19.00 €

vol. LXIV. September-December 2016

N° 277

Four-monthly Journal
ISSN 0006-6761

BPA

3/3

Bollettino di Psicologia Applicata

APPLIED PSYCHOLOGY BULLETIN

Indexed in PsycINFO® – Scopus Bibliographic Database

Research

Experiences & Tools

GIUNTI O.S. Organizzazioni Speciali

CONTENTS

⬢ Research

▲ Experiences & Tools

A quali-quantitative study on the definition of types of non-hospital residential facilities for psychiatric patients

Massimo Miglioretti[1], Augusto Monge Roffarello[2], Marcella Ercole[2], Fabrizio Zucca[2]

[1] Department of Psychology, University of Milano-Bicocca, Milan, Italy
[2] Studio Co.S.S. – Consulting & Services for Health, Turin, Italy

ABSTRACT. Questo studio si proposto di identificare alcune tipologie di strutture residenziali per pazienti psichiatrici presenti sul territorio e verificare se vi siano differenze tra i pazienti che vivono in ciascuna di queste. Lo studio, quali-quantitativo, ha permesso di identificare 8 tipologie di strutture. Ciascuna di esse ospitava pazienti psichiatrici con caratteristiche significativamente differenti. Tale classificazione delle strutture residenziali per pazienti psichiatrici può essere utile in sede di programmazione sanitaria in quanto mette in luce i diversi approcci di cura che vengono utilizzati negli interventi di comunità e l'identità specifica di ogni approccio.

SUMMARY. The de-institutionalisation of psychiatric patients has led to the construction of various forms of residential facilities for people with mental illness in the community. This study had two aims: to identify the types of residential facilities for psychiatric patients and to determine whether there are differences between patients who live in different types of these. A mixed method approach was used. Interviews with the managers of 13 residential facilities were carried out. Quantitative data about the environmental characteristics, human resources, and characteristics of patients recovered of each residential facility were collected. We identified 8 types of facilities. The characteristics of the psychiatric patients of each residential facility were significantly different from those of the patients of the others. The classification of residential facilities for psychiatric patients is useful for describing different approaches to care that are used in community interventions and the identify the specificity of each approaches.

Keywords: *Residential facilities, Psychiatric patients, Communities treatment, Mixed method approach*

BACKGROUND

Reviews of the systems of psychiatric services that began mainly in the second part of the last century in Italy and, more generally, in Europe have led to the goal of de-institutionalisation. Several studies have shown that the dissolution of the asylum system has favoured the emergence of various residential solutions that are more or less integrated with the community and offer different types of assistance and rehabilitative or therapeutic possibilities (Brunt & Hansson, 2002; de Girolamo et al., 2007; Fakhoury, Murray, Shepherd & Priebe, 2002; Lora, 2009). Most research on this subject has highlighted how these solutions have effectively responded to the different needs of users, although questions remain about the quality of care offered and the integration of these solutions into a coherent system (de Girolamo et al., 2007; Morris, Lora, McBain & Saxena, 2012; Thornicroft & Tansella, 2004).

In recent years in Europe, some attention has been paid to how targeted structures for the assistance, care and rehabilitation of patients with psychiatric disorders have been developing. The DEMoBinc project (Development of a European Measure of Best Practice for People with Long Term Mental Illness in Institutional Care) is a striking example. This project is aimed at building and validating an appropriate tool to assess the living conditions and care quality provided to patients enrolled in psychiatric residential facilities (Taylor et al., 2009). This project has led to the development of the QuIRC (Quality Indicator for Rehabilitative Care), which was the first tool to compare, in the very diverse context of European psychiatric care, aspects of the quality of services provided by residential facilities for psychiatric patients (Killaspy et al., 2011).

In Italy, the PROGRES research programme was intended to carry out the first survey of, and an initial evaluation of, the complete range of assistance facilities that arose after the approval of Law 180, which mandated deinstitutionalisation and disclosure by psychiatric hospitals. This research is unique in its descriptive power and the quality of the data acquired and has highlighted several positive aspects of residential facilities and their operation, but it has also clearly left some gaps; for example, the current research has failed to ascribe any therapeutic-rehabilitative qualities to these facilities, which are described as "homes for life" rather than transitional support (Picardi, de Girolamo & Morosini, 2003). This research has shown that, in Italy, heterogeneous residential facilities for psychiatric patients have been developed. Currently, a classification system is needed to account for both the services that these facilities provide and the needs of the users of these facilities (Santone et al. 2005).

This study was developed in light of existing questions about the definitions of appropriate criteria for the indication of treatment, care and rehabilitation programs for residential facilities for psychiatric patients that have arisen in the Italian context. The present work had two primary, inter-connected aims. The first was to identify the different types of residential facilities for psychiatric patients; this process began with an analysis of the services that each facility provided and continued by defining aspects of the methods, assistance processes, treatments and rehabilitation of the guests of each residential facility type. Second, this research sought to identify differences between patients who live in each type of residential facility identified.

METHOD

Participants

Five private companies took part in this research; some of these companies owned a single residential facility, and others owned and/or operated multiple residential facilities in both the Piedmont or, more generally, in Northern Italy. Seven semi-structured interviews were carried out with the managers of the facilities (team-leaders of community staffs and presidents and CEOs of the companies) that resulted in the collection of data from 13 different residential facilities. These facilities included the following: two high-intensity therapeutic communities [Type A communities in terms of the legislation of the Piedmont region (Com.1, Com.2)], two middle-intensity therapeutic communities [Type B communities in terms of the legislation of the Piedmont region (Com.3, Com.4)], a housing community (Com.5), and eight groups housed in apartments (AG 1, AG 2, AG 3, AG 4, AG 5, AG 6, AG 7, AG 8). Overall, 121 patients lived in the communities that were examined (male: 79.3%; age: 39.77±12.48). Among these patients, 42.5% suffered from schizophrenia or other psychotic disorders, 10% had diagnoses of personality disorders, 1.7% had mood disorders, 38.3% had diagnoses of both psychiatric disorders and substance abuse, and 7.5% had diagnoses both of psychiatric disorders and intellectual deficits. The patients had been living in the same residential facilities for 28.70±35.71 months.

Procedure

This research follows the methodological approach known as the mixed-method approach (Johnson & Owuebugzie, 2004). This method is characterised by a highly pragmatic understanding of research results that employs both qualitative and quantitative methods to answer research questions. It was considered useful to integrate qualitative and quantitative data to describe the different types of community residential facilities to achieve a flexible, yet logical, comparison of the different aspects of each facility. Specifically, this research involved the integration of the following diverse data sources: documentary material collected in the various residential facilities for psychiatric patients (e.g., from the website of the provider, the service charter, the project structure, the procedural rules and the therapeutic contract); semi-structured interviews with the management of each facility (to analyse cultural and organisational characteristics of the different residential facilities); and tabulated quantitative data about the human resources of each community residential facility. Table 1 shows a summary of the themes studied and the integration of the main data sources that were used to gather information in each area. Moreover, to identify differences between users of the different types of residential facilities studied, tabulated quantitative data about patients were collected. Specifically, the team leaders of the community staffs provided data about the socio-demographic (e.g., age and sex), clinical (e.g., diagnoses and age of diagnoses) and therapeutic statuses of each patient.

All interviews were recorded and transcribed and, together with documentary material, were analysed with a content analysis procedure. This procedure involved reading of the collected qualitative material by each member of the research group and the creation of an analysis matrix that defined codes that analytically described the emergent content of the interviews. Table 2 shows the codes used and their definitions.

This process was followed by insertion of the material collected (from interviews or documents taken from the different facilities) in a matrix of codes. Finally, the research group created a range of second-order categories, which began with first codes, through a process of group discussion. Based on these secondary order categories, our research group developed typologies of facilities studied that were used in the next phases of this study.

The quantitative data were analysed with SPSS 18 statistical software to highlight, using the simplest statistical indices (ANOVA's, Student's t-tests, χ^2), any differences or similarities amongst the diverse types of facilities identified and their users.

Table 1 – Summary of the themes studied in this research and the main data sources of this research

Themes investigated	Sources
Mission and goals of facility, as well as theoretical raison-d'être and development plan	Interviews with management, project structure and card services
General characteristics of the facility (name, date of establishment, type of facility by regional classification nomenclature, m^2, number of rooms, number of beds, hours of coverage, number of guests present, number of admissions and discharges in 2011)	Data collection sheet, interviews with management
The user route within the system (selection framework of the referrer, admission, evaluation, intervention, follow-up) (Ovretveit 1996)	Interviews with management
Activities and services offered by the facility (type of activity, leader, frequency of participation)	Data collection sheet, interviews with management
Staff organisation within the facility, staff management (characteristics, roles, recruitment process)	Data collection sheet, interview with management
Referrers' network	Interview with management

Table 2 – Analysis matrix for qualitative material

Content categories	Description
Mission and objectives of the facility	All the contents that refer to the culture and values that form the basis of the facility are reported here; to these are added objectives as they emerge from the collected material
Environmental characteristics of the facility	All physical, spatial and geographical location references to the facilities are reported here
User pathway	The general characteristics of the user pathway (but only limited information about the specific characteristics of each phase) are reported here
Selection, admission and assessment	This category refers to specific procedures carried out by the facility to select, evaluate and welcome guests
Treatment	Types of interventions provided by the facility, together with assumptions and values that underpin the different types of treatment proposed
Relationship with family members	Material relating to activities with and for the guests' families is reported here
Relations with the community	Material about the use of the surrounding community as a resource for the guest, including where the use of community resources to treat or rehabilitate guests are highlighted
Guest features	Material covering all attempts to categorise guests by diagnosis, and, more widely, by characteristics that would favour or not favour a successful outcome
Staff and their characteristics	Material defining or specifying the staff who are necessary and fundamental to the work in the facility is reported here
Staff management	Staff selection methods, the degree to which staff "sign-up" to the aims and ideals of the organisation, whether training is provided
Referral networks	Material describing referrers: their number, geographic proximity, and similarities or dissimilarities in terms of operational methodology

RESULTS

The content analysis we conducted permitted us to postulate that different types of facilities exist for psychiatric patients. These types were constructed based on two reference axes. The first axis was substantially related to the physical and environmental characteristics of these facilities and the support hours provided by the staff. We considered the number of beds for each structure, the space dedicated to each guest (in m3 for guest), the space for rehabilitative activity, and the number of hours dedicated by every member of the staff (psychiatrist, nurses, psychologist, educators). On this first axis, the first type of facility refers to large structures with a large number of beds that are normally defined as communities. In contrast, we also identified types of facilities that were akin to normal living spaces, i.e., smaller structures with a more limited number of beds, which are referred to here as protected homes and apartment groups and are grouped by the amount of support hours provided by the staff. The first group entailed very high support (24 hours), and the second group entailed more limited support (4, 6, or 8 hours per day).

The second axis that emerged from the other identified content categories refers to the operating methodologies chosen by each facility to work with guests. Here, we classified the structures in relation to their philosophy and their position about rehabilitation and recovery of patients with mental disorders. In this work we use, as theoretical framework, the model of recovery, in which the word "recovery" refers "both to internal conditions— the attitudes, experiences, and processes of change of individuals who are recovering—and external conditions—the circumstances, events, policies, and practices that may facilitate recovery. Together, internal and external conditions produce the process called recovery. These conditions have a reciprocal effect, and the process of recovery, once realized, can itself become a factor that further transforms both internal and external conditions" (Jacobson & Greenley, 2001, p. 482). In this axis, the first type of structures uses methodologies that focus on the care and management of what we call the guests' social skills. These facilities focus on rehabilitation, have a close relationship with the local community, and develop occupational therapy-based activities for their guests in partnership with local authorities and churches. In addition, the facilities that favour this approach were quite well organised and regulated and ensured that guests had supervised, secure accommodations. The second type refers to the operating methods of facilities that were strongly rooted in everyday life. These facilities favoured maintenance-stabilisation rather than change in their users. These facilities offered long-term residence spanning several years, the creation of space and autonomous projects that were "protected" by a low-key staff presence. These structures were particularly flexible, staff carried out educational activities and treatment, and planning was strongly determined on a case-by-case basis. The interviews revealed that these facilities had older guests with longer histories of illness.

Finally, there was a third type of facility that was characterised by operating methods that focused mainly on the mental and intrapsychic functioning of the guests. Establishments favouring this type of work were characterised by strong psychotherapeutic frameworks, which were typified by acceptance procedures, evaluations of the guests and well-defined activities that often occurred in groups. These facilities provided stays of finite durations (one or two years), and the goal of these facilities was to change the individual. From the perspective of these facilities, crisis-management is preferred to crisis-avoidance as a specific working objective. These facilities contained higher proportions of staff who were trained specifically for psychiatric and psychotherapeutic work (psychotherapists, psychiatrists).

Table 3 graphically represents these different axes and the different structures that were analysed in our research. In summary, we identified the following 8 types of residential facilities based on to their environmental characteristics and their care focus: apartment groups focused on social skills; protected homes focused on social skills; apartment groups focused on daily life; protected homes focused on daily life; community homes focused on daily life; apartment groups focused on mental and intrapsychic life; protected homes focused on mental and intrapsychic life; and community homes focused on mental and intrapsychic life. In addition, we hypothesise that another type of residential facility exists: communities focused on social skills; however, we did not identify this type of facility in the current study.

We tried to determine whether there were significant differences in the characteristics of the guests across the different types of facilities. Table 4 shows the results of this comparison. Specifically, the apartment-based groups focused on social skills, had guests who were young, had shorter residencies (approximately 1 year), and had projects that focused on employment. The protected homes focused on social skills, had guests with long periods of residency and were characterised by patients with lower educational achievement and psychotic disorders. These facilities offered socialisation activities such as sports and occupational therapy. Additionally, the guests of these facilities were characterised by histories of chronic psychiatric pathologies that most likely impacted their basic social skills. The groups in apartments and communities focused on daily life had guests who were generally older than the residents of the other types of facilities; the residents of these facilities also exhibited longer histories of mental illness. Community and protected homes that were focused on daily life tended to have rather long durations of guest residency. This finding did not apply to apartment groups; however, these data may not be applicable because apartment groups are newly created facilities. Facilities that focused on intrapsychic functioning (i.e., the community, protected home and apartment groups) tended to have shorter residency durations, lower average guest ages and shorter illness histories. The main guest activities were psychological and involved different types of group participation rather than individual participation. In addition to these activities, in the protected homes and apartment groups, there were significant introductory activities focused on job placement or self-management of leisure time.

Table 3 – Spectrum of facility types based on the environmental characteristics axis and the facility operational focus axis

AXIS OF ENVIRONMENTAL CHARACTERISTICS	AXIS OF OPERATIONAL FOCUS		
	Operation focused on social skills	**Operation focused on daily life**	**Operation focused on mental and intrapsychic life**
Apartment Group up to 5-7 guests, a few hours of daily support	*AG 3; AG 8* facilities that focus on the acquisition of social skills necessary for independent living. Strong focus on employment	*AG 7* facilities with low levels of support, focused on providing guests with the necessary support for independent living	*Com. 5* low-support facilities whose work focuses on the establishment and verification of independent living and crisis management abilities
Protected Home up to 5-7 guests, 24 h support / day	*AG 1* facilities involved in the acquisition of basic social skills needed for communal living and contact with the outside world	*AG 2; AG 5; AG 6* facilities devoted to the development of autonomy, with continuous work on the skills necessary for the self-management of daily routine	*AG 4* facilities devoted to the verification of the ability to self-manage intrapsychic stability, in the context of greater autonomy
Community 20-22 guests, 24 h support / day		*Com. 4* facilities devoted to the strengthening of autonomy for the management of everyday life amongst guests with high support needs	*Com. 1; Com. 2; Com. 3* facilities with a strong psychotherapy regime and an emphasis on change to help the guest better manage crisis situations

DISCUSSION

The literature reports a considerable diversity of models related to supportive housing and other facilities for psychiatric patients and the importance of research that seeks to identify specific features that discriminate among different settings (Fakhoury et al., 2002). The results of our study highlight different types of residential facilities for psychiatric patients that were defined initially by the characteristics of the structures and the aims and techniques of treatment, care and rehabilitation provided to users. Moreover, analyses of the characteristics of the patients who lived in different types of residential facilities revealed that different types of residential facilities matched different types of users. Specifically, our study identified different facilities based on their environmental characteristics and operative approaches to the care, assistance and rehabilitation of patients. The characteristics that we used to define the different type of facilities are not new; the literature related to the study of the quality of institutional care focuses on similar aspects, such as living conditions, the characteristics of interventions, and therapeutic relationships, among others. However, the studies comprising this literature often aim to identify the "ideal institution" (Taylor et al, 2009). In contrast, in this study, we have shown the characteristics of the structures that seem to be more suitable for certain patients depending, for example, on their ages and histories of psychiatric illness. The creation of types of psychiatric residential facilities may have the following important consequences: a) the specification, of guests better suited to a particular facility will improve the efficacy of treatment; b) assistance guidance in the development of health policies, particularly the planning of facility types based on user characteristics, the staff numbers required and the main activities to be delivered; and c) a description of some diagnostic and therapeutic methods based on current practice in different types of establishments that are recognized as effective in the national and international literature. In addition, identification of the

Table 4 – Differences between guest characteristics in different types of facilities

	Type of facility	Number of guests	Mean	Standard Deviation	F	p
Age (years)	AG social skills	4	33.00	2.70	4.88	<.001
	AG daily routine	5	55.60	6.54		
	AG mental functioning	7	35.86	5.24		
	PH social skills	5	48.00	7.90		
	PH daily routine	15	43.47	11.47		
	PH mental functioning	5	34.40	12.81		
	Com daily routine	20	47.25	15.04		
	Com mental functioning	60	35.70	10.84		
Time in facility (number of months)	AG social skills	4	13.75	9.60	6.99	<.001
	AG daily routine	5	3.00	.00		
	AG mental functioning	7	8.00	7.43		
	PH social skills	5	63.80	16.10		
	PH daily routine	15	27.73	29.85		
	PH mental functioning	5	11.60	9.65		
	Com daily routine	20	65.80	57.37		
	Com mental functioning	60	20.63	22.45		
Hospital admissions after patients are admitted to the facility	AG social skills	4	.25	.50	1.18	n.s.
	AG daily routine	5	.20	.44		
	AG mental functioning	7	.00	.00		
	AG social skills	5	.80	.83		
	PH daily routine	15	.67	1.29		
	PH mental functioning	5	.00	.00		
	Com daily routine	20	.30	.73		
	Com mental functioning	59	1.14	2.12		
Number of typical antipsychotics per guest	AG social skills	4	.50	.57	2.51	.019
	AG daily routine	5	1.00	.00		
	AG mental functioning	7	.14	.37		
	PH social skills	5	.60	.54		
	PH daily routine	15	.73	.59		
	PH mental functioning	5	.80	.44		
	Com daily routine	20	1.15	.81		
	Com mental functioning	59	.64	.63		

continued on next page

continued

	Type of facility	Number of guests	Mean	Standard Deviation	F	p
Number of atypical antipsychotics per guest	AG social skills	4	.50	.57	1.21	n.s.
	AG daily routine	5	.60	.54		
	AG mental functioning	7	.71	.75		
	PH social skills	5	1.20	.44		
	PH daily routine	15	.87	.64		
	PH mental functioning	5	.40	.54		
	Com daily routine	20	.70	.65		
	Com mental functioning	59	.59	.52		
Age at original diagnosis	AG social skills	4	17.00	3.46	2.36	.028
	AG daily routine	5	29.40	16.33		
	AG mental functioning	7	16.57	4.82		
	PH social skills	5	16.60	4.82		
	PH daily routine	14	26.86	12.45		
	PH mental functioning	5	21.20	12.21		
	Com daily routine	20	17.85	8.03		
	Com mental functioning	55	22.00	8.21		
Disease duration (years)	AG social skills	4	16.00	5.22	8.44	<.001
	AG daily routine	5	26.20	11.43		
	AG mental functioning	7	19.28	7.13		
	PH social skills	5	31.40	7.26		
	PH daily routine	14	15.07	9.14		
	PH mental functioning	5	13.20	6.30		
	Com daily routine	20	29.40	15.55		
	Com mental functioning	55	13.52	6.71		

Note. AG = Apartment Group; PH = Protected Home; Com = Community.

types of facilities that correspond to specific permutations of environmental characteristics and operating methodologies should not only allow for better choices of facilities based on how well suited those facilities are to each individual but also allow for the recruitment of appropriate staff for the care, treatment and rehabilitation culture of each particular facility. The development of facilities with appropriate work cultures and management climates would, by extension, also promote staff wellbeing.

Limitations

This study was conducted in a relatively small number of facilities and in a limited geographic area in Italy. Therefore, our results, although interesting, require further testing in a wider range of facilities that are not restricted to Italy. In this study, we used the same group of facilities to define the typologies and to verify the differences between the users who lived in these facilities. We believe that the characteristics of the facilities drove

the choices of patients and not vice versa; however, based on our data, it is not possible to reach this conclusion. We can only state that there was a correspondence between facilities with certain characteristics and guests with certain characteristics. Therefore, future research will be necessary to determine whether different types of residential facilities are appropriate for psychiatric patients with different characteristics.

CONCLUSIONS

Currently, a proportion of people with mental health conditions live in residential facilities. In the present research, we identified the following types of facilities based on their environmental characteristics and their focuses of care: apartment groups focused on social skills; protected homes focused on social skills; apartment groups focused on daily life; protected homes focused on daily life; communities focused on daily life; apartment groups focused on mental and intrapsychic life; protected homes focused on mental and intrapsychic life; and communities focused on mental and intrapsychic life. According to our data, the patients of these different types of facilities were also different in terms of age, diagnosis, and duration of disease. We believe that defining the types of residential facilities for psychiatric patients is important both for improving the definitions of the different approaches of care that are used in community interventions and for better defining the "quality of care" in each types of facilities.

Acknowledgements
This study was supported by FENASCOOP (Italian Association of Psychotherapeutic Community).

References

BRUNT, D. & HANSSON, L. (2002). A comparison of psychosocial environment of two types of residences for persons with severe mental illness: Small congregate community residences and psychiatric inpatient settings. *International Journal of Social Psychiatry*, *48*, 243-252.

DE GIROLAMO, G., BASSI, M., NERI, G., RUGGERI, M., SANTONE, G. & PICARDI, A. (2007). The current state of mental health care in Italy: Problems, perspectives, and lessons to learn. *European Archives of Psychiatry and Clinical Neuroscience*, *257*, 83-91.

FAKHOURY, W.K.H., MURRAY, A., SHEPHERD, G. & PRIEBE, S. (2002). Research in supported housing. *Social Psychiatry and Psychiatric Epidemiology*, *37*, 301-315.

JACOBSON, N. & GREENLEY, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Service*, *52*, 482-485.

JOHNSON, R.B. & OWUEBUGZIE, A.J. (2004). Mixed Methods Research: A Research Paradigm Whose Time Has Come. *Educational Researcher*, *33*, 14.

KILLASPY, H., WHITE, S., WRIGHT, C., TAYLOR, T.L., TURTON, P., SCHUTZWOHL, M., SCHUSTER, M., CERVILLA, J.A., BRANGIER, P., RABOCH, J., KALISOVÀ, L., ONCHEV, G., ALEXIEV, S., MEZZINA, R., RIDENTE, P., WIERSMA, D., VISSER, E., KIEJNA, A., ADAMOWSKI, T., PLOUMPIDIS, D., GONIDAKIS, F., CALDAS-DE-ALMEIDA, J., CARDOSO, G. & KING, M.B. (2011). The development of the Quality Indicator for Rehabilitative Care (QuIRC): A measure of best practices for facilities for people with longer term mental health problems. *BMC Psychiatry, 11*, 35.

LORA, A. (2009). An overview of the mental health in Italy. *Annali dell'Istituto Superiore di Sanità, 1*, 5-16.

MORRIS, J., LORA, A., McBAIN, R. & SAXENA, S. (2012). Global mental health resources and services: A WHO survey of 184 country. *Public Health Review*, *34*, 1-19.

OVRETVEIT, J. (1996). *La qualità del servizio sanitario*. Napoli: EdiSES.

PICARDI, A., DE GIROLAMO, G. & MOROSINI, P. (2003). Le strutture residenziali psichiatriche in Italia. Risultati preliminare dalla fase 2 del progetto PROGRES. *Notiziario dell'Istituto Superiore di Sanità*, *2*, 3-9.

SANTONE, G., DE GIROLAMO, G., FALLOON, I., FIORITTI, A., MICCIOLO, R., PICCARDI, A. & ZANALDA, E. (2005). The process of care in residential facilities. *Social Psychiatry and Psychiatric Epidemiology*, *40*, 540-550.

TAYLOR, T.L., KILLASPY, H., WRIGHT, C., TURTON, P., WHITE, S., KALLERT, T.W., SCHUSTER, M., CERVILLA, J.A., BRANGIER, P., RABOCH, J., KALISOVÀ, L., ONCHEV, G., DIMITROV, H., MEZZINA, R., WOLF, K., WIERSMA, D., VISSER, E., KIEJNA, A., PIOTROWSKI, P., PLOUMPIDIS, D., GONIDAKIS, F., CALDAS-DE-ALMEIDA, J., CARDOSO, G. & KING, M.B. (2009). A systematic review of international published literature relating to quality of institutional care for people with longer term mental health problems. *BMC Psychiatry*, *9*, 55.

THORNICROFT, G. & TANSELLA, M. (2004). Components of a modern mental health service: a pragmatic balance of community and hospital care: overview of systematic evidence. *The British Journal of Psychiatry*, *185*, 283-290.