The organisation of the Mental Health Department Services in Trieste.
Brief presentation.

The current network of services in Trieste was already operational, with very few variations, in 1978, even before the new law reforming psychiatric assistance in Italy went into effect.

This network was the result of the total re-conversion of the resources of the psychiatric hospital over a nine-year period of working within the actual hospital, and which culminated in its effective and formal closure in 1980.

Today, the Mental Health Department (MHD) guarantees that the psychiatric services and emergency stations operating within the community constitute a **single organisational complex**, thereby avoiding fragmentation and shortfalls and ensuring the close **co-ordination between the services** themselves and **linkage between the community and its institutions**.

The MHD is made up of the following services:

1) **Community Mental Health Services**

2) **Diagnostic and Treatment Station (within the General Hospital)**

3) **Rehabilitation and social integration structures and services.**

The University Psychiatric Clinic is also connected to the MHD.

The staff currently consists of:

- 25 medical psychiatrists
- 170 nurses,

(as compared to 13 psychiatrists and 460 nurses in 1971).

- 10 psychologists
- 9 social workers.

Given that the Province of Trieste has a population of 250,000, there is a ratio of about
1 doctor/10,000 - 1 nurse/1,500 inhabitants.

The MHD has its own budget, which is allocated annually.
Today, the Service cost is:
ITL 23 billion per year (12 millions Euro),
as opposed to the ITL 5 billion spent by the Psychiatric Hospital in 1971 (at today's values this signifies a cost reduction of nearly 50%).

The Community Mental Health Services, or "Mental Health Centres" (MHC), are the services which are responsible for providing psychiatric assistance, each for a specific catchment area.

The MHC's work-group is composed of nurses, social workers, psychologists and psychiatrists and it can provide meals to users, either in its own facility or in subsidised public eating-places.

The MHC operates 24 hours a day, 7 days a week. During the night, the operators assist persons in crisis who are receiving overnight hospitality (8 beds).

The MHC's have the task of safeguarding the public's mental health. They represent real, practical alternatives to hospitalisation and help avoid recourse to the **Psychiatric Diagnostic and Treatment Station** (**PTDS**) within the General Hospital.

The PTDS is an emergency psychiatric service. It has **8 beds** and provides psychiatric primary care and counselling services for the other hospital wards. It also acts as a filter for the demand which arrives in the General Hospital Emergency Room, and makes referrals to the community mental health services if necessary.
If the patient arrives during the night, he/she may be kept under observation and put in contact or referred to the competent MHC the following day.

The MHC's control and manage the PTDS's activities directly and are responsible for activating the community responses as quickly as possible. Even when hospitalisation occurs, which is quite rare, it always takes place within the continuity of the community interventions being carried out by the competent MHC.
This prevents it becoming a separate intervention or, worse, an alternative to such comprehensive responses.

Even the Mandatory Health Treatments (MHT) are preferably applied in the competent MHC and not in the Hospital.

The Empowerment, Rehabilitation and Social Integration Service combines and co-ordinates structures and initiatives for the training, empowerment and rehabilitation of users, in an organic relationship with the MHC's and other MHD services.

The work of training and rehabilitation entails creating strategies, obtaining tools, activating resources, implementing practices for the development of autonomy and developing social networks and productivity for users, especially for those with serious mental health problems and disabilities, who must be considered, first and foremost, as citizens with full and equal legal and social rights.

This service articulates its interventions for empowerment among different structures and facilities, which include:

1)Residential-empowerment Structures

2)Day Centres

3)Specialised Co-operatives.

1. Residential-empowerment Structures

On the grounds of the former Psychiatric Hospital there are currently
6 residential structures which host from 3 to 12 guests each, for a total of about **55 guests**,
the majority of which are ex- long-term inmates of the Hospital itself.
3 of these structures require 24hr nursing assistance, due to the typology of the residents, while the remaining 3 require 1 or 2 nursing shifts, depending on the autonomy levels of those who live there.

There are also
6 group homes in town,
with about **50 guests**.

2. Day Centres

For users from one or more Community Service.

Their purpose is to provide a place for the development of educational/training activities, social skills and scholastic learning and for a wide variety of group activities.

They are therefore provided with computers, tools and production materials for expressive activities.

In particular, the Day Centre located on the grounds of the former Psychiatric Hospital ("The Polytechnic") has workshops for theatre, painting, graphics, ceramics, serigraphy, music, body expression, computer science, and numerous other sports, games and group activities.

The Centre is frequented by users who have not yet been placed in a work activity, and who therefore need individualised programmes aimed and stimulating and strengthening their learning, expressive, emotional and social abilities.

The Day Centres also promote the organisation of professional training courses, and recreational and scholastic activities in collaboration with public agencies and institutions, as well as other individuals or entities with specific teaching/professional abilities.

In addition to health operators, these activities **involve the participation of volunteers, escorts, teachers and professional operators from various disciplines (artists, actors, engineers, etc.).**

There is thus considerable contact with forms of professionalism and approaches and teaching methods which are very different from those generally found in health programs.

The participation of non-Service users is encouraged to promote forms of social integration and enhance the quality of the initiatives.

For several years now, “scholastic programmes” recognised by the Public Education Ministry have also been in effect. These include literacy courses for adults who have regressed or who have mental handicaps (30 persons), and remedial literacy courses which also include group and reality-orientation activities. There are also courses of 150 hours each for obtaining a junior high school diploma. These are aimed at young people who have been expelled from school or who come from areas of social marginalisation.

3. Social/integrated Co-ops.

The first co-operative, which was created in 1973 in opposition to “work-therapy”, has since been joined by ten other coops.

They provide work for nearly 200 workers (40% of whom come from disadvantaged areas) and at the same pay-scales as stipulated by current national labour contracts.

The coops, which also made use of contributions from the European Community, are aimed at starting up work projects, engaging in “enterprise” and competing in the marketplace. They especially seek to involve young people with psychiatric or substance abuse problems, or who have been marginalised in other ways.

In addition to their 200 worker-members,

the coops also provide training for at least 100 young people who work part-time (20 hours weekly) and are paid through work subsidies.

Currently, the coops are involved in 20 different sectors, including :

- **cooking and cleaning services for the MHD facilities,**
- **a small hotel, a restaurant, a bar,**
- **a catering crew,**
- **a book-bindery,**
- **a construction crew,**
- **a moving crew,**
- **a radio station,**
- **maintenance and cleaning crews for public gardens and facilities.**

The MHD also supports the job training and placement of users within the various coops by means of its own personnel and by providing for the free use of its own facilities, equipment and vehicles.

A comprehensive look at the services provided.

The MHC's actively support or provide the following range of interventions:

- TOTAL OR DAY/NIGHT HOSPITALITY, or the providing of temporary shelter in a MHC to whoever may need such assistance.

- VOLUNTARY HEALTH TREATMENT IN HOSPITALISATION CONDITIONS in the Psychiatric Diagnostic and Treatment Station (PDTS), the University Psychiatric Clinic or in other general hospital wards. Such treatment is applied only in those cases where an intervention outside of the hospital, as provided for by law, is not possible. It remains, however, under the control of a MHC.

- MANDATORY HEALTH TREATMENT, which is applied in a MHC or in the user's home or, when necessary, by hospitalisation in the PDTS.

- DAY HOSPITAL/HOSPITALITY, carried out in the MHC or in one of the Department's residential or semi-residential structures. Meals may also be included.
  Day hospitality is proposed for cases where it represents an alternative to day-night hospitality or hospitalisation, or in intensive rehabilitation programmes.

- OUT-PATIENT VISITS include the first contact and/or referral of a case; the exchange of information and opinions with the user and/or their family members; the verification of therapeutic programmes; the verification and control of drug therapies; counselling in emergency situations; examinations for medical certificates and specialised medical reports.

The purpose of HOME VISITS is to contact the user and/or his family or other persons involved; to verify and intervene with respect to living conditions; for crisis interventions, when and where possible; to administer, control and verify drug therapies; to accompany the user from his home to hospitals, public agency or elsewhere, and in order to learn more about the person's real living situation. Out-patient and home visits may be medical and/or psychological, and of an emergency or non-emergency nature.

- By INDIVIDUAL THERAPEUTIC WORK we mean repeated, programmed meetings and discussions with the user of a psychotherapeutic or counselling nature.

- By GROUP THERAPY WORK we mean programmed meetings with groups of users (including family member groups) which are therapeutic in nature or for the promotion of self-help and health education.

- By FAMILY THERAPY WORK we mean programmed meetings of a psychotherapeutic or counselling nature with the user's family members.

- INTERVENTIONS FOR THE ACTIVATION OF THE NON-FAMILY SOCIAL NETWORK are aimed at those figures which are significant for the user, such as friends, co-workers and neighbours, in order to involve them therapeutically, and for support and social integration.

- The Services carry out CONSULTANCY ACTIVITIES with all the health structures and other institutions in their area.

- The Services are required to promote SOCIAL-WELFARE INTERVENTIONS (DIRECT OR INDIRECTLY THROUGH THE ACTIVATION OF OTHER AGENCIES). These include: paying subsidies, home living support, managing residences, providing meals, overseeing, in accord with the user, the management and administration of their possessions and financial resources, managing leisure activities, day trips and holidays, social-therapeutic and group activities, etc..

- Each MHC promotes REHABILITATION INTERVENTIONS AND JOB TRAINING, PLACEMENT AND SUPPORT ACTIVITIES and provides cultural and informational access.

- With respect to rehabilitative functions, and specifically in the RESIDENTIAL area, the Services promote forms of co-habitation among users and group-homes.

Macro-indicators.

The average number of persons who contact the Services each year is :
12 per thousand.
Private structures and specialists are used by a very low percentage of the population and there has been no evidence of trans-institutionalisation.

In 1977, one year before the reform Law, the number of mandatory hospitalisations reached a high of 177.
Today, the number of **Mandatory Health Treatments** has stabilised at around **20 per year** (or **7 per 100,000**).

Turnover has increased with respect to 1971 to about **3,000 contacts annually** (as opposed to 1,600 in '71), in a total population of 250,000 (310,000 in 1971).
Users no longer come almost exclusively from marginal or disadvantaged social groups, as was the case with the Psychiatric Hospital when nearly 97% came from disadvantaged groups, but from all social classes.

There has been a **definite reduction** in the number of patients who have been referred by the Judiciary to Forensic Hospitals following a psychiatric evaluation, **from 15** such referrals in **'77** to **less than 30 total in the 20 years** following the Reform Law.

Today, there is **1** Trieste's resident interned in such a structure.

The number of suicides annually, a figure which is above the national average, has changed in the last 4 years: from an average **22** per 100,000 (1978-1997) to **17,9** per 100.000.

There has been no increase in crimes related to mental illness following the shut-down of the Psychiatric Hospital.

There are no longer requests for "internment" by family members.

Shock therapy and physical restraint were abolished at the very outset of the transformation process in the Psychiatric Hospital.

Cost for psycho-active drugs represent **0.5%** of the total budget.