Tilsynet i henhold til grundlovens § 71 2011-12
§71 alm. del Bilag 77
Offentligt

Community alternatives to inpatient care

The practicalities of running a community based system of acute care in Trieste, Italy - outcomes & lessons learned

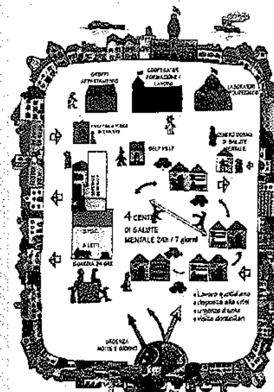
Roberto Mezzina, MH Dept of Trieste
– Director, WHO CC

October 2011

Today's features of the Mental Health Department in Trieste(245.000) 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 (12 group-homes with a total of 59 beds, provided by staff at different levels and a Day Centre including training programs and workshops);



Partners:

-15 accredited Social Co-operatives.

-Families and users associations, clubs and recovery homes.

Staff:

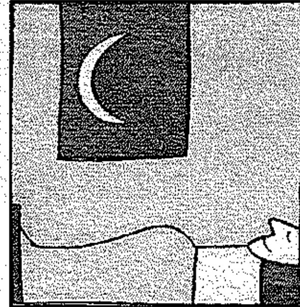
- 215 people (26 psychiatrists, 8 psychologists, 163 nurses, 9 social workers, 9 psychosocial rehabilitation workers).

Where are the "beds" today?

Year 1971: 1200 beds in Psychiatric Hospital, closed down in 1980 after a 9-year process of phasing out.

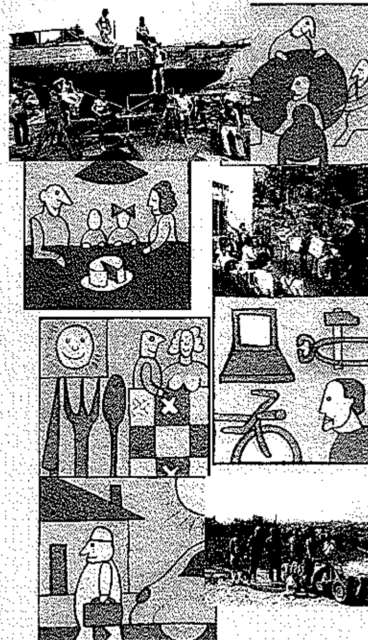
Year 2010: 91 beds of different kind:

- 26 community crisis beds available 24 hrs. Mental Health Centres (11 / 100.000 inhabitants)
- 59 places in group-homes (24 / 100.000)
- 6 acute beds in General Hospital (3,5 / 100.000)



Some relevant outcomes

- In 2010, only 16 persons under **involuntary treatments** (7 / 100.000 inhabitants), the lowest in Italy(national ratio: 25 / 100.000); 2 / 3 are done within the 24 hrs. CMHC
- **Open doors**, no restraint, no ECT in every place including hospital Unit
- No psychiatric users are **homeless**
- Every year 220 trainees in Social Coops and open employment, of which 10% became employees
- Social cooperatives **employ** 600 disadvantaged persons, of which 30% suffered from a psychosis
- The **suicide** prevention programme lowered suicide ratio 40% in the last 15 years (average measures)
- No one in **Forensic** Hospitals



Outcomes in Trieste (crisis)

- No involuntary treatments in Barcola
- Reduction of nights in acute service in the general hospital
- Even reduction of bed use in the Centre (to ¼) in 20 years including long term bed use.
- Reduction of people arriving at the emergency call (118) and casualty dept. (50% in 20 years) – because of work carried out by CMHC
- Acute presentations not so frequent anymore – less disorganised
- Long-term care only in the community (at home, in the centres and group-homes), not in hospital – but it decresed.
- Available alternatives e.g. woman recovery home

How much does it cost?

1971:

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

2009:

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

The CMHC

- The Community Mental Health Services, or "Community Mental Health Centres" (CMHC), are responsible for a specific catchment area.
- The CMHC's work-group is composed of about 25 nurses, 1-2 social workers, 2 psychologists, 1-2 rehabilitation specialists and 4-5 psychiatrists. The MHC operates 24 hours a day, 7 days a week.
- During the night, the operators assist persons in crisis who are receiving overnight hospitality.

The 24 hrs Community Mental Health Centre

- The 24-hours community mental health centre is a non-hospital residential facility, not conceived just as a crisis centre.
- It is in fact **multi-purpose**, multi-functional: also a day centre, an outpatient service, a base for community teams.
- The quality of the **environment (home-like, but also a social habitat)** and of the **atmosphere (friendly)** is based on staff attitudes mainly focused on flexibility and reasonable negotiation with the user's concerns and needs.

- The main duty is to be responsible and try to provide a comprehensive response.
- A **single multidisciplinary team acts rotating inside and outside,** for those who are "guests" on a 24 hours scheme and for the users attending daily or reached at home.
- Knowledge and trust are the main tools for building up therapeutic relations.
- Users' participation and contribution in the centre ordinary life is seen as crucial.
- Hence **crisis is addressed by 'indirect' strategies** of management using these peculiarities.

Access and response in a crisis

- 8-20: Direct referrals to the CMHC, non formality, real time response (mobile front line) - as a roster
- 20-8: access to the consultation by the casualty dept, then overnight accomodation in the emergency unit.

But:

- No admissions in the emergency unit as a rule.

Thus:

- The day after the CMHC team comes. The 24 hrs rule: within 24 hrs otherwise admitted.

Usually:

- Crisis supported at home or hosted in the Centre
- Avoiding invol. treatments
- Invol. Treatments in the CMHC as a first choice

Treatments

- Biological (mostly oral medications)
- Psychological (individual and group therapies)
- Family interventions & psycheducation
- Social network intervetions (neighbours, employers etc)
- Cultural and vocational rehab - work placement
- Social support
- Peer support & networking
- Leisure time

Responsibility / accountabilty

- They aim of the MH Dept. is to shoulder the **whole burden of psychiatric morbidity** within the catchment area they serve (**no institutions behind**).
- The three core activities of prevention, acute care and rehabilitation are seamlessly integrated.
- The CMHCs work on the basis of a shared and **collective team responsibility.**
- The **small scale**: the size of catchment area makes it possible for most staff to have direct knowledge at least of the most complex cases.

Key elements of crisis management

- 1) Negotiating reasons, even in difficult situations
- 2) Maintaining the social system
- 3) Mobilising human and institutional resources

1) Negotiating reasons, even in difficult situations

- The hospitality/admission response in the CMHC is applied on the basis of "case by case" evaluations and not merely severity and risk assessment.
- It's important to negotiate and openly express the reasons leading to the decision to provide hospitality for someone in a Centre (**transparency**)
- If the user **leaves the centre**, every effort is made to re-establish contact by seeking him out and listening to his requests and claims (**re-contracting**).
- Resistance conditions in general can be overcome if we put attention on flexibility, availability, and informal style of relating. It allows at maintaining an extremely low use of compulsory treatments.

2) Maintaining the social system

- **Shared responsibility** (among user, service, family and other users who will provide support) and constant search for agreement.
- The **inside** and the **outside** of the therapeutic context (the user can go outside, though perhaps accompanied, may go back home for a period of time, request the response to immediate needs, etc.).
- This form of hospitality will thus be situated within the **continuity of a project**, of a before and after, of which it will be a temporary and passing moment.
- Instead, in a community Service, the **"bed"** can be used in a flexible way, depending on the need for institutional **protection** of the most varied user-types.
- The CMHC's 24-hour hospitality **does not sever ties** with his/her environment (family contacts, time away from the centre alone or accompanied, taking care of specific personal needs).

3) Mobilising human and institutional resources

- A **first network of relationships** is provided by the **operators** whose willingness and availability is in direct relation to the closeness of their relationship with the patient.
- Out of this informal way of containing his anxiety there emerges, at minimum, a **personalized therapeutic relationship** with a limited nucleus of operators who make themselves more directly available in the various stages of the intervention, and thus "enter into play" with him.
- **Decoding crisis** through the confrontation and mediation among different viewpoints and needs **(PARTICPATORY DECODIFICATION OF THE CRISIS).**

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)