Folketingets § 71-tilsyn og Socialudvalget
Rejserapport
Studierejse til Trieste, Italien

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Ledsaget af:	Anne Mette Risager og Gitte Ravn Jensen, Udvalgssekretariatet

1. **Formål**
   Formålet med besøget var at høre om erfaringer fra Trieste i Italien, hvor man siden 1971 har arbejdet målrettet med at etablere en lokalt baseret og let tilgængelig, tværfaglig psykiatri blandt andet med oprettelse af lokale Community Mental Health Centers med døgnåbent, som i høj grad har afløst det tidligere psykiatriske hospital.

   Programmet er vedlagt.

2. **Væsentligste punkter fra besøget**
   Transformationen i psykiatrien i Trieste går tilbage til 1971, hvor Franco Basaglia bliver direktør for the Provincial Psychiatric Hospital of Trieste. Tanken var at bevæge sig væk fra institutionaliseringen af patienterne og erstatte det med et netværk af distriktsbaserede services med flere funktioner så som omsorg, bolig, arbejde og anden assistance. Fokus skulle flyttes fra de psykiatriske hospitaler ud i lokalsamfundet. Idéen var at minimere varigheden af indlæggelse og i stedet fastholde patienterne i deres eget miljø, sådan at det gav en bedre baggrund for helbredelse frem for institutionalisering.

   Tankegangen er baseret på 3 kerneaktiviteter: Forebyggelse, akut behandling og rehabilitering. Udgangspunktet i krisehåndteringen er:

Forhandling, fastholdelse af det sociale netværk og mobilisering af menneskelige og institutionelle ressourcer.

I 1978 blev en lov vedtaget i Italien (Lov 180), som havde til formål at nedlægge de psykiatriske hospitaler for at erstatte det med community services. Denne lov blev siden hen inkluderet i en anden lov (Lov 833), som gav individet ret til sundhed og omsorg og gik bort fra farlighedskriteriet.

I Trieste regionen betød det en nedlæggelse af det psykiatriske hospital og opbygning af en helt ny struktur med Mental Health Departement som den øverste administrative ledelse. Herunder findes 4 Mental Health Centres, som er placeret i hvert sit distrikt i Trieste og har åbent 24 timer i døgnet. Disse centre råder hver over 6-8 sengepladser.

Derudover findes der en mindre enhed på hospitalet (Psychiatric Unit Diagnosi e Cura), der har 6 akutsenge. Endvidere findes der en rehabiliteringsenhed (Service for Rehabilitation and Residential Support) bestående af 12 bofællesskaber med i alt 59 senge, med tværfagligt personale og et dagcenter, hvor der er forskellige træningsprogrammer og værksteder. Derudover samarbejder man med et antal sociale kooperativer, som kan tilbyde beskæftigelse til de psykisk syge.

Tilgangen til behandlingen af psykisk syge tager udgangspunkt i det enkelte menneske og dets rettigheder. Der tages afsæt i den samlede livssituation - ikke kun den psykiske sygdom. Behandlingen foregår som udgangspunkt frivilligt og uden brug af tvang og ved involvering af familie, venner og lokalsamfundet og hvis muligt i patientens eget hjem.

Arbejdet i de 4 distriktscentre er organiseret i teams med flerfaglige kompetencer. Disse teams arbejder primært som udgående.

Møder
Under besøget havde delegationen møder med Trieste Mental Health Department, rehabiliteringsenheden, den psykiatriske enhed på General Hospital Maggiore, den sociale distriktsenhed og et af de fire Mental Health Centers.

Opfølgning
Rejsedeltagerne har efterfølgende skrevet en artikel om indtrykkene fra studieturen "Kan tvang i psykiatrien undgås?", bragt i Politiken søndag den 9. december 2012 (vedlagt som bilag).
Desuden overvejer § 71-tilsynet at afholde en høring i det nye år om samme emne.

Med venlig hilsen

Liselott Blixt
formand

Bilag

- Artiklen "Kan tvang i psykiatrien undgås", Politiken 9. December 2012
- Program
- The Trieste Mental Health Department
- From the asylum to territorial services for mental health

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Kan tvang i psykiatrien undgås?

Hvad nu hvis en af de ledende psykiatere i Trieste har ret, når han siger, at det ikke er patienterne, der er farlige, men at det er det institutionaliserende og undertrykkende psykiatriske system, der gør ham farlig?

PSYKIATRI

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EN MAND kommer ind i den akutte psykiatriske modtagelse. Han er voldsomt psykotisk og råber højt, at han må hive alle sine tænder ud. Han fægter om sig med armene og er helt vild. »Hvad gør I med sådan en som ham?«. Den ledende psykiater smiler mildt og svarer efter lidt tid: »Vi taler med ham. Vi spørger, hvad der er sket. Vi spørger, hvorfor han må hive tænderne ud. Vi spørger, om der er noget, vi kan gøre for ham«.

FOLKETINGETS paragraf 71-tilsyn har med gæster fra Folketingets Socialudvalg været på studiebesøg i psykiatrien i Trieste. Ovenstående spørgsmål blev stillet af et af medlemmerne i vores forsøg på at blive klogere på, hvordan de ifølge sig selv næsten helt kan undgå at bruge tvang. Svaret kom fra den ledende psykiater fra den mest akutte enhed i Trieste. Her indespærrer og fastspænder de aldrig patienterne, og tvangsmedicinering bruges kun meget sjældent.

Psykiatrien i Trieste er baseret på lokale psykiatriske centre, der arbejder tværfagligt og helhedsorienteret.

De har ansvaret for al psykiatrisk støtte og behandling i området, fra den akutte indsats til langvarige rehabiliteringsindsatser i forhold til bolig, arbejdsliv, fritidsliv, økonomi og familieforhold.

På den måde kan man – helt uden indlæggelse – tilbyde borgere psykiatrisk behandling, fleksibel støtte og andre former for hjælp til at håndtere deres situation.

Derfor har man også nedlagt de fleste hospitalssenge. Der er faktisk kun 15 senge/100.000 indbyggere, og de er sjældent alle i brug. Det fik os til at drøfte, om vi herhjemme har den rette balance mellem sengepladser og botilbud/andre tilbud.

I DANMARK fremhæves psykiatrien i Trieste med mellemrum, men hver gang mødes den af kritik. Det har f.eks. været fremført, at tallene for brugen af tvang ikke er dækkende, fordi der ikke registreres systematisk.

Det har været nævnt, at der er mange psykisk syge i fængslerne, at brugen af tvang i den private sektor ikke tælles med, og at patienterne må være stærkt medicinerede. Og det har været nævnt, at modellen kun virker, fordi familiestrukturen er anderledes, og familierne er villige til at løse flere opgaver for deres pårørende.

Derfor er vi selvfølgelig nysgerrige efter at finde ud af, hvad der er op, og hvad der er ned.

PSYKIATRILOVGIVNINGEN i Italien er helt anderledes end den danske. Der er i den italienske psykiatrilov ikke grundlag for at fastholde, fastspænde eller indespærre en patient. Derimod kan der bruges tvangsmedicinering, men kun når det er forsøgt i tilstrækkelig grad at forhandle og samarbejde med patienten, kun ud fra en formodning om, at medicinen vil hjælpe patienten, og kun efter at tvangsmedicineringen er godkendt af to offentligt ansatte psykiatere og den lokale borgmester. Endelig gælder tilladelsen kun en uge, hvorefter der på ny skal begrundes og indhentes tilladelse.

Hvis man skal sammenholde med danske forhold, kan man se, at Trieste årligt anvender tvangsbehandling over for 7 personer pr. 100.000 indbyggere. Og i den private sektor anvendes der slet ikke tvang. I Danmark udsættes 16 personer pr. 100.000 indbyggere årligt for tvangsbehandling, og 57 personer pr. 100.000 indbyggere er udsat for fiksering eller fysisk magt.

Grundlæggende var holdningen, som vi mødte i Trieste, at hvis patienten ikke vil tage medicinen, er det psykiaterens ansvar. Det må være, fordi der ikke er informeret godt nok, fordi doserne er forkerte, eller fordi der er for lidt opmærksomhed på bivirkningerne. Al anden magtanvendelse end den sjældne tvangsmedicinering – herunder indgriben, hvis en borger er til fare for andre end sig selv – kan kun udføres af politiet efter de almindelige retsregler.

I FÆNGSLERNE tilses de få indsatte med sindslidelser af den lokale psykiatri. Men ender alle de svære patienter så bare i fængslerne? Nej, faktisk ikke. De 30 indsatte med psykiske lidelser, som overlægen fortæller lige nu er i deres fængsler, svarer til 13/100.000 indbyggere.

Selv om der stadig er mulighed for retspsykiatriske foranstaltninger i Italien, er ingen patienter fra Trieste aktuelt indlagt i retspsykiatrien. Tilsvarende var der i Danmark 48/100.000, der var indlagt i retspsykiatrien, og 80/100.000, der var frihedsberøvet i psykiatrien.

> **I de seneste år er psykiatridebatten heldigvis også kommet på den landspolitiske dagsorden i Danmark. Det var på tide**

Og hvad så med medicinforbruget, er det steget, nu hvor man ikke bruger så meget tvang? På et af de lokale psykiatriske centre, som vi besøgte, og som står for al længerevarende behandling inden for et afgrænset lokalområde, fortalte de, at de havde meget fokus på at reducere brugen af medicin.

NÅR EN BORGER er i medicinsk behandling, arbejdes der altid for at bruge mindst mulig dosis, så kort tid som muligt. Og en sidste god nyhed fra Trieste er, at ud over at de pårørende oplever, at byrden ved at være pårørende er mindre, er det faktisk også meget billigere at forebygge og at sikre, at patienterne bevarer tilknytningen til deres lokalmiljø frem for lange indlæggelser.

Det er nok rigtigt, at der er meget, man ikke kan kopiere fra Trieste. Der er mange forhold, der er anderledes i Trieste, og der er helt sikkert også folk, der falder igennem i systemet. (Selv om det dog ikke kan ses ud fra antallet af hjemløse). Men det er vores synspunkt, at der er faktisk er rigtig meget at lære.

HELDIGVIS ER man mange steder i Danmark allerede i gang med rigtig spændende tiltag i socialpsykiatrien med inddragelse af familie og netværk og med en helhedsorienteret faglighed til patienterne. Og der popper hele tiden nye lokale tiltag op, hvor man gør indsatsen over for de sindslidende endnu mere tværfaglig. Det er meget spændende og kommer forhåbentlig til at få endnu bedre muligheder, nu hvor der som resultat af førtidspensionsreformen skal sættes gang i ressourceforløb for især unge sindslidende.

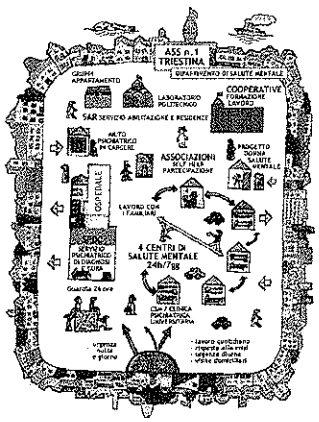
Og i de seneste år er psykiatridebatten er heldigvis også kommet på den landspolitiske dagsorden i Danmark. Det var på tide. Også at udenlandske erfaringer i større grad inddrages i vores hjemlige debat. Og at vi alle åbent tillader os at stille spørgsmål til vores danske behandlingsstruktur:

HVORFOR ER alternativet til bæltefikseringer i Danmark altid en anden form for tvang, f.eks. med medicin?

Hvad ville der ske, hvis man afskaffede låste døre og bæltefikseringer uden for retspsykiatrien i morgen? Hvad ville der ske, hvis man blev bedre til at inddrage netværk og pårørende fra starten af? Hvis man lod spørgsmålet om diagnose og medicinering vente lidt og i øvrigt så det i relation til patientens egne oplevelser og erfaringer?

Hvad nu hvis en af de ledende psykiatere i Trieste har ret, når han siger, at det ikke er patienterne, der er farlige, men at det er det institutionaliserende og undertrykkende psykiatriske system, der gør ham farlig? Kan vold og magt på de psykiatriske enheder ses som et udtryk for, at 'systemet' bør arbejde anderledes?

Vi ved godt, vores tur ikke var et fagligt, men et politisk besøg. Men vi håber, mange i de faglige miljøer vil tage debatten op. Vi deltager gerne heri.



The Trieste Mental Health Department

In Trieste, the most significant achievement after the psychiatric hospital was shut down in 1980 was the creation of a Department of Mental Health which completely replaced the old asylum. Community Mental Health Centres are open 24 hours a day and equipped with beds for overnight or extended hospitality and offer a wide range of responses, including supported housing, social support in ordinary living, leisure time, job training and placement for more than 200 users annually, e.g. social coops. Care is provided on a person-centred and rights-based approach (abolishing all forms of restraint, using compulsory treatments only when absolutely unavoidable (7 per 100,000 inhabitants annually, no people in forensic). Among the Service's most important programmes is a suicide prevention project which has contributed to reducing the suicide rate by half (from 25 to 12 per 100,000).

In parallel with the development of the psychiatric services, the last decade has also seen the significant growth and development of integrated, community health care services (Health Care Districts). The Districts are integrated community services which stress the active involvement of the general public and the inter-sectorial offer of the health care services in order to achieve their aims.

FUNCTIONS/ACTIVITIES

- Overnight hospitality
- Hospitality/Day hospital/Day centre
- Out-patient activities
- Home-care activities
- Individual and group therapy
- Psycho-social support/activation of networks
- Psycho-social rehabilitation
- Residences
- Professional training
- Job placement
- Aggregation and free time

PROGRAMMES

- User training and involvement
- Information for family members
- Involvement of GP ("Health tutor")
- Prison consultancy service
- Prevention of "lonely deaths" ("Amalia" project)
- Suicide prevention ("Special Telephone" project)
- Continuous improvement of quality
- Facilitating itineraries for membership in associations etc.
- Basic and professional training activities
- Promotion of social enterprise activities
- Creative/play activities
- Promotion of self-help activities
- Intensifying relationships with health districts
- Intensifying relationships hospitals
- Relationships with the city's cultural agencies
- Gender difference and mental health

The MH Department of Trieste as WHO CC

The MH Department of Trieste has been reconfirmed as WHO Collaborating Centre for Research and Training, with the following terms of reference:

1) Support and guidance in various countries for deinstitutionalisation and development of integrated/comprehensive Community Mental Health services:
   - drafting of policies at the local and national level
   - leadership and management
   - implementation and development of local services network
   - workforce development (multidisciplinary teams)
2) Collaboration, partnership and networking with some countries/areas which demonstrate the willingness and capacity to deliver community based service development
3) Diffusion of Whole Systems & Recovery approaches: innovative practices in community MH (e.g. alternatives for acute care; comprehensive CMH Centres; rehabilitation, recovery & social inclusion services; deinstitutionalisation & whole systems change; early intervention integrated network; social enterprises & Cooperatives technology, operation & policies).

WHO Collaborating Centre
for Research and Training
in Mental Health

A.S.S. n. 1 Triestina
Dipartimento di Salute Mentale

FROM THE ASYLUM
to territorial services for mental health

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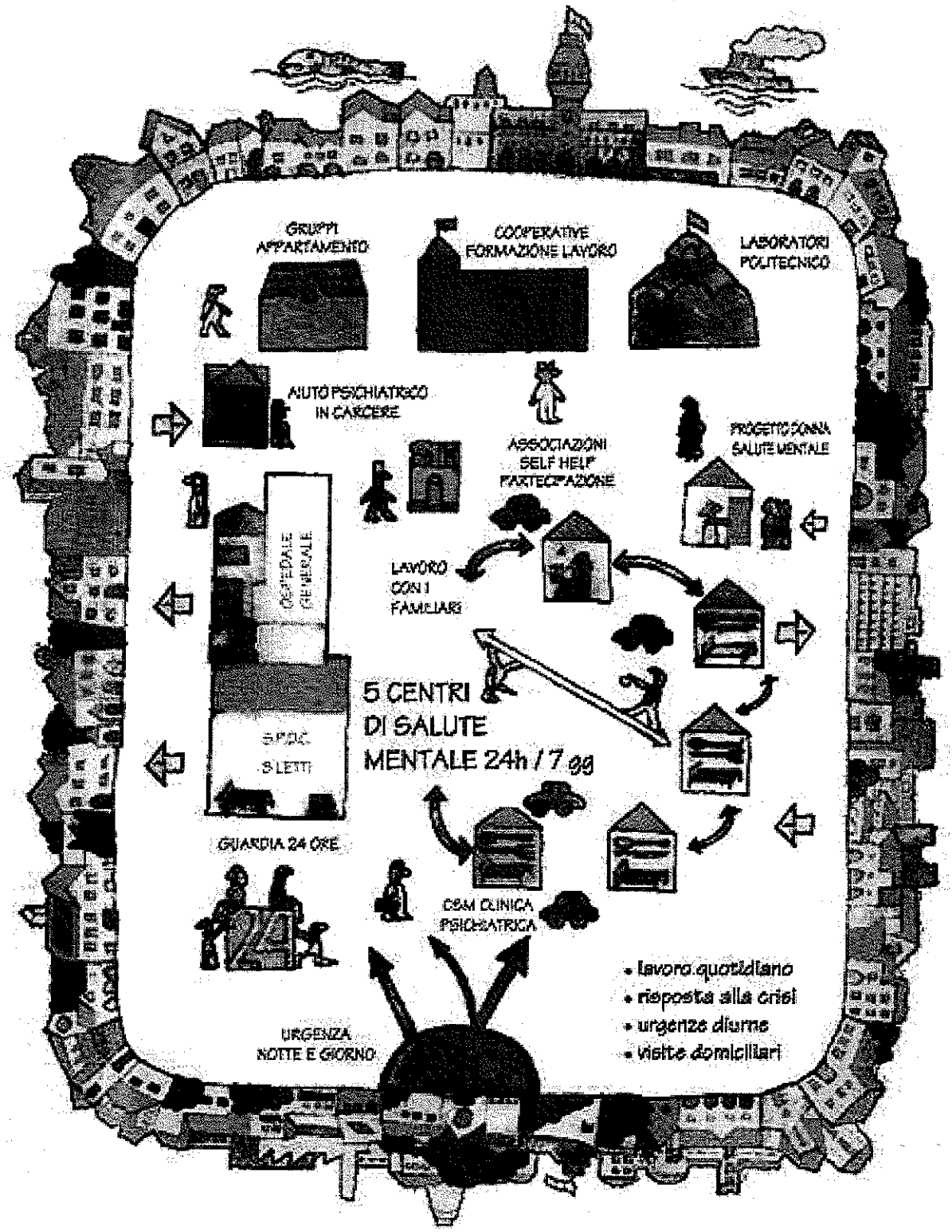
In 1978 in Italy, the law that reformed psychiatric assistance, also known as Law 180, started a national process to eliminate mental hospitalizations by the end of the 90s, closing all asylums and introducing at the same time, many new community services that allow mentally disabled people to conduct their lives in a normal social contest. This law, which was the first of its kind in the world, radically changed care and assistance methods.

Presentation

by Peppe dell'Acqua



"...The important thing is that we have proved that the impossible is possible. Ten, fifteen, twenty years ago it was unthinkable that an asylum could be destroyed. Maybe the asylums will again be closed and more closed than before, I do not I know, but anyway we have shown that a mad person can be assisted in another way, and this demonstration is of crucial importance. I do not think that just because something becomes generalized it means that the battle has been won. The important thing is that now we know what we can do..."

Franco Basaglia, Brazilian Lectures, 1979

In August 1971, Franco Basaglia became director of the Provincial Psychiatric Hospital of Trieste, where there were 1182 inmates. There, he started his work on transformation, rehabilitation, and the construction of alternatives. This process was carried on by a team of operators and involved institutions, organizations, associations and volunteers from all over the world.

By 1980, under the supervision of Franco Rotelli, the new community services had already replaced the old assistance methods.

For over 30 years the city of Trieste (240,000 inhabitants) has not had any kind of mental hospital. The asylum was replaced by 40 different structures with different roles and tasks, such as home care for patients. The results prove that the new psychiatric assistance methods have also reduced spending in the sector. Furthermore, at the end of 1971 the budget for the management of the Psychiatric Hospital amounted to approximately 55 million euros; in 2010 instead, the management of all local services cost about 18 million euros. Staff decreased from 524 in 1971 to 225 in 2010. The 1,182 hospital beds in 1971 became 140 beds distributed throughout the entire area. The proportion of persons involved in these services each year is close to 20 per thousand people.

The building that housed the psychiatric hospital was gradually returned to the city. Today it houses university departments and city services. It still plays a significant part in Trieste's culture, a crucible of tensions and utopias, a laboratory of cultures, tolerance, and home to a beautiful rose garden.

Since 1987 the WHO has recognized the experience of Trieste as a point of reference for innovative approaches to psychiatric care. In 2010 the Department of Mental Health of Trieste was reconfirmed as a WHO Collaborating Centre for Mental Health. In 30 years, more than 50 countries in Europe and other continents have visited the mental health services in Trieste to set up similar processes with the technical assistance of their colleagues in Trieste. About 1000 persons every year take part in study-tours.

The Trieste Department of Mental Health

The Department's strong points are its 4 Mental Health Centres, located in 4 neighbourhoods, each with 8 beds and operating 24 hours a day. The mental health centres provide health and social care, psychosocial rehabilitation and, if necessary, treatment in acute cases.

For those who need longer term assistance, protected apartments have been created for small groups of people, offering a friendly and non medical environment. The Habilitation and Accommodation Service coordinates the apartments (with 55 beds), habilitation, rehabilitation and social integration activities with workshops and projects across the city. Finally, job opportunities have made it possible to ensure effective integration into society. The Service coordinates 15 affiliated social cooperatives, which, through work grants, have been able to integrate about 375 people in the last 15 years.

The Psychiatric Diagnosis and Treatment Service, with 6 beds, deals with psychiatric emergencies, filters cases and orients the patients towards the local services.

The number of compulsory health treatments, with an average of 8 per 100,000 inhabitants in the last 10 years, is the lowest in Italy. No citizen of Trieste is interned in the forensic hospital.

Which problem does it help to solve?

Basaglia wrote in 1964 that the "destruction of the psychiatric hospital" was "something urgently needed"

"... From the moment he goes behind the wall of internment, the patient enters a new dimension of emotional void (the result of an illness described by Burton as Institutional Neurosis, and which I would call simply institutionalization); the patient is put into a place that was originally created to render him inoffensive while offering treatment at the same time; it is in practice a place that was designed paradoxically for the complete annihilation of the personality, a place of total objectification. If mental illness is, at origin, a loss of individuality, of liberty, for a sick person an asylum is nothing more than a place of permanent loss, in which they are objects of illness and subjected to the pace of internment. The absence of any future prospect, being constantly at the mercy of others without the slightest personal affection, a life dictated only by organizational needs which - as such – cannot take into account the individual and their particular circumstances: this is the institutionalizing setup that marks life in the asylum."

In the 2010 publication *Mental health and development: targeting people with mental health conditions as a vulnerable group*, , the WHO stresses that ... Despite their vulnerability, people with mental health problems - schizophrenia, bipolar disorder, depression, epilepsy, alcohol use disorders and drug problems of childhood and adolescence, intellectual delays - are been largely overlooked by development programs. This happens despite the widespread nature of mental health problems, their economic impact on families and communities, and related phenomena of discrimination, marginalization and stigmatization. The mental health problems affect millions of people around the world. The World Health Organization (WHO) estimates that 151 million people suffer from depression, 26 million from schizophrenia, 125 million people suffer from alcohol use disorders, 40 million people suffer from epilepsy, and 24 million suffer from Alzheimer's and other dementias. Every year there are approximately 844 000 cases of suicide. In low-income countries, depression is a major issue, almost like malaria (3.2% vs. 4.0%), but the funds invested to combat it are a very small fraction of the total allocated.

In the world, large portions of the population still live in conditions of oppression due to various factors: extreme poverty, economic and cultural imbalances between rich and poor countries, lack of recognition of basic human rights. In a context marked by deep inequalities, people suffering from mental disorders are one of the most oppressed minorities, not only because it is a group which is usually denied citizenship rights but because the denial of access to certain rights is legitimated by a misunderstanding of the scientific status of "disease".

Most funds for psychiatric hospitalization are still invested to hospitalize or segregate people suffering from mental disorders in closed institutions. Therefore a priority for governments is to promote policies which, with a view to the closure of all places of restraint and confinement, give impetus to interventions focusing on the creation of mental health services that operate in local area with a mandate to identify operational choices and health promotion strategies and access to rights.

The WHO is providing support to all countries interested in implementing policies for the reform of mental health services. In this framework, the Department of Mental Health of Trieste has been recognized as a WHO Collaborating Centre to provide politicians, civil servants and professionals in interested countries with the knowledge accumulated over the last 40 years. The Trieste experience, which back in the 70s was a futuristic plan, is still continuing to experiment innovative ways of "how to" to provide care to people in need, while respecting their rights and helping them integrate into social and working life.

In August 1971 Franco Basaglia, taking over the psychiatric hospital in Trieste, formed a working group made up of young doctors, sociologists, social workers, volunteers and students from different Italian and European cities. Many were attracted by Trieste because of the relevance of the issues on deinstitutionalization of asylums in the media, social movements and in the political debate. In his book "The denied institution" (1968), while documenting their efforts to humanize asylums, Basaglia denounces for the first time the fact that psychiatric hospitals do not meet the objectives of assistance and care, since they operate according to the rules and laws of public order and social control; in effect they are the producers of the disease.

Trieste's goal was to go beyond the asylum: transforming the organization of the service to replace it with a network of territorial services with multiple functions of care, accommodation, protection and assistance. The challenge was difficult because, despite the many experiences of reform started in France and England after World War II, no one had ever really been able to shift the focus of care from hospital to the community. There was no knowledge or established practice to underpin the reform process. Even legal rules and laws were still based on judgments of the danger posed by the mentally ill, and were not in themselves sufficient to promote a process of real openness and civilization of psychiatric care in the direction of a territorial approach.

The main goal was to change the place of treatment to change the methods of care; it was not enough to change just one or the other. The focus had to be shifted from the disorder itself to the whole person: their needs and rights, while also focusing on capacity and resources. Interventions had to target not only the individual but also the context, the network of belonging and social reference groups.

In other words, the task of the central and local governments is to promote citizenship for the most disadvantaged and vulnerable population. More specifically, people suffering from severe mental disorders need access to material and economic aid, even transient, to earn an income and make a decent living; satisfactory living conditions in homes, the chance to live in communities and also in protected and semi-protected transitional accommodation; work placement in relation to their needs, capacities and inclinations; access to education, information, training, social contexts and opportunities, the chance to take part in different activities and have free time.

When a person goes through the experience of mental illness, he risks losing their essential personal and social rights. In 1995, the Department of Mental Health of Trieste approved the "Bill of Rights for Users" of mental health services. These rights are normally enshrined in the Italian constitution but in reality they are hardly applied to people suffering from mental disorders. But, above all, it is the work carried out by the Department to guarantee that people suffering from mental disorders can exercise their concrete rights.

Finally, one of the problems that the territorial organization of services has helped to resolve in a different way was that of taking charge of moments of crisis and their evolution. The non-bureaucratic approach to crisis situations, outside the medical model, tends to reduce the use of hospital admissions or make them unnecessary, working to re-establish conditions of equilibrium as rapidly as possible. This approach decreases the risk of relapse. In this way, crises become part of the personal history, with their own meanings to be understood, reconstructed and satisfied by activating resources and links.

The territorial services adopt an operating style that differs from the clinical hospital model. They go to the patients, no longer using filters and strict, standardized skills, but enhancing social network relations, insisting on the quality and abilities of people rather than symptoms. These are models that do not define protocols and hospitalization operating times, but take care at the specific program of each person, while maintaining the quality of their home space, furnishings, cleanliness, and food, as well as the quality of relationships.

In Italy the process of replacing archaic cultures and laws, in contradiction with the general system of mental health instituted by the transformation of mental hospitals, is still in progress. In 2011 the community is still working on the closure of six forensic psychiatric hospitals that are still in use, where 1200 people are hospitalized and deprived of basic rights. Also in this case, the psychiatric mental health services that are already taking care at national level of about 1,000,000 patients are the alternative to institutionalization.

The reform of psychiatry and the implementation of mental health services in practice

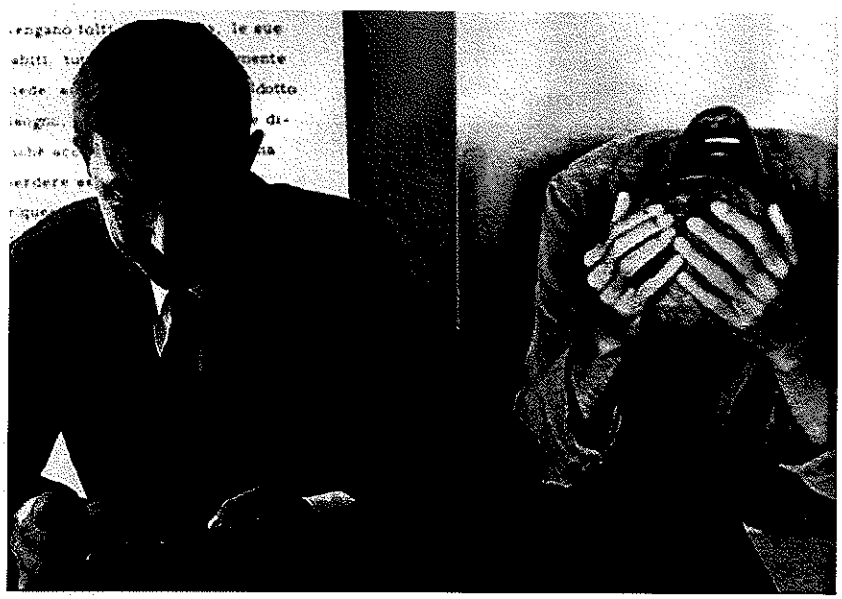
It would be impossible to define a model (applicable everywhere) of reform for mental health services, considering the complexity of these processes and the great differences between countries, cultures, and services. However, following the phases of the experience of Trieste, it is possible to indicate the universal aspects of a reform process for mental health services.

The Law 180 of psychiatric reform

On May 13, 1978, under the pressure of the process of deinstitutionalization in place in Trieste and in other parts of Italy, Law 180 was approved in Italy, which decreed the gradual replacement of psychiatric hospitals with a radically new model of territorial care services. At the time of the promulgation of the law, the structures of the psychiatric hospital in Trieste were almost completely dismantled and the turnover of patients was minimal.

The Law 180, states that, even in psychiatry, the basis of health care is a person's right to care and health rather than the assessment of dangerousness. Treatment becomes voluntary and usually carried out in facilities operating to a minimum in local areas.

In the case of needed hospitalization, treatment is carried out by the Psychiatric Diagnosis and Treatment Services of General Hospitals. Law 180 establishes that no one can be hospitalized in psychiatric hospitals. It is the first law in the world that bans mental asylums and represents a fundamental victory for those who worked for reform.



The reform initiative and its legislative requirements

In 1971 when Franco Basaglia took over the provincial psychiatric hospital in Trieste and started the experience of transformation, psychiatric care in Italy was governed by a law of 1904 which focused on the need to protect society from the mentally ill. Hospitalization occurred with the certification of a physician and the order of a commissioner, and alienated the civil rights of the person. Psychiatric care was administered by the provinces, each of which had their own mental hospital.

Law 180 initiates a new phase of work to introduce new provisions in national and local regulatory frameworks to progressively define the responsibilities of the Departments of Mental Health, their services and standards of operation. In March 1999 the Ministry of Health announced the successful final closure of all public psychiatric hospitals. This completed a cycle, which lasted more than two decades, and included the startup and testing of the reform, characterized by lively debate among workers, family members, administrators, politicians and public sectors.

The change in the organization of the psychiatric hospital

Until 31st December 1971, 1182 people were hospitalized in Trieste, with an annual turnover of 2500 patients, of which 90% underwent forced hospitalization. The introduction of voluntary admissions meant that patients were not deprived of their rights, patients were given freedom of movement in and out of hospital, and treatment and care was improved thanks to a change in the relationship between patient and doctor through dialogue. Starting in the first months of 1972, a great deal of attention was focused on the organizational changes needed in the interior spaces and on improvements in relations between staff and patients.

The operators were organized into 5 teams, each of which was in charge of an area of the city. There were daily team meetings and discussions. In periodic assemblies, coordinated by Basaglia, patients were presented with the reform process. The doors of the hospital wards were opened and shock therapies and physical constriction methods ended. Also sexual segregation was abolished and mixed departments introduced.

Hospital community activities include parties, bars, and newsletters. However, patients also have the chance to go around the city alone or in small groups. In this way, people are also gradually reintegrated even by using money to access public places, thanks to subsidies provided by the provincial administration.

The return of rights to inmates

Team work focuses on reconstructing patient's needs and personal lives, trying to rebuild relations with their families and places of origin. As the larger departments are downsized, housing groups are organized, first at the hospital and then in the city. The style of work is oriented to the involvement of nurses, who must abandon the traditional role of "guardian" to take an active role in the changing process.

Many different patients' organizations were instituted, and among these, the most important was established in 1972, the United Workers Cooperative, which includes 60 hospitalized people, with different tasks: cleaning the departments, working in the kitchens and in the park.

The assignment of a regular union contract to each hospital-worker is a big change from the old practice of exploitation of the internees, improperly referred to as "occupational therapy". Instead this new practice anticipated what in later years would lead to the creation of social cooperatives.

The recognition of the right to work, and the replacement of hospital wards with smaller and autonomous community units, demonstrates that it is not a disability or disorder that obstructs the construction of rehabilitative processes but the juridical and administrative status of the patients. Day and night care is also recognized as a right for people who, while not requiring hospitalization, are still obliged to reside in the hospital as "guests" due to a lack of alternative housing.

When the transformation process started there was opposition from nurses and alarm among citizens

"... The prevailing view was that mad people were dangerous and had to be locked up in a mental hospital. So at first it was a case of convincing them that things were not like that. Day by day we tried to show that by changing the relationship with the patient we also changed the sense of this relationship. Nurses began to believe that their work could be different, and thus become agents of transformation. On the other hand, to convince the population we first had to take the mentally sick back onto the streets, to social life. By doing this we stimulated the city's aggression against us. We needed to create a tense situation, to show the change that was happening. In time the city realized what was happening. The important change in the training of nurses was that the new kind of reality led them to no longer be dependent on doctors, to be persons who could make decisions on their own."

Franco Basaglia, Brazilian Lectures, 1979

The construction of relations between the hospital and the territory

Even though operators continue to work in the hospital, from 1973 their tasks are carried out mainly outside the institution, trying to re-establish inmates' relations with their families, taking them to the city to look for jobs and accommodation. The hospital itself is open to cities organizing art exhibitions, parties and concerts, so that the psychiatric experience interacts with social actors: young people, women's organizations, student movements, political organizations and unions, information agencies, public opinion, intellectuals and artists.

In the first empty ward painting, sculpture, theatre, and writing workshops are organized. More and more often, vacations and tours are organized so that patients can participate in normal city activities.

Between 1973 and 1974 patients, before put in wards based on the criterion of seriousness (agitated, violent, filthy, sick, and chronic), were reassigned on the basis of their territorial origin. From this initial situation, the explicit goal became that of discharging patients so they could support themselves at home in their own living environment.

Work outside the hospital met with opposition and numerous conflicts, since it was the first significant change in therapeutic practices and institutional, administrative, and hierarchical organization; it was also a training school for nurses and doctors.

The establishment of the first territorial Centres for Mental Health

At the beginning of 1975, the number of inmates had dropped to 800, and those discharged were placed with their families or in housing groups.

The first Mental Health Centres were activated in the Health Districts in 1975-1976, to support the patients discharged from the mental asylum and care for those in crisis. As day centres, they worked to reduce the number of hospitalized patients and the duration of hospitalization. They were established before the national reform law, while the psychiatric asylums were still operational, so two different organizational and cultural assistance models were operating at that time. This situation was putting the new system at risk with a possible paralysis of the transformation process.

In this situation, the team therefore took the bold decision to upgrade services so that the mental health centres could operate 24 hours a day. Towards the end of 1977, Basaglia decided to announce the closure of the psychiatric hospital as an irreversible fact.

The number of patients had decreased to 132, while guests in the protected structures inside the hospital numbered 433. That same year, a psychiatric ward service was established, working 24 hours a day, at the General Hospital Emergency Department, to make psychiatric assessments, find the best solutions to crisis situations, and counter the automatic recourse to compulsory admissions.

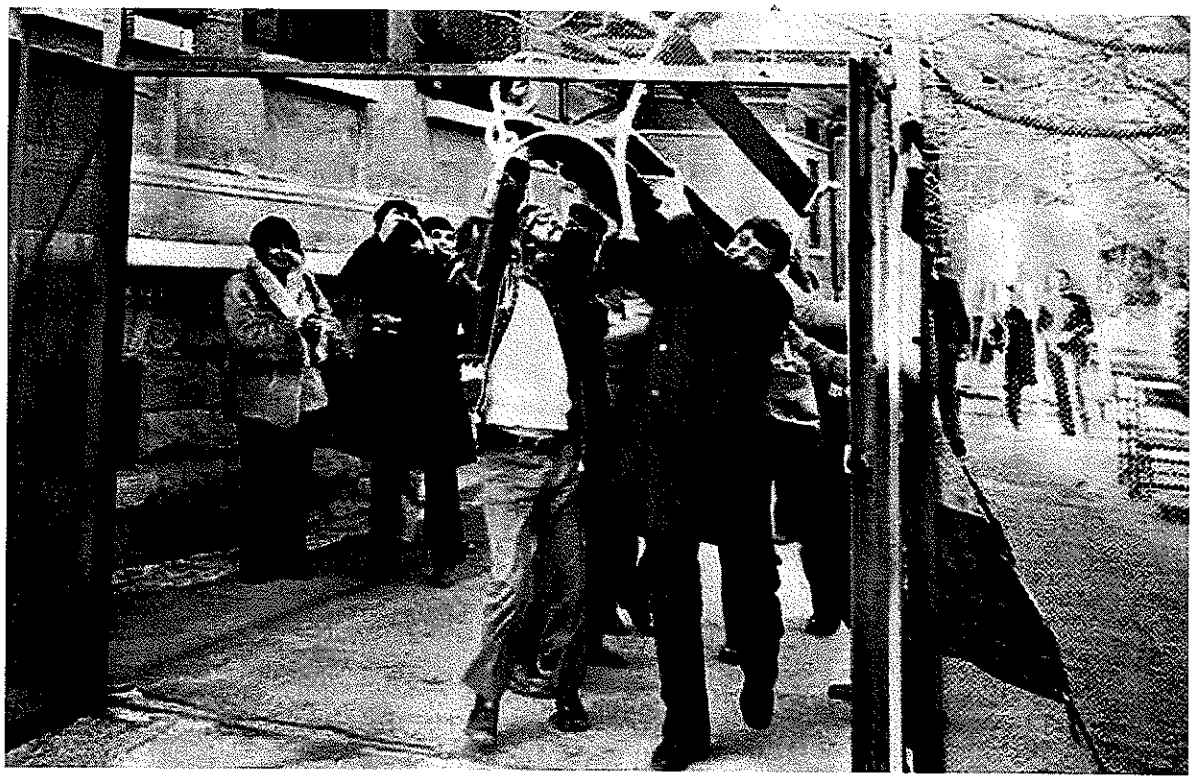
The closure of the Psychiatric Hospital

The enactment of Law 180 in 1978 represents a victory for all the players involved in the transformation of mental hospitals, and became an essential tool to complete the psychiatric reform process in Trieste, boosting both local services and new initiatives, considering also the allocation of administrative resources.

The General Hospital Psychiatric Service was transformed by law into the Psychiatric Diagnosis and Treatment Service, providing an emergency psychiatric consultancy service to various hospital departments, also having the responsibility of orienting the patients to the territorial Mental Health Centres.

In November 1979, Franco Basaglia was called to supervise the psychiatric services of the Lazio Region, and the new director, Franco Rotelli, was in charge of overseeing the definite closure of the Trieste hospital.

These were years of organizational transition, in which the governance of the psychiatric reform was included in the national health system, transferring powers from the province to the territorial health services. On 21st April 1980, the Provincial Administration passed an internal resolution declaring an end all to the functions and definitive closure of the Psychiatric Hospital of Trieste.



The institution of the Mental Health Department and its services

In 1981 the Department of Mental Health (DSM) was instituted by law. The DSM guarantees the technical, administrative and managerial unity of the territorial service network, its programs and activities. The operational standards of the Mental Health Centres were also defined, each being responsible for 50,000 people, with 8 beds and a refectory for day and day/night care.

In local areas, residential and housing groups were enhanced, to provide accommodation not only to discharged patients but also to people that had never been hospitalized but lived in precarious situations or in conflict with their families.

Rehabilitation, training and socialization programs were developed: recreational and leisure activities, expressive workshops, literacy courses and schooling. The mid 1980s saw an increase in the number of cooperatives involved in work placement, and their range of competences and activities were gradually extended.

In the following years the cooperatives increasingly focused on empowering people with handicaps and disabilities of various kinds, or those who were victims of addiction or social marginalization. The strengthening of their activity, in a perspective of social enterprise, coincided in the 90s with a significant work of DSM helping users of mental health services to fully exercise their citizenship rights. The rehabilitation and empowerment programs, focusing on accommodation, work, social relations, education and training, aimed increasingly at building networks and self-help groups, targeting populations at risk.

Results

During the complex reform process to replace the asylum and implement territorial mental health services, there were structural results, in terms of both service organization and response quality for the population. The new organizational and operational setups also represent a point of reference for those interested in building local area alternatives to traditional psychiatric care.

The Department of Mental Health

The Department of Mental Health, established in 1981, is part of the Trieste Health Agency. The Agency, which covers a population of about 240,000 inhabitants, is divided into four Healthcare Districts. In each of the Healthcare Districts there is a Mental Health Centre (MHC).

Access to mental health services

To access mental health services in Trieste, the person concerned or their family, relatives, friends, or neighbours, can contact their local Mental Health Centre. Any action taken respects the rights of confidentiality and privacy; and even when the request is made by others it is still up to the person who is suffering to apply to the service for help.

Requests for appointments can be made directly, by phone, or by the attending physician. First contacts can be made at the Health District, at home, or other social or medical areas. The General Hospital's Psychiatric Diagnosis and Treatment Service may require the intervention of the MHC for people whose application has been received by emergency services.

There are no waiting lists and the first interview takes place within 24 hours of request. The application is received by the staff on duty and the first assessment, after the initial interview, is conducted by a psychiatrist or psychologist, in collaboration with the team.

An assessment is made of the problematic aspects as they are presented, and of the viability of taking charge of the case.

Responses and treatment are tailored to the specific problems and needs of the people concerned and the service aims to provide, as far as possible, personalized and not standardized interventions.

The Department of Mental Health, directed by Peppe Dell'Acqua since 1995, is the operational centre for prevention, diagnosis, treatment and rehabilitation and the organization of mental health care for citizens. The Department is also responsible for removing any form of discrimination, stigmatization, and exclusion of people with mental illnesses and disturbances, and helps to actively promote the full and complete rights of citizenship. The Department ensures that the mental health services in the Health Agency operate as a single coherent whole, in coordination with other health services, with the community and its institutions. The Department also organises training and refresher courses for all professionals, for local operators and those in other Italian regions and other countries. The services offered by the Department are provided by 220 professionals (psychiatrists, psychologists, nurses, social workers, rehabilitation engineers), staff in social cooperatives, and finally trainees and volunteers, often from other cities, regions and countries of the world.

The Mental Health Centres

The Department manages the 4 Mental Health Centres (MHC) in the 4 Districts into which the Trieste Health Agency is divided, each providing services to a population of about 60,000 inhabitants. Each Centre is open 7 days a week, 24 hours a day, and has 8 beds. The Centres are the access points and planning centres of the mental health system. Work practices focus on providing therapeutic and rehabilitative continuity, especially for people who suffer from severe mental disorders. The service operates in the places where the user is to be found, not only in the home but also the hospital, nursing homes, prisons and forensic hospitals. The Centres carry out the following activities:

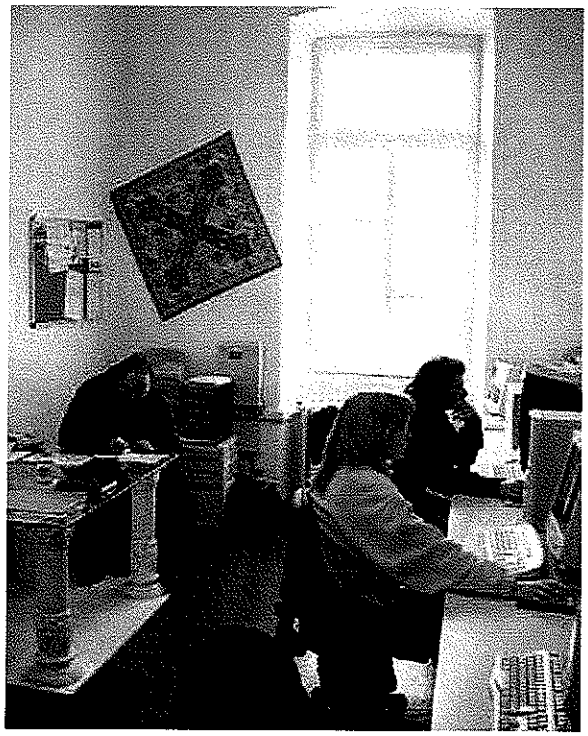
- Night Accommodation, for varying periods of time, in response to crisis situations, to protect against specific risks, or give a respite to both patient and family.
- Daytime Accommodation, to provide protection in situations of crisis and tension, to provide pharmacological therapies and psychotherapeutic support, to stimulate participation in reintegration activities.
- Outpatient services, to offer initial consultation and monitoring of developments in the treatment program.
- Home services, to learn about the living conditions of the person and their family, to mediate in conflicts with the neighbourhood in crisis situations, to administer medication, to accompany people to hospital, government offices, work.
- Individual therapeutic work, to listen and study the problems and living conditions of the person, to look for ways out and build a new balance.
- Therapeutic work with the family, to verify and discuss dynamics and conflicts, to stimulate possible changes, build alliances in the therapeutic program.
- Group activities involving operators, volunteers, users and families, to activate a social network of friends, colleagues, neighbours, or others who play an important role in therapeutic processes and social reintegration.
- Rehabilitation and prevention, through cooperatives, expressive workshops, school, sports and recreational activities, youth groups and self-help.
- Support for the most disadvantaged and their families, through economic benefits (social integration, job training, support for rehabilitation activities) or by sending or accompanying the patient to organizations and institutions that can meet their needs.
- Support for rehabilitation at home, in housing groups and during treatment, with different degrees of assistance and protection tailored to the needs of people with disabilities.
- Consulting activities in health services, hospital wards, health districts and prison, where there are users already in the care of the MHC, for further diagnostic study, to recommend specific therapies and initiate care processes.
- Responses to calls for urgent help, advice, appointments and monitoring of therapeutic activities in progress.

The Psychiatric Diagnosis and Treatment Service in the General Hospital

The Psychiatric Diagnosis & Treatment Service is provided by the General Hospital of Trieste. It is provided with 8 beds and is open 24-hours. There are psychiatrists and nurses on duty but it also offers the services of psychiatrists from all operational units of the DSM.

It provides psychiatric consultancy for emergencies at the General Hospital Emergency Service, and offers advice to the hospital's Departments on request. After specialist assessment and after providing initial treatment, the team can activate the competent MHC to continue the care service.

The aim of the Service is to minimize the duration of hospitalization, which in any case is not considered as an alternative or a substitute for care by territorial units. The Service makes sure that patients, even the most serious cases, maintain contact with their environment so that they can recover from the crisis more easily and avoid institutionalization. The doors are always open, and in no case is use made of constriction.



Social integration accommodation

Managed by the Health Agency, accommodation is given to people with reduced capacity to live independently and who require support in daily life activities. One or more guests live in their homes or rented accommodation supported by service staff. Support is planned in relation to the different needs and levels of autonomy of the guests.

The Residential Service

This Service, which works closely with all the MHCs, cooperatives and training agencies, carries out rehabilitation, training and work placement activities.

The Service set up a Day Centre, which organizes workshops and offers artistic activities, crafts and culture. There are teachers, art teachers, artists, cultural and voluntary associations. It is open to citizens that are making use of mental health services, but it is also accessible to all. Theatre, visual arts, music, cloth making, and body care activities are the most popular.

In 1996, the Office for training and work placement was set up, with the support of operators from the different services of the department. The users involved in the training/work programs can enjoy cash benefits (job training grants), which constitute a very important therapeutic tool. Since 1998, the Office has been working closely with the Trieste Province social cooperatives to develop strategies to combat social exclusion and build territorial partnership projects for integration and development.

Mental health services in the Districts

These services, which operate in the Trieste Health Districts, provide psychiatric consultation at the request of family doctors or in response to warnings, and help people who find it difficult to apply directly to the MHC. They take prompt action in cases of people with previously unrecognised psychiatric problems, improving the quality of local medical and hospital care for people with mental disorders, reducing the frequency and duration of hospital stays and their costs. Other actions are carried out in different contexts with specific programs, in conjunction with other services, to support families, provide rehabilitation services in the home and in residential areas, improve living and relational conditions in accommodation facilities. For example, there are programs for the support and socialization of the elderly, in collaboration with operators of other services and with local associations, to avoid the risk of institutionalization in nursing homes.

Therapeutic-rehabilitative accommodation

There are 12 houses or apartments, rented or owned by the Health Agency, managed by Service staff or affiliated social cooperatives or voluntary associations. They house people with great disability problems, who cannot rely on their family or social network, such as former long-stay psychiatric hospital patients, or people who need individualized and ongoing rehabilitation and treatment programs.

The University Psychiatric Clinic

The University Psychiatric Clinic carries out teaching, research and assistance activities in the field of mental health. It has 12 beds, for both inpatients and outpatients.

The Clinic is home to the School of Psychiatry and carries out epidemiological, clinical and psychopharmacological research on psychiatric disorders. Activities focus in particular on the psychopathological aspects of mood, problems related to suicidal behaviour and eating disorders. As regards dementia, the Clinic is a point of reference for the Trieste Health Agency and the Agencies of other Italian regions.

Programs operating in the territory

These programs began in the early to mid 1980s and deal with the most pressing territorial problems, creating a network of local resources involving all the operational units of the DSM. Some examples:

- The Trieste Prison Service, established in 1979 and implemented in collaboration with voluntary organizations, carries out prevention and treatment of mental health problems during detention and ensures the continuity of care for detainees and people already in the care of the mental health services; it also promotes the application of measures other than detention (parole, custody, outside work) and strives to avoid detention in forensic psychiatric hospitals.
- Self-help programs promotes clubs and other forms of association for service users, particularly people who have experienced or are experiencing personal, family and social difficulties.
- Working with the family. Launched in 1987, it helps members of the family to deal with emotional problems and the everyday difficulties of life with a relative who suffers from severe mental disorder. The DSM also organizes information programs, meetings with groups of family members from different geographical areas, meetings with parents of children showing the first signs of disorder.

The Special Phone

This was launched in 1996 to reduce the social isolation and loneliness felt by the elderly in a city where it is not rare to find people who die in solitude or commit suicide. The Free Phone is operative 24 hours a day and is connected to the social services network. In 2003, after four years of work, more than a thousand elderly women and men were cared for by the program in Trieste. The project also organizes campaigns and interventions in the local press.

Social cooperatives

The first cooperatives to help disadvantaged people integrate into society were established in Trieste in 1980. In 1991, taking into account the positive experiences throughout the country, the Italian government passed a law regulating these cooperatives, allowing them to manage health, social and educational services and other activities (agricultural, industrial, commercial and service) aimed at helping disadvantaged people to find employment. The law stipulates that disadvantaged people must make up at least 30% of the workers in cooperatives. The Trieste Department of Mental Health has an agreement with two cooperatives to manage social, health and educational services in residential facilities, and ten cooperatives that help the disadvantaged to work in very different activities: gardening, crafts for decoration and fashion, architectural ornaments, screen printing, catering, cleaning, recovery and recycling of used materials, transport and others.

Links with voluntary associations

The Department of Mental Health has established relations with numerous organizations that defend and promote the rights of persons suffering from mental disorders and their families. These associations also work with the services in therapeutic - rehabilitation programs and activities (homes, accommodation, leisure activities, telephone help-lines). They are very effective in promoting the image of people with mental disorders in the fight against stigma, discrimination and exclusion. The DSM also works closely with 11 local associations that manage facilities and programs through agreements with local governments.

The development of the Trieste health territorial system

In 1998 the Friuli Venezia Giulia Region established the Health Agency n°1 of Trieste, to boost community health services. The Agency incorporates the Department of Mental Health and also promotes local services as an alternative to hospital care in other areas of medicine. The establishment of the Agency, greatly inspired by the work done in psychiatry, led to the development of the 4 Health Districts, which organize services to avoid and reduce hospitalization in all areas: cardiology, pneumology, geriatrics, physiotherapy and oncology.

The aim of reducing the role of hospitals was to guide the work of the health districts over the years in the development of multi-purpose services and facilities, including general practitioners and primary care, offering a vast quantity of territorial services.

This development of Trieste's health territorial system, as well as representing an achievement of the Department of Mental Health, allows for effective local mental health interventions, with the active cooperation of a great network of facilities whose aim is to provide assistance that is closer to citizens' needs.

International interest

In 2010, the Mental Health Department of the Azienda per i Servizi Sanitari of Trieste, was designated a WHO Collaborating Centre for Research and Training in Mental Health. The designation is effective for a period of four years.

Since 1987, Trieste has been at the avant-garde in deinstitutionalization and community mental health services in Italy and Europe and has become a point of reference for the deinstitutionalization process and development of community services. The Mental Health Department of Trieste was first designated WHO Collaborating Centre in 1987 and for over 30 years it has been developing activities and providing support to numerous countries in all continents.

In 2005, the Mental Health Department of Trieste was designated Lead Collaborating Centre for Service Development in the framework of WHO-Euro Helsinki Declaration and Action Plan. It offered internship visits to a large number of European and international professionals from 28 countries.

Internships, services and seminars were offered to 47 groups, including 35 foreigners, making a total of 700 persons, during 2009. They included doctors, psychologists, social workers and medical assistants, managers, administrators, politicians, students and interns, users, family and volunteers associations, social cooperatives from the following countries: Italy, Greece, Great Britain, Norway, Finland, Sweden, France, Switzerland, Germany, Serbia, Ireland, Slovenia, Croatia, Portugal, Poland, Netherlands, Japan, Australia, New Zealand, USA, Brazil, Argentina, Venezuela, Colombia, Korea, Turkey, Palestine, Jordan, Iran, Malaysia.

The work-plan approved by WHO for the next four years includes cooperation for the development of local mental health services mainly in countries that have undertaken or are planning to undertake, not without difficulties, psychiatric reform processes. In particular, it will support the South American network of good practices as well as ongoing reform processes, particularly in Argentina and Brazil.

The WHO Collaborating Centre of Trieste can offer interested actors:

- Support and guidance in various countries in deinstitutionalization and development of integrated/comprehensive community mental health services: drafting of policies at the local and national level; leadership and management; implementation and development of local services networks; workforce development (multidisciplinary teams).
- Collaboration, partnership and networking with countries/areas which demonstrate the willingness and capacity to deliver community based services.
- Dissemination of Whole Systems & Recovery approaches: innovative practices in community MH (e.g. alternatives for acute care; comprehensive CMH Centres; rehabilitation, recovery & social inclusion services; deinstitutionalization & whole systems change; early intervention integrated networks; social enterprises & cooperatives technology, operation & policies).

The Training Centre in Trieste is equipped with a library and comprehensive archives open to the public, created with innovative software for interactive consultation (more than 16,000 files have already been archived). Oltre il giardino (1908-2009): historical archive, including an internet version; teleconference and videoconference equipment available; University Psychiatric Clinic with training facilities, rooms, library and free accommodation at any time for up to 1 year for about 15 trainee professionals and internees (mainly from Italy - mandatory training for psychologists; Argentina and Brazil with specific projects; other countries on demand)

The international meeting "Trieste 2010: What is 'mental health'?" (February 2010) was attended by over 1500 people from around the world and ended with the proposal to establish a Permanent Conference, under the auspices of the World Health Organization. A group of promoters therefore created an NGO called Permanent Conference for Mental Health Worldwide: Franco Basaglia. Through the International Committee, the Conference's goal is to involve actors and experiences in various countries of the world and represent their specific realities.

More information

For more information about the WHO Collaborating Centre for Research and Training in Mental Health of Trieste, visit:
http://www.triestesalutementale.it/english/index.htm

The WHO Head Quarters website provides general information on WHO Collaborating Centres at the page:
http://www.who.int/collaboratingcentres/en

Other website: http//:www.forumsalutementale.it

Contacts

The Trieste Department of Mental Health and the WHO Collaborative Centre provide technical assistance to countries wishing to initiate mental health reform processes. To learn more and to establish future collaborations, please contact:

Trieste Department of Mental Health
e-mail: dsm@ass1.sanita.fvg.it

WHO Collaborative Centre
e-mail: who.cc@ass1.sanita.fvg.it

Ugo Guarino is the author of the cover design of the brochure. Born in Trieste in 1930, painter, sculptor and graphic artist, he has actively participated since 1972 to the opening of the Trieste hospital, and the promotion of the territorial services. The paper Rainbow and the improvised workshops were the first concrete and evident signs of the patients' desire to communicate. He worked for several American galleries and participated to the artistic avant-garde of the sixties. He has published many works. In the book *Zitti e buoni! Tecniche del controllo* published by Feltrinelli in 1979, he puts together the hilarious and tragic graphic observations of his work in the hospital.

The IDEASS Programme - Innovation for Development and South-South Cooperation - is part of the international cooperation Initiative ART. IDEASS grew out of the major world summits in the 1990s and the Millennium General Assembly and it gives priority to cooperation between protagonists in the South, with the support of the industrialised countries.

The aim of IDEASS is to strengthen the effectiveness of local development processes through the increased use of innovations for human development. By means of south-south cooperation projects, it acts as a catalyst for the spread of social, economic and technological innovations that favour economic and social development at the local level. The innovations promoted may be products, technologies, or social, economic or cultural practices. For more information about the IDEASS Programme, please consult the website: www.ideassonline.org.

IDEASS

Innovation for Development and South-South Cooperation

UNDP

UNESCO

UNIFEM

World Health Organization

ILO

UNOPS
United Nations Office for Project Services

ART - Support for territorial and thematic networks of co-operation for human development - is an international co-operation initiative that brings together programmes and activities of several United Nations Agencies. ART promotes a new type of multilateralism in which the United Nations system works with governments to promote the active participation of local communities and social actors from the South and the North. ART shares the objectives of the Millennium Development Goals.

In the interested countries, ART promotes and supports national co-operation framework programmes for Governance and Local Development - ART GOLD. These Programs create an organized institutional context that allows the various national and international actors to contribute to a country's human development in co-ordinated and complementary ways. Participants include donor countries, United Nations agencies, regional governments, city and local governments, associations, universities, private sector organizations and non-governmental organizations.

It is in the framework of ART GOLD Programmes where IDEASS innovations are promoted and where cooperation projects are implemented for their transfer, whenever required by local actors.