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Roberto Mezzina

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Creating mental health services without exclusion or restraint but with open doors Trieste, Italy

Roberto Mezzina

Dipartimento di Salute Mentale,
WHO Collaborating Centre for Research
and Training, AAS n. 1, Trieste, Italy

Abstract. The city of Trieste is an internationally known experience that started in 1971 under the direction of the great figure of Franco Basaglia, and resulted in the first closure of a psychiatric hospital in Europe more than 35 years ago. The Mental Health Department has been recognised as a WHO collaborating centre for many years and it is considered as a sustainable model for service development without any psychiatric hospital support. Trieste has shown a different approach for innovative community mental health that has moved from a narrow clinical model based on the illness and its treatment to a broader concept that involves the whole person at the centre of the care system, with the highest attainable level of freedom and respecting their power of negotiation. The accent is on recovery as well as human and citizenship rights, in order to respond according to needs, to integrate care in people's lives and aspirations and foster participation to service development. The organization is based on 24 hour CMH centres with a few community beds in each centre, a very small GH unit, a high number of social cooperatives, supported housing schemes and other innovative programmes in the area of recovery and social inclusion. Results show a demonstration of cost-effectiveness as well as the capacity to contrast stigmatisation, discrimination and exclusion of people suffering from mental health issues.

Key words: social psychiatry, de-institutionalization, freedom to come and go, recovery, psychiatric care organization, Italy

Résumé. Créer des services de santé mentale sans exclusion, avec les portes ouvertes et sans contention. Trieste est un site exemplaire, centre collaborateur OMS, sans hôpital psychiatrique depuis 35 ans. La pratique est centrée sur la personne, axée vers le plus haut degré de liberté de l'utilisateur et de respect de son pouvoir de négociation. L'accent a été mis sur le rétablissement et le respect des droits humains et citoyens, pour apporter une réponse adaptée aux besoins de la personne, pour lui permettre d'intégrer ses soins à sa vie et à ses aspirations et de participer lui-même au développement du service de soins. Les services présents à Trieste s'organisent autour de quatre centres communautaires de santé mentale ouverts 24 heures, une petite unité d'urgence en hôpital général, un service de réhabilitation et de support résidentiel, des centres de jour, des coopératives sociales, foyers, clubs, associations de familles et d'usagers. Les résultats sont cliniquement positifs selon le rapport coût-efficacité ainsi que contre la stigmatisation, la discrimination et l'exclusion des personnes souffrant de problèmes de santé mentale.

Mots clés : psychiatrie sociale, déinstitutionnalisations, liberté d'aller et de venir, rétablissement, organisation des soins psychiatriques, Italie

Resumen. Crear servicios de salud mental sin exclusión, con las puertas abiertas y sin contención, Trieste, Italia. Trieste es un sitio ejemplar. Centro colaborador OMS, sin hospital psiquiátrico desde hace 35 años. La práctica está centrada en la persona, con la vista puesta hacia el más alto grado de libertad del usuario y del respeto de su poder de negociación. Se ha puesto el énfasis en el restablecimiento y el respeto a los derechos humanos y ciudadanos, para aportar una respuesta adaptada a las necesidades de la persona, para permitirle que la atención que se le brinda se integre en su vida y aspiraciones participando él mismo en el desarrollo del servicio de los cuidados. Los servicios presentes en Trieste se organizan en torno a cuatro centros comunitarios de salud mental abiertos las 24 horas, una pequeña unidad de urgencias en el hospital general, un servicio de rehabilitación y de soporte residencial, de centros de día, de cooperativas sociales, residencias, clubs, asociaciones de familias y de usuarios. Los resultados son clínicamente positivos según la relación costo-eficacia así como contra la estigmatización, la discriminación y exclusión de las personas con problemas de salud mental.

Palabras claves : psiquiatría social, desinstitutionalizaciones, libertad de ir y venir, restablecimiento, organización de la atención psiquiátrica, Italia

Correspondance : R. Mezzina
<romezzin@gmail.com>

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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 previous 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 (ten days), avoiding heavy institutional careers for service users. The forensic sector has been now included in a gradual de-institutionalization (on 31 March 2015, the law n. 81 declared the closure of all six forensic hospitals, replaced by small regional units linked to mental health departments (MHD), with the current reduction of cases detained to less than 600 from 1,500 in two years [1, 2].

The transformation of the psychiatric service organization in the city of Trieste started in 1971 following the activities of Franco Basaglia and his team and resulted in closing the psychiatric hospital in 1980 along with setting up a network of community-based services. The 1,200 inpatients were discharged to their original families, to an independent living or to group homes and other types of community dwellings [3-5].

Main innovations were the shift from a condition of inmates to one of citizens, who use services without losing 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 [6]. An "open door-no restraint" system of community mental health services, totally alternative to the former psychiatric institution, has been implemented, with a right-based approach that enhances the status of citizenship for people with mental health problems and provides comprehensive care. The 24 hours Community Mental Health Centres (CMHC) started with the aim of reducing psychiatric hospital admissions and promoting rehabilitation and social re-integration. They became capable to deal with the most severe conditions and to support clients in their ordinary life in a view of recovery and social inclusion.

This model of community-based mental health services has been implemented in the whole Region Friuli Venezia Giulia (1.217.864 population) as a regional model, based on "strong" comprehensive 24 hour CMHCs, capable to deal with the most severe conditions and to support clients in their ordinary life in a view of recovery and social inclusion. This kind of 24 hour community based service was not achieved for the whole country, despite the request of family and user organizations.

Recognised as an experimental pilot area of mental health de-institutionalisation by the WHO in 1974 (Babini, 2009), considered as an example of proven success in 2001 (WHO, 2001), the MHD of Trieste has been the first appointed collaborating centre by the WHO in 1987 and more recently it was designated the WHO 'Lead' collaborating centre for

service development (from 2005 on). Many organizations from all over the world visit Trieste (every year up to 900 persons as professionals, managers, politicians and stakeholders in general) [7] and this experience contributed to a whole movement of innovative practices for de-institutionalization and against social exclusion [8].

Trieste: description of the program

Service structure

The MHD in Trieste has a catchment area of some 232,395 inhabitants. Staffs are 215 people - about 1/1,000 inhabitants (22 psychiatrists, 8 psychologists, 130 nurses, 9 social workers, 6 psychosocial rehabilitation workers). Currently, four CMHCs - open 24 hours/7 days a week and provided with six beds each - each competent for a catchment area of approximately 60,000 inhabitant, are the core of mental health services in Trieste.

A small General Hospital Psychiatric Unit (GHPU) provides inpatient mental health services, but its six beds (also meant for a wider territory including Gorizia) 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 services as soon as possible.

A Rehabilitation and Residential Support Service runs day-care activities in a partnership with volunteer and social promotion associations, which include users and carers. They 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". There is a network of 12 social cooperatives which covers a wide range of activities, for e.g., cleaning, building maintenance, portage 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. 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 [9-11].

There are about 45 beds in group homes and supported housing schemes, whose main aim is to encourage users to move from living together towards an individual home with the required daily support [12]. 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. About 150-160 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. Independent living (instead of institutional care) is supported also for persons with severe disabilities as regards to housing, work and social integration through the personal healthcare budgeted programme [13].

The MHD is a Structure of the Local Healthcare Agency, that is the public health service provider covering the territory of Trieste. 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 the CMHCs send their professionals for consultations and joint plans of care. Particularly the s.c. "micro-area programme" has to be mentioned as a proactive outreach community development project aimed at improving health indicators and social capital. Collaborations with healthcare districts and general hospitals occur 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. Health promotion in schools is also implemented through the Prevention Department.

Criteria / Principles of community practice

The organization is based on the following criteria (or principles) of care clearly defined as the Department's mission [7]:

- responsibility for the mental health of the community;
- active presence and mobility towards the demand;
- accessibility;
- care continuity;
- responding to crisis in the community;
- comprehensive care;
- teamwork and stakeholder participation.

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 transition 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, teamwork 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 [14].

New solutions have been developed to enhance user voice and participation. From their individual care plans, developed through negotiation with one of the lowest use of compulsion in the world (see data below) to the achievement of valid social roles as workers, like members of cooperative societies for job placement with more than 30 types of real jobs (these have 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 volunteer and cultural associations, etc. 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 [15].

The whole movement led to a stakeholder involvement strategy, toward a shared ownership of the "common good".

The process of care

How services operate

Treatments provided by the MH Department in Trieste are biological (medications), psychological (individual and group therapies), psychosocial such as family interventions & psycho-education, social network and social support interventions (neighbors, employers, etc.), cultural and vocational rehabilitation and work placement, social and life skills training, etc. The Trieste model contains elements of social and vocational skills training, case management, home and intensive community residential treatment, medication management and compliance strategies [16], recovery-orientated approaches, integrated in a very coherent offer that is tailored on the individual.

During the day, from 8-20, the CMHC is the main point of entry in the system. It admits direct referrals as a walk-in service, where everybody can enter or call and receive a response in "real time", usually within 1-2 hours. All staffs run a reception rotating on intake functions. This means that there is no waiting list. Morning shift starts by 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, as a "social habitat" to promote normalization of the experience and relationships. There is a morning meeting with 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 for fetching users to the Centre for day

Table 1. Hospitalization vs. hospitality.

Hospitalization	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

hospital or for scheduled activities (like medical assessments at hospital or health district, or to the pension, the bank, the police station, work, etc. etc). 'Doing with' and 'being with' is a principle for establishing trustee relations. Staff meetings at the shift change plan afternoon priorities [17].

The intake is problem-based, rather than diagnosis-based; if urgent, even from the person or the carer's subjective viewpoint, it is quickly addressed. The first contact happens in the community, in the persons' living places [18, 19]. As soon as possible, a key-worker is envisaged within the overall team. The contact usually involves significant others, fostering a full use of social support networks, kept involved even in case of a difficult conflict, in a dialogical process of "understanding together what has happened and why". This helps to mediate and even resolve conflicts, within the scope of preserving the autonomy of the client. Rapid response can avoid emergency and does not usually require an admission, but the client can stay at home or at CMHC as a short-time guest. The persistent offer of relationship and care usually avoids involuntary treatments too, by negotiating and sharing decisions. Then the service offers to follow the person on the long run.

The second point of entry is the GHPS where during the day CMHCs are quickly called to come and contribute to assess and develop a care plan, usually within 24 hours, while at night the client may be accommodated overnight and put in contact or referred to the competent CMHC on the following day. People are fetched from the centre if they require respite or detachment from their own home environment, or can be accompanied and supported at home. When hospitalisation at GHPS occurs, which is quite rare, it always requires continuity of care provided by the competent CMHC. Even the involuntary treatments are preferably applied in the CMHC and not in the Hospital [20, 21].

The practice of hospitality

The 24 hrs "hospitality" at the CMHC, usually for respite and protection, is agreed without formalities with user and relatives and managed by the whole team. 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). This is not only for crisis, for e.g., people who require a transitional rehabilitation plan anew or whose social needs that are temporarily unmet (for 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.

We can say that there is a shift from hospitalisation to hospitality in a system where the concept of "hospitality/guest" is applied by the formal status of 'hospitality for health' with a number of related consequences. [17] In a hospital-driven approach, the attention is on treatment of symptoms and behaviors, while it is difficult to avoid locked door units, isolation rooms, restraint, and ultimately violence; while in the "hospitality", in an open door system, the discourse is definitely around a person in crisis and thus a subjective experience, with a focus on life events, needs and issues (see *table 1*).

Recovery pathways

During the process of care, CMHC must be able to create a therapeutic/rehabilitative pathway that fosters recovery 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 access to opportunities for recovery and social inclusion [22], for 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 accessing job training and placement, for e.g., in a social coop. Free participation to centre's life can provide a sense of familiarity.

The shift from an individual to a collective level of involvement is possible only if the service is able to recognize the subjectivity of each individual as a person, with a unique life story and experience [23]. Clients are encouraged to explore their aspirations as a basis for an individual program or a whole "life project" [24], being helped with money, work

Table 2. Data of the Trieste MHD, 2015

Catchment area	Trieste: 232,395	For each CHMC: Around 60,000	For the acute unit: 400,000	
No. units	Total: 6 (75 beds)	CMHC: 4 (24 beds)	Acute unit: 1 (6 beds)	Dwellings: 12 (45) beds
No. users	Total: 5,121	Users cared by CMHC teams: 3,944	Users with home treatment and other community interventions: 2,562 (49%)	
Involuntary treatment	Users: 29 (13/100,000)	Days (total): 417	In the acute unit	In the CMHC
Job training and placement	199			
Forensic care	Users in forensic hospitals: 0	Beds in forensic unit: 2	With community alternatives: 4	
Costs (euros)	Total: 18,236,000	Per citizen: 77,25	Percentage of healthcare expenditures in Trieste: 4,81 %	Personal budgets + social expenditures (work grants, economic supports, social activities, daycare with NGOs): 3,516,455 + 8,348,763 (19% + 5%)

or training, education, living places, activity, relations when they are 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 partners of care [13]. Personalized projects, also with home support, aim at emancipation and empowerment of individuals as active actors of personal and system change.

Groups for mutual welcome and support meet regularly in the CMHC and develop social activities and support [15]. There is an intensive work with heavy burden families (from psychoeducation to mutual support to associations), and for aggregation and self-organization of young clients (from activity groups to self-help and peer support). The management, by partner associations, of small recovery houses for a transitional period of time includes peer support workers. Other programmes 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 de-stigmatisation.

Results

Freedom in care, with no need for new asylums is demonstrated to be successful by a series of data and key-facts [7]:

- Compulsory Treatment Orders (CTOs) discharge rates in the Region Friuli Venezia Giulia are one of the lowest in Italy, with 13 cases per 100,000 population per year compared to a national average of 17 (Ministry of Health, 2011). Moreover, about two thirds of people under the CTOs were treated within CMHCs rather than at GHPU, anyway with an open door policy;

- there are no people in forensic hospitals from Trieste from 2006;

- mental health services do not make use of restraint measures, such as locked doors and mechanical restraint;

- suicide ratio has been lowered from 25/100,000 to 13/100,000 in the city of Trieste over the last 15 years, also as a result of a proactive prevention programme [7, 25];

- a new culture of rights developed, the concept of dangerousness of people disconnected from mental disabilities (as demonstrated by cross cultural research made by Lille WHOCC and previous ones) [26];

- independent living (instead of institutional care) is supported also for people with severe disabilities as regards to housing, work and social integration;

- the sustainability is demonstrated because the overall cost of services provided by the MHD is no more than 60% of the cost of the former asylum (with less than the half of staff, and the number of beds decreased from 1200 to 75);

- the number of people treated in a more humane system of care is more than 5000 as compared to 1200 in 1971;

- hospitality in the CMHCs replaced most of the admissions in the GHPU. Only one person spends a night in the hospital service for every ten 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 three for people who are admitted to the GHPU, because of the rapid turnover described above [7];

- crisis care in the community is effective and sustainable. All figures and rates concerning emergencies, acute presentations and crises decreased. Even the use of CMHC beds constantly decreased through these decades to 1/3 of the original value. Readmission rate to CMHCs is about 30% (table 2).

Table 3. Processes and outcomes in Trieste MHD according to the 3 E's (Ethics, Evidence, Experience).

Ethics	Evidence	Experience
No restraint Open door	Low rate of accidents and offence 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 per year, 1/10 resulted in a permanent 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 facilities to supported housing (cluster housing) Research show people with SMI accommodated using personal budgets No homeless user	Individualized 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)	142 personalized projects	High degree of negotiation and choice
The right to recover	Subsidies, work grants, rehab cheques 2 transitional recovery houses	Response to needs, individual and social, material and not
Prevention of trans-institutionalization	0 people in forensic care 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 activities	Offer of activities for developing your potential (sport, art, culture, etc.)
Support to carers	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 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 on compliance 75% [29]	Therapeutic adherence, negotiation Acceptability of treatment
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 Gender approach	70 women involved in self-help and cultural activities 'recovery' home Migrant women involved in the project to prevent sexual slavery	A normalized social identity Solidarity Mutual help and social inclusion

Independent research evaluated the Trieste approach as "holistic, ecological and legal" [27]. Can an approach that is mostly rights- and values-based generate evidence? In our view, processes and outcomes can be also described using the 3e's system (Thorncroft and Tansella) [28] that take into account that values are paramount, have an impact on outcomes and are also meaningful at the qualitative level of the living experience of care for either providers or users (table 3).

Discussion

Some general indications can be outlined as follows:

–a 'systemic' vision has to be based on the person's whole life. Creating personalised itineraries is the organizational-strategic key, in which the person has an active role and contractual power of negotiation. Considering the nexus between illness and institution, all human components of this whole system of healthcare, including

professionals, always risk to be entrapped in oppressive power dynamics;

– therefore, a “parallel” empowerment of professional and users is necessary: for the staff, from hierarchy to peer-to-peer organizations; for clients and carers, from welfaristic passive dependence tied to an active role as agent of change with aspects of “reciprocity” [27]. A circular dynamic is then required, because we cannot assume that “the person key” is capable alone to change the systems or the system change as such, toward a more integrated service, that can eventually “reach the person” and to empower him/her;

– to shift from healthcare hierarchical ‘institutions’ to horizontal healthcare ‘organizations’ requires:

- a low threshold and a single access point (one-stop-shop),
- avoiding or reducing transitions in care that results from fragmentation of services system,
- developing home care, focused on the person in their actual living context, and thus on their life story and social capital, and not on the illness, creates a system of possible options which diversifies flexible and personalised responses;

– considering the organization of the care process, the 24hr CMHC has some clear advantages:

- a point of reference open 24 hrs,
- staff can be utilised flexibly,
- the person can receive a wide range of responses and is always assisted by a single team through a negotiation,
- any crisis comes into immediate contact with a system of resources/options, including for rehabilitation,
- both admission (hospitality) and release can be decided and agreed to immediately, without formal requirements and the stigma of hospitalisation,
- the CMHC avoids the immediate loss of contact with normal living contexts and networks and the loss of ability and social role, leaving the user active and free;

– from this simple and unique point of entry, all the pathways of care are aimed at 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 [11]. This concept of rehabilitation 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, which 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 community services;

– the responsibility for care processes has been rooted in the community. It implies fostering the service’s responsibility and accountability towards the community; recognising the importance of social contexts as producers of

meaning and bearers of resources; providing choices which are based on the contexts where they are applied; developing leadership of individuals and social groups as stake- or shareholders in the healthcare system implies activation of processes of strategic/organizational change, in ‘rushes’ or continuous cycles [30];

– the wider movement of rehabilitation toward a “lived citizenship” [31-34], includes 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 [11].

Conclusions

Community mental healthcare in Trieste can be seen as passage which derives from organization, where systems of care are built around individuals/communities. Practices aimed at deconstructing the total institution and developing a full range of community services and support networks proved to be sustainable on the long run and to improve population health.

At the same time, this required enhancing rights of citizenship of people with mental health problems and responding 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 totally alternative to psychiatric hospitals.

A comprehensive, holistic approach must combine health with welfare systems in a powerful synergy, according to the concept of “whole systems, whole life approach” [14]. The focus on a person in the community and on citizenship rights raises the issue of values which underpin practices and services (“values-based” services) [35] as well as the shift from reparative medicine to participatory health. ‘Integration’ is a key word widely used to describe a continuum of care and support systems, in a multisectoral approach [36]. 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. We assume that this is a new model, or even a new paradigm, that derives from de-institutionalisation at its heuristic-operational level [37]. A deep change also occurred in the attitude of the community toward an open view on mental health issues.

Conflicts of interest none.

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