IMHCN

Italia e UK – The completion of the reforms

Are the Reforms Ever Complete?

History of Institutionalisation

How we have tried to change the Thinking, Practices and Systems

Community Mental Health today

IMHCN

The birth of the Asylum, Psychiatric Institutions

1300 In the UK, Bethlem hospital in 1377

Florence had 15 beds in the Pazzeria for the poor insane, founded in 1688 in S. Maria Nuova Hospital, and about 30 beds for the paying insane in S. Dorotea, opened in 1643.

Norwich,1713,Manchester,1766,Exeter,1801

Maddalena insane asylum, *1813*

Rapid expansion in the 18th and 19th Centuries

To 100,000 beds in Italy, 150,000 beds in UK, 1950's and the world

IMHCN

The challenge to overcome the institutional system in the world

How we have tried to do this

- Reformers and human rights activists, Pinel,Beers, Rogers,Tuke,Dix,Weyer,Whitbread,Willberforce,Cooper, Connoly Goffman,Laing,Szasz,Polak,Basaglia,Stein,Jones,Bennet,Barton, Antonucci, Tommasini,Rotelli, DellAcqua, Jenkins, Mezzina

- National Mental Health Laws, Policies and Strategies,

  UK,1890,1930,Poor Law 1959,1968,1975, 2001, 2004, 2015, 2017

  Italy, 1904, 1960, 1978, 2016

- Mental Health Laws and legislation, present in many other countries, ? effect

- Human Rights legislation,International Convention on human rights MH 1991, WHO Qualityrights

- Community Mental Health Centers- innovation and good practice, CMHC's-USA 1960's, UK Paington 1980, Italy Trieste !978

- Homecare teams,Amsterdam,Boston,Birmingham,Vancouver,Madison,Sydney

- User Movement, USA, UK, Italy, Europe, World

- Carer support organisations, NSF, Italy

- NGO's, community services, advocacy, lobbying, user support.

- Present in all 192 countries

IMHCN

Physical Restraint

John Connoly inspired by Robert Hill of Lincoln Asylum. On his appointment to Hanwell in 1839 <u>Connolly proceeded to abolish it in a large asylum. Several English asylums were practising **non-restraint by 1844.**</u>

IMHCN

Italy

Osservanza, Imola, closed 1996

Perugia

Colorno, Parma

Reggio Emilia

Gorizia

Trieste

Arezzo

Ferrara

Udine

UK

Holloway Sanitorium,Virginia Water, Berkshire, Closed 1980

Warlingham Park, Croydon, first to offer community care, closed 1999

Exe Vale, Devon, Closed 1985

Banstead, closed 1986

Saxondale, closed 1987

Coney Hill, Gloucester, closed 1991

The Retreat, York, Private and open

Dingleton, Scotland, open doors 1946, closed 2001

IMHCN

- Therapeutic communities,Tom Maine,Maxwell Jones, 1950's
- Acute Units in General Hospitals, 1960's++
- Fountain House, developed in1940,s New York, 55,000 worldwide
- Soteria House,Loren Mosher,USA, Switzerland,Sweden,UK,
- 24hr CMHC's, Trieste, integrated community team with guest beds
- Host families,Boston, Madison, Lille and Hertfordshire
- Student/user shared accommodation,Lille
- Social cooperatives/ firms, Trieste, Brescia,Italy,UK
- Basic Needs For Mental Health and Development in 8 countries, they have helped 45,000 mental health users by developing work schemes:
  India, Sri Lanka, Ghana, Uganda, Tanzania, Kenya and Laos PDR, Colombia.
- User run services, acute alternatives, Cornwall, Birmingham,Colorada
- Self help, Prato, Italy and many others
- Peer support, France,USA,UK, Italy and other countries
- NGO's – thousands of good practice services in many countries
- Open Dialogue,Finland, Trieste and UK
- Hearing voices across the world
- Research Programs on quality as well as quantity including by service users

IMHCN

The Development of the User Movement

Has had a profound influence in changing services and practices

- UK,1620 Petition of the Poor Distracted People in the House of Bedlam
- France,1780 Jean-Baptiste Pussin
- 1848 in England, the Alleged Lunatics' Friend Society
- USA,1851Utica State Lunatic Asylum in New York, OPAL
- USA,1909 Beers founded the "National Committee for Mental Hygiene"
- 1970,s Peer run services, Insane Liberation Front, Portland,Oregon, Network Against Psychiatric Assault.
- Canada,1972 Mental Patients Association, Canada in 2007, called Interrelate.
- Voice of Soul is a user/survivor organization in Hungary.
- Germany,Organisation for the Protection from Psychiatric Violence,
- UK,1986 Survivors Speak Out, UKAN, MIND, Italy
- 1970,s Netherlands,Sweden,Denmark,Finland,Iceland,NZ,Aust, many more
- 1985 Kerala India
- ENUSP Europe 1991
- WNUSP World 2003, 120 organisations in 35 countries
- Self help groups, mutual support organisations, Italy USA, 7500,UK,500+

IMHCN

Run Down and Closure of the Psychiatric Institutions

1954 Peak of numbers resident in English and Welsh Mental Hospitals. 150,000 beds

Italy 100,000 beds in the 1960's

In the hospitals that pioneered community care, the numbers had been falling since 1948. Now the movement to avoid hospital admission and shorten in-patient stay began to effect overall numbers.

Day hospitals, community houses, Out patient clinics, NGO's, anti psychotic medication, scandals in the 30 Psychiatric hospitals

These had a profound effect on the numbers in the institutions.

From 1970-2006 All Psychiatric Hospitals in Italy and the UK were closed and community mental health services were implemented

IMHCN
Essential Reform Objectives

- Change the thinking

- Change the practice

- Change the system

Emancipation = Equality = Responsibility

IMHCN

- It was around this time that a group of radical texts began to circulate in Italy — Foucault's *History of Madness (which also provided a critique of reformist approaches to madness and historical context), R.D. Laing's The Divided Self (which saw what was called schizophrenia as an understandable and even rational reaction to the pressures of modernity) and perhaps above all, Erving Goffman's Asylums*

- *The Negated Institution: Report from a Psychiatric Hospital (John Foot)*

IMHCN

The "great internment" described by Foucault

gave way, in the 1970s, to a "great liberation."

IMHCN

Community Mental Health

Both in Italy and the UK

Community Mental Health Centers in Italy comprehensive across the country, some 24 hr

UK

Community Mental Health Teams, not 24hr for populations of 60-80.000

Crisis Teams in every NHS Trust and Health Boards

Assertive Outreach Teams in every Trust

Early Intervention Teams in every Trust

Primary Care Teams in every NHS Trust and Health Board

IMHCN

- Mental health, learning disabilities and autism services
- At the end of March, there were 1,254,365 people in contact with services; the majority of these 1,012,781 were in adult mental health services.
- There were 195,271 people in contact with children and young people's mental health services and 85,395 in learning disabilities and autism services .
- 280,613 new referrals were received into services during March and 1,705,404 care contacts were attended.
- 20,314 people were subject to the Mental Health Act at the end of March, including 14,808 people detained in hospital
- .In the year between 1 April 2017 and 31 March 2018 there were 2,510,745 people in contact with services.Of these; 573,270 were aged 18 years or less , 1,319,514 were aged between 19 and 64, and 616,796 were aged 65 years or more
- .Of the people in contact with services between 1 April 2017 and 31 March 2018 103,952 had an inpatient spell.Of these; 4,714 were aged 18 years or less , 78,883 were aged between 19 and 64, and 20,284 were aged 65 years or more.
- Adult mental health services
- Between 1 January and 31 March 3,484 referrals with suspected first episode psychosis started treatment, of which 2,148 (61.7 per cent) waited two weeks or less.
- 77.8 per cent of people in contact with adult mental health services at the end of March who had been treated under the Care Programme Approach for twelve months received a review during that time.
- There were 8,343 open ward stays at the end of March in adult acute mental health inpatient care, and 5,722 open ward stays in specialised adult mental health services .
- Children and young people in contact with mental health servicesBetween 1 January and 31 March 2,721 new referrals for people aged under 19 with eating disorder issues were received.
- There were 389,004 referrals active at any point during March for people aged under 19, of which 56,127 were new referrals and 41,559 people under 19 were discharged during the month.
- Of the 1,191,779 in contact with mental health services at the end of March, 284,599 (23.9 per cent) were aged under 19.

IMHCN

UK Polices and Plans, last few years

National Mental Health Framework 1998

Mental Health Plan 2002 Community Functional
   Teams

New Horizons (2009)

A Whole Life Recovery approach

A holistic view of needs of people

No Health without Mental Health 2011

Not fully implemented

IMHCN

Whole Person, Whole Life-Whole System Approach

Developed in 2000 in NIMH(E) to implement policies since 1975 and the National Service Framework

Approach to bring together;

- Biological
- Psychological
- Social determinates of Health and Mental Health
- Anthropological, Meaning and Culture
- Philosophical, Critical Thinking. Dialogue
- Whole Life, Recovery Paradigm
- Whole Systems Thinking and Development
- Education and Knowledge,Sharing and Learning from International best Practice

IMHCN
Whole Person, Whole Life- Whole System

The Whole Person, Life,Recovery approach is founded in human values and their application by the service user, families and the community, professionals and the service itself.

>Recognition of the power of institututionalisation as reflected in stigma, practice and outcomes

>It requires a paradigm shift in thinking from pathology and illness

>It Believes in the power of individuals to self determine their whole life

>Peoples life stories, events and experiences are at the centre of the problems and solutions

IMHCN
The Whole Person, Whole Life-Whole Systems Approach

- This focuses on the need to help and support patients(users) to be able to continue or regain a whole life in all its domains, wellbeing, health, socially included, access to education, work, housing,cultural and leisure activities, sports, faith, etc.

- This cannot be achieved by the health service on its own and by only replacing psychiatric hospitals with isolated community mental health facilities.

- Therefore there needs to be developed a community whole system with an overall common purpose building partnerships with various local authorities, community organisations, users, family members and business leaders.

- Based on Recovery Values, Principles and Practice

IMHCN

Recovery, Discovery practice

Recovery and Discovery practice is about enabling and assisting the active participation of people in their own life journey.

- This approach involves assisting people to find the time, space and opportunity to identify their own recovery and discovery goals and meet them.

- It asks the "helping community" to work in ways that are fundamentally different.

- Recovery and Discovery practice is not something that is considered as an after thought or bolted onto existing practices.

- It asks us to think of our value framework and invites us into an "expansive space" with people in distress. Time and Space.

- Inviting people to create their own opportunity within their space, where the goal is to enjoy a whole life (where citizenship is more real, with more meaning and purpose in their lives).

- This approach requires the "helping community" to intuitively work in ways that can hold a space for this to occur. Providing traditional and fixed models do not provide the opportunities for this to occur. In fact they may only serve to contribute to shutting down the space where people can have opportunities to commence and continue their recovery and discovery journey.

- Recovery and Discovery practice is therefore as much a learning process for practitioners, carers, and the wider community as it is for people in distress.

IMHCN

Emancipation, Equality and Responsibility

Values and Principles

A New Paradigm in Taking the Reforms forward

IMHCN

EMANCIPATION

- The guiding principle and application of 'Freedom First' in mental health services, is not completed just by the process of deinstitutionalisation.

- It is an ongoing priority in community and hospital services and practices.

- For a persons freedom in services, a democratic process is a prerequisite for a therapeutic experience.

- Services must hold this as a central guiding principle for determining ways of working with and alongside the person and their social network.

- This has implications for thinking, culture and practice. "Nothing about the person without the person" is more than a statement of intent it needs to be Embedded in practice.

- This has implications for service organisations including how they enable the service user to have choice in treatments

IMHCN

- This also has consequences for the way in which services work with the person and how information about the person is gathered, held and decisions reached.

- Inclusion and reintegration of people, who, because of their mental health problems, continually deal with exclusion mechanisms in society, is an ongoing process.

- Apart from the legal right to freedom, the restoration of social relations is essential for recovery and discovery.

- Isolation by locking people up counteracts this.

- In some enlightened services it is therefore a recurring, conscious decision not to lock up people, this is 'open doors' at all time.

- In our aim of reducing the hospital capacity and building a good support system in the community, another mission emerges: reducing coercion in treatment, stopping in-patient practices of

  locked doors, seclusion, restraint and over medication

IMHCN

- Shaping good alternative acute and crisis services where people can have time and space for reflection in times of crisis is essential if we are going to address the whole life needs of people.

- The present services, outpatient clinics, acute units, community teams, and intensive treatment is no longer sufficient, We need a new Acute and Crisis Whole Life-Whole System based on the principles of freedom, choice, co-production, emancipation and self determination.

- A service user to be considered emancipated has to be independent, free and autonomous in their decision-making.

- Emancipation is linked to the process of self-reflection, to acquiring new knowledge, motivations, values and goals, which will free the individual from preconceived and impairing beliefs

- Emancipation involves setting the service user free from the control exercised by nurses, doctors, psychologists, occupational therapists, social workers, managers and organisations (acting as institutions). A person with a mental health issue needs to have greater knowledge and understanding of their whole life situation which can support individual emancipation and increases self-management.

IMHCN

EQUALITY

- To attain social inclusion, the focus must be on equal citizenship.
- This concept combines classical human rights (such as liberty and equality) with civil rights such as the right to education, employment, social security, housing, etc.
- The problem with mental health law is that too many people have their liberty curtailed. This needs to be addressed by a fundamental review of the mental health legislation
- This is done in three ways: by strengthening the position of the individual (through knowledge, education, skills and social networks)
- By strengthening the 'social fabric' of the individual's environment, through social corporations, anti-stigma programs, Whole System development; and addressing the human rights of the individual.
- Because of the Whole Life-Whole System approach, these three ways are intertwined organisationally and in the daily practice of mental health professionals.

IMHCN

EQUALITY and CITIZENSHIP

- This requires a new vision on how personal support is organised and funded.
- Reciprocity: In cultural anthropology the principle of reciprocity is described as a way to create and perpetuate equal relationships of exchange.
- An active giver (professional) and a passive receiver (service user) have an unequal (power) relationship.
- The creation of situations where a service user who receives personal support through co-production works more effectively, and also provides opportunities for education, employment, housing, social support and is more likely to shape equal relationships and better outcomes.
- This will promote the empowerment, recovery and discovery of users and family members.
- Following this line of reasoning, the next step should be to swap the attitude of professional distance for a more personal relationship founded on connectedness, continuity and trust.
- This aligns with values and principles for supportive recovery and discovery approaches.

IMHCN

RESPONSIBILITY

- People have a responsibility for determining for themselves the lives they lead and their own wellbeing.

- All too often services and professionals prevent people being responsible adults, in hospitals but also in community services. Mental Health Act in collusion with this.

- This is particularly relevant when there are concerns about the persons mental health and well being.

- The importance of shared responsibility (users, family members, professionals, organisations) in taking risks and being jointly accountable.

- The services should encourage and support the important principle of self determination by providing services and practices that support and underpin this.

- Choice: Service users should be able to determine their own recovery, discovery plan in collaboration and co-production with their workers, families and significant others.

IMHCN

- Service providers should accept that recovery/discovery is a process requiring every service user to be regarded as a unique individual and the course of this journey has its ups and downs

- Their wishes, needs and hopes should be at the centre of service provision and practice.

- Relationships: The service user should be able to determine the person they want to work with based on the importance of reciprocity in a trusting relationship.

- Ownership: Service providers should accept that the service users are experts in their own life experience and this should be the foundation of a therapeutic alliance with the expert by profession.

- Opportunities. The service user should have available whole life opportunities based on their unique needs.

IIMHCN

Today, institutions and institutional thinking and practice in the world as well as Italy and the UK is still "alive and well". The biological approach and model is also still dominant

- We need to recipricate and implement the good practices and innovations in more places

- We need to identify existing and help find new reformers, champions,pioneers, advocates for change and reform. Can you identify them in your country?

- We need to work more together through stronger networking, lobbying and influence policy,services, practice,research

- We need to expose bad practice,abuse,neglect that is still widespread in institutions and communities in many places and countries

- We need to promote a Whole Life-Recovery philosophy,concept, practice and action in all our work, Emancipation, Equality and Responsibility

- We need to be aware of the dangers today of the market economy in health that leads to competition not collaboration

This we need to do, to overcome and finish off the powerful influence of the belief system(people cannot recover) that created and still perpetuates Asylumdom and its power over people

The Reform needs to Go ON

ONCE AGAIN IT IS OUR RESPONSIBILITY