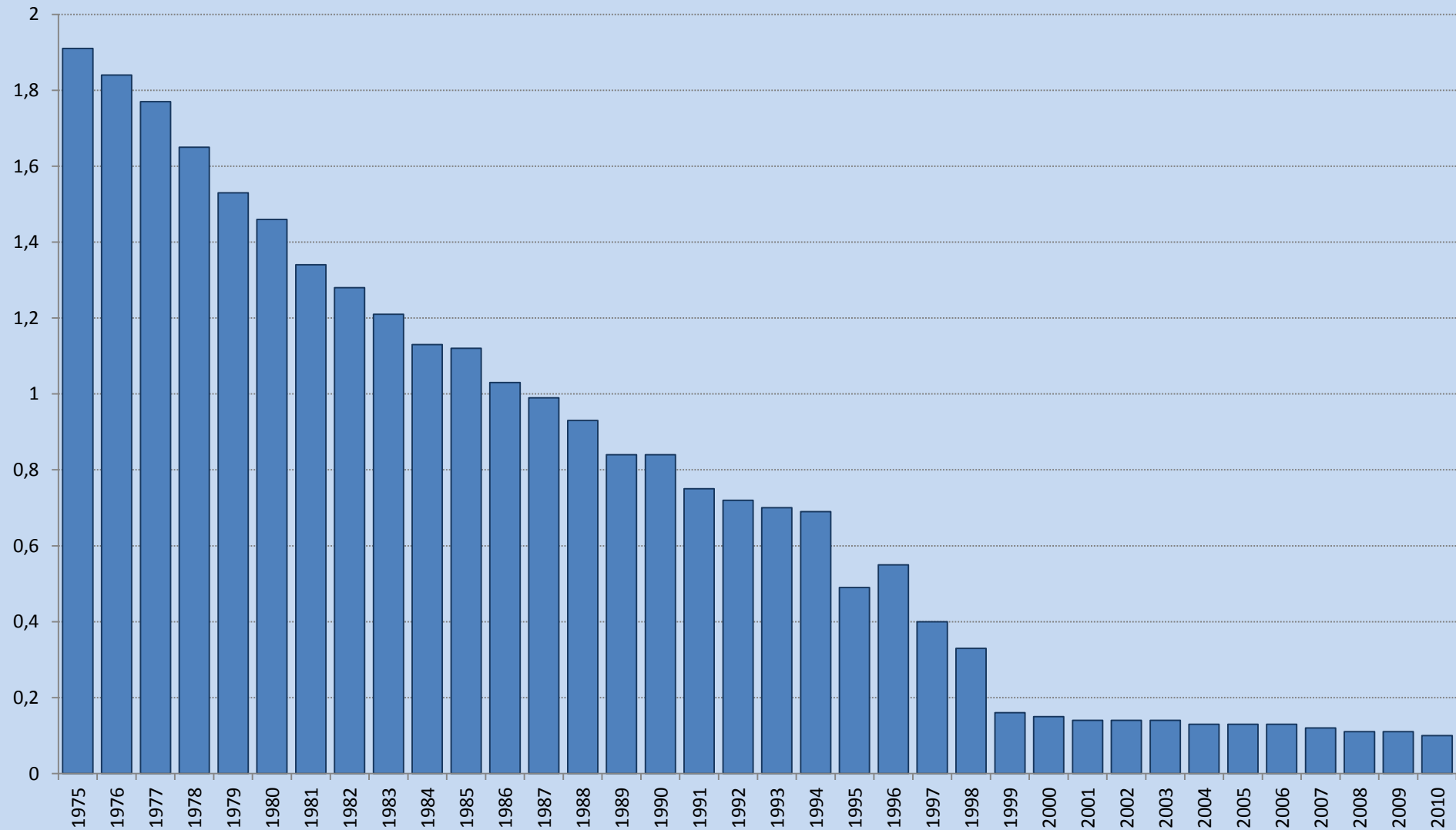


# Deinstitutionalization and community based services in Italy – the experience in Trieste

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WHOCC / MHDept., Trieste

# Number of psychiatric beds per 1 000 population – Italy 1975-2010.

Source: OECD health database



# A picture of Italy today:

## 13th of May 2013, 35 years later

- 100.000 inpatients in 1971 in PHs
- 48.000 inpatients in 1978
- All PHs closed in 2000, 22 years after the **1978 Reform Law**.

### **IT DECLARED:**

- no Phs admission, no new PHs
- community based care as a rule
- human rights focus: involuntary treatment duration reduced (1 week +) – 2 psych. to mayor
- No police / justice involved – just health protection

# Involuntary Treatment

3 major conditions under which the IT could apply:

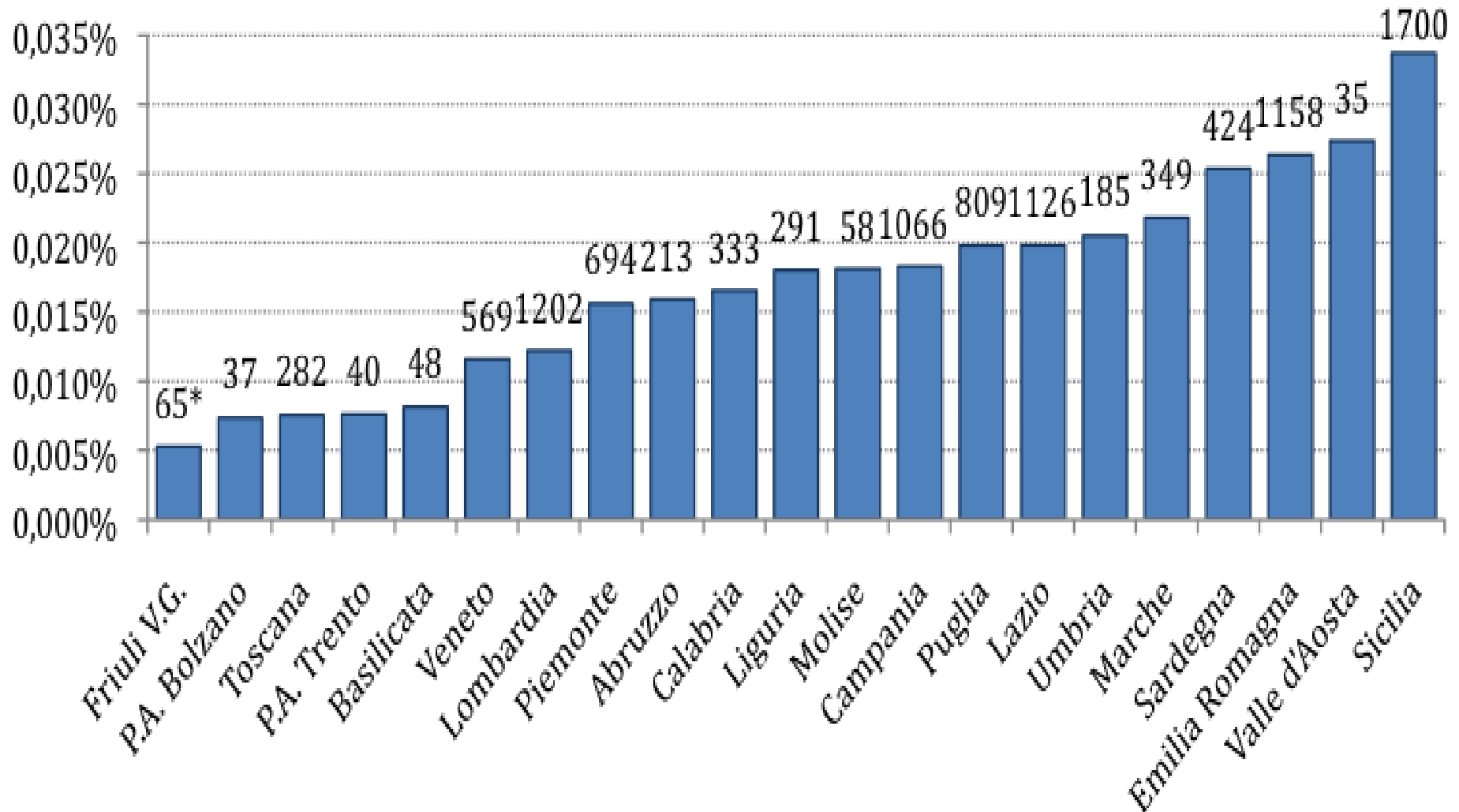
- the person is affected by some kind of mental health illness and subsequently needs urgent medical treatment;
- the person refuses to be treated;
- besides hospitalisation, there is no other timely and appropriate measure that could be undertaken to treat the person.

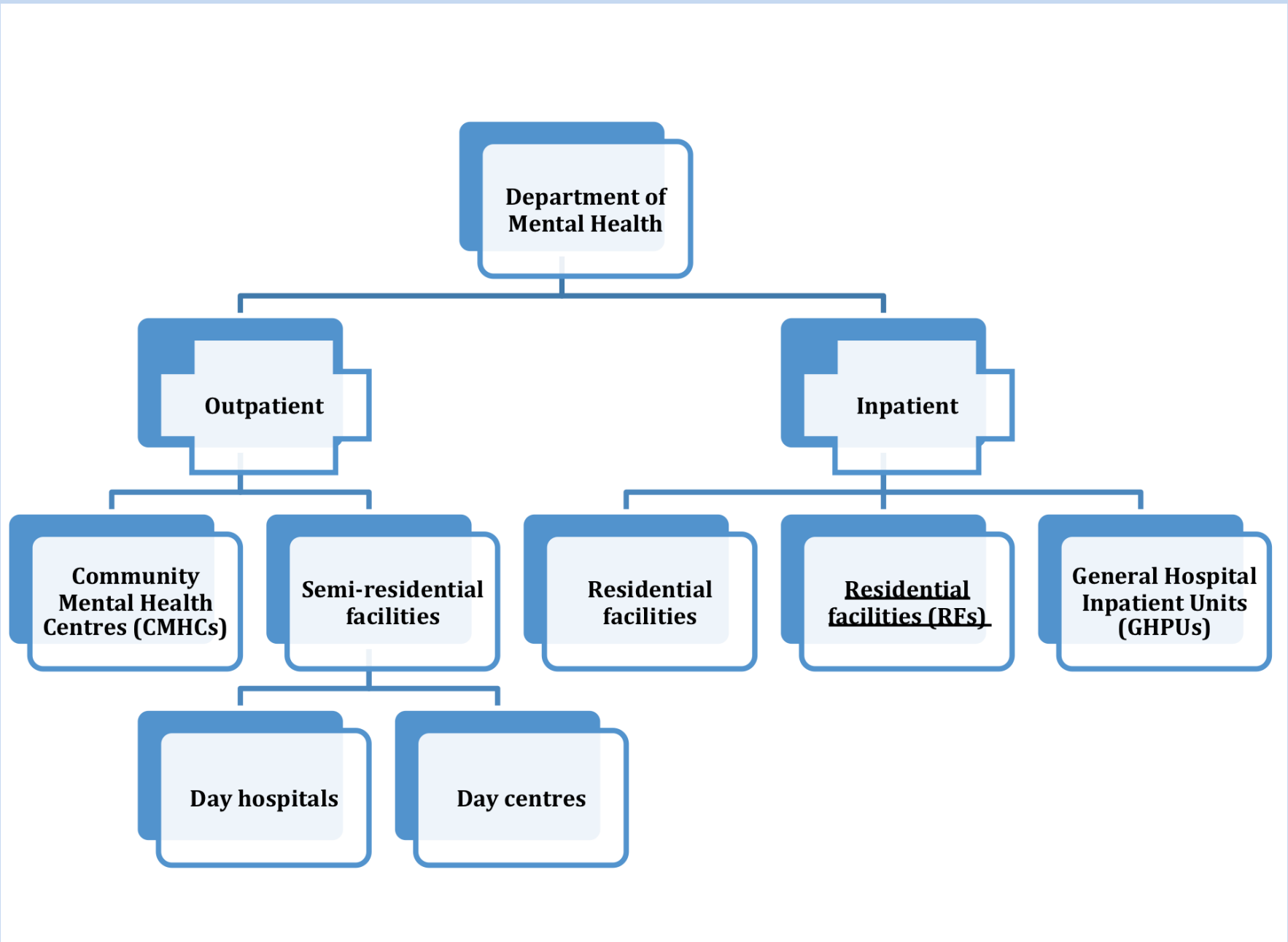
## DATA

- ITs accounted for **50% of total admissions in 1975** (3 years before the introduction of Law 180), whilst the figure dropped to 20% in 1984 and to approximately **14% in recent years** (De Girolamo et al., 2006a).

# CTOs discharge rates out of total population and total number of cases, by region – 2010

Source: MINISTRY OF HEALTH





**Department of  
Mental Health**

**Outpatient**

**Inpatient**

**Community  
Mental Health  
Centres (CMHCs)**

**Semi-residential  
facilities**

**Residential  
facilities**

**Residential  
facilities (RFs)**

**General Hospital  
Inpatient Units  
(GHPUs)**

**Day hospitals**

**Day centres**

# Mental Health Departments

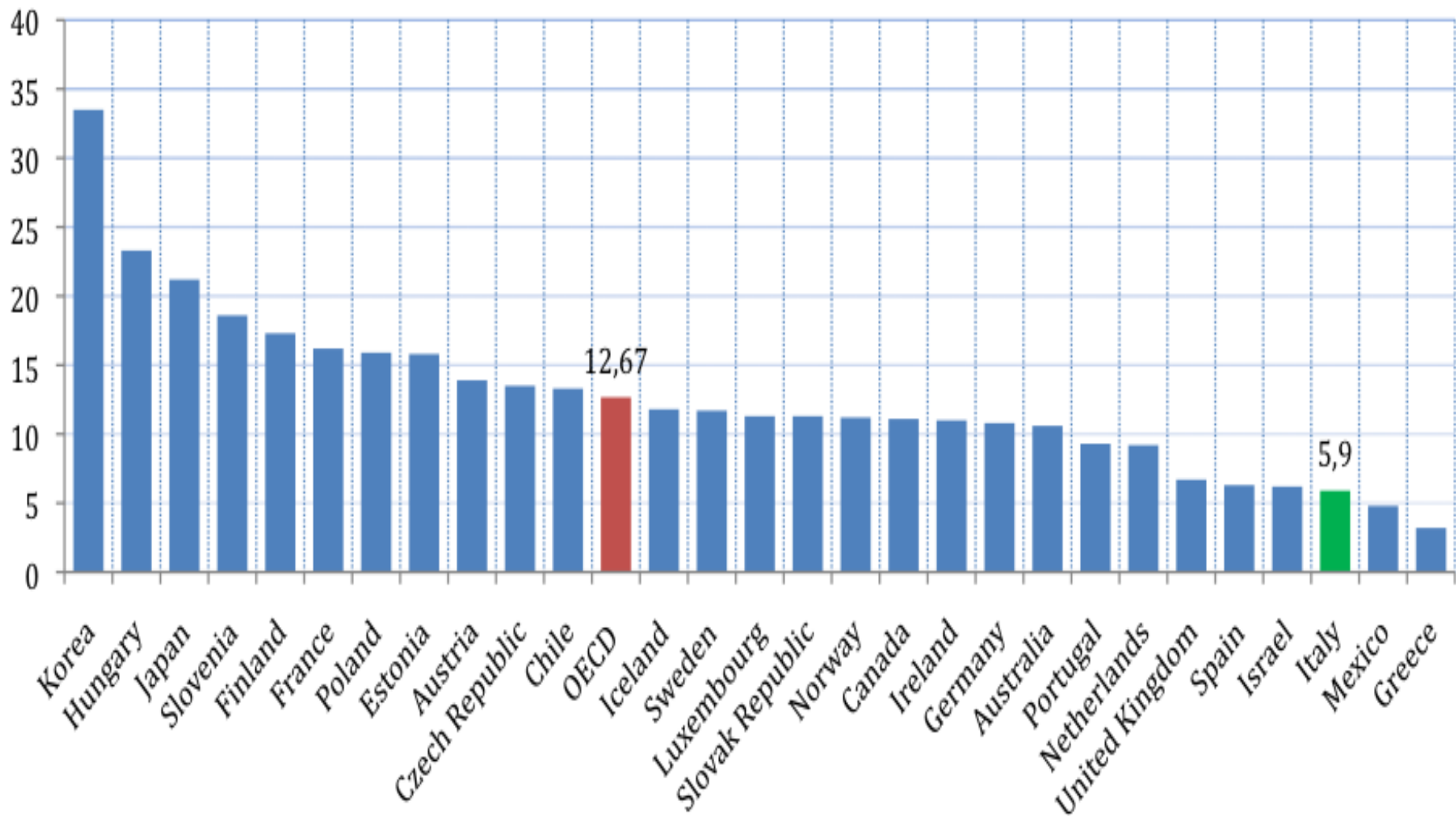
- They are rooted in areas of about 300.000 inhabitants and encompasses a number of components:
  1. Small general hospital acute units (15 beds), 1/10.000
  2. Community Mental Health Centers (up to 12hr, sometimes 24hr) 1/80.000
  3. Group-homes 2/10.000 with a wide range of support up to 24hr (17.000 beds in Italy, mostly NGOs)
  4. Day Centre (also with NGOs)

# Italy and suicide

- In 2010 there were 3 048 deaths for suicide in Italy, representing **5.1 suicides per 100 000** population (ISTAT, 2012).
- **One in three** people who committed suicide during 2010 was referred to be suffering from some kind of **mental health problem** (1 100 cases) (ISTAT, 2012).
- The suicide rate has **decreased considerably from 8.3** per 100 000 population in 1993 **to 5.1** per 100 000 in 2010.



# Suicide per 100 000 population in OECD countries, 2010 or latest available year

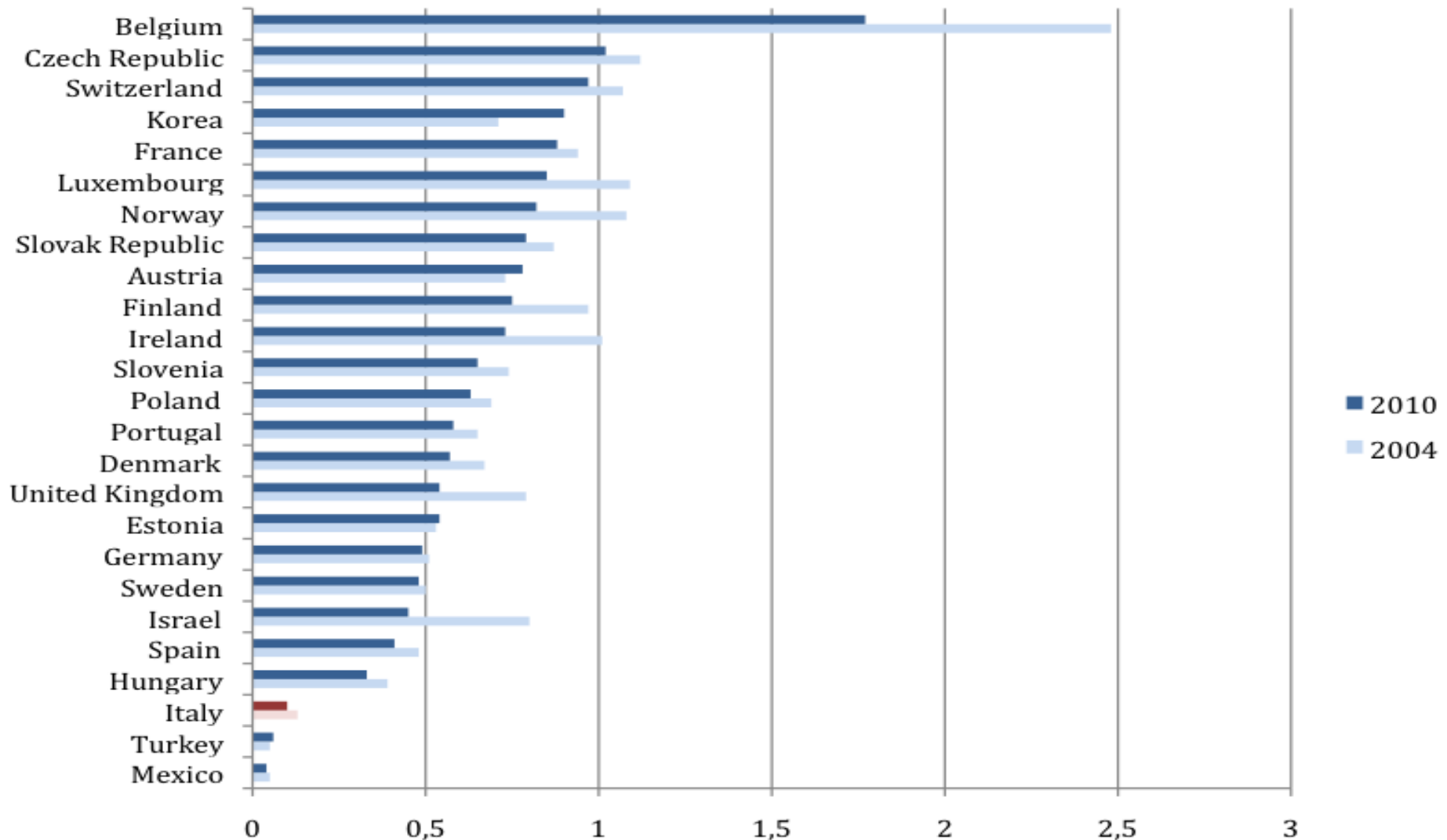


# Psychiatric beds

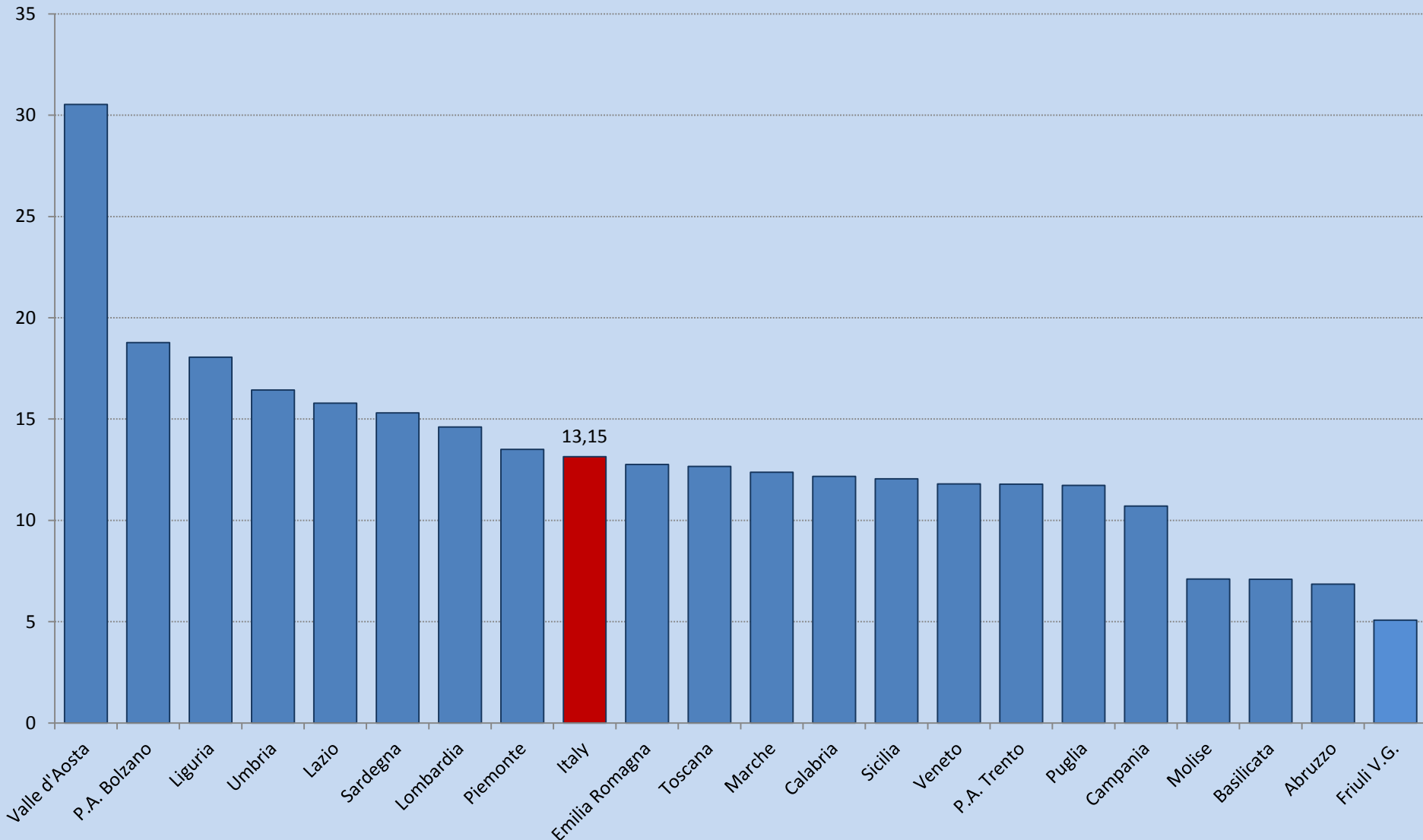
- With a rate of **1.08 total psychiatric beds per 10 000 inhabitants** (over 18) (0.97 publicly and 0.11 private accredited beds), the availability of public acute beds in Italy was slightly above the national standards in 2009 (1 bed per 10 000 population).
- Parallel to the increase of community-based mental health services, the number of psychiatric beds in Italy has **dramatically decreased** over the last 35 years, in line with the decrease in the overall number of hospital beds (OECD health database 2013).

# Psychiatric beds per 1 000 population in some OECD countries, 2004-2010.

Source: OECD health database.

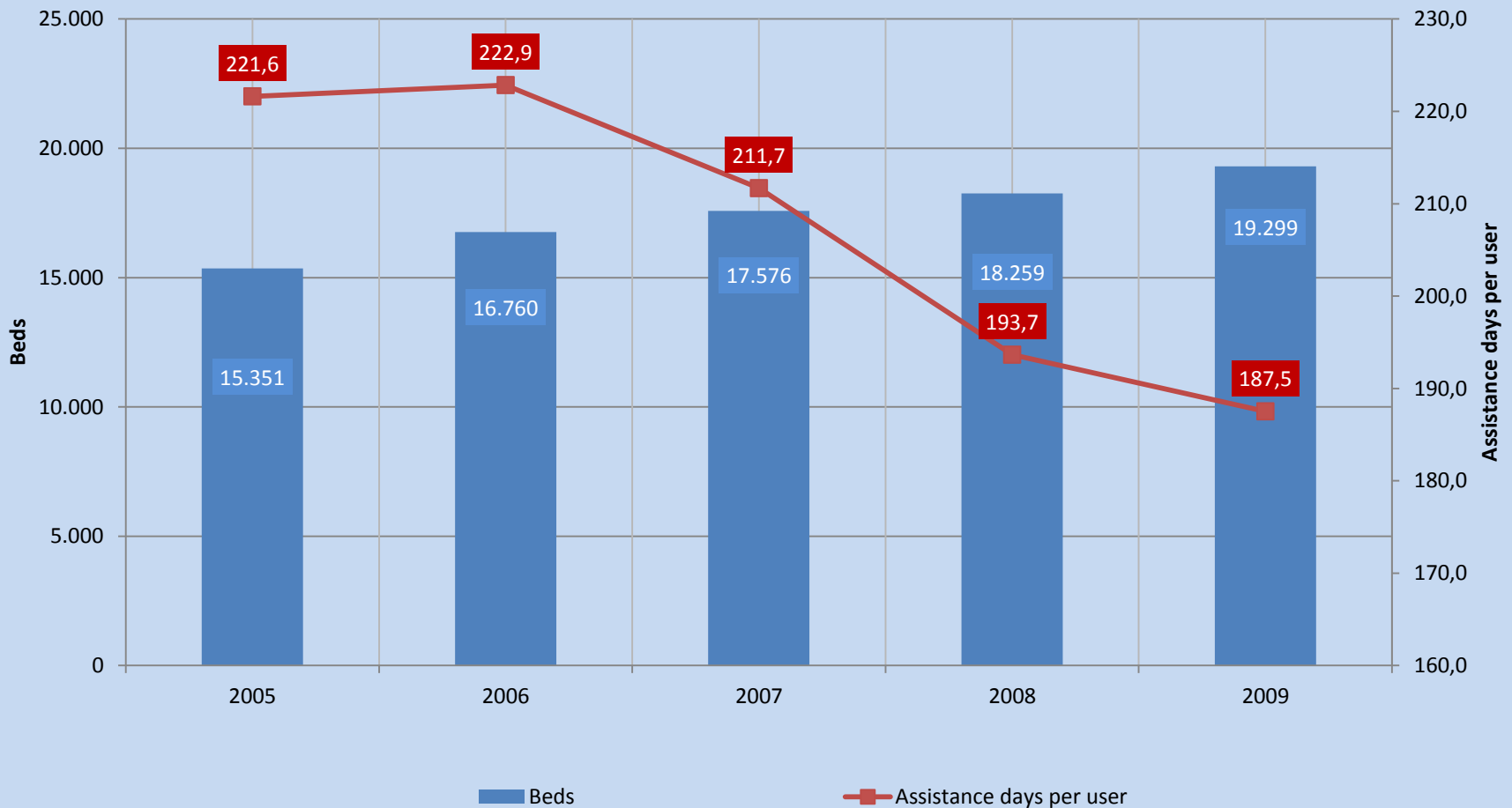


# Unplanned schizophrenia re-admission rate (< 30 days from discharge - same hospital) out of total schizophrenia discharges by region – 2010. SOURCE: MINISTRY OF HEALTH



# Number of assistance days per user and psychiatric beds provided in RFs, 2005-2009.

**SOURCE: MINISTRY OF HEALTH**



# Mental Health Care expenditure

- As most of OECD countries, overall health expenditures in Italy have unevenly increased over the last 10 years. The latest available data (2010) show that total health expenditures in Italy accounted for above EUR 130 million (OECD health database 2013), which corresponds to approximately **9% of GDP**. This is in line with the average of OECD countries.
- It was established through the Conference of Regions (*Conferenza delle Regioni*) that **no less than 5%** of the local health budget would be allocated to mental health services (WHO, 2011).

# 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 attitudes (DEMOskopea).
- Cross-cultural researches demonstrate this change in comparison with other countries (Vicente et al 1995; Roelandt et al, 2007).
- Other transnational researches demonstrated 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 anymore.
- 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.

# Key lessons from Italy

- A clear policy with **investments**
- working directly **within total institutions** – not a simple administrative 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 **comprehensive community mh centres** and services.



**TRIESTE, the icon of the reform : a town without a psychiatric hospital for 35 years.**

From total institution to a fully **community based service**, without barriers, immersed in the community, and a low threshold of access, with the highest degree of **freedom**, following the principle of a **need-based approach** and **negotiation**.



# 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.

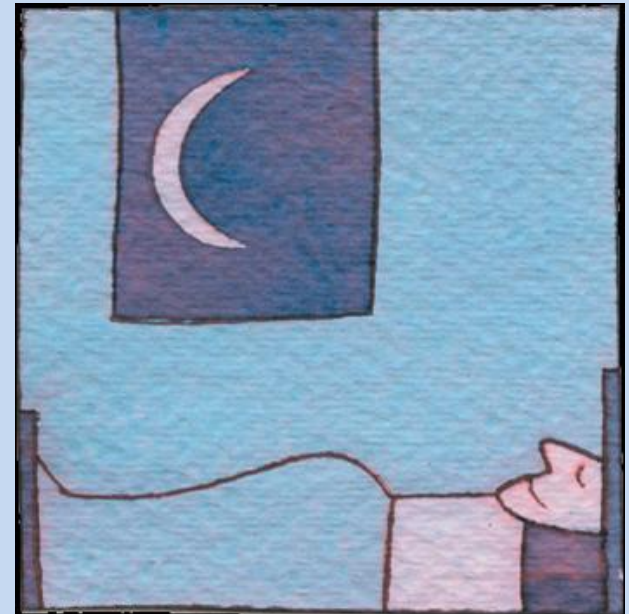
## Staff:

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



# Where are the "beds" today?

- Year 1971:
- 1200 beds in Psychiatric Hospital
  
- Year 2012:
- 78 beds of different kind in the community:
- 26 community crisis beds available 24 hrs. Mental Health Centres (11 / 100.000 inhabitants)
- 6 acute beds in General Hospital (3,5 / 100.000)
- 45 places in group-homes (20 / 100.000)



## What is a **CMH Centre**? Building an alchemy

- 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 cooperatives do **home management**
- Leisure and **daily life support** (self care; breakfast, lunch and dinner)
- And many other ordinary and extraordinary things ...



CSM DOMIO



CSM  
BARCOLA

## **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 = multidisciplinary and creativity in a whole team approach

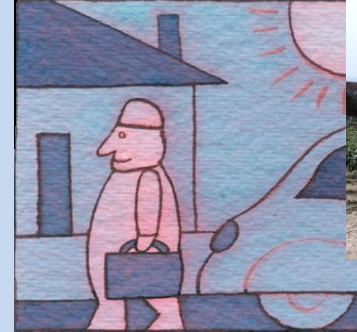
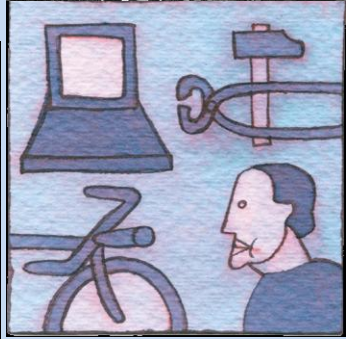
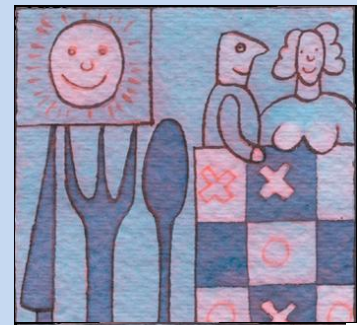
***Whole life approach = recovery and citizenship,  
person at the centre***

# 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)

# 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;
- 
- 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.





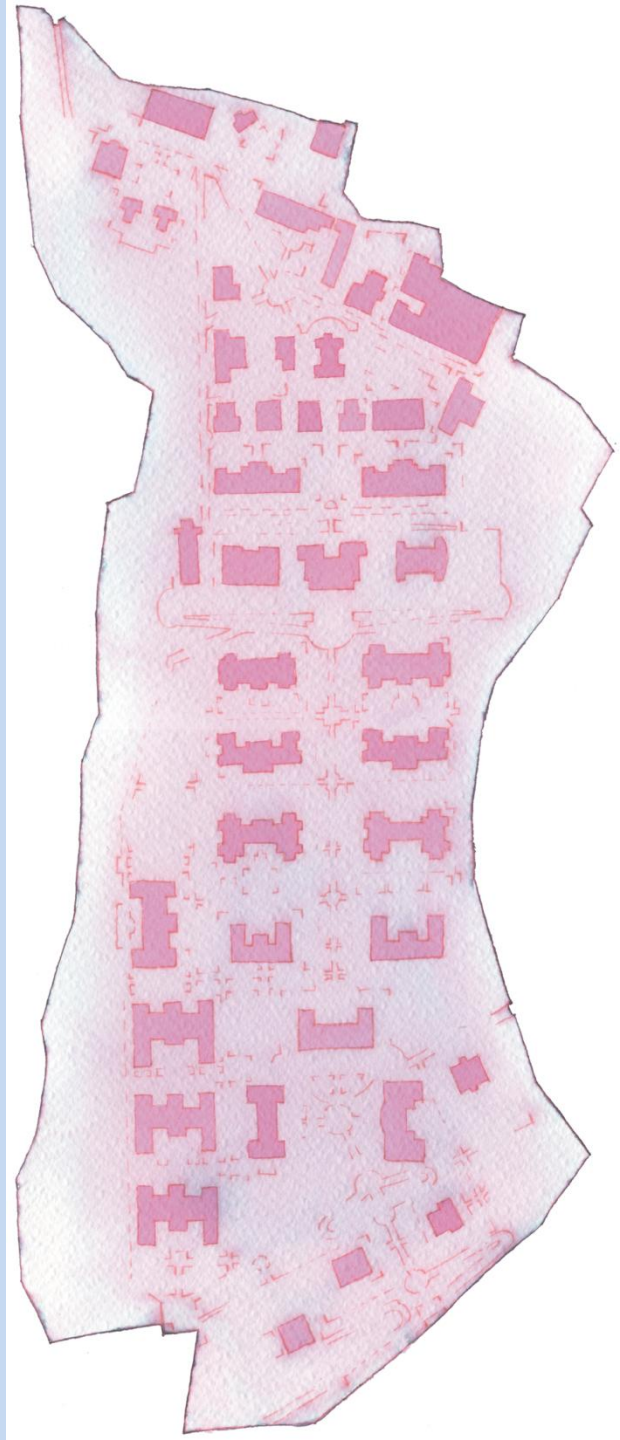
# How much does it cost?

- 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



# Costs of MHD - 2010

	Costs	%
Staff	€ 11.158.171,01	59%
Medication	€ 1.077.500,03	6%
General expenditure	€ 2.920.853,95	16%
Social expenditure	€ 956.802,88	5%
Personal Health Budget	€ 2.645.362,81	14%
Total	€ 18.758.690,68	100%



# The coops: activities in Trieste

- cleaning and building maintenance (diverse agencies)
- Canteens and catering, incl. Home service for elderly people
- Porterage and transport
- Laundry
- tailoring
- Informatic archives for councils, etc
- furniture and design
- cafeteria and restaurant services (Teatro Verdi)
- Hotel Tritone
- Front-office and call-center of public agencies
- Museums'staff
- agricultural production and gardening handicraft
- carpentry
- photo, video and radio production
- computer service, publishing trade, CD-Rom
- serigraphics
- theatre
- administrative services
- Group-homes (type A)
- Parking
- Beach(Ausonia)

# Personalised Plan (PP)

- ***PP funded by Personalised Healthcare Budget and organised along 3 axes indispensable for full social functioning and empowerment : housing, work, socialisation.***
- ***The PP accesses other services (mental health services, healthcare districts, social services) and community resources (volunteers, social coops, associations, families), and works as much as possible within the user's family, physical and social setting.***
- ***The Healthcare Agency must guarantee the quality of the PP.***

# Personalised Plan (PP)

*identifies:*

- needs/goals*
- expected results*
- interconnection of interventions*
- resources required*
- role/duties of professionals and services*
- verification (when & how)*





07/10/2008

# Conclusions

**The transformation process requires multiple levels:**

- Involvement of civil society and of all stakeholders
- Policy level
- Legislation
- Service models and practices
- Inter-sectoral change (Mainstreaming of MH at community level, not in the General Hospitals only)









# Key messages

- The deinstitutionalisation process is **not only downsizing or even suppressing psychiatric hospitals**, but undertaking a complex process of removing the ideology and power of the institution by **putting the person over the institution** with their subjectivity, needs, life story, significant relationships, social networks, social capital.
- In order to do that, it is necessary to **shift the power** in order to empower people with mental health problems, shift resources from hospitals to a range of community based services useful for his/her whole life. It opens pathways of care and programs that integrate social and health responses and actions.

- This latter means no longer managing processes for exclusion through the segregation of persons, but placing the individual at the centre of the system, with their human and social rights, and their needs, in a perspective which is **based on the person's 'whole life' and on recovery from the experience of a mental disorder.**

# From hospitalisation to hospitality

- Institutional rules
  - Institutionalised Time
  - Institutionalised (ritualised) relations:  
among workers / and with users
- Time of crisis disconnected from ordinary life
- Stay inside
- A stronger patients' role
- Minimum network's inputs

- Agreed / flexible rules
- Mediated time according to user's needs
- Relations tend to break rituals
- Continuity of care before/during/after the crisis
- Inside only for shelter /respice
- Maximum co-presence of SN

# Hospitalisation / hospitality

Difficult to avoid:

Locked doors

- Isolation rooms
- Restraint
- Violence

Illness /symptoms /body-  
brain

- Open Door System
- Crisis / life events /  
experience / problems



- **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)*