Community Mental Health Services with open doors and without restraint:

Trieste, Italy

Roberto Mezzina

Como citar: MEZZINA, R. Community Mental Health Services with open doors and without restraint: Trieste, Italy. *In*: SADE, R. M. S. (org.). **Boas práticas:** caminhos e descaminhos no processo de desinstitucionalização. Marília: Oficina Universitária; São Paulo: Cultura Acadêmica, 2017. p. 11-40.
DOI: https://doi.org/10.36311/2017.978-85-7983-933-7.p11-40

Community Mental Health Services with open doors and without restraint: Trieste, Italy

Roberto Mezzina

1 Introduction

De-institutionalization has been completed in Italy till the very closure of all Psychiatric Hospitals in two decades (1978-1999), as a result of a previuos movement and of the reform law enforced in 1978. The law is based on full rights, such as free communication, right to appeal, no prolonged involuntary treatments, no detention during those treatments, and does not involve any authority of justice or public order. These principles fostered the lowest rate of involuntary treatment in Europe (17/100.000) and their shortest duration (10 days), avoiding heavy institutional careers for service users. Forensic sector has been now included in a gradual de-institutionalization (on 31 March 2015 the law n. 81 declared the closure of all 6 Forensic hospitals, replaced by small regional units linked to MH Depts), with the current reduction of cases detained to less than 600 from 1.500 in two years (ROSEN et al. 2012; 2014).

Community mental healthcare is the rule today in this country, but the nature, the function and the organization of Community Mental Health Services (CMHS) looks the central practical-theoretical point.

https://doi.org/10.36311/2017.978-85-7983-933-7.p11-40

On one hand, the original Italian concept of Community Mental Health Centre (CMHC) was conceived as the standpoint of a Mental Health Department (MHD), being the main – or the one – point of reference for all psychiatric requirements of an entire catchment area, while Psychiatric hospitals were closed. This peculiar position allows and even obliges CMHCs to conduct a continual cycle check on thier own effectiveness on overall pathways of care in the community it serves, without discarding their "residuals" ("not affordable cases") to institutions, like for instance complex cases with severe symptomology and disability. Inversely, if a CMHC is conceived as a simple out patient clinic, that means accepting an unavoidably subordinate situation similar to the hospital-based services and private clinics. In presence of weak and not focused community based services, the system is often dysfunctional and produces 'residuals' who are stuck in long term residential care - even if this happen in community settings (Progres CSM).

Each CMHC should be linked to basic medical care, social services, services for the elderly, co-ordinated by "Health Care Districts", but this kind of mainstreaming does not apply easily because of wide regional variations, and when happened seemed to give priority to the treatment of common mental disorders - CMD (Lora, 2009). The development of a "strong" CMHC working 24 hours a day, equipped with beds and having great flexibility as far as facilities, resources, duties and modes of intervention are concerned, was implemented by Trieste and furthermore by the whole Region Friuli Venezia Giulia. There are only few other examples in Italy, despite recommendations of the Parliament Commission (2013), the official recommendations of some regions, and a wide support by carers and users organisations.

Spreading the historical examples of Trieste and Pordenone, in the Region Friuli Venezia Giulia (1.200.000) the implementation of the Reform Act was based on a public health approach ensured by MH Departments in order to co-ordinate all services, according to principles of contrasting social exclusion, stigma and discrimination and promoting social inclusion. The development of 24 hrs CMH Centres with respite beds allowed a very small number of general hospital beds (30 for the whole Region), and is supported by a network of services

for rehab and social integration, e.g. group homes, day centres and social cooperatives.

All regional services reached a similar organisation with comparable results, as low rate of hospitalisation in the General Hospital, low compulsory treatment rate, efficient job placement, personalised budgets, very few forensic patients, a lowered (-30%) suicide rate in the last 15 years (SOURCE SISSR, Regional Data Service).

2 The Trieste model

Description

The transformation of the psychiatric service in the city of Trieste (236,000 inhabitants) directly derives from deinstitutionalisation of the Psychiatric Hospital with 1,200 inpatients and the simultaneous creation of a complete alternative service network in the community (BENNETT, 1985; ROTELLI et al. 1988; ROTELLI et al. 1994; DELL'ACQUA; COGLIATI DEZZA, 1986).

Currently the Mental Health Department has four Community Mental Health Centres, open 24 hours a day, with 6 beds each, that are competent for a catchment area of 50-65,000 inhabitants; a Psychiatric Diagnosis and Treatment Service (PTSD) in the General Hospital, that is mainly used as a filter for emergency situations, at night, and that normally doesn't admit patients for more than 24 hours but refers them as soon as possible to the appropriate Centre. Moreover, the Habilitation and Residential Service also provides currently 45 beds in group-homes and residential housing facilities at different levels of supervision, up to 24 hours, but main aim is to encourage users to live independently or share their resources. There is also a network of social cooperatives (12 at the moment).

The Community Mental Health Centres (CMHC) are responsible for a specific catchment area. Their team is composed of about 30 nurses, 1-2 social workers, 2 psychologists, 1-2 rehabilitation specialists and 4-5 psychiatrists. The CMHC operates around the clock. During the night, two operators assist people hosted overnight. In Trieste, each

CMHC is expected to respond to the full range of psychiatric demand in its catchment area, including acute demand, which is therefore not confined to a specific service or separated from prevention, treatment and rehabilitation practices also provided. The function of the CMHC is related to day-night hospitality, outpatient visits, home treatment, assertive community treatment, day care, individual, family and group therapy, social support and enhancement of social networks, supported housing and social inclusion through job placement, sport, art, leisure time.

The PTDS is an emergency psychiatric service which is managed as a part of the community service organisation and not as a separate hospital facility. It has 8 beds and provides psychiatric primary care and counselling services for the other hospital wards. It also acts as a filter for the demand arriving to General Hospital Emergency Room, and makes referrals to the community mental health services if necessary. If the client arrives at night, he/she may be kept under observation and put in contact or referred to the competent CMHC the following day. CMHCs control and manage PTDS activities directly and are responsible for activating community interventions as quick as possible, usually passing by to the CMHC within 24 hours. When hospitalisation occurs, which is quite rare, it always takes place within the continuity of the community interventions being carried out by the competent CMHC. This prevents it to become a separate intervention or, worse, an alternative to such comprehensive responses. Even the Mandatory Health Treatments (MHT) are preferably applied in the competent CMHC and not in the Hospital.

The Habilitation and Residential Service also provides currently 45 beds in group-homes and residential housing facilities at different levels of supervision, up to 24 hours, but its main aim is to encourage users to live independently or to share places and resources. There is a partnership with with several associations which include users and carers and manage social spaces in the city, club-style, and promote self-help and peer-support, recovery oriented activities, and other educational activities, that is "the diffused day centre". About 12 Social cooperatives are also partners for social and work inclusion, as we will describe further on.

Human resources encompass about 210 staff, plus non governmental organization - NGO support services for housing and community living.

In parallel with the development of the mental health services, the last decade has also seen the significant growth and development of integrated, community health care services (Health Care Districts), where CMHC send their professionals for consutations and joint plans of care. Particularly the s.c. "microarea programme" has to mentioned as a proactive outreach community development project aimed at improving health indicators and social capital. Collaborations with healthcare districts and general hospitals occurs in the areas of elderly, child and adolescent, services, the disabled, GPs and physical health, specialist medicine, eating disorders, early detection and intervention in psychosis. Heath promotion in schools is also implemented thorugh the Prevention Department.

Several department programmes are cross-cutting

- User social and cultural training and involvement, participation and advocacy
- Family programme (Psycho-education, self-help, multifamily groups)
- Involvement of GP for healthcare and comorbidity with chronic physical conditions
- Prison consultancy service
- Support network for prevention of suicide and of "lonely deaths" in the elderly
- Facilitating itineraries for membership in associations etc.
- Promotion of social enterprise activities
- Creative/play/sport/leisure activities with community agencies
- Promotion of self-help groups, programmes, clubs with associations
- Collaborations with healthcare districts and general hospitals, e.g. the elderly, child and adolescent, the disabled, specialist medicine, eating disorders, early detection and intervention in psychosis
- Relationships with the city's cultural agencies (theatre, university,etc)
- Programmes on gender difference and mental health

Criteria/Principles of community practice

The organisation is based on criteria (or principles) of care clearly defined as the Department's mission (MEZZINA, 2014). These are:

1) Responsibility for the mental health of the community, that means: assuming responsibility for the entire psychiatric demand in a given catchment area without a severity selection.

2) Active presence and mobility towards the demand:

-avoid waiting lists for urgent cases and bureaucratic filters

-promote the approach of "shouldering the burden" in user's living environment

3) Accessibility:

-walk-in, drop-in service

-quick response after referral

4) Therapeutic continuity in space and time:

-interventions take place in the patient's actual living environments, within social-health institutions, in legal-penal institutions (courts of law, prison, forensic sector)

-temporal continuity is defined based on the need for care and the threefold criteria of prevention, treatment and rehabilitation.

5) Responding to crisis in the community:

-alternatives to hospitalisation (home treatment, respite at the CMHC)

-an organisation of CMHC which is able to deal with emergencies and, if necessary, mandatory hospitalisations.

6) Comprehensiveness:

-comprehensive/integrated responses between social and health, therapeutic and welfare assistance, e.g. the use of the available resources

of the Service; the activation of health and social services; the use of resources which may be present in the micro-social context.

7) Team work:
-collective formulation of therapeutic projects
-coordination between various professional figures
-multidisciplinary and multi-professional approaches
-constant on-site training and team inter-vision activities
-circulation of information within the Service
-integration of non-professional and volunteer work

If we translate these overarching criteria and principles in the dynamic of day-to day community practice and procedures of MHD, responsibility (accountability) for the mental health of the community means a single point of entry and of reference, in a public health perspective. Being actively present and mobile requires a low threshold accessibility, with a proactive and assertive care. The key-concept of continuity implies no transitions in care, with the CMHC team involved at any stage of the client illness and related needs of care, maintaining them in their usual social context and reaching them out wherever they live, thus avoiding de-socialisation and/or institutionalisation like in prison and forensic hospitals. An early and quick response to crisis in the community implies, as a rule, no acute inpatient care in hospital beds. Comprehensiveness is linked to a mandatory intersectoral work, the search of social capital enhancement, the recognition of social network, i.e. the family and the closed community, using and integrating their resources. Finally, team work implies the development of a shared vision and culture in the service, where the multidisciplinary approach is connected to creativity and subjectivity of its members, including peers, volunteers and trainees. The whole team is implemented through daily meetings, which framework is a "whole life" approach, with the person and his/her narratives at the centre.

3 The process of care

Service operations and procedures

The 24-hours community mental health centre is located in a non-hospital residential facility, usually a rather big house, with 2 or 3 floors. It is not conceived just as a crisis centre, but is in fact multi-purpose, multi-functional, i.e. a daycare centre, an outpatient service, a base for community teams. The quality of the environment (home-like) and of the atmosphere is connected to staff attitudes, mainly focused on flexibility and reasonable negotiation with the user's concerns and needs. A single multidisciplinary team acts rotating inside and outside, for those who are "guests" on a 24 hours scheme and for the users attending daily or reached at home (MEZZINA; JOHNSON, 2008).

The CMHC works as a walk-in service, where everybody can enter or call and receive a response in "real time", usually within 1-2 hours. All staff run a reception rotating on intake functions. This means that there are no waiting list. The intake is problem-based, rather than diagnosis-based – if the problem is urgent, even from the person or the carer's subjective viewpoint, it is addressed. Morning shift starts organizing daily priorities and adjusting them to already scheduled work. A couple of clinicians take care of the internal tasks, like shared care of the rooms with the "guests", in-house care (outpatients visits, medications, informal contacts / talk groups, lunch/dinner together, day hospital-like). Their main aim is creating and keeping a therapeutic, informal and friendly environment. There is a morning meeting with new-old guests (knowledge, orientation, re-assuring, self-disclosure). Clinicians not involved that day on internal tasks go out, for scheduled domiciliary visits, for network activities, or fetching users to the Centre for day hospital or for scheduled activities (like medical assessments at hospital or health district, or to the pension, the bank, the police station, work, etc). Doing with, being with is a principle of good support and establishing truste relations. Staff meetings at the shift change planning afternoon priorities.

From 8-20h the Centre admits direct referrals with non formality, using that mobile front-line we described above. From 20-8h, crises

access to the consultation by the casualty department, then overnight accommodation in the PTSD. It does not apply admissions as a rule, but it can use an extended assessment up to 24 hrs (the "24 hrs rule"). Usually the day after the CMHC team comes to that service and discuss a plan for ongoing care. People are fetched to the centre if they require respite or detachment from home environment, or supported at home.

The 24 hours hospitality at the CMHC is also agreed without formalities with user and relatives and managed by the whole team (DELL'ACQUA; MEZZINA, 1988, 1988a). 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). Users are considered "guests": they 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 rehabilitation, therefore crisis is "dissolved" and un-emphasised in everyday life, and it is often followed by a period of day hospital attendance, in a view of strengthening the therapeutic relationship and developing an ongoing plan of care. Mean duration of 24hr admissions is 10-12 days. This is not only for crisis, e.g. people who requires rehabilitation plans anew or whose social needs that are temporarily unmet (e.g. homeless) are hosted in the CMHC, in order to avoid any form of social drift. It means focusing service's attention and resources for a new plan of care.

Some of the practices at the CMHC can be summarized as follows (MEZZINA; JOHNSON, 2008):

- Don't separate persons receiving hospitality from other users ('dissolve' the crisis in normal, everyday living)
- Minimise barriers between operators/users
- Reduce the compartmentalisation and 'turf' issues connected with individual locations / facilities (no to roles/spaces)
- Open door, even for compulsory treatments
- Do normal things in a normal environment

- Share together and live together
- Negotiate and be accountable for everything
- 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, inside and outside the CMHC.

We can say that there is a shift from hospitalisation to hospitality in a system where the concept of "hospitality / guests" is applied by the formal status of 'hospitality for health' with a number of related consequences (MEZZINA; JOHNSON, 2008).

Table 1 - Hospitalisation *vs* hospitality

Hospitalisation	**Hospitality**
- Institutional rules	- Agreed / flexible rules
- Institutionalised time	- Mediated time according to user's needs
- Institutionalised (ritualised) relations	- Relations tend to break rituals
- Time of crisis disconnected from ordinary life	- Continuity of care before/during/after the crisis
- Stay inside	- Inside only for shelter /respite
- A stronger patients' role	- A person in a context
- Minimum network's inputs	- Maximum co-presence of social network

Pathways of care and recovery through the service

During the process of care, CMHC must be able to create a therapeutic/rehabilitative pathway across a series of options from which the user can choose, make other proposals and engage a therapeutic dialogue. Through a series of programmes developed in the community,

clients are offered to access opportunities for recovery and social inclusion, e.g. sports, leisure, wellness, culture. Courses on language, self-care, social identity, use and knowledge of the community have been organised with associations and cultural agencies. Clients can experience reciprocal relationships and new social roles, particularly when access job training and placement, e.g. in a social coop. Free participation to Centre's life can provide a sense of familiarity. They are encouraged to explore their aspirations as a basis for an individual program or "a life project", being helped with money, work or training, education, living places, activity, relations when they're broken. For those with the most complex needs and situations, a personalised plan and the related healthcare budget is the main tool for affirming the central role of the person and their needs and guaranteeing care continuity, with the contribution of social cooperatives as partenrs of care. Personalized projects, also with home support, aim at emancipation and empowerment. Groups for mutual welcome and support meets regularly in the CMHC and develop social activities and support. The management, by partner associations, of small recovery houses for a transitional period of time includes peer support workers.

Other programs are provided by associations, such as cultural initiatives (courses, creative writing, films, museums, etc), sport programs, self-help activities, leisure time experiences, wellness and health promotion, usually involving community agencies and promote destigmatisation.

The wider movement of rehabilitation toward citizenship

In this framework, the Trieste experience developed a "social enterprise" strategy which reconverted the human and economic resources of the mental hospital in community services; fostered the local administration in delivering resources directly to users (benefits, job-wages, housing); promoted the identification of other resources (institutional, NGOs) and laymen available for a creative involvement; created productive, integrated cooperative societies that offer diversified job opportunities and educational and vocational training with user involvement in the economic and decisional structure of the various

enterprises, thereby bridging the gap between the labor market and welfare system (ROTELLI et al. 1994).

Cooperatives cover a wide range of activities like cleaning and building maintenance, porterage and transport, furniture and design, cafeteria, hotel and restaurant services, agricultural production and gardening, handicraft, photo, video and radio production, computer service, serigraphs, administrative services, human services, etc. The purchasers are public agencies as well as private citizens (LEFF; WARNER, 2006; DAVIDSON et al. 2010). The number of persons working in these cooperatives are about 600 in the town, of which about 70% are "disadvantaged" members while about 150 are trainees receiving work-grants, mostly users of mental health, drug addiction or handicap services, or "youth at risk". There are managers, mental health professionals, teaching experts and collaborators for the specific sector.

User and carer involvement in Services

Like other innovative experiences during recent years, Trieste community services aimed at developing their very social life, work organization and contacts with the community in such a way as to optimize exchanges and relationships among all stakeholders - mental health workers, primary consumers, family members, neighbours, volunteers (MEZZINA et al. 1992; MEZZINA, 2010).

Client and carer empowerment through their active participation in mental health promotion also means accepting their contribution to further modifications of a mental health service, in a common action against institutional inertia and welfare passive dependence ties. Some of the developments in the last twenty years are the shift from an individual to a collective level of involvement, if the service is able to recognize their unique life stories and needs and empower them as active actors; the work with heavy burden families (from psychoeducation to mutual support to associations), and the aggregation and self-organization of young clients (from activity groups to self-help and peer support).

4 Evaluation

Data on activites, relevant indicators of outcome and other surveys

Only one client person spends a night in the hospital service for every 10 who spend a night in the Community Mental Health Centres throughout the year. The average stay for people who are admitted in crisis conditions is 10-12 days, whereas it is less than 3 for people who are admitted to the PTSD, because of the rapid turnover above described. In recent years all figures and rates concerning emergencies, acute presentations and crises decreased.

Less than 10 people every 100.000 population in a year undergoes mandatory health treatment in Trieste, usually for about 7-10 days, which is about 1% of al episodes of residential care. Hospitality in the CMHCs replaced most of General hospital admissions in the PTSD, which ratio is 1:10 as compared to the former. Even mandatory health treatments are provided by the open-door CMHC. Readmission rate to a CMHCs is 30%. The use of CMHC beds constantly decreased through these decades (to 1/3). The "no-restraint" principle includes every service, and no ECT are used.

There are no homeless clients abandoned in the streets, because the CMHC are also shelters to some extent in order to get an accommodation, and no people from Trieste are currently in forensic hospitals. Furthermore, in the last few years we have built up the possibility of investing large sums of money in a short amount of time to help particularly difficult patients using personalised healthcare budgets, and by setting up special projects with the support of NGOs. In fact, about 160 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, social relationships. This is about 18% of the overall budget of the Mental Health Department, while another 4% is for economic aids, training grants, leisure, projects with NGOs.

About 200-250 people are in professional training every year using work grants, and 30 of these have been employed, each year, in Trieste job market, in proper jobs, many in the field of social cooperation and about a third also in private firms.

There are now almost 50 different locations of different kinds in the city where mental health activities are carried out. Each person living in Trieste contributes about 80 Euros per year, which enables the Mental Health Department to spend 18,000 Euros to provide all these services. Only 6% of this sum is spent on hospital services and 94% is used to finance community-based services.

Among the Service's most important programmes is a suicide prevention project which has contributed to reducing the suicide rate by half (from 25 to 12 per 100,000 in 20 years) (DELL'ACQUA et al. 2003).

Even if in Trieste it has not been possible to evaluate the effectiveness of single interventions (i.e. psycho-educational, rehabilitative, psycho-therapeutic, etc.) because they are interwoven in "whole system" approach, some surveys and outcome studies have been conducted. Some of these have been published, as cohort studies of patients suffering by psychosis, family burden studies, and other researches on crisis intervention, satisfaction and attitudes of users and family members toward community care, and so forth.

First follow-up study after reform law (1983-1987) showed better outcomes for 20 patients with schizophrenia in Trieste and Arezzo as compared to other 18 Italian centres (KEMALI et al. 1989). Crisis management by CMHCs proved to be effective in preventing relapses and chronic course (MEZZINA; VIDONI, 1995).

In more recent years, a national survey among 13 centres proved crisis care in 24 h community services better for crisis resolution and 2-years follow-up, particularly related to trusting therapeutic relationships, continuity and flexibility of care, service comprehensiveness (MEZZINA et al. 2005a, 2005b). Reduction of 70 % of emergency presentations at General Hospital Casualty occurred in about 20 years.

In an unpublished survey so far, a sample of 27 high priority users at a 5 years follow-up showed a high rate of social recovery: significant reduction of symptoms (the most severe group, over 65 p at BPRS 16 items, from 20% to 4% score reduction), improved social function (increased score by 50%), while 9 users got a real job with a real pay, 12 got independent living, and the overall of level unmet needs (measured by

also CAN) dropped from 75% to 25%; there was also a 70% reduction of bed days, and only a client dropped out.

Qualitative research particularly highlighted relevant social factors connected with services and the connection between recovery, social inclusion and lived citizenship (DAVIDSON et al. 2005; BORG et al. 2005; MARIN; MEZZINA, 2005; MEZZINA, 2006; MEZZINA et al. 2006a, 2006b; 2005a; SELLS et al. 2006).

Recent data encompassed 75% compliance to antipsychotic medications (n=587) related to service provision and social network enhancement (PALCIC et al. 2011). Satisfaction of users with services was rated 83% in two CMHCs.

Comparing the model

Treatments provided by the MH Department in Trieste are biological (medications), psychological (individual and group therapies), psycho-social such as family interventions & psycho-education, social network and social support interventions (neighbours, employers etc), cultural and vocational rehabiltation and work placement, social and life skills training, etc.

If compared to Integrated Community Treatment strategies, and taking into account those treatments which seem to have a proven effectiveness for psychosis at the international level, the Trieste model can be formalized with a certain degree of simplification as follows, and in accordance with the articulation of the integrated community treatment – ICT (FALLOON; FADEN, 1993):

1) Social and vocational skills training through education and literacy; social-cultural pre-vocational training, through the courses organised by the department with training and cultural community agencies; "on-site" living skills training and social learning ("on-site" and not in a "setting"; i.e. within the family, at the CMHC, within sheltered residences; in patient's self-help groups and therapeutic social clubs, and through recreational and social activities); job placement in social cooperatives and supported employment in private companies.

2) Team-work with key-workers, towards a model of case management (balanced with a whole team approach based on de-institutionalised professional roles).

3) Use of cognitive-behaviourial therapy principles in daily programming of activities, or time structuring; ability of coping with symptoms and crises; cognitive restructuring towards the production of meaning or "sensemaking" of the subjective experience.

4) Psycho-educational interventions for the heavily-burdened family: counselling, stress management sessions with the patient, psycho-educational interventions for patients, self-help groups for family members, multi-family group approach, with information and small group encounters on coping.

5) Home crisis intervention and, if required, intensive community residence treatment (in the 24 hour health centers) or crisis management in the day-hospital (also in the mental health center)

6) Medication management strategies with information and negotiation.

If compared this array of treatments of integrated community care strategies, and taking into account those programmes which prove to be effective for psychosis at the international level, the Trieste model contains elements of social and vocational skills training, case management, psychotherapy principles, psycho-educational interventions, home and intensive community residencial treatment, medication management and compliance strategies.

The work organisation has also some point in common with the assertive community treatment or ACT (MARSHALL; LOCKWOOD, 2002):

ACT

1. Multidisciplinary team
2. Targeted user group

3. Shared responsibility
4. Health and social care directly managed
5. Care offered in vivo
6. Assertive treatment
7. Negotiation on programme

Trieste approach

1. Not a dedicated team but a function of the whole CMHC team
2. Part-time service of a limited sub-team for high priority people, while other staff integrate interventions
3. Whole team approach with key workers
4. Not just individualised programmes but recovery-oriented pathways of care

The following table summarizes previous contents in terms of structure-process-outcome.

Table 2 - 24 hours Community MH Centre / integrated service (MEZZINA; JOHNSON, 2008)

Structure/ organisation	Processes/ chosen procedures	Outputs/ clinical outcomes	Critical points/ warnings
24 hrs opened	Real-time reception / intake Open door Low threshold	Responding around the clock No waiting lists for psych. emergencies Accessibility and user satisfaction	"real" 24 hrs: direct intake at night?

Single location	Single point of reference for users and institution Diverse functions (day care, social work, etc) are integrated and not in separate places Service as a space for social relations Low threshold	Integrated response, immediate access to rehab and socialisation programs (group settings) Maintaining and developing social skills (tertiary prevention) Accessibility and user satisfaction	Need to better organise referrals Social over stimulation for users?
Single team	Integrated workforce Collective knowledge of main cases Direct relationship with users	Shared style of work, strategic vision Formulation and review of individual care plans Flexibility Therapeutic continuity / program compliance Secondary prevention (relapses) Decreased involuntary treatments	A sustained focus on single cases or objectives Complex group dynamics, between individual autonomy and interdependence
On-site availability of 'neighbourhood' or community beds	Alternatives to hospitalisation Capability of handling crises with open door	Decreased hospital beds occupancy Acceptability of care Decreased involuntary treatments Timely admission, shorter crisis time Integrated process of care (not excluding acute presentations)	Abusing bed use – keeping hospital mentality

Simultaneous inside-outside work	Rotating internal, external and reception tasks and / or duties Developing activities for hospitality / admission Day care alongside crisis care / outpatient consultations etc.	Changing and contaminating areas / styles of work Flexibility of programs / of workers - complexity Shared burden / Diminished burn-out ? Therapeutic shared Culture	Less focused on tasks, more on complexity Confusion, delegation Maintaining a correct balance between outside projection and internal work
Team case-management	Identifying high priority cases Defining key-workers within the team Wide information sharing Mastery of work	Culture based on responsibility / accountability - Balancing autonomy and individual responsibility Not forsaking difficult users / working out failures	Because of night shifts, more discontinuous day presence Delegating to the team and the managers

Can an approach that is mostly rights- and values-based generate evidence? In our view, processes and outcomes can be also described using the 3 e's system (THORNICROFT; TANSELLA, 2009) that takes into account qualitative levels with the EBM.

Table 3 – The 3 E's in Trieste

ETHICS	EVIDENCE	EXPERIENCE
No restraint / Open door	Low rate of accidents and offense Low rate of compulsion / involuntary treatments	"Humane" negotiation Innovative practices to avoid closing doors Alternative crisis management Welcoming services and social habitat High degree of freedom

Open access / low threshold	Real-time intake and response No waiting list	Immediate response, without formal referrals
Inclusion in work and social fabric	About 200 job placements p year, 1/10 result in a permament job	Integration in community spaces and places, in neighborhood Integration in culture, art, sport programmes developed with community agencies
Right to have a home	General move from residential facilites to supported housing (cluster housing) Research show people with SMI accommodated using personal budgets No homeless user	Individualised supported housing provides maximum autonomy within a gradient of support
Social Habitat / humane environment	No 'security' barriers in CMHC, acute care unit, group homes	High degree of freedom and normal life in Department sites and facilities
Personalized life plans (health and social care)	n. 142 personalised projects	High degree of negotiation and choice
Approach to whole life projects through focused economic resources	Subsidies, work grants, rehab cheques n.2 transitional recovery houses	Response to needs, individual and social, material and not
Prevention of trans-institutionalisation	n. 0 people in forensic care n. 30 users supported into jail per year and ACT use of additional resources aimed at that purpose (FAP)	Development of alternative to jail and recovery / social inclusion projects
Human development / habilitation	About 400 users in habilitation activites	Offer of activities for developing your potential (sport, art, culture, etc)

Support to carers	n. 70 families involved in a course per year including 1st episode of psychosis Multi family groups dialogue with family association	Decrease of family burden Peer support and professional advice
Social and community participation	Participation Committee n. 15 associations accredited Researches on recovery demonstrate value of participation as citizenship	Protagonism of users Dialogue around needs Associations involved in day care center and programmes
Appropriate use of medication	Research data of compliance 75%	
Tutelage of health and life	Decrease suicide rate by 50% in the last 15 years	Access to specific programme of prevention
Rights to health of women in a gender approach	n. 70 women involved in self-help and cultural activities 'recovery' home Migrant women involved in the project to prevent sexual slavery	Mutual help and development of project for improving quality of life and social inclusion

5 Discussion

General indications

Rehabilitation in Trieste has been conceived as a program of restitution and re-construction of full rights of citizenship for individuals suffering by mental health problems, and the material construction of these rights (ROTELLI et al. 1994). This implies not only the legal recognition of civil rights for mental health users, but also of social rights. Resources related to housing, jobs, goods, services, relationships) were acquired primarily through de-institutionalisation process, that reconverted total institutions into community services. Access to resources can be improved

either by developing user capabilities through training (living and vocational skills, education) and information (psycho-education, social awareness), or creating social support networks, which are managed by comprehensive community services totally alternative to the psychiatric hospital.

Rehabilitation practices of community mental health services in Trieste tried also to maximize the use of abilities and human resources of individuals, allowing them to participate, at different levels, to service activities and therapeutic program elaboration, thus producing a participation and social support network, by helping patients in their own environment, preventing forms of regression and institutionalization and developing their social and "health" abilities.

Community health can be seen as a passage which derives from deinstitutionalisation, where systems are built around individuals/communities. A comprehensive, holistic approach must combine health with welfare systems in a powerful synergy, see the concept of "whole systems, whole life approach" (JENKINS; RIX, 2003). The focus on individuals and the rights of citizenship raises the issue of values which underpin practices and services - "value-based" services (FULFORD, 2004). A shift from reparative medicine to participatory health is another relevant shift, that is occurring in some of the most advanced experiences, that requires no black box as funnel for specialistic approaches.

Despite the uniqueness of the experience in Trieste, some general indications can be outlined as follows:

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

2. Avoid or reduce transitions in care that results from fragmentation of services system.

3. Foster the service's responsibility and accountability towards the community: the responsibility for care processes should be rooted in the community.

4. Recognising the importance of social contexts as producers of the meaning of health actions and as bearers of resources means refusing

automatic choices which are not differentiated based on the contexts where they are applied.

5. Developing leadership of individuals and social groups as stake- or shareholders in the healthcare system implies activation of processes of strategic/organisational change, in 'rushes' or continuous cycles.

6. A shift from healthcare hierarchical 'institutions' to horizontal healthcare 'organisations' is necessary.

7. A 'systemic' vision has to be based on the person's life (whole systems, whole life approach) with a low threshold, single access point (one-stop-shop).

8. Developing home care, both network and networked, focused on the person in their actual living context, and thus on their life story and social capital, not on the illness, creating a system of possible options which diversifies responses, making them flexible and personalised, should therefore be provided for.

One should wonder how important is the whole system, and the specific context of application of rehab and social inclusion initiatives? Good practices on a small scale are useful as model programmes to demonstrate "that is possibile" but must be generalised at the system level. While a whole systems approach requires an integrated service, a whole life vison refers to the person in a social context.

Considering the nexus between iIlness and institution (BASAGLIA, 1987; GOFFMAN, 1961; WING; BROWN, 1970), human beings, including professionals, always risk to be entrapped in oppressive relationships.

Therefore a "parallel" empowerment of professional and users is necessary. But should we use "the person key" to change the systems? How use their power, rights, values?

Does it not implies the risk of ideology? Should we use the system change, toward a more integrated sevice, to "reach the person" and to empower him/her? Here we can avoid the risk of pure pragmatism.

What about community building around mental health?

Integration is a key-word widely used to describe a continuum of care and support systems, but integration also means promoting inter-subjective relations within a wider political dimension. It means bringing together social and healthcare interventions, and recognising the social determinants of illness and healthcare processes based on a 'whole life' approach to the person.

Mental health is not the only area that must assume this commitment, for 'there is no health without mental health, as stated by WHO in 2005. Beginning with local mental health, to what extent was it possible to create a level of inter-sectorial integration and collaboration among services, and between services and a specific NGO, so as to guarantee a systemic impact/approach to community healthcare? What were the key elements involved?

In what way is a systemic approach to healthcare not limited to merely creating a system of services? What are its strengths, sources of energy and components?

Is it possible to create a comprehensive healthcare system for a specific community which can respond to the healthcare needs and personal aspirations of users, while promoting health in the community as a whole? And if so, how? How can a community's human, economic, social and cultural resources be activated, mobilised and co-ordinated in operational terms? Are there mechanisms which can guarantee economic sustainability, especially in less affluent countries?

Beyond Trieste and worldwide

Trieste international role is strongly implied in these issues and developments. Since the time of Basaglia the Trieste experience has played an important role in the international scenario, begun as WHO pilot centre in 1973 and acknowledged as WHO Collaborating Centre for Research and Training from 1987. It is and declared to be a considered as a sustainable and cost-effective example and model for service development model by WHO Geneva (WHO, 2001) and Copenhagen and declared (as Lead

WHOCC for Service development in the framework of Helsinki Action Plan in 2005). The MHD has been confirmed as a WHO Collaborating Centre for Research and Training in 2010 in order to assist WHO in guiding countries in deinstitutionalisation and development of integrated and comprehensive Community Mental Health services; contribute to WHO work on patient centred care through applying Whole Systems & Recovery approaches and innovative practices in community Mental Health; Support WHO in strengthening Human Resources for Mental Health (especially through the International School established in 2011).

Programmes of co-operation have been developed for more than 30 years in all continents, with a particolar focus on Latin America, South-East Europe, Palestine, often under WHO umbrella and in collaboration with other advanced organisations. While the flow of study visits has raised up to a thousand people every year, Trieste established connections with some of the most innovative experiences in community mental health worldwide, in order to support each other in a network (MEZZINA, 2010a).

They offered, through twinning collaborations and other forms of international mutual learning processes, the know-how about setting up innovative services and programmes. We can quote for example the multi-purpose integrated CMHC, social cooperatives, de-institutionalisation of the mental hospital (like Trieste), host family schemes, practices for community integration (like Lille), user involvement, 24-hrs. opened centres (like South Stockholm), integration with primary care, social firms (like Oviedo), multidisciplinary community mobile teams (as developed in North Birmingham and in Monaghan, Ireland). Programs of co-operation have been developed for more than 30 years in all continents, with a particular focus on Latin America, South and East Europe, Palestine, often under WHO patronage and in collaboration with other organisations. While the flow of study visits has raised up to a thousand people every year, Trieste established connections with some of the most innovative experiences in community mental health worldwide, in order to support each other in a network (MEZZINA, 2010; JENKINS, 2010). They offered, through twinning collaborations and other forms of international mutual learning processes, the know-how about setting up

innovative services and programs. Apart from what has been outlined here for Trieste, such as social coops and the multi-purpose integrated CMHCs, we can quote for example the foster family schemes and the practices for community integration of Lille, the user involvement schemes of South Stockholm, the liaison with primary care and the social firms of Asturias, the multidisciplinary community mobile teams as developed in North Birmingham and in Monaghan, Ireland, and so forth.

Trieste is considered a model also in western countries like the UK, the Netherlands, Scandinavia, Australia and New Zealand, the USA and Canada, while there is also a strong interest in Japan, Korea, China, Iran, India, Malaysia and other Asian countries. The problem seems to be "what is replicable", because, beyond a reliable, apparently simple but very complex and coherent organisation of services, there is an emphasis on a slightly different approach, still based on a strong critical view on mainstream clinical psychiatry.

6 Conclusions

We assume here that there is a new model, or a paradigm, that derives from de-institutionalisation at its heuristic-operational level (MEZZINA, 2005). It is based on the principle of complexity through the flexible interaction between observer and observed, "scientists' and 'patients' (MACCACARO, 1978). What is pivotal is meaning and sense making within new therapeutic actions, which could be called 'whole life projects' for the people in need (JENKINS; RIX, 2003). It could be defined as an 'interactive comprehension model'. Hence new solutions of community care can be really effective only if they do not limit themselves as being efficient in terms of the management of target population of service users, defined by their illness features and/or related deviant behaviours (BASAGLIA, 1987.); but instead must seek to preserve the idea of the person as a whole.

Moving from an institution or hospital-centered model to a whole system of services for the whole life of a community (public health approach) – responsible, accountable means acting a positive risk-taking about alternatives. De-institutionalisation means also distance, power,

language. In the new scenario of community care there has been a shift from the relationship of domination/control to the therapeutic relationship, seen as a reciprocal relationship and not merely its objectification in the illness, and the rediscovery of the whole person and their subjectivity. From this point of view, deinstitutionalization can be seen as the change in relations of power. As we demonstrated in qualitative cross-cultural researches, a lived citizenship, 'having a whole life' can be captured to be at the heart of a recovery process, as stated by individuals themselves in their narratives.

Therefore "the person and not the illness at the center of the process of care for recovery and emancipation, through users' active participation in the services".

References

BASAGLIA, F. Institutions of Violence. In: HUGHES, N. S.; LOWELL, A. (Ed.) *Psychiatry Inside-out*. Selected Writings of Franco Basaglia. New York: Columbia University Press, 1987.

BENNETT, D. H. The Changing Pattern of Mental Health Care in Trieste. *International Journal of Mental Health,* v. 14, p. 7-92, 1985.

BORG, M. et al. What Makes a House a Home: the Role of Material Resourses in Recovery from Severe Mental Illness. *American Journal of Psychiatric Rehabilitation*, v. 8, p. 243-256, 2005.

COMMISSIONE Parlamentare di inchiesta sull'efficacia e l'efficienza del Servizio Sanitario Nazionale. *Relazione finale sull'attività della Commissione*, Senato della Repubblica, 30 gennaio 2013.

DAVIDSON, L. et al. Process of Recovery in Serious Mental Illness Findings from a Multinational Study. *American Journal of Psychiatric Rehabilitation*, v. 8, p. 177-201, 2005.

DAVIDSON, L. et al. A Life in the Community: Italian Mental Health Reform and Recovery. *Journal of Mental Health*, v. 19, p. 36-43, 2010.

DE LEONARDIS, O.; MAURI, D.; ROTELLI, F. Deinstitutionalization: a Different Path. The Italian Mental Health Reform. *Health Promotion*, v. 2, p. 151-165, 2010.

DELL'ACQUA, G.; COGLIATI, D. M. G. The End of the Mental Hospital: a Review of the Psychiatric Experience in Trieste. *Acta Psychiatrica Scandinavica*, v. 316, p. 45-69, 1986.

DELL'ACQUA, G.; MEZZINA, R. Approaching Mental Distress. In: RAMON, S.; GIANNICHEDDA, M. G. (Ed.) *Psychiatry in Transition:* the British and Italian Experiences. London: Pluto Press, 1988.

_____. Responding to Crisis: Strategies and Intentionality in Community Psychiatric Intervention'. *Per La Salute Mentale/For Mental Health*. Trieste: Centro Studi Salute Mentale, 1988a.

DELL'ACQUA, G. et al. Trieste e il suicidio: un progetto di prevenzione. In: *Quaderni Italiani Di Psichiatria* 2003, v. 22, n. 11-23.

FALLOON, I. R. H.; FADDEN, G. *Integrated Mental Health Care:* a Comprehensive Community Based Approach. New York: Cambridge University Press, 1993.

FULFORD, K. W. M. Ten Principles of Values-Based Medicine. Ch 14. In: RADDEN, J. (Ed.) *The Philosophy of Psychiatry:* a Companion. New York: Oxford University Press, 2004.

GOFFMAN E. *Asylums:* essays on the Social Situation of Mental Patients and Other Inmates. New York: Anchor Books, Doubleday, 1961.

JENKINS, J.; RIX, S. *The Whole Life Programme*. NIMHE East Region, NHS, 2003.

KEALI, D. et al. Patterns of Care in Italian Psychiatric Services and Psycho-Social Outcome of Schizophrenic Patients: a Three-Year Prospective Study. *Psychiatry & Psychobiology,* v. 4, p. 23 – 31, 1983.

LEFF, J,; WARNER, R. *Social Inclusion of People with Mental Illness*. Cambridge University Press, 2006.

MACCACARO, G. A. Appunti per una ricerca su: epidemiologia dell'istituzione psichiatrica come malattia sociale. *Fogli d'Informazione*, v. 50, p. 306-310, 1978.

MARSHALL, M.; LOCKWOOD, A. Assertive community treatment for people with severe mental disorders. *Cochrane Library*. Oxford: Update Software, 2002.

MARIN, I. et al. The Persons'Role in Recovery. *American Journal of Psychiatric Rehabilitation*, v. 3, p. 223-242, 2003.

MEZZINA, R.; JOHNSON, S. Home Treatment and 'Hospitality' within a Comprehensive Community Mental Health Centre. In: JOHNSON, S. et al. (Ed.) *Home Treatment and Crisis Resolution in Mental Health*. Cambridge University Press, 2008.

MEZZINA R. Paradigm Shift in Psychiatry: Processes and Outcomes. In: RAMON, S.; WILLIAMS, J. E. (Ed.) *Mental Health at the Crossroads:* the Promise of the Psychsocial Approach. Hants, England: Ashgate, 2005.

_____. Citizenship: the Social Dimension of Recovery. In: ROBERTSON, S.; KELLEHEAR, K. (Ed.) *Dancing to the Beat of a Different Drum. Mental Health, Social Inclusion, Citizenship. TheMHS Conference Book of Proceedings* 2005. Sydney, Australia: TheMHS Conference, 2006.

_____. Outcomes of Deistitutionalisation in Trieste. In: TORESINI, L.; MEZZINA, R. (Ed.) *Beyond the walls.* Deinstitutionalisation in European Best Practices in Mental Health. Merano, Italy: Alpha Beta Verlag, 2010.

_____. From Italy to Europe and back, practices for emancipation. In: TORESINI, L.; MEZZINA, R. (Ed.) *Beyond the walls.* Deinstitutionalisation in European Best Practices in Mental Health. Merano, Italy: Alpha Beta Verlag, 2010a.

_____. Community Mental Healthcare in Trieste and Beyond. An "Open Door-No Restraint" System of Care for Recovery and Citizienship. *J Nerv Ment Dis*, v. 202, p. 440-445, 2014.

MEZZINA, R. et al. Networking Consumers Participation in a Community Mental Health Service: Mutual Support Groups, Citizenship, Coping Strategies. *The International Journal of Social Psychiatry,* v. 38, p. 68-73, 1992.

MEZZINA, R.; VIDONI, D. Beyond The Mental Hospital: Crisis and Continuity of Care in Trieste. A Four-Year Follow-Up Study in a Community Mental Health Centre. *The International Journal of Social Psychiatry*, v. 41, p. 1-20, 1995.

MEZZINA, R. et al. *Crisi psichiatrica e sistemi sanitari.* Una ricerca italiana. Trieste, Italy: Asterios, 2005.

_____. Gli interventi territoriali a 24 ore dalla crisi sono basati sull'evidenza? Indicazioni da uno studio multicentrico longitudinale. *Psichiatria di Comunità*, v. 4, n. 4, 2005.

_____. From Participation to Citizenship: How to Regain a Role, a Status, and a Life in the Process of Recovery. *American Journal of Psychiatric Rehabilitation*, v. 9, p. 39-61, 2006.

_____. The Social Nature of Recovery: Discussion and Implications for Practice. *American Journal of Psychiatric Rehabilitation*, v. 9, p. 63-80, 2006a.

PALCIC, S.; BROUSSARD, P.; PETTINELLI, A.; GIRALDI, T.; MARTINIS, E.; FURINA, C.; BRACCO, R.; ZANELLO, E.; RIOLO, A.; MEZZINA, R. Studio comparativo sull'utilizzo dei farmaci antipsicotici nel territorio dell'ASS n. 1 "Triestina". *Giornale Italiano di Farmacia Clinica,* v. 25, n. 4, 2011.

ROSEN, A.; O'HALLORAN, P.; MEZZINA R. International Trends in Community Mental Health Services. In: MCQUISTON, H.; FELDMAN, J.; SOWERS, W. (Ed.) *Handbook of Community Psychiatry*. New York, Doirdrecht, Heidelberg, London: Springer, 2012.

ROSEN, A. et al. International Trends in Community-Oriented Mental Health Services. In: MPOFU, E. (Ed.) *Community-Oriented Health Services. Practices Across Disciplines.* New York: Springer, 2014.

ROTELLI, F. Changing Psychiatric Services in Italy. In: RAMON, S.; GIANNICHEDDA, M. G. (Ed.) *Psychiatry in Transition.* The British and Italian Experiences. London: Pluto Press, 1988.

ROTELLI, F. et al. *Is Rehabilitation a Social Enterprise?* Initiative of Support to People Disabled by Mental Illness, World Health Organisation, Division of Mental Health, Geneva 1994. Disponivel em: <http://www.triestesalutementale.it/english/doc/rotelli-et-al_xxxx_rehabilitation.pdf>.

SELLS, D. et al. Arenas of Recovery for Persons with Severe Mental Illness. *American Journal of Psychiatric Rehabilitation,* v. 9, p. 3-16, 2006

THORNICROFT, G.; TANSELLA, M. *Better Mental Health Care.* Cambridge, New York, Melibourne, Madrid, Cape Town, Singapore, São Paulo, Delhi: Cambridge University Press, 2009.

WING, J. K.; BROWN, G. W. *Institutionalism and Schizophrenia*. Cambridge, MA: Cambridge University Press, 1970.

WORLD HEALTH ORGANIZATION. *Stop exclusion – Dare to care. World Health Day 2001.* Department of Mental Health and Substance Abuse, Geneva, 2001.