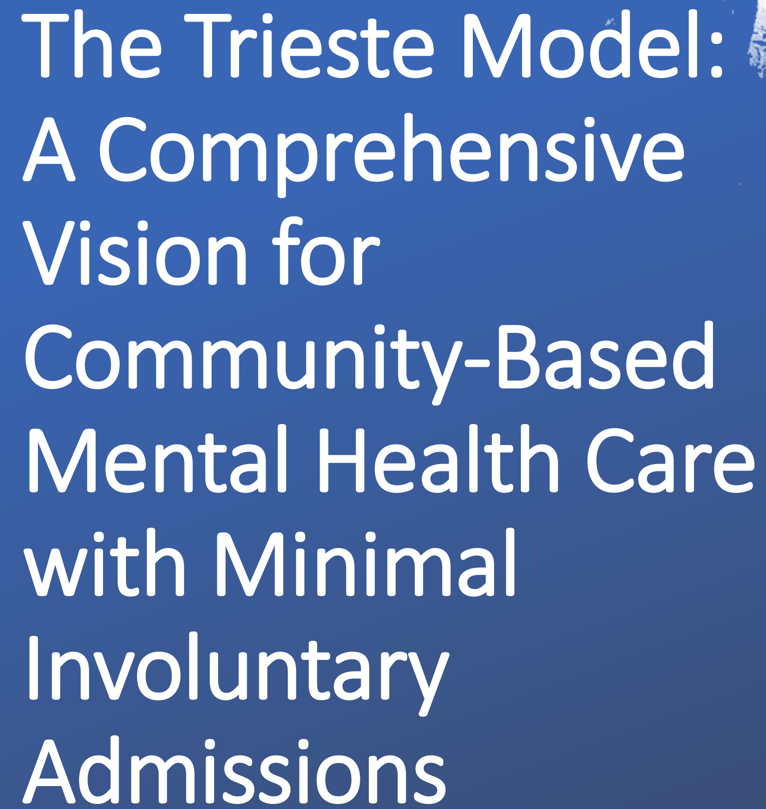


The Trieste Model: A Comprehensive Vision for Community-Based Mental Health Care with Minimal Involuntary Admissions

Vermont Program for Quality in Health Care

Roberto Mezzina, former Director, Trieste MH Dept and WHO CC

VP, World Federation For Menatl Health

Chair, International Mental Health Collaborating Network

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 (2014-2017).

The Italian constitution and the Law

Law 180 was rooted in what the Italian Constitution of 1948 anticipated:

- “The Republic recognizes and guarantees the inviolable rights of man, both as an individual and in social formations where his personality is turned” (art 2 Constitution);
- “No health treatment can be mandatory except by law. Practices harmful to human dignity are not permitted” (art 32 Constitution).

The Legislation of 1978 was based on the discovery of rights as the key tool in mental healthcare.

It fostered not only the closure of all asylums, but also the **lowest rate of involuntary treatment in Europe (17/100.000 in 2015)** and the shortest duration (10 days).

Dangerousness is not anymore mentioned as the reason for involuntary treatment

There is **no power assigned to the judiciary system** but the role of the ‘tutelary judge’ to **protect the rights** of the person (e.g. checking the consistency of the proposal of involuntary treatment according to the law’s criteria, the right to communication and right to appeal).

Searching for **voluntary care** is a clear mandatory rule, and this is a recognition of contractual power to the person

Involuntary treatments are **time limited** (usually a week) and they do not suspend all constitutional rights including freedom (obligation of care, not detention or seclusion)

This guarantees a totally different career for the patients, **without long-term institutionalisation.**

The Trieste model

Trieste is an internationally known experience that started in 1971 under the direction of the great figure of **Franco Basaglia**, and resulted in the **first closure of a psychiatric hospital in Europe in 1980** (Bennett, 1985; Dell'Acqua & Cogliati Dezza, 1986; Rotelli, 1988; Dell'Acqua, 2010). Moreover, it was also a process of change of thinking, practice and services.

Trieste showed a different way for an innovative community mental health, that has moved from a **narrow clinical model** based on the illness and its treatment to a wider concept that involves the **whole person – a whole life and a whole system engaging the social fabric** (Zero Project, 2015; The Economist Intelligence Unit, 2014).

The Mental Health Department is recognized as a **WHO Collaborating Centre for more than 30 years** and it is considered as a sustainable model for service development – even in a context of economic crisis, because of its clear demonstration of cost effectiveness (Mezzina, 2010, 2014, 2016).

According to the WHO (WHO, 2001), Trieste is one of the clearest examples of how the Italian movement achieved deinstitutionalization, intended as a complex process **"from within" a psychiatric hospital** resulting in the gradual relocation of its economic and human resources, and the creation of 24 hour community based services together with the development of social inclusion programs (Rotelli et al. 1986).

Closing the asylum

- The experience in Trieste became internationally known because of the **first closure of a psychiatric hospital in Europe in 1977** (Bennett, 1978), dismantling the apparatus and the institutional norms build on the person as a patient, as an object of the psychiatric institution.
  - 1. This work is marked by the first years (1971-1974) of transformation of the asylum and the creation of a state of **rights for the inmates**:
    - opening of wards and gates, assemblies, review of the status of hospitalization, increase in voluntary admissions, establishment of hospitality, economic subsidies, creation of the first working cooperative for patients, review of guardianships.
  - 2. This was followed by a phase of opening of the Community Mental Health Centers (1975-1978) together with the search for **housing solutions** for an increasing number of discharged patients (group-apartments).
  - 3. Finally, the closure of the asylum with its total substitution by the territorial network (1978-1980) that identifies organizing all **CMHCs** around the clock and with beds.

The Italian way to D.I.

- Why the ‘Italian way to deinstitutionalization’ remains a model of reform?
- Some of the key lessons learned during the course of this experience are:
- **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** – co-ordinated by a Mental Health Department - 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;

The Italian way to deinstitutionalization

- **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 national and regional context of healthcare

Mental Health Departments (from 1999): comparing Italy and Trieste

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 / 6 beds in Trieste

-**Community Mental Health Centers** (up to 12hr, possibily 24hr) 1/80.000 / 1/60.000 in Trieste, 24 /7

-Residential facilities - e.g. group-homes - with a wide range of support up to 24hr (30.000 beds in Italy, mostly NGOs) / no more than 4 people now in Trieste in a supported housing scheme

-Day Centre (also with NGOs) / not one, but multiple sites in the city in Trieste

ITALIA

FRIULI VENEZIA GIULIA

1.215.538 abitanti

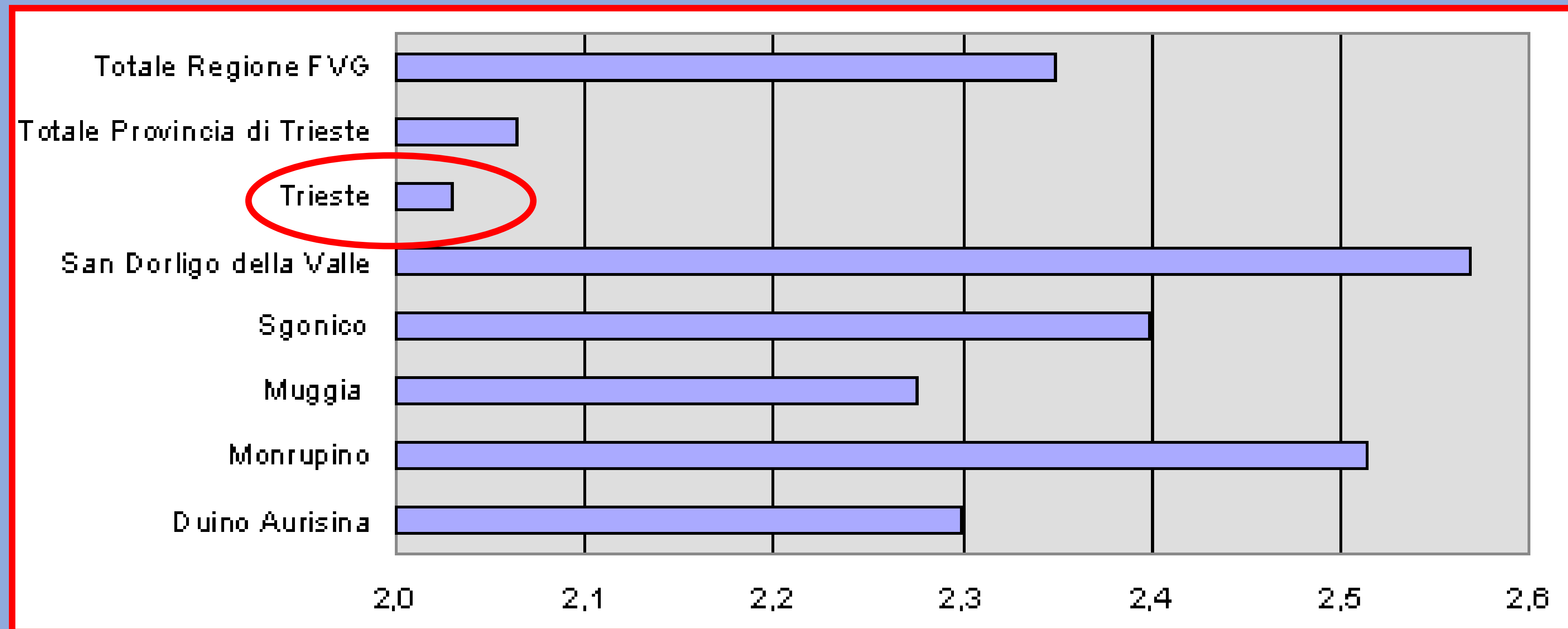
234.638 abitanti

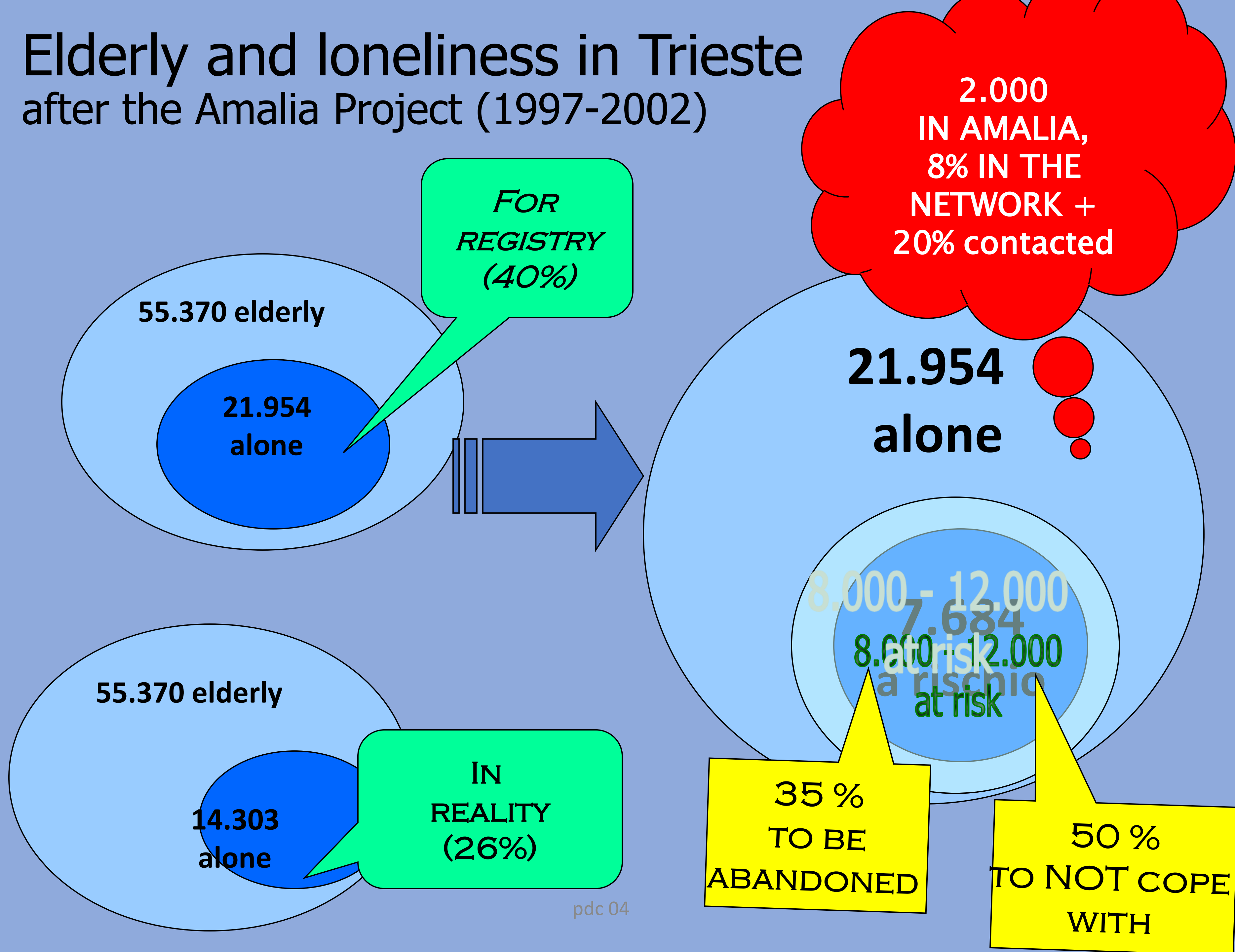
ITALIA

60.483.973 abitanti

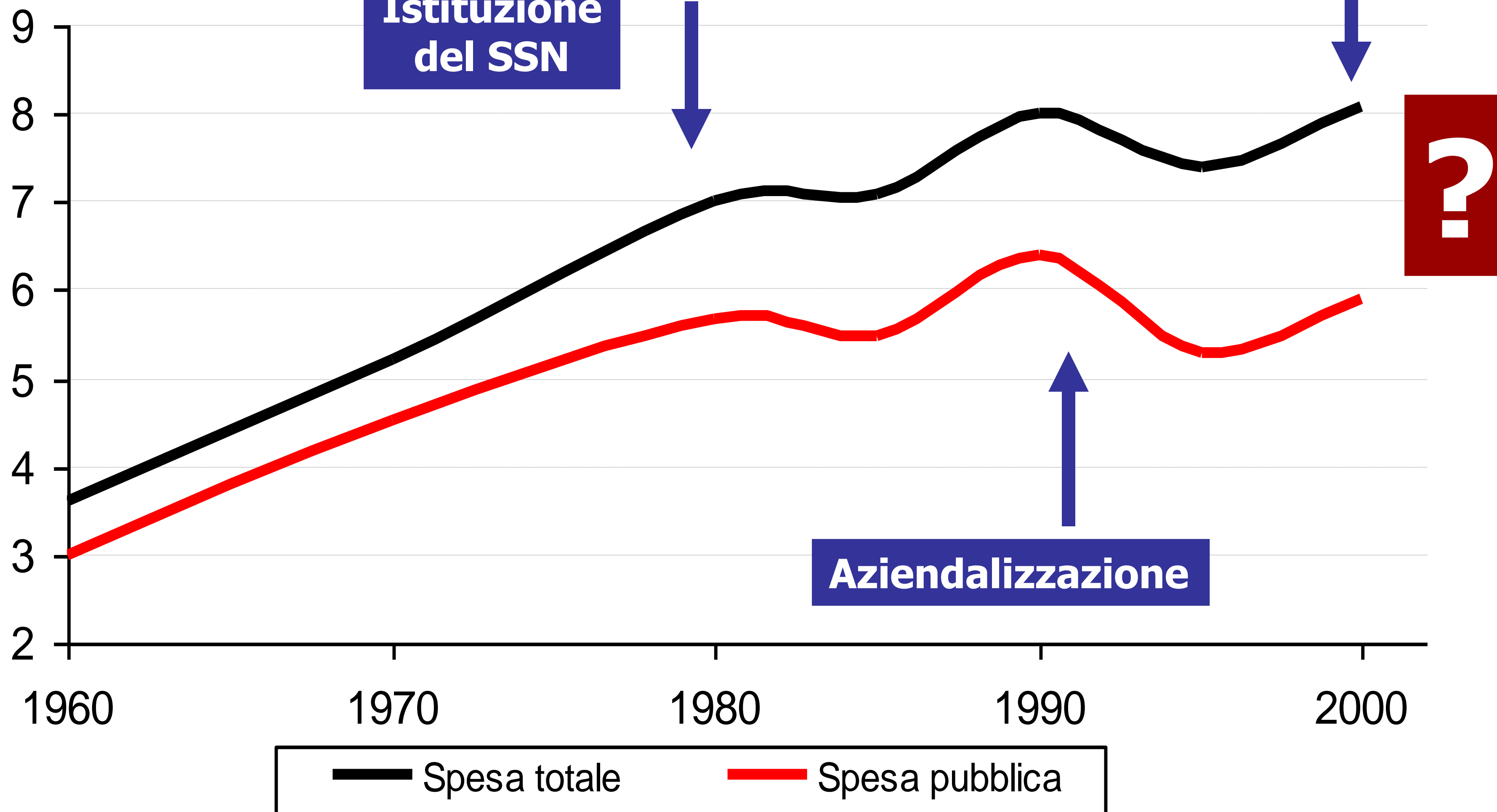
Fonte ISTAT 2018

Mean dimension of the family (2001)





Elderly and loneliness in Trieste
after the Amalia Project (1997-2002)
For registry (40%)
55.370 elderly
21.954 alone
55.370 elderly
14.303 alone
In reality (26%)
2.000 IN AMALIA, 8% IN THE NETWORK + 20% contacted
21.954 alone
8.000 - 12.000
7.684
8.000 - 12.000
at risk
a rischio
at risk
35 % TO BE ABANDONED
50 % TO NOT COPE WITH
pdc 04



Spesa sanitaria totale e pubblica in % Pil Italia
1960-2000
Istituzione del SSN
Federalismo
?
Aziendalizzazione
9
8
7
6
5
4
3
2
1960
1970
1980
1990
2000
Spesa totale
Spesa pubblica

Le leggi fondanti i nuovi servizi sanitari e sociali

DL 229/1999

"Art. 1

(Tutela del diritto alla salute, programmazione sanitaria e definizione dei livelli essenziali e uniformi di assistenza)

1. La tutela della salute come **diritto fondamentale dell'individuo ed interesse della collettivita' e' garantita, nel rispetto della dignita' e della liberta' della persona umana, attraverso il Servizio sanitario nazionale**, quale complesso delle funzioni e delle attivita' assistenziali dei Servizi sanitari regionali e delle altre funzioni e attivita' svolte dagli enti ed istituzioni di rilievo nazionale, ….

L. 328/2000

Art. 1.

(Princìpi generali e finalità)

La Repubblica **assicura** alle persone e alle famiglie un sistema integrato di interventi e servizi sociali, promuove interventi per **garantire la qualità della vita, pari opportunità, non discriminazione e diritti di cittadinanza, previene, elimina o riduce le condizioni di disabilità, di bisogno** e di disagio individuale e familiare, derivanti da inadeguatezza di reddito, difficoltà sociali e condizioni di non autonomia, in coerenza con gli articoli 2, 3 e 38 della Costituzione.

LIVELLI ESSENZIALI DI ASSISTENZA (LEA)

- **Collective health care** ***(life and working enviroments, prevention activities, protection from pollution – related risks, veterinary public health, consumer protection, vaccination & prophylaxis for communicable diseases)***

- **District health care** *(OUTPATIENT CARE : health and primary care, family physicians, pharmaceutical assistance and prostheses, home care, residential care, care for chronically ill or disabled people, rehabilitation,* ***mental care services****)*

LIVELLI ESSENZIALI DI ASSISTENZA (LEA)

- **Hospital care** *(emergency wards, ordinary hospitalization, day hospital and day surgery, long-term hospitalization, rehabilitation, ecc)*

- **NOT included** *(plastic surgery, non conventional medical treatments, some types of physiotherapy : hydromassage therapy, ultrasound-therapy ,ecc ….)*
- **PARTIALLY included** *(e.g. dentistry…)*

Health and social care

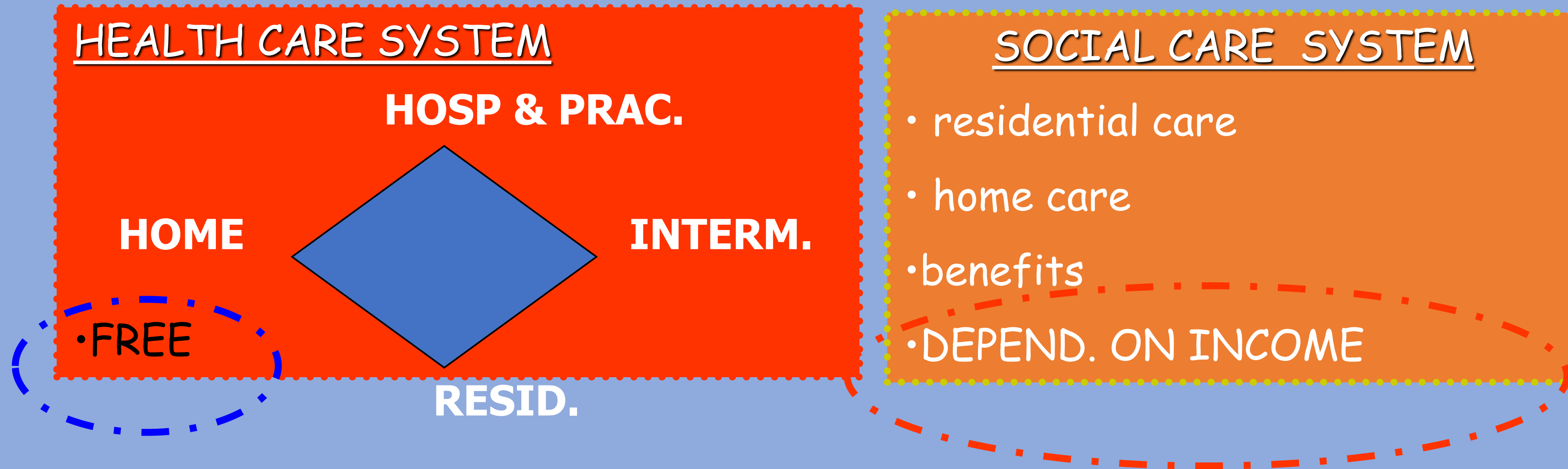
HEALTH CARE

- hospital
- primary care
- intermediate structures (country hospital, rehab. Homes, hospice)
- residential care
- home care
- prevention

SOCIAL CARE

- interventions in the area of : normality, difficulty, risk
- Home care
  - global service (meals, laundry, ecc), financial support, housing
- residential care
  - for all degrees of disability/disautonomy

The costs for citizens



FINANCING FOR SOCIAL & COMMUNITY HEALTH PUBLIC SYSTEM

year 2001	COUNCIL T.	ASS N.1
CURRENT EXP.	Social serv.	Health serv.
employeed	10.8	36.2
purchase of services	12.4	258.3
transfer to citizens of services	20.7	258.3
TOTAL	46.0	305.3
FINANCING		
from Region FVG	20.7	289.3
entrance from fee for services	5.7	4.6
financing		
general taxation	13.4	
local taxes	10.8	
fee for services	3.6	
TOTAL	27.9	293.9
pdc 04	mil.euro	

Service structure in Trieste

REGIONE AUTONOMA FRIULI VENEZIA GIULIA

Azienda Sanitaria Universitaria Integrata di Trieste

DIREZIONE GENERALE

- COMUNICAZIONE, RELAZIONI ESTERNE AZIENDALI E UFFICIO STAMPA
- S.C. RICERCA, INNOVAZIONE CLINICO-ASSISTENZIALE, QUALITA', ACCREDITAMENTO E RISCHIO CLINICO
- S.C. CONTROLLO DI GESTIONE
- S.C. STAFF, INNOVAZIONE, SVILUPPO ORGANIZZATIVO E FORMAZIONE
- S.S.D. PREVENZIONE E PROTEZIONE AMBIENTI DI LAVORO

DIREZIONE SANITARIA

- S.C. DIREZIONE INFERMIERISTICA E OSTETRICA
- S.C. ASSISTENZA FARMACEUTICA
- DIPARTIMENTO ASSISTENZA TERRITORIALE
- DIPARTIMENTO DI PREVENZIONE
- DIPARTIMENTO DI ASSISTENZA OSPEDALIERA

DIREZIONE AMMINISTRATIVA

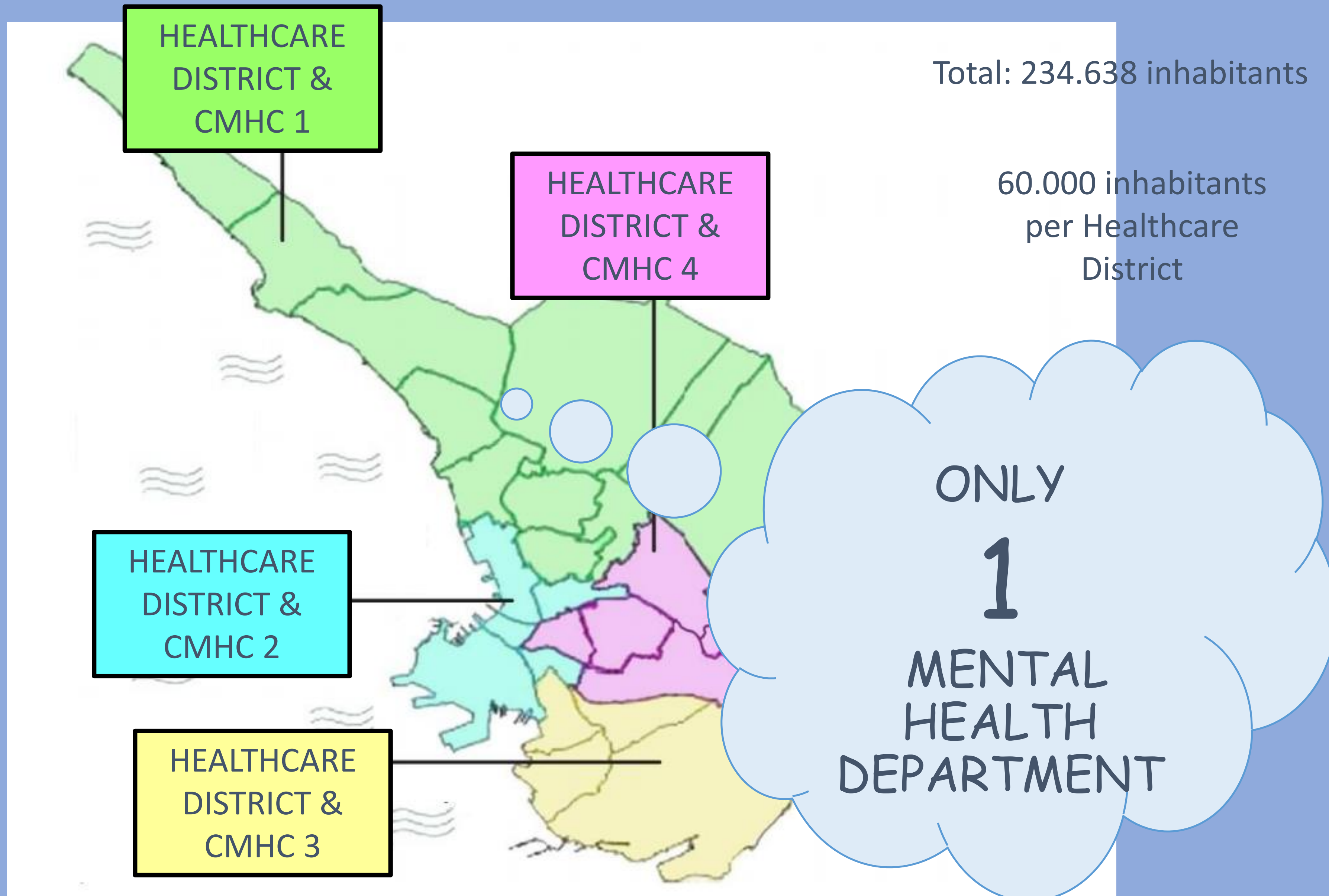
- DIPARTIMENTO AMMINISTRATIVO
  - S.C. GESTIONE DEL PERSONALE
  - S.S.D. CONVENZIONI, RAPPORTI CON IL TERZO SETTORE, ACQUISIZIONE E VALORIZZAZIONE IMMOBILIARE
  - S.C. ECONOMICO FINANZIARIA
  - S.C. AFFARI GENERALI, LEGALI ED ASSICURAZIONI
- DIPARTIMENTO TECNICO
  - S.C. APPROVVIGIONAMENTI E GESTIONE SERVIZI
  - S.C. INGEGNERIA CLINICA
  - S.C. MANUTENZIONE E SVILUPPO DEL PATRIMONIO
  - S.C. INFORMATICA E TELECOMUNICAZIONI

DIREZIONE DEI SERVIZI SOCIOSANITARI

- S.S.D. INTEGRAZIONE SOCIOSANITARIA

Dall'ATTO AZIENDALE d.d. 06/12/2017

The 4 CMHCs of Trieste



Total: 234.638 inhabitants

60.000 inhabitants per Healthcare District

GD

Target people and activities in the 4 districts

THE TARGET

ALL CITIZENS (not only ill)

ALL CITIZENS (prevention programmes)

IMMIGRATES

PEOPLE WITH MENTAL HEALTH DISORDERS

PEOPLE WITH DRUG DEPENDANCE

CHRONICITY

TERMINAL PATIENTS

ELDERLY

DISABLED

WOMEN

CHILDREN

COUPLES & FAMILIES

THE ACTIVITIES

The 'caring city': community health and development in Microareas

- **Non-medical determinants for health** – social deprivation and isolation, hence:
- **<u>Microarea Habitat Project</u>** (**global, local, plural**) activated in Trieste in collaboration with the City of Trieste and the Public Housing Agency (Ater), and then expanded to include other Regional areas in the context of the Microwin project.
- 20 areas of te city, with an average population of approx. 1000 persons each, for a total of 15,000 inhabitants.
- **Interventions:**
- learning about residents, verifying health conditions,
- guaranteeing integrated good healthcare and social-healthcare practices,
- reducing inappropriate hospitalisations or stays in nursing homes,
- verifying the appropriateness of therapies, diagnostics and analyses,
- promoting self-help,
- developing collaboration among services and among other actors, such as volunteer groups and/or stakeholders,
- promote community development and cohesion.

Features of the Mental Health Department in Trieste – 2019

- **Facilities:**
- 4 Mental Health Centres (equipped with 6/8 beds each and open around the clock) plus the University Clinic)
- A small Unit in the General Hospital with 6 emergency beds
- A Service for Rehabilitation and Residential Support 5(98 supported living places for no more than 4 people together) and a diffused Day Centre with associaitions including training programs and workshops);
- **Partners:**
- 11 accredited Social Co-operatives.
- 8 Families and users associations, incl. clubs and recovery homes.
- **Staff: 214 people**
- 23 psychiatrists, 7 psychologists, 111 nurses, 10 psychosocial rehabilitation workers, 8 social workers, 27 support operators, 12 administrative staff.

D.I. is the motor for Trieste

Individuals cared in their SN

NO ASYLUM

Free **open access** (20 spots)

24/7 service

open doors, no coercion (invol. Treaments, forensic), **no restraint** (freedom first or freedom is therapeutic)

Value base: Rights, citizenship, civil rights, house, work, mainstreaming in welfare and health systems.

Empowerment: liberating relationships of care from social control connected to psychiatry.

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

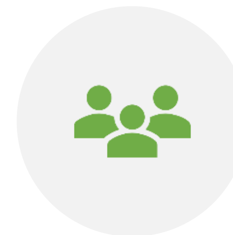
A value based service

HELPING THE PERSON, NOT TREATING AN ILLNESS.

RESPECTING THE SERVICE USER AS A CITIZEN WITH RIGHTS

MAINTAINING SOCIAL ROLES AND NETWORKS

FOSTERING RECOVERY AND SOCIAL INCLUSION



ADDRESSING PRACTICAL NEEDS THAT MATTER TO SERVICE USERS

CHANGE THE ATTITUDE IN THE COMMUNITY

Hospitalisation / hospitality (CMHC)

- 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

From Trieste to the **whole Region** FRIULI VENEZIA GIULIA: what has been achieved (from 1996 on)

- The **24 hrs open access** community services
- A clear transition from residential structures to transitional houses to **supported housing, to independent living flats**, also thanks to personal budgets
- the regional resolution to **overcome restraint in all health and social structures**, etc. including nursing homes and general hospitals
- As an important **indicator, involuntary treatments show some of the lowest rates in Italy (7-9 / 100,000) and about 40% of them are managed in the CSMs.**

What is a 24hr CMH Centre?

An open door on the street

A multidisciplinary team in a normalised therapeutic environment (domestic) for day care and respite, socialisation and social inclusion

A multifunctional service: outpatient care, day care, night care for the guests, social care & work, team base for home treatment and network interventions, group & family meetings / therapies, team meetings, mutual support, relatives and other lay people visits, inputs and burden relief.

Social cooperative home management

Leisure and daily life support (self care; breakfast, lunch and dinner)

And many other ordinary and straordinary things ...

CSM DOMIO

CSM BARCOLA

Access and response in a crisis

- 8-20: **direct referrals** to the CMHC, non formality, real time
- response (mobile front line) - as a roster

- 20-8: **access** to the consultation at the emergency Unit (6 beds)
- through casualty dept, then overnight accomodation in the
- emergency unit.

But:

- No admissions in the emergency unit as a rule.

Thus:

- The day after the CMHC team comes. The 24 hrs rule: within 24
- hrs otherwise admitted.

Usually:

- Crisis supported at home or hosted in the Centre
- Avoiding invol. treatments
- Invol. Treatments in the CMHC as a first choice

Key procedures

- Emergency reduced to a minimum (proactivity and continuity of care de-construct emergencies)
- Walk-in, immediate intake and assesment, easy access, low threshold to early signs, respite to de-escalate, etc
- Early and quick intervention in real time: take your role and be responsible. This reassures agents of referral, e.g. relatives and the SN in general.
- NEGOTIATION – shared decision making process

The Centre as a resort for crisis respite

- Hospitality is agreed **without formalities** with user and relatives, and decided and **managed by the same team** (e.g. in case of a not agreed self-discharge, the team operates a re-negotiation; the plan of care is decided or re-discussed during the admission / hospitality) – **team sense of ownership**
- users/guests can receive **visits** without restrictions and are encouraged to **keep their ordinary life** activities and the links with their environment (operators and volunteers do activities outside with them everyday)
- it is done in the same place where users come for everyday care and rehab, therefore crisis is **"soluted" and un-emphasised** in everyday life
- often it is followed by a period of **day hospital attendance** to strengthen and develop the therapeutic relationship and the ongoing plan of care. Mean duration of 24 hr admissions is 10-12 days.

Crisis management in the Centre

Actions in crisis management

- Personalise the ‘control’ of the problematic or difficult user, including **personalised side-by-side assistance** if necessary
- Negotiating acceptance/admission with the user, from the DH to day-night hospitality (status of **‘hospitality for health’)**
- Continuous effort to **obtain compliance with treatment**/care through a relationship based on trust
- Inclusion of the user in crisis in both structured and non-structured activities
- Escape” / looking for / **re-negotiating** return: “what was wrong with you in the centre?”

Involving the team

- Information managed collectively (not by select individuals/operators) / **TEAM MEETINGS**
- Case notes and the team’s activities: should always be related to **individual life-stories**, group discussion and the group’s sense of community

Mobilising human and institutional resources

- A **first network of relationships** is provided by the **operators** whose willingness and availability is in direct relation to the closeness of their relationship with the patient.
- Out of this informal way of containing his anxiety there emerges, at minimum, a **personalized therapeutic relationship** (key workers) with a limited nucleus of operators who make themselves more directly available in the various stages of the intervention, and thus “enter into play” with him.
- **Decoding crisis** through the confrontation and mediation among different viewpoints and needs **(PARTICIPATORY DECODIFICATION OF THE CRISIS) when the social system is involved.**

Maintaining the social system

- **Shared responsibility** (among user, service, family and other users who will provide support) and constant search for agreement.
- The **inside** and the **outside** of the therapeutic context (the user can go outside, though perhaps accompanied, may go back home for a period of time, request the response to immediate needs, etc.).
- The CMHC's 24-hour hospitality **does not sever ties** with his/her environment (family contacts, time away from the centre alone or accompanied, taking care of specific personal needs).

A social system intervention

The only way to **make social systems work** is **sharing responsibility and empowering them**

- De-codifying crisis through knowledge and narratives: participatory meaning-making aorund the question: “why the crisis?”
- Individual plans (recovery phase) using all support systems, incl. the Centre as such.
- Participatory de-codifying: understanding reasons and meanings / explanations
- Mediating points of view: overlapping consensus
- Relieving the burden: helping the others

The 24hr CMHC is not:

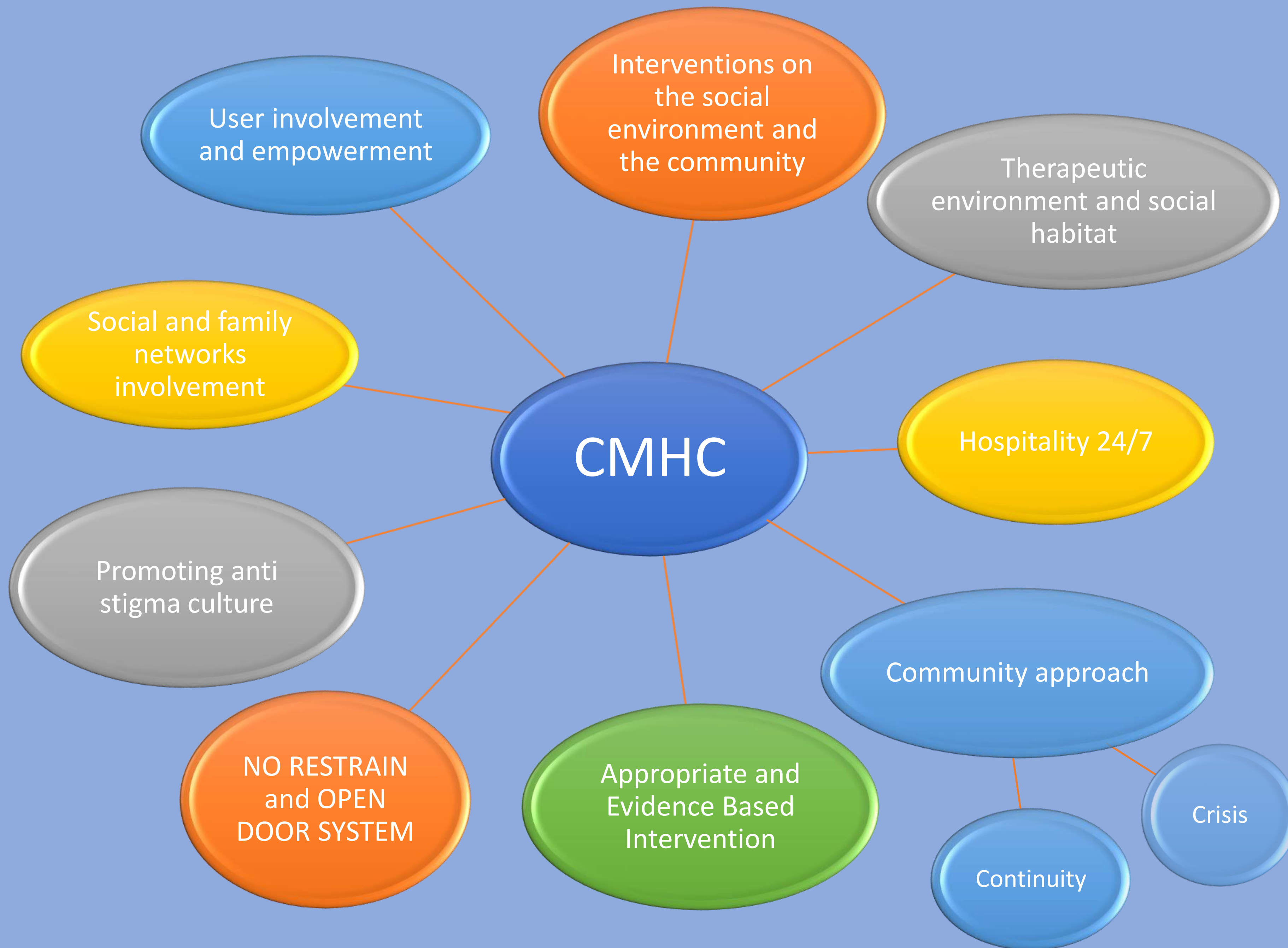
- A ward, which maintains the rituals of the hospital and where the community cannot enter
- A residential facility, with different hours and rhythms that are modulated in accordance with everyday life
- The availability of beds within a community service, or in facilities connected to it (respite)
- A simple extension of service hours
- The addition of a night-time on-call service in the community

Advantages of the 24hr CMHC

- Point of reference open 24 hrs
- The personnel can be utilised flexibly
- Users can receive a wide range of responses
- The crisis comes into immediate contact with a system of resources/options, including for rehabilitation
- The user is always assisted by a single team that has a contractual relationship with him/her

Advantages of the 24hr CMHC

- Both admission (hospitality) and release can be decided and agreed to immediately, without bureaucracy or referrals
- Avoids the immediate loss of contact with normal living contexts and networks
- Avoids the immediate loss of ability, and the role connected to one’s abilities, leaving the user active and free
- Reduces the stigma of hospitalisation



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Services Network

Healthcare Districts
Hospitals
General Practictioner
Social cooperatives
Schools
Popular housing Agency
Tutelary Judge
Prison
Region
Community Mental Health Center
Municipality Social Services
Labor office
Department of Addiction
Residential facilities
Volunteer Associations
Department of Prevention
Citizen Associations
Relatives
Law Enforcement
Employers
Emergency Services
Support Administrators

CF

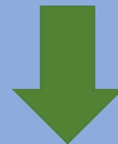
Team composition

- Psychiatrists
- Psychologists
- Nurses
- Social Workers
- Psychiatric Rehabilitation Technicians
- Support Operators
- Administrative Staff
- Professional Educators
- Peer support workers, volunteers, trainees, students,….

1 - Functions of the CMHC 24/7

- Acceptance of referral
- Continuity of care
- Crisis home treatment or CMHC hospitality

DEALING WITH COMPLEX NEEDS



MULTIDISCIPLINARY TEAM AND CASE MANAGEMENT

6 – Continuity of care

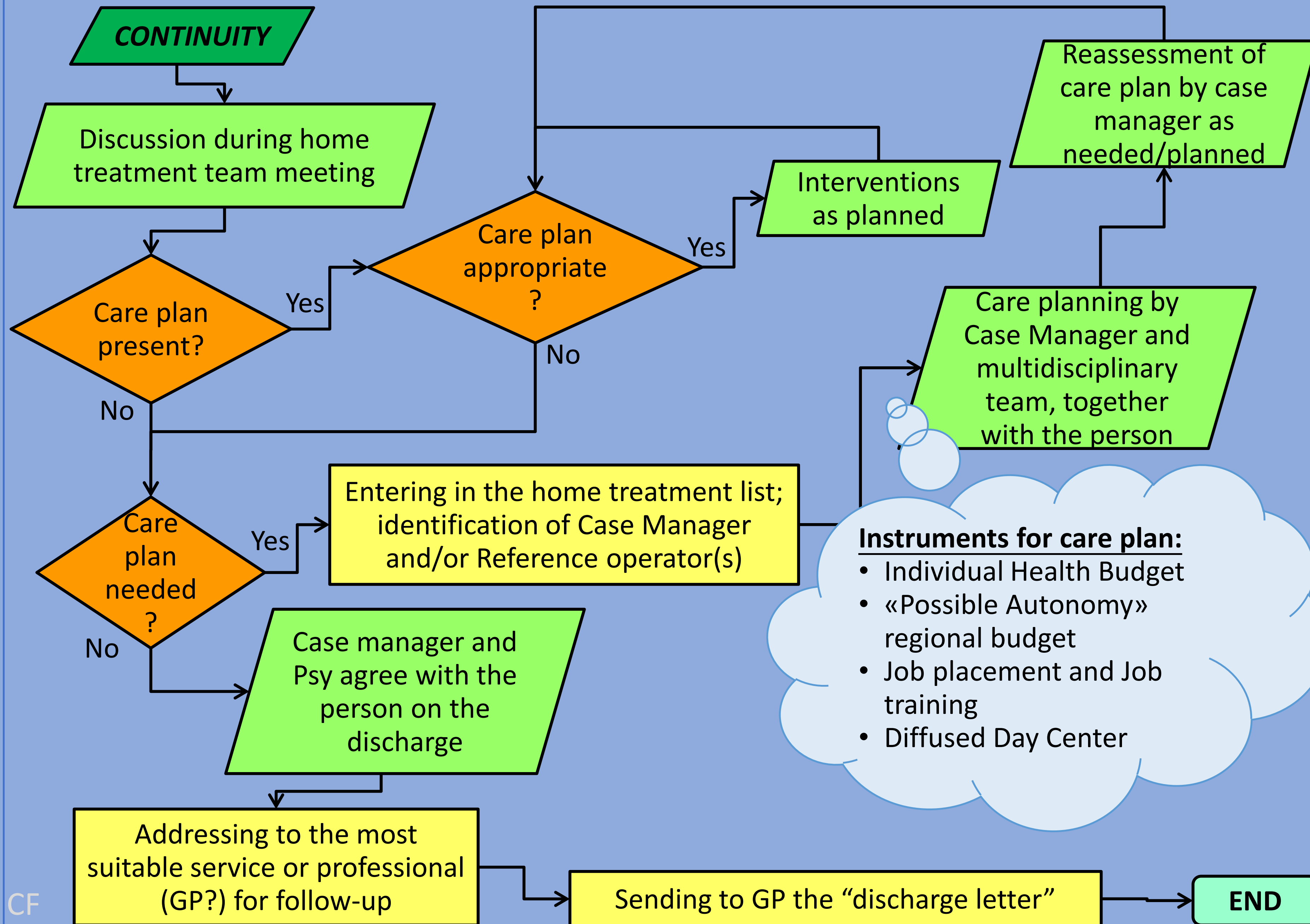
AIMS:

PROACTIVITY AND PREVENTION

METHODS:

- Individual and group case management;
- Secondary prevention;
- Recovery pathways, rehabilitation and social inclusion;
- Integration at community level;
- Networking

6.d – Continuity of care flow chart



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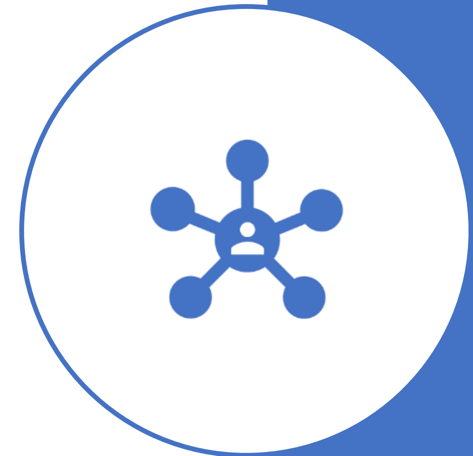
Service networking

- Beyond the acknowledgment of the value of the single individuals and the families, the need for the valorization of **families and consumers as collective subjects** gradually becomes imperative as far as they present themselves to the attention of the service.
- Thus at a some stage in this process, a need for working out new strategies to open to **more collective levels of participation** startes emerging.



A parallel empowerment

It is necessary also to **work on the institutional relationships.**

Clients' and families empowerment through their active participation in mental health also means **accepting their contribution to further modifications of a mental health service** in a common action

- Peer support (in **recovery house** and **CMHCs)**

In parallel modifying the **mental health worker's role**: deinstitutionalizing his knowledge, his actions, demystifying his power or using it in other directions as compared to the "control of the patient", e.g.

favouring a comprehensive approach of client's problems toward **a whole life approach**, by meeting the needs and by re-acquiring a status of right (that is **citizenship**).

Pathways of care and recovery – work, housing, social inclusion

Pathways of recovery through the service

- Contact into community, in living places
- A key-worker but also a team, a place (the CMHC) which is the only reference
- through significant others (full use of SSN, kept involved even if conflictive)
- Understanding toghether
- Helping to find mediations and even solutions of conflicts, preserving autonomy
- avoiding emergency by a rapid response
- Stay at home or at CMHC, not in hospital,
- Persistent offer of relationship and care
- Avoid involuntary treatments, negotiation and shared decision making, everything, follow you on the long run

- Immediate offer of rehab and access to opportunities (a sereis of programmes developed into community and with -)
- Offer of reciprocal relationships, social roles
- Participation in the Center’s life, sense of familiiarity
- Discuss “what do you want to do with your life” as a basis for an individual program or “a project”
- Helped with money, work or training, education, living places, acitivity, relations when they’re broken
- Creating opportunities for recovery and emancipation from dependency, social exclusion e.g sports, leisure, culture, wellness etc

Personal healthcare budgets

- From 2005 **PHB have been developed** to help particularly **people with complex needs** using personalised healthcare budgets, by setting up special projects with the support of NGOs.
- **150 clients** per year receive a personal budget in order to fulfil the aims of a joint and shared plan of recovery in the areas of **housing, work and social relationships.**
- This allowed the process of reducing group homes and developing independent living
- This represented about 20% of the overall budget of the DMH, while about 4% is devoted to economic aid, training grants, leisure and projects with NGOs (s.c. extra-clinical activities).

Moreover:

- About 300 people are in professional training every year on work grants, and 20-25 of these find proper jobs each year in the Trieste job market, many in the field of social cooperation and about a third in private firms.

ALTRE MODIFICHE INTERVENUTE NEL CORSO DEL 2018

attivata una nuova tipologia di Budget Individuali di Salute (di seguito BIS) ad altissima flessibilità per le particolari esigenze del servizio "Supporto e Trattamento Intensivo Domiciliare (di seguito STID). Si tratta di un "pacchetto" ore, indicativamente 90h/mese con eventuale conguaglio a fine anno se lo sforamento risultasse superiore/inferiore alle 30h sul totale annuale, da utilizzarsi al bisogno che si differenzia dagli interventi flessibili, quantificati in un massimo di 4/h per settimana, proprio per l'imprevedibilità del suo utilizzo in termini quantitativi. Questa tipologia di BIS è contabilizzata con un canone mensile pari a E. 2.000 (+ IVA),

formalizzata l'attività della Recovery House, sia per le persone accolte in regime h24 sia per i supporti diurni e le attività collettive a sostegno del al progetto,

ATTIVITA' COLLETTIVE

TITOLO	DESCRIZIONE
Settimane benessere	Attività circoscritta ai mesi estivi (max 10 sett/anno) è un intervento diversificato intensivo per favorire il recupero psico-fisico
Aurisina Orto	Nuova progettualità specifica per sensibilizzare le persone alla cura dei prodotti (non si svolge nei mesi di novembre, dicembre e gennaio)
Aurisina Cucina	Nuova progettualità specifica per formare/informare gli utenti rispetto ad un'alimentazione corretta
Recovery diurno	Nuova attività a supporto dei progetti Recovery House conclusi o in fase di definizione
Attività collettiva WRAP	Wellness Recovery Action Plan (Piano per la ripresa e il benessere) attività per facilitare la percezione, gestione e autocontrollo del malessere.
Attività collettiva famigliari	Nuova attività erogata nell'ambito del progetto Recovery House diretta ai famigliari coinvolti
Capacitazione stili di vita	L'attività è la prima sperimentazione del progetto "Riconversione pasti". Sono stati chiusi 6 BIS a bassa intensità e le risorse reimpiegate collettivamente (75% x interventi individuali, 20% interventi di gruppo, 5% presenza presso il CSM Barcola)

ABITARE

LUOGO	NUMERO POSTI
VILLA CARSIA	9
V. NEGRI	9
PENDICE SCOGLIETTO 14	3
OPICINA/DOBERDO'	3
Vle MIRAMARE	5
Viale XX SETTEMBRE 43	9
RECOVERY HOUSE	4
TOTALE	**42**

ASSISTENZA H 24 TALVOLTA IN CO-PRESENZA

TALVOLTA COMPARTECIPAZIONIALLA SPESA

07/10/2008

Trieste

- **Homes, jobs, goods, services, relationships** have been favored by the de-institutionalization process with the conversion into investments and community services.
- **Trieste pioneered in 1972** the social coops movement.
- The first cooperative society was set up by patients themselves, supported by professionals, for the economic recognition of the **work they were doing to clean the psychiatric hospital of Trieste**.
- The patients refused to keep on without a proper payment and had a strike with the support of the nurse's trade unions happened. Their **right to associate and negotiate a contract** for the maintenance of the hospital was supported.
- Eventually patients involved in the so-called "**work-therapy**" became members of the new cleaning cooperative ("**Cooperativa Lavoratori Uniti – Franco Basaglia**") under union rules and salaries.
- Shifted of condition **from inmates to workers** with salaries and rights.
- In the following years, Social coops started to grow as a **National and also and International movement.**

Social coops in Italy: type A and B (1991)

- (1) cooperatives for the management of socio-health and educational services (**type A cooperatives**): they work closely with statutory services, and provide, for example, sheltered housing supervision.
- (2) cooperatives that carry out activities aimed at the employment of disadvantaged people (**type B cooperatives**): agricultural, industrial, commercial and service; the quota is at least 30% of the workforce, but they are all **equal members**.
- They offer job opportunities and educational/ vocational training.
- A and B can be combined.

THE ITALIAN VISION THEORY OF SOCIAL ENTERPRISE (De Leonardis, Mauri & Rotelli, 1991)

A social enterprise:

- actively seeks out and produces **synergies between the productive and welfare** worlds.
- finds its focus and dynamic in the utilization of concurrent vocational **training and work processes.**
- constructs areas of **risk as well as safety** nets for the participants.
- conquers and combines energies in the **local environment**.
- builds on **small dimensions** and the **diversification** of its scope of action.
- produces **quality**: of products,
  processes,
  social habitat.
- **restores local resources and individual capacity**.
- changes the **standard of welfare** assistance.

Data from research on job placement in MH in Italy

- **80% of MH Departments** in Italy have Social Cooperatives **type B as main partners.**
- CMHTs have **dedicated staff** for job placement.
- **Training on the job and acting as coordinator** of team is the main strategy, while individual support is offered by the business partners.
- People with **relational skills** are required more than experts.
- Main success factors are **the presence of a comprehensive care plan** (70%) and the **opportunities** offered (40%), then **motivation** (23%) and **vocational skills** (23%).
- Job placement is a wide **network intervention**.
- Use of economic incentives like **work-grants** are usually provided by the service (47%), or municipality (26%).
- The **user sample** (n=14.403): mostly male (56%), aged 35-44, predominant diagnosis of **psychosis** (49%).
- Outcomes show high **quality of life (65%), good satisfaction (59%), clinical Improvement (57%)**.
- Primary outcome -To **become employed**: 1.448 individuals (10%).

National data on social coops

- Between 2011 and 2015, a growth of social cooperatives. The N. of social enterprises / ONLUS in Italy appears to have gone from 11,264 to 16,125, or **+ 43%,** and overall the non-profit sector + **11.6**.
- Among them, the n. of those operating in the area of economic and social development fell, however, from 7,458 to 6,838 (-8.3%).
- The **social cooperatives, which amount to 86% of the total of the third sector**, have 92,696 ordinary members (+ 25.9%), 45,566 voluntary members (-21.1%).
- The cooperatives operating in **social assistance** have had an increase of no. shareholders, + 26.1%; in the health sector + 11.9%.
- Type B social cooperatives are 3,671 out of 13604 (source: INPS).
- There was an **8.5% increase in disadvantaged members from 2008 to 2014, while the invested capital increased by 50.7%.**
- In 2014, the members of cooperatives A and B **were 530,788, of which 32,611** were disadvantaged (Borzaga, 2018).

From policy to practice

- **Occupation, work and education** are among the most important tools for recovery and emancipation, this path can begin with personal (life) projects, developed with the user by the community mental health services, involving his social network.
- It is also needed to transform the culture of services and the community, and the **prejudice on mental illness as "unproductive".**
- The challenge of **productivity is linked to the possibility of real social and work inclusion**.
- It is particularly true when **users become entrepreneurs** or members of social cooperatives, that are protagonists of social inclusion.

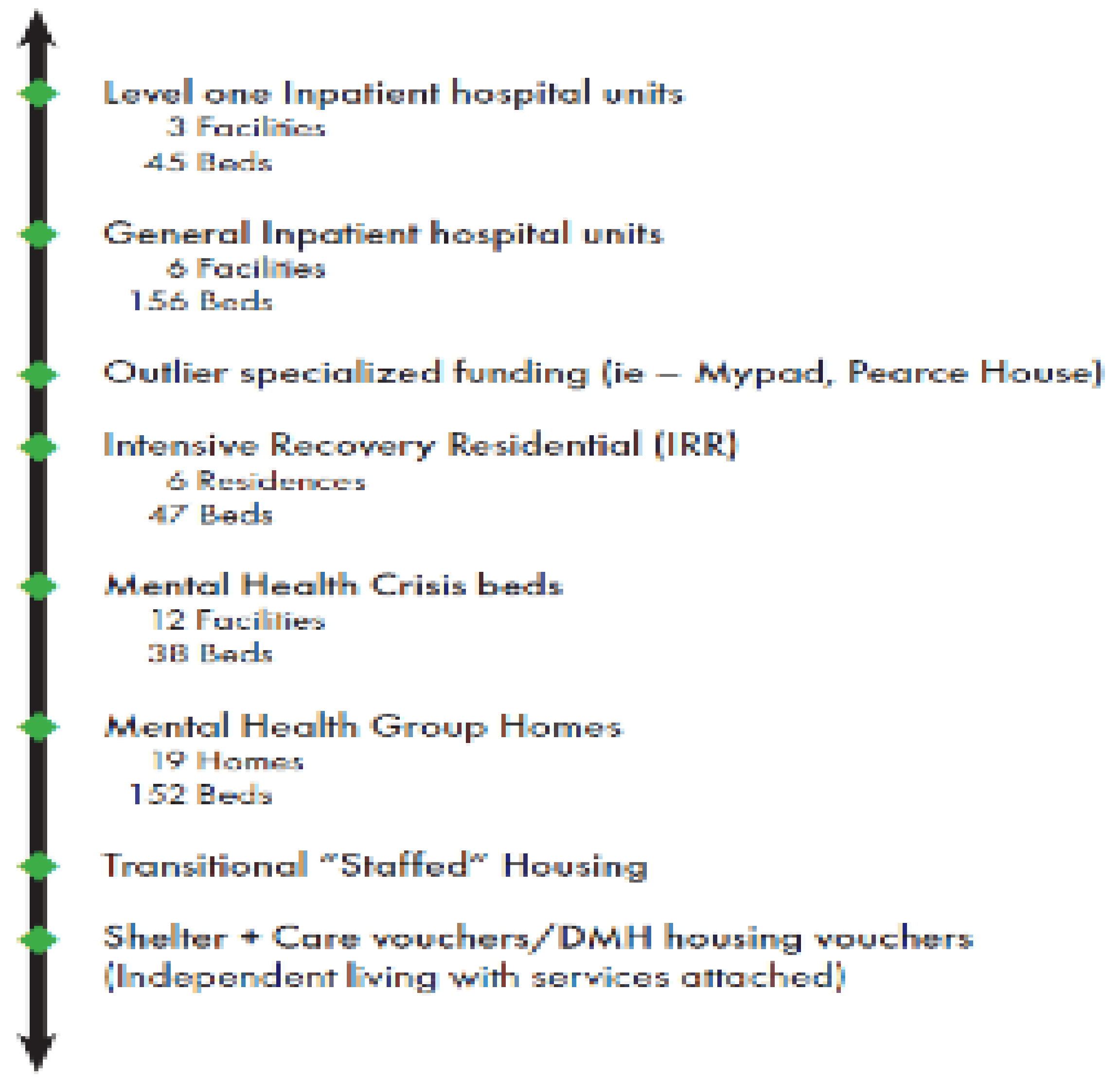
Conclusion

- Social enterprise's theory and practice can be seen not just as "treatment" in the field of rehabilitation, but as the development of a **whole "social economy"**.
- It has been central to the **experiences of deinstitutionalization, rehabilitation programs and recovery and social inclusion** paths.
- In the perspective of community mental health, the possibility of work has become an essential element in the constitution of a **social role for people with psychosocial disabilities.**
- Social enterprises need **specific policies** aimed at encouraging both training internships with ad hoc resources and at developing their business with public contracts; **regional or territorial agreements**, with the active involvement of the social and health sector as a whole in their community.

Data on process and outcomes

Vermont
623,000

32,000 clients



Epidemiologia (adulti)

Popolazione in carico ai DSM (2015)

- 20.000 persone
- 60% Donne ; 40% Uomini
- Circa 35% 30-49 aa e 35% 50-69 aa
- Giovani < 30aa: <10%
- Anziani > 70aa: >20%
- Prevalenza media: 19,5 per 1000 abitanti
- Incidenza media: 4,9 per 1000 abitanti

Region Friuli Venezia Giulia: services and beds

- 1,200,000 inhabitants
- N. 3 healthcare agencies (Trieste-Gorizia, Udine and Pordenone)
- N. 3 MH Dept

with:

- N. 15 24 hour CMHCs / 113 beds + N.7 12 hours CMHCs
- N. 3 acute units in GH (SPDC) with 36 beds
- N. 3 forensic units (REMS) with a total of 10 beds (6 people accepted)

TOTAL: 159 beds

FVG: Residential facilites and supported housing

- Reduction in the number of residences hosting people with mental disorders and in the number of beds dedicated:
- From 31 RF in 2004 to 23 RF in 2016 (-28%).
- From 210 p.l. of 2004 to 152 p.l. in 2016 (-26%).

- Reduction inRF with 24-hour assistance intensity.

- Overcoming the RF managed directly by the MHD with its own staff.

- Management of RF with agreements between MHD and the third sector and with partnership agreements between private companies, associations, voluntary contributions from guests.

Risultati dell'introduzione dei BIdS per la domiciliarità innovativa

	ASUI di Trieste	AAS 2 - Bassa Friulana - Isontina	AAS 3 Alto Friuli - Collinare - Medio Friuli	ASUI di Udine	ASL 6 Friuli Occidentale	FVG
Persone in contatto con il DSM	4.470	3.732	3.580	3.656	4.542	19.980
Tasso persone accolte nelle SR x 1.000 persone in contatto con il DSM	11,9	19,0	28,8	24,6	15,0	20,8
Spesa annua BIdS per le attività riabilitative e la domiciliarità innovativa	€ 3.522.701	€ 3.947.090	€ 1.501.844	€ 3.340.789	€ 2.357.386	€ 14.669.810
Persone sostenute con un BIdS per la domiciliarità innovativa	53	71	103	90	68	415
Bilancio 2016	€ 14.582.669	€ 12.635.719	€ 9.012.655	€ 13.297.714	€ 13.441.389	€ 62.970.145
Rapporto spesa per le attività riabilitative e l' domiciliarità innovativa / Bilancio 2016	24%	31%	17%	25%	18%	23%

Epidemiologia (adulti)

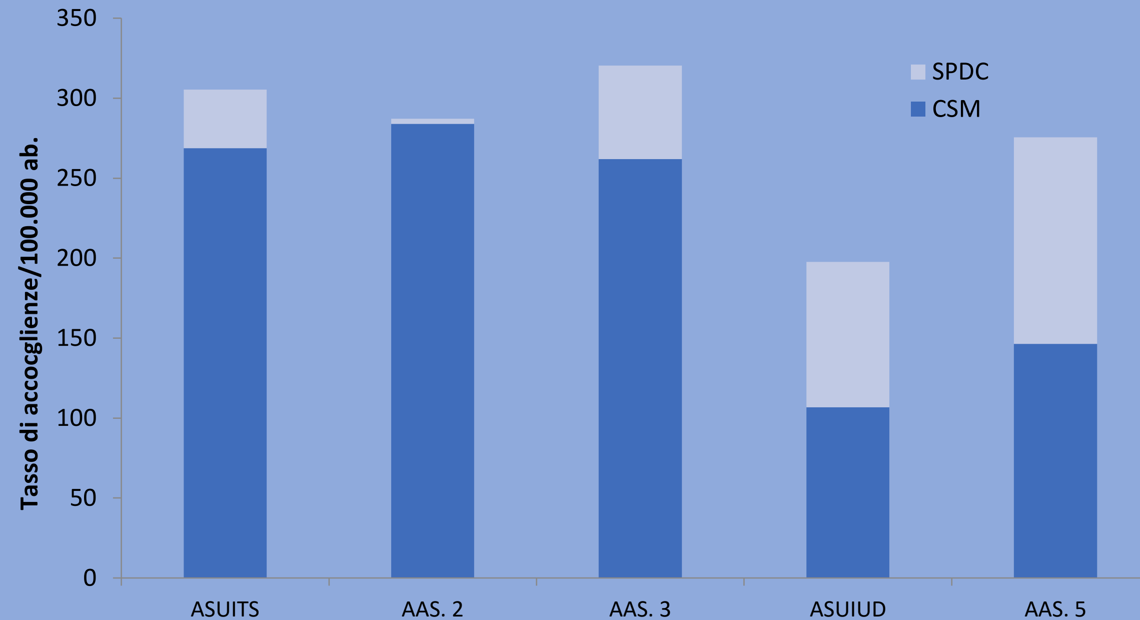
Prevalenza ed incidenza nei DSM, anno 2015 (fonte: SISSR estrazione luglio 2017)

DSM	Popolazione ≥18 anni	Utenti totali 2015	Utenti primo contatto 2015	Prevalenza per 1000 pop,≥18 anni	Incidenza per 1000 pop,≥18
ASUITS	203999	4410	1023	21,6	5,0
AAS 2	214580	4025	1101	18,8	5,1
AAS 3	144996	3434	931	23,7	6,4
ASUIUD	214641	3632[a]	828	16,9	3,9
AAS 5	260953	4779	1193	18,3	4,6
TOTALE	1039169	20280	5076	19,5	4,9

[a] Il dato non include i pazienti visti in consulenza

Epidemiologia (adulti)

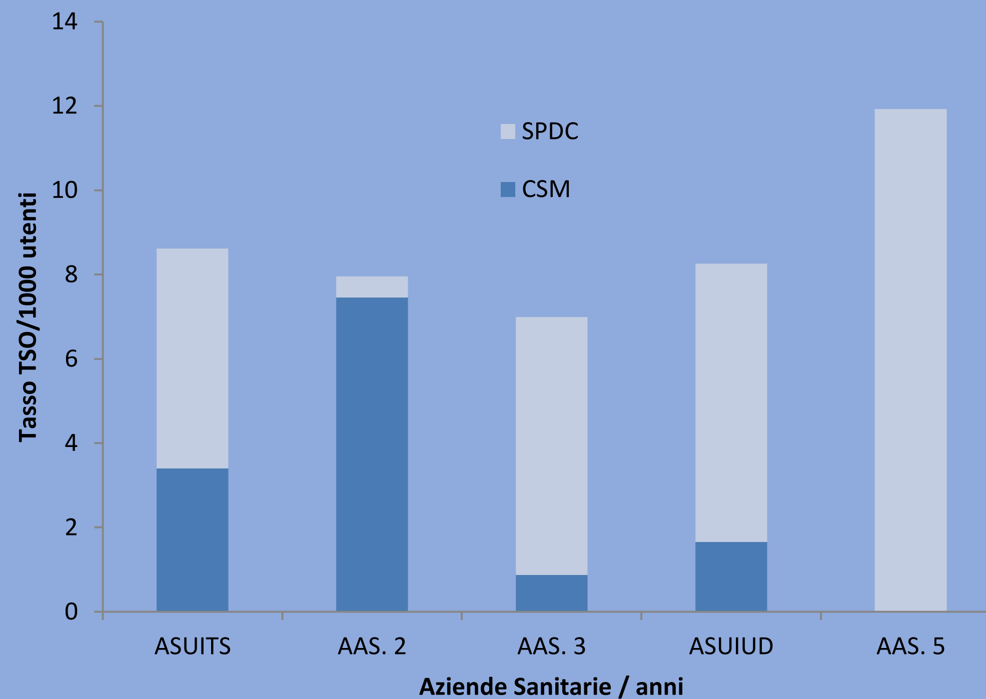
Tassi di ricovero per 100.000 ab in FVG per Azienda sanitaria, nei CSM e negli SPDC, anno 2015



REGIONE AUTONOMA
FRIULI VENEZIA GIULIA

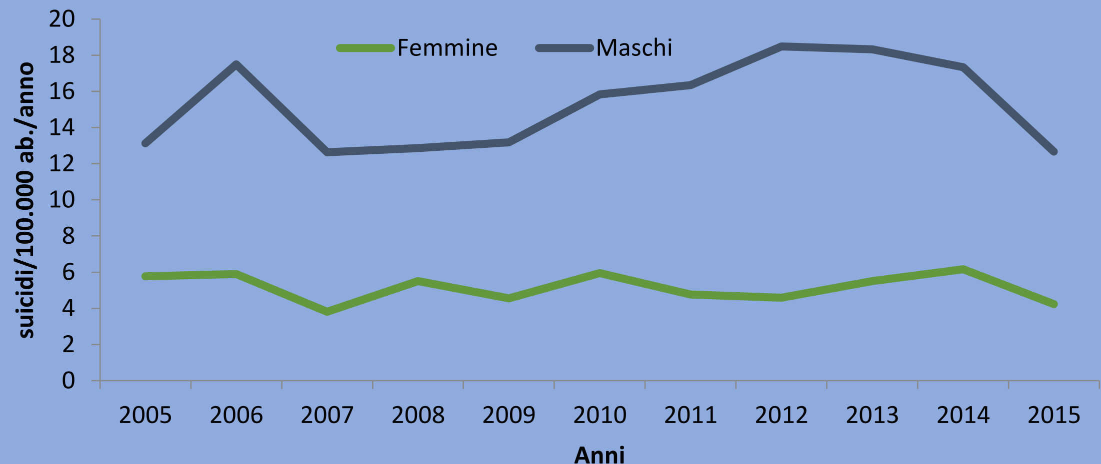
Epidemiologia (adulti)

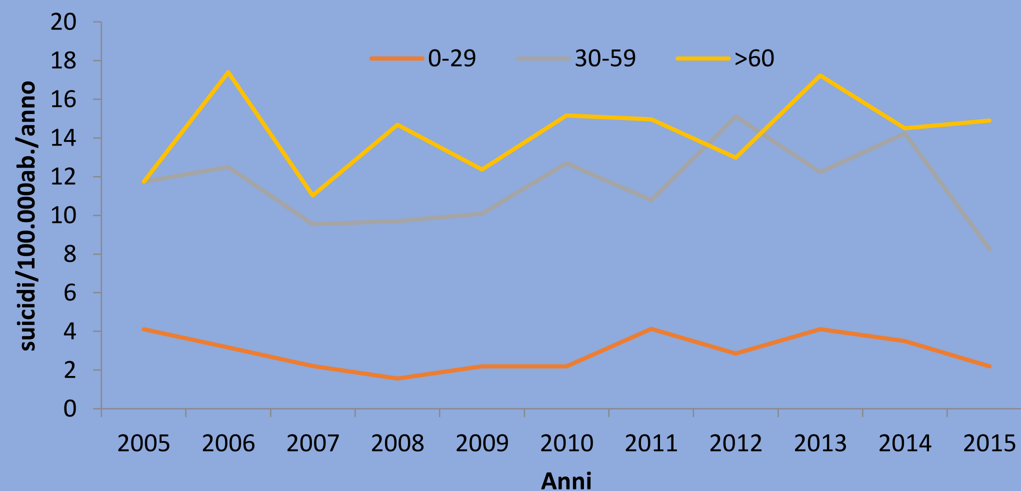
Tassi di TSO per 1000 utenti, per Azienda sanitaria e Servizio, anno 2015



Epidemiologia (adulti)

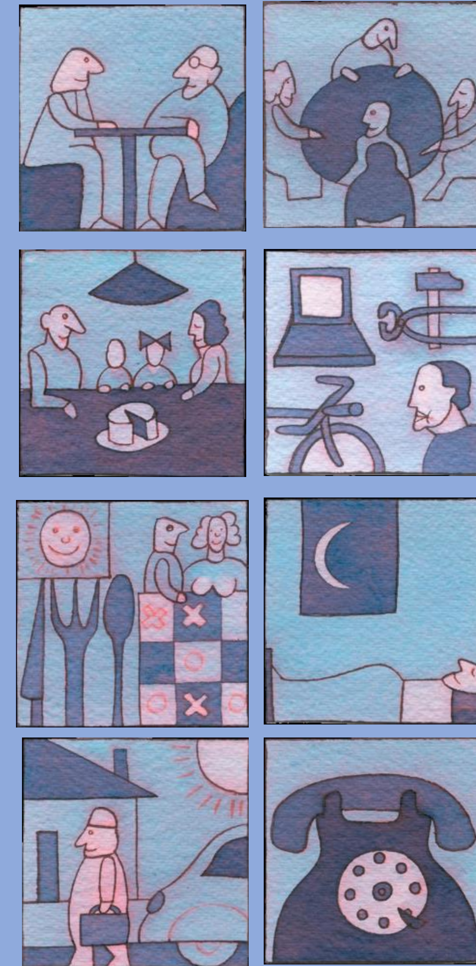
Andamento del tasso suicidario in FVG diviso per sesso, e gruppi d'età, anni 2005-2015





DSM / MH Dept Trieste - Data 2018

- **4.800 users in the year, mean age 55, 55% women.**
- **2.413 users contacted outside the service locations, mostly in living environments**
- **18 persons involuntary tretated (9/100.000 adult inhabitants), 2/3 treated in the 24 hr CMHC**
- **Open doors**, no restraint, no ECT in every place including the Hospital Unit
- No psychiatric users are **homeless**
- **292 users** engaged in place-and-train (**social co-operative societies** and **for-profit**).
- **159** users with **Personal Health Budgets.**
- The **suicide** prevention programme **lowered suicide ratio 40%** in the last 20 years (average measures).



Integrated services provided

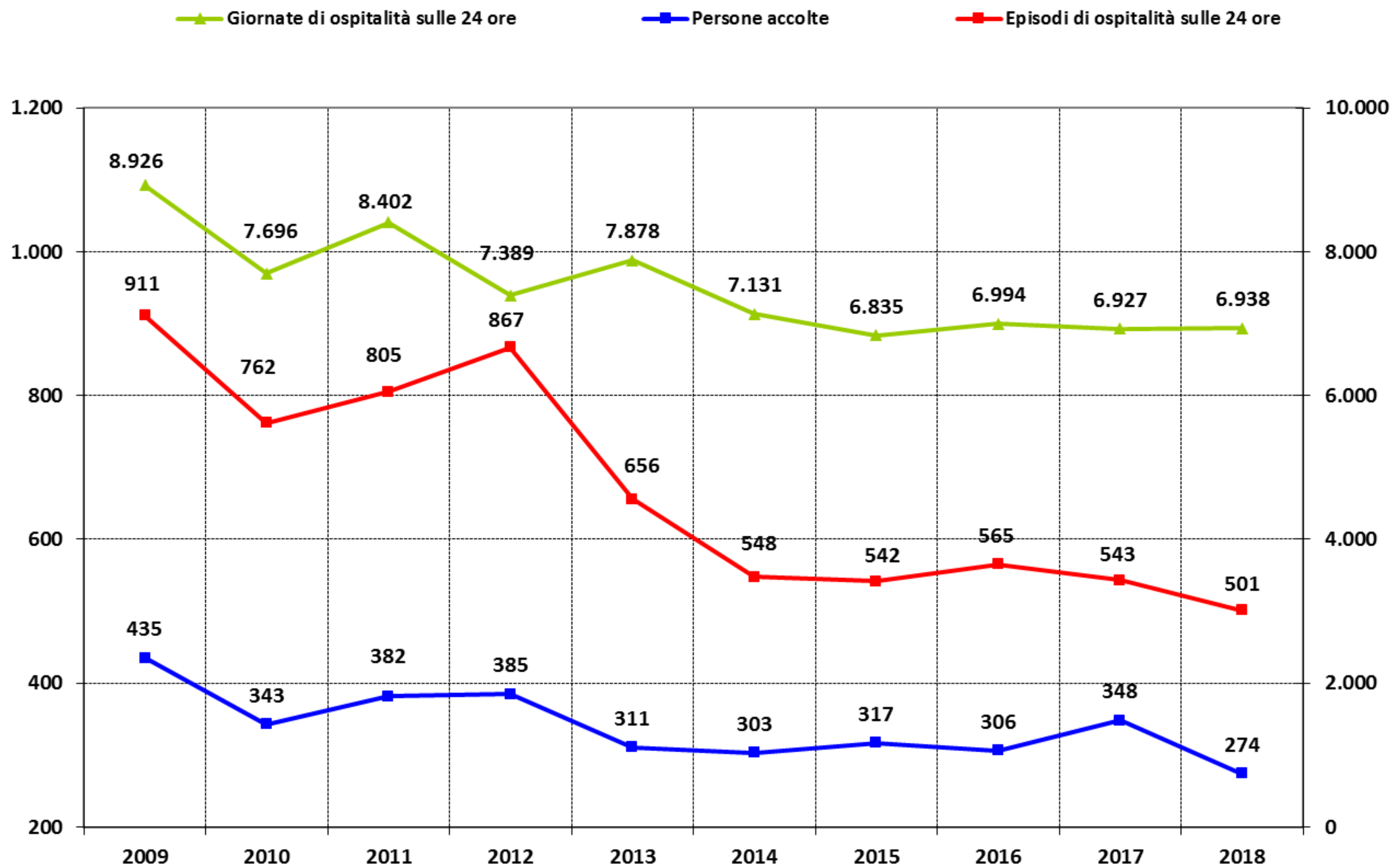
- Microarea for 655 people (14%)
- 838 people in the diffused Day Centre
- 44 housing schemes for 98 people
- Health and social care integrated programs for 404 people (8%)
- Interventions in nursing homes for 179 people
- Co-management with drug addiction for 203 people

Indicatori	Valore Nazionale
Strutture Territoriali	2,6 / 100.000 ab.
Strutture Residenziali	3,6 / 100.000 ab.
Strutture Semiresidenziali	1,6 / 100.000 ab.
Posti letto ospedalieri	9,5 / 100.000 ab.
Posti Residenziali	52 / 100.000 ab.
Posti Semiresidenziali	28 / 100.000 ab.
Dotazione complessiva del personale	62,4 / 100.000 ab.
Costo pro-capite per la salute mentale	€ 75,5
Spesa per la salute mentale sul totale della spesa sanitaria	3,5%
Prevalenza trattata	1.609 / 100.000 ab.
Prevalenza trattata di Schizofrenia	319 / 100.000 ab.
Incidenza trattata	689 / 100.000 ab.
Incidenza trattata di Schizofrenia	71 / 100.000 ab.
Prestazioni per utente	15,4
Dimissioni da reparti psichiatrici	214,9 / 100.000 ab.
Degenza media ricoveri reparti psichiatrici	12,7 giorni
Dimissioni con diagnosi psichiatrica da reparti non psichiatrici	95,7 / 100.000 ab.
Riammissioni entro 30 giorni	17,7%
Continuità assistenziale	40,1%
TSO	16 / 100.000 ab.
Accessi in PS con diagnosi psichiatrica	1.135,9 / 100.000 ab.
Presenze in strutture residenziali	63 / 100.000 ab.
Ammissioni in strutture residenziali	34,7 / 100.000 ab.
Durata media del trattamento residenziale	673,9 giorni
Presenze in strutture semiresidenziali	56 / 100.000 ab.
Accessi in strutture semiresidenziali per utente	63,1
Soggetti trattati con antidepressivi	127 / 1.000 ab.
Soggetti trattati con antipsicotici	30,2 / 1.000 ab.
Soggetti trattati con litio	2 / 1.000 ab.

Elaborazione SIEP su dati Ministero della Salute relativi all'anno 2016

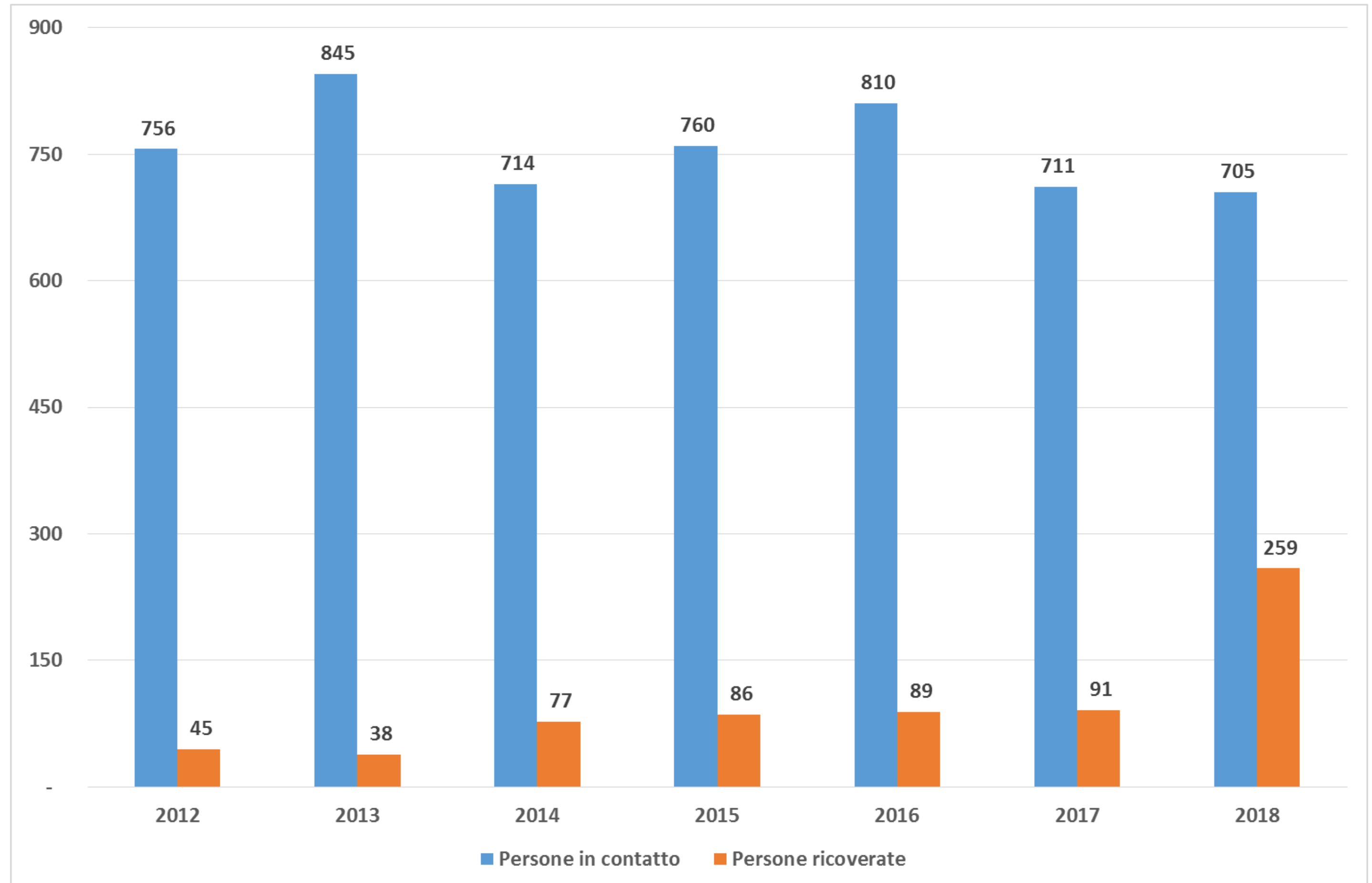
Outcome research on the model

- 1983-1987, first f-up after reform law showed better outcomes for Trieste and Arezzo among 20 centres due to better organisation and social integration.
- 24 h services (among 13 centres) better for **crisis care** (2-year f-up), through trust, continuity, comprehensive health and social care (2005).
- Reduction of emergency presentations in the GH casualty of 70 %over tha last 30 years.
- Satisfaction of users is 78% (2008)
- 75% **adherence** to antipsichotics (n=587) related to service provision and SN enhancement (2009)
- **Social recovery** of the most severe conditions (2017)
- 27 people - high priority, 5 years f-up: Highly significant reduction of symptoms severe > 65 p at BPRS from 20% to 4%), increase of social function (50% score), 9 at work, 12 indep living, unmet needs (CAN) from 75% to 25%, 70% reduction of night accomodations. Only 1 drop-out.
- Qualitative research on **recovery / social dimension** (IRRG, Am J Psy Rehab 2006)
- **Personal Healthcare budgets** fostered the shift from residential facilites to supported housing and co-production (2015)



24 hr hospitality in 4 CMHC - Trend 2009 - 2018

SPDC - People in contact and admitted



Cost-efficiency

DSM – Re-valuated historical costs PH / MHD 2018

ISTAT coefficient for monetary revaluation at 31 December 2018	17,457
Value 2018 (Lire)	£ 87.285.000.000,00
Change Lira / Euro	£ 1.936,27
Cost of PH in Euro (1971)	**€ 45.078.940,44**
Budget DSM (2018)	**€ 16.676.131,52**
Ratio of costs of territorial services to psychiatric hospital	**37%**

Macroindicators: from hospital to community services

	PH - 1971	MH Dept - 2018
Costs	€ 45.078.940,44	€ 16.676.131,52
Staff	524	219
Facilities	1	23
Beds	1.160	52
Population Cost (per capita)	271.879 euro	234.638 euro 71 euro

Continuity of care – cost-efficiency

- In 2015, 3,959 people came into contact with CSMs.
- Among these, 377 people were identified (10% of the users of the CSMs) for high amd medium priority by the territorial sub-teams (monitored continuity).
- 55% of this target is made up of men (206) with an average age of 45 years. Women are a little older in years (average age 49 years).
- 22 young people under 25 (6%) also belong to the monitored group.
- 16 people (4%) were patients at the first contact with MSMs, 10 men and 6 women.
- 76% of the users monitored at home (287 people) suffer from a severe mental disorder (F2, F3, F6).
- 133 people (35%) are people with complex needs which require integrated care with other agencies in the area.

Interventi a domicilio dei team per le persone delle continuità monitorata nel 2015

	Sotto équipe	Personale trasversale	Interventi dei team e personale trasversale	Personale di altra sotto équipe	Interventi	% interventi team
CSM D1	5.729	1.931	7.660	1.610	9.270	83%
CSM D2	3.351	3.303	6.654	2.514	9.168	73%
CSM D3	2.769	2.740	5.509	1.804	7.313	75%
CSM D4	2.712	2.749	5.461	2.522	7.983	68%
Interventi	14.561	10.723	25.284	8.450	33.734	75%
% interventi	43%	32%	75%	25%	100%	

Valorizzazione degli interventi domiciliari per le persone della continuità monitorata

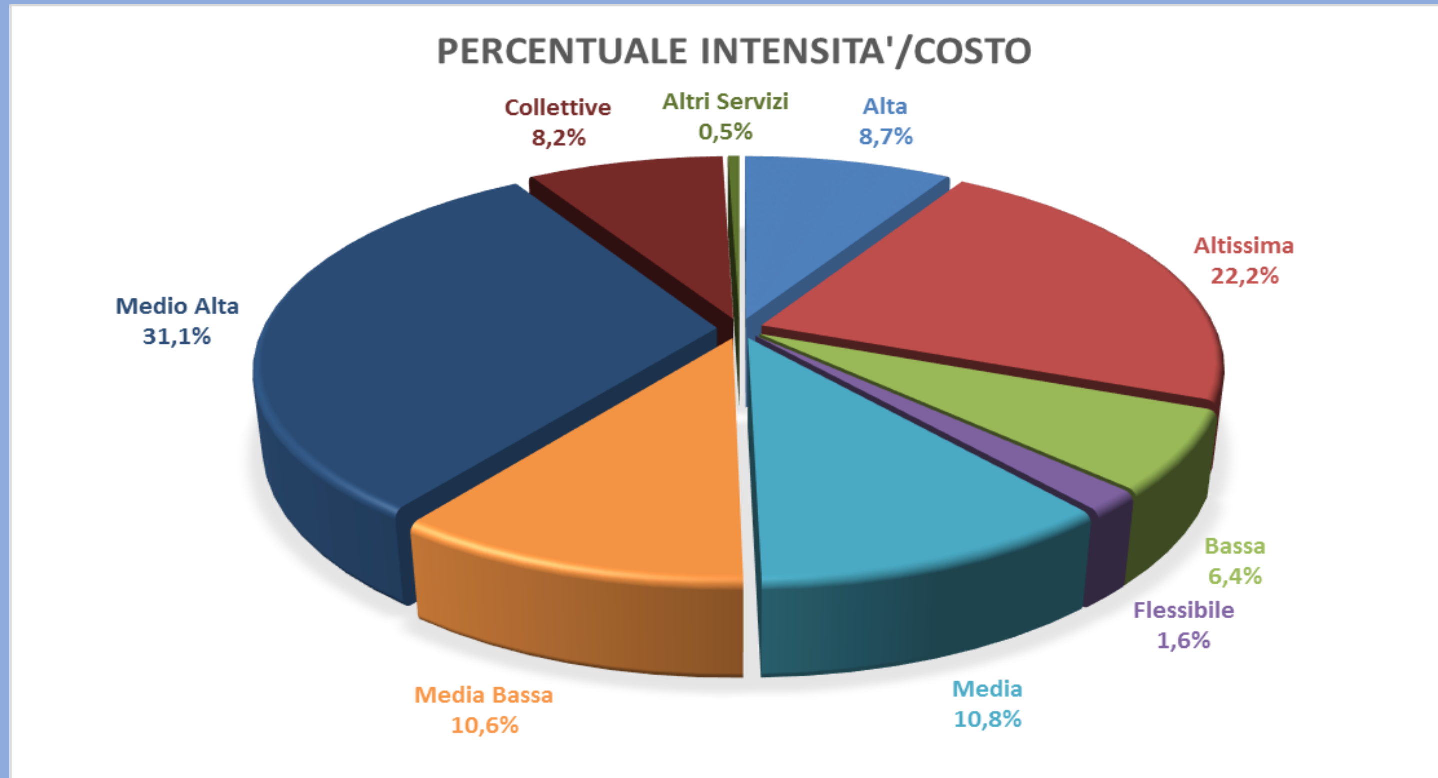
Figure professionali	Altri luoghi	Costo orario medio	Costo per profilo professionale
Altro	133	€ 0,00	€ 0,00
Assistenti Sociali	1.946	€ 18,69	€ 36.367,14
Assistenti Sanitari	392	€ 18,98	€ 7.440,50
Educatori	383	€ 18,98	€ 7.269,67
Infermieri	21.271	€ 18,98	€ 403.742,03
Medici specializzandi	768	€ 0,00	€ 0,00
OSS	3.100	€ 14,76	€ 45.756,86
Psichiatri	2.239	€ 50,45	€ 112.951,98
Psicologi	1.127	€ 45,91	€ 51.739,30
Terp	2.337	€ 18,98	€ 44.358,29
Costo Complessivo	**33.734**		**€ 709.625,77**

Invece di ....

Valore economico dell'intervento	€ 709.625,77
Valore medio di una giornata in SPDC	€ 381,10
Giornate di ricovero in SPDC	1.862
Persone ricoverate	5,0
Valore economico dell'intervento	€ 709.625,77
Valore medio di una giornata in SR terapeutica	€ 300,00
Giornate di accoglienza in SR terapeutica	2.365
Persone ricoverate	6,5
Valore economico dell'intervento	€ 709.625,77
Valore medio di una giornata in SR di integrazione socio sanitaria	€ 150,00
Giornate di accoglienza in SR di integrazione socio sanitaria	4.731
Persone ricoverate	13,0

2018			
Intensità	Intensità per anno	Imponibile	Ivato
Alta	12	€ 271.133,00	€ 284.689,65
Altissima	24	€ 694.000,00	€ 728.700,00
Bassa	53	€ 199.027,20	€ 208.978,56
Flessibile	19	€ 50.967,92	€ 53.516,31
Media	23	€ 336.217,90	€ 353.028,80
Media Bassa	45	€ 330.464,60	€ 346.987,83
Medio Alta	44	€ 970.820,80	€ 1.019.361,84
Collettive	161 – 214 (no peer)	€ 256.437,36	€ 269.259,23
Altri Servizi	vedi collettive	€ 15.127,00	€ 15.883,35
Totale	220	€ 3.124.195,78	€ 3.280.405,57

Utenti in Budget Salute 159



2019 Ripartizione dei Costi			
Intensità	Intensità per anno	Imponibile	Ivato
Costi Fissi Residenze	6	€ 1.561.692,00	€ 1.639.776,60
Budget Salute Individuali	12	€ 835.679,34	€ 877.463,31
Attività Collettive	31	€ 478.396,56	€ 502.316,39
Altri Servizi	13	€ 24.000,00	€ 25.200,00
Totale	62	€ 2.899.767,90	€ 3.044.756,30

Innovations 2014-2019

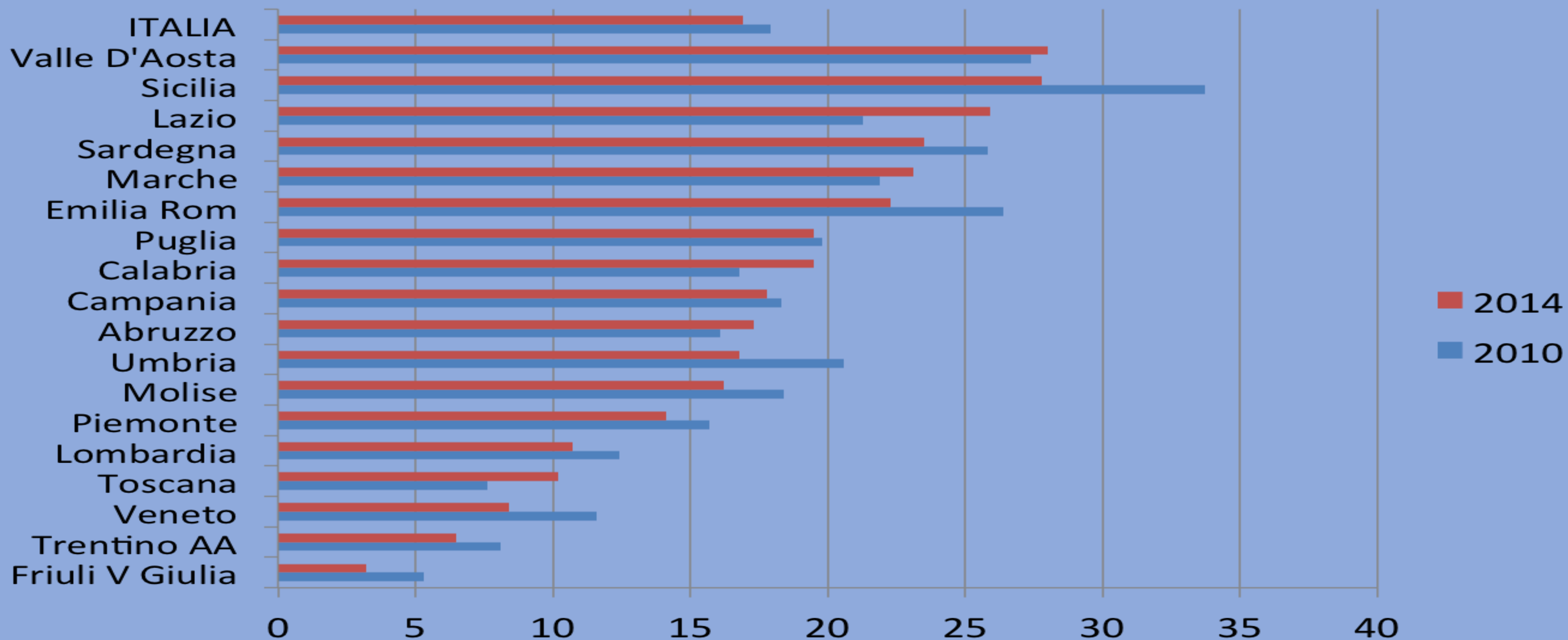
- Agorà (Forum)
- Diffused Day Centre
- **Rems with open door**
- Open dialogue
- **Recovery house**
- **Closure of all residential facilites in the ex-PH**
- Peer support training: 30 people and job placement
- STID (**Home treatment** and overcoming acute unit)
- Operative Manual of CMHC
- Personal budget procedure and catalogue of offer
- Participation committee
- Mental health green number
- mhGAP training to all GPs
- QRs implementation

Impact in Italy and worldwide

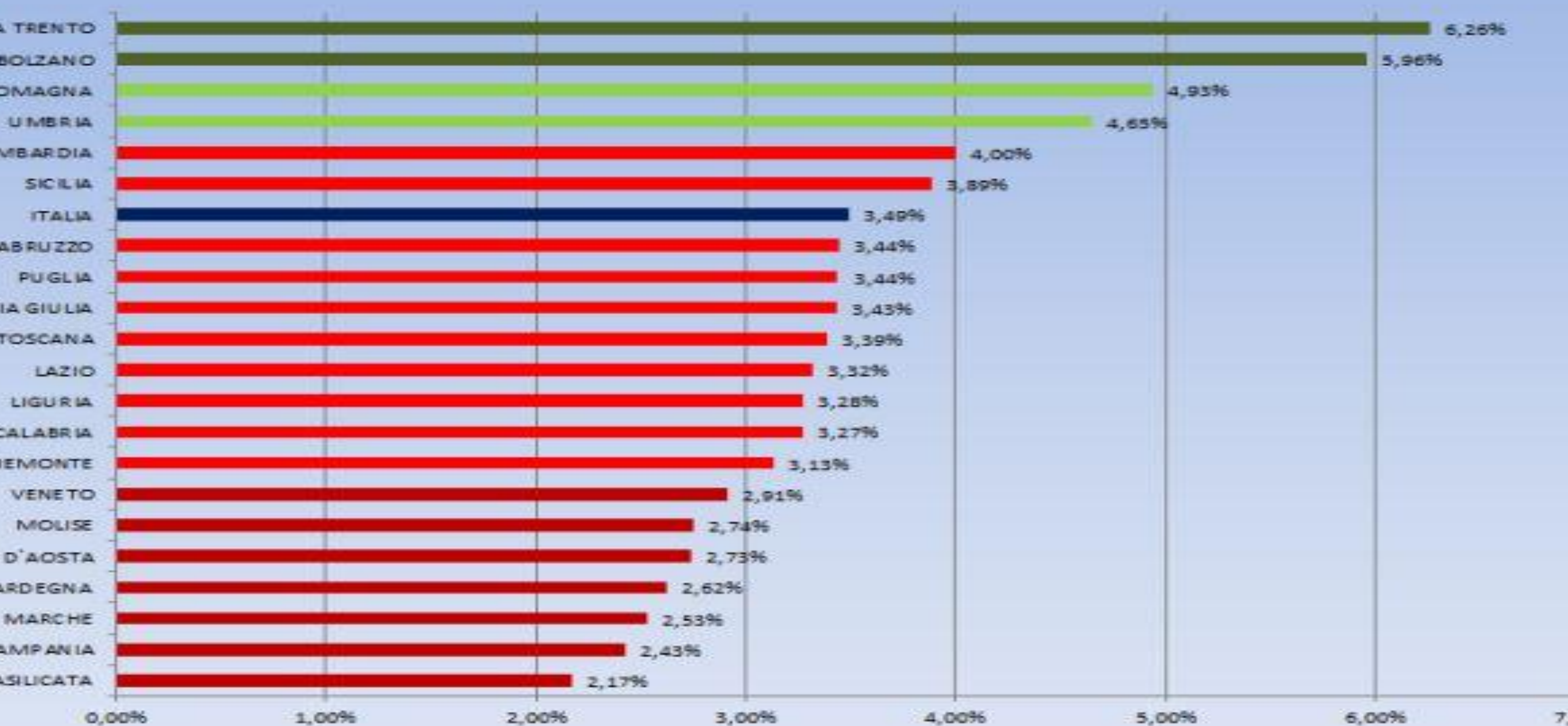
National impact in Italy

- This **complete 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% in 2015**).
- The main characteristsics: 24 hrs CMHC / 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 internationaly in Sweden, Brazil, ex-Stability Pact countries (e.g. Kosovo), and more recently in the Czech Republic, Wales, Crakow (Poland), Los Angeles, and other places.

Tassi (non standardizzati) di Ospedalizzazione per TSO
per 100.000 residenti anni 2010-2014
Ministero Salute elaborazione banche dati SDO 2010 e 2014/ popolazione ISTAT



Spesa per la salute mentale in % della spesa sanitaria



F. Starace, 2016. Elaborazione su dati Ministero Salute, 2016 e Conferenza Stato-Regioni-PPAA, 201

WHO guidance and technical packages on community mental health services: Promoting person-centred and rights-based approaches (2021)

- The purpose of these WHO documents is to provide information and guidance to all stakeholders who wish to develop or transform their mental health system and services.
- The guidance provides in-depth information to develop good practice services that meet international human rights standards and obligations and that promote a person-centred, recovery approach.
- It promotes the creation of mental health services that operate without coercion, that are responsive to people's needs, support recovery and promote autonomy and inclusion, and that involve people with lived experience in the development, delivery and monitoring of services.
- <u>Ultimate aim is to:</u>
- Demonstrate that it is possible to develop person-centred and rights-based services that respect rights, and promote inclusion and that do not exclude, isolate or resort to coercion
- inspire policy makers, service providers & other key actors to take action to develop these services in their countries
- Scale up these new and innovative approaches to mental health in countries across the world.

Structure and content of WHO guidance and technical packages on rights based community mental health services

- The WHO guidance comprises:
  - An overall document which sets the context, summarises the good practices and presents specific recommendations for integrating person-centred and rights-based services in health and social sectors
  - Seven supporting technical packages containing detailed descriptions of the good practice mental health services, practical insights into challenges faced and solutions put in place by the services as they evolved, as well as action steps towards the development of these services. The seven technical packages comprise the following:
- *Mental health crisis services*
- *Hospital-based mental health services*
- *Community mental health centres*
- *Peer support mental health services*
- *Community outreach mental health services*
- *Supported living for mental health*
- *Comprehensive mental health service networks*

From Trieste to the world: general indications

Community health as passage which derives from deinstitutionalisation: systems built around individuals/communities

Comprehensive, holistic approach which combines medicine with welfare systems for powerful synergies - concept of whole systems, whole life approach (Jenkins, Rix, 2002)

The focus on individuals and the **rights of citizenship** raises the issue of values which underpin practices and services (value-based services, Fulford, 2001)

Creating **personalised itineraries as organisational-strategic key**, in which the person has an active role and contractual power.

Indications

- **Avoid or reduce transitions in care: fragmentation of services system.**
- Foster the service's **responsibility and accountability towards the community.** The responsibility for care processes should be rooted in the community.
- Recognising the importance of social **macro- and micro-contexts as producers of the meaning of health actions and as bearers of resources.**
- Passage **from reparative medicine to participatory health** (no black box as funnel for specialistic approaches)
- Developing the **protagonism of individuals as stake- or shareholders in the healthcare system** (concept of leadership linked to the activation of processes of strategic/organisational change, in 'rushes' or continuous cycles) – <u>**caring cities.**</u>

Indications

- A shift from **healthcare institutions to healthcare organisations**
- Also required is a **'systemic' vision** based on the person's life **(whole systems, whole life approach)** with a low threshold, single access point (one-stop-shop),
- Developing home care, both network and networked, focussed on the person in their actual living context, and thus on their **life story and social capital**, and not on the illness.
- A system of possible options which **diversifies responses**, making them flexible and personalised, should therefore be provided for.

The right to citizenship is the core aspect

- Eventually, **the right to be a citizen is the right to have a life**. Thus we must speak about entitlements: we need a social and human development that could converge, not conflict, with substantive, individual rights.
- A **possibility seems to be a focus on exclusion in society**, therefore a focus on social determinants like home, work, supports, relationships, participation and many other aspects.
- A **political and social action** must be combined with a change of institutional practice and thinking in mental health and social care.

Freedom is therapeutic

UGO GUARINO

Liberty as a fondamental value

- “Liberty is therapeutic” was the original motto in the Trieste experience. The experience of Trieste can be emphasized especially as far as principles such as **open door, hospitality, negotiation and alternatives to coercion** are concerned.
- Service should also recognize the value of participation of all stakeholders, through networking, forms of coproduction, cooperation and exchange.
- ‘**Freedom first**’ (Muusse, Van Rojen) **can be a new slogan** of the international movement for better care in a rights-based and person-centered approach, emphasizing that personal liberty is not the outcome but **a pre-condition for care** which overturns control mechanisms and supersedes them with people empowerment.

The 3 approaches in Trieste

- 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.

Barriers to overcome

- Among the most consistent barriers, apart from the co-existence or persistence of psychiatric hospitals, there is
- the lack of leadership in the Service,
- the lack of participation of staff and stakeholders,
- a dominant biomedical approach together with clinical reductionism and no consideration of social factors,
- the persistence of disempowering attitudes in staff and institutional leaders;
- the limited resources in term of staff ratio (1:1000 at least) in order to set up a 24 hours CMHC system.
- In medium and especially in low income countries, a limitation can be the over-reliance on secondary care and thus the need to task shifting.

London
Cite this as: BMJ 2021;373:n1597
http://dx.doi.org/10.1136/bmj.n1597
Published: 21 June 2021

Trieste's mental healthcare model is under threat, claim supporters of the community based approach

Michael Day

Experts in Italy and beyond claim that right wing politicians are seeking to dismantle one of the world's most celebrated and progressive mental healthcare systems, established in the port of Trieste.

The city's mental healthcare model, based on the theories of the reforming psychiatrist Franco Basaglia, who believed that psychiatry in large institutions unfairly ostracised people with mental problems, has seen a radical switch to community based care.

While it is not without controversy, proponents of the Trieste system in Italy and around the world say that it is more humane, more effective, and even economically more viable.

But political upheavals, organisational changes, and encroaching privatisation in the northern Italian region of Friuli Venezia Giulia, have led to an outcry among professionals and some politicians who say that the system is under attack, although the regional government denies this.

Political control

The fears have led to a petition on Change.org to "save Trieste's mental health system," signed by eminent mental health experts. The petition claims that the region's right wing regional government, "on poorly informed and ideological grounds, is fast and impulsively dismantling Trieste's wonderful system of community care. . . that has made Trieste a beacon of hope for the world's most vulnerable citizens."[1]

Among the signatories is the US psychiatrist Allen Frances, professor emeritus in psychiatry at Duke University in North Carolina and chair of the DSM-IV Task Force. He tweeted, "I never beg, but I'm begging now: If you care about mental illness, please sign [the] petition to save Trieste's great mental health system—model of best practice for the entire world."

A chief concern among people who back the Trieste system is that well qualified candidates for the vacant post of mental health director have been excluded from being considered for the post.

"It's clear that local people with better CVs were blocked from the process," said Roberto Mezzina, psychiatrist and former director of mental health in Trieste and current vice president World Federation for Mental Health's European region. "The process of dismantling the Trieste model began when the right took over the region in 2018, by merging authorities and centralising power."

A public letter signed by an international group of mental health experts including Benedetto Saraceno, former mental health director at the World Health Organization, said that the Friuli Venezia Giulia region, in which Trieste lies, was aiming to give the city's mental health director job to a candidate who was "completely alien to consolidated. . . progressive care, and who, instead, came from backward services, from psychiatric wards that are often closed and that still use physical restraint."

In 2018 Massimiliano Fedriga, a member of the far right Lega party, became governor of Friuli Venezia Giulia. He now heads a regional coalition with the even more extreme Fratelli d'Italia party and the conservative Forza Italia.

Mezzina said, "Their aim is to take back control by putting in place a director of mental health services under the control of the regional politicians."

"Still innovative"

A group of centre left regional councillors has pledged to fight further changes—and has even invited Fedriga and his vice president and councillor in charge of health services, Riccardo Riccardi, to spend half a day with patients, families, and staff to see how the service "is viewed with envy and admiration from across the world."

One of the opposition councillors, Andrea Ussai of the Five Star Movement, said, "We are not defending positions of power but a model that's been shown to work in Italy . . . and we're alarmed that an ideological approach by the centre right is trying to dismantle the services and gradually entrust all of them to the private sector." The Five Star Movement is considered right wing because of its anti-immigration stance, although it describes itself as a movement that does not fit the traditional right or left model.

Riccardi told *The BMJ* that despite the criticism he regarded "Franco Basaglia as the father of an innovative culture in the field of mental health [who has] revolutionised the entire Italian psychiatry," giving rise to a model "that is still innovative today."

And he denied that political considerations were downgrading services or leading to inappropriate managerial appointments.

"The aim of the Friuli Venezia Giulia region and its regional health service is to further improve the level of care, gauge best practice, and provide services to the community," he said. "In Friuli Venezia Giulia, the assignment of managerial positions is based on the results of examinations, tests, and curricular assessments that take into account the professional qualifications."

He added that the "goal of psychiatry should be to guarantee the best possible service to patients, and not to waste precious energy in an attempt to build fiefdoms that can only damage the health service."

BMJ: first published as 10.1136/bmj.n1597 on 21 June 2021. Downloaded from http://www.bmj.com/ on 22 June 2021 at Azienda Per L'Assistenza Sanitaria N 5 Bassa Friulana. Prote
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Conclusions
Trieste system of care

- 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

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Contact

- Roberto Mezzina, Director of the **International School "Franca and Franco Basaglia – The Practice of Freedom"**

- **WHO Collaborating Centre for Research and Training, Trieste**
- romezzin@gmail.com
- who.cc@asugi.sanita.fvg.it
- www.triestementalhealth.org