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Abstract

This work is part of a research project that aims to measure organizational well-being, human rights respect and quality of care in mental health services in Sardinia, Italy, country that has replaced long-stay psychiatric hospitals with community mental health services.

We started from previous contributions that have seen Italian health professionals and users as the most satisfied and optimistic about the quality of the mental health care provided and the respect for users' rights.

The aim is to investigate whether these positive results are confirmed by comparing users of mental health services point of view with those of other care services in the same region.

The results indicated that users of mental health services show high level of satisfaction for care and a perception of users' human rights respect as users of non-mental health facilities. They have also greater satisfaction with services organizational aspects and are more convinced that the rights of health professionals are respected.

In contrast, they are less satisfied with the resources available to care centers than other users and require more professional psychosocial support. We want to allow future comparisons to other regions on quality assessment through the perception of users and worker on respect for standards and human rights.

Keywords

Human rights; Organizational Well-Being; Quality of care; Users; Mental Health

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Consent: Any service user in research has given written consent to the inclusion of material pertaining to themselves, they acknowledge that they cannot be identified via the paper. The manuscript does not contain any individual person's data in any form. Data are fully anonymized.

Geolocation information: Sardinia, Italy

Background

The UN Convention on the Rights of Persons with Disabilities (CRPD) claims the respect of human rights and the need of care of quality for persons with disabilities (UN, 2006). The QualityRights (QR) program of the World Health Organization is implementing the CRPD in the field of psychosocial disability (WHO, 2017; Funk & Derew, 2017); according to QR fundamental points form improving the quality of care are: 1) placing at the center of the evaluation of care the respect for the human rights of users (in the belief that there is no quality of services without respect for rights and there is no respect for rights without guarantees of quality care) and 2) the direct involvement of users in the process of improving the quality of care (Moro et al., 2021; Carta et al., 2020).

The process that led to the transition from institutional to community mental health contexts drastically shifts reflection beyond the personal narrative towards a collective concept of mental health. An extended context in which the actors involved deal with patient recovery. In this framework a culture is created in which the recipients of the service feel safe, they are involved in patient-centered approaches, they are supported and they are aware of their rights.
For this reason, thinking about best practices, in community setting can not ignore human rights perspective for carrying out the provision of mental health treatment. This level marks the medium for measuring good practice.
In this extended socio-cultural level, the whole community context cooperates in treatments outcome and the overall perception of justice. Access to goods and supplies, even transportation can contribute to promoting and maintaining good mental health outcomes (Guttman, 2018).

This work is part of a research project that aims to measure the judgments on organizational well-being, respect for human rights and quality of care in the services that provide mental health care by comparing different points of view. In this specific work we analyzed the opinions of users of mental health services with those of users of health services of different medical fields in an Italian region, Sardinia. Comparing the satisfaction of mental health users with users of other health disciplines in the same region it allows to highlight specific discrimination regarding mental health and allows future comparisons with other national and regional realities. In fact, if we consider that the quality of health care delivered could be influenced by resources, a comparison between transnational differences mental health vs other health disciplines can be more clarifying than a direct comparison between the quality of mental health care in the same different countries. Although the effort towards the respect of rights have components even independent of the accessibility to resources.
This work starts from previous contributions that have seen Italian health professionals as the most satisfied and most optimistic about the quality of the mental health care provided and the respect for users' rights towards those of other Mediterranean countries (Zgueb et al., 2020) and, in comparison with health professionals employed in different sectors than mental health of the same Italian region (Carta et al., 2022). Furthermore, users of mental health services in the same area of Italy have themselves demonstrated levels of satisfaction that are comparable or even higher than that of mental health workers (Carta et al., 2022b).
The comparison between users of mental health and those of other health disciplines therefore closes a cycle of research that has so far shown good levels of satisfaction in users and health professionals of that Italian region.

As encouraged by the QR toolkit, the evaluation was carried out between outpatient mental health services and health services of different medical fields of the same general health facility and provision of the community: metropolitan city of Cagliari, Sardinia

This result was placed in relation to the way of organizing mental health in Italy which is totally centered on the care provided in the community and has passed and closed the psychiatric hospitals. The contingent situation linked to the Covid pandemic may have accentuated the acceptability of these characteristics, the hospital may be seen as a place of risk and the treatments provided in small units near the houses are even more accessible in this context.

The aim of this work is to verify whether these positive results are confirmed by comparing users of mental health services with those of other care services in the same region, whereas our working hypothesis is that the satisfaction of health mental users shouldn't be worse.
A further objective of this work is also to define a useful reference point for future transnational comparisons.
This precise work was carried out by including in the team some users who had conducted training courses on human rights and mental health and on the quality assessment of rights-centered mental health services. The same people, together with experts with a history of episodes of mental health conditions and experts in evaluating the quality of care, from international contexts were also involved in the reading of the results and in the discussion.

Methods

The research team was composed of clinicians, researchers, activists and service users.

Design
Cross Sectional Observational Study

Sample
A sample of users from 4 community mental health centers and 4 outpatients health facilities (dermatology, oculist, pain care and endocrinology) of the same Italian region (Sardinia) was recruited on volunteer basis. The interviews were carried out at the collaborating health centers.

Study Tools
Participants signed of informed consent and then could fulfilled:

a) A simple questionnaire on: Age, Gender and Educational Level
b) The user versions of the "Well-Being at work and respect for human rights questionnaire" (WWRR) (Husky et al., 2020). The WWRR was inspired and built according to above mentioned World Health Organization QualityRights project (WHO, 2017; Funk & Bold, 2017; Carta et al., 2020; Moro et al., 2021). WWRR measures how users (and potentially other actors including health workers) perceive the respect of human rights of users and health workers, the organizational climate and the quality of care in the health care facilities.

The original version has been developed in Italian and English, translation and validation was carried out in Italian, Macedonian and Arabic (Hursky et al., 2020). The first five items required answered coded according to a Likert scale 1 to 6, with 1 indicate "Not satisfied at all" and 6 indicate "Completely satisfied" (item 1 personal satisfaction, 2 perception of general user's satisfaction, 3 satisfaction of organization aspect in facility delivering care, 4 user's human rights respect, 5 health professional's human rights respect). The Item number 6 about the perception of the state of resources in health service providing care is coded in a Likert scale1-5 with 1 indicating resources completely adequate and 5 "serious resource deficits". Item 7 ask about the kind of health professionals would be most useful to add in the service providing care, with only one answer admitted. The tool was described in detail in the paper about validation (Hursky et al., 2020).

Statistical Analysis

Statistical analysis was conducted by comparison of the mean score of responses to each items between users' of mental health and users of other facilities by means of ANOVA 1 way test. The answers to item 7 were analyzed by means chi square test (with Yates's correction if necessary).

Ethics

The Ethical Board of the University Hospital of Cagliari, Italy ("Comitato Etico Indipendente dell'Azienda Ospedaliero Universitaria di Cagliari"), Italy, approved the study. The protocol of the survey respected d the 1995 Declaration of Helsinki and its following revisions (World Medical Association, 2019).

Results

The interviewed samples included 342 people, 200 mental health services users and 140 users of other health facilities. Table 1 shows the characteristics of the two samples according to sex, age (<50 and ≥50) and education (degree, high school and <9 years of education). More males were found in the users of mental health services (60% vs 36.6%, OR 2.59, CI95% 1.67-4.04) as well as more people <50 years old (35.5% vs 65.5%, OR = 0.20, CI95% 0.18-0.45). No significant differences were found in the 3 categories that divided the samples by level of education.

Table 2 shows a comparison about mean±standard deviation of scores at items 1-6 of WWRR achieved by the two group of mental health and health services users of Sardinia. No differences were found in the mean score of the two groups on item 1 ("How satisfied are you of the services in which you are cared"), in which the score found in mental health users was 5.14±1.17 against 5.13±1.26 in users of Health Care networks other than Mental Health and with both groups scoring over 85% of the maximum score, and on item 4 concerning the perception how human rights of the people cared in the facilities are respected (Item 4, mean score 5.26±1.10 of mental health users against 5.37±1.16, F=0.794, p=0.374) and with both groups scoring over 85% of the maximum score. Users of mental health care, in comparison with users of other health facilities, show a perception that all users of the care service to which they themselves turn have a better satisfaction about the care received (Item 2, mean score 5.26±0.99 against 4.97±1.12 of users of other health facilities, F=6.305, p=0.012); a higher score on satisfaction concerning the organizational aspects of health facilities (Item 3; mean score 5.14±1.10 against 3.91±1.32, F=4.734, p=0,030); a higher perception about human rights of health workers working in facilities delivering care are respected (Item 5, mean score 5.35±0.96 against 4.94±1.08, F=13.644, p<0.0001). In item 6 on satisfaction about resources in health facilities delivering care, users of mental health services showed a worse perception (men score 2.68±1.10 against 2.31±0.96, F=10.426, p=0.001).

Table 3 shows the answers in the two groups about "Needs for type of health workers in the service in which I work / I'm cared" (Item 7 WWRR). Users of mental health services believe, compared to users of non-mental health care services, that their care facility require more psychiatric rehabilitation technicians/occupational therapists (35% vs 2.1%, OR =24.95, CI95% 7.67-81.20) and psychologists (27.5% vs 6.3%, OR =1.86, CI 95% 1.09-3.19). On the opposite, still comparing to users of non-mental health care services, they show less answered about "No health professionals need to be

incremented" (0% vs 12.7%, OR =0.14, CI95% 0.05-0.42) and they believe they need less nurses (2.1% vs 35.0%, OR =0.21, CI95% 0.11-0.39) and medical doctors (13.5% vs 30.3%, OR =0.36, CI95% 0.21-0.62). No difference was found about need of professional for personal care; Social Workers and Staff Security.

Discussion

It is useful to first discuss the evidence that the two samples under examination are unbalanced by sex and age. It is known that, although many mental health conditions affect women more frequently, nevertheless males often express a greater frequency of access to mental health services (Bertani et al., 2012; Carta et al., 2013), moreover mental health services in Italy treat more often conditions with juvenile onset (Ruggeri et al., 2007) and therefore the percentage of people with a young age may be higher compared to health services in which a large slice of clients have chronic diseases related to age (just think of type II diabetes in endocrinology or neoplastic diseases in the center for pain therapy). Apparently, there are no differences in educational level on the two samples examined, however the level of schooling in Italy depends on age. Those born after the 60-70s had a greater ease of access to education, the homogeneity in this field is only apparent if we consider the imbalance by age. The characteristics of the two samples therefore differ not for a selection bias but for real differences in the populations of which the samples are representative.

Satisfaction with care and perceived level of respect for human rights

The results indicated that users of mental health services of an Italian region show a similar (high) level of satisfaction for care received and a perception of respect of user's human rights in health care facilities of users of non-mental health facilities. In addition, they have even greater satisfaction with organizational aspects in the services they receive treatment, a higher perception that all users of the services are satisfied with the care and are more convinced that the rights of health professionals are respected in comparison of non-mental health service users.

Satisfaction with available resources for care

In contrast, users of mental health services are less satisfied with the resources available to care centers than users of non-mental health care services. This result is consistent with the fact that none of the users of the mental health care network are convinced that there is no need to increase any professional figure in the care services. However, among the respondents to this question (question number six), significant differences emerge between the two groups. Those receiving mental health care require more professionals giving psychosocial support (psychiatric rehabilitation technicians/occupational therapists and psychologists) those receiving other health care would want more traditional sanitarian professional as medical doctors and nurses. It is noteworthy that there is no significant difference in the demand for security personnel.

The results of this research seem consistent with the previous studies already published of the same project in which: a sample of health professionals employed in the network of services in the same region showed average higher scores on the same questionnaire compared to those of three other countries in the Mediterranean area (ie. Tunisia, North Macedonia, Gaza) (Zgueb et al., 2020); a

sample of health professionals employed in the network of services in the same region shoved mean score at the same questionnaire even higher than professional of other health facilities (but except for satisfaction of resources) (Carta et al., 2022a); a sample of users of mental health services of the same area showed similar o even higher level of satisfaction comparing to health professionals (Carta et al., 2022 in press).

It is conceivable that these results as a whole are due to interaction of some characteristic factors of the Italian framework in this specific historical moment:

1) Outpatients care in mental health are provided in the areas of residence of the users in geographical proximity to their homes, while non-psychiatric specialistic care such as dermatology, pain therapy, endocrinology and ophthalmology are often logistically located in "distant" hospital units from the residences. This proximity makes mental health care network more capable of integrating with the network of social services (which in Italy are managed by the municipalities) and with the community voluntary network which often knows well the users with more severe problems and interacts with the health services to their support
2) The specific situation of the pandemic may have worsened the problems of hospital care: it accentuated waiting lists (while in small territorial units this problem was less impactful), it increased the risk of infection for healthcare personnel and forced the staff to grueling shifts (hence the perception that the rights of the treating staff were not respected); it may have increased users' fear of getting infected more than it was going to small units in head offices with no bed and therefore this may have increased organizational dissatisfaction; it made it difficult to use telemedicine and distance contacts with users than in small territorial units where users and family members were much better known by the staff.
3) The greater dissatisfaction of users of mental health services towards users of other care services with regard to the available resources appears realistic and a source of reasonable alarm compared to a picture that on the whole appears to be almost optimal with respect to general satisfaction and the perception of rights. In fact, dissatisfaction for resources is realistic because it is not only consistent if we take into consideration the previous comparison between the staff of the mental health services and the staff of the other care servants, but it is perfectly in line with the recent data relating to the progressive decline in health expenditure and specifically mental health expenditure in Italy. The countries of the European Union with similar income to Italy have a health budget that is about 15% higher than the Italian one; of these budgets for whole health care they spend on average around 10% on mental health. According to the latest data, Italian spending on mental health has progressively narrowed with the crisis to about 3.5% of the health budget (of a whole health budget more meager than elsewhere). But this average is the result of a range that goes from 8% of the autonomous provinces of Trento and Bolzano (on average with Europe) to 2.5% of Calabria and Sardinia.

In conclusion, the perception of users is that of treatments that are still effective that the respect for rights of users and staff that are respected, but with a strong of reasonable alarm for the drop in available resources. This phenomenon could unfortunately lead, in our opinion, to a future compromise of the current Italian situation. In this regard, it should be remembered that Article 4 paragraph 2 of CRPD states'. . .each State Party undertakes to implement measures to the maximum of its available resources. . . with a view to achieving progressively the full realization of these rights,. . . '." and The Global Ministerial Mental Health Summit 2018 recommended the proportion of a

country’s health budget that should be spent on mental health is five percent (5%) for low- and middle-income countries and ten percent (10%) for high-income countries.
From this perspective, it would be discouraging in the future to have to witness a compromise of the excellent objectives achieved by the health reform in Italy (the only country in the world to have closed psychiatric hospitals), documented by our research in terms of user's satisfaction, due to a progressive decrease of available resources. Where the economic crisis can be a factor but not the only factor given that expenditure relating to mental health has mainly decreased in terms of percentage of total expenditure.
An important point that emerged in the discussion, especially by some users, is that the results of this study could be affected by a selection bias, i.e. the centers that joined the study, by the very fact of accepting the research and its principles, they would not be representative of all mental health services in the region.
In other words, the scarcity of resources, which emerged in the results, would have an even greater impact on other services. Such a lack of resources in mental health care services somehow leads people very often to turn to private practitioners, with severe economic costs for them.
Users’ impression is often that services may further deteriorate in the coming years, given the trend of tangible scarce resources invested.
The disproportion between professionals and the growing demand for mental health care inevitably exposes practitioners to burnout and work-related stress.
From the users’ point of view some initiatives aren't completely absent or very scarce in number in mental health service in Sardinia: adequate training on human rights, especially on the CRPD, networking activity with advocacy groups that can help them to be active part of the community. It should be emphasized that users’ movement, as pivotal social actor, can go beyond, through bottom-up action, along with other factors to ensure that resources and mental health policies will be progressively improved making progressively more efficient and fully actualize their human rights in service.

Conclusions

The study seems to indicate substantial satisfaction in mental health service users with the care received and the perception of respect for human rights despite the pandemic and lockdown periods, but with a concern about the scarcity of resources in the care network. The fact that the level of satisfaction is higher than that of other users of outpatient services of other medical specialties may be the consequence of the history of interpenetration in the territories and of solid links with other formal support and informal support networks of mental health services, while the other services are still provided in hospitals. These differences may have been amplified by the pandemic and lockdowns. However, the results may have been affected by a selection bias that led to the involvement of particularly sensitive services, the results, therefore, although emblematic of conditions of good practice, may not be generalizable.

Table 1 **Socio-demographic characteristics of the study samples**

		Users of Mental Health Care Services N (%)	Users of Health Care networks other than Mental Health services (%)	Chi square (with Yates correction if needed) - p	
Gender	Men	120 (60)	52 (36.6)	18.1 P<0.0001	OR 2.59 (CI9% 1.67-4.04)
Age	>49	71 (35.5)	93 (65.5)	29.93 P<0.0001	OR 0.20 (CI9% 0.18-0.45)
Education	Degree	22 (11)	22 (15.5)	1.49 P=0.221	OR 0.67 (CI9% 0.35-1.27)
	High school	71 (35.5)	51 (35.9)	0.01 P=0.937	OR 0.98 (CI9% 0.62-1.54)
	<9 years ed.	107 (53.5)	69 (48.6)	0.80 P=0.371	OR 1.21 (CI9% 0.79-1.87
	Total	200	142		

Table 2, Comparison on answers at item 1-6 of WWRR about health workers and users of mental health services of South Sardinia

	1).How satisfied are you of the services in which you are cared	2). How much the users of the service in which you are cared are satisfied of the care received?	3).How satisfied are you with the organizational aspects of the services in which you are cared)	4). To what extent do you believe that the human rights of the people who are cared are respected in the health service in which you are cared	5) To what extent do you believe that the human rights of the staff working are respected In the services in which you are cared?	6) How do you evaluate the current state of care in mental health service in which you are cared with reference to resources?
Users of Mental Health Care Services N (%) (N=200)	5.14±1.17	5.26±0.99	5.14±1.10	5.26±1.10	5.35±0.96	2.68±1.10
Users of Health Care networks other than Mental Health services (%) (N=142)	5.13±1.26	4.97±1.12	4.85±1.36	5.37±1.16	4.94±1.08	2.31±0.96
F (df 1. 340)	0.006	6.305	4.734	0.794	13.644	10.426
P	0.940	0.012	0.030	0.374	<0.0001	0.001

Tab 3 Needs for type of health workers in the service in which I work / I'm cared (Item 7 WWRR)

	Users of Mental Health Care Services N (%) N (%)	Users of Health Care networks other than Mental Health services (%) N (%)	Chi square (with Yates correction if needed) - p	OR CI 95%
Nurses	15 (7.5)	40 (28.2)	26.287 P<0.0001	0.21 (0.11-0.39)

OSS – Professional for personal care	9 (4.5)	9 (2.8)	0.563 p=0.453	0.70 (0.27-1.80)
Medical Doctors	27 (13.5)	43 (30.3)	14.366 p<0.0001	0.36 (0.21-0.62)
Psychologists	55 (27.5)	24 (6.3)	5.251 p=0.022	1.86 (1.09-3.19)
Occupational Therapists /Educators / Technicians of Rehabilitation	70 (35)	3 (2.1)	53.497 P<0.0001	24.95 (7.67-81.20)
Social Workers	15 (7.5)	4 (2.8)	2.636*- P=0.104	0.80 (0.91-8.61)
Staff Security	5 (2.5)	0 (0)	2.876* P=0.50	INF (NV-INF)
None needs to be incremented	4 (2)	18 (12.7)	14.001* p<0.0001	0.14 (0.05-0.42)

*With Yate's correction

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