Deinstitutionalization and community based services in Italy – the experience in Trieste

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European policy documents

EU Union Green paper (2006) on social inclusion

European Pact for MH and Wellbeing, 2008

- Combating stigma and social exclusion
- Develop mental health services which are well integrated in the society, put the individual at the centre and operate in a way which avoids stigmatisation and exclusion

WHO, 2009

- Psychiatric hospitals (PHs) have a history of serious human rights violations, poor clinical outcomes, and inadequate rehabilitation programmes. They also are costly and consume a disproportionate proportion of mental health expenditures.
- WHO recommends that psychiatric hospitals be closed and replaced by services in general hospitals, community mental health services, and services integrated into primary health care

WHO Zero draft – Global Action Plan.

- Reduction of 20% of long term beds within 2020.
- MH laws updated within 2016 in 80% of countries.
- All large institutions with neglect must be closed.

Italy

- 100.000 inpatients in 1971 in PHs
- 48.000 inpatients in 1978
- All PHs closed in 2000

1978 reform law:

-no Phs admission, no new PHs

-community based care

-human rights focus / involuntary treatment
duration reduced (1 week +) – 2 pych. to mayor

-No police / justice involved – just health protection

Mental Health Departments

- 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
- -Community Mental Health Centers (up to 12hr, sometimes 24hr) 1/80.000
- -Group-homes 2/10.000 with a wide range of support up to 24hr (17.000 beds in Italy, mostly NGOs)
- -Day Centre (also with NGOs)

Changing public attitude and family burden

- Social acceptance of the law and a general decrease of stigma attached to psychiatry mark a series of fundamental changes in public attitu-des (DEMOskopea).
- Cross-cultural researches demostrate this change in comparsion with other countries (Vicente et al 1995; Roelandt et al, 2007).
- Other transnational researches demostrated less family burden in the new community scenario (Fadden et al, 2002).
- It is generally accepted that the Mental Hospitals belongs to the past and cannot be accepted any more. Carers associations as UNASAM, as well as professional ones (e.g. the Society of Italian Psychiatrists), for many years claim for better community services rather than for a new law.

Deinstitutionalization vs. dehospitalization

‘Dehospitalisation’ is a reduction of the number of beds, while ‘deinstitutionalisation’ in Italy was a complex process resulting in:

- a gradual relocation of the economic and human resources from a profoundly modified MH (open wards, open to community) and the subsequent creation of CMH Services; then closing PHs.
- a profound change in the living conditions of the former in-patients, giving them a chance of being placed in alternative accommodations, possibly outside the MH.

Deinstitutionalization, another way

- a critical attitude towards the hierarchical social organisation as an oppressive system even for the staff, which is being replaced by a more flexible organisation.
- a transfer to the nursing staff of increased autonomy related to their increased abilities and new skills.
- a critical attitude towards the traditional psychiatric treatment, and a profound change in the operative philosophy in order to support the basic needs of the patients.

Key lessons from Italy

- A clear policy with investments
- working directly within total institutions – not a simple adminstrative closure
- Total reconversion of staff and resources of PH into community MH Depts (no parallel systems “hospital-community”, no double spending);
- creating alternative networks of coherent services that work in synergy within the community, thereby
- avoiding useless and often harmful fragmentation and specialisations
- Avoiding implementation of general hospital services only instead of comprehenevive community mh centres and services.

Lessons from Italy (2)

- Coordination of services in a given area of the community (MH Department)
- A strong community service / Centre (up to 24 hrs) for delivering care in an integrated and comprehensive way. Then the components and contents of care can have a framework (not separate techniques)
- Citizen's input through participation (usres, carers, community)
- Health care and general health integration

Criteria of intervention in Community Based comprehensive Services (Trieste, started 1971, PH closed 1980)

- Responsibility
- Proactive, mobile service
- Accessible service (walk in, no formal referrals)
- Continuity of care
- Responding to crisis in community / using MH beds for people in crisis)
- Comprehensive care (social-clinical)

- WHOLE LIFE, WHOLE SYSTEM

Toward a value-driven service

- Focus on a citizen with rights
- Helping the person and not treating an illness
- Understand events of life, overcome crisis
- Explain and discuss experience
- Not losing value as a person (invalidation, neglect, violence)
- Keep social roles and maintaining social networks / systems
- Help social support networks e.g. family
- Develop growth potential (recovery)
- Have opportunities – real empowerment
- Change living conditions using material resources (work, money, practical help)

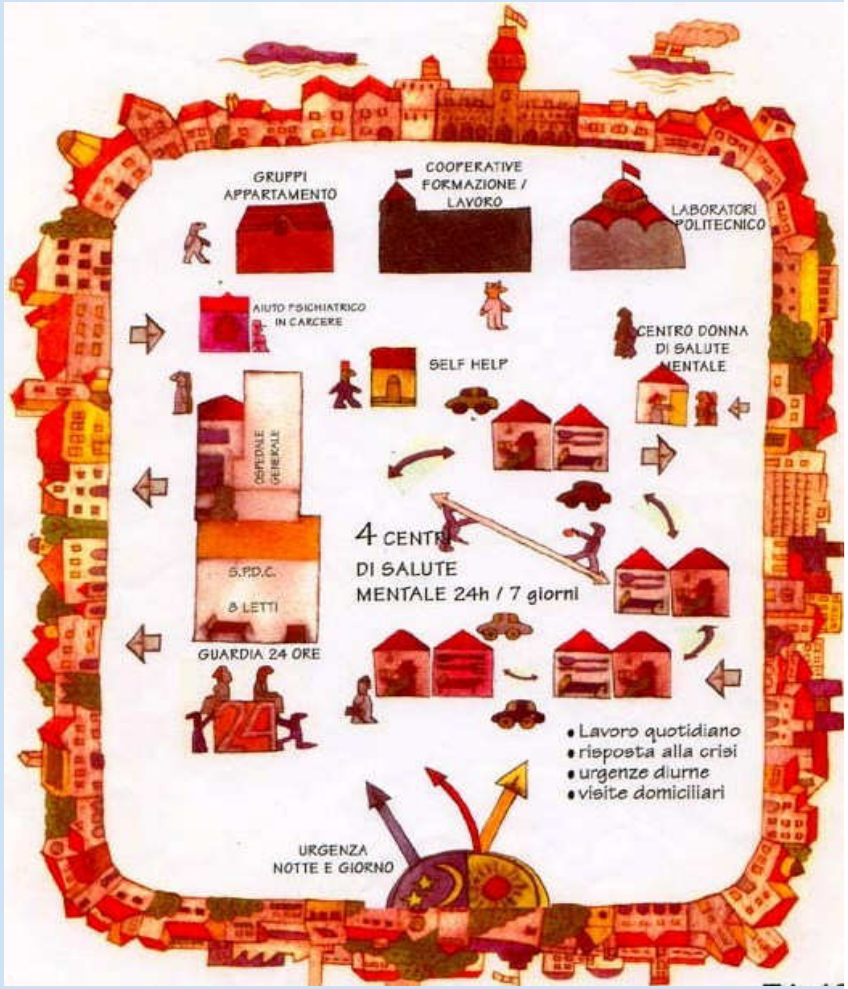
Today's features in Trieste (WHO CC lead for service development) are:

Services:

- **4 Community Mental Health Centres (equipped with 6-8 beds each and open around the clock) incl. the University Clinic**
- **1 small Unit in the General Hospital with 6 emergency beds;**
- **Service for Rehabilitation and Residential Support (12 group-homes with a total of 60 beds, provided by staff at different levels;**
- **2 Day Centres including training programs and workshops;**
- **13 accredited Social Co-operatives);**
- **Families and users associations, clubs and recovery homes.**

Staff:

- **215 people - 1/1.000 (26 psychiatrists, 9 psychologists, 130 nurses, 10 social workers, 6 psychosocial rehabilitation workers).**



Some relevant outcomes

- In 2010, only 16 persons under involuntary treatments (7 / 100.000 inhabitants), the lowest in Italy (national ratio: 30 / 100.000); 2 / 3 are done within the 24 hrs. CMHC;
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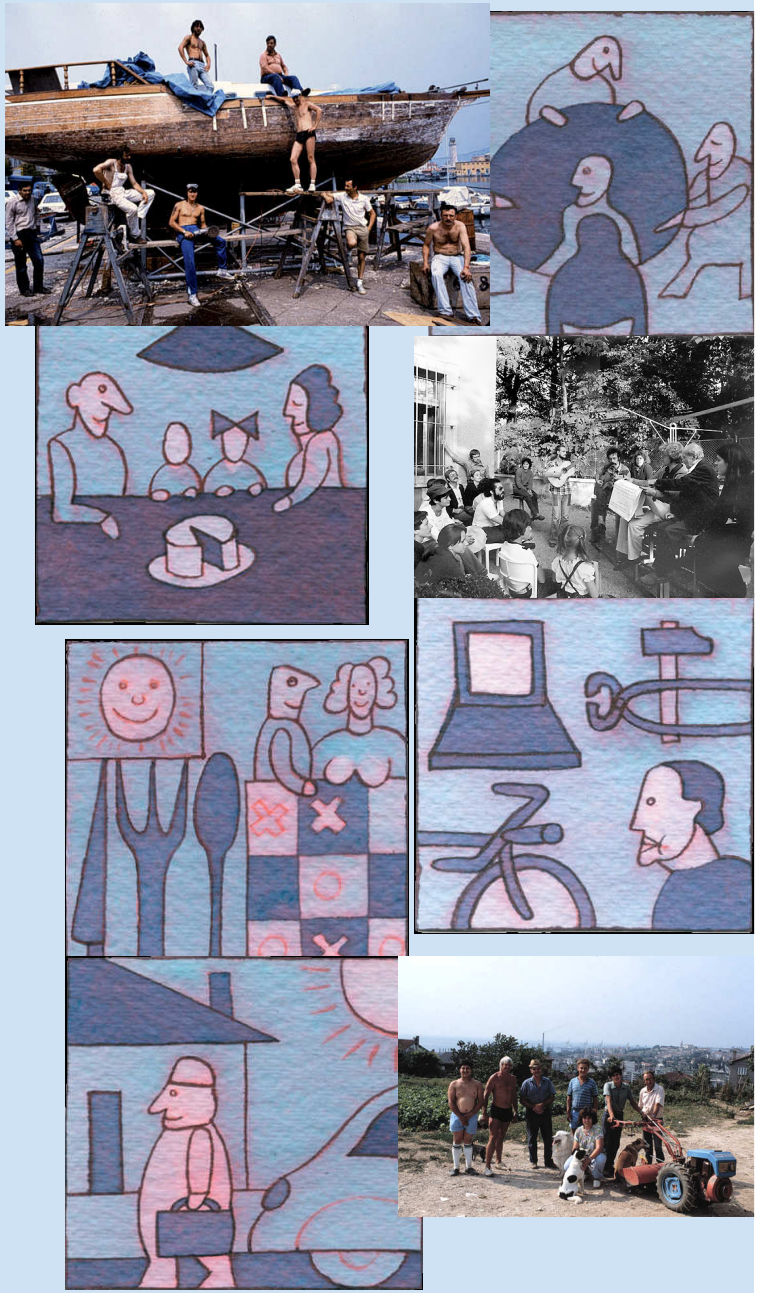
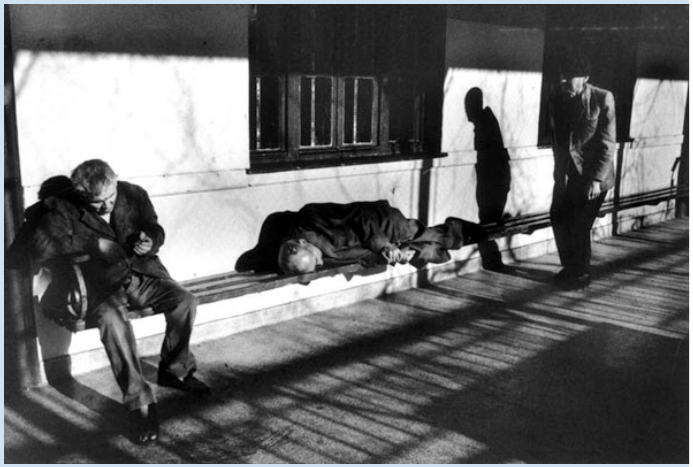
- Open doors, no restraint, no ECT in every place including hospital Unit;
- No psychiatric users are homeless;
- Social cooperatives employ 600 disadvantaged persons, of which 30% suffered from a psychosis;
- Every year 240 trainees in Social Coops and open employment, of which 20-30 became employees;
- The suicide prevention programme lowered suicide ratio 50% in the last 20 years (average measures);
- No patients in Forensic Hospitals.



How much does it cost?

- 1971:
- Psychiatric Hospital 5 billions of Lire (today: 28 million €)



- 2011:
- Mental Health Department Network 18,0 millions €
- 79 € pro capita
- 94% of expenditures in community services, 6% in hospital acute beds

Conclusions

The transformation process requires **multiple levels**:

- Involvement of civil society and of all stakeholders
- Policy level
- Legislation
- Service models and practices
- Involvement
- Inter-sectoral change

- **The person and not the illness** at the center of the process of care for recovery and emancipation through users' active participation in the services

(up close, nobody is normal)