Trieste coordinated network of services: whole life, recovery and citizenship for 50 years

Good Practice Services: Promoting human rights and recovery in mental health
Trieste, 23-25 September 2019
Roberto Mezzina, Director, DSM Trieste / WHOCC for research and training
The Trieste model

• 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 in 1980 (Bennett, 1985; Dell’Acqua & Cogliati Dezza, 1986; Rotelli, 1988; Dell’Acqua, 2010). Moreover, it was also a process of change of thinking, practice and services.

• Trieste showed a different way for an innovative community mental health, that has moved from a narrow clinical model based on the illness and its treatment to a wider concept that involves the whole person – a whole life and a whole system engaging the social fabric (Zero Project, 2015; The Economist Intelligence Unit, 2014).

• The Mental Health Department is recognized as a WHO Collaborating Centre for 30 years and it is considered as a sustainable model for service development – even in a context of economic crisis, because of its clear demonstration of cost effectiveness (Mezzina, 2010, 2014, 2016).

• According to the WHO (WHO, 2001), Trieste is one of the clearest examples of how the Italian movement achieved deinstitutionalization, intended as a complex process “from within” a psychiatric hospital resulting in the gradual relocation of its economic and human resources, and the creation of 24 hour community based services together with the development of social inclusion programs (Rotelli et al. 1986).
Closing the asylum

• The experience in Trieste became internationally known because of the first closure of a psychiatric hospital in Europe in 1977 (Bennett, 1978), dismantling the apparatus and the institutional norms build on the person as a patient, as an object of the psychiatric institution.

  • 1. This work is marked by the first years (1971-1974) of transformation of the asylum and the creation of a state of rights for the inmates: opening of wards and gates, assemblies, review of the status of hospitalization, increase in voluntary admissions, establishment of hospitality, economic subsidies, creation of the first working cooperative for patients, review of guardianships.

  • 2. This was followed by a phase of opening of the Community Mental Health Centers (1975-1978) together with the search for housing solutions for an increasing number of discharged patients (group-apartments).

  • 3. Finally, the closure of the asylum with its total substitution by the territorial network (1978-1980) that identifies organizing all CMHCs around the clock and with beds, which in a coherent and pragmatic manner have been supported by the new director Franco Rotelli, as the axis of the alternative to the asylum (Gallio et al. 1983).
The recovery prospect, the legal level, the social movement in Italy

- D.I. involved breaking roles and rules, creating reciprocity and shifting power toward a real encounter, a recognition of the contractual power of the user.
- The legal level, based on 1978 Legislation, was a result for the Italian experience, and it acknowledged the issue of rights as the key tool in mental healthcare.
- Moreover, it was an expression of a social movement for expanding civil and social rights.
- Today a whole life – whole systems approach provides a new framework that is comprehensive and value-based, not only for individuals but also for communities.
The Law 180 and the CRPD

• In many ways, the reform law anticipated the CRPD, issued by UN in 2006. The fundamental right to health care, including MH care, is highlighted in a number of international covenants and standards (WHO, 2005).

• Chiefly, the right to health is now also included in the promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to personal, social, economic, cultural and political development (United Nations, 2017).

• Even the WHO Resource Book has been withdrawn because of the CRPD, as far as it legitimated involuntary treatment, no coercion in care is now admitted by the Committee of CRPD (2015) and this is a clear direction also for WHO Quality Rights Programme (WHO, 2017).

• In the Law 180, involuntary treatments are made possible through a substitute decision-making, seen as a denial of legal capacity.
Mental Health Departments: Italy and Trieste

- They are rooted in areas of about 300,000 inhabitants and encompasses a number of **components**:
  - Small general hospital acute units (15 beds), 1/10,000 / 6 beds in Trieste
  - Community Mental Health Centers (up to 12hr, sometimes 24hr) 1/80,000 / 1/60,000 in Trieste, 24 /7
  - Group-homes with a wide range of support up to 24hr (30,000 beds in Italy, mostly NGOs) / no more than 4 people now in Trieste in a supported housing scheme
  - Day Centre (also with NGOs) / not one, but multiple sites in the city in Trieste
D.I. is the motor for Trieste

- Subjects in their SN
- Values
- Rights
- NO ASYLUM
- Free open access (50 spots, 24/7 service), open doors, no coercion (invol. Treatments, forensic)
- No Restraint (freedom first - therapeutic)
- Value base: Rights, citizenship, cosil rights, house, work, mainstream in welfare and health systems.
- Empowerment: liberating relationships of care from social control connected to psychiatry.
Trieste system of care

• 24 hrs CMHC are a system of opportunities and are local solutions (responsibility and accountability), hub of care for continuity.
• Health / illness interplay in everyday life
• Access – response
• Holistic, ecological, person centered, recovery, SN, connections, inclusion, capital – extraclinical / social determinants
• Resources and opportunities – diffused daycare with associations (wellness-wellbeing, social aggregation, participation, expression, gender, work)
• Social determinants of health = individual and collective responses (25% budget): personal budgets and microareas are examples, work grants, socialization funds.
• + Mainstreaming MH in community health systems
• NGOs represent “the city”.
• BUILDING BRIDGES TO COMMUNITY - THE CARING CITY
<table>
<thead>
<tr>
<th>Art 9</th>
<th>Accessibility</th>
<th>To be able to access and participate in all areas of life as would a person without disabilities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Art 10</td>
<td>Right to life</td>
<td>To have the same chance as anyone else to live their lives.</td>
</tr>
<tr>
<td>Art 12</td>
<td>Equal recognition before the law</td>
<td>To be treated equally by the law and to have equal access to legal representation as well. To make decisions and choices for themselves. To identify people that they know and trust who can support them to make decisions.</td>
</tr>
<tr>
<td>Art 14</td>
<td>Liberty &amp; security of person</td>
<td>To be free &amp; safe, not be locked up just because their disability or prejudice about dangerousness.</td>
</tr>
<tr>
<td>Art 15</td>
<td>Freedom from torture or cruel, inhuman or degrading treatment or punishment</td>
<td>To be free from neglect and abuse eg. in institutions, as well as to restraint practices.</td>
</tr>
<tr>
<td>Art 16</td>
<td>Exploitation, Violence &amp; Abuse</td>
<td>To ensure people with disabilities are protected from violence and abuse in the home and in the community.</td>
</tr>
<tr>
<td>Art 19</td>
<td>Living independently and being included in the community</td>
<td>To make the same decisions about where they live just like everyone else &amp; they should be part of their communities. To access the full range of supports and services to enable them to lead independent lives in the community.</td>
</tr>
<tr>
<td>Art 21</td>
<td>Freedom of Expression</td>
<td>To have the right to say what they want. To have their voices listened to.</td>
</tr>
<tr>
<td>Art 23</td>
<td>Home &amp; Family</td>
<td>To lead normal family &amp; sexual lives, and personal relationships.</td>
</tr>
<tr>
<td>Art 24</td>
<td>Education</td>
<td>To have the opportunity to go to mainstream schools and have their learning and educational needs met in those schools.</td>
</tr>
<tr>
<td>Art 25</td>
<td>Health</td>
<td>To access health services on an equal basis with everyone else, and get the same standard of service as others, with their informed consent to treatment. Services must be close to where people live to make it easier for them to access and make them more effective.</td>
</tr>
<tr>
<td>Art 26</td>
<td>Habilitation/rehabilitation</td>
<td>To lead an independent and healthy life as possible and to receive services and supports in health, work, education and social services to help that happen. To have access to peer support services.</td>
</tr>
<tr>
<td>Art 27</td>
<td>Work &amp; Employment</td>
<td>To have the right to work on an equal basis as others.</td>
</tr>
<tr>
<td>Art 28</td>
<td>Standard of living and social protection</td>
<td>To have an equal right to the same standard of living and social protection as everyone else, eg. to housing.</td>
</tr>
</tbody>
</table>
Trieste

- The organization and philosophy of these 24 hrs CMHCs is based on the principles of:

  1. **easy access, non selection** of demand and **low threshold** (i.e., not based on particular diagnoses, severity thresholds, or other exclusion criteria);

  2. **non hospitalization and alternatives to it**;

  3. **service flexibility and mobility, proactivity and assertiveness** - toward crisis and long term support;

  4. the involvement of multiple **comprehensive** resources, such as a wide range of welfare provisions, in the therapeutic and support programs (Mezzina & Vidoni, 1995; Mezzina & Johnson, 2008) and, moreover,

  5. **continuity** instead of transitions in care (Segal, 2004).
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*
The issues in the regional model of mh healthcare

• Our experience in Trieste and in the whole Region Friuli Venezia Giulia (1,200,000) for reform implementation is based on:
  • A clear action for deinstitutionalisation of PH
  • The development of 24 hrs CMH Centres (17 out of 21)
  • The development of a network of services for rehab and social integration, e.g. group homes (now personal budgets), day centres and social cooperatives
  • The creation of “strong” MH Departments in order to co-ordinate all services according to principles of contrasting social exclusion, stigma and discrimination and promoting social inclusion.
Trieste and the Region

- A clear transition from residential structures to transitional houses to supported housing, to independent living flats, also thanks to personal budgets,
- and the regional resolution to overcome restraint in all health and social structures, etc. including nursing homes and general hospitals
- are some of the key facts that have been determined.
- Involuntary treatments show some of the lowest rates in Italy (7-9 / 100,000) and about 40% of them are managed in the CSMs.
Trieste and the Region

• A public system, in coproduction with NGOs, with 24-hour services, as realized in FVG, costs less than the national average (3.43% of the FSN compared 3.49% in 2015).

• 24 hrs CMHC

• personalized projects

• the elimination of restraint

• are the main points of the report of the Parliamentary Commission on the State of the NHS that visited all of Italy in 2011-2013 and started the closure of the OPG

• The Trieste model has been adopted recently in the Czech Republic, Wales, Crakow (Poland), Los Angeles, and other places.
outcome research of the model

• 75% compliance to antipsychotics (n=587) related to service provision and SN enhancement.

• 27 people - high priority, 5 years f-up: Highly significant reduction of symptoms severe > 65 p at BPRS from 20% to 4%), increase of social function (50% score), 9 at work, 12 indep living, unmet needs (CAN) from 75% to 25%, 70% reduction of night accomodations. Only 1 drop-out.

• Qualitative research on recovery / social dimension (IRRG, Am J Psy Rehab 2006)

• 24 h services (among 13 centres) better for crisis care and 2-year f-up, trust, continuity, comprehensive health and social care (2005). Reduction of emergency presentations in the GH casualty of 70 % in 20 years.

• 1983-1987, first f-up after reform law showed better outcomes for Trieste and Arezzo among 20 centres due to better organisation and social integration.

• Satisfaction of users is 78% (2008)

• Personal Healthcare budgets for the transition from residential facilites to supported housing and co-production (2015)
Freedom is therapeutic

UGO GUARINO
Liberty as a fundamental value

• “Liberty is therapeutic” was the original motto in the Trieste experience. The experience of Trieste can be emphasized especially as far as principles such as open door, hospitality, negotiation and alternatives to coercion are concerned.

• Service should also recognize the value of participation of all stakeholders, through networking, forms of coproduction, cooperation and exchange.

• ‘Freedom first’ (Muusse, Van Rojen) can be a new slogan of the international movement for better care in a rights-based and person-centered approach, emphasizing that personal liberty is not the outcome but a pre-condition for care which overturns control mechanisms and supersedes them with people empowerment.
Today’s features of the Mental Health Department in Trieste (236,393) are:

**Facilities:**
- 4 Mental Health Centres (equipped with 6/8 beds each and open around the clock) plus the University Clinic
- A small Unit in the General Hospital with 6 emergency beds
- A Service for Rehabilitation and Residential Support (98 supported living places for no more than 4 people together) and a diffused Day Centre with associations including training programs and workshops);

**Partners:**
- 11 accredited Social Co-operatives.
- 8 Families and users associations, incl. clubs and recovery homes.

**Staff: 214 people**
23 psychiatrists, 7 psychologists, 111 nurses, 10 psychosocial rehabilitation workers, 8 social workers, 27 support operators, 12 administrative staff.
Where are the "beds" today?

Year 1971: 1,200 beds in Psychiatric Hospital, closed down in 1980 after a 9-year process of phasing out.

Year 2016: 67 beds of different kind:

- **26 community crisis beds** available 24 hrs. Mental Health Centres (11 / 100,000 inhabitants)
- **6 acute beds** in General Hospital (2.5 / 100,000)
- **98 people** in their homes - sheltered housing
What is a 24hrs CMH Centre?

- An open door on the street
- A multidisciplinary team in a normalised therapeutic environment (domestic) for day care and respite, socialisation and social inclusion
- A multifunctional service: outpatient care, day care, night care for the guests, social care & work, team base for home treatment and network interventions, group & family meetings / therapies, team meetings, mutual support, relatives and other lay people visits, inputs and burden relief.
- Social cooperative home management
- Leisure and daily life support (self care; brekfast, lunch and dinner)
- And many other ordinary and straordinary things ...
Service networking

• Beyond the acknowledgment of the value of the single individuals and the families, the need for the valorization of families and consumers as collective subjects gradually becomes imperative as far as they present themselves to the attention of the service.

• Thus at a some stage in this process, a need for working out new strategies to open to more collective levels of participation startes emerging.
A parallel empowerment

- Clients' empowerment through their active participation in mental health also means accepting their contribution to further modifications of a mental health service in a common action
  - against inertia and passive dependence ties,
  - against the overall medicalization of individual and social needs and daily life problems,
  - against the new forms of institutionalization.
- Peer support in recovery house and CMHCs

- It is necessary also to work on the institutional relationships.

- The room for the critical advancement of the client goes together with modifying the mental health worker's role: deinstitutionalizing his knowledge, his actions, demystifying his power or using it in other directions as compared to the "control of the patient", e.g.

- favouring a comprehensive approach of client's problems toward a whole life approach, by meeting the needs and by re-acquiring a status of right (that is citizenship).
DSM / MH Dept Trieste - Data 2018

- 4,800 users in the year, mean age 55, 55% women.
- 2,413 users contacted outside the service locations, mostly in living environments.
- 18 persons involuntary treated (9/100,000 adult inhabitants), 2/3 treated in the 24 hr CMHC.
- **Open doors**, no restraint, no ECT in every place including the Hospital Unit.
- No psychiatric users are **homeless**.
- **292 users** engaged in place-and-train (**social co-operative societies** and **for-profit**).
- **159 users** with **Personal Health Budgets**.
- The **suicide** prevention programme lowered **suicide ratio 40%** in the last 20 years (average measures).
Services provided

• Microrea for 655 people (14%)
• 838 people in the diffused Day Centre
• 44 housing schemes for 98 people
• Health and socialcare integrated programs for 404 people (8%)
• Interventions in nursing homes for 179 people
• Co-management with drug addiction for 203 people
La circolazione dell’utenza all’interno della rete dei servizi di salute mentale territoriali genera 4.800 accessi ai servizi dipartimentali.
Persone in contatto con i servizi del DSM per tipologia di utente e punto di accesso alla rete dei servizi di salute mentale (N=4.800)
DSM - Persone in contatto con i servizi di salute mentale
Trend storico 2009 - 2018

<table>
<thead>
<tr>
<th>Anno</th>
<th>Persone in contatto con il DSM</th>
<th>Persone al primo contatto</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>4.547</td>
<td>1.370</td>
</tr>
<tr>
<td>2010</td>
<td>4.769</td>
<td>1.320</td>
</tr>
<tr>
<td>2011</td>
<td>4.989</td>
<td>1.363</td>
</tr>
<tr>
<td>2012</td>
<td>4.951</td>
<td>1.310</td>
</tr>
<tr>
<td>2013</td>
<td>4.905</td>
<td>1.240</td>
</tr>
<tr>
<td>2014</td>
<td>4.683</td>
<td>1.255</td>
</tr>
<tr>
<td>2015</td>
<td>4.431</td>
<td>1.158</td>
</tr>
<tr>
<td>2016</td>
<td>4.470</td>
<td>1.071</td>
</tr>
<tr>
<td>2017</td>
<td>4.890</td>
<td>1.056</td>
</tr>
<tr>
<td>2018</td>
<td>4.800</td>
<td>1.065</td>
</tr>
</tbody>
</table>
DSM - Persone in contatto con i servizi di salute mentale
Trend storico 2009 - 2018
CSM – Persone in contatto con i CSM per inquadramento diagnostico ICD10 (N=3.713)
CSM – Persone in contatto con i CSM per tipologia del contatto (N=3.713)

- CSM D1: 161 contatti unici, 235 episodi di cura (<5 contatti), 449 presa in carico (>6 contatti)
- CSM D2: 151 contatti unici, 210 episodi di cura (<5 contatti), 515 presa in carico (>6 contatti)
- CSM D3: 164 contatti unici, 249 episodi di cura (<5 contatti), 567 presa in carico (>6 contatti)
- CSM D4: 226 contatti unici, 247 episodi di cura (<5 contatti), 539 presa in carico (>6 contatti)

Legenda:
- Contatto unico
- Episodio di cura (< 5 contatti)
- Presa in carico (> 6 contatti)
CSM – Persone in contatto con i CSM per tipologia del luogo del contatto (N=3.713)
CSM – Persone in contatto con i CSM con bisogni complessi che richiedono una presa in carico sociosanitaria (n=1.184)
CSM – Persone in contatto con i CSM con una presa in carico sociosanitaria integrata (N=3.713)
CSM – Persone in contatto con i CSM titolari di Budget Individuali di Salute (N=152)

€ 1.000.000

€ 750.000

€ 500.000

€ 250.000

€ -

<table>
<thead>
<tr>
<th>CSM 1</th>
<th>CSM 2</th>
<th>CSM 3</th>
<th>CSM 4</th>
</tr>
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<tbody>
<tr>
<td>€ 713.734</td>
<td>€ 722.754</td>
<td>€ 893.271</td>
<td>€ 662.067</td>
</tr>
</tbody>
</table>

36 persone
39 persone
48 persone
36 persone

Costi BldS
CSM – Accoglienza sulle 24 ore nei CSM

- CSM D1: 1.842 Giornate complessive - 77 Persone accolte - 139 Episodi di accoglienza
- CSM D2: 1.684 Giornate complessive - 65 Persone accolte - 116 Episodi di accoglienza
- CSM D3: 1.451 Giornate complessive - 64 Persone accolte - 115 Episodi di accoglienza
- CSM D4: 1.961 Giornate complessive - 68 Persone accolte - 130 Episodi di accoglienza

Legenda:
- Grigio: Giornate complessive in TSO - TSV
- Azzurro: Persone accolte in TSO - TSV
- Arancione: Episodi di accoglienza in TSO - TSV
Accoglienza sulle 24 ore nei CSM del DSM dell’ASUI di Trieste
Trend 2009 - 2018
Tassi di accoglienza sulle 24 ore nei CSM del DSM dell’ASUI di Trieste
Trend 2009 - 2018
Servizio Psichiatrico di Diagnosi e Cura

Trieste

1 SPDC 1/360.000 abitanti
6 p.l.

dal 1° ottobre 2011 con funzioni di Area Vasta su ASS2

Media nazionale 1/186.000 abitanti

SPDC di Trieste

porte aperte

mai usata la contenzione
SPDC - Persone in contatto e persone ricoverate (n=703)
Ricoveri in TSO nel DSM dell’ASUI di Trieste – Trend 2008 - 2018

- N. di giornate di TSO
- Persone sottoposte a TSO

Giornate di ricovero/accoglienza con le modalità del TSO

Persone accolte con le modalità del ricovero in TSO

Anni 2008 - 2018
Luoghi dei TSO nel DSM dell’ASUI di Trieste – Trend 2008 -2018

Anni 2008 - 2018

N. di giornate di TSO nei CSM 24 ore
N. di giornate di TSO in SPDC
<table>
<thead>
<tr>
<th>DSM - Trend storico budget 2014 – 2018</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>2014</td>
<td>%</td>
<td>2015</td>
<td>%</td>
<td>2016</td>
<td>%</td>
<td>2017</td>
</tr>
<tr>
<td>Personale</td>
<td>€ 9,920,000</td>
<td>59%</td>
<td>€ 10,342,066</td>
<td>60%</td>
<td>€ 9,935,457</td>
<td>59%</td>
<td>€ 10,138,762</td>
</tr>
<tr>
<td>Farmaci</td>
<td>€ 424,055</td>
<td>3%</td>
<td>€ 364,788</td>
<td>2%</td>
<td>€ 381,302</td>
<td>2%</td>
<td>€ 413,542</td>
</tr>
<tr>
<td>Servizi generali - Altro</td>
<td>€ 2,371,984</td>
<td>14%</td>
<td>€ 2,395,704</td>
<td>14%</td>
<td>€ 2,419,661</td>
<td>14%</td>
<td>€ 2,334,666</td>
</tr>
<tr>
<td>Fondo LR 72/80</td>
<td>€ 736,874</td>
<td>4%</td>
<td>€ 728,548</td>
<td>4%</td>
<td>€ 743,210</td>
<td>4%</td>
<td>€ 720,430</td>
</tr>
<tr>
<td>Budget di Salute</td>
<td>€ 3,476,939</td>
<td>21%</td>
<td>€ 3,417,020</td>
<td>20%</td>
<td>€ 3,381,104</td>
<td>20%</td>
<td>€ 3,578,490</td>
</tr>
<tr>
<td>DSM - Bilancio</td>
<td>€ 16,929,852</td>
<td>100%</td>
<td>€ 17,248,126</td>
<td>100%</td>
<td>€ 16,860,734</td>
<td>100%</td>
<td>€ 17,185,890</td>
</tr>
</tbody>
</table>
## DSM – Trasformazione OPP verso i servizi di salute mentale territoriali DSM

<table>
<thead>
<tr>
<th></th>
<th>OPP nel 1971</th>
<th>DSM nel 2018</th>
<th>Indici per 100.000 residenti</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>1971</td>
</tr>
<tr>
<td>Personale</td>
<td>524</td>
<td>219</td>
<td>193</td>
</tr>
<tr>
<td>Luoghi</td>
<td>1</td>
<td>23</td>
<td>0,4</td>
</tr>
<tr>
<td>Numerosità dei p.l.</td>
<td>1.160</td>
<td>52</td>
<td>427</td>
</tr>
<tr>
<td>Popolazione adulta residente</td>
<td>271.879</td>
<td>234.638</td>
<td>-</td>
</tr>
</tbody>
</table>
## DSM – Rivalutazione costi OPP - Costi DSM

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>Costi OPP 1971</strong></td>
<td>£ 5.000.000.000,00</td>
</tr>
<tr>
<td>Coefficiente ISTAT per la rivalutazione monetaria al 31 dicembre 2018</td>
<td>17,457</td>
</tr>
<tr>
<td>Valore 2018 in Lire</td>
<td>£ 87.285.000.000,00</td>
</tr>
<tr>
<td>Cambio Lira / Euro</td>
<td>£ 1.936,27</td>
</tr>
<tr>
<td>Valore dei costi OPP in Euro</td>
<td>€ 45.078.940,44</td>
</tr>
<tr>
<td><strong>Bilancio DSM 2018</strong></td>
<td>€ 16.676.131,52</td>
</tr>
<tr>
<td><strong>Rapporto costi servizi di salute mentale territoriali vs. OPP</strong></td>
<td>37%</td>
</tr>
</tbody>
</table>
Spesa per la salute mentale in % della spesa sanitaria

Tassi (non standardizzati) di Ospedalizzazione per TSO per 100.000 residenti anni 2010-2014
Ministero Salute elaborazione banche dati SDO 2010 e 2014/ popolazione ISTAT
From Residential Facilities to Supported Housing: The Personal Health Budget Model as a Form of Coproduction

Pina Ridente\(^1\) and Roberto Mezzina\(^2\)

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\(^2\)Dipartimento di Salute Mentale, (DSM), WHO Collaborating Center for Research and Training, Trieste, Italy

Abstract: During the deinstitutionalization process in Trieste, an array of different residential facilities were identified and used for different purposes in the course of time. They were integrated in the Mental Health Department and operated in close connection with 24-hour Community Mental Health Centres. Over the last decade, a steady decline in residential beds was achieved also thanks to the implementation of a health budget model in connection with a bespoke therapeutic rehabilitation program. The whole process was focused on reorganizing and transforming existing facilities
Community health and development

- **Non-medical determinants for health** – social deprivation and isolation, hence:
  - **Microarea Habitat Project** *(global, local, plural)* activated in Trieste in collaboration with the City of Trieste and the Public Housing Agency (Ater), and then expanded to include other Regional areas in the context of the Microwin project.
  - 20 areas of the city, with an average population of approx. 1000 persons each, for a total of 15,000 inhabitants.

- **Interventions:**
  - learning about residents, verifying health conditions,
  - guaranteeing integrated good healthcare and social-healthcare practices,
  - reducing inappropriate hospitalisations or stays in nursing homes,
  - verifying the appropriateness of therapies, diagnostics and analyses,
  - promoting self-help,
  - developing collaboration among services and among other actors, such as volunteer groups and/or stakeholders,
  - promote community development and cohesion.
RISULTATI

Hazard ratio: Microaree/Non microaree

**REGRESSIONE DI COX***

**PSICOSI**

(ICD9-CM 290-299)

PRIMI RICOVERI URGENTI (n. 21)

Hazard ratio **0.49 (IC95% 0.19-1.27)**

**PERICARDITI, ENDOCARDITI, IMIocarditi**

(ICD9-CM 420-429)

PRIMI RICOVERI URGENTI (n. 197)

Hazard ratio **0.72 (IC95% 0.54-0.97)**

*Analisi aggiustata per età, indice di Charlson e indice di deprivazione*
REGRESSIONE LOGISTICA*

*Analisi aggiustata per età, indice di Charlson e indice di deprivazione

RISULTATI

RICOVERI MULTIPLI

Odds ratio 0.93 (IC95% 0.89-0.98)

Odds ratio 0.98 (IC95% 0.93-1.03)

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*Analisi aggiustata per età, indice di Charlson e indice di deprivazione
Innovations 2014-2019

• Agorà (Forum)
• Diffused Day Centre
• Rems with open door
• Open dialogue
• Recovery house
• Closure of all residential facilities in the ex-PH
• Peer support training: 30 people and job placement

• STID (Home treatment and overcoming acute unit)
• Operative Manual of CMHC
• Personal budget procedure and catalogue of offer
• Participation committee
• Mental health green number
• mhGAP training to all GPs
• QRs implementation
Trieste: general indications

• Community health as passage which derives from deinstitutionalisation: systems built around individuals/communities

• Comprehensive, holistic approach which combines medicine with welfare systems for powerful synergies - concept of whole systems, whole life approach (Jenkins, Rix, 2002)

• The focus on individuals and the rights of citizenship raises the issue of values which underpin practices and services (value-based services, Fulford, 2001)

• Creating personalised itineraries as organisational-strategic key, in which the person has an active role and contractual power.
Indications

• **Avoid or reduce transitions in care: fragmentation of services system.**

• Foster the service’s **responsibility and accountability towards the community.** The responsibility for care processes should be rooted in the community.

• Recognising the importance of **contexts as producers of the meaning of health actions and as bearers of resources.**

• Passage **from reparative medicine to participatory health** (no black box as funnel for specialistic approaches).

• Developing the **protagonism of individuals as stake- or shareholders in the healthcare system** (concept of leadership linked to the activation of processes of strategic/organisational change, in ‘rushes’ or continuous cycles).
Indications

• A shift from **healthcare institutions to healthcare organisations**

• Also required is a ‘**systemic’ vision** based on the person’s life (**whole systems, whole life approach**) with a low threshold, single access point (one-stop-shop),

• Developing home care, both network and networked, focussed on the person in their actual living context, and thus on their **life story and social capital**, and not on the illness.

• A system of possible options which **diversifies responses**, making them flexible and personalised, should therefore be provided for.
The Trieste approach to therapy

1. *Ethical / rights based*

Empowerment - no restraint to recognize the individual and his/her subjectivity, recovery, autonomy, emancipation, QoL.

2. *Dialogical.*

- Open dialogue: building up a relationship on the basis of reciprocity and responsibility. Therapeutic alliance achieved through the pairity of those who speak.
The approach

3. **Meaningful**
   - Acting the meaning: participatory decodification of meaning, narratives, life-stories.

4. **Ecological and systemic**
   - Involving the social network.
   - Service as a network – nexus between organizational and therapeutic work.
   - Social Habitat of services as construction of space of experience and interaction/integration.
The approach

5. Wholistic.

• Whole person whole life whole system. Perspective of a living being: Biological and complexity/identity (Morin). Tactical use of medication and self-administration as a value. Plastic modification of the brain?

In conclusion:

• From D.I. to social inclusion and recovery. Open door - open dialogue - open access;

• recovery and human rights.

• Passage from a medical model, based on specialization and invariance, as an application to the living being of the scientific method, based on specialization and invariance, to an wholistic approach based on the person (Theories of normalization and social role valorisation.)
The right to citizenship

• Eventually, **the right to be a citizen is the right to have a life**. Thus we must speak about entitlements: we need a social and human development that could converge, not conflict, with substantive, individual rights.

• A **possibility seems to be a focus on exclusion in society**, therefore a focus on social determinants like home, work, supports, relationships, participation and many other aspects.

• A **political and social action** must be combined with a change of institutional practice and thinking in mental health and social care.
Basic values related to democracy
- as the main shift in mental healthcare

• A shift from (unmet) needs to (affirmed, declared) rights - through laws. This point is connected to addressing social determinants of health, that is “the way people live”, their quality of life, and it is now addressed in several ways, e.g. through personal budgets.

• A shift from hospitalization of an “inpatient” to hospitality of a guest” in a community facility, such as CMH Centre.

• A shift from the monologue of psychiatry (and of the psychiatrist), that is based on a judgement of diversity, to listening and dialogue (not only as a specific therapy), and trustee relationships. Knowledge is based on information, that must be provided to all stakeholders, starting from the person in need.
Shift

• A shift from power on - (a person subjected to a power), through the pedagogy of power (Basaglia), toward empowerment, that is bottom-up, or power with - (shared power, power of the subjects).

• A shift from seclusion and restraint to freedom, as the fundamental move of deinstitutionalization. Acceptable care is the first step to achieve an accessible care, and then to fulfill the right to the highest attainable degree of health.

• A shift from individual to collective rights: awareness of citizenship, self reflection on a person social life. Citizenship is exercising rights and acting rights, not just a status but a development, and it includes civil and social rights (work, house, social roles). All of this can be called human rights.
Shift

• A shift from guardianship to free will, from imposition to negotiation (working out micro-conflicts), toward a therapeutic alliance, shared decision making and self determination. Finally,

• The paradigm shift from illness to the person in a whole life view (the kind of life we want) and a whole system of care and support.

• Capability to deal with power issues and microsocial conflicts (Mezzina et al. 2018; MHEN, 2017) is based on a form of empowerment that recognizes “the other” in a conversation and a negotiation towards a therapeutic alliance that respects people’s wills and preferences and that is displayed in their living environments (on ‘their turf and terms’).
• While it is true that Trieste is a small city, of fewer than 250,000 inhabitants, and that the implementation of the reforms inspired by Franco Basaglia to achieve this system took many years, this example, taken together with the arguments from within more conventional social psychiatry that I have just cited, shows that it is possible for psychiatry to overcome that tension between care and control that Basaglia argued ran through his very existence – and to resolve it on the side of care.
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