Innovative Practice 2015:

*De-Institutionalisation and Community Living since 1980*

- Italy/Trieste Mental Health Department & WHOCC

—Roberto Mezzina, Director, MH Dept / WHOCC of Trieste
Summary of Project

• Since 1980 the city of Trieste has closed psychiatric hospitals and set up a network of 24-hour community mental health centres capable of dealing with the most severe conditions and of supporting clients in their daily life, with a view towards recovery and social inclusion.

• “As a result of the community mental health centres, deep changes have also occurred in the attitude of communities towards mental health issues.”
Facts & Figures

• The Trieste DMH manages 4 community mental health centres, each open 24 hours/7 days a week, with 4–8 beds.
• The mental health system includes a rehabilitation and residential support service, with 45 beds in group-homes, as well as a network of 15 social cooperatives, that integrate persons with mental health issues and other disabilities as full members of a social firm.
• Each year 160 clients receive a personal budgeted plan of care.
• About 180 people are in professional training on work grants, 20–25 of whom find employment in the Trieste job market annually.
Problems targeted

- Persons with mental health issues used to be held, treated, and categorized as inmates, kept in a locked institution, and excluded from families and community.

- The main aim of the experience in Trieste - starting in 1971 - was the phasing out of total institution and the development of a full system of community services.
- It opened the way to the Italian Mental Health Reform Law 180.
- The law was then enforced in 1978 as the first worldwide to declare that psychiatric total institutions (asylums, large psychiatric hospitals) should be closed and replaced by Mental Health Departments.
- Moreover the law forbids detention while obliges services to use compulsory treatments when patients refuse care only for a limited period of a week (replicable).
- The law was implemented very slowly in Italy because of resistences and lack of funding, but eventually at the end of 1999 all psychiatric hospitals were closed down.
Solution & Methodology

• As a result of the Italian Mental Health Reform Law, psychiatric total institutions (e.g., asylums, large psychiatric hospitals) were all closed and replaced by regional Mental Health Departments over a period of two decades.

• These offer a wide range of services, such as community mental health centres, small units in general hospitals, day-care centres, and community residential solutions for supported housing.

• Inpatient beds were closed and patients discharged to their original families, to independent living, or to group-homes.

• The Trieste Mental Health Department represents not only the pioneer, but also the most successful example of this reform effort.

• Beneficiaries can now use services without losing any rights, such as community membership, employment, and the full respect of their human rights.
Objectives / goals

- Replacing psychiatric institutions with a network of community services totally alternative to it.
- At the same time, enhancing rights of citizenship of people with mental health problems and providing a whole-life whole system response to their needs of care.
- The subjectivity of clients, their life stories and their aspirations are considered as the main tools for providing treatments and developing services.
Methodology used

• Practices aimed at deconstructing the total institution and developing a full range of community services and support networks.
• Development of local policies.
• Enforcement of the Italian Law n. 180 (1978) and regional law n. 72 (1980).
Key features

• All 1200 inpatient beds were closed from 1971 to 1980 and patients discharged to their original families, independent living or to group-homes and other types of community dwellings.

• New solutions has been developed to enhance their voice and participation:
  • from their individual care plans, developed thorough negotiation with the lowest use of compulsion in the world (see data below)
  • to the achievement of valid social roles as workers, like members of co-operative societies for job placement with more than 30 types of real jobs (these has been developed from 1972 on, in order to overcome work-therapy and actual exploitation);
  • as neighbors of (cluster) housing schemes;
  • as stakeholders of services through committees, forums, mutual support groups, members of community mh and cultural associations, etc.
Innovation

- Main innovation was the shift from a condition of inmates to that one of citizens, who use services without loosing any rights; the restitution to community;
- the reconstruction of an income and a social role;
- the right of care as any other person in the full respect of human rights.
• The DMH in Trieste has a catchment area of some 232,395 inhabitants. Currently the DMH in Trieste manages four Community Mental Health Centres (CMHCs) – open 24 hours/7 days a week and provided with 4-8 beds each – each competent for a catchment area of approximately 60,000 inhabitant.

• Started with the aim of reducing psychiatric hospital admissions and promoting rehabilitation and social re-integration, the four CMHCs provide the core of mental health services in Trieste.

• The General Hospital Psychiatric Unit (GHPU) provides inpatient mental health services, but its 6 beds are mainly used as a filter for emergency situations at night, and normally do not admit patients for more than 24 hours but refers them to the CMHC of the area where they live or to other service as soon as possible.

• Total beds: from 1200 to 73 in the community.
The Mission of MHD of AAS 1 - Trieste

• The MHD shall operate for the elimination of any form of stigmatisation, discrimination and exclusion concerning the mentally ill persons.
• The MHD is engaged to actively improve full rights of citizenship for the mentally ill persons.
• The MHD shall ensure that the community mental health services of the LHC have a coherent and unique organisation as a whole, through a strict co-ordination of actions and links with the other services of LHC, particularly with general health districts and emphasizing the relationships with the Community and its institutions.
The Healthcare Agency is organised as follows:

- **4 Healthcare Districts** (each responsible for approx. 60,000 inhabitants), operating according to area (primary care and home care, the elderly, specialised medicine, Rehabilitation, Children and adolescents, Family counselling, District diabetes centre)
- **3 Departments** (Mental Health, Dependency, Prevention)
- **2 Specialised Centres** (Cardiovascular and Oncological).
- **118** Service for health emergencies
- **1215** employees.
- **Budget**: cash balance € 29,327,155.82
How much does it cost?

1971:
- Psychiatric Hospital 5 billions of Lire (today: 28 million €)

2014:
- Mental Health Department Network 18,0 millions €
- 79 € pro capita
- 94% of expenditures in community services, 6% in hospital acute beds
Housing (1)

- In community psychiatry, the residence matter is key in autonomy and recovery processes (Borg et al., 2005) for people with mental disorders.
- The lack or impossibility to live in a place of one’s own are causes that worsen any form of difficulties and exclusion, if not the main cause of distress where they lead to undesired or detrimental cohabitation, or prevent the same person from experiencing more emancipating situations.
- In any case, people who access residential facilities are mainly those with the least bargaining power, at a higher risk of stigma and social invalidation, hindered in their exercise of essential citizenship rights, sometimes because of difficult family situations, severe social isolation and poor self-care skills.
- This category of people is precisely the most exposed to the risk of being offered de-personalising management methods and involved in institutionalisation conditions.
Housing (2)

• In this framework, it is important to distinguish between residential care and the housing issue, which sometimes see people suffering from severe disorders and social exclusion without a home; moreover, the housing facilities mostly focused on care are even different.
• Most of the times residential facilities are a mix of all this and mainly stand as an answer to the question “where do I put them”, rather that to the needs, times and priorities of the users.

Therefore it is important to distinguish between:
• -a residential therapeutic and rehabilitative type of community, in which the style of work is clearly focused and temporality is important;
• -the need for a place to live, and live, with due support, for people with severe mental disorders.
Personal healthcare budgets

• In the last few years Trieste has built up the possibility of investing large sums of money to help particularly difficult patients using personalised healthcare budgets, by setting up special projects with the support of NGOs.

• 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 and social relationships.

• This allowed the process of reducing group homes and developing independent living

• This represented about 17% of the overall budget of the DMH in 2011, while about 4% is devoted to economic aid, training grants, leisure and projects with NGOs (s.c. extra-clinical activities).

Moreover:

• About 180 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.
The coops: activities

- Cleaning and building maintenance (diverse agencies)
- Canteens and catering, incl. Home service for elderly people
- Porterage and transport
- Laundry
- Tailoring
- Informatic archives for councils, etc
- Furniture and design
- Cafeteria and restaurant services
- Hotel
- Front-office and call-center of public agencies
- Museums’ staff
- Agricultural production and gardening handicraft
- Carpentry
- Photo, video and radio production
- Computer service, publishing trade, CD-Rom
- Serigraphy
- Theatre
- Administrative services
- Group-homes (type A)
- Parking
Table 1. Development of people in high-intensity residential facilities between 2002 and 2012.

<table>
<thead>
<tr>
<th>No. of years</th>
<th>No. of facilities</th>
<th>Beds</th>
<th>Deceased</th>
<th>Transferred to nursing homes</th>
<th>Transferred between facilities</th>
<th>No. of supported housing projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>12</td>
<td>93</td>
<td>-</td>
<td></td>
<td></td>
<td>-</td>
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<tr>
<td>2005</td>
<td>12</td>
<td>88</td>
<td>8</td>
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<td>2012</td>
<td>8</td>
<td>42</td>
<td>6</td>
<td>10</td>
<td>44</td>
<td>49</td>
</tr>
<tr>
<td>10-year summary</td>
<td>-4</td>
<td>-51</td>
<td>14</td>
<td>19</td>
<td>71</td>
<td>70</td>
</tr>
<tr>
<td>Reduction</td>
<td>--55%</td>
<td>9.60%</td>
<td>13.00%</td>
<td>49.00%</td>
<td>48.00%</td>
<td></td>
</tr>
</tbody>
</table>
Facts on outcome, impact and effectiveness

• Freedom in care with no need for new asylums.
  • (a) Compulsory Treatment Orders (CTOs) discharge rates in the Region Friuli Venezia Giulia are one of the lowest in Italy, with 9 cases per 100 000 population per year compared to a national average of 17 (Ministry of Health, 2011). Moreover, two thirds of people under the CTOs were treated within CMHCs rather than in inpatient facilities in Trieste
  • (b) There are no people in forensic hospitals from Trieste from 2006.
  • (c) Mental health services do no make use of restraint measures, such as locked doors and mechanical restraint.
Transferability, scalability and cost-efficiency

• This organization has become the regional model for all mh Services in Region Friuli-Venezia Giulia (1.200.000) but not for the whole country, despite the request of family and user organizations.
• Many organisations from all over the world visit Trieste every year (up to 900 persons as professionals, managers, politicians and stakeholders in general).
• Trieste is Lead WHO Collaborating Centre for service development from 2005.
• The sustainability is demonstrated because the overall cost of services provided by the MH Dept is no more than 60% of the cost of the former asylum.
• The number of people treated in a more humane system of care is more than 5000 as compared to 1200 in 1971.
Outlook & Transferability

• The practice was recognised as an experimental pilot area of mental health de-institutionalisation by the World Health Organization in 1974, became a WHO Collaborating Centre in 1987 and is reconfirmed as such until 2018.

• This means assisting WHO in guiding other countries in de-institutionalisation and development of integrated and comprehensive Community Mental Health services, contributing to WHO work on person centred care and supporting WHO in strengthening Human Resources for Mental Health.

• Because de-institutionalisation was so successful in Trieste, the community-based approach has been implemented in the whole Friuli Venezia Giulia region and is acting as inspiring model for services, organisations and countries in more than 30 countries - so far particularly in Europe, Asia, South America, Australia and New Zealand.
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