRQoL. This was estimated as:

$$\text{SCRQoL gain} = \text{current SCRQoL} - \text{expected SCRQoL}$$

Because ASCOT development work highlighted that the various domains are not rated as equally important, results of each domain are weighted before they are included in the final ASCOT score. The estimated weights for each domain are based on preferences of the general population using Best-Worst Scaling (BWS) techniques. The weightings and methods of calculation can be found elsewhere (Netten *et al.*, 2011). Questions number 1, 4, 7, 10, 13, 16, 19, and 23 were used to calculate current SCRQoL. A current SCRQoL score of 1.00 exemplifies the ‘ideal’ situation, whereas a score of 0.00 indicates a state that is equivalent to being dead. The score also can drop below zero into negative values, the bottom of the range being -0.17. The same applies to the expected SCRQoL score, although with a few minor differences. Questions 3, 6, 9, 12, 15, 18, and 21 were used to calculate expected SCRQoL, although for the ‘dignity’ question there is not a corresponding question to ask how the situation would be in the absence of services. It is assumed that in the absence of service there is no impact on dignity and so the 2nd level (*no needs*) is used for the calculation of expected SCRQoL.

In this study, ASCOT was completed by 108 people out of the total sample of 220. These were service users receiving social care services at the time of the interview. As ASCOT was meant to capture outcomes of social care interventions, before conducting the interview it was checked that the interviewee was receiving social care interventions. This was confirmed by asking the staff of the mental health service or consulting the Mental Health Information Systems. However, it was always double-checked with the service user at the time of the interview, especially because respondents were asked to include all social care services, regardless of the funding source or the service provider, when answering the questions. As for interventions provided by the mental health service, it was made clear that the questionnaire included only services offered by social workers, care workers or educators working in such settings. Thus, interviewees were reminded not to think about care provided by healthcare staff, such as psychiatrists, psychologists, nurses, other medical doctors and rehabilitation therapists.

Overall ASCOT scores are presented in Table 42. As illustrated, the overall SCRQoL gain was of 0.20 points. Interestingly, 4 respondents reported negative SCRQoL gain scores, indicating a situation where the care was actually undermining the users' quality of life. Ten users had a SCRQoL gain equal to zero, meaning that social services had a null impact on people's wellbeing. The minimum score was -0.17 and the maximum 0.68. If considering differences among centres (not reported in the table), current SCRQoL was higher in Lecco MHD (mean = 0.74; S.D. = 0.13) and lower in South Verona CMHS (mean = 0.72; S.D. = 0.16). Expected SCRQoL was higher in Legnago MHD (mean = 0.60; S.D. = 0.13) and lower in South Verona CMHS (mean = 0.47; S.D. = 0.20). The overall SCRQoL gain was higher in Verona (mean = 0.25; S.D. = 0.19) and lower in Legnago (mean = 0.15; S.D. = 0.14).

Table 42. Multicentre study: Overall ASCOT scores (weighted)

	N	Mean	S.D.	Min-Max
Current SCRQoL	105	0.73 (0.14)	0.14	0.31-0.98
Expected SCRQoL	96	0.54 (0.19)	0.19	0.00-0.94
SCRQoL gain	95	0.20 (0.17)	0.17	-0.17-0.68

Figure 9 illustrates ASCOT scores for each domain. Figure 10 and Figure 11 present separately current SCRQoL and expected SCRQoL scores. Unweighted scores are presented, calculated as the average SCRQoL score in each domain as a percentage of the total possible score. Data show that there were substantial levels of SCRQoL gain in higher-order domains (i.e. control over daily life, occupation, social participation) rather than in fundamental or basic aspects of SCRQoL, such as accommodation, personal cleanliness, and meals.

Figure 9. Social care related quality of life (unweighted)

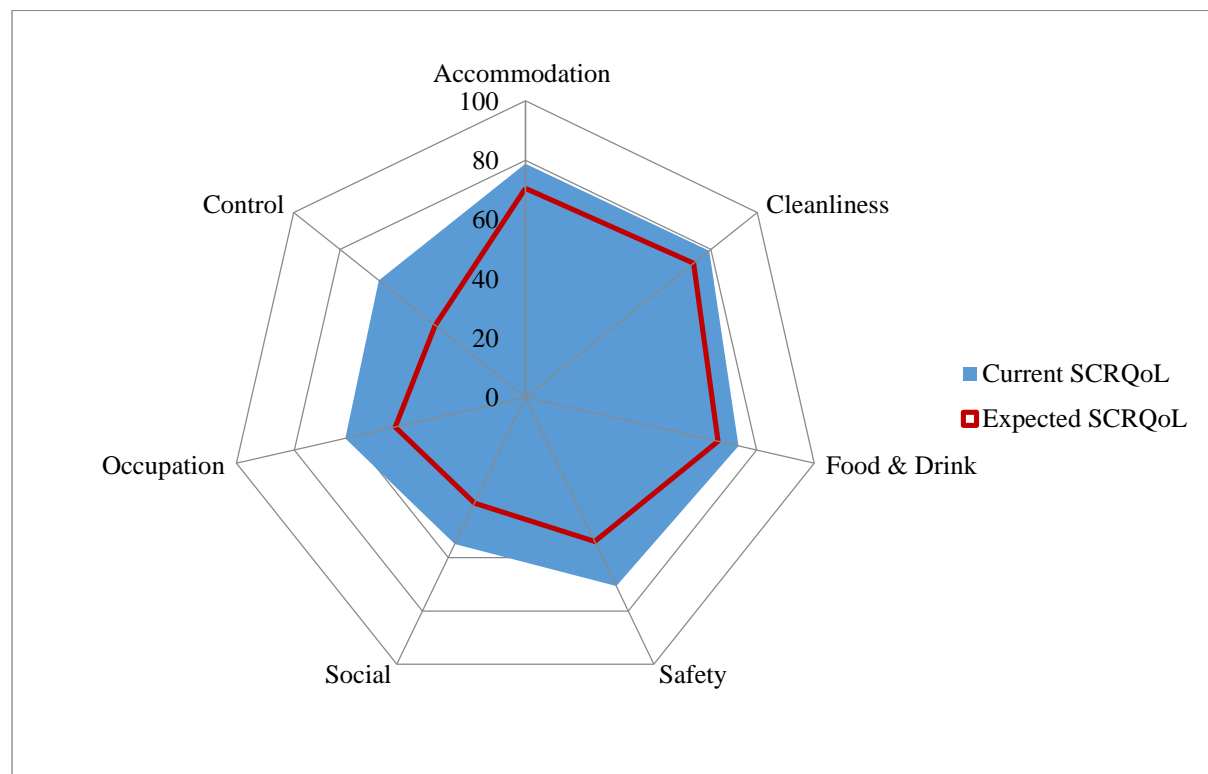


Figure 10. Current SCRQoL by domain (unweighted)

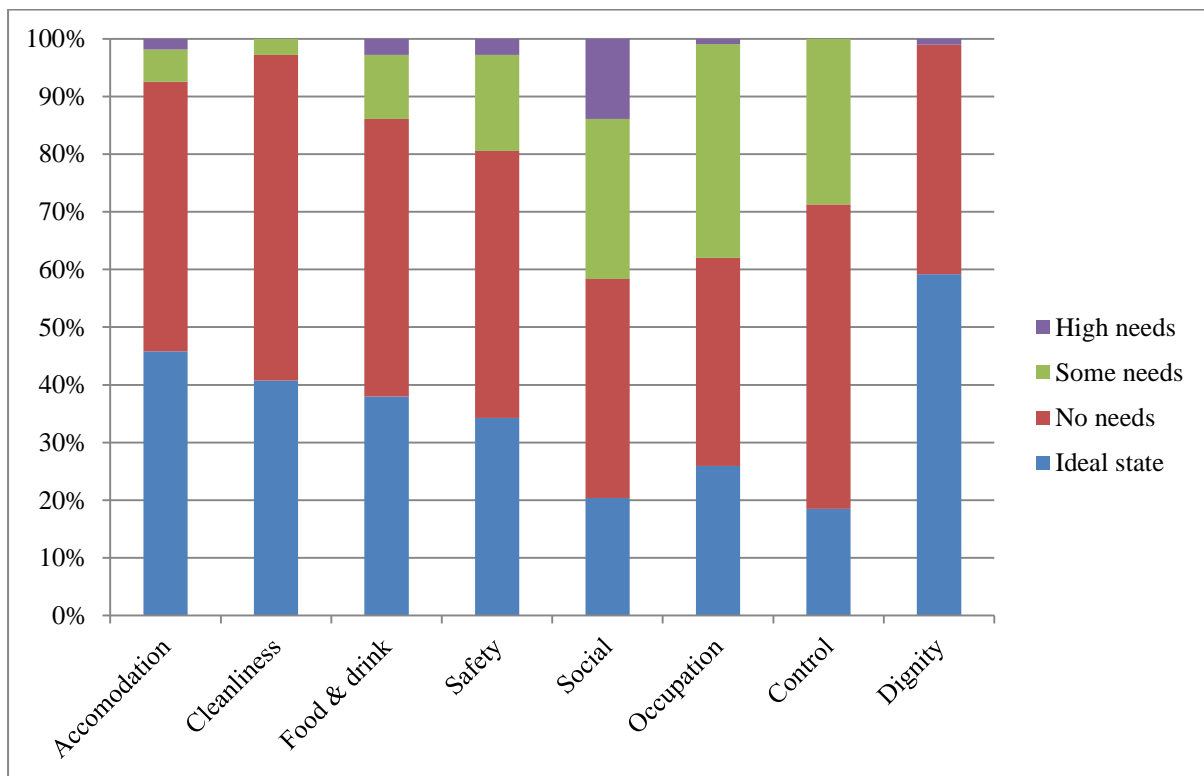
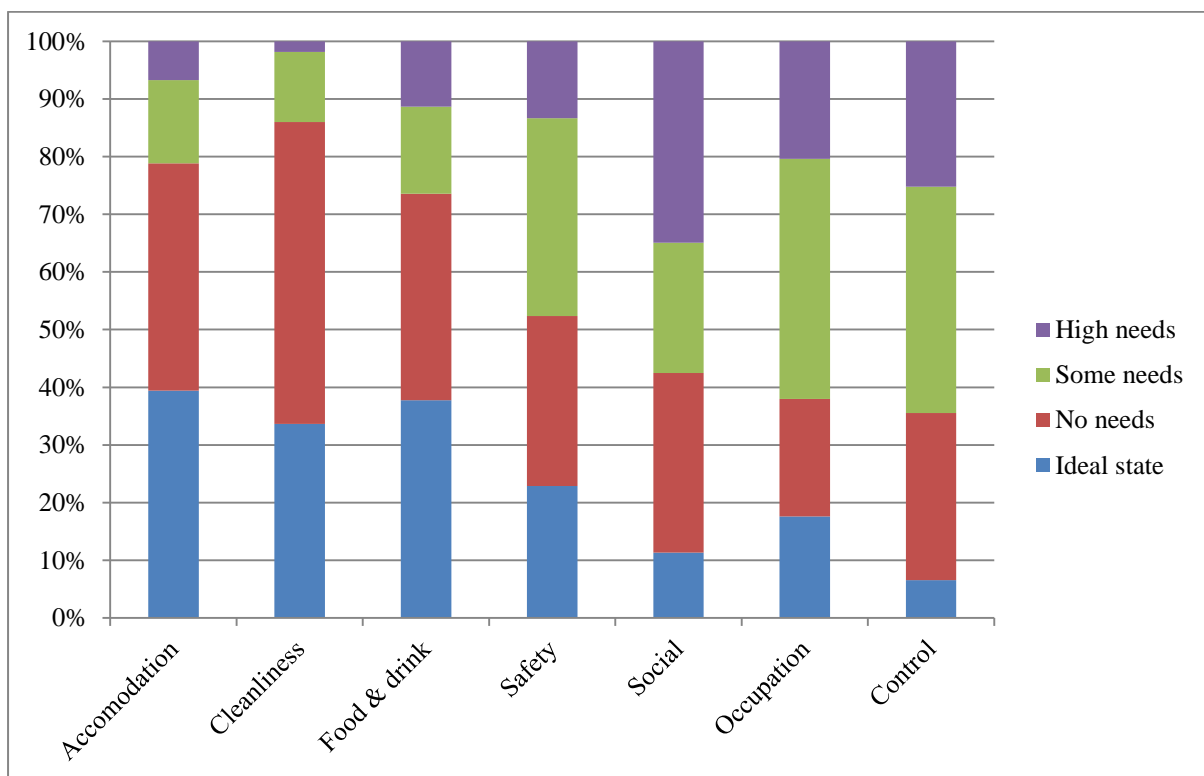


Figure 11. Expected SCRQoL by domain (unweighted)



5.5 CORRELATIONS BETWEEN CONTINU-UM AND ASCOT SCORES

Pearson's correlation analyses were performed in order to assess the relationships between social care-related quality of life and continuity of care. The results are showed in Table 43. Interestingly, the three items of ASCOT were significantly correlated with each other. More specifically, current SCRQoL was positively correlated with both expected SCRQoL (coefficient = 0.49; p-value < 0.001) and SCRQoL gain (coefficient = 0.26; p-value = 0.01), while expected SCRQoL was negatively correlated with SCRQoL gain (coefficient = -0.71; p-value < 0.001). Interestingly, current SCRQoL was positively correlated with both experience and satisfaction items of CONTINU-UM. More specifically, it was found that the better a person's quality of life was, the better experience of continuity of care (coefficient = 0.30; p-value = 0.002). Furthermore, the better wellbeing a person perceived, the more satisfied he/she was with aspects of continuity (coefficient = 0.37; p-value < 0.001). Finally, SCRQoL gain was positively correlated with the experience of continuity (coefficient = 0.31; p-value = 0.002). That is, people who benefitted more from social services had also a better experience of continuity of care.

Table 43. Correlations between CONTINU-UM and ASCOT scores

	Current SCRQoL	Expected SCRQoL	SCRQoL gain	Importance CONTINU- UM	Experience CONTINU- UM	Satisfaction CONTINU- UM
Current SCRQoL	1					
Expected SCRQoL	0.4909**	1				
SCRQoL gain	0.2625*	-0.7118**	1			
Importance	-0.1032	-0.1090	0.0498	1		
Experience	0.2995**	-0.0651	0.3086**	0.2262**	1	
Satisfaction	0.3658**	0.0972	0.1770	0.2212**	0.6901**	1

*Correlation is significant at the 5% level.

**Correlation is significant at the 1% level.

5.6 PREDICTORS OF CONTINU-UM AND ASCOT SCORES

In order to further assess factors potentially associated with CONTINU-UM and ASCOT scores, multivariate regression analyses were performed, using the following as outcomes: importance, experience, and satisfaction items of CONTINU-UM, current SCRQoL and expected SCRQoL. Given the linear dependency between current, expected and SCRQoL gain values - *gain* being the difference between *current* and *expected* value - only two of them were included in the analysis of outcomes. SCRQoL gain was excluded, given its range depends on the expected value (the higher the expected SCRQoL, the lower the maximum possible gain, and vice versa). The following variables were used as possible predictors:

- Centre (i.e., Lecco MHD, Legnago MHD, or Verona MHD);
- ICD-10 diagnosis (i.e., schizophrenic disorders, affective disorders, neurotic and somatoform disorders, personality disorders, or other diagnosis);
- Socio-demographics (i.e., age, gender, marital status, nationality, education, living situation, accommodation, employment status, primary source of income, gross monthly income); and
- Services utilization variables (i.e., whether or not more than 14 inpatient days or 52 other contacts with mental health services were reported, having had at least one contact with other health and social services, number of years from first contact with mental health services, whether a break in mental health contacts lasting at least 6 months occurred).

Centre and diagnosis were single variables, whereas socio-demographics and services utilization were composite variables including sub-groups of variables, as outlined above. When the aforementioned variables were jointly considered, no statistical significance was found after correcting for the number of tests performed (i.e., using a p-value of $0.05/5=0.01$ for each regression). Thus, the results seemed to show scarce variability across the variables

analyzed, meaning that the positive situation outlined in the previous sections was rather stable across groups of patients with different characteristics.

The expected SCRQoL was conceptually different from the other outcomes. Indeed, since expected SCRQoL measured the potential situation in the absence of services, it was assumed that it could predict variables related to the receipt of services. Thus, services utilization variables were not included in the regression model with expected SCRQoL as outcome. On the contrary, as it was assumed that the expected situation could predict variables related to the receipt of services: a series of regressions with expected SCRQoL as the only explanatory variable were then performed. The outcome measures included in the analysis were the following:

- Having had at least one contact with a general practitioner;
- Having had at least one contact with other health or social services;
- Having received support from social services;
- Having received a welfare benefit;
- Number of years from first contact with mental health services;
- Having had at least one inpatient admission;
- Having had at least one day care contact;
- Having had at least one outpatient/day hospital contact;
- Having received at least one domiciliary visit;
- Having had at least one contact with a psychiatrist;
- Having had at least one contact with a psychologist;
- Having had at least one contact with a nurse;
- Having had at least one contact with a social worker;
- Having had at least one contact with a rehabilitation therapist/support worker/educator; and

- Whether a break in contacts lasting at least 6 months occurred.

Interestingly, when considering each of the variables listed above separately, expected SCRQoL turned out as a predictor of having at least one:

- Day care contact (coefficient = -3.3; p-value = 0.006).
- Domiciliary visit (coefficient = -2.6; p-value = 0.043).
- Contact with a social worker (coefficient = -3.5; p-value = 0.005).
- Contact with a rehabilitation therapist/support worker/educator (coefficient = -2.4; p-value = 0.040).
- Break in contacts for more than 6 months in the last 2 years (coefficient = 9.1; p-value = 0.039).

These results were expected and confirmed the conceptual structure of ASCOT. Indeed, among all types of services considered in this analysis (i.e., general practitioner, psychiatrist, psychologist, nurse, outpatient care, inpatient admissions, etc.), only services providing care activities (i.e., day care services and domiciliary visits) and those offered by social care staff (i.e., social workers, support workers, educators, rehabilitation therapists) produced results that were statistically significant. Indeed, the results showed that the more a person perceived a possible negative wellbeing in the absence of services, the more he/she was likely to use day care services, receive domiciliary visits, and have contact with social care staff. In addition, the more positive a person's expected quality of life was, the more likely an interruption in contacts with mental health services was.

Finally, possible nonlinear relationships between the number of years from first contact with mental health services and the five outcomes (i.e., importance, experience, and satisfaction items of CONTINU-UM, current and expected SCRQoL) were investigated. By adding quadratic and cubic terms, no significant associations were found. Thus, results are rather homogeneous with respect to service user 'seniority', suggesting that experience and

satisfaction with continuity of care do not depend on duration of care, and that social services show their effectiveness for users in the first years, and maintain it over time.

5.7 DISCUSSION

The study reported on here analyzed quality of mental health and social care services from an innovative perspective, by using both a measure of continuity of care developed from the perspective of service users and the Adult Social Care Outcomes Toolkit for the assessment of social care outcomes. Both CONTINU-UM and ASCOT were translated and adapted from their original English version and used in this study for the first time in Italy. This study applied two principles that have been highlighted as critical for effective outcomes assessment. First, by focusing on patient-rated measures this study enabled the capture of a perspective, i.e. that of service users, that is generally underestimated. Secondly, by focusing on social aspects of outcome assessment, this study recognized that services can affect various dimensions of patients' lives and that clinical aspects give only a partial picture of the effectiveness of services (Lasalvia & Ruggeri, 2007).

Before using CONTINU-UM, the instrument was tested and discussed in focus groups with 20 service users. The focus groups results suggested that the measure was valid in that it captured key dimensions of continuity as prioritized by users. Moreover, the study found a positive relationship between experience and satisfaction. As expected, satisfaction with a service was strongly related with a positive experience with it. Significant relationships were also found with the importance item. That is, the more important a dimension was rated, the more positive the experience and satisfaction were too. Moreover, importance, experience and satisfaction items all reported fairly positive ratings. These findings may be explained in three different ways. First, the instrument might have elicited positive ratings, this resulting in scarce variability in the data. Second, it can be argued that the three centres involved in the

study are likely to provide services of good quality. Third, there might have been lack of variation in the sample, due also to the criteria applied for inclusion of participants. On one hand, the criterion of being in touch with mental health services for at least two years meant that the participants were likely to have received a range of services and thus to have experience of continuity/discontinuity. On the other hand, this criterion excluded people who had experiences that were more sporadic and those who had dropped out from care. This aspect will be discussed later when addressing the limitations of the study. Furthermore, CONTINU-UM shed light on the aspects valued as most important by participants. These were individual progress, care plans, information, access, and range of services. These factors, except care plans, have been defined by Sweeney and colleagues (2012) as preconditions or building blocks for continuity of care and have been previously found among the most important elements of continuity of care (Rose *et al.*, 2009). Moreover, the least endorsed aspects were avoiding services, peer support, life histories, and out of hours support. As for life histories and avoiding services, a similar finding was found elsewhere (Rose *et al.*, 2009). The aspects that prompted the less positive experiences were out of hours support, peer support, avoiding services, and day centres. The latter showed peculiar results: here, one of the highest ratings was reported in the satisfaction item, although the mean value in the experience item was one of the lowest. As for out of hours support, peer support and avoiding services, it should be noted that quite frequently respondents commented that not having the experience was not problematic as these aspects were either not needed or considered less important, as confirmed by importance ratings. These results need further investigation as they seem to disclose elements that are not prioritized by service users.

When analyzing ASCOT data, significant findings emerged. Generally, the results suggest that mental health service users obtain positive outcomes by using social services. SCRQoL gains were found in all the eight domains of ASCOT; data also showed that there were

substantial levels of SCRQoL gain in higher-order domains (i.e. control over daily life, occupation, social participation) rather than in fundamental or basic aspects of SCRQoL, such as accommodation, personal cleanliness, and meals. Interestingly, the opposite was found in a study measuring outcomes of care homes for older people in England: care homes seemed to be more successful in delivering basic than higher-order domains (Netten *et al.*, 2012b). In the present study, instead, social care services seemed to be focused on providing recovery-oriented interventions, i.e. on supporting people to use self-management skills in their own life as well as develop a positive identity and valued social roles (Slade, 2009).

Interesting findings were also found when assessing the relationships between CONTINUUM and ASCOT scores. The three items of ASCOT were significantly correlated with each other. In particular, as could be easily argued by the structural relation among the three items, the current quality of life was positively correlated with both the expected SCRQoL and with its gain. However, the strongest and most interesting correlation was found between expected quality of life and SCRQoL gain. The two elements were negatively correlated, indicating that those users whose quality of life would have been worst in the absence of services were those who benefited more from them. Moreover, it was found that the better the experience of continuity was, the better a person's quality of life. This finding is in line with previous research in showing that experience of continuity is related to greater quality of life (Sweeney *et al.*, 2012). Furthermore, SCRQoL gain was positively correlated with the experience of continuity. That is, people who benefited more from social services also had a better experience of continuity of care. Finally, the more satisfied with aspects of continuity a person was, the better the wellbeing he/she perceived. Satisfaction with continuity was more strongly associated with current quality of life than its gain. It could be argued that satisfaction depends on current quality of life rather than on the effect of services on it. These correlations may be seen as a further confirmation of the validity of the two instruments.

Moreover, multivariate analyses were performed using the following as outcomes: importance, experience, and satisfaction items of CONTINU-UM, current SCRQoL and expected SCRQoL. Regressions to predict the aforementioned outcomes turned out to be globally non-significant. These results seemed to show scarce variability across the variables analyzed, meaning that the positive situation outlined above was rather stable across groups of users with different characteristics. The expected SCRQoL was conceptually different from the other outcomes. Indeed, since expected SCRQoL measured the potential situation in the absence of services, it was assumed that it could predict variables related to the receipt of services. Thus, variables related to utilization of services were excluded from the regressions with expected SCRQoL as outcome and, by contrast, a series of regressions with expected SCRQoL as the only explanatory variable and services utilization variables as outcomes were performed. The results showed two significant findings. First, among all types of services considered in this analysis, expected SCRQoL was a significant predictor of only social care activities (i.e., day care services and domiciliary visits) and services offered by social care staff (i.e., social workers, support workers, educators). More specifically, the results showed that the more a person imagined a negative wellbeing in the absence of services, the more he/she was likely to use social care services. Secondly, the more positive a person's expected quality of life was, the more likely an interruption in contacts with mental health services was. These two findings seem to show that people whose quality of life would be worse in the absence of services are more likely to use services and less likely to interrupt contacts.

Some limitations of the study should be acknowledged. A selection bias might have occurred. Quite a substantial number of participants from the initial randomly selected sample did not take part in the study. Quite frequently, the case manager (i.e., the psychiatrist), whose opinion on the opportunity to conduct the interview was asked, discouraged it. This happened when the patient was considered unable to sustain the interview because of significant

cognitive difficulties or serious circumstances due to mental ill-health. In some other instances, it was the user him/herself who was not willing to be involved in the study. Consequently, the final sample of respondents might not necessarily be representative of the population of users of mental health services. Indeed, the findings seem to reveal quite an homogeneous sample. Users with major difficulties were less likely to take part in the study, although their insights and experiences are especially crucial in order to appraise services outcomes. Thus, it is priority to develop different and more engaging ways of involving service users in research (Beresford & Branfield, 2006). In addition, the sample represent people that actually use services and also quite regularly, given the two inclusion criteria (i.e., being in contact with the mental health service for at least two years and having had at least one contact during the last two years). Thus, people who dropped out from care, remained untreated or sought help elsewhere were not included in the study. Moreover, it would be interesting to replicate the research in other Italian contexts, as there is much heterogeneity in the availability of resources for mental health care throughout the country (Amaddeo *et al.*, 2012). The cross-sectional nature of the study could be an additional limitation. Finally, although interviewers received a basic training before starting the study, interviewer biases may have occurred.

CONCLUSIONS

This thesis analyzed the issue of assessment of quality of mental health and social care services from different perspectives. First, the European REFINEMENT project allowed framing the notion of quality of care within the international context. The literature review revealed a substantial body of work on quality of mental health care internationally, however limited by lack of agreement on both the definition of quality and the methods to be used for quality assessment. The REFINEMENT project aimed at tackling these limitations by developing a suite of tools for collecting standardized information on mental health care systems. These tools were piloted in eight European countries and subsequently revised according to the results of such testing. Thus, they have been proven valid and feasible tools for data collection. These tools are now available to policy makers, researchers and services providers to systematically assess mental health systems; they can also be adapted to issues concerning other aspects of the health care system. The REFINEMENT tools are also useful in understanding the structure of interfaces and interconnections between components of services including those provided by primary and social care services. The latter was given a special interest in this thesis and specific elements of quality of social care provided to people with mental health problems were analyzed. Thus, another perspective from which quality of care was examined was that of considering complex mental health systems, therefore including different types of services, not necessarily and solely provided in the health care sector.

Moreover, another aspect of quality that was given particular attention in this work was that of perceived quality. In this study, both perceptions of staff and service users were considered. As for staff, perceptions about the quality of their life at work were investigated. A large set of variables were identified in order to analyze the issue of professional quality of life as much

comprehensively as possible, including objective variables such as socio-demographic status and occupational characteristics, and subjective experiences of both quality of work and work-life balance. This study showed interesting findings that might be useful to managers and administrators to appraise elements affecting their staff's quality of working life and how they could possibly affect the quality of care. However, professional quality of life is not the only relevant aspect to be considered when examining quality of care. Indeed, in this work, that was treated as one of several possible predictors of quality of care. In order to assess the core characteristics of quality of care other important elements should be further examined, e.g. the application of evidence-based clinical and care guidelines. Moreover, perceived quality was investigated from the point of view of service users. Perceived quality can be defined as the service user's perception of the overall quality or superiority of the service, with respect to its intended purpose and compared to its alternatives/competition (Sofaer & Firminger, 2005). The experiences and perceptions of service users were emphasized in this work by privileging focus groups and in-depth interviews as methods of data collection. In addition, CONTINU-UM, an instrument completely created by service users, was adapted from its original English version and used for the first time in the Italian context. The same procedure of translation and adaptation was used for the Adult Social Care Outcomes Toolkit. This instrument made it possible to evaluate outcomes of social care interventions in terms of perceived quality of life. Most important, the instrument was used to analyze the impact of social services on quality of life as the difference between current and expected (in the absence of services) quality of life. This is a unique and innovative approach, being ASCOT the only measure in the social care literature that allows conducting such an accurate analysis. This study allowed collecting relevant information on what aspects of services organization are prioritized by service users. Indeed, the results offer interesting suggestions for advancing mental health and social services towards a more patient-centered care system. However, it

should be outlined that perceptions are influenced by a number of factors that are not necessarily dealt with the actual characteristics of the care provided. Indeed, service users' ratings of quality are influenced by their expectations, which in turn are influenced by various elements such as personal characteristics (e.g., age, gender, and educational level), needs and health status, previous experiences, extent of choice, and reputation of provider (Sofaer & Firminger, 2005). Thus, limiting the assessment of quality of care to the exploration of service users' perceptions can generate conceptual and methodological inconsistencies. This thesis attempted to overcome this issue by incorporating other sources of information, and specifically mental health information systems (MHISs). The objective of a MHIS is to serve as a tool for improving the mental health of a population and its individual members. A MHIS is used primarily for patient management, program and policy management, administrative purposes, and in support of research programs (Gulbinat *et al.*, 2012). The last purpose was of special interest in this thesis, which incorporated – among others – an epidemiological approach. This allowed studying pattern of mental health services utilization and investigating the effect that clinical and social variables have on services' utilization.

To conclude, a few considerations about how this thesis fits within the issue of quality improvement. In the study we conducted in Northern Italy a successful collaboration with managers and mental health staff in the three centres was developed from the very beginning and throughout the whole research process. In the near future a series of meetings will be held in each of the three centres in order to discuss results and exchange views among researchers and practitioners. In addition, a strategy will be set to involve service users in the discussion of these findings.

BIBLIOGRAPHY

Abu-Bader S.H. (2000). Work satisfaction, burnout, and turnover among social workers in Israel: a causal diagram. *International Journal of Social Welfare*, 9, 191-200.

Adams R.E., Figley C.R., Boscarino J.A. (2008). The compassion fatigue scale: Its use with social workers following urban disaster. *Research on Social Work Practice*, 18, 238-250.

Agency for Healthcare Research and Quality (2005). *Guide to healthcare quality: How to know it when you see it*. Washington, DC: U.S. Department of Health and Human Services.

Allen R. (2014). *The role of the social worker in adult mental health services*. London: The College of Social Work.

Amaddeo F., Barbui C., Tansella M. (2012). State of psychiatry in Italy 35 years after psychiatric reform. A critical appraisal of national and local data. *International Review of Psychiatry*, 24, 314-320.

Amaddeo F., Tansella M. (2013). Quality of mental health care indicators to improve care. *Epidemiology and Psychiatric Sciences*, 22, 1-2.

American Medical Association (1986). Quality of care. *Journal of the American Medical Association*, 256, 1032-1034.

Anthony W.A. (1993). Recovery from mental illness: the guiding vision of the mental health system in the 1990s. *Psychosocial Rehabilitation Journal*, 16, 11-23.

Arah O.A., Westert G.P., Hurst J., Klazinga N.S. (2006). A conceptual framework for the OECD Health Care Quality Indicators Project. *International Journal for Quality in Health Care*, Supplement 1, 5-13.

Barbato A., D'Avanzo B., D'Anza V., Montorfano E., Savio M., Corbascio C.G. (2014). Involvement of users and relatives in mental health service evaluation. *The Journal of Nervous and Mental Disease*, 202, 479-486.

Becker T., Hülsmann S., Knudsen H.C., Martiny K., Amaddeo F., Herran A., Knapp M., Schene A.H., Tansella M., Thornicroft G., Vázquez-Barquero J.L., the EPSILON Study Group (2002). Provision of services for people with schizophrenia in five European regions. *Social Psychiatry and Psychiatric Epidemiology*, 37, 465-474.

Beresford P., Branfield F. (2006). Developing inclusive partnerships: user-defined outcomes, networking and knowledge - a case study. *Health and Social Care in the Community*, 14, 436-444.

Bland R., Renouf N. (2001). Social work and the mental health team. *Australasian Psychiatry*, 9, 238-241.

Bressi C., Porcellana M., Gambini O., Madia L., Muffatti R., Peirone A., Zanini S., Erlicher A., Scarone S., Altamura A.C. (2009). Burnout among Psychiatrists in Milan: A multicenter survey. *Psychiatric Services*, 60, 985-988.

Bride B.E., Radey M., Figley C.R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal*, 35, 155-163.

Burgalassi M. (2007). *Il welfare dei servizi alla persona in Italia*. Milano: FrancoAngeli.

Burns T., Catty J., White S., Clement S., Ellis G., Jones I.R., Lissouba P., McLaren S., Rose D., Wykes T. for the ECHO Group (2009). Continuity of care in mental health: understanding and measuring a complex phenomenon. *Psychological Medicine*, 39, 313-323.

Cameron A., Lart R., Bostock L., Coomber C. (2012). *Factors that promote and hinder joint and integrated working between health and social care services*. Research briefing 41. London: Social Care Institute for Excellence.

Carpenter J., Schneider J., McNiven F., Brandon T., Stevens R., Wooff D. (2004). Integration and targeting of care for people with severe and enduring mental health problems: users' experiences of the care programme approach and care management. *British Journal of Social Work*, 34, 313-333.

Casacchia M., Roncone R. (2014). Italian families and family interventions. *The Journal of Nervous and Mental Disease*, 202, 487-497.

Chisholm D., Knapp M.R., Knudsen H.C., Amaddeo F., Gaité L., van Wijngaarden B. (2000). Client Socio-Demographic and Service Receipt Inventory-European Version: development of an instrument for international research. EPSILON Study 5. European Psychiatric Services: Inputs Linked to Outcome Domains and Needs. *British Journal of Psychiatry*, Supplement 39, 28-33.

Clarkson P., Challis D.J. (2002). Developing performance indicators for mental health care. *Journal of Mental Health*, 11, 281-293.

Clifton J., Thorley C. (2014). *Meeting the workforce challenges in mental health social work*. London: Institute for Public Policy Research.

Costamagna F. (2013). The Provision of Social Services in Italy between Federalization and Europeanization. In Neergaard U., Szyszczak E., van de Gronden J.W., Krajewski M. (Eds.), *Social Services of General Interest in the EU*. The Hague, The Netherlands: T.M.C. Asser Press.

Czaja A.S., Moss M., Mealer M. (2012). Symptoms of posttraumatic stress disorder among pediatric acute care nurses, *Journal of Pediatric Nursing*, 27, 357-365.

de Girolamo G., Barbato A., Bracco R., Gaddini A., Miglio R., Morosini P., the PROGRES – Acute group (2007). Characteristics and activities of acute psychiatric inpatient facilities: national survey in Italy. *British Journal of Psychiatry*, 191, 170-177.

de Girolamo G., Picardi A., Micciolo R., Falloon I., Fioritti A., Morosini P. for the Italian PROGRES study group (2002). Residential care in Italy: A national survey of non-hospital facilities. *British Journal of Psychiatry*, 181, 220-225.

Department of Health (2006). *Our health, our care, our say: a new direction for community services*. London: The Stationery Office.

Donabedian A. (1979). The quality of medical care: A concept in search of a definition. *Journal of Family Practice*, 9, 277-284.

Donabedian A. (1980). *Explorations in quality assessment and monitoring Vol. 1. The definition of quality and approaches to its assessment*. Ann Arbor, MI: Health Administration Press.

Donabedian A. (1988). The quality of care: How can it be assessed? *Journal of the American Medical Association*, 260, 1743-1748.

Donisi V., Amaddeo F., Brunn M., Cid J., Hagmair G., Kalseth B., Malin M., McDaid D., Park A-L., Prigent A., Salazzari D., Sfectu R. and the REFINEMENT Group (2013). *Report on Quality of Care in the REFINEMENT Partner Countries. Data on Quality of Care Collected via REQUALIT (REfinement QUALity Tool)*. Work Package 8, Deliverable 8.1. Quality of Care and Met/Unmet Needs. FP7 - research project HEALTH-F3-2010-261459 REFINEMENT – Financing systems' effects on the quality of mental health care in Europe.

Eborall C., Garmeson K. (2001). *Desk Research on Recruitment and Retention in Social Care and Social Work*. London: Business and Industrial Market Research.

Eurofound (2012). *Fifth European Working Conditions Survey*. Luxembourg: Publications Office of the European Union.

Evans S., Huxley P., Gately C., Webber M., Mears A., Pajak S., Medina J., Kendall T., Katona C. (2006). Mental health, burnout and job satisfaction among mental health social workers in England and Wales. *British Journal of Psychiatry*, 188, 75-80.

Fakhoury W., Priebe S. (2007). Deinstitutionalization and reinstitutionalization: major changes in the provision of mental healthcare. *Psychiatry*, 6, 313-316.

Ferrera M. (2006). *Le politiche sociali. L'Italia in prospettiva comparata*. Bologna: Il Mulino Editore.

Figley C.R. (1995). *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*. New York: Brunner Mazel.

Figley C.R. (2002a). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of Clinical Psychology*, 58, 1433-1441.

Figley C.R. (2002b). *Treating compassion fatigue*. New York: Brunner-Routledge.

Fioritti A., Amaddeo F. (2014). Community mental health in Italy today. *The Journal of Nervous and Mental Disease*, 202, 425-427.

Foster J. (2005). *Where are we going? The Social Work Contribution to Mental Health Services*. London: Social Perspectives Network.

Franx G., Kroon H., Grimshaw J., Drake R., Grol R., Wensing M. (2008). Organizational change to transfer knowledge and improve quality and outcomes of care for patients with severe mental illness: a systematic overview of reviews. *The Canadian Journal of Psychiatry*, 53, 294-305.

Franzini M., Raitano M. (2007). Welfare state universalistici e selettivi: definizioni, tendenze ed effetti. In Pizzuti F.R. (Ed.). *Rapporto sullo stato sociale 2007*. Roma: Utet.

Freeman G., Shepperd S., Robinson I., Ehrich K., Richards S., Pitman P. (2000). *Continuity of Care: report of a scoping exercise for the SDO programme of NHS R&D*. London: National Coordinating Centre for Service Delivery and Organisation.

Gaebel W., Becker T., Janssen B., Munk-Jorgensen P., Musalek M., Rössler W., Sommerlad K., Tansella M., Thornicroft G., Zielasek J. (2012). EPA guidance on the quality of mental health services. *European Psychiatry*, 27, 87-113.

Galeazzi G.M., Delmonte S., Fakhoury W., Priebe S. (2004). Morale of mental health professionals in Community Mental Health Services of a Northern Italian Province. *Epidemiologia e Psichiatria Sociale*, 13, 191-197.

Goldenberg M.J. (2012). Defining 'quality of care' persuasively. *Theoretical Medicine and Bioethics*, 33, 243-261.

Gosetti G. (2012). Dalla qualità del lavoro alla qualità della vita lavorativa: persistenze e innovazioni nel profilo teorico e nelle modalità di analisi. In Gallie D., Gosetti G., La Rosa M. (Eds.). *Qualità del lavoro e della vita lavorativa. Cosa è cambiato e cosa sta cambiando*, numero monografico di Sociologia del lavoro, n. 127. Milano: FrancoAngeli.

Gosetti G. (2014). *Lavorare nell'impresa artigiana. Cultura del lavoro e qualità della vita lavorativa*. Collana di Sociologia del lavoro. Milano: FrancoAngeli.

Gough D., Elbourne D. (2002). Systematic research synthesis to inform policy, practice and democratic debate. *Social Policy and Society*, 1, 225-236.

Gulbinat W., Amaddeo F., Ito H., Medina-Mora E., Mubbashar M., Ndeti D., Plovnick R. (2012). Statistics and Information Systems. In Saxena S., Esparza P., Regier D.A., Saraceno B., Sartorius N. (Eds.). *Public Health Aspects of Diagnosis and Classification of Mental Health and Behavioural Disorders. Refining the Research Agenda for DSM-V and ICD-11*. Arlington, US, and Geneva, CH: American Psychiatric Publishing and World Health Organisation.

Hermann R.C., Leff S., Palmer R.H., Yang D., Teller T., Provost S., Jakubiak C., Chan J. (2000). Quality Measures for Mental Health Care: Results from a National Inventory. *Medical Care Research and Review*, 57, 136-154.

Hermann R.C., Mattke S., and the Members of the OECD Mental Health Care Panel (2004). *Selecting Indicators for the Quality of Mental Health Care at the Health Systems Level in OECD Countries*. Paris: OECD.

Hermann R.C., Mattke S., Somekh D., Silfverhielm H., Goldner E., Glover G., Pirkis G., Mainz J., Chan J. (2006). Quality indicators for international benchmarking of mental health care. *International Journal for Quality in Health Care*, 18, Supplement 1, 31-38.

Hesse A.R. (2002). Secondary trauma: how working with trauma survivors affects therapists. *Clinical Social Work Journal*, 30, 293-309.

Huisman J.M.E. (1999). *Item nonresponse: Occurrence, causes, and imputation of missing answers to test items*. Leiden: DSWO Press.

Hunsaker S., Chen H.C., Maughan D., Heaston S. (2014). Factors that influence the development of compassion fatigue, burnout, and compassion satisfaction in emergency department nurses. *Journal of Nursing Scholarship*, 47, 186-194.

Institute of Medicine (1990). *Medicare: A strategy for quality assurance (vol. 1)*. Washington, DC: National Academy Press.

Institute of Medicine (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press.

Jacobs R., McDauid D. (2009). Performance assessment in mental health services. In Smith P., Mossialos E., Leatherman S., Papanicolas I. (Eds.). *Performance Measurement for Health System Improvement: Experiences, Challenges and Prospects*. Cambridge: Cambridge University Press.

Johnson S., Kuhlmann R., the EPCAT Group (2000). The European Service Mapping Schedule (ESMS): development of an instrument for the description and classification of mental health services. *Acta Psychiatrica Scandinavica*, Supplement 405, 14-23.

Junjan V., Miclutia I., Popescu C., Ciumăgeanu M., Sfetcu R., Ghenea D. (2009). The provision of psychiatric care in Romania - need for change or change of needs? *Transylvanian Review of Administrative Sciences*, 26E, 81-93.

Klopper H.C., Coetzee S.K., Pretorius R., Bester P. (2012). Practice environment, job satisfaction and burnout of critical care nurses in South Africa. *Journal of Nursing Management*, 20, 685-695.

Kohn R., Saxena S., Levav I., Saraceno B. (2004). The treatment gap in mental health care. *Bulletin of the World Health Organization*, 82, 858-866.

Lasalvia A., Bonetto C., Bertani M.E., Bissoli S., Cristofalo D., Marrella G., Ceccato E., Cremonese C., De Rossi M., Lazzarotto L., Marangon V., Morandin I., Zucchetto M., Tansella M., Ruggeri M. (2009). Influence of perceived organizational factors on job burnout. A survey of staff working in Italian community mental health services. *British Journal of Psychiatry*, 195, 537-544.

Lasalvia A., Ruggeri M. (2007). Assessing the outcome of community-based psychiatric care: building a feedback loop from “real world” services research into clinical practice. *Acta Psychiatrica Scandinavica*, 116, 6-15.

Li A., Early S.F., Mahrer N.E., Klaristenfeld J.L., Gold J.I. (2014). Group cohesion and organizational commitment: protective factors for nurse residents’ job satisfaction, compassion fatigue, compassion satisfaction, and burnout. *Journal of Professional Nursing*, 30, 89-99.

Lo Scalzo A., Donatini A., Orzella L., Cicchetti A., Profili S., Maresso A. (2009). Italy: Health System Review. *Health Systems in Transition*, 11, 1-216.

Lora A. (2009). An overview of the mental health system in Italy. *Annali Istituto Superiore di Sanità*, 45, 5-16.

Malley J., Fernández J.-L. (2010). Measuring quality in social care services: theory and practice. *Annals of Public and Cooperative Economics*, 81, 559-582.

Maslach C. (2003). *Burnout: The Cost of Caring*. Cambridge, MA: Malor Book.

McDaid D., Oliveira M.D., K. Jurczak, M. Knapp, the MHEEN Group (2007). Moving beyond the mental health care system: An exploration of the interfaces between health and non-health sectors. *Journal of Mental Health*, 16, 181-194.

Megivern D., McMillen J.C., Proctor E.K., Striley C.W., Cabassa L.J., Munson M.R. (2005). Quality of care: Expanding the social work dialogue. *Social Work*, 52, 115-124.

Montero-Marín J., García-Campayo J., Fajó-Pascual M., Carrasco J.M., Gascón S., Gili M., Mayoral-Cleries F. (2011). Sociodemographic and occupational risk factors associated with the development of different burnout types: the cross-sectional. *BMC Psychiatry*, 29, 11-49.

Montero-Marin J., Prado-Abril J., Piva Demarzo M.M., Gascon S., García-Campayo J. (2014). Coping with stress and types of burnout: explanatory power of different coping strategies. *PLoS One*, 9, 1-9.

Morgan C. (2007). The role of social care. *Psychiatry*, 6, 347-348.

Munizza C., Gonella R., Pinciaroli L., Rucci P., Picci R.L., Tibaldi G. (2011). CMHC adherence to National Mental Health Plan standards in Italy: a survey 30 years after national reform law. *Psychiatric Services*, 62, 1090-1093.

Netten A., Beadle-Brown J., Caiels J., Forder J., Malley J., Smith N., Towers A., Trukeschitz B., Welch E., Windle K. (2011). *ASCOT Adult Social Care Outcomes Toolkit: Main Guidance v2.1*. Discussion Paper DP2716/3, Personal Social Services Research Unit, University of Kent, Canterbury.

Netten A., Burge P., Malley J., Potoglou D., Brazier J., Flynn T., Forder J. (2009). *Outcomes of Social Care for Adults (OSCA) Interim findings*. Discussion Paper 2648/2, Personal Social Services Research Unit, University of Kent, Canterbury.

Netten A., Burge P., Malley J., Potoglou D., Towers A., Brazier J., Flynn T., Forder J., Wall B. (2012a). Outcomes of Social Care for Adults: Developing a Preference-Weighted Measure. *Health Technology Assessment*, 16, 1-165.

Netten A., Trukeschitz B., Beadle-Brown J., Forder J., Towers A., Welch E. (2012b). Quality of life outcomes for residents and quality ratings of care homes: is there a relationship? *Age and Ageing*, 41, 512-517.

Newbigging K., McKeown M., Habte-Mariam Z., Mullings D., Jaye-Charles J., Holt K. (2008). *Commissioning and Providing Mental Health Advocacy for African and Caribbean Men*. Resource guide 10. London: Social Care Institute for Excellence.

Orel N.A., Groves P.A., Shannon L. (2003). Positive Connections: A programme for children who have a parent with a mental illness. *Child and Family Social Work*, 8, 113-122.

Palestini L., Prati G., Pietrantonio L., Cicognani E. (2009). La qualità della vita professionale nel lavoro di soccorso. Un contributo alla validazione italiana della Professional Quality of Life Scale (ProQOL). *Psicoterapia Cognitiva e Comportamentale*, 15, 205-227.

Pedrini L., Magni L. R., Giovannini C., Panetta V., Zacchi V., Rossi G., Placentino A. (2009). Burnout in non hospital psychiatric residential facilities. *Psychiatric Services*, 60, 1547-1551.

Picardi A., Lega I., Candini V., Dagani J., Iozzino L., de Girolamo G. (2014) Monitoring and evaluating the Italian mental health system: The “Progetto Residenze” study and beyond. *The Journal of Nervous and Mental Disease*, 202, 451-459.

Piccinelli M., Politi P., Barale F. (2002). Focus on psychiatry in Italy. *British Journal of Psychiatry*, 181, 538-544.

Pines A.M., Maslach C. (1978). Characteristics of Staff Burnout in Mental Health Settings. *Hospital and Community Psychiatry*, 29, 233-237.

Pines A.M., Aronson E. (1988). *Career Burnout: Causes and Cures*. New York: Free Press.

Pizzuti F.R. (Ed.) (2008). *Rapporto sullo stato sociale. Anno 2008. Il tendenziale slittamento dei rischi sociali dalla collettività all'individuo*. Torino: Utet Università.

Prosser D., Johnson S., Kuipers E., Szmukler G., Bebbington P., Thornicroft G. (1997). Perceived sources of work stress and satisfaction among hospital and community mental health staff and their relation to mental health, burnout and job satisfaction. *Journal of Psychosomatic Research*, 43, 51-59.

Radey M., Figley C.R. (2007). The Social Psychology of Compassion. *Clinical Social Work*, 35, 207-214.

Ray M., Pugh R., Roberts D., Beech, B. (2008). *Mental health and social work*. Research briefing 26. London: Social Care Institute for Excellence.

REFINEMENT Group (2012). *Report REMAST. REFINEMENT Mapping Services Toolkit*. Verona: Università degli Studi di Verona.

Rose D., Sweeney A., Leese M., Clement S., Jones I.R., Burns T., Catty J., Wykes T. (2009). Developing a user-generated measure of continuity of care: brief report. *Acta Psychiatrica Scandinavica*, 119, 320-324.

Rossi A., Cetrano G., Pertile R., Rabbi L., Donisi V., Grigoletti L., Curtolo C., Tansella M., Thornicroft G., Amaddeo F. (2012). Burnout, compassion fatigue, and compassion satisfaction among staff in community-based mental health services. *Psychiatry Research*, 200, 933-938.

Ruggeri M., Lora A., Semisa D., SIEP DIRECT'S Group (2008). The SIEP-DIRECT'S Project on the discrepancy between routine practice and evidence. An outline of main findings and practical implications for the future of community based mental health services. *Epidemiologia e Psichiatria Sociale*, 17, 358-368.

Salvador-Carulla L., Alvarez-Galvez J., Romero C., Gutierrez-Colosia M., Weber G., McDaid D., Dimitrov H., Sprah L., Kalseth B., Tibaldi G., Salinas-Perez J., Lagares-Franco C., Romá-Ferri M.T., Johnson S. (2013). Evaluation of an integrated system for classification, assessment and comparison of services for long-term care in Europe: The eDESDE-LTC study. *BMC Health Services Research*, 13, 1-12.

Salvador-Carulla L., Dimitrov H., Weber G., McDaid D., Venner B., Sprah L., Romero C., Ruiz M., Tibaldi G., Johnson S., for DESDE-LTC Group (Eds.) (2011). *DESDE-LTC: Evaluation And Classification Of Services For Long Term Care In Europe*. Spain: Psicost and Catalunya Caixa.

Salvador-Carulla L., Poole M., González-Caballero J.L., Romero C., Salinas J.A., Lagares-Franco C.M., RIRAG/PSICOST Group, DESDE Consensus Panel (2006). Development and usefulness of an instrument for the standard description and comparison of services for disabilities (DESDE). *Acta Psychiatrica Scandinavica*, Supplement 432, 19-28.

Salvador-Carulla L., Romero C., Martinez A., Haro J., Bustillo G., Ferreira A., Gaité L., Johnson S. (2000). Assessment instruments: standardization of the European Service Mapping Schedule (ESMS) in Spain. *Acta Psychiatrica Scandinavica*, Supplement 102, 24-32.

Salvador-Carulla L., Saldivia S., Martinez-Leal R., Vicente B., Garcia-Alonso C., Grandon P., Haro J.M. (2008). Meso-level comparison of mental health service availability and use in Chile and Spain. *Psychiatric Services*, 59, 421-428.

Slade M. (2009). *100 Ways to Support Recovery: A Guide for Mental Health Professionals*. Rethink recovery series, volume 1. London: Rethink Mental Illness.

Social Care Institute for Excellence (2010). *Finding excellence in adult social care services. Excellence definition materials*. London: SCIE.

Sofaer S., Firminger K. (2005). Patient perceptions of the quality of health services. *Annual Reviews in Public Health*, 26, 513-559.

Sprang G., Clark J.J., Whitt-Woosley A. (2007). Compassion fatigue, compassion satisfaction, and burnout: Factors impacting a professional's quality of life. *Journal of Loss and Trauma*, 12, 259-280.

Stamm B.H. (2002). Measuring Compassion Satisfaction as Well as Fatigue: Developmental History of the Compassion Fatigue and Satisfaction Test. In Figley C.R. (Ed.). *Treating Compassion Fatigue*. New York: Brunner Mazel.

Stamm B.H. (2005). *The ProQOL Manual: The Professional Quality of Life Scale: Compassion satisfaction, burnout and compassion fatigue/secondary trauma scales*. Baltimore: Sidran Press.

Steffen G.E. (1988). Quality medical care: A definition. *Journal of the American Medical Association*, 260, 56-61.

Sweeney A., Rose D., Clement S., Jichi F., Jones I.R., Burns T., Catty J., McLaren S., Wykes T. (2012). Understanding service user-defined continuity of care and its relationship to health and social measures: a cross-sectional study. *BMC Health Services Research*, 12, 1-10.

Think Local Act Personal (2013). *Driving up quality in adult social care. What is quality?* London: TLAP.

Thornicroft G., Tansella M. (2009). *Better Mental Health Care*. Cambridge: Cambridge University Press.

Thornicroft G., Tansella M. (2014). Community mental health care in the future: Nine proposals. *The Journal of Nervous and Mental Disease*, 202, 507-512.

Tibaldi G., Munizza C., Pasian S., Johnson S., Salvador-Carulla L., Zucchi S., Cesano S., Testa C., Scala E., Pinciaroli L. (2005). Indicators predicting use of mental health services in Piedmont, Italy. *The Journal of Mental Health Policy and Economics*, 8, 95-106.

Watters C. (2001). Emerging paradigms in the mental health care of refugees. *Social Science and Medicine*, 52, 1709-1718.

Whiteford H.A., Degenhardt L., Rehm J., Baxter A.J., Ferrari A.J., Erskine H.E., Charlson F.J., Norman R.E., Flaxman A.D., Johns N., Burstein R., Murray C.J., Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. *Lancet*, 382, 1575-1586.

World Health Organization (1992). *The ICD-10 Classification of Mental and Behavioural Disorders: clinical description and diagnostic guidelines*. Geneva: WHO.

World Health Organization (1997). *WHOQOL Measuring Quality of Life*. Geneva: WHO.

World Health Organization (2003). *Mental Health Policy and Service Guidance Package. Organization of services for mental health*. Geneva: WHO.

World Health Organization (2008). *Policies and practices for mental health in Europe. Meeting the challenges*. Copenhagen: WHO Regional Office for Europe.

World Health Organization (2009). *Improving health systems and services for mental health*. Geneva: WHO.

World Health Organization (2011). *Mental Health Atlas 2011*. Geneva: WHO.

World Health Organization (2013a). *Mental health action plan 2013-2020*. Geneva: WHO.

World Health Organization (2013b). *European Mental Health Action Plan 2013-2020*. Copenhagen: WHO Regional Office for Europe.

Zeidner M., Hadar D., Matthews G., Roberts R.D. (2013). Personal factors related to compassion fatigue in health professionals. *Anxiety Stress Coping*, 26, 595-609.

APPENDICES

APPENDIX 1: PROQOL III QUESTIONNAIRE

PROFESSIONAL QUALITY OF LIFE SCALE

Revision III

Aiutare gli altri La pone a diretto contatto con la vita delle altre persone. Come avrà probabilmente sperimentato, la Sua compassione verso coloro che aiuta ha aspetti sia positivi che negativi. Vorremmo rivolgerLe alcune domande relative alle Sue esperienze, sia positive che negative, come professionista che offre il proprio aiuto. Consideri ognuna delle seguenti affermazioni in relazione a Lei e alla Sua situazione attuale. Scriva con onestà il numero che mostra quanto spesso l'affermazione sia stata veritiera per Lei *negli ultimi trenta giorni*.

0 = mai 1 = raramente 2 = poche volte 3 = piuttosto spesso
4 = spesso 5 = molto spesso

- _____ 1- Sono felice.
- _____ 2- Sono preoccupato per più di una delle persone che aiuto.
- _____ 3- Traggo soddisfazione dal poter aiutare le persone.
- _____ 4- Mi sento legato agli altri.
- _____ 5- Sobbalzo o sussulto per rumori imprevisti.
- _____ 6- Ho più energia dopo aver lavorato con coloro che aiuto.
- _____ 7- Trovo difficoltà a separare la mia vita privata dalla mia vita come professionista che offre aiuto.
- _____ 8- Sto perdendo il sonno per le esperienze traumatiche di una persona che aiuto.
- _____ 9- Penso di poter essere stato “contaminato” dalle esperienze traumatiche di coloro che aiuto.
- _____ 10- Mi sento intrappolato dal mio lavoro di aiuto.
- _____ 11- Per il mio offrire aiuto, mi sono sentito “sull’orlo di un baratro” in molteplici situazioni.
- _____ 12- Mi piace il mio lavoro come professionista che offre aiuto.

- _____ 13- Mi sento depresso in conseguenza al mio lavoro di aiuto.
- _____ 14- Sento come se stessi provando il trauma di qualcuno che ho aiutato.
- _____ 15- Ho delle convinzioni che mi sostengono.
- _____ 16- Sono soddisfatto di come riesco a stare al passo con le tecniche e i protocolli di aiuto.
- _____ 17- Sono la persona che ho sempre voluto essere.
- _____ 18- Il mio lavoro mi fa sentire soddisfatto.
- _____ 19- Mi sento esausto a causa del mio lavoro come professionista che offre aiuto.
- _____ 20- Ho pensieri e sentimenti positivi riguardo a coloro che aiuto e come li potrei aiutare.
- _____ 21- Mi sento sopraffatto dalla quantità di lavoro o dal numero di assistiti di cui mi devo occupare.
- _____ 22- Credo di poter fare la differenza attraverso il mio lavoro.
- _____ 23- Evito certe attività o situazioni perché mi ricordano esperienze paurose delle persone che aiuto.
- _____ 24- Penso di continuare ad offrire il mio aiuto agli altri per molto tempo.
- _____ 25- Come conseguenza del mio aiutare, vengo assalito da improvvisi ed involontari pensieri di paura.
- _____ 26- Mi sento bloccato dal sistema.
- _____ 27- Penso di avere successo come professionista che offre aiuto.
- _____ 28- Non sono in grado di ricordare aspetti importanti del mio lavoro con le vittime di un trauma.
- _____ 29- Sono una persona eccessivamente sensibile.
- _____ 30- Sono felice di aver scelto di fare questo lavoro.

APPENDIX 2: QUALITY OF WORKING LIFE QUESTIONNAIRE

LAVORO E VITA LAVORATIVA

Analisi della cultura e vita lavorativa nei servizi di salute mentale

1. IL PROFILO DELL'OPERATORE

1. Da quanto tempo lavora nell'attuale servizio psichiatrico: (indicare la somma complessiva degli anni, anche se vi sono state interruzioni)

n. anni	
---------	--

2. Ha lavorato anche: (una risposta per riga)

	sì	No	se sì, può indicare il n. di anni
- in altri servizi psichiatrici	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	
- in altri servizi socio-sanitari	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	

3. Il suo attuale ruolo professionale è:

- psichiatra	<input type="checkbox"/> ₁
- psicologo	<input type="checkbox"/> ₂
- caposala	<input type="checkbox"/> ₃
- infermiere professionale	<input type="checkbox"/> ₄
- infermiere generico	<input type="checkbox"/> ₅
- assistente sanitario/a	<input type="checkbox"/> ₆
- assistente sociale	<input type="checkbox"/> ₇
- educatore professionale	<input type="checkbox"/> ₈
- medico in formazione / specializzando	<input type="checkbox"/> ₉
- tecnico della riabilitazione psichiatrica	<input type="checkbox"/> ₁₀
- operatore socio-sanitario/addetto all'assistenza (oss/ota)	<input type="checkbox"/> ₁₁
- ausiliario specializzando socio-assistenziale	<input type="checkbox"/> ₁₂
- operatore amministrativo	<input type="checkbox"/> ₁₃
- altro (specif. _____)	<input type="checkbox"/> ₁₄

4. La sua organizzazione di appartenenza è:

- Azienda ospedaliera (Servizio sanitario nazionale)	<input type="checkbox"/> ₁
- Azienda sanitaria locale (USL – ULSS – APSS)	<input type="checkbox"/> ₂
- Università, con integrazione Azienda ospedaliera	<input type="checkbox"/> ₃
- Università	<input type="checkbox"/> ₄
- Cooperativa	<input type="checkbox"/> ₅
- Altro (specificare _____)	<input type="checkbox"/> ₆

5. Il suo contratto di lavoro è: (una risposta)

- tempo indeterminato – tempo pieno	<input type="checkbox"/> ₁
- tempo indeterminato – part-time (n. ore: _____)	<input type="checkbox"/> ₂
- tempo determinato – tempo pieno	<input type="checkbox"/> ₃
- tempo determinato – part-time (n. ore: _____)	<input type="checkbox"/> ₄
- borsista/assegnista/co.co.co.	<input type="checkbox"/> ₅
- altro (specif. _____)	<input type="checkbox"/> ₆

6. Se lavora part-time, il suo è: (una risposta)

- part-time volontario	<input type="checkbox"/> ₁
- part-time involontario	<input type="checkbox"/> ₂

7. Quanto tempo nella settimana dedica, in termini percentuali, alle seguenti attività:

<i>tipo di attività</i>	<i>%</i>
- attività clinica/assistenziale diretta (con il paziente) e indiretta (compilazione cartelle, relazioni cliniche, riunioni e discussione sui casi, ecc.)	
- attività di ricerca	
- attività didattica	
- attività di supporto amministrativo/organizzativo	
totale	100

2. IL SIGNIFICATO DEL LAVORO**1. Per lei, quanto sono importanti i seguenti aspetti del lavoro? (una risposta per riga)**

	nulla	poco	abbast.	molto	molt.mo
- la retribuzione	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- la stabilità del posto di lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- l'orario di lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- i ritmi e il carico di lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- l'ambiente fisico di lavoro (sicurezza, rumore, ...)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- la possibilità di rimanere vicino a casa	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- il contenuto del lavoro (varietà, non ripetitività, ...)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- l'organizzazione del lavoro (compiti ben definiti, ...)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- i rapporti con i colleghi di lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- i rapporti con i superiori	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- la possibilità di esprimere le proprie capacità	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- il livello di autonomia nel fare il lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- la partecipazione alle decisioni del servizio	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- l'apprezzamento per il lavoro fatto	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- l'utilità sociale del lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

2. Nel suo lavoro, per lei, per gli utenti e per l'ente di appartenenza, quali sono gli aspetti più importanti per essere apprezzati? (ATTENZIONE: massimo due risposte per ogni colonna)

	<i>per lei</i>	<i>per gli utenti</i>	<i>per l'ente di appartenenza</i>
- sapersi adattare a situazioni lavorative diverse	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁
- saper collaborare con i colleghi	<input type="checkbox"/> ₂	<input type="checkbox"/> ₂	<input type="checkbox"/> ₂
- lavorare bene tecnicamente	<input type="checkbox"/> ₃	<input type="checkbox"/> ₃	<input type="checkbox"/> ₃
- saper organizzare il proprio lavoro	<input type="checkbox"/> ₄	<input type="checkbox"/> ₄	<input type="checkbox"/> ₄
- rispettare gli ordini dei superiori	<input type="checkbox"/> ₅	<input type="checkbox"/> ₅	<input type="checkbox"/> ₅
- sapersi assumere responsabilità	<input type="checkbox"/> ₆	<input type="checkbox"/> ₆	<input type="checkbox"/> ₆
- avere iniziativa personale	<input type="checkbox"/> ₇	<input type="checkbox"/> ₇	<input type="checkbox"/> ₇
- dare la massima disponibilità	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈
- avere capacità di dialogo	<input type="checkbox"/> ₉	<input type="checkbox"/> ₉	<input type="checkbox"/> ₉
- altro (specif. _____)	<input type="checkbox"/> ₁₀	<input type="checkbox"/> ₁₀	<input type="checkbox"/> ₁₀

3. LE CONDIZIONI DI LAVORO

1. Oltre alla componente di base, la sua retribuzione comprende: (una risposta per riga)

	sì	no
- una parte variabile legata alla posizione (responsabilità, ecc.)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- una parte variabile legata a obiettivi/risultati raggiunti	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- altro (specif. _____)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

2. Nel nucleo familiare vi è un altro reddito oltre al suo (da lavoro o da pensione)?

- sì <input type="checkbox"/> ₁	- no <input type="checkbox"/> ₂
--	--

3. Come giudica la sua retribuzione attuale? (una risposta)

- non è sufficiente	<input type="checkbox"/> ₁
- è sufficiente per pagarmi le cose essenziali della vita	<input type="checkbox"/> ₂
- mi consente di avere un buon tenore di vita	<input type="checkbox"/> ₃
- mi consente un buon tenore di vita e di pagarmi anche degli extra	<input type="checkbox"/> ₄

4. Il suo lavoro comporta: (una risposta per riga)

	mai	raram.	abbast.	spesso	sempre
- temperature troppo alte o troppo basse	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- luminosità troppo alta o troppo bassa	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- spazio inadeguato per le attività	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- condizioni igieniche inadeguate	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- carenza di presidi di protezione	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- carichi pesanti da sollevare e trasportare	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- tempi stretti di lavoro (ritmo e intensità)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- attività prolungata al computer	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- pericolo di aggressioni	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

5. Quanti minuti impiega normalmente per arrivare sul posto di lavoro?

n. minuti	
-----------	--

6. Il suo orario giornaliero di lavoro è: (una risposta)

- fisso, con orario stabilito di inizio e fine giornata (fra le 6 e le 18)	<input type="checkbox"/> ₁
- fisso, ma con orario flessibile di inizio e fine giornata	<input type="checkbox"/> ₂
- flessibile, con un monte ore settimanale/mensile da rispettare	<input type="checkbox"/> ₃
- flessibile, con un monte ore settimanale e turni	<input type="checkbox"/> ₄
- fisso, con turni solo diurni (fra le 6 e le 22)	<input type="checkbox"/> ₅
- fisso, con turni anche notturni (fra le 22 e le 6)	<input type="checkbox"/> ₆
- altro (specif. _____)	<input type="checkbox"/> ₇

7. Il suo orario di lavoro prevede reperibilità:

- sì <input type="checkbox"/> ₁	- no <input type="checkbox"/> ₂
--	--

8. Il suo lavoro prevede: (una risposta per riga)

	mai	raram.	abbast.	spesso	sempre
- compiti da svolgere diversi fra loro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- imprevisti e problemi da risolvere	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- compiti che richiedono esperienza di lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- compiti con elevato livello di responsabilità	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- rotazione di compiti con i colleghi di lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- coordinamento del lavoro di altre persone	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

9. Nel suo lavoro, in maniera prevalente, lei dipende direttamente da:

- direttore del dipartimento	<input type="checkbox"/> ₁
- primario	<input type="checkbox"/> ₂
- responsabile dell'équipe	<input type="checkbox"/> ₃
- responsabile dell'unità operativa	<input type="checkbox"/> ₄
- caposala	<input type="checkbox"/> ₅
- altro (specif. _____)	<input type="checkbox"/> ₆

10. Quale delle seguenti situazioni si verificano nel suo lavoro? (una risposta per riga)

	mai	raram.	abbast.	spesso	sempre
- il responsabile conosce bene i miei compiti	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- sono libero nel lavoro e poco controllato	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- se ho problemi nel lavoro il responsabile mi aiuta	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- se ho problemi nel lavoro i colleghi mi aiutano	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- il responsabile si fida di me	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

11. Nel corso della sua attività lavorativa lei può in autonomia: (una risposta per riga)

	mai	raram.	abbast.	spesso	sempre
- decidere di fare pause durante il lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- scegliere come fare un lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- risolvere un problema organizzativo	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- stabilire l'ordine con il quale eseguire i compiti	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- definire il ritmo e l'intensità del lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- scegliere quali compiti fare	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- fare programmi di lavoro settimanali o mensili	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- scegliere il livello di qualità delle cose da fare	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

12. Nel corso degli ultimi 12 mesi ha partecipato a riunioni per: (una risposta per riga)

	mai	talvolta	spesso
- discutere l'organizzazione del servizio	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
- definire metodi, tecnologie e tecniche di lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
- pianificare e verificare le attività del servizio	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
- decidere quali progetti e servizi realizzare	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

13. Esistono nel servizio riunioni giornaliere o settimanali:

- sì <input type="checkbox"/> ₁	- no <input type="checkbox"/> ₂
--	--

14. Se sì, servono per: (una risposta per riga)

	Mai	talvolta	spesso
- scambio di informazioni	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
- riflessione e confronto sui casi	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
- programmazione delle attività	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
- comunicazioni di tipo organizzativo	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

15. Se sì, le consentono di: (una risposta per riga)

	mai	raram.	abbast.	spesso	sempre
- affrontare argomenti interessanti	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- essere libero di portare il suo contributo	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- essere apprezzato per il suo contributo	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- incidere sulle decisioni prese dal gruppo	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- approfondire in maniera sufficiente le problematiche	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- ricevere supporto emotivo	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

16. Vi sono momenti, diversi da quelli programmati, per affrontare aspetti del suo lavoro:

- sì <input type="checkbox"/> ₁	- no <input type="checkbox"/> ₂
--	--

17. L'équipe o l'unità operativa alla quale appartiene: (una risposta per riga)

	nulla	poco	abbast.	molto	molt.mo
- ha un'idea chiara degli obiettivi del servizio	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- sente propri gli obiettivi del servizio	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- è coinvolta nel raggiungimento degli obiettivi	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- riflette criticamente sul proprio lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- riceve supporto dalla direzione nello sviluppo delle proprie idee e dei propri progetti	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

18. Il servizio in cui lavora nel corso degli ultimi dodici mesi ha: (una risposta per riga)

	sì	no
- fatto cambiamenti organizzativi	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- introdotto innovazioni tecnologiche	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- aumentato i dipendenti	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- diminuito i dipendenti	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- aumentato le attività	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- diminuito le attività	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- sviluppato progetti innovativi	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

19. Quanto è soddisfatto del suo lavoro attuale?

nulla	poco	abbast.	molto
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

20. Potrebbe dirmi quanto è soddisfatto rispetto ai seguenti aspetti del suo lavoro?
(una risposta per riga)

	nulla	poco	abbast.	molto	molt.mo
- la retribuzione	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- la stabilità del posto di lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- l'orario di lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- i ritmi e il carico di lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- l'ambiente fisico di lavoro (sicurezza, rumore)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- la possibilità di rimanere vicino a casa	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- il contenuto del lavoro (varietà, non ripetitività)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- l'organizzazione del lavoro (compiti ben definiti)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- i rapporti con i colleghi di lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- i rapporti con i superiori	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- la possibilità di esprimere le proprie capacità	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- il livello di autonomia nel fare il lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- la partecipazione alle decisioni del servizio	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- l'apprezzamento per il lavoro fatto	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- l'utilità sociale del lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

21. Nel corso degli ultimi due anni (24 mesi) ha fatto formazione?

- sì <input type="checkbox"/> ₁	- no <input type="checkbox"/> ₂
--	--

22. Se sì, era: (una risposta per riga)

	sì	no
- pagata dall'ente/cooperativa di appartenenza in orario di lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- pagata dall'ente/cooperativa di appartenenza fuori dell'orario di lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- pagata personalmente	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

23. Se sì, i contenuti hanno riguardato: (una risposta per riga)

	sì	no
- aspetti tecnici/clinici del suo lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- aspetti organizzativi del lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- aspetti relativi alla sicurezza sul lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- altro (specif. _____)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

24. Sente il bisogno di fare formazione?

- sì <input type="checkbox"/> ₁	- no <input type="checkbox"/> ₂
--	--

25. Se sì, su quali argomenti: (una risposta per riga)

	sì	no
- aspetti tecnici/clinici del lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- aspetti organizzativi del lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- aspetti relativi alla sicurezza sul lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- altro (specif. _____)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

4. LAVORO, VITA E FUTURO

1. Può dirmi quanto il lavoro condiziona gli altri aspetti della sua vita? (una risposta per riga)

	nulla	poco	abbast.	molto	molt.mo
- prendermi cura della famiglia (figli, genitori)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- assolvere i compiti domestici (lavori in casa)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- coltivare interessi extralavorativi (amici, sport)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- svolgere attività politica, sociale o religiosa	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

2. Quanto i compiti di vita (cura dei figli, attività extralavorative, ecc.) condizionano il suo lavoro nei seguenti aspetti? (una risposta per riga)

	nulla	poco	abbast.	molto	molt.mo
- possibilità di carriera	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- crescita professionale	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- possibilità di accettare ulteriori incarichi	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
- possibilità di cambiare di lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

3. Rispetto al suo futuro, pensa concretamente di correre il rischio di: (una risposta per riga)

	sì	no
- perdere il lavoro	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- non avere una professionalità adeguata	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- non poter mantenere degnamente la famiglia	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- non poter affrontare una spesa rilevante (casa, ...)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- non avere una pensione adeguata	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- altro rischio concreto (specif. _____)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

5. SCHEDA DELL'INTERVISTATO

1. Sesso

maschio	femmina
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

2. Età (anni compiuti)

fino 29	30-39	40-49	50-59	60 e oltre
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

3. Titolo di studio più elevato conseguito

- nessun titolo	<input type="checkbox"/> ₁
- licenza elementare	<input type="checkbox"/> ₂
- licenza media inferiore	<input type="checkbox"/> ₃
- diploma professionale	<input type="checkbox"/> ₄
- diploma media superiore	<input type="checkbox"/> ₅
- diploma universitario o laurea	<input type="checkbox"/> ₆
- titolo post-laurea (specializzazione, master, dottorato, ...)	<input type="checkbox"/> ₇

4. Condizione familiare

- celibe-nubile	<input type="checkbox"/> ₁
- sposato/a-convivente	<input type="checkbox"/> ₂
- separato/a	<input type="checkbox"/> ₃
- divorziato/a	<input type="checkbox"/> ₄
- vedovo/a	<input type="checkbox"/> ₅

5. Con chi vive

- da solo	<input type="checkbox"/> ₁
- con altri	<input type="checkbox"/> ₂

6. Se vive con altri, specificare con chi vive (più possibilità di risposta)

	<i>Convivono con lei</i>	<i>indichi se qualcuno che convive con lei sta lavorando</i>
- genitori (padre e/o madre)	<input type="checkbox"/>	<input type="checkbox"/>
- moglie/marito (o convivente)	<input type="checkbox"/>	<input type="checkbox"/>
- fratelli/sorelle	<input type="checkbox"/>	<input type="checkbox"/>
- figli (n. ____)	<input type="checkbox"/>	<input type="checkbox"/>
- altri conviventi	<input type="checkbox"/>	<input type="checkbox"/>

7. Livello di scolarità dei genitori

	padre	madre
- nessun titolo	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁
- licenza elementare	<input type="checkbox"/> ₂	<input type="checkbox"/> ₂
- licenza media inferiore	<input type="checkbox"/> ₃	<input type="checkbox"/> ₃
- diploma professionale	<input type="checkbox"/> ₄	<input type="checkbox"/> ₄
- diploma media superiore	<input type="checkbox"/> ₅	<input type="checkbox"/> ₅
- diploma universitario o laurea	<input type="checkbox"/> ₆	<input type="checkbox"/> ₆
- titolo post-laurea (master, dottorato, ...)	<input type="checkbox"/> ₇	<input type="checkbox"/> ₇

8. Lavoro dei genitori (lavoro fatto in prevalenza nella loro vita)

	padre	madre
lavoratore dipendente		
- dirigente (direttore, medico, prof. univ., ...)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁
- insegnante	<input type="checkbox"/> ₂	<input type="checkbox"/> ₂
- militare di carriera, poliziotto, carabiniere, vigile urbano	<input type="checkbox"/> ₃	<input type="checkbox"/> ₃
- quadro intermedio (capoufficio, caporeparto, ...)	<input type="checkbox"/> ₄	<input type="checkbox"/> ₄
- addetto ai servizi alla persona (infermiere, assist. sociale, ...)	<input type="checkbox"/> ₅	<input type="checkbox"/> ₅
- impiegato diplomato (ragioniere, geometra, tecnico di labor., ...)	<input type="checkbox"/> ₆	<input type="checkbox"/> ₆
- impiegato generico (segretaria, ...)	<input type="checkbox"/> ₇	<input type="checkbox"/> ₇
- operaio specializzato (con diploma profess., inquadramento, ...)	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈
- operaio comune (manovale, addetto ai servizi di pulizie, ...)	<input type="checkbox"/> ₉	<input type="checkbox"/> ₉
- collaborare domestico	<input type="checkbox"/> ₁₀	<input type="checkbox"/> ₁₀
- altro (specif. _____)	<input type="checkbox"/> ₁₁	<input type="checkbox"/> ₁₁
lavoratore autonomo		
- imprenditore	<input type="checkbox"/> ₅₁	<input type="checkbox"/> ₅₁
- libero professionista	<input type="checkbox"/> ₅₂	<input type="checkbox"/> ₅₂
- artigiano	<input type="checkbox"/> ₅₃	<input type="checkbox"/> ₅₃
- commerciante	<input type="checkbox"/> ₅₄	<input type="checkbox"/> ₅₄
- agricoltore (azienda agricola, allevamento, ...)	<input type="checkbox"/> ₅₅	<input type="checkbox"/> ₅₅
- mezzadro	<input type="checkbox"/> ₅₆	<input type="checkbox"/> ₅₆
- altro (specif. _____)	<input type="checkbox"/> ₅₇	<input type="checkbox"/> ₅₇
casalinga/o	<input type="checkbox"/> ₉₉	<input type="checkbox"/> ₉₉

APPENDIX 3: SOCIO-DEMOGRAPHIC INFORMATION SHEET

SCHEDA SOCIO-DEMOGRAFICA E SULL'UTILIZZAZIONE DEI SERVIZI

1. INFORMAZIONI SOCIODEMOGRAFICHE

1. Anno di nascita:

2. Genere:

Maschio	<input type="checkbox"/> ₁
Femmina	<input type="checkbox"/> ₂

3. Stato civile:

- Celibe/Nubile	<input type="checkbox"/> ₁
- Sposato	<input type="checkbox"/> ₂
- Separato	<input type="checkbox"/> ₃
- Divorziato	<input type="checkbox"/> ₄
- Vedovo/Vedova	<input type="checkbox"/> ₅

4. Nazione di nascita:

5. Titolo di studio più elevato conseguito:

- Nessun titolo	<input type="checkbox"/> ₁
- Licenza elementare	<input type="checkbox"/> ₂
- Licenza media inferiore	<input type="checkbox"/> ₃
- Diploma professionale	<input type="checkbox"/> ₄
- Diploma media superiore	<input type="checkbox"/> ₅
- Diploma universitario o laurea	<input type="checkbox"/> ₆
- Titolo post-laurea (specializzazione, master, dottorato, ...)	<input type="checkbox"/> ₇

2. SITUAZIONE PERSONALE

1. Con chi vive in questo momento? (più possibilità di risposta)

	<i>convivono con lei</i>	<i>indichi se qualcuno che convive con lei sta lavorando</i>
- genitori (padre e/o madre)	<input type="checkbox"/>	<input type="checkbox"/>
- moglie/marito (o convivente)	<input type="checkbox"/>	<input type="checkbox"/>
- fratelli/sorelle (n. ____)	<input type="checkbox"/>	<input type="checkbox"/>
- figli (n. ____)	<input type="checkbox"/>	<input type="checkbox"/>
- altri conviventi (n. ____)	<input type="checkbox"/>	<input type="checkbox"/>

2. Che tipo di sistemazione ha?

- Abitativa/familiare	- Appartamento o casa di proprietà	<input type="checkbox"/> ₁
	- Appartamento o casa in affitto	<input type="checkbox"/> ₂
	- Appartamento in affitto di edilizia pubblica	<input type="checkbox"/> ₃
- Residenziale (non ospedaliera)	- Sistemazione con presenza del personale per 24 ore	<input type="checkbox"/> ₄
	- Sistemazione con presenza del personale inferiore alle 24 ore	<input type="checkbox"/> ₅
- Ospedaliera	- Servizio Psichiatrico di Diagnosi e Cura (SPDC)	<input type="checkbox"/> ₇
	- Clinica Psichiatrica Privata	<input type="checkbox"/> ₈
	- Altro reparto ospedaliero	<input type="checkbox"/> ₉
- Senza casa/senza tetto		<input type="checkbox"/> ₁₀
- Altro (specificare: _____)		<input type="checkbox"/> ₁₁

3. LAVORO E REDDITO

1. Qual è la sua condizione lavorativa?

- Dipendente o in proprio	<input type="checkbox"/> ₁
- Lavoro come volontario	<input type="checkbox"/> ₂
- Lavoro Protetto	<input type="checkbox"/> ₃
- Disoccupato	<input type="checkbox"/> ₄
- Studente	<input type="checkbox"/> ₅
- Casalinga	<input type="checkbox"/> ₆
- Ritirato dal lavoro/pensionato	<input type="checkbox"/> ₇
- Altro (specificare: _____)	<input type="checkbox"/> ₈

2. Se è occupato: Status lavorativo:

- Dirigente/amministratore	<input type="checkbox"/> ₁
- Professionista (es: settore sanitario, didattico, legale)	<input type="checkbox"/> ₂
- Carriera intermedia (settore tecnico, infermieristico)	<input type="checkbox"/> ₃
- Impiegato/a; Segretario/a	<input type="checkbox"/> ₄
- Operaio specializzato (es: edile, elettricista, ecc.)	<input type="checkbox"/> ₅
- Operatore settore Commercio o Servizi	<input type="checkbox"/> ₆
- Operaio	<input type="checkbox"/> ₇
- Altro (specificare: _____)	<input type="checkbox"/> ₈

3. Se è occupato: indichi per cortesia quante giornate di lavoro ha perso, negli ultimi 6 mesi, per motivi di salute:

Numero di giornate non lavorate	
---------------------------------	--

4. Se non è occupato: Indichi per cortesia il numero di settimane di disoccupazione negli ultimi 3 mesi:

Numero di settimane	
---------------------	--

5. Qual è la sua principale fonte di reddito?

- Stipendio/Retribuzione	<input type="checkbox"/> ₁
- Pensione sociale	<input type="checkbox"/> ₂
- Pensione di anzianità	<input type="checkbox"/> ₃
- Pensione di invalidità/inabilità	<input type="checkbox"/> ₄
- Sostegno familiare	<input type="checkbox"/> ₅
- Altro (specificare: _____)	<input type="checkbox"/> ₆

6. Qual è il suo reddito mensile netto derivante da tutte le fonti?

- Meno di 300 Euro	<input type="checkbox"/> ₁
- Da 300 a 500 Euro	<input type="checkbox"/> ₂
- Da 501 a 1.000 Euro	<input type="checkbox"/> ₃
- Da 1.001 a 2.000 Euro	<input type="checkbox"/> ₄
- Più di 2.000 Euro	<input type="checkbox"/> ₅

4. USO DEI SERVIZI SOCIO-SANITARI TERRITORIALI**1. Per cortesia elenchi ogni contatto con i servizi sociali e sanitari nell'arco degli ultimi 12 mesi (Nota: segnare '0' se i servizi non sono stati usati)**

Servizio	N. totale di contatti (nell'arco degli ultimi 12 mesi)
- Medico di Base	
- Neuropsichiatria Infantile	
- Servizio per le Dipendenze/Alcolologia	
- Servizi per la Disabilità	
- Servizio Integrazione Lavorativa	
- Consultorio Familiare	
- Servizio Sociale di base	
- Volontariato/Auto-aiuto/ Cooperative sociali	
- Ospedale Psichiatrico Giudiziario	
- Ufficio Esecuzione Penale Esterna (U.E.P.E.)	
- Tribunale Minorile	
- Altro (specificare: _____)	

2. Nell'arco degli ultimi 12 mesi, ha ricevuto dai servizi sociali un supporto rispetto a (una risposta per riga):

	Sì	No
- Problemi abitativi	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- Problemi lavorativi	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- Problemi legali (es. amministrazione di sostegno)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- Problemi economici	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- Problemi familiari	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- Problemi giudiziari	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
- Altro (specificare: _____)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

3. Ha ricevuto specifiche prestazioni di assistenza sociale?

Sì	<input type="checkbox"/> ₁
No	<input type="checkbox"/> ₂

4. Se sì, indichi che tipo di prestazioni ha ricevuto (più possibilità di risposta):

- Cassa Integrazione	<input type="checkbox"/> ₁
- Indennità di disoccupazione	<input type="checkbox"/> ₂
- Pensione di invalidità/inabilità	<input type="checkbox"/> ₃
- Assegno per malattia	<input type="checkbox"/> ₄
- Contributo per l'affitto	<input type="checkbox"/> ₅
- Integrazione al minimo vitale	<input type="checkbox"/> ₆
- Pensione sociale	<input type="checkbox"/> ₇
- Assegni familiari	<input type="checkbox"/> ₈

APPENDIX 4: CONTINU-UM QUESTIONNAIRE

LA CONTINUITÀ DELLE CURE NELLA SALUTE MENTALE

Analisi dell'esperienza e della soddisfazione degli utenti sulla continuità delle cure nella salute mentale

QUESTIONARIO

Versione tradotta e adattata dello strumento CONTINU-UM (Burns *et al.*, 2007)

- L'obiettivo di questo questionario è di conoscere la percezione, le esperienze e la soddisfazione degli utenti riguardo a vari aspetti della continuità delle cure sperimentati nei precedenti 12 mesi.
- La compilazione non dovrebbe richiedere più di 30 minuti.
- Il questionario copre 16 argomenti. Si raccomanda di leggere attentamente il testo introduttivo di ciascun argomento.
- Ogni argomento contiene tre domande brevi. Si raccomanda di cerchiare la risposta a ciascuna domanda.
- Le tue risposte dovrebbero fare riferimento alle tue esperienze dei servizi in generale.
- Se ritieni che un argomento non sia applicabile alla tua situazione, ti chiediamo di scrivere "NA" vicino al numero della domanda. Se lo desideri a parte puoi anche spiegare perché la domanda non è applicabile.
- Se non sei sicuro su qualcosa puoi tranquillamente chiedere spiegazioni al/ai ricercatore/i.
- Al termine di ciascun argomento hai la possibilità di aggiungere qualcosa, se lo desideri. Ti chiediamo cortesemente di scrivere in maniera chiara nello spazio dedicato.

TEMA 1: ACCESSO AI SERVIZI

Il primo argomento riguarda l'accesso ai servizi. Parliamo di quanto ritieni sia facile ricevere i servizi di cui hai bisogno nel momento in cui ne hai bisogno.

1.a. Quanto è importante per te poter accedere facilmente ai servizi quando ne hai bisogno?

Molto importante	Importante	A volte importante/a volte no	Non importante	Assolutamente non importante
------------------	------------	-------------------------------	----------------	------------------------------

1.b. Negli ultimi 12 mesi, hai potuto accedere facilmente ai servizi quando ne hai avuto bisogno?

Decisamente sì	In gran parte sì	A volte sì/ a volte no	Parzialmente	Decisamente no
----------------	------------------	------------------------	--------------	----------------

1.c. Quanto sei soddisfatto di ciò?

Molto soddisfatto	Soddisfatto	A volte soddisfatto/a volte no	Non soddisfatto	Totalmente insoddisfatto
-------------------	-------------	--------------------------------	-----------------	--------------------------

1.d. Vorresti aggiungere qualcosa sull'accesso ai servizi?

TEMA 2: GAMMA DEI SERVIZI

Questa sezione riguarda tutti i servizi che ricevi. Parliamo dell'intera gamma di servizi che pensi ti possano aiutare (ad esempio: cure mediche specialistiche, assistenza a domicilio, psicoterapia, partecipazione a gruppi di supporto, altro).

2.a. Quanto è importante per te poter ricevere tutti i servizi di cui pensi di aver bisogno?

Molto importante	Importante	A volte importante/a volte no	Non importante	Assolutamente non importante
------------------	------------	-------------------------------	----------------	------------------------------

2.b. Negli ultimi 12 mesi, hai potuto ricevere tutti i servizi di cui pensi di aver bisogno?

Decisamente sì	In gran parte sì	A volte sì/ a volte no	Parzialmente	Decisamente no
----------------	------------------	------------------------	--------------	----------------

2.c. Quanto sei soddisfatto di ciò?

Molto soddisfatto	Soddisfatto	A volte soddisfatto/a volte no	Non soddisfatto	Totalmente insoddisfatto
-------------------	-------------	--------------------------------	-----------------	--------------------------

2.d. Vorresti aggiungere qualcosa sulla gamma dei servizi?

TEMA 3: ATTESA

Questa sezione riguarda l'attesa. Parliamo di quanto devi aspettare per ricevere i servizi di cui hai bisogno.

3.a. Quanto è importante per te non dover aspettare per ricevere i servizi?

Molto importante	Importante	A volte importante/a volte no	Non importante	Assolutamente non importante
------------------	------------	-------------------------------	----------------	------------------------------

3.b. Negli ultimi 12 mesi, hai dovuto aspettare molto per ricevere i servizi?

Decisamente sì	In gran parte sì	A volte sì/ a volte no	Parzialmente	Decisamente no
----------------	------------------	------------------------	--------------	----------------

3.c. Quanto sei soddisfatto di ciò?

Molto soddisfatto	Soddisfatto	A volte soddisfatto/a volte no	Non soddisfatto	Totalmente insoddisfatto
-------------------	-------------	--------------------------------	-----------------	--------------------------

3.d. Vorresti aggiungere qualcosa relativamente all'attesa per ricevere i servizi?

TEMA 4: SUPPORTO FUORI ORARIO

Questa sezione riguarda il supporto che puoi ricevere dai servizi fuori dai normali orari d'ufficio. Parliamo della possibilità di ricevere il supporto di cui hai bisogno in qualsiasi momento del giorno o della notte, durante i fine settimana o in periodi di ferie.

4.a. Quanto è importante per te avere accesso ai servizi fuori dagli orari d'ufficio?

Molto importante	Importante	A volte importante/a volte no	Non importante	Assolutamente non importante
------------------	------------	-------------------------------	----------------	------------------------------

4.b. Negli ultimi 12 mesi, hai avuto accesso ai servizi fuori dagli orari d'ufficio?

Decisamente sì	In gran parte sì	A volte sì/ a volte no	Parzialmente	Decisamente no
----------------	------------------	------------------------	--------------	----------------

4.c. Quanto sei soddisfatto di ciò?

Molto soddisfatto	Soddisfatto	A volte soddisfatto/a volte no	Non soddisfatto	Totalmente insoddisfatto
-------------------	-------------	--------------------------------	-----------------	--------------------------

4.d. Vorresti aggiungere qualcosa sul supporto fuori dagli orari d'ufficio?

TEMA 5: DIMISSIONE OSPEDALIERA

Questa sezione approfondisce ciò che succede quando le persone vengono dimesse dal reparto di psichiatria. Ti chiediamo se ricevi, da parte dei servizi, il supporto di cui hai bisogno quando lasci l'ospedale.

Sei stato dimesso dal reparto di psichiatria negli ultimi 12 mesi?

Sì, passa alla domanda 5.a.

No, passa alla domanda 6.a.

5.a. Quanto è importante per te ricevere dai servizi il supporto di cui hai bisogno quando lasci il reparto di psichiatria?

Molto importante	Importante	A volte importante/a volte no	Non importante	Assolutamente non importante
------------------	------------	-------------------------------------	----------------	---------------------------------

5.b. Negli ultimi 12 mesi, hai ricevuto dai servizi il supporto di cui avevi bisogno quando lasciavi il reparto di psichiatria?

Decisamente sì	In gran parte sì	A volte sì/ a volte no	Parzialmente	Decisamente no
----------------	------------------	---------------------------	--------------	----------------

5.c. Quanto sei soddisfatto di ciò?

Molto soddisfatto	Soddisfatto	A volte soddisfatto/a volte no	Non soddisfatto	Totalmente insoddisfatto
-------------------	-------------	--------------------------------------	-----------------	-----------------------------

5.d. Vorresti aggiungere qualcosa sulla dimissione dal reparto di psichiatria?

TEMA 6: CAMBIAMENTI DELLO STAFF

Questa sezione riguarda i cambiamenti dei membri dello staff. Per rispondere pensa a tutti i professionisti coinvolti nella tua cura (medico, psicologo, assistente sociale, infermiere, ecc.).

6.a. Quanto è importante per te che i professionisti coinvolti nella tua cura non cambino frequentemente?

Molto importante	Importante	A volte importante/a volte no	Non importante	Assolutamente non importante
------------------	------------	-------------------------------------	----------------	---------------------------------

6.b. Negli ultimi 12 mesi, i professionisti coinvolti nella tua cura sono cambiati frequentemente?

Molto spesso	Spesso	Qualche volta	Non spesso	Mai
--------------	--------	---------------	------------	-----

6.c. Quanto sei soddisfatto di ciò?

Molto soddisfatto	Soddisfatto	A volte soddisfatto/a volte no	Non soddisfatto	Totalmente insoddisfatto
-------------------	-------------	--------------------------------------	-----------------	-----------------------------

6.d. Vorresti aggiungere qualcosa sui cambiamenti dello staff?

TEMA 7: INFORMAZIONI

Questa sezione riguarda le informazioni. Con informazioni intendiamo qualsiasi cosa desideri sapere, che può essere scritta o riferita. Nello specifico, ti chiediamo se ricevi dal personale del servizio le informazioni che desideri o di cui hai bisogno.

7.a. Quanto è importante per te ricevere informazioni appropriate dal personale del servizio?

Molto importante	Importante	A volte importante/a volte no	Non importante	Assolutamente non importante
------------------	------------	-------------------------------------	----------------	---------------------------------

7.b. Negli ultimi 12 mesi, hai potuto ricevere informazioni appropriate dal personale del servizio?

Decisamente sì	In gran parte sì	A volte sì/ a volte no	Parzialmente	Decisamente no
----------------	------------------	---------------------------	--------------	----------------

9.c. Quanto sei soddisfatto di ciò?

Molto soddisfatto	Soddisfatto	A volte soddisfatto/a volte no	Non soddisfatto	Totalmente insoddisfatto
-------------------	-------------	--------------------------------------	-----------------	-----------------------------

9.d. Vorresti aggiungere qualcosa sulle informazioni?

TEMA 8: GRADO DI SUPPORTO

Questa sezione riguarda il grado di supporto che ricevi e se questo cambia in base ai tuoi bisogni.

8.a. Quanto è importante per te che il grado di supporto che ricevi dai servizi cambi in base ai tuoi bisogni?

Molto importante	Importante	A volte importante/a volte no	Non importante	Assolutamente non importante
------------------	------------	-------------------------------------	----------------	---------------------------------

8.b. Negli ultimi 12 mesi, il grado di supporto che hai ricevuto dai servizi è cambiato in base ai tuoi bisogni?

Decisamente sì	In gran parte sì	A volte sì/ a volte no	Parzialmente	Decisamente no
----------------	------------------	---------------------------	--------------	----------------

8.c. Quanto sei soddisfatto di ciò?

Molto soddisfatto	Soddisfatto	A volte soddisfatto/a volte no	Non soddisfatto	Totalmente insoddisfatto
-------------------	-------------	--------------------------------------	-----------------	-----------------------------

8.d. Vorresti aggiungere qualcosa sul grado di supporto?

TEMA 9: PROGRESSO INDIVIDUALE

Questa sezione riguarda come gli operatori e i servizi aiutano le persone a fare progressi. Ciò significa che i servizi cercano di aiutarti a progredire, piuttosto che a lasciarti nel punto in cui ti trovi.

9.a. Quanto è importante per te che i servizi cerchino di aiutarti a progredire?

Molto importante	Importante	A volte importante/a volte no	Non importante	Assolutamente non importante
------------------	------------	-------------------------------	----------------	------------------------------

9.b. Negli ultimi 12 mesi, i servizi che hai ricevuto ti hanno aiutato a progredire?

Decisamente sì	In gran parte sì	A volte sì/ a volte no	Parzialmente	Decisamente no
----------------	------------------	------------------------	--------------	----------------

9.c. Quanto sei soddisfatto di ciò?

Molto soddisfatto	Soddisfatto	A volte soddisfatto/a volte no	Non soddisfatto	Totalmente insoddisfatto
-------------------	-------------	--------------------------------	-----------------	--------------------------

9.d. Vorresti aggiungere qualcosa sul progresso individuale?

TEMA 10: CENTRI DIURNI

Questa sezione riguarda i centri diurni. Parliamo della possibilità che avresti di frequentare un centro diurno se lo desiderassi.

10.a. Quanto è importante per te avere accesso a centri diurni che rispondano ai tuoi bisogni?

Molto importante	Importante	A volte importante/a volte no	Non importante	Assolutamente non importante
------------------	------------	-------------------------------	----------------	------------------------------

10.b. Negli ultimi 12 mesi, hai avuto accesso a centri diurni che rispondessero ai tuoi bisogni?

Decisamente sì	In gran parte sì	A volte sì/ a volte no	Parzialmente	Decisamente no
----------------	------------------	------------------------	--------------	----------------

10.c. Quanto sei soddisfatto di ciò?

Molto soddisfatto	Soddisfatto	A volte soddisfatto/a volte no	Non soddisfatto	Totalmente insoddisfatto
-------------------	-------------	--------------------------------	-----------------	--------------------------

10.d. Vorresti aggiungere qualcosa sui centri diurni?

TEMA 11: PROGETTO TERAPEUTICO

Questa sezione riguarda il progetto terapeutico. Un progetto terapeutico è un accordo tra te e gli operatori/servizi su come è organizzato il tuo percorso di cura. Questo comprende le cure mediche, il supporto sociale e quello psicologico.

Hai un progetto terapeutico?

Sì, passa alla domanda 11.a

No, passa alla domanda 12.a

11.a. Quanto è importante per te essere coinvolto nelle decisioni sul tuo progetto terapeutico?

Molto importante	Importante	A volte importante/a volte no	Non importante	Assolutamente non importante
------------------	------------	-------------------------------------	----------------	---------------------------------

11.b. Negli ultimi 12 mesi, sei stato coinvolto nelle decisioni sul tuo progetto terapeutico?

Decisamente sì	In gran parte sì	A volte sì/ a volte no	Parzialmente	Decisamente no
----------------	------------------	---------------------------	--------------	----------------

11.c. Quanto sei soddisfatto di ciò?

Molto soddisfatto	Soddisfatto	A volte soddisfatto/a volte no	Non soddisfatto	Totalmente insoddisfatto
-------------------	-------------	--------------------------------------	-----------------	-----------------------------

11.d. Vorresti aggiungere qualcosa sul progetto terapeutico?

TEMA 12: CRISI

Questa sezione riguarda le modalità con cui affrontare una crisi. Significa che tu, i tuoi familiari o amici ed il servizio avete concordato un piano di intervento per aiutarti quando ne hai estremo bisogno.

12.a. Quanto è importante per te che sia previsto un piano di intervento per affrontare una crisi?

Molto importante	Importante	A volte importante/a volte no	Non importante	Assolutamente non importante
------------------	------------	-------------------------------------	----------------	---------------------------------

12.b. Negli ultimi 12 mesi, ti è sembrato che fosse previsto un piano di intervento per affrontare una tua crisi?

Decisamente sì	In gran parte sì	A volte sì/ a volte no	Parzialmente	Decisamente no
----------------	------------------	---------------------------	--------------	----------------

12.c. Quanto sei soddisfatto di ciò?

Molto soddisfatto	Soddisfatto	A volte soddisfatto/a volte no	Non soddisfatto	Totalmente insoddisfatto
-------------------	-------------	--------------------------------------	-----------------	-----------------------------

12.d. Vorresti aggiungere qualcosa sulla crisi?

TEMA 13: COMUNICAZIONE TRA PROFESSIONISTI

Questa sezione riguarda la comunicazione tra i professionisti che si occupano di te (medico, assistente sociale, psicologo, educatore, ecc.). Significa che le persone coinvolte nella tua cura si confrontano su che cosa succede e sono informati sui cambiamenti del tuo stato di salute e del tuo progetto terapeutico.

13.a. Quanto è importante per te che i professionisti coinvolti nella tua cura comunichino tra di loro?

Molto importante	Importante	A volte importante/a volte no	Non importante	Assolutamente non importante
------------------	------------	-------------------------------------	----------------	---------------------------------

13.b. Negli ultimi 12 mesi, ti è sembrato che i professionisti coinvolti nella tua cura comunicassero tra di loro?

Decisamente sì	In gran parte sì	A volte sì/ a volte no	Parzialmente	Decisamente no
----------------	------------------	---------------------------	--------------	----------------

13.c. Quanto sei soddisfatto di ciò?

Molto soddisfatto	Soddisfatto	A volte soddisfatto/a volte no	Non soddisfatto	Totalmente insoddisfatto
-------------------	-------------	--------------------------------------	-----------------	-----------------------------

13.d. Vorresti aggiungere qualcosa sulla comunicazione tra i professionisti?

TEMA 14: SUPPORTO DAGLI ALTRI UTENTI

Questa sezione riguarda il supporto che ricevi da altre persone che utilizzano i servizi di salute mentale. Parliamo dell'aiuto che ricevi da chi ha vissuto esperienze simili alle tue.

14.a. Quanto è importante per te ricevere supporto da altre persone che hanno avuto un problema di salute mentale?

Molto importante	Importante	A volte importante/a volte no	Non importante	Assolutamente non importante
------------------	------------	-------------------------------------	----------------	---------------------------------

14.b. Negli ultimi 12 mesi, hai ricevuto supporto da altre persone che hanno avuto un problema di salute mentale?

Decisamente sì	In gran parte sì	A volte sì/ a volte no	Parzialmente	Decisamente no
----------------	------------------	---------------------------	--------------	----------------

14.c. Quanto sei soddisfatto di ciò?

Molto soddisfatto	Soddisfatto	A volte soddisfatto/a volte no	Non soddisfatto	Totalmente insoddisfatto
-------------------	-------------	--------------------------------------	-----------------	-----------------------------

14.d. Vorresti aggiungere qualcosa sul supporto da parte di altri utenti?

TEMA 15: RIPETERE LA STORIA DELLA TUA VITA

Questa sezione riguarda la necessità di ripetere la storia della tua vita e spiegare la tua situazione a operatori (medici, psicologi, assistenti sociali, educatori, ecc.) che vedi per la prima volta.

15.a. Quanto è importante per te non dover raccontare la storia della tua vita a nuovi operatori?

Molto importante	Importante	A volte importante/a volte no	Non importante	Assolutamente non importante
------------------	------------	-------------------------------------	----------------	---------------------------------

15.b. Negli ultimi 12 mesi, hai dovuto raccontare la storia della tua vita a nuovi operatori?

Molto spesso	Spesso	Qualche volta	Non spesso	Mai
--------------	--------	---------------	------------	-----

15.c. Quanto sei soddisfatto di ciò?

Molto soddisfatto	Soddisfatto	A volte soddisfatto/a volte no	Non soddisfatto	Totalmente insoddisfatto
-------------------	-------------	--------------------------------------	-----------------	-----------------------------

15.d. Vorresti aggiungere qualcosa sul ripetere la storia della tua vita?

TEMA 16: EVITARE IL CONTATTO CON I SERVIZI

Questa sezione riguarda i contatti che hai con i servizi. Ti chiediamo se puoi scegliere quando vedere i servizi, come pure se puoi scegliere di non avere contatti con i servizi se non lo desideri.

16.a. Quanto è importante per te poter evitare il contatto con i servizi quando lo desideri?

Molto importante	Importante	A volte importante/a volte no	Non importante	Assolutamente non importante
------------------	------------	-------------------------------------	----------------	---------------------------------

16.b. Negli ultimi 12 mesi, ti è stato possibile evitare il contatto con i servizi se lo desideravi?

Decisamente sì	In gran parte sì	A volte sì/ a volte no	Parzialmente	Decisamente no
----------------	------------------	---------------------------	--------------	----------------

16.c. Quanto sei soddisfatto di ciò?

Molto soddisfatto	Soddisfatto	A volte soddisfatto/a volte no	Non soddisfatto	Totalmente insoddisfatto
-------------------	-------------	--------------------------------------	-----------------	-----------------------------

16.d. Vorresti aggiungere qualcosa sull'evitare il contatto con i servizi?

Alcune domande finali

- A. Quale dei temi presenti in questo questionario (dall'1 al 16) è il più importante secondo te? (leggere l'elenco sottostante)

☐

- B. Quale dei temi presenti in questo questionario (dall'1 al 16) è il meno importante secondo te? (leggere l'elenco sottostante)

☐

Elenco dei temi:

1. Accesso ai servizi
2. Gamma dei servizi
3. Attesa
4. Supporto fuori orario
5. Dimissione ospedaliera
6. Cambiamenti dello staff
7. Informazioni
8. Grado di supporto
9. Progresso individuale
10. Centri diurni
11. Progetto terapeutico
12. Crisi
13. Comunicazione tra professionisti
14. Supporto dagli altri utenti
15. Ripetere la storia della tua vita
16. Evitare il contatto con i servizi

- C. Hai trovato qualcuna delle domande:

Stressante?	Sì	<input type="checkbox"/>	No	<input type="checkbox"/>
Confusa?	Sì	<input type="checkbox"/>	No	<input type="checkbox"/>
Difficile da capire?	Sì	<input type="checkbox"/>	No	<input type="checkbox"/>

D. Lunghezza del questionario: Il questionario ti è sembrato..

Troppo lungo? ☐ Giusto? ☐ Troppo corto? ☐

E. Apprezzamento del questionario: Compilare il questionario..

Mi è piaciuto ☐ Mi ha lasciato indifferente ☐ Non mi è piaciuto ☐

F. Quanto è stato facile compilare il questionario?

Facile ☐ Un misto ☐ Difficile ☐

Puoi usare questo spazio per aggiungere dei commenti finali

[illegible]

APPENDIX 5: ASCOT INT-4 QUESTIONNAIRE

ADULT SOCIAL CARE OUTCOMES TOOLKIT (ASCOT)

Versione Italiana

Note per l'intervistatore

1. Definizione di Supporto e Servizi:

L'intervista è flessibile, per far sì che la definizione di supporto e servizi possa essere adattata agli scopi del proprio particolare progetto di ricerca. Nel testo, per definire il supporto e i servizi, l'intervistatore può:

- a. Specificare il nome del particolare servizio che si sta analizzando: per esempio, l'assistenza domiciliare, il budget personale; oppure
- b. (Se l'intervista è focalizzata sull'intera gamma di servizi sociali che l'utente riceve) fornire alcuni esempi del supporto e dei servizi che l'utente riceve.

L'intervista è volta a misurare la qualità di vita degli utenti in relazione all'assistenza ricevuta (Social Care Related Quality of Life, SCRQoL). Abbiamo verificato che una definizione chiara di questo concetto, quindi di ciò che esso include ed esclude, facilita l'intervistato nel rispondere alle domande.

Suggeriamo (benché sia possibile apportare degli adattamenti in base agli scopi specifici della ricerca) quanto segue:

- a. Se ci sono servizi specifici che si desidera escludere (per esempio, i servizi del Sistema Sanitario Nazionale), l'intervistatore dovrà ricordare di non considerare tali servizi nelle domande filtro (es., domanda 2) e in quelle sulla situazione attesa (es., domanda 3).
- b. Si potrebbe anche decidere di includere alcuni servizi del Sistema Sanitario Nazionale, se per esempio si intervistano utenti con problemi psichiatrici che ricevono supporto da un servizio territoriale di salute mentale co-finanziato dai servizi sociali locali e dal Sistema Sanitario Nazionale. In casi del genere, raccomandiamo di chiarire tale aspetto nella definizione di supporto e servizi all'inizio e durante tutta l'intervista.
- c. Può capitare che gli utenti ricevano servizi sociali finanziati da settori diversi da quello sociale. È fondamentale chiedere agli utenti di includere tutti i servizi sociali, indipendentemente dalla fonte di finanziamento, nelle risposte alle domande filtro e a quelle sulla situazione attesa.

2. Suggerimenti per facilitare l'intervista:

- a. Quando si chiede all'utente come sarebbe la qualità della sua vita in assenza dei servizi (domanda sulla situazione attesa, es. domanda 3) è importante:
 - i) Chiarire all'intervistato di non basare le proprie risposte sull'idea che sia intervenuto qualche altro tipo di aiuto.
 - ii) Rassicurare l'intervistato che la domanda si riferisce a una situazione puramente immaginaria e che non incide in nessun modo sui servizi che lui/lei riceve.
- b. Nel corso di tutta l'intervista è importante ripetere la definizione di “supporto e servizi”, poiché le interviste cognitive hanno dimostrato che ciò facilita la risposta.
- c. Nel chiedere all'utente la sua situazione attuale, l'intervistatore dovrà ricordargli/le di fare riferimento al momento presente.

3. Note sulle domande filtro (es., domanda 2): Nel porre le domande filtro è importante:

- a. Spiegare all'intervistato che ciò che si chiede non è se il supporto e i servizi lo aiutano in generale, ma se questi influenzano (in positivo o in negativo) quel particolare aspetto della sua vita (per esempio, “il supporto e i servizi che ricevi influenzano il modo in cui occupi il tuo tempo?”).

4. Note sulla sensibilità dei dati: È importante notare che le domande richiedono all'intervistato di pensare alla propria vita e alle proprie esperienze. Questo può risultare doloroso per alcuni, se per esempio stanno attraversando un momento di difficoltà. Raccomandiamo all'intervistatore di spiegare chiaramente la natura delle domande prima di ottenere il consenso informato, e di sottolineare il diritto dell'intervistato di interrompere l'intervista o di non rispondere a domande specifiche senza ulteriori spiegazioni.

Le domande sulla “situazione attesa” possono essere particolarmente delicate nei casi in cui l'utente abbia sperimentato di recente un taglio del supporto e dei servizi di cui usufruiva. In questi casi è importante che l'intervistatore sia consapevole della potenziale delicatezza delle domande e che sia preparato a terminare o interrompere l'intervista, se necessario.

Introduzione

Per misurare l'impatto che hanno i servizi, vorremmo parlarne con le persone che effettivamente li utilizzano. Pensiamo che siano loro a poter meglio giudicare come i servizi e il supporto che ricevono influenzano la loro vita.

Quando parliamo del “supporto e dei servizi” che ricevi dai Servizi Sociali, ti chiediamo di pensare a:

L'intera gamma di servizi sociali forniti da diverse organizzazioni, quindi dal Sistema Sanitario Nazionale, dagli Enti Locali, dal privato sociale, dal volontariato. Rispetto ai servizi forniti dal Sistema Sanitario Nazionale (es. il Servizio Psichiatrico Territoriale, il Servizio per le Dipendenze, il Consultorio Familiare, ecc.) ti chiediamo di pensare solo al supporto che ricevi dai professionisti del sociale - quindi assistenti sociali, educatori, operatori addetti all'assistenza - presenti all'interno di questi servizi. Non intendiamo qui l'aiuto che puoi ricevere dagli amici, dai familiari o dai vicini e nemmeno il supporto di professionisti sanitari, come i medici, i medici di medicina generale, gli infermieri o i tecnici della riabilitazione.

Ti verranno poste delle domande su diversi aspetti della tua vita in questo momento. Ti verrà anche chiesto se il supporto e i servizi che ricevi hanno un impatto su ciascun aspetto della tua vita. Infine, ti verrà chiesto di immaginare una situazione in cui non avresti il supporto e i servizi che hai a disposizione in questo momento. Si tratta di una situazione puramente immaginaria e la tua risposta non avrà alcun effetto sui servizi che ricevi. L'obiettivo di queste domande è di misurare come i servizi e il supporto che ricevi influenzano la tua vita.

Controllo sulla vita quotidiana

1. Quale delle seguenti frasi descrive al meglio quanto controllo hai sulla tua vita quotidiana?

Nota per l'intervistatore: Per "controllo sulla tua vita quotidiana" s'intende poter scegliere di fare le cose o che gli altri le facciano per te come e quando vuoi.

Per favore spuntare una sola casella	
Ho tutto il controllo che vorrei sulla mia vita quotidiana	<input type="checkbox"/>
Ho un adeguato controllo sulla mia vita quotidiana	<input type="checkbox"/>
Ho un certo controllo sulla mia vita quotidiana ma non abbastanza	<input type="checkbox"/>
Non ho controllo sulla mia vita quotidiana	<input type="checkbox"/>

2. Il supporto e i servizi che ricevi dai Servizi Sociali influenzano il controllo che hai sulla tua vita quotidiana?

Nota per l'intervistatore: Per "supporto e servizi" intendiamo l'intera gamma di servizi sociali forniti da diverse organizzazioni, quindi dal Sistema Sanitario Nazionale, dagli Enti Locali, dal privato sociale, dal volontariato. Rispetto ai servizi forniti dal Sistema Sanitario Nazionale (es. il Servizio Psichiatrico Territoriale, il Servizio per le Dipendenze, il Consultorio Familiare, ecc.) ti chiediamo di pensare solo al supporto che ricevi dai professionisti del sociale - quindi assistenti sociali, educatori, operatori addetti all'assistenza - presenti all'interno di questi servizi. Non intendiamo qui l'aiuto che puoi ricevere dagli amici, dai familiari o dai vicini e nemmeno il supporto di professionisti sanitari, come i medici, i medici di medicina generale, gli infermieri o i tecnici della riabilitazione.

Per favore spuntare una sola casella	
Sì	<input type="checkbox"/>
No	<input type="checkbox"/>
Non so	<input type="checkbox"/>

Se 2=Sì, andare alla domanda 3

Se 2=No, andare alla domanda 4

3. Immagina di non aver ricevuto il supporto e i servizi che ricevi ora dai Servizi Sociali e che non sia intervenuto qualche altro tipo di aiuto. In tale situazione, quale delle seguenti frasi descriverebbe al meglio quanto controllo avresti sulla tua vita quotidiana?

Nota per l'intervistatore: È importante che la persona non basi le proprie risposte sull'idea che sia intervenuto qualche altro tipo di aiuto; raccomandiamo di sottolineare questo aspetto. Se necessario si può rassicurare l'intervistato che si tratta di una situazione puramente immaginaria che non influisce in nessun modo sui servizi ricevuti.

Per favore spuntare una sola casella	
Avrei tutto il controllo che vorrei sulla mia vita quotidiana	<input type="checkbox"/>
Avrei un adeguato controllo sulla mia vita quotidiana	<input type="checkbox"/>
Avrei un certo controllo sulla mia vita quotidiana ma non abbastanza	<input type="checkbox"/>
Non avrei controllo sulla mia vita quotidiana	<input type="checkbox"/>

Pulizia e comfort personale

4. Pensando alla tua pulizia personale e al tuo aspetto, quale delle seguenti frasi descrive al meglio la tua situazione?

Per favore spuntare una sola casella

Mi sento pulito e capace di presentarmi come mi piace	<input type="checkbox"/>
Mi sento adeguatamente pulito e presentabile	<input type="checkbox"/>
Non mi sento abbastanza pulito o presentabile	<input type="checkbox"/>
Non mi sento per niente pulito o presentabile	<input type="checkbox"/>

5. Il supporto e i servizi che ricevi dai Servizi Sociali influiscono sulla tua cura personale, ossia sul modo in cui ti senti pulito e presentabile?

Nota per l'intervistatore: Per "supporto e servizi" intendiamo l'intera gamma di servizi sociali forniti da diverse organizzazioni, quindi dal Sistema Sanitario Nazionale, dagli Enti Locali, dal privato sociale, dal volontariato. Rispetto ai servizi forniti dal Sistema Sanitario Nazionale (es. il Servizio Psichiatrico Territoriale, il Servizio per le Dipendenze, il Consultorio Familiare, ecc.) ti chiediamo di pensare solo al supporto che ricevi dai professionisti del sociale - quindi assistenti sociali, educatori, operatori addetti all'assistenza - presenti all'interno di questi servizi. Non intendiamo qui l'aiuto che puoi ricevere dagli amici, dai familiari o dai vicini e nemmeno il supporto di professionisti sanitari, come i medici, i medici di medicina generale, gli infermieri o i tecnici della riabilitazione.

Per favore spuntare una sola casella

Sì	<input type="checkbox"/>
No	<input type="checkbox"/>
Non so	<input type="checkbox"/>

Se 5=Sì, andare alla domanda 6

Se 5=No, andare alla domanda 7

6. Immagina di non aver ricevuto il supporto e i servizi che ricevi ora dai Servizi Sociali e che non sia intervenuto qualche altro tipo di aiuto. Quale delle seguenti frasi descriverebbe al meglio la tua pulizia personale e il tuo aspetto?

Nota per l'intervistatore: È importante che la persona non basi le proprie risposte sull'idea che sia intervenuto qualche altro tipo di aiuto; raccomandiamo di sottolineare questo aspetto. Se necessario si può rassicurare l'intervistato che si tratta di una situazione puramente immaginaria che non influisce in nessun modo sui servizi ricevuti.

Per favore spuntare una sola casella

Mi sentirei pulito e capace di presentarmi come mi piace	<input type="checkbox"/>
Mi sentirei adeguatamente pulito e presentabile	<input type="checkbox"/>
Non mi sentirei abbastanza pulito o presentabile	<input type="checkbox"/>
Non mi sentirei per niente pulito o presentabile	<input type="checkbox"/>

Cibo e bevande

7. Pensando al cibo e alle bevande che hai a disposizione, quale delle seguenti frasi descrive al meglio la tua situazione?

Per favore spuntare una sola casella	
Ho a disposizione tutto il cibo e le bevande che mi piacciono quando lo desidero	<input type="checkbox"/>
Ho a disposizione cibo e bevande adeguate al momento opportuno	<input type="checkbox"/>
Non sempre ho a disposizione cibo e bevande adeguate o al momento opportuno	<input type="checkbox"/>
Non sempre ho a disposizione cibo e bevande adeguate o al momento opportuno, e penso che questo comporti un rischio per la mia salute	<input type="checkbox"/>

8. Il supporto e i servizi che ricevi dai Servizi Sociali influenzano la disponibilità che hai di cibo e bevande che desideri o di cui hai bisogno?

Nota per l'intervistatore: Per "supporto e servizi" intendiamo l'intera gamma di servizi sociali forniti da diverse organizzazioni, quindi dal Sistema Sanitario Nazionale, dagli Enti Locali, dal privato sociale, dal volontariato. Rispetto ai servizi forniti dal Sistema Sanitario Nazionale (es. il Servizio Psichiatrico Territoriale, il Servizio per le Dipendenze, il Consultorio Familiare, ecc.) ti chiediamo di pensare solo al supporto che ricevi dai professionisti del sociale - quindi assistenti sociali, educatori, operatori addetti all'assistenza - presenti all'interno di questi servizi. Non intendiamo qui l'aiuto che puoi ricevere dagli amici, dai familiari o dai vicini e nemmeno il supporto di professionisti sanitari, come i medici, i medici di medicina generale, gli infermieri o i tecnici della riabilitazione.

Per favore spuntare una sola casella	
Sì	<input type="checkbox"/>
No	<input type="checkbox"/>
Non so	<input type="checkbox"/>

Se 8=Sì, andare alla domanda 9

Se 8=No, andare alla domanda 10

9. Immagina di non aver ricevuto il supporto e i servizi che ricevi ora dai Servizi Sociali e che non sia intervenuto qualche altro tipo di aiuto. Quale delle seguenti frasi descriverebbe al meglio la tua situazione rispetto al cibo e alle bevande?

Nota per l'intervistatore: È importante che la persona non basi le proprie risposte sull'idea che sia intervenuto qualche altro tipo di aiuto; raccomandiamo di sottolineare questo aspetto. Se necessario si può rassicurare l'intervistato che si tratta di una situazione puramente immaginaria che non influisce in nessun modo sui servizi ricevuti.

Per favore spuntare una sola casella	
Avrei a disposizione tutto il cibo e le bevande che mi piacciono quando lo desidero	<input type="checkbox"/>
Avrei a disposizione cibo e bevande adeguate al momento opportuno	<input type="checkbox"/>
Non sempre avrei a disposizione cibo e bevande adeguate o al momento opportuno	<input type="checkbox"/>
Non sempre avrei a disposizione cibo e bevande adeguate o al momento opportuno, e penso che questo comporterebbe un rischio per la mia salute	<input type="checkbox"/>

Sicurezza personale

10. Quale delle seguenti frasi descrive al meglio quanto ti senti sicuro?

Nota per l'intervistatore: Con “sentirsi sicuro” si intende quanto sicuro ti senti sia dentro che fuori casa. Include la paura di ricevere abusi, di cadere, o di subire un danno fisico.

Per favore spuntare una sola casella	
Mi sento sicuro quanto vorrei	<input type="checkbox"/>
Generalmente mi sento adeguatamente sicuro, ma non quanto vorrei	<input type="checkbox"/>
Non mi sento abbastanza sicuro	<input type="checkbox"/>
Non mi sento per niente sicuro	<input type="checkbox"/>

11. Il supporto e i servizi che ricevi dai Servizi Sociali influiscono su quanto ti senti sicuro?

Nota per l'intervistatore: Per “supporto e servizi” intendiamo l'intera gamma di servizi sociali forniti da diverse organizzazioni, quindi dal Sistema Sanitario Nazionale, dagli Enti Locali, dal privato sociale, dal volontariato. Rispetto ai servizi forniti dal Sistema Sanitario Nazionale (es. il Servizio Psichiatrico Territoriale, il Servizio per le Dipendenze, il Consultorio Familiare, ecc.) ti chiediamo di pensare solo al supporto che ricevi dai professionisti del sociale - quindi assistenti sociali, educatori, operatori addetti all'assistenza - presenti all'interno di questi servizi. Non intendiamo qui l'aiuto che puoi ricevere dagli amici, dai familiari o dai vicini e nemmeno il supporto di professionisti sanitari, come i medici, i medici di medicina generale, gli infermieri o i tecnici della riabilitazione.

Per favore spuntare una sola casella	
Sì	<input type="checkbox"/>
No	<input type="checkbox"/>
Non so	<input type="checkbox"/>

Se 11=Sì, andare alla domanda 12

Se 11=No, andare alla domanda 13

12. Immagina di non aver ricevuto il supporto e i servizi che ricevi ora dai Servizi Sociali e che non sia intervenuto qualche altro tipo di aiuto. In tale situazione, quale delle seguenti frasi descriverebbe al meglio quanto ti sentiresti sicuro?

Nota per l'intervistatore: È importante che la persona non basi le proprie risposte sull'idea che sia intervenuto qualche altro tipo di aiuto; raccomandiamo di sottolineare questo aspetto. Se necessario si può rassicurare l'intervistato che si tratta di una situazione puramente immaginaria e che non influisce in nessun modo sui servizi ricevuti.

Per favore spuntare una sola casella	
Mi sentirei sicuro quanto vorrei	<input type="checkbox"/>
Generalmente mi sentirei adeguatamente sicuro, ma non quanto vorrei	<input type="checkbox"/>
Non mi sentirei abbastanza sicuro	<input type="checkbox"/>
Non mi sentirei per niente sicuro	<input type="checkbox"/>

Partecipazione e coinvolgimento sociale

13. Pensando ai contatti che hai con persone che ti piacciono, quale delle seguenti frasi descrive al meglio la tua situazione sociale?

Per favore spuntare una sola casella

Ho tutti i contatti sociali che desidero con persone che mi piacciono	<input type="checkbox"/>
Ho un numero di contatti sociali adeguato	<input type="checkbox"/>
Ho qualche contatto sociale ma non abbastanza	<input type="checkbox"/>
Ho pochi contatti sociali e mi sento socialmente isolato	<input type="checkbox"/>

14. Il supporto e i servizi che ricevi dai Servizi Sociali influiscono su quanti contatti hai con persone che ti piacciono?

Nota per l'intervistatore: Per "supporto e servizi" intendiamo l'intera gamma di servizi sociali forniti da diverse organizzazioni, quindi dal Sistema Sanitario Nazionale, dagli Enti Locali, dal privato sociale, dal volontariato. Rispetto ai servizi forniti dal Sistema Sanitario Nazionale (es. il Servizio Psichiatrico Territoriale, il Servizio per le Dipendenze, il Consultorio Familiare, ecc.) ti chiediamo di pensare solo al supporto che ricevi dai professionisti del sociale - quindi assistenti sociali, educatori, operatori addetti all'assistenza - presenti all'interno di questi servizi. Non intendiamo qui l'aiuto che puoi ricevere dagli amici, dai familiari o dai vicini e nemmeno il supporto di professionisti sanitari, come i medici, i medici di medicina generale, gli infermieri o i tecnici della riabilitazione.

Per favore spuntare una sola casella

Sì	<input type="checkbox"/>
No	<input type="checkbox"/>
Non so	<input type="checkbox"/>

Se 14=Sì, andare alla domanda 15

Se 14=No, andare alla domanda 16

15. Immagina di non aver ricevuto il supporto e i servizi che ricevi ora dai Servizi Sociali e che non sia intervenuto qualche altro tipo di aiuto. In tale situazione, quale delle seguenti frasi descriverebbe al meglio i contatti che avresti con persone che ti piacciono?

Nota per l'intervistatore: È importante che la persona non basi le proprie risposte sull'idea che sia intervenuto qualche altro tipo di aiuto; raccomandiamo di sottolineare questo aspetto. Se necessario si può rassicurare l'intervistato che si tratta di una situazione puramente immaginaria che non influisce in nessun modo sui servizi ricevuti.

Per favore spuntare una sola casella

Avrei tutti i contatti sociali che desidero con persone che mi piacciono	<input type="checkbox"/>
Avrei un numero di contatti sociali adeguato	<input type="checkbox"/>
Avrei qualche contatto sociale, ma non abbastanza	<input type="checkbox"/>
Avrei pochi contatti sociali e mi sentirei socialmente isolato	<input type="checkbox"/>

Occupazione

16. Quale delle seguenti frasi descrive al meglio come occupi il tuo tempo?

Nota per l'intervistatore: Se è necessario aiutare l'intervistato, si può dire: “Quando pensi a come occupi il tuo tempo, includi qualsiasi cosa ritieni importante e che ti piace, quindi le attività di svago, il lavoro, le attività di volontariato, il lavoro non remunerato e la cura per gli altri”.

Per favore spuntare una sola casella

Posso occupare il mio tempo come desidero, facendo cose che ritengo importanti o che mi piacciono	<input type="checkbox"/>
---	--------------------------

Posso fare abbastanza delle cose che ritengo importanti e che mi piacciono con il tempo che ho a disposizione	<input type="checkbox"/>
---	--------------------------

Faccio un po' delle cose che ritengo importanti e che mi piacciono con il tempo che ho a disposizione, ma non abbastanza	<input type="checkbox"/>
--	--------------------------

Non faccio nessuna delle cose che ritengo importanti o che mi piacciono con il tempo che ho a disposizione	<input type="checkbox"/>
--	--------------------------

17. Il supporto e i servizi che ricevi dai Servizi Sociali influenzano il modo in cui occupi il tuo tempo?

Nota per l'intervistatore: Per “supporto e servizi” intendiamo l'intera gamma di servizi sociali forniti da diverse organizzazioni, quindi dal Sistema Sanitario Nazionale, dagli Enti Locali, dal privato sociale, dal volontariato. Rispetto ai servizi forniti dal Sistema Sanitario Nazionale (es. il Servizio Psichiatrico Territoriale, il Servizio per le Dipendenze, il Consultorio Familiare, ecc.) ti chiediamo di pensare solo al supporto che ricevi dai professionisti del sociale - quindi assistenti sociali, educatori, operatori addetti all'assistenza - presenti all'interno di questi servizi. Non intendiamo qui l'aiuto che puoi ricevere dagli amici, dai familiari o dai vicini e nemmeno il supporto di professionisti sanitari, come i medici, i medici di medicina generale, gli infermieri o i tecnici della riabilitazione.

Per favore spuntare una sola casella

Sì	<input type="checkbox"/>
----	--------------------------

No	<input type="checkbox"/>
----	--------------------------

Non so	<input type="checkbox"/>
--------	--------------------------

Se 17=Sì, andare alla domanda 18

Se 17=No, andare alla domanda 19

18. Immagina di non aver ricevuto il supporto e i servizi che ricevi ora dai Servizi Sociali e che non sia intervenuto qualche altro tipo di aiuto. In tale situazione, quale delle seguenti frasi descriverebbe al meglio come occuperesti il tuo tempo?

Nota per l'intervistatore: È importante che la persona non basi le proprie risposte sull'idea che sia intervenuto qualche altro tipo di aiuto; raccomandiamo di sottolineare questo aspetto. Se necessario si può rassicurare l'intervistato che *si tratta di una situazione puramente immaginaria che non influisce in nessun modo sui servizi ricevuti.*

Per favore spuntare una sola casella

Potrei occupare il mio tempo come desidero, facendo cose che ritengo importanti o che mi piacciono ☐

Potrei fare abbastanza delle cose che ritengo importanti e che mi piacciono con il tempo che avrei a disposizione ☐

Farei un po' delle cose che ritengo importanti e che mi piacciono con il tempo che avrei a disposizione, ma non abbastanza ☐

Non farei nessuna delle cose che ritengo importanti o che mi piacciono con il tempo che avrei a disposizione ☐

Pulizia e comfort della casa

19. Quale delle seguenti frasi descrive al meglio quanto è pulita e confortevole la tua casa?

Per favore spuntare una sola casella

La mia casa è pulita e confortevole quanto vorrei ☐

La mia casa è adeguatamente pulita e confortevole ☐

La mia casa non è abbastanza pulita o confortevole ☐

La mia casa non è per niente pulita o confortevole ☐

20. Il supporto e i servizi che ricevi dai Servizi Sociali influiscono sulla pulizia e il comfort della tua casa?

Nota per l'intervistatore: Per "supporto e servizi" intendiamo l'intera gamma di servizi sociali forniti da diverse organizzazioni, quindi dal Sistema Sanitario Nazionale, dagli Enti Locali, dal privato sociale, dal volontariato. Rispetto ai servizi forniti dal Sistema Sanitario Nazionale (es. il Servizio Psichiatrico Territoriale, il Servizio per le Dipendenze, il Consultorio Familiare, ecc.) ti chiediamo di pensare solo al supporto che ricevi dai professionisti del sociale - quindi assistenti sociali, educatori, operatori addetti all'assistenza - presenti all'interno di questi servizi. Non intendiamo qui l'aiuto che puoi ricevere dagli amici, dai familiari o dai vicini e nemmeno il supporto di professionisti sanitari, come i medici, i medici di medicina generale, gli infermieri o i tecnici della riabilitazione.

Per favore spuntare una sola casella

Sì ☐

No ☐

Non so ☐

Se 20=Sì, andare alla domanda 21

Se 20=No, andare alla domanda 22

21. Immagina di non aver ricevuto il supporto e i servizi che ricevi ora dai Servizi Sociali e che non sia intervenuto qualche altro tipo di aiuto. In tale situazione, quale delle seguenti frasi descriverebbe al meglio quanto la tua casa sarebbe pulita e confortevole?

Nota per l'intervistatore: È importante che la persona non basi le proprie risposte sull'idea che sia intervenuto qualche altro tipo di aiuto; raccomandiamo di sottolineare questo aspetto. Se necessario si può rassicurare l'intervistato che *si tratta di una situazione puramente immaginaria che non influisce in nessun modo sui servizi ricevuti.*

Per favore spuntare una sola casella

La mia casa sarebbe pulita e confortevole quanto vorrei	<input type="checkbox"/>
La mia casa sarebbe adeguatamente pulita e confortevole	<input type="checkbox"/>
La mia casa non sarebbe abbastanza pulita o confortevole	<input type="checkbox"/>
La mia casa non sarebbe per niente pulita o confortevole	<input type="checkbox"/>

Dignità

22. Il fatto di ricevere assistenza come influenza la considerazione che hai di te stesso?

Per favore spuntare una sola casella

Ricevere assistenza mi fa avere una migliore considerazione di me stesso	<input type="checkbox"/>
Ricevere assistenza non influenza la considerazione che ho di me stesso	<input type="checkbox"/>
Ricevere assistenza a volte mi fa avere una scarsa considerazione di me stesso	<input type="checkbox"/>
Ricevere assistenza mi fa avere sempre una scarsa considerazione di me stesso	<input type="checkbox"/>

23. Il modo in cui vieni assistito e trattato come influenza la considerazione che hai di te stesso?

Per favore spuntare una sola casella

Il modo in cui vengo assistito e trattato mi fa avere una migliore considerazione di me stesso	<input type="checkbox"/>
Il modo in cui vengo assistito e trattato non influenza la considerazione che ho di me stesso	<input type="checkbox"/>
Il modo in cui vengo assistito e trattato qualche volta mi fa avere una scarsa considerazione di me stesso	<input type="checkbox"/>
Il modo in cui vengo assistito e trattato mi fa avere sempre una scarsa considerazione di me stesso	<input type="checkbox"/>

APPENDIX 6: DATA FROM MENTAL HEALTH INFORMATION SYSTEMS

SCHEDA SULL'UTILIZZAZIONE DEI SERVIZI

Compilata attraverso il sistema informativo per i servizi di salute mentale

1. Diagnosi secondo il Sistema di Classificazione ICD-10:

- Diagnosi:
- Raggruppamento:

2. Qual è la data del primo contatto con il servizio psichiatrico territoriale?

/ /

3. Elencare ogni ricovero presso il Servizio Psichiatrico di Diagnosi e Cura (SPDC) avuto nell'arco degli ultimi 12 mesi (Nota: segnare '0' se i servizi non sono stati usati)

N. Ricoveri		N. totale di giorni di ricovero (nell'arco degli ultimi 12 mesi)	
-------------	--	--	--

4. Elencare ogni utilizzo dei servizi psichiatrici territoriali nell'arco degli ultimi 12 mesi (Nota: segnare '0' se i servizi non sono stati usati)

Servizio	N. di contatti
- Contatti ambulatoriali territoriali	
- Contatti ambulatoriali ospedalieri	
- Centro Diurno (attività riabilitative)	
- Day hospital ospedaliero	
- Day hospital territoriale	
- Visite domiciliari	
- Altro (specificare: _____)	

5. Elencare ogni contatto con i professionisti del servizio psichiatrico territoriale nell'arco degli ultimi 12 mesi

Servizio	Contatti Sì/No (nell'arco degli ultimi 12 mesi)
- Psichiatra/Specializzando in Psichiatria	Sì <input type="checkbox"/> ₁ No <input type="checkbox"/> ₀
- Psicologo	Sì <input type="checkbox"/> ₁ No <input type="checkbox"/> ₀
- Infermiere	Sì <input type="checkbox"/> ₁ No <input type="checkbox"/> ₀
- Assistente sociale	Sì <input type="checkbox"/> ₁ No <input type="checkbox"/> ₀
- Educatore/ Tecnico della Riabilitazione Psichiatrica/O.S.S.	Sì <input type="checkbox"/> ₁ No <input type="checkbox"/> ₀
- Altro (specificare)	Sì <input type="checkbox"/> ₁ No <input type="checkbox"/> ₀

6. Negli ultimi 2 anni si sono interrotti o sospesi per più di 6 mesi i contatti con lo Psichiatra?

Sì	<input type="checkbox"/> ₁
No	<input type="checkbox"/> ₂

