10 years of the International School and more: current challenges of the reform process in some countries

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The experience of collaboration – Trieste WHO CC (established 1987)

- Linking with other experiences of change: e.g. with Lille, B'Ham, South Stockholm, Oviedo, Monaghan (IMHCN)

- Greece (Leros)

- Croatia, Bosnia-Herzegovina, Kosovo, Albania, Makedonia

- Mozambique

- Brasil, Colombia, Argentina, Cuba, Dominican Republic

- Japan, China, Malaysia, India, South Korea.

- Italian Regions: Campania, Sardegna

- 900 professionals visiting Trieste every year

English-speaking countries

- New Zealand, dec 2010, sept 2012 – 'La via Trieste' – Minister of Health, Blueprint II

- Australia, TheMHS conference, Minister of Health NSW and Victoria, MH Commissions, RANZCP conferences, cooperation for PH campus to the community (La Rozelle)

- USA, San Francisco, 2006-2009; L.A., 2017

- Twinning collaboration with 3 SW England Trusts through IMHCN (UK, 2009-10 – Hertfordshire, September 2009; Study visit to Elderly Services, Cornwall, Jan 2010; Plymouth, Newtwork Conference, March 2010)

- Twiining Collaboration with Wales Health Boards (Hywel Dda, ABMU): 24hrs CMHCs – Trieste model

Deliverables

- **"Trieste Declaration 2011"** together with a theoretical background document, was approved and signed by all the delegates attending the meeting in 2011. As indicated by the Director of the WHO Department of Mental Health and Substance Abuse in Geneva, Dr. Shekar Saxena, and Regional Director for Mental Health-WHO Copenhagen, Dr Matt Muijen, the Declaration was officially sent to WHO and the European Commission,

- **"The Charter of de-institutionalisation actions" that consists of a series of over 20 projects and cooperation measures attached to the Declaration.** The projects and concerted actions are an indication of important business to realize the shared intention to change services emerged from the meeting. "Charter of deinstitutionalization actions in Europe and worldwide," and the WHO CC in Trieste intends to follow and support it in cooperation with the international organizations;

- **Translation of Global and Eurpean MH Action Plans, "mh GAP Intervention Guide" into Italian (2013-2016).**

- Dr Mezzina was invited to contribute to the draft of WHO Mental Health Global Action Plan and WHO European Action Plan, and also engaged on needs / possibilities to align activities of WHO CCs to the Strategy objectives.

- WHO-CC Trieste hosted on 6-7 of November 2012 the Meeting of the European Collaborating Centres for the WHO Mental Health Programme, and the purpose of this meeting comprises the following:

- 1. To present the draft European MNH Action Plan;

- 2. To agree activities and products and ways of dissemination and implementation;

- 3. To consult with participants on the areas for future collaboration;

- 4. To begin the development of targets and indicators that will allow evaluation of progress.

- There is a strong **collaboration** with other WHO CCs (Verona, Lille, Lisbon, Switzerland, Stockholm), WARP,   Network of European Psychiatric Hospitals in Transition, The "COPERSAMM - Conferenza Permanente per la Salute Mentale nel Mondo (Permanent Conference for Mental Health Worldwide) – ConfBasaglia", IMHCN (International Mental Health Collaborating Network), EAOF (European Assertive Outreach Foundation) and other relevant International organisations in Australia (as Travelling Professor), Denmark (visit of the Minister of Health in delegation to Trieste), USA (International Conferences), Japan (consistent number of delegations from Japan visit Trieste MH Services). Spain (International Seminar and visit to MH Services in Murcia), Egypt, Philippines and India.

Overview of the Mental Health Action Plan
2013 -2020
Vision

- "A world in which mental health is valued, promoted, and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high-quality, culturally appropriate health and social care in a timely way to promote recovery, all in order to attain the highest possible level of health and participate fully in society and at work free from stigmatization and discrimination".

Cross-cutting Principles

Universal health coverage

Regardless of age, sex, socioeconomic status, race, ethnicity or sexual orientation, and following the principle of equity, persons with mental disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health.

Human rights

Mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.

Evidence-based practice

Mental health strategies and interventions for treatment, prevention and promotion need to be based on scientific evidence and/or best practice, taking cultural considerations into account.

Life course approach

Policies, plans, and services for mental health need to take account of health and social needs at all stages of the life course, including infancy, childhood, adolescence, adulthood and older age.

Multisectoral approach

A comprehensive and coordinated response for mental health requires partnership with multiple public sectors such as health, education, employment, judicial, housing, social and other relevant sectors as well as the private sector, as appropriate to the country situation.

Empowerment of persons with mental disorders and psychosocial disabilities

Persons with mental disorders and psychosocial disabilities should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation.

Objectives and Targets

To strengthen effective leadership and governance for mental health

Global target 1.1: 80% of countries will have developed or updated their policy/plan for mental health in line with international and regional human rights instruments (by the year 2020).

Global target 1.2: 50% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments (by the year 2020).

To provide comprehensive, integrated and responsive mental health and social care services in community based settings

Global target 2: Service coverage for severe mental disorders will have increased by 20% (by the year 2020).

To implement strategies for promotion and prevention in mental health

Global target 3.1: 80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes (by the year 2020).

Global target 3.2: The rate of suicide in countries will be reduced by 10% (by the year 2020).
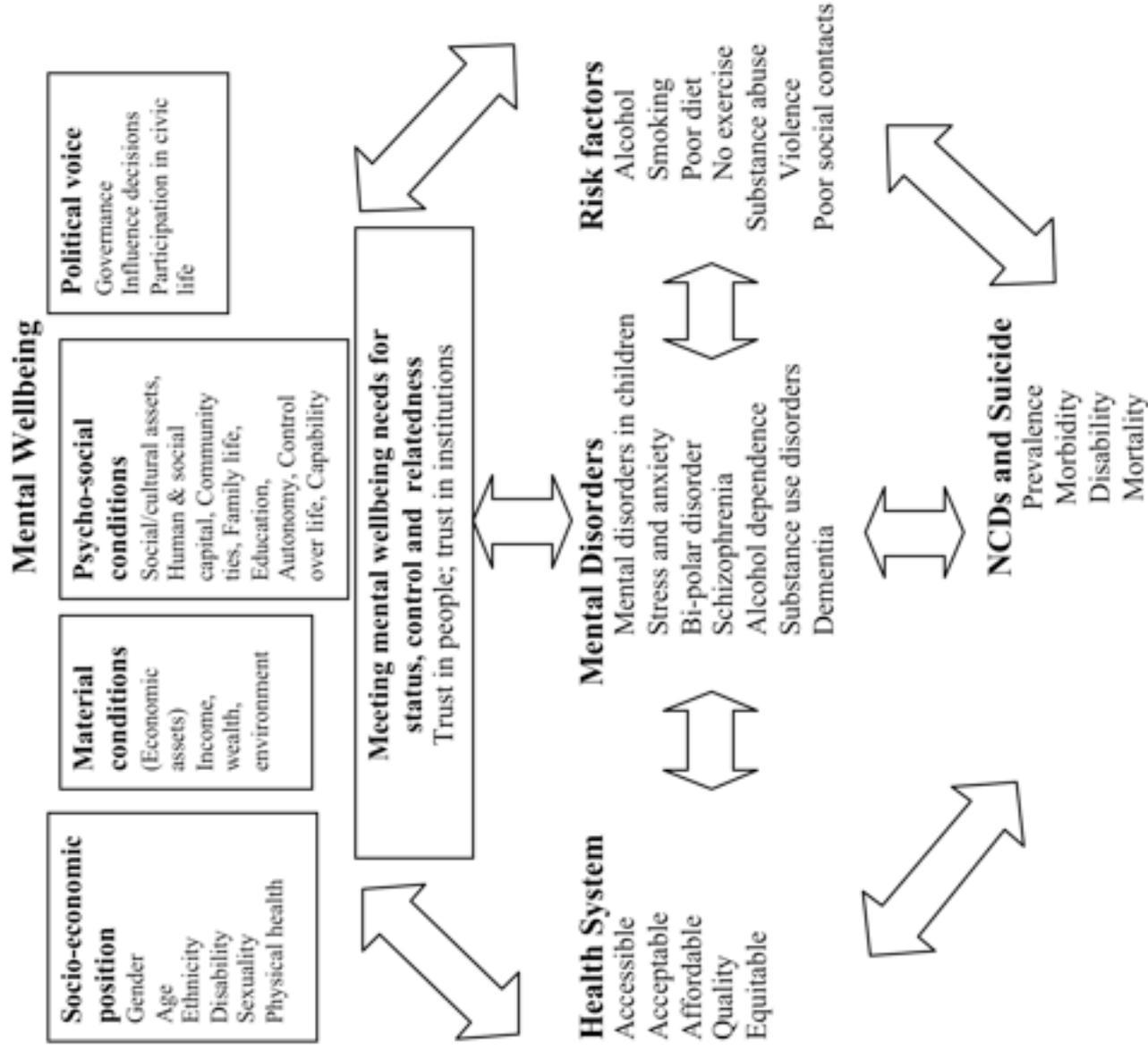
To strengthen information systems, evidence and research for mental health

Global target 4: 80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems (by the year 2020).

European MH Action Plan: scope

- Improve the **mental wellbeing** of the population and reduce the burden of mental disorders, with a special focus on vulnerable groups, exposure to determinants and risk behaviours;

- Respect the **rights, addressing stigma and discrimination, and offer equitable opportunities** to people with mental health problems (including dementia and substance use disorders) to attain the highest quality of life;

- Establish **accessible, safe and effective services** that meet people's mental, physical and social needs and the expectations of people with mental health problems and their families.

Figure x: The cycle of mental wellbeing

Mental Wellbeing

Socio-economic position
Gender
Age
Ethnicity
Disability
Sexuality
Physical health

Material conditions
(Economic assets)
Income, wealth, environment

Psycho-social conditions
Social/cultural assets, Human & social capital, Community ties, Family life, Education, Autonomy, Control over life, Capability

Political voice
Governance
Influence decisions
Participation in civic life

Meeting mental wellbeing needs for status, control and relatedness
Trust in people; trust in institutions

Mental Disorders
Mental disorders in children
Stress and anxiety
Bi-polar disorder
Schizophrenia
Alcohol dependence
Substance use disorders
Dementia

Risk factors
Alcohol
Smoking
Poor diet
No exercise
Substance abuse
Violence
Poor social contacts

Health System
Accessible
Acceptable
Affordable
Quality
Equitable

NCDs and Suicide
Prevalence
Morbidity
Disability
Mortality

Strategic objectives

Four core strategic objectives

- Everyone has an **equal opportunity to realize mental wellbeing throughout their lifespan**, particularly those who are most vulnerable or at risk.

- People with mental health problems are **full citizens whose human rights are valued, protected and promoted**.

- **Mental health services are accessible and affordable, available in the community** according to need.

- People are entitled to **respectful and effective treatment, and to share in decisions.**

Objective 3.
Mental health services are accessible and affordable, available in the community according to need

- Aggregated info on social inclusion of socially marginalized groups / access to CBMH services and methodology.
  - Lead: UK-244

- Share guidelines / methodology on PHC and deinstitutionalisation.
  - Lead: ITA-91

- Share results of relevant surveys, guidelines, tools on mental health services.
  - Involved: All CCs

Outcomes

- 4.Large institutions which are associated with neglect and abuse are closed.

- 5.Hospital care is therapeutic, provided in a decent environment.

- 6.People with long term mental health problems lead lives as full citizens.

- 7.Mental health services offer appropriate care for different age groups.

- 8.Family capacity and needs are assessed periodically, and training and supportprovided.

- 9.A multi disciplinary workforce is available in sufficient numbers.

- As shown by a recent survey of WHO, **80% of government spending on mental health care are absorbed by psychiatric hospitals** (Saxena et a., 2011).

- The data regarding a number of experiences in Italy show that savings of up to 50% can derive from such a total reconversion into a network of community services and related instruments for social inclusion.

Deinstitutionalisation as a process/ Trieste Declaration 2011

The process of the deinstitutionalisation of PHs necessarily implies a **major involvement on the part of both the general population and psychiatric operators**. In fact, these latter do not necessarily have a decision-making role in cases involving a purely administrative deconstruction and the emptying of hospitals, which can only be activated by policymakers.

By deinstitutionalisation we mean that **process** which aims at the gradual transformation of living conditions, treatment and care and the restoration/construction of patient rights, together with the progressive substitution of the rules of internment with procedures based on a full negotiability between patients and operators.

a) staff culture

- criticism of psychiatry's custodial mandate and the re-elaboration of the mandate for control;

- abolishing practices of violence and restraint as a form of institutional management vs 'no restraint' at all levels;

- top-down vs bottom-up lead of change;

- contributions of new, diverse actors who are not part of 'normal' institutional life (e.g. volunteers, citizens, artists, intellectuals, family members, non-profit organisations).

b) relations with the user

- changing institutionalised behaviour, responding to needs, listening and reconstructing life stories, restoring voices, instigating and sustaining empowerment, creating participation

c) the organisation of life in the hospital

- **'humanisation'** (e.g. dignity of habitat; personalising patient living spaces; private possessions, clothes, keys, wardrobes; managing own money,; contacts with outside world; first outings; finding life stories)

- **'liberalisation'** (e.g. opening up wards; mixed m/f wards; therapeutic community-type meetings; break up totalised life of patients; giving patients a voice; focus on primary needs such as income and housing; individual and group outings; parties; invite family members)

- **deinstitutionalisation** (e.g. planning the phasing out and suppression of the PH through sectoralisation and internal reorganisation; closing wards and a gradual reconversion moving towards community services; transfer resources to services and directly to users, guaranteeing life in the community through economic resources for subsidies and training; opening the first group homes and single residences, with appropriate support; create social enterprises / coops, etc.)

d) interventions and deinstitutionalisation policies

- involving and influencing administrations and policies, **administrative management of transformation**;

- involving **civil society**, creating public awareness and fighting stigma;

- contaminating the **judicial and forensic** psychiatric system;

- changing the **legal framework** for Mental Health and inclusion;

- **integrating Mental Health into general healthcare** (e.g. at the community level / primary care and not just hospitalisation for acute cases);

- **integrating Mental Health with welfare systems** (e.g. inter-sectorial link with social services for housing, work, free time, education and cultural training);

- reconverting or **restoring** psychiatric hospital sites to the community.

- Despite international recommendations, even those of the WHO (The Optimal Mix of Services for Mental Health, 2011) which stress that PHs can be reduced or suppressed only if community services and structures have already been established – and thus thanks to new funds specifically allocated for that purpose –we believe that a contemporaneous **process of reconversion** which can impact profoundly not only on the renewal of services but also on the community and its culture, is not only practicable but desirable.

- Despite the significant disparities due to national and local contexts, we believe that while this process can be instigated by a **top-down** impetus and be guided by a responsible institutional leadership, it can only be fully achieved thanks to a **bottom-up** process which mobilises actors and resources.

- working directly **within total institutions** but without deceiving ourselves that their closure can come from outside or due to a *'natural death'*;

- creating alternative networks of **coherent services that work in synergy within the community**, thereby avoiding useless and often harmful fragmentation and specialisations, and thus working not according to preconceived models but by processes that are verified collectively by users, families and caregivers, and the community and its institutions;

- **avoiding priority implementation of hospital services for crisis/emergencies instead of community structures.**

- assign to the community services the task of **taking responsibility for persons who come from their territory of competence, who are still interned in the PH;**

- plan the phasing out of PHs at the local, regional and state levels, with specific **time-frames** and the possibility of applying administrative sanctions in cases of non-compliance.

- The deinstitutionalisation process is not only downsizing or even suppressing psychiatric hospitals, but undertaking a complex process of removing the ideology and power of the institution by **putting the person over the institution** with their subjectivity, needs, life story, significant relationships, social networks, social capital.

- In order to do that, it is necessary to **shift the power** in order to empower people with mental health problems, shift resources from hospitals to a range of community based services useful for his/her whole life. It opens pathways of care and programs that integrate social and health responses and actions.

- This complex process of change **involves users, carers, professionals and the general citizenry**, and extends to the legislative and political level.

Terms of reference 2014-18

- TOR 1 - Assist WHO in guiding countries in deinstitutionalisation and development of integrated and comprehensive Community Mental Health services.

- TOR 2 - Contribute to WHO work on person centred care through applying Whole Systems & Recovery approaches: innovative practices in community Mental Health.

- TOR 3 - Support WHO in strengthening Human Resources for Mental Health.

Action 1 - To support WHO in promoting mental health reform processes with focus on deinstitutionalization

- (1) Technical support in countries as agreed with WHO, particularly in South/East Europe for deinstitutionalization and development of integrated and comprehensive Community Mental Health services.

- (2) Promoting intersectoral and integrated approaches and related technologies for governance in low, medium (Czech Republic) and also for high income countries (e.g. Australia and New Zealand, Japan, the Netherlands, the UK), to support social inclusion.

- In collaboration with GOs, NGOs, community organisations and welfare and general health services incl. Primary Care.

- Current cooperation: **Czech Republic, Poland, Spain, UK, Holland; Belgium, Hungary, Japan, USA, China**

Deliverables

- (1) Guidelines for phasing out psychiatric hospitals, based on actual experiences in deinstitutionalization.

- (2) Guidelines for setting comprehensive community-based services.

- (3) Local report of activities for each countries of pilot sites.

- (4) Contribute to the collection of Europan good practices on recovery and to the 10 point recovery message (FRA 17).

- WHO deliverable: contribution to implementation of th European and Global Mental Health Action Plans. Relevant outputs described under WHO/EURO Key Priority Outcome 7 as per WHO/EURO MNH workplan 2014-15: Member States offer evidence based interventions to improve mental wellbeing of the population and the quality of life of people with mental disorders by applying the Global and European Mental Health Action Plans.

Action 2 - To support the development of reform processes in South America through Latin American networks

- The activity is aimed at providing support to the implementation of Reform Law of 2010 in Argentina, through WHO, by enhancing a network of good practicies and offer training in Trieste to young professionals;

- in Brazil the shift from institutions to community services will be promoted through training (twinning conventions with Universities).

- Other countries can be involved in agreement with WHO.

- Current coperation: **Brazil, Argentina**

Deliverables

- (1) Organization of the International School in Brazil.

- (2) Local reports of activities for each project.

- (3) Training material related to deinstitutionalization and rehabilitation.

- WHO deliverable: Contribution to implementation of the Global MH Action Plan: Objective 2: To provide comprehensive, integrated and responsive mental health and social care services in community-based settings.

Action 3 - Collaboration with WHO QualityRights Programme (implementation of WHO programmes and activities at country level)

- To support human right issues and developments in institutions together with NGOs – collaboration with WHO QualityRights in identified countries such as Malaysia and India.

- Deliverables: (1) A project to implement a no restraint approach in Johor Bahru (Malaysia) and related report.

- (2) A project for implementing WHO QualityRights toolkit in India (Chennay) and related report

- WHO deliverable - Contribution to implementation of the Global Mental Health Action Plan. Programme Budget outputs 2.2.1 and 2.2.2.

- Current cooperation: **India. Malaysia, Eurpope (empowerment college)**

Action 4 -Strengthening Human Resources for mental health through Franca and Franco Basaglia International School

- (1) In coordination with WHO, to offer study visits and training courses in Trieste and other relevant demonstration sites from countries named in all other activities or proposed by WHO; and (2) to develop a formal curriculum (International School / Master Course) on organization of community based MH Services, together with other International NGOs and Institutes, as agreed with WHO.The latter is organized in modules (study visits; training packages; workshops; longer stage periods).

- Deliverables: (1) Each year: n. 5 study visits with 2/3 daystraining packages; a 5-7 days workshop; stage periods of 3-6 months. Trainees: from 40 to150 per year ca.; an expected number of about15 trainee mh professionals will be trained in Trieste for longer stage periods. (2) Diffusion of documents and other material focused on innovative practices in community MH (e.g. alternatives for acute care; comprehensive CMH Centres; rehabilitation,recovery & social inclusion services; deinstitutionalisation & whole systems change; early intervention integrated network; social enterprises & Cooperatives technology, operation & policies).

WHO Deliverable

- Contribution to implementation of the European and Global Mental Health Action Plans. Relevant outputs described under WHO/EURO Key Priority Outcome 7 as per WHO/EURO MNH workplan 2014-15: Member States offer evidence based interventions to improve mental wellbeing of the population and the quality of life of people with mental disorders by applying the Global and European Mental Health Action Plans. (Programme Budget outputs 2.2.1 and 2.2.2).

- **L'International School Franca e Franco Basaglia** é realizzata dal CC OMS di Trieste, col sostegno della Regione FVG, in collaborazione con Università e istituti di ricerca e formazione nazionali e internazionali.

- Essa intende insegnare, trasmettere e attualizzare il pensiero e la pratica di Franca e Franco Basaglia e dell'esperienza di Trieste, fondata sulla **centralità della persona come cittadino dotato di pieni diritti,** e in generale l'approccio critico alla psichiatria nel senso della lotta all'istituzionalizzazione e alla medicalizzazione, promuovendo un concetto integrato di cura basato sulla comunità che esclude l'impiego di mezzi oppressivi e repressivi.

- Essa pertanto intende diffondere tutte le **pratiche ed esperienze** che a ciò si ispirano, fondate sui medesimi **valori**, e riconosciute come utili all'**innovazione** in salute mentale.

- Mira alla costruzione di **curricula** adeguati e riconosciuti a livello internazionale, attraverso un metodo di apprendimento teorico pratico basato sulla conoscenza e lo studio dei servizi e delle pratiche, interagendo concretamente con le realtà locali. Privilegia i giovani operatori e coloro che sono impegnati a vari livelli nei processi di cambiamento. **Replicata in altri paesi (Brazil, Japan, Spain)**

Contribute to WHO implementation of mhGAP and related support to specific countries

- In countries where the WHOCC already established contacts with WHO National Counterparts or Programme Leaders and Officers, mhGAP outcomes are addressed through specific agreements within WHO mhGAP Programme. Local developments in Primary and Secondary Care will be supported by mhGAP training and development of multidisciplinary teams.

- Deliverables: (1) Local report of activities. (2) Planning and adaptation of toolkits and training packages. (3) Related seminars and courses. All deliverables will be shared and exchanged through mhGAP community. Participation tomhGAP annual meeting.

- WHO deliverable: Contribution to implementation of the Global Mental Health Action Plan. Programme Budget outputs 2.2.1 and 2.2.2.

- Current cooperation: **Italy and WHO HQ Geneva**

International School

- The Franca and Franco Basaglia International School is realized by the WHOCC of Trieste, with the support of Region Friuli-Venezia Giulia, in collaboration with Universities and National and International Research and Training Institutes.

- It aims at teaching, transmit and updating the thinking and practice founded on the centrality of the person as citizen with full rights, such as Franca and Franco Basaglia lesson and the Trieste experience, and more generally a critical approach to psychiatry as far as fighting against institutionalization and medicalization is concerned, promoting an integrated concept of care based on the community, that excludes the use of oppression and restraint methods.

- Therefore it intends to diffuse all practices and experiences inspired to those principles, based on same values, and acknowledged as useful to innovation in the mental health domain.

- It aims at constructing adequate and internationally recognized curricula, through theoretical and practical learning based on knowledge and study of services and practices, interacting effectively with local settings. It privileges young staff and all those who are engaged in the process of change. It teaches and documents innovations in areas such as alternatives about crisis care, comprehensive CMHCs, early intervention, social enterprises, rehabilitation and social inclusion, of recovery oriented practices and coproduction.

The International School

- CONFERENCE: "Beyond the walls: the transition from hospital to community based care. Deinstitutionalisation and International Cooperation in mental health" Trieste, 13 – 16 April 2011. 300 participants from 28 countries.

- TRAINING MODULES

- First module: September 19-24, 2011:"Beyond the walls - how to open the doors of psychiatric hospitals towards community based care and services. Focus on Europe and the East".
  37 participants from 9 countries.

- 2nd module: 22-27 October 2012: "Services People Need. A Rationale For A Fully Integrated, Person- Centered Mental Health System Of Care".
  Title: "Comprehensive Community Services. Learning and Practising"), 42 participants from 16 countries.

- + CONFERNCE "Why Change? Creativity and Innovation in Mental Health Development", 152 participants

Int School

- MEETINGS

- International Seminar "Recovery and occupation: users as protagonists of social inclusion. Changing the culture - focusing on real experiences", Trieste, 7-8 November 2013. 180 participants from 16 different countries.

- International Meeting "Franco Basaglia's vision: mental health and complexity of real life. Practice and research", 9-12 December, 2014. 250 participants from 25 countries.

- International Meeting (CONFERENCE) "A community without secluson: The challenge of the open door, open discourse, open access in mental health care and services through practices of freedom", 15-18 December 2015. More than 300 participants from 21 countries.

Int School

- SPECIAL WORKING GROUPS

- The "Think Thank Conference – Crossroads of change", Trieste on 17th and 18th October 2016. Compendium of good practices for WHO. 76 Delegates.

- Working Group "Developing the Psychiatric Hospitals in Transition Alliance in Europe", Trieste on 15th and 16th December 2016. 75 Delegates.

Trieste: la storia in avanti
1. La sfida della riproducibilità e della appropriazione (da parte di altri).

- **Riprodurre che cosa?** Che cosa si può generalizzare? Che cosa estrapolare? Le teorie della complessità negano che estrapolazione e generalizzazione possano evitare le invarianze, la standardizzazione, e dunque il "modello" in astratto. Le Etiche, secondo il Trimbos Instituut olandese, sarebbero l'elemento generatore.

- **Non riproducibilità** Non vi è una riproducibilità perché esiste un'assoluta unicità? L'insistenza sui valori è corretta, ma vi è forse soprattutto l'insistenza su un metodo, che é quello di affrontare la realtà e le sue contraddizioni guidati dal valore fondante della libertà dall'oppressione e dalla gestione aperta dei poteri, da una mediazione fondata sul negoziare, sul riconoscere l'altro, battendosi perché l'altro separato e muto, incomunicabile e incomunicante, non sia.

2. La sfida della riproduzione e della deistituzionalizzazione che continua.

- **Lo scambio e il collettivo** E' stata una grande avventura collettiva – o un'impresa collettiva. Attraverso scambi si costituisce una comunità di intenti e di pratiche – o, più tragicamente detta, di destini? Una comunità dove tutti i membri "possano – attraverso la contestazione reciproca e la dialettizzazione delle reciproche posizioni – ricostruire il proprio corpo proprio e il proprio ruolo" (Franco Basaglia, l'Utopia della Realtà).

- **L'istituzione negata o inventata** L'Istituzione negata - l'istituzione inventata è qui svelata come falso dualismo. L'istituzione inventata va costantemente smontata perché si renda possibile l'innovazione, la creatività, il cambiamento, i cento fiori. Il campo del pratico-inerte di Sartre (Critica della Ragione Dialettica), spesso citato da Rotelli, va costantemente animato.

- **Complessità e normalità** I saperi della complessità sono anche i saperi della normalità, e come tali sospesi tra banale e straordinario. La complessità va oggi intesa come codeterminazione, coevoluzione dei servizi e delle persone nel campo della psichiatria. Complicità e alleanza, essere immersi nella stessa realtà, e stare insieme a dialogare.

- **Cambio di Paradigma** Il Cambio Paradigmatico che si può più chiaramente discernere, in epoca post-istituzionale (se per istituzione ci riferiamo a quella totale, al manicomio), è forse quello che porta dalla malattia al soggetto o meglio alla persona nel suo contesto sociale, in cui insiste anche il servizio.

3. Gli esiti finali – il telos

- **I diritti esigibili** Gli esiti sono rappresentati dai soggetti stessi, per cui diventano esigibili questi diritti, e che vedono la "recovery" legata indissolubilmente alla loro cittadinanza (non saranno più i tecnici). In salute mentale un approccio basato sui diritti e sulle etiche può essere efficace, generare evidenze? Le "tre e" (etica, evidenza, esperienza) possono venire interconnesse?

- **La persona nel mondo della vita** Nel senso dei diritti, questo approccio é centrato sulla persona, o olistico sulla interezza della sfera di vita; parte da valori condivisi: libertà e umanità innanzitutto. Come mai è efficace, come pare sia? Forse perché produce un mondo condiviso e coerente, leggibile e coabitato, a cui ciascuno é chiamato a contribuire e ad essere responsabile. Dove esiste continuo scambio, e una produzione di senso, di un senso intersoggettivo, che implica un'uscita dall'alienazione e una re-inclusione sociale.

- **Le riforme istituzionali** Gli esiti sono all'interno della sfida delle riforme, della democrazia, la trasformazione di istituzioni autoritarie o violente. Le promesse della cura, la ricomposizione dei bisogni nella politica sociale e il welfare di comunità, le differenze, la prevenzione e i modelli di consumi e comportamento sociale, la lotta per i diritti generali e settoriali, la speranze di una medicina di comunità **senza perdita del soggetto**: ci sono oggi due, tre, quattro, molte Trieste.

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