A Fresh Look at the Person-Centred Occupation Focus and Social Integration of Consumers through the Trieste Experience.

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Abstract

The mental health services in Trieste are widely recognised for their pioneering efforts in community based mental health - not only in terms of social and legislative reform but also in the therapeutic process related to deinstitutionalisation and social integration of users in the Trieste community. Occupations are used in Trieste to facilitate social integration under the motto 'no-one is normal here'. This concept is used to reinforce the psychosocial philosophies of the service that have bought mental illness into the mainstream community of Trieste.

Three final year occupational therapy students from the University of Sydney completed their fourth year fieldwork education placement with the Trieste Mental Health Services in northern Italy in the European summer of 2001. As there were no occupational therapists in this service we were fortunate to be in a position to increase our learning though interactions with a variety of other professions and enhance our inter-professional learning.

The purpose of this paper is to present the impact of our inter-professional learning in the context of our experience in the Trieste Mental Health Service. Firstly we will provide an overview of this service from our perspective's, then we will discuss how and what we learnt whilst participating in this service and finally we will raise some questions for discussion about the implications of the person-centred occupations focus of Trieste Mental Health Services and the Australian Mental Health Services and reflect on our learning as students in a unique cultural context.

Our professional understanding of occupations has been challenged and ultimately strengthened. We have seen the importance of engaging in occupations as a person - not a consumer - and how that understanding can be introduced to the client therapist relationship

The mental health services of Trieste.

Prior to being revolutionised in the 1970's, the psychiatric services of Trieste were centred in the 'Ospedale Psychiatrico', located in the Trieste suburb of San Giovanni. The service was operated under laws dating back to 1904 (Invernizzi, 1998), which attempted to isolate people with mental illness, locking them away from society in large institutions, often for life. The majority of the inmates would have the following stamped on their papers when they were admitted to the asylum: *OSPEDALE PSYCHIATRICO: Decreto di Ricovero Definitivo,* indicating that their admission to the hospital was final or definitive - they would not leave.

The early seventies saw the Institution come under the direction of Franco Basaglia, a psychiatrist who had already begun deinstitutionalising the psychiatric services in nearby Gorizia (Cohen, 1999). Basaglia's vision for Trieste was to create a service that operated outside of the institution, that was able to return inmates to mainstream society, and could assist future service consumers in the community, where they belonged without isolating them from their own society. Basaglia generated enough following for his cause to support a political party, *Psychiatrica Democratica*, which by 1978 had created enough political pressure to change the national mental health laws, resulting in the introduction of Law 180 (Invernizzi,1998; Papeschi, 1985; McCarthy, 1985). This legislation called

for the transition of psychiatric services from the institutional asylums that dominated Italian mental health to community based services, structured on the community services that Basaglia had established in Trieste.

By 1978 the services in Trieste were already famous for their pioneering anti-psychiatry approach, in fact by 1976 Basaglia was claiming that 'at Trieste we can show that we have destroyed a hospital (cited in Donnelly, 1992, p62).' Not only had he begun work that had seen service consumers returning to their community even after many years of hospitalisation, but he had also begun to change the way that the community saw the hospital itself, as the epitome of mental health (Dell'Acqua & Grazia, 1985). Destroying the hospital meant a reduction in its institutional power, and this power was returned to the service consumers by reinstating their basic human rights, allowing them to receive psychiatric care without being ostracised by their own community. Although Franco Basaglia died in 1980, his legacy continues. Law 180 is still seen as highly influential throughout Italian psychiatry and Trieste continues to be recognised as a leader in community mental health more than 20 years later (Cohen, 1999).

Our first introduction to Trieste was as third year students, completing a fieldwork placement with Mental Illness Education - Australia (NSW inc). This experience was our first in community mental health, and whilst there we were invited to attend a presentation at the Royal North Shore Hospital, by Dr Roberto Mezzina, an Italian Psychiatrist. Dr Mezzina's presentation relayed the history of the service and the revolution that it had undergone in the seventies, but also focused on how that philosophy was continued today and represented in the current services. What we saw in the presentation was a model of effective social integration, destigmatisation and deinstitutionalisation, all based on an inherent belief in the individual as a person, not as a client or a consumer, but as a person. The take home message we received that day, as students, was that there could be a different approach to mental health, and that not only could services change, but so could whole communities.

But inspiring as this was, what particularly interested us were the tools that were being used to deliver the therapeutic change, a system of therapy based on engagement in occupation. And not just any occupations - occupations that were meaningful in terms of culture, community, society and the individual. We were not shown occupations without purpose or those that are used to fill in time between other therapeutic sessions, but occupations that enabled real interaction with the community, paving the way for effective social integration. We decided then that we would be doing our fourth year fieldwork in Italy.

Trieste today.
Today the mental health services of Trieste are divided into four geographical zones, serving a total population of around 250 000 (Mezzina, Mazzuia, Borghi, & Sedmak, 2000). There is a central Direction building at San Giovanni, in the grounds of the old hospital, referred to as Ex-Ospedale Psychiatrico San Giovanni. Only some of the buildings on the grounds are now used by the mental health service, others being used by organisations such as the university and district health services. The main thrust of

service delivery takes place in the community centres, with one centre being located in each of the four zones with the exception of one zone that maintains two centres as a result of the amalgamation of two zones.

These community centres provide a range of services, including a recovery unit that provides 24 hour care, a day hospital and access to therapists including psychosocial rehabilitation workers (Mezzina, et al, 2000). New consumers, or 'users', as they are referred to in the services, are often admitted to the general hospital if the are having a crisis. However, it is not unusual for the mental health services to be informed of members of the community who may be unwell and for the services to make the first contact. If a new consumer is admitted to the general hospital they will be taken to the psychiatric ward, which is managed by the mental health services. There they will be assessed by the psychiatrist on duty and after this initial assessment will often be referred on to the community centre in their district. If the consumer is still in need of high level care they will be looked after in the recovery ward of their community centre and as there needs decrease they also have the option of utilising the day hospital. The focus is on returning consumers to the community and their homes as soon as possible.

This description of the clinical pathway is somewhat of a generalisation, and it is not meant that every consumer progresses through the services in the same way. However these services are available to all consumers, with their final pathway being tailored to their needs. All of the five community centres work in roughly the same way, although all have different atmospheres and operate in different ways, utilising different methods, programs and activities. Psychiatrists manage all the services, the rest of the staff being made up of other psychiatrists, psychologists, social workers, mental health nurses and psychosocial rehabilitation workers.

What we knew and what we have learnt.

Occupations for health versus occupations for life.
Standard occupational therapy talks about the therapeutic benefits of occupations in terms of health (Clark, Wood & Larson, 1998). As students we have learnt how to apply occupations to the therapeutic process to arrive at positive health outcomes. In this sense, occupations are a means unto an end; occupations are seen as therapeutic tools. Even in terms of an individual's roles, which can be broken down into groupings of occupations - those activities that we do to fulfil certain aspects of our lives - occupations are seen as part of a bigger whole (Hasselkus, 1998). As students we have often thought about occupation as our tool, unique to our trade - our professional cure - and our understanding of the importance of occupations in context with the whole individual allows us to make therapeutic use of them (Christiansen & Baum, 1997).

In Trieste we saw another side of occupations. Once we had begun to understand and adapt to the culture we were able to observe people in a different cultural context, and we began trying to see how they incorporated occupations into their lives (Clark et al, 1998). The biggest difference we found was that occupations are not always a means unto an

end, often they are an end unto themselves. While our prior understanding taught us that occupations are very useful for the sake of roles or health in general, the occupations that we saw in Italy were almost celebrations for their own sake - they are there to be enjoyed. Of course this has its own repercussions for health, but when we talk in terms of *meaningful occupations,* we saw a whole new cultural meaning to occupation in Trieste.

A lot of the culture centres around people and the sharing of experiences (McGruder, 1998). These experiences do not have to be complex or hugely significant, often they are simple day to day experiences that are a part of life. Everyone sitting around one great big table and sharing a meal with each other - cooking together - watching the football - lying around at the beach. Life is for the enjoying - 'being' is an integral part of 'doing'. Italians seem to find enjoyment in the actual engagement in occupation, not necessarily just the occupation itself. Meals weren't just enjoyed because the food and the wine was good, it was the actual sitting down to a meal together, being part of it that made for an enjoyable engagement in the occupation.

In this sense occupations are not just for health, they are for life. While our own Australian culture is in many ways different to Italian culture, our professional understanding of occupations is now more than just occupations for health, and engaging in occupations can be worthwhile for their own sake, and not always as a specific therapeutic tool for predetermined health goals.

Client centred versus person centred
Client centred practice has become more the norm in occupational therapy in recent years. As students we are taught that involving the consumer in the therapeutic process is often paramount to the success of the therapy. Client centred practice allows us to individualise therapy to the consumer, by providing them with the opportunity to input into the therapeutic process (Christiansen & Baum, 1997).

This is not dissimilar to a person centred approach. The main difference is that consumers are always seen as a person first, not a consumer. Working with the psychosocial rehabilitation workers allowed us to see the way in which the philosophy pervades day to day practice with consumers. Consumers are seen as people first and foremost, and some people need to access the services and they become consumers for a period - but they are still people. A focus on *people* first, as normal human beings, carries the inference of normal human rights, normal expectations and normal opportunities. *People* have normal capabilities.

Of course there is a reason why *people* become *consumers,* often defined by diagnosis, but in Trieste that reason is largely ignored, *'user'* defines a person as needing the service, not as a person with a particular type of diagnosis. A focus on diagnosis carries an inference on prognosis, limited capabilities, reduced capacity, reduced responsibility - somehow less than human - and that is seen as inferring less human rights. The consumer as a person approach gives respect and power to the consumer.

Holistic practice: Diagnosis versus function
Our understanding of occupational therapy prior to going to Trieste saw it as a holistic profession, which indeed it is compared to the reductionist nature of biomedicine (Bridge & Twible, 1997). But as holistic as we are, in Australia occupational therapists and other mental health workers still work in a reductionist atmosphere. We saw occupational therapy as working with consumers and, depending on their diagnosis, developing therapeutic programs in a consumer centred fashion that allowed them to maximise their function in a range of occupations.

The role of the psychosocial rehabilitation workers was also to maximise function, but that remained their complete focus. In the time that we were working with them, we were not told the diagnosis of one consumer. This was not because of any confidentiality issues, but because the diagnosis itself was deemed irrelevant to function. It was understood that diagnosis was dealt with by the psychiatrists whose role included stabilising consumers with medication, but beyond that diagnosis was almost discounted.

One of the psychosocial rehabilitation workers explained that although he had basic psychiatric education and understood the differences and implications of different diagnosis, he did not need that information for the majority of his work. He explained that the psychiatrists maintained the consumer's health while he maintained their functional ability. Consumers were seen in terms of their ability to function as part of their community, and their performance as such could be improved through therapy, while their diagnosis may never change.

While we can understand the importance of looking beyond the diagnosis, we do not necessarily believe that diagnosis can be completely ignored either, and that an understanding of psychiatric illnesses can provide insight into symptomatic outcomes of which can prove helpful in understanding the therapeutic process. But this raised some issues for us: how effective can you be treating an illness without a diagnosis? How holistic are you being if you resort to basing your treatment on a reductionist diagnosis? Should diagnosis be left to psychiatrists, as a definition for medication purposes only, and the rest of therapy be based on the ability of a person to perform regardless of their diagnosis?

Working *in* communities versus working *with* communities
Several of our previous fieldwork experiences have seen us working in community settings, with a focus on helping people in the community. Often this has meant working out of a community centre, reducing the need for hospital contact when consumers have needed to access the service. We have learnt the importance of working with people in their own environments and dealing with the issues that arise there. This however has often been the limit of community work, there is not always the resources to go further into the community.

During their fieldwork placement with Mental Illness Education – Australia (NSW) inc Nicole Grimberg and Jim Herbert worked with a program, which did not have a consumer focus, but instead looked at ways in which work could be done with the community beyond the consumer. This program aimed to increase the mental health literacy of the general community, enabling it as a whole to be more proactive in the care of it's mental health and to reduce some of the barriers such as stigma that can make it difficult for individuals to access services.

The mental health services in Trieste certainly work with individuals, but when they do, and especially when the individual is being returned to the community, they also look at ways of working with the community itself, to help create effective support networks for consumers as they return to community settings. Generally speaking this is in terms of psychoeducation of the community itself, from the family, friends and neighbours to other important community groups such as the police forces.

The mental health services in Trieste have a very strong focus on social inclusion. This is important if consumers are going to be accepted back into their community. One of the main tools for social integration is the Borsa program (Norcio & Baldi, 2001). A Borsa is a payment that is made to consumers that enables them to partake in progressive workplace training. Consumers who receive the Borsas are required to attend their workplace for a certain amount of hours per week, depending on the level of Borsa they receive. The goal is that they will be offered a job with their employer and move to being a regular employee.

The importance of this program is the workplace expectations placed upon consumers. While the Borsa requirements include a reduced amount of hours per week, the standard of work is expected to be of the same level as any new employee. Many of the workplaces that are used with the Borsa system are social co-operatives, profit based enterprises that need to be competitive in the market place. While accommodating to the needs of consumers, workplaces also give the same rights and responsibilities to all of their employees.

By not being given special concessions in the workplace, consumers feel that they are able to make the same contributions as anyone else and that the quality of their work is acceptable without compromise. Also, many of these workplaces are staffed with both consumers and non-consumers, allowing members of the wider community the opportunity to work alongside consumers, in an environment where they are considered equals.

HOW

How do three university students end up in an Italian mental health service for 6 weeks doing their fourth year fieldwork placement? And how exactly do they learn, and from whom, in a foreign culture, with a different language and without the direct supervision of occupational therapists?

Our learning experience really began after that initial presentation in 2000 where we first saw Dr Mezzina's presentation on Trieste. Our first step was to start researching the services, conducting literature reviews and scouring the Internet. Not only did this serve our own curiosity, but also put us into an excellent position to begin negotiations with the University of Sydney to give approval to the project. Although Nicole Grimberg and Jim Herbert were the original developers of the plan, they formed a team with four other students who were able to help with research and planning. Although the final team that left for Trieste consisted of Jim Herbert, Nicole Grimberg and Rachelle Cotterill, the planning and research stages made for an excellent opportunity to be involved in some great teamwork.

As a team we identified our own learning objectives and the methods we would use to reach them. We also tried to fill as many gaps in our own understandings of the current mental health situation in Australia, resulting in many visits to community mental health services in and around Sydney. We also had to prepare our proposal to both the Italian services and to the University of Sydney, the latter especially requiring much attention to detail such as supervision requirements, contingency plans and the general logistics of international study.

We developed our own supervision model, with a special focus on Internet supervision, a model we feel will be useful for the expansion of future fieldwork placements to remote locations. Under this model our main supervision was through Moy Dibden at the University of Sydney, with the further support of Dr Maureen Fitzgerald also of the University of Sydney and Lee Davies, an occupational therapist based in England.

Although our experience showed us where improvements could be made, the fact that we were given the opportunity to develop our own initiative gave us a sense of ownership that inspired us to make the most of our placement, to prove that we could make such a venture worthwhile. This motivation helped us to overcome some of the other barriers that we faced, particularly language and culture.

Each of the three students that went to Trieste completed at least a basic course in Italian, and so we did go with some language skills. Unfortunately these skills were only barely sufficient to get by in basic conversation, and although our Italian improved over the time we were in Italy, it was still impossible to pick up on everything that was passed in conversation. This meant that we had to rely on other skills to follow what was going on.

Also there were many things that constantly reminded us that we were in a different cultural setting, and that some things were inherently different, and profoundly so. One example of this is the average age that young people leave the family home, being in the early thirties. Not only did this surprise us, but it made us think about just how many things in life that affected, from attitudes, responsibilities, the importance of families, support networks and so on. Probably the biggest cultural lesson to be learnt, and it is a generic one, is that some things are just not equatable when you are crossing cultural barriers, and these things must be accepted and accounted for, if not always understood.

The skills that we needed to refine and use as students in this setting included observation skills, the ability to participate and be included, making the most of any opportunity to get involved in any level of discussion available and to maintain as much autonomy as possible.

Observation was a skill that we relied on heavily, as we were largely working without language. Fortunately the spoken Italian language is highly animated, even at times exaggerated which makes it an easier language to read by observing body language. But our improving body language skills have made us much better communicators, relying less on language skills and more on visual cues. This was especially important when working with some consumers who were verbally difficult to understand.

Being part of group outings, meetings, communal lunches, soccer matches - anything that we could - made it much easier for us to participate, increasing our opportunities to be active observers. Of course this also meant that we had more chance to interact with staff and consumers, but it also meant that we were accepted much sooner, even though we had little language skills we were respected for having a go and at least trying. Participating and being included allowed us to develop our language skills and we often found basic English skills in many of the people that we spoke to. This allowed us to begin forming meaningful relationships with staff and consumers alike, and as mutual language skills improved we could ask more questions, understand people better and make more sense of our observations.

Maintaining our autonomy was also essential - our needs changed often over the course of the six weeks as new questions arose and challenges were overcome. As the entire experience had been established as an exercise in self-directed learning, we felt it was necessary to maintain our independence. Establishing ourselves as independent learners brought us a certain level of respect amongst the staff and the consumers in Trieste, removing the responsibility of our learning from them. This made for more professional relationships, where we consulted with them as equals.

Another very important aspect of our learning process was the opportunity to learn from a variety of health professionals, from mental health nurses to social workers, psychologists and psychiatrists, and the unique position of psychosocial rehabilitation workers. We were fortunate enough to allow not only health professionals but also the community to be our teachers.

So was it worth it?

Undoubtably. We learnt and practiced many skills just researching and presenting a proposal to both Sydney University and the Trieste mental health services. But the real goal of the placement, to learn more about occupational therapy and mental health, was certainly achieved. Our understanding of occupations and their value in the therapeutic process has certainly been strengthened, and especially the intrinsic nature of occupations in their cultural context. We have experienced the implementation of pyschosocial philosophy in mental health services, and seen the legacy of deinstitutionalisation. We have participated in activities and programs that have introduced us to mental health

consumers as members of a community where we were able to interact as equals. We have observed the work that is done by consumers in Borsa programs, and the positive difference that that makes to social acceptance and inclusion.

We have seen a service that is dynamic enough to make radical decisions, experiment with new ideas and be influenced by a wide range of philosophies, practices and professional bodies. We have been able to learn from not only mental health professionals and consumers, but from a whole community.

Most importantly we have been actively involved in treating people like people, regardless of their health status or the social stigma that is so often attached to mental illness. We have had to work without language, where it is necessary to form meaningful relationships with consumers so that communication with real understanding can be achieved. We have seen the value in removing the concept of diagnosis from the client therapist relationship and working with the abilities of the individual to help them achieve their own personal goals. Finally we have seen the importance of creating a community environment that supports effective social integration for mental health consumers.

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