International trends in community mental health – including Trieste

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Community mental health as the new horizon: is (finally) now the time?

- It is now appropriate to sanction without delay, on a theoretical and practical level, the **transition from psychiatry to community mental health.**
- We define "**Community Mental Health**" an approach that is primarily concerned with the health of the population and not just that of individuals, and which is rooted in defined communities / territories, offering treatments that are carried out in contexts of life using the resources of the services of communities and other resources available in the area, but also orienting themselves towards health promotion, prevention and community development.

The Italian way to D.I.

- Why the ‘Italian way to deinstitutionalization’ remains a model of reform?
- Its community services and good practices derive **directly from the process of deinstitutionalisation** and the transformation that results, and not only in institutional terms (i.e. eliminating the asylum) but also with **respect to the philosophy of intervention, the values expressed, and the role and social significance** of the services.

History

- Italy pioneered deinstitutionalisation in the 60’s and the 70’s and enforced a famous mental health reform law in 1978.
- The Law 180 was the first Act worldwide to **abolish the psychiatric hospital and to give back the full rights of citizenship** to people with mental health disorders.
- De-institutionalization has been completed in Italy till the very closure of all Psychiatric Hospitals in **two decades** (1978-1999).
- After another 20 year period also **forensic hospitals** were overcome (2014-2018).

The 2 D.I.’s in Italy

- **The first D.I.**
- 100.000 inpatients in 1971 in PHs
- 48.000 inpatients in 1978
- All PHs closed in 2000

1978 reform law:

-no Phs admission, no new PHs

-community based care

-human rights focus / involuntary treatment duration reduced (1 week +) – 2 pych. to mayor

-No police / justice involved – just health protection

The second D.I.

In 2014-2018 Closure of all forensic hopsitals with 1400 inpatinets and opening of the small regional Units (20 beds max) called REMS.

Current problems:

Weakened CMH services, loss of staff, budget (from 3,6% to 2,75% in 3 years)

Most of money spent in residential facilities (37,000 users)

Mental Health Departments

- They are rooted in areas of about 300.000 inhabitants and encompasses a number of **components**:
- -Small general hospital acute units (15 beds), 1/10.000
- -Community Mental Health Centers (up to 12hr, sometimes 24hr) 1/80.000
- -Group-homes 2/10.000 with a wide range of support up to 24hr (30.000 beds in Italy, mostly NGOs)
- -Day Centre (also with NGOs)

- The decisive step in the process of phasing out PHs is identifying where to accept or **admit new psychiatric cases**.
- Generally, one opts for a mix between the use of specific wards (or beds) in general hospitals and hospitality in mental health centres or in other types of non-hospital residential structures, with preferably a very limited number of beds.
- The suppression of the PH should coincide with the creation of **networks of totally alternative services** capable of providing care for a given population (as in sector policies), but which stress the recovery and reinclusion of patients/inmates (as opposed to the sector model).

- Despite international recommendations, even those of the WHO (The Optimal Mix of Services for Mental Health, 2011) which stress that PHs can be reduced or suppressed only if community services and structures have already been established – and thus thanks to new funds specifically allocated for that purpose –we believe that a contemporaneous **process of reconversion** which can impact profoundly not only on the renewal of services but also on the community and its culture, is not only practicable but desirable.
- Despite the significant disparities due to national and local contexts, we believe that while this process can be instigated by a **top-down** impetus and be guided by a responsible institutional leadership, it can only be fully achieved thanks to a **bottom-up** process which mobilises actors and resources.

- working directly **within total institutions** but without deceiving ourselves that their closure can come from outside or due to a ***'natural death'***;
- creating alternative networks of **coherent services that work in synergy within the community**, thereby avoiding useless and often harmful fragmentation and specialisations, and thus working not according to preconceived models but by processes that are verified collectively by users, families and caregivers, and the community and its institutions;
- **avoiding priority implementation of hospital services for crisis/emergencies instead of community structures.**
- assign to the community services the task of **taking responsibility for persons who come from their territory of competence, who are still interned in the PH;**
- plan the phasing out of PHs at the local, regional and state levels, with specific **time-frames** and the possibility of applying administrative sanctions in cases of non-compliance.

- The deinstitutionalisation process is not only downsizing or even suppressing psychiatric hospitals, but undertaking a complex process of removing the ideology and power of the institution by **putting the person over the institution** with their subjectivity, needs, life story, significant relationships, social networks, social capital.
- In order to do that, it is necessary to **shift the power** in order to empower people with mental health problems, shift resources from hospitals to a range of community based services useful for his/her whole life. It opens pathways of care and programs that integrate social and health responses and actions.
- This complex process of change **involves users, carers, professionals and the general citizenry**, and extends to the legislative and political level.

- This latter means no longer managing processes for exclusion through the segregation of persons, but placing the individual at the centre of the system, with their human and social rights, and their needs, in a perspective which is **based on the person's 'whole life' and on recovery from the experience of a mental disorder.**

Based on what we have described above, the transformation process takes place at the following **multiple levels**:

- movements (civil society)
- political
- legislation
- service models and practices
- networks and organised actors, autonomously or through the institutions, and community development, as a general raising of awareness regarding these issues, and the activation of non-technical resources and initiatives.

D.I. – a summary

Meaning

- DI is not just closing and discharging people, but transforming their lives and mindset as our as care providers.
- DI is a whole system change, of practice, thinking and service, to liberate fra the need of institutions (Rotelli), by creating an effective service alternative.
- But it requires also a paradigm changes not just a technical refurbishment, with putting not the illness, but the person 'over the institution', at the centre of care.
- It must be completed, otherwise a parallel system will be created, with the risk of reverting reforms, the balance can go back in favor of the old institutional system (Brazil?).

Key points

1 It needs a **clear mandate** for local powers, administrative and political.

- It happens either top down or bottom up - small changes on turf, significant but limited. But it also requires social participation and co-production, stemming from stakeholders.

2 **Transformation plans** must include in-house changes, it is not just about re-locating people outside, as well as the development of community based services.

- **Resistance to change** is always the main problem inside - never the clients are. They are instead the energy to push the process on.
- Institutions "own" their people, they are their reason to exist and the economic capital - but they are a social capital!

D.I.

3 **Rehabilitation and recovery** (also of professionals) starts from within - using internal energies to transform them.

4 **Comprehensiveness** : Whole life issues and clinical care together.

5 Which **change for users**?

- Ensuring human rights -
- Realizing citizenship that is participation to community.
- From inmate to citizen using services and support needed, active in care processes (till the peer support). But also other identities, as worker (social co-operatives).

6 **Autonomy and responsibility** are key to social recovery.

- Personal plans - budgets aiming at fulfilling the highest level of independence are key, but also service re-organization is important means to allow it.

7 **Social and health care** come together. The misunderstanding of mh long term conditions as just social issues leds to contain them in residential facilities and institutions.

Summary

- The concept of deinstitutionalization has been widely misunderstood, but it regards not just the closure of total institutions as asylums, but a **whole system change** and moreover a full transformation of psychiatry towards mental health.
- This encompassed the **interpretation of the illness concealing human experience of a person.**
- Deinstitutionalization can be seen as the **main strategy to overturn oppression, to mobilize resources for recovery and social integration, creating services and supports in the community.**
- Community-based services promoted the response to needs and the fulfillment of **citizenship rights by catalyzing those resources and opportunities**.

Introduction: the mature age of communuty approach

Benchmarking community service models

- While not losing an evolutionary vision of the mental health system, on the other hand it appears necessary to think about a **standardization (or rather modeling) of the best community based services experiences**, often accused of remaining empirical.
- Benchmarking proposals (OECD, 2018) refer to principles and related indicators, even if the former appear to be still too general and above all unrelated to organizations, practices and treatments, while the latter appear too simple or too generic.
- In terms of services, also the **OECD Mental Health Performance Network** (2021) set these 6 principles for a high performing mental health sector:
- Focuses on individual who is experiencing mental ill-health
- Has accessible, high-quality mental health services
- Takes an integrated, multi-sectoral approach to mental health
- Prevents mental illness and promotes mental wellbeing
- Has strong leadership and good governance
- Is future-focused and innovative

Focus on:

- - not just the **content** but the **delivery of care**, or rather the overall impact of a service system, even on the entire community and not just on individuals;
- - not just **techniques** to be inserted in an amorphous or indifferent context or to be cut out on the settings, but to the construction of **processes of care** (or taking charge of-) that give overall answers to the entire range of life needs, in integration with welfare systems and services (MH Integration Index, the Economist, 2015),

but:

- working hypotheses should be favored that go beyond the medical and / or psychological model, which give an answer to the social determinants of mental health, and which therefore move towards **integration between social and health care**.

That is:

- **Integration** between public and third – voluntary sector (NGOs)

- **Co-production** with stakeholders and with other community representatives.

Functions vs structures of care

- A static vision based on service **structures or components** should be avoided, as already stated for example in the **balanced care model** (Thornicoft and Tansella, 2013).
- **Each structure does not exhaust** the various functions to which it must respond, and the two areas cannot be identified.
- **Functions overlap** across different structures, override them and force us to think along paths and responses, integrated in a continuum, to care needs.

Specialization

- With respect to the emergence of new range of needs, there is a tension between **comprehensive vs specialized services** in high-income countries. In our opinion, one cannot go to specialize (eg EIP for young people) if the basics of care and **early intervention / open access** for all users have not been resolved and guaranteed (*early intervention of nearly everything*, Rosen and Byrne, 2014)
- Rather, specialized functions should be defined rather than separate services, in order to **avoid the risk of fragmentation** of the pathways.
- We should not think of a **sum of interventions**, linear and horizontal, but a **vertical synergy**, as a contemporary multidimensional stratification.
- It is therefore necessary to overturn the balanced care model, meaning it as a **balanced system of territorial responses**, up to the full inclusion and community development.

Organizations based on principles

- The **three levels** (Weick, 1998) - **principles, procedures, interactions** between the actors - must be satisfied together, and linked to each other. The principles are translated into processes and interactions between institutional subjects in the different care contexts.
- Among the principles, those enunciated by **WHO MH Action Plan** (now extended until 2030) should be considered:
- **Rights-based services** (person-centered), **empowerment, multisectoral approach**.

The three parameters replaced by **ethics, evidence and experiences** must be linked and articulated together (Thornicroft and Tansella, 2009), none of the three should prevail in an exclusive way.

- The **issue of rights, traditionally connected in Italy to the issue of citizenship** of people with mental disorders, avoiding their discrimination and social exclusion, is today updated on the horizon of human rights established by the Convention on the Rights of Persons with Disabilities (CRPD) of Nations Unite, ratified by Italy in 2009. WHO links quality with rights
- Some examples of areas sensitive to the issue of rights:
  - Physical, mechanical, chemical restraint;
  - Alternatives to the use of drugs;
  - Reduction of coercion in general.

Alternatives to coercion?

- Usually there are innovative programs considered to be **“alternatives” rather than mainstreamed, generalized or systemic forms of approach and care.**
- Individual or specialist interventions aimed to **reduce coercive interventions in routine clinical practice**, by themselves, are unlikely to be effective or can be sustained in the long term.
- This is because coercive practices in mental health are more likely to be linked to systematic problems such as **the culture and ethos** of prevailing clinical care and **organisation and delivery of mental health services.**
- For example, variations in the rates of coercive care, across countries and over time, may be the result of differences in policies and practice and the culture of metal health systems (e.g Italy).

An example: Italy’s involuntary treatment

- Today Italy has the **lowest compulsory treatment rate** in Europe (16.7/100.000 in 2018) and good outcomes data (e.g. readmission rate, suicide rate etc.).
- It is necessary to make real what the **law 180 (1978)** prescribes: seeking consent and putting in place all alternative territorial measures before requesting an involuntary treatment (TSO).
- Experience shows that to reduce TSOs it is necessary to try to **engage people and their families**, which requires active attitude, mobility and flexibility of the service, and other components such as:
  - Quick and easy access
  - Proactivity, assertiveness and continuity of care
  - Whole life approach, equality and at the same time uniqueness of needs
  - Integrate 'extra-clinical' activities and responses to social determinants
  - Orientation towards recovery and inclusion of peers

24 hour services

- Community based systems must function as a **full alternative** to hospitals, so they need to guarantee a 24-hour response (required by the European Action Plan of Helsinki, 2005).

This requires:

- Integrate a **rapid and mobile response to crisis with the subsequent continuity of care**: here different territorial EB models are available as alternatives to hospitalization, from crisis teams to crisis homes and ‘sanctuaries’ to foster families up to CMHCs open 24 hours with a few beds (Trieste model).
- a **rehabilitation developed in its community dimension**, which is linked to processes of social inclusion.

24 hrs CMHC: reasons for

- Why should 24 hours be set as the gold standard of territorial services? A multifunctional CMHC with a wide range of responses should be conceived.
- It is a therapeutic offer related to the response to the crisis and other permanence needs aimed at therapeutic-rehabilitative projects.
- The domestic housing dimension favors the greatest possible normalization of the psychotic experience, with an open door and in relation to the territory and its social networks (while eg. in the Soteria model the entry and exit of strangers to the community is not allowed and the place is circumscribed).

24 hrs CMHC (1)

1. is a unique point of reference of the territory throughout the demand for care
2. is a place of integration of the multidisciplinary team that works inside and out and constantly connects
3. allows the integration of all the answers and therefore facilitates a global management
4. it ensures that people are followed by the same team, which knows them, even when they are in crisis.

- In addition:

1. few beds avoid the concentration of acute and the consequent management difficulties
2. the bed is located in a domestic environment
3. during the night people feel closer and knowledge and trust is created
4. there is immediate continuity between overcoming the crisis and continuity of care

24 hrs CMHC (2)

1. it is easier to involve the family in the management of the crisis and in the enabling therapeutic project
2. it can simply offer a moment of rest and withdrawal from a stressful situation, even for one night
3. Health hospitality is not characterized as a shelter
4. It allows you to wait to design a rehabilitation and housing solution and reduces the need for residential
5. what emerges from the crisis becomes a moment of knowledge and construction of answers even after it, facilitating the creation of personalized care projects
6. we necessarily operate with the door open, overcoming restraint and respecting rights
7. the team can be used flexibly.

A comprehensive community service

- Here we need to emphasize the importance of **community based services, operating 24 hrs a day, 7 days a week,** to **mainstream them in healthcare organizations and integrating them with welfare services**, **promoting prevention of disability through early interventions, contrast to institutionalizazion, and responding to whole life needs, from housing to work to social inclusion.**
- Such services need to be planned, delivered and evaluated in co-production with stakeholders, starting from people with lived experience and their carers. The low level of coercive care is one of the most encouraging indicators, as in Italy

European countries (1)

- **Czech Republic & Belgium**
- Both these countries have chosen to develop community teams to provide some alternatives to hospitalization. The Czech reform, supported by structural European funds, combines a welfare component in these teams, that promotes social integration.
- The Belgian reform (Jacob et al, 2016; Borgermans, 2018) promotes wide ranging mobile teams which are only loosely linked with private hospitals with no clearly defined catchment areas.
- **Germany**
- Most mental health services are still heavily hospital based, with (Brunn et al 2021) community outreach components. Hospital-centric systems often take a lead role in coordinating different care providers for individuals with long lasting conditions, (Cruz-Arez, 2021).
- **France**
- Lille has developed reforms with a particular emphasis on supporting social inclusion through foster families for persons in crisis, a wide variety of residential solutions and promoting products of artists with lived experience of mental illness (Roelandt, 2010, 2016).
- France has otherwise failed to substantially reduce the role of psychiatric hospitals (Brunn et al, 2021). However, it has issued a new law for reinforcing the decentralization of welfare and health services and the government began looking at the examples of Trieste and Lille in 2019.

European countries (2)

- **Spain**
- Spain began to close their asylums and developing community services (Aparicio Basauri, 2010) around the same time as Italy. There were 120 psychiatric hospitals in 1975, with 91 still functioning in 2003, co-existing with a mix of community services.
- There was a national heath law in 1986 but regional models varied as they were autonomous (Aparicio Basauri & Sanchez Gutierrez, 2002).
- Job orientation and supported employment in the open market has commonly been provided. There were day hospitals, rehabilitation communities, and community mental health teams (Lopez, 2004).
- There is a successful implementation of ACT teams (Martinez-Jambrina, 2009).
- **Netherlands**
- Ari Querido pioneered a citywide mobile crisis team with follow-up management in the 1930's, with a focus on social factors precipitating mental disorders (Querido,1935). Nonetheless, the Netherlands' mental health-care remains dependent on hospital-based care, although there are policies aimed at its reduction.
- The Netherlands have implemented FACT teams (flexible assertive community treatment). FACT fidelity to the ACT model appears variable (Keet, et al, 2019). The Netherlands initiated the European Community Mental Health Services Provider EUCOMS Network (Keet, 2019) to combine evidence-based service delivery systems with recovery orientation, peer workers and other community mental health reforms.

European countries (3): Scandinavia

- **Sweden and Denmark**
- Sweden closed most of its asylums and pioneered a 24 hr “social psychiatry” service in Stockholm. The general trend is toward evidence based and clinically orientated community mental health services. A strong service user movement and involvement in care actively advocates for human rights. The separation of healthcare and social welfare programs still lets vulnerable individuals “slip between the cracks” (Topor, 2020).
- Similar reforms in Denmark and Norway (with mobile teams) have been at an impasse, split between an institutional highly biological-orientated hospital psychiatry and fairly advanced services run by local municipalities.
- **Finland**
- The world-renowned program of Open Dialogue originated here, centred in rural Western Lapland, but a traditional hospital-based system remains dominant (Wahlbeck K & Salvador-Carulla, personal communications & ESMS-R/DESDE reports, 2015).
- Many of the principles on which it is based on are similar to standard crisis intervention (e.g., rapid response, home care, network involvement, dialogue and negotiation) with more emphasis on tolerating uncertainty and sharing of responsibility.

UK (1)

- In 1999, the National Service Framework (NSF) for Mental Health was published (DoH, 1999) outlining a quality framework for services. This was accompanied by NSF's detailed strategic approach to implementation of community care, known as the NHS (National Health Service) Plan (Department of Health, 2000). The NSF clearly spelled out for the first time a blueprint for community-based services.
- The NSF's NHS Plan for Mental Health set out, for the first time in the UK, a clear and progressive national policy. Importantly, it included a prescriptive, centrally-driven, performance-managed and relatively well-funded 10- year plan of implementation.
- The performance management dimension involved clear targets, centralized monitoring, and primary care-based entities called Primary Care Trusts (PCTs).
- The latter involved 'payment by results and development of more competitive quasi-market forces. NHS Trusts (the main entity of public mental health) were redeveloped as more locally responsive 'business' entities, which shifted planning away from a top-down direction and toward integration of health and social care functions.
- There was a partial redirection of savings from the closure of over 130 psychiatric institutions in England.

UK (2)

- These reforms pushed for 24 hour per day/7 days per week community treatment with on-demand accessibility, early detection and prevention, consumer-centered care, evidenced based practices, care-coordination.
- A multi-disciplinary approach with greater promotion of self-management and peer support was planned.
- In 2008, the IAPT (Improving Access to Psychological Therapies) program was launched.
- New Horizons, the UK's 2010 national mental health policy, was built on these NSF achievements with a greater focus on self-management, emphasizing social outcomes of work, housing and inclusion.

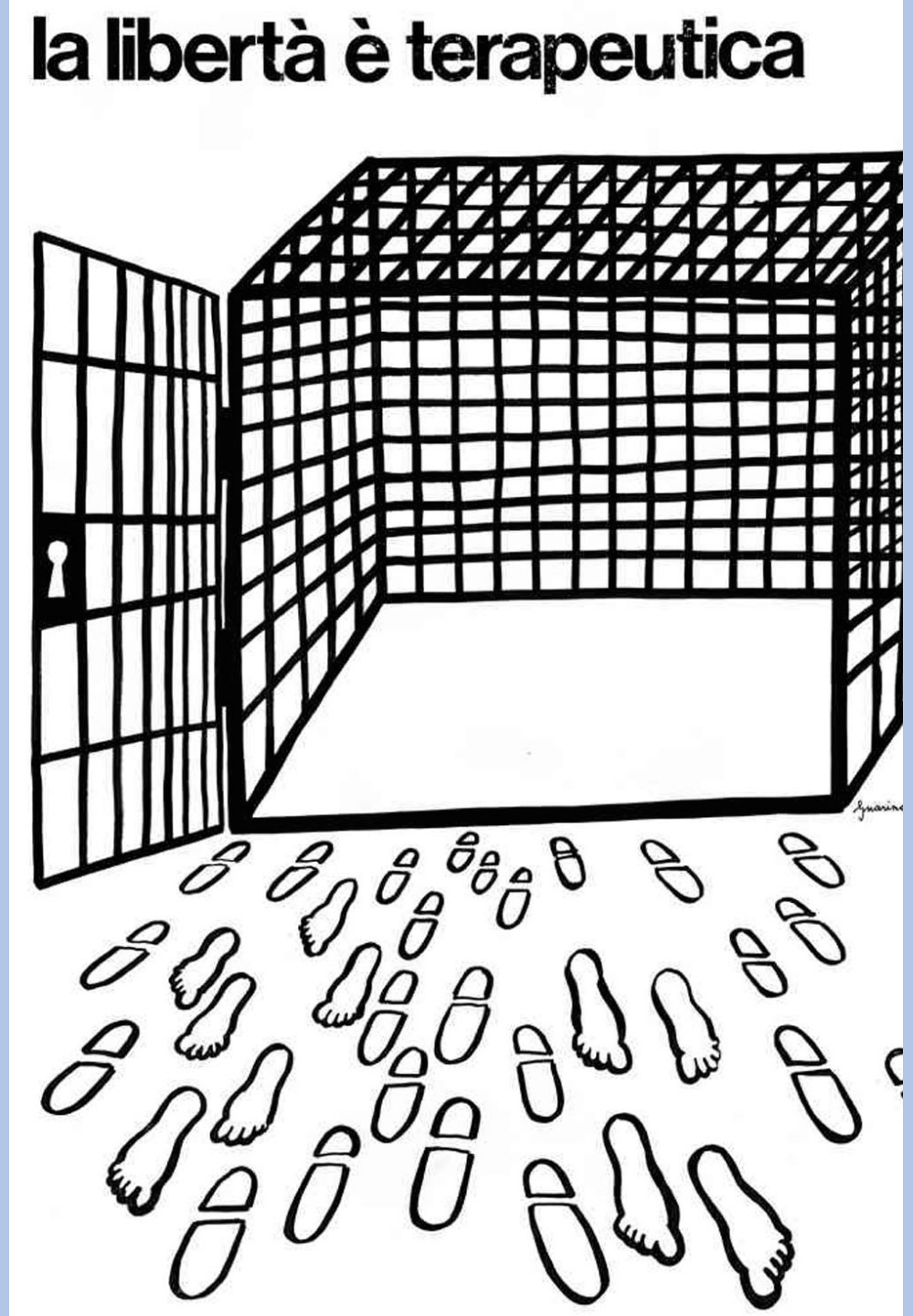
UK (3)

- A disinvestment in ACT in England deprived many individuals and their families of the intensive support they needed (Rosen et al, 2013).
- A review of UK mental psychiatric rehabilitation services (Rethink Mental Illness & Royal College of Psychiatrists, 2020) demonstrated that fewer than one in four mental health trusts employed a dedicated community mental health rehabilitation team to help these patients in their local area.
- In 2019 new NHS funding led to a new 5 year plan, caled “The Long-Term Plan” which for mental health would lead to an increase in annual funding of £2.3 billion. The prime focus for investment was to be community mental health where services had declined over the last decade, even though service users’ preference is for treatment in the community.
- In the CMHF, the extra community investment would be at the neighbourhood level, amounting to an extra £1.3 million for each 50,000 population, which is similar in size to Trieste’s population for a CMHC.
- The aspirations for the CMHF are also similar to Trieste: community mental health will aim to maintain continuity of care for anyone in their neighbourhood; will no longer allow people to be rejected from care because they don’t fit the service specification ie: no ‘hand-off’ and will instead adopt a ‘no wrong door’approach , seeing whoever needs to be seen. Neighbourhood-based teams will be familiar and build relationships with their community.

Trieste: encompassing human rights and person centered approaches

Nikolas Rose, Our psychiatric future, 2018

- *While it is true that Trieste is a small city, of fewer than 250,000 inhabitants, and that the implementation of the reforms inspired by Franco Basaglia to achieve this system took many years, this example, taken together with the arguments from within more conventional social psychiatry that I have just cited, shows that it is possbile for psychiatry to overcome that tension between care and control that Basaglia argued ran through his very existence – and to resolve it on the side of care.*

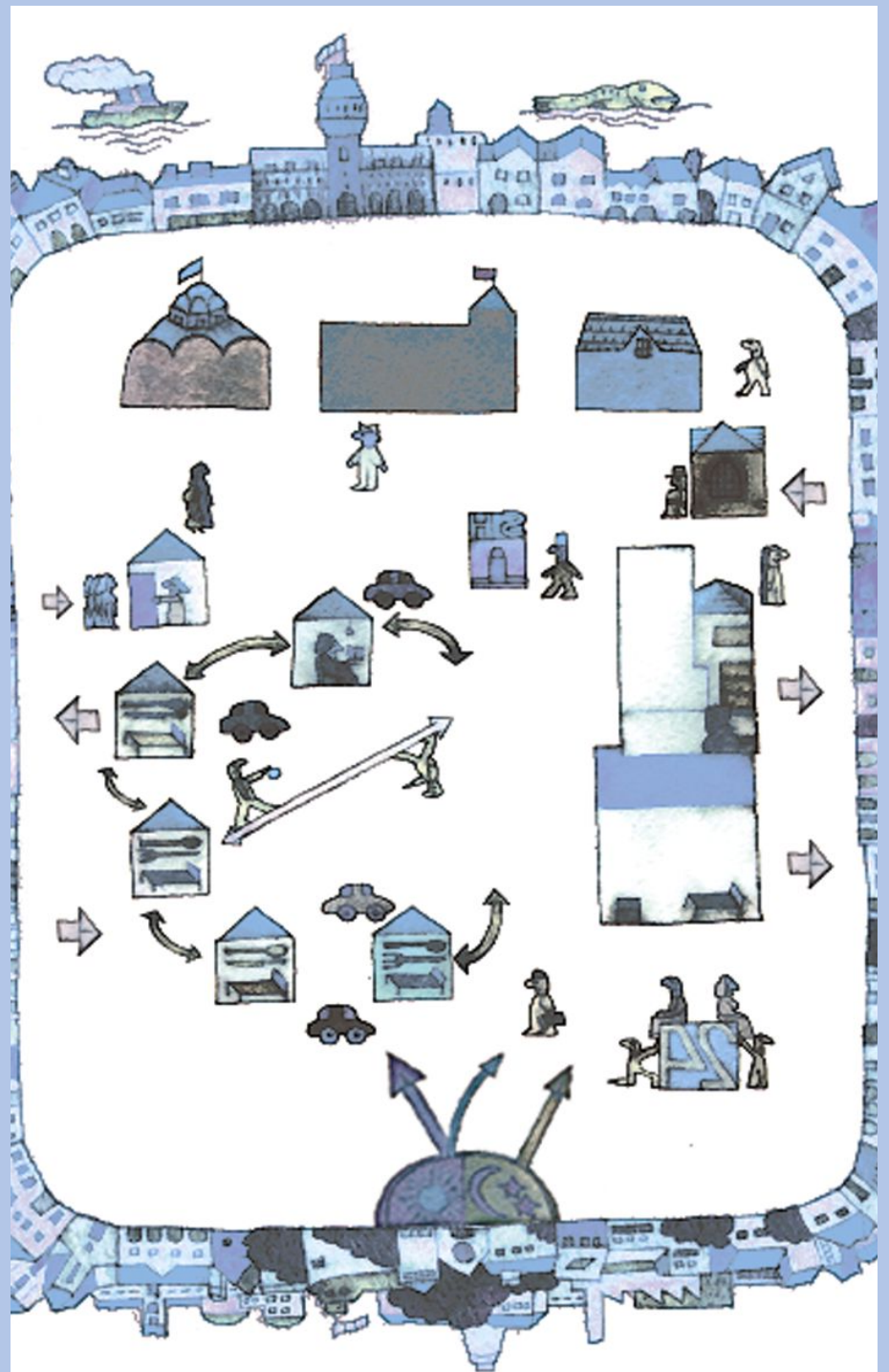


Freedom is therapeutic

(UGO GUARINO)

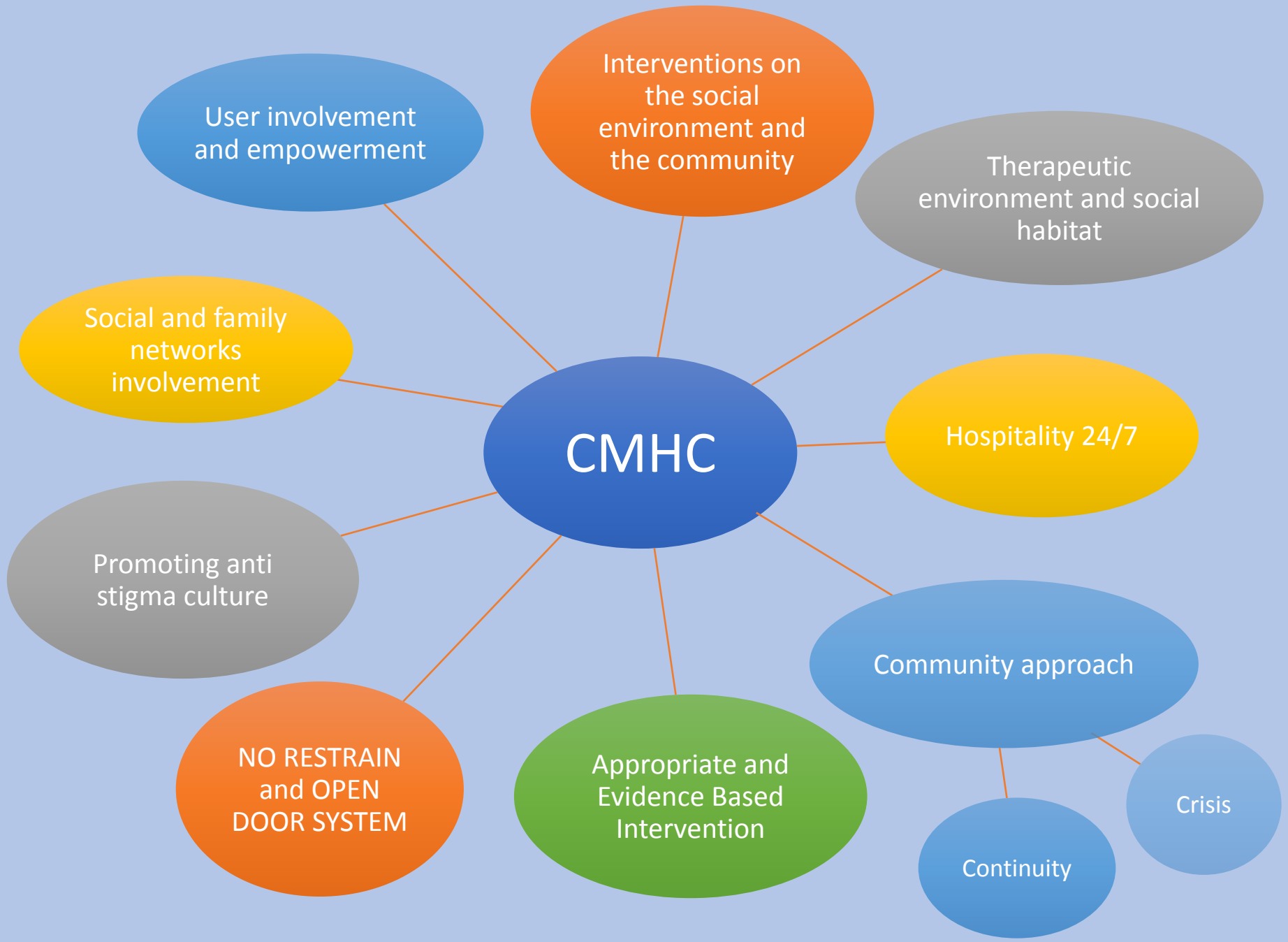
Trieste system of care (2019)

- 24 hrs CMHC are a a **system of opportunities** and are local solutions (responsibility and accountability), hub of care for continuity.
- **Health / illness interplay** in everyday life and of services
- Free **open access – immediate response**
- Holistic, ecological, person centered, recovery oriented
- SN, connections, inclusion, capital – extraclinical / social determinants
- Addressing **social determinants** of health = individual and collective responses (25% budget): personal budgets and microareas are examples, work grants, socialization funds.
- Mainstreaming MH in community health systems
- Resources and opportunities – diffused **daycare** with associations (wellness-wellbeing, social aggregation, participation, expression, gender, work)
- NGOs represent “the city”.
- BUILDING BRIDGES TO COMMUNITY - THE CARING CITY



Overarching criteria / principles of community practice in the MH Dept.

- **Responsibility (accountability) for the mental health of the community** = single point of entry and reference, public health perspective
- Active presence and mobility towards the demand = low threshold **accessibility, proactive and assertive** care
- Therapeutic continuity = **no transitions** in care
- Responding to **crisis in the community** = reduce the use of acute inpatient care
- Comprehensiveness = social and clinical care, **integrated** resources
- **Team work** = multidisciplinarity and creativity in a whole team approach
- ***Whole life approach = recovery and citizenship, person at the centre***


User involvement and empowerment
Interventions on the social environment and the community
Therapeutic environment and social habitat
Social and family networks involvement
CMHC
Hospitality 24/7
Promoting anti stigma culture
Community approach
NO RESTRAIN and OPEN DOOR SYSTEM
Appropriate and Evidence Based Intervention
Crisis
Continuity

The issues in the regional model of mh healthcare

- Our experience in Trieste and in the whole Region Friuli Venezia Giulia (1,200,000) for reform implementation is based on:
- A clear action for deinstitutionalisation of PH
- The development of 24 hrs CMH Centres (17 out of 21)
- The develpoment of a network of services for rehab and social integration, e.g. **group homes (now personal budgets), day centres and social cooperatives**
- The creation of “strong” MH Departments in order to co-ordinate all services according to principles of contrasting social exclusion, stigma and discrimination and promoting social inclusion.

Trieste ct’d

- A clear transition from residential structures to transitional houses to **supported housing, to independent living flats**, also thanks to personal budgets,
- and the regional resolution to **overcome restraint in all health and social structures**, etc. including nursing homes and general hospitals
- are some of the key facts that have been determined.
- **Involuntary treatments show some of the lowest rates in Italy (7 / 100,000) and about 40% of them are managed in the CSMs.**

Trieste ct.'d 2

- A public system, in coproduction with NGOs, with 24-hour services, as realized in FVG, **costs less than the national average (3.43% of the FSN compared 3.49%**).
- CSM 24 hours,
- personalized projects,
- the elimination of restraint
- are the main points of the report of the **Parliamentary Commission on the State of the NHS that visited all of Italy in 2011-2013** and started the closure of the OPG
- The **Trieste model** has been adopted recently in the Czech Republic, Wales, Crakow (Poland), Los Angeles, and other places.

Hospitalisation / hospitality

Institutional rules

Institutionalised Time

Institutionalised (ritualised) relations among workers / and with users

Time of crisis disconnected from ordinary life

Stay inside

A stronger patients' role

Minimum network’s inputs

Agreed / flexible rules

Mediated time according to user’s needs

Relations tend to break rituals

Continuity of care before/during/after the crisis

Inside only for shelter /respite

Maximum co-presence of SN

Hospitalisation / hospitality

Difficult to avoid:

Locked doors

- Isolation rooms
- Restraint
- Violence

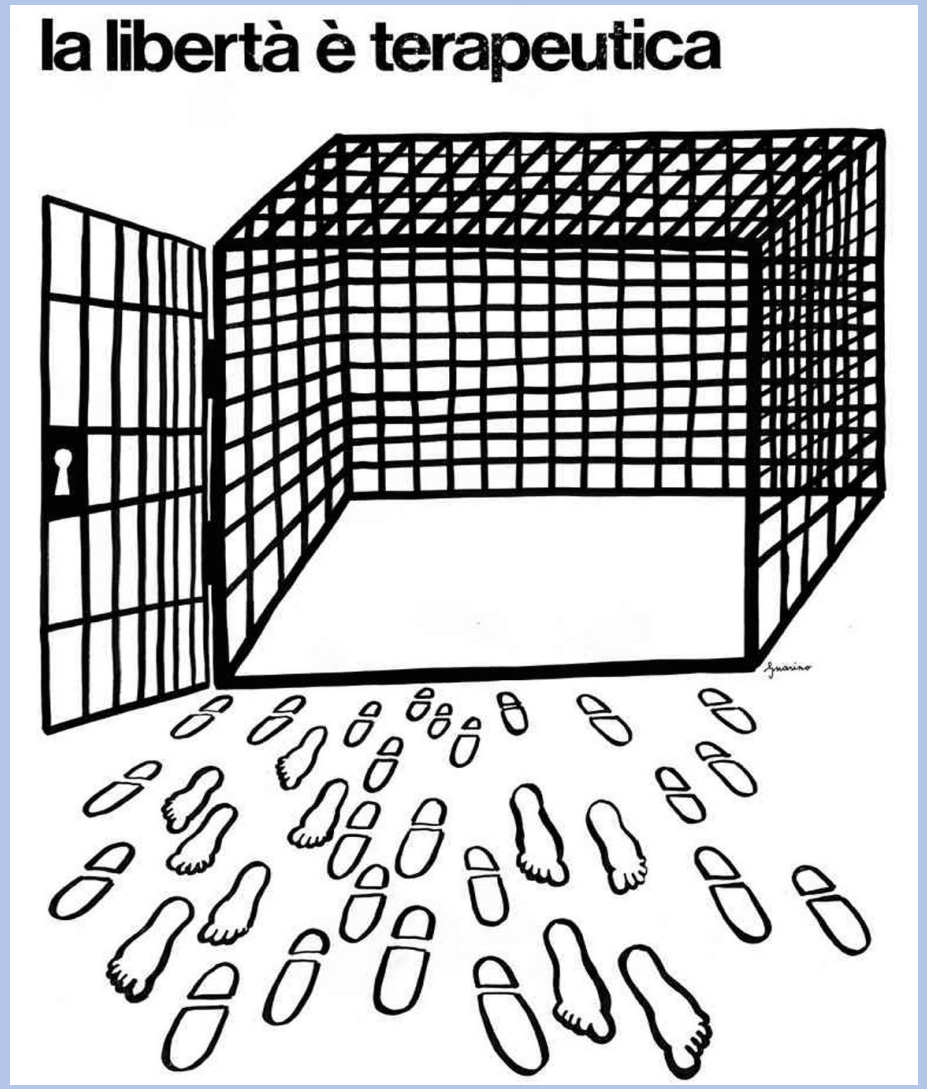
Illness /symptoms /body-brain

- Open Door System
- Crisis / life events / experience / problems

CSM DOMIO

CSM
BARCOLA


07/10/2008



Freedom is therapeutic

UGO GUARINO

For alternatives to coercion: a no restraint general framework

- The three E's
  Changing the relationship of power / law but also the structure of services and practices
- NO internment
  Citizenship rights
  Open door and non-restraint
  Critical and marginal use of involuntary treatment
  Negotiation
  Non-clinical but useful answers to life issues
  Alternatives to hospitalization
  No selection by gravity
  Continuity of relationship of trust

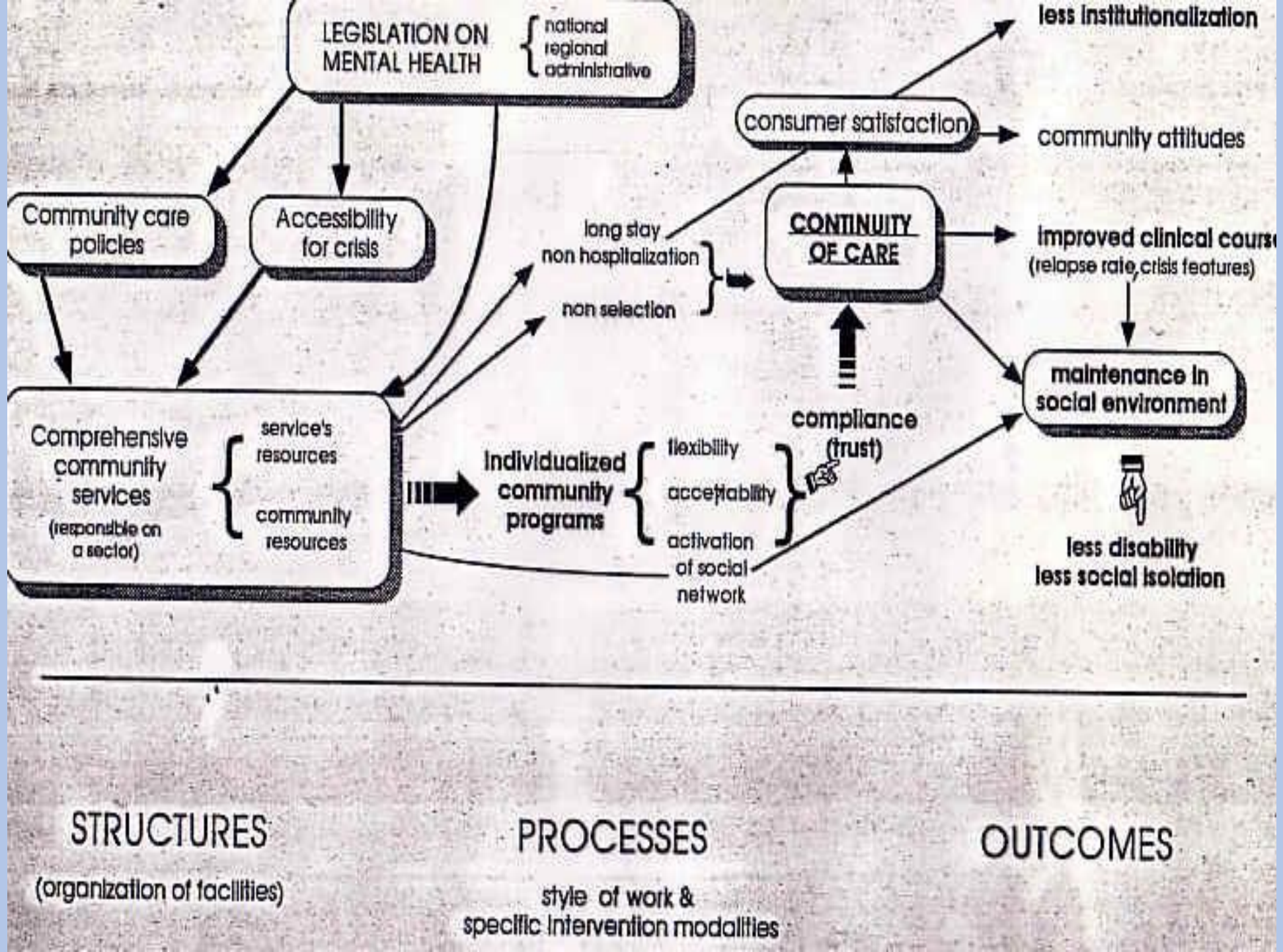
The 3 approaches in Trieste (Muusse and Van Roijen, 2015)

- 1) A **holistic approach**: in mental healthcare, the individual, and not the disorder, is emphasized. There are no patients or clients, but users, 'utenti'. Social exclusion is seen as a result of the medical model with its particular language, hierarchical relations and structure. The 'relational world view' is expressed by the following:
  - a) An individual's needs are assessed on the basis of his personal story/history, which also addresses his social relations, from family to neighbourhood.
  - b) In order to meet the needs of a user, personal relations between care work-ers and users are considered central.
  - c) Services are evaluated in terms of personal routes to recovery and empow-erment. To back up this idea, the community service centre is open 24-7.

- 2) An **ecological approach**: the emphasis is on the social context, the network and the social groups to which an individual belongs.
- Care is offered by the community, is outreaching, proactive and accessible, and aims at social inclusion.
- Care workers enter into relationships with the individual and his family, with housing services etc.
- The community centre offers prevention, as well as basic and spe-cialist treatment for all users in the region for which it is responsible; because of its 'territorial responsibility' for users, the community centre cannot transfer pa-tients with complex problems to other centres.

The 3 approaches

- 3) A **legal approach**: there is an emphasis on the civil rights of individuals with psychiatric problems, both in a legal and a social perspective.
- To create a community which guarantees inclusion and the possibility that everyone can exer-cise their social rights, a support network is essential.
- De-institutionalisation means having individual control over one’s own route to recovery.


LEGISLATION ON MENTAL HEALTH
national
regional
administrative
Community care policies
Accessibility for crisis
Comprehensive community services
(responsible on a sector)
service's resources
community resources
long stay
non hospitalization
non selection
CONTINUITY OF CARE
consumer satisfaction
less institutionalization
community attitudes
improved clinical course
(relapse rate, crisis features)
maintenance in social environment
compliance (trust)
Individualized community programs
flexibility
acceptability
activation of social network
less disability
less social isolation
STRUCTURES
(organization of facilities)
PROCESSES
style of work &
specific intervention modalities
OUTCOMES

Trieste: current threat

- The experience of Trieste, begun in 1971, represents the “practically true” invoked by Basaglia
- For 40 years asylum-free, it became a demonstration that is possible to act in a new way to foster subjectivity, empowerment, recovery and social inclusion while embracing a human rights approach (e.g. principles of open door, no restraint, hospitality, negotiation).
- Current regional policies are now posing a major threat to Trieste and the Friuli-Venezia Giulia Region, through the insecurity of institutional leadership, the impoverishment of teams, the linear cuts in services, that can open up spaces for privatization.

Lessons from Italy and Trieste

Community mental health and D.I.

- From what has been said, it emerges that **a really alternative community mental health nust derive directly from deinstitutionalization** through systems built around **individuals and communities** (Mezzina 2014, 2016).
- This refers to a **global and holistic approach** that relates medicine to welfare systems in a powerful synergy - the whole systems, whole life approach concept (Jenkins, Rix, 2002, IMHCN 2015).
- Attention **to individuals and citizenship rights raises the question of the values from which practices and services derive** (value-based services, Fulford, 2004).
- The construction of **personalized paths** is the main organizational-strategic key, in which the person has an active role and a bargaining power.
- Avoiding or **reducing "transitions in care"** (Segal, 2004) allows to reduce the risks of fragmentation of the service system.
- It is necessary to build **accountability** of services towards the community.
- The ownership of the care processes must be placed in the territory, but it is necessary to recognize the relevance of the **social contexts** as producers of meaning of health actions and as bearers of resources, which implies a refusal of the automatism of **"care packages"** indifferent to contexts of real application.
- The transition from **restorative medicine to participatory health** requires the development of the **protagonism of the subjects (stake- or shareholders) of the health system**, proposing a concept of leadership linked to the activation of change processes strategic and organizational cascade and continuous cycle.

FREEDOM FIRST :
realize human rights in mental healthcare

- There is now a momentum for addressing the transformation of mental healthcare by embracing human rights, and especially **personal freedom**, as a precondition of care.
- Human rights must be respected and practically realized as regards to **legal capacity, freedom of treatment, open door and no restraint policy, abandoning confinement and seclusion, right to work, housing, social inclusion.**
- It is a preliminary step to address **social justice and reduce stigma and discrimination** for people with mental health problems.
- Usually freedom is seen as a result of **recovery pathways**, instead it has to be seen as a basic component of the whole care relationships in mental health, a **preliminary choice** to address a real respect, empowerment and possibility of negotiation for people even in extreme mental distress.

Service principles: Community centered work in mental health. Integration

- Planning for the **integration of community mental health whole system** through:

- Using methodologies and structures for co-planning and co-management of all services, approaches and interventions.
- **Mainstreaming:** All mental health services should be an equal part of the general health care system and delivered at a local community level.
- **Co-production:** The participation and empowerment of service users and carers (both past and present) is necessary in the planning, management and evaluation of services. The energy for successful service transformation comes from the knowledge of those who use the services based on their whole life needs.
- **Equalities and Participation:** The participation of all stakeholders in decision making and self determination is essential for a co-production approach.

Services: deinstitutionalization and no coercion

- **No coercion:** All levels of involuntary and imposed treatments must be limited and considered a last resort after having possible alternatives. These practices based on human rights include having open doors, open access, no seclusion, no restraint, no compulsory treatment. These should be enforced legally and through shifting the power balance between the service user and the professional promoting a culture of positive / shared risk taking and developing specific training opportunities.
- **Work towards reducing the use of secure beds / units** means recognising that institutional forms of limiting freedom are contradictory and need to be addressed. We also need to manage the contradictions of sanctions within the prison system
- **No long term psychiatric hospitals:** The process of de-institutionalisation and closure of large psychiatric institutions is the foundation of community based mental health services. They should not coexist as this undermines the quality of the care and support in the community and peoples human rights.

Services: fully community based

- **Proximity:** Services should be offered as close as possible to people homes and in neighbourhoods known to the person. Person / group / network / local community / institutions / society: this is the progression from the individual to the collective and social dimension
- **Community based services** must be small scale, accountable, responsible, accessible, mobile, flexible, not only physically located in the community, including utilising social media, apps and other internet based supports. These must be accessible 24 hours a day, seven days a week with multidisciplinary staff also providing home treatment and respite beds as alternatives to hospitalisation.This should have the aim and the capacity to care for people with severe problems.
- **The Holistic approach:** to all aspects of life (health and social determinants) does not separate the mental health condition, life experiences and the vicissitudes of life as they should be understood and responded to in relation to the whole life needs of the person. This approach should apply to every organisation, system and interventions in many respects. This approach is antithetical to biomedical reductionism and therefore should be central to the new paradigm.
- **Evidence based ethics:** The adoption of ethical, bioethical, rights-based values must be founded upon a person centred approach. This requires the development of participatory, dialogical, dialectical, multilateral relations between services, citizens and communities.

Conclusions: recommendations

- Set up a **comprehensive / whole system** of care, based on clear values then procedures as safeguard of deinstitutionalisation
- Ensure coordination of services in a **given area** of the community (MH Department)
- Organise a strong comprehensive community service (**CMH Centre**, up to 24 hrs) for delivering care in an integrated and comprehensive way;
- then the components and contents of care can **have a clear common framework** (not as separate techniques) that is value based
- Integrate it into **mainstream health and welfare services to ensure an intesectorial approach**
- Improve **intensive case management**
- Consider it as a platform for accessing integrated care and individual recovery planning
- Include components of a **whole life** offer
- Provide **exits** from 'the circuit' to other social roles.

conclusions

- **Responsibility and accountability of the service enlarged to stakeholders ownership, are the core of the Public health approach in a given community.**
- Stepped care is not a need, while low threshold is much preventative
- Multisectorial approach through integration with healthcare districts, welfare services, community organizations
- **Individual perspective (person-centered - whole life)** and communities (community engagemente and devlopment) are not in opposition in whole system view. SDH mediated by a subectivity.
- Personal budgets and microareas are **practical examples** how to address **social determinants** of mental health at collective and individual level.
- **Deinstitutionalisation remains not only the primum movens of the whole process from hospital to community based care, but it is a continous effort to come closer to the needs of the persons with mh issues and the community to which they belong.**

Paradigm shifts

- This implies further paradigmatic passages or **shifts** (Mezzina, 2005):
- 1-from legal responsibilities for professionals, related to aspects of social control, assessed in terms of risk, to a **broader concept of responsibility** related to mental health of / for a given community (to which they respond - 'accountability').
- 2-from "specialized" services, inhomogeneous and fragmented, to holistic and global services ('comprehensive'), built around the idea of the person as a unit, supported in continuity of care, through '**life projects**' rather than by therapeutic programs and rehabilitation as such.
- 3-from services offered, measured in terms of outcomes in terms of efficiency and effectiveness, to **options / opportunities**, connected to the concept of an individual (personalized) path towards recovery and emancipation.
- 4-from **formal rights** (civil rights), as guaranteed by legislation, **to human and social rights** linked to the concept of citizenship, which implies the invocation of policies aimed at combating exclusion and providing resources and access to social inclusion.
- The degrees of freedom, which we can define among the main outcomes of the process and can be delineated by the opportunities and alternatives present in each phase of the process, **by the 'access to the exit'** from the network of services.

Shift

- A shift from **power on** - (a person subjected to a power), through the pedagogy of power (Basaglia), toward empowerment, that is bottom-up, or **power with** - (shared power, power of the subjects).
- A shift from **individual to collective dimension**: awareness of citizenship, self reflection on a person social life. Citizenship is exercising rights and acting rights, not just a status but a development, and it includes civil and social rights (work, house, social roles).
- All of this can be called **human rights today**.