FROM THE PSYCHIATRIC HOSPITAL TO THE COMMUNITY BASED SERVICES

MENTAL HEALTH DEPARTMENT
WHO CC FOR RESEARCH AND TRAINING
TRIESTE

Daniela Speh
Segregation in the psychiatric hospital

- stigma
- “dangerous for self and others” and “public order”
- Protecting people outside (safety)
- protecting people “outside”: the wall
- Asylums: seclusion, loss of Identity, not private ownership
- In Trieste: asylum built on a sunny side, clean air, in a beautiful park - but it is also surrounded by a wall
CLOSING OF THE PSYCHIATRIC HOSPITAL AND DE-INSTITUTIONALISATION

1978 reform law n. 180 (Basaglia)

**Basic principles and values**: Personal **Freedom** and **Dignity**.

The idea is to start from the concepts of **RIGHTS** and **RESPONSABILITY**

- Right to **citizenship**
- Right to **housing**
- Living **inside the city**
- Dynamics of **normality** fighting the risk of **exclusion**.
MHD Current Services

- De-institutionalization process
- 7 24 hours/7 days a week Community Mental Health Centres (CMHCs) providing support and avoiding new admissions in PH (1980)
- Strong work with families/parents/neighborhood
- Flats/group homes
- Job placement (1° social coop)
Le microaree nei distretti dell’ASSI Triestina
Open door – no restraint

Is it possible?

HOW?
A Quality indicator?

It is a different system of care!!!!

• Persons and not patients
• A different way of thinking
• A different way of working
• To negotiate
Person at the centre

- Beyond the illness

RIGHTS, RESPONSABILITY, PERSONAL STORY AND NEEDS
• 4 Community Mental Health Centres (CMHCs) (catchment area 60,000 inhabitants) open 24 hours/7 days a week and provided with 4-8 beds each, incl. the University Clinic

• CMHCs central axis (beyond the illness-needs-rights-responsability) (2016)
Functions, activities, interventions in the CMHC

- **CMHCs central axis:** comprehensive care (social and clinical care, integrated resources)

- **Functions:** intake, night/day hospitality, D.H., home visits, therapeutic consultations, individual and group therapy, group activities, pharmacological therapy, care support, psycho-social support, activation of networks, psycho-social rehabilitation, residences, job placement, job money / income (grants/cash subsidies), socialization and free time etc.
Community-based services: aims of 24h MHC/7 days a week

- Community Mental Health Centres (CMHC) are **responsible** for a specific **catchment area** including acute demand.
- Involving all **agencies** and available **services** (avoid total delegation)
- Strong **work** with **families/parents/neighborhood**
- **Not fragmented** system of care: single point of entry
- **CMHC**: neither out-patient nor intermediate service, but “**Core**” of service network.
- “**whole life**” support
Overarching criteria / principles of community practice in the MH Dept.

- **Responsibility** (accountability) for the mental health of the community = single point of entry and reference, public health perspective
- Active presence and mobility towards the demand = **low threshold** accessibility, **proactive** and **assertive** care
- Therapeutic **continuity** = no transitions in care
- Responding to **crisis** in the **community** = no acute inpatient care in hospital beds
- **Comprehensiveness** = social and clinical care, integrated resources
- **Team work** = multidisciplinarity and creativity in a whole team approach

**Whole life approach = recovery and citizenship, person at the centre**
CMHC Characteristics

• the relationship is the first priority (during the crisis too)

• recovery and citizenship

• Low threshold

• Responses are quick and flexible (work organization), avoiding waiting lists

• Team work: multidisciplinarity and creativity, no strict role (the same team with several functions such as crisis intervention, ACT etc)

• Therapeutic plans are based on individual story, needs and wishes

• During the crisis personalised side-by-side assistance if necessary
Access and response in a crisis

- **8-20**: Direct referrals to the CMHC, non formality, **real time** response (mobile front line)
- **20-8**: access to the consultation at the **Psychiatric Emergency Unit** (6 beds) through **Casuity Dept**, then overnight accommodation in the emergency unit (**psychiatrist on call**)

But:
- No admissions in the emergency unit as a rule.
- The **day after at 8.00** at eight o'clock the CMHC team calls

Usually:
- **Crisis supported at home or hosted in the Centre**
- **Avoiding invol. treatments**
- In case of Invol. Treatments in the CMHC as a first choice.
- Walk-in, immediate intake and assessment, easy access, low threshold to early signs, respite to de-escalate, etc
- Early and quick intervention in real time
The **Social Habitat** of a Community Mental Health Centre is an alchemy created by a mix of different aspects, multiple factors that can influence and condition the atmosphere of these places, just because the social habitat can change in response to changes in those present, both operators and users. It’s the element that permeates and sustains everything, but also the most sensitive characteristic of a service.
Ultimately, a **MHC Social Habitat** is the product of a series of **factors** and **variables** which interact, both **structural** (architectonic, design, furnishings) and **human/relational** (including ways in which institutional variables of roles and power come into play).
- **Community spaces**, open to all, with common areas and some areas with more limited access.
- **Specific areas** for specific activities (e.g. kitchen, laundry, etc.).
- **Multifunctional spaces** that can be transformed mixing functions/activities, operators/users, visitors/volunteers (e.g. sitting room).
- **Socialisation**: strong social/relational dimension
- **Self-help**, friendships, group activities
- **Flexibility**: capacity of the MHC to enter into crisis for the level more structured and organized.
QUALITY, STRUCTURAL AND ENVIRONMENTAL ASPECTS OF A MHC

- **low threshold** (easy-to-access service) **Home-like** environment (rooms, furniture)
- **Night-day** area
- Living room / **social space**
- **Few beds** (maximum 8)
- **No rigid distinctions** between offices and spaces for users
- **OPEN DOOR**
- great **attention** to the habitat
- No unpleasant **smells**
- **Accessible** and **multi-funcional** common spaces
- **Reception desk** (intake of demand)
- **NO RESTRAIN**
- Flexible **visiting hours**

- **Shared dining room** for users and staff
- Spaces ensuring **privacy**
- Individual **locker & bedside table**
- **Leisure equipment** (radio, TV set, projector, pc, table tennis, etc.)
- **Furnishings**: functional but **not** medicalized
- Pleasant and comfortable **interior design**
- **Decent** environment (clean, sanitized and properly maintained)
- Good **food** (dressed tables with all the cutlery)
- **terrace / garden**
- Availability of **means of transport**
Community and Hospital: Emergency Unit in General Hospital

- **Emergency Units** are usually located within general hospitals and generally look like a “normal hospital ward”.
- Often squalid, cold, inhospitable and overly medicalised.
- Replicate *self-deprivation* and institutionalisation of asylums.
- Emergency Unit in Trieste: *bridge between community and hospital*, esp. for coordination and links with MHCs.
- Attempt to create a *non-hospital space within hospital*.
- Problems: waitings, high turnover, limited knowledge of users, elderly people, etc.
- Improving the habitat has finally reduced *aggressive behaviours*.
- STID (Supported Intensive Home Treatment)
Where are the ”beds” today?

**Year 1971:**
- 1200 beds in Psychiatric Hospital

**Year 2014:**
- 4692 people in the community:
  - 27 community crisis beds available 24 hrs. Mental Health Centres (900-1200 people)
  - 6 acute beds in General Hospital (3,5 / 100.000 - 814 accesses)
  - 48 places in group-homes

*average length of stay 11 days*
Working with the open door

• Without ‘open door’ professional/relational abilities cannot be expressed.

• Freedom to **enter** and esp. **leave** enables person to exercise their own power.

• Operator must get involved both personally/professionally: **negotiate** as equals, **offer alternatives**, orient person’s interests and resources, manage conflicts.

• **Stay with**.....
HOW?

Solve the needs of the person with the person

with respect

confidence

relationship
daniela.speh@asuits.sanita.fvg.it
who.cc@asuits.sanita.fvg.it
ASUI Trieste
Mental Health Dept.
WHO CC for Research and Training - Trieste - Italy