MENTAL HEALTH SERVICES REPORT




Senator Lyn Allison

Chair, Senate Select Committee on Mental Health

Report of site visits and meetings in Trieste, Italy, with Dr Roberto Mezzina, Dr Peppe Dell'Acqua, Dr, Franco Rotelli and others related to the deinstitutionalisation of people with mental illness in the region.

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My visit to Trieste was hosted by Dr Mezzina; a psychiatrist and head of the Barcola Mental Health Centre (MHC) located on the seafront not far from central Trieste. I spent time at this and another MHC in a more industrial part of Trieste, visited several group homes, stayed at the Hotel Tritone which is run by a cooperative (almost half of whose employees had a mental illness), visited the former asylum, the buildings in which are gradually being refurbished for other uses including a cooperative-run restaurant and a secondary school. I also met with the head and staff of the general hospital in Trieste, toured the hospital and met with the head of health services for the region.

A brief history

Mental health reformed commenced in Italy in the early 1970s with deinstitutionalisation and provision of services in the community and in the Trieste region that reform has been particularly successful. 94% of mental health budget is spent on community-based services, health and social services are well integrated, employment rates are high, as are the functioning levels of those affected by mental illness and few with mental illness are caught up in the criminal justice system.

This success story is in no small part due to the fact that the Italian leader of the move to deinstitutionalisation – Dr Franco Basaglia - was based in the region from 1971 to 1980. There was also a strong commitment by key political figures to overcoming the profound social and health disadvantages experienced by people with mental illness through major legislative reform in 1978.

Italy is divided into 20 regions and the Trieste region - *Region Friuli-Venezia Giulia* - is one of four regional governments that have autonomy over their health and other expenditure.

It is an economic success story too. The Trieste budget for mental health services is around half that spent in 1971 at the end of a long era of routine and usually permanent institutionalisation for those with mental illness and this cost comparison takes no account of the many wider economic benefits.

In 1971 the psychiatric hospital in Trieste had 1,200 patients.

In 1974 the doors to the hospital were unlocked and patients were allowed to come and go as they wished. The hospital wall was demolished and there was a public procession of patients and staff led by a 8 foot high, blue papier-mache horse; a symbol of the fact that for so long, apart from staff, only the horse delivering laundry was permitted to leave.

Community-based mental health services, Trieste style

A significant difference between the Italian and Australian systems is that mental health services provided to people with mental illnesses are delivered by specialists in the community. GPs are not involved. The team of mental health workers at each of the community based mental health centres (MHC) is headed up by a psychiatrist but the responsibility for care is shared with psychologists, social workers and psychiatric nurses. Staff morale and commitment is high.

MHCs are in airy, open, well designed buildings with ample multi-purpose indoor and outdoor spaces. They are abuzz with activity, provide 'guest' accommodation for up to 8 people overnight or longer, as necessary, and three meals a day are served to many more. No one is turned away yet it is unusual for all beds to be occupied.

An unwell person is assessed by a mental health worker very soon after they present at the centre. All MH workers at the centre are rostered on reception duty and two psychiatric nurses are on duty overnight.

MCHs are drop in centres and provide lots of formal and informal engagement between staff and people with mental illness and their families and, importantly, with the outside world.

The eight beds in the psychiatric ward of the general hospital are used principally by those with a mental illness that also require treatment for a physical illness and are rarely fully utilised.

The commitment to deinstitutionalisation, re-engagement with community. civic rights, integration, innovation and evidence-based practice drives service delivery.

A separate consumer/advocacy sector has not evolved as it has in Australia, because services are there for people who need them and social cooperatives and work give people with mental illness a meaningful voice.The Trieste region's achievements include:

- 70% of the population now have a low threshold of access to local, 24 hour, 7 days a week clinical support including immediate assessment and attention from a mental health worker and 'guest' emergency and respite accommodation at its community mental health centres, as necessary.

- An average of only 7 per 100,000 residents are subject to involuntary treatment (and none in 2004/5 in one of the 4 areas) compared with 30 per 100,000 Italy-wide.
- ECT is no longer used
- No one with mental illness is homeless in the region
- Only 1 mentally ill person is in a forensic hospital
- Suicide rates have been reduced by 30% over the last 8 years
- 400 people with mental illness are employed on award wages in social cooperatives operating business ranging from restaurants, horticulture, gardening, the arts, museums, hotels, etc and 30% of these people are affected by psychosis. A further 200 people are employed in private firms.

Some philosophies and rationale underpinning Trieste's mental health system:

- That people must have the opportunity to be not just patients but people who are individuals with complex lives and needs
- That the social capital of relational resources of individuals, measured by trust, reciprocity, the use of the power of negotiation, political awareness and civic participation, are positively correlated with health conditions.
- That participation in society is an important indication that the person is emerging from isolation. The terms 'recovery' and 'emancipation' are used to emphasise the lack-of-freedom, the loss of rights, the denial of access to resources and the effort which must be made in order to "come back".
- That belonging to a place, or a group, can provide a sense of communality with other people's experiences.
- That the citizenship rights (political, legal, social) of an individual and the acquisition of material resources (housing, jobs, goods, services), training (living and work related) and information (psycho-education, social awareness) are all necessary for recovery.
- That people have a right to be treated with respect and dignity and to be partners with health professionals in the progress of their recovery
- That an individual's strengths and experiences must be built upon and a sense of ownership of and responsibility for their actions accepted
- That the community must openly take responsibility its own mental health problems
- Work is not so much as a goal as an instrument for recovery and emancipation and for defeating stigmatisation and a very important way out of the psychiatric 'circuit'.

Trieste's mental health services are delivered through

- Four community-based MCHs serving a catchment area of around 50,000 each with mostly short term, 'guest' accommodation for 8 people.
- A four-bed university based clinic and 8 emergency beds in the psychiatric unit of the general hospital
- No physical, structural or service restraints, even for people who are under compulsory orders.
- 237 mental health workers – 28 psychiatrists, 7 psychologists, 180 psychiatric nurses, 10 social workers and 6 psychosocial rehabilitation workers. Staff levels are set at around 1 per 1,000 residents
- Two psychiatric nurses are on duty overnight in MCHs

- Case loads for psychiatric nurses of 25 people each supported by a 'whole team' approach including daily case meetings
- Family and user associations, clubs and recovery homes.
- 12 group homes with a total of 72 beds, staffed at a range of levels according to need
- 2 day centres including training programs and workshops
- Individual projects, developed for each person engaged in MHCs, including objectives and time frames
- An open door policy
- A focus on familial relations and engagement of the family
- The engagement of clients in regular paid employment through training and ongoing support and a close working relationship with 13 accredited social cooperatives and private employers
- Services that include inpatient, outpatient and home care, individual and group therapy, psycho social rehabilitation, a GP 'health tutor' and facilitation of membership of associations and social enterprise activities
- A prison consultancy service
- Basic and professional training activities

National Government initiatives in mental health

Legislation in 1978 required the closure of psychiatric institutions which was carried out over a period of some years during which time staff in those institutions were retrained in community based clinical services and supports and patients transferred to community care once services were in place.

The national Italian government raises taxes and determines the legislative basis for service provision. Italy has 20 regional governments and Trieste is one of four regions that receive back from the national government 70% of taxes collected in the region and has autonomy over its own expenditure in health, education, transport and other services.

Overall health budgets are provided by the National government on a per capita basis with weightings for disadvantage. The percentage of that budget to be spent on mental health is not prescribed and ranges from 5% in the Trieste -province to 2% in others.

Local government provides social security services and there is a high level of integration with mental health although some tensions remain in deciding which level of government is responsible for funding some of the psychosocial supports for those with mental illness. The health budget for instance currently funds employment schemes referred to later which would normally fall to municipalities.

In the Trieste region 94% of the mental health budget is spent in community services and the balance on acute hospital beds.

By law, general hospitals can have no more than 16 psychiatric beds and there must be no more than 1 acute care bed for 10,000 inhabitants. In Trieste, the 8 psychiatric beds are in the main used by people who have a mental illness but principally require treatment for other health conditions.

Where in 1971 there were more than 100,000 patients in 75 to 80 mental health institutions, Italy with 57 million inhabitants, now has just 3,500 public psychiatric beds (with roughly the same number in private psychiatric clinics although these are largely for high prevalence disorders). A further 17,000 people with mental illness are accommodated in group homes of up to 20.

Italy has a mental health forum made up principally of family association members (carers) who look at the gap between the legislation and services.

Mental Health and the Criminal Justice System

The National Minister of Justice sets progressive goals to reduce the number of people in forensic hospitals, currently down to 2 per 100,000 residents – a total of 1,100 for all Italy.

The Trieste region currently only has one forensic patient and every effort is taken to keep people with mental illness out of the criminal justice system.

The police play a useful role in the mental health system but always in partnership with mental health teams. For consumers who are delusional, the police presence is often seen as an assurance that their rights are being protected. Police receive no special training in dealing with people with mental illness but their close working relationship with the MHC teams has ensured their responses are appropriate.

Police are often called to attend incidents but are accompanied by a mental health worker once it is established that the person concerned may be mentally ill and he or she is usually taken to the MHC in an ordinary vehicle (not a divvy van). If the person arrives at the general hospital, a worker from the MHC will attend within a very short time to assess and usually transfer the person to the MHC for accommodation and treatment, even if he or she has been charged with an offence. This avoids the need for people requiring care to be in remand if their health in that environment would further deteriorate.

The MHC team is involved at every stage, providing assessments and briefs for police and legal representatives, physically taking responsibility for the person concerned and providing treatment until they are well enough to face the charges, arranging legal representation, providing expert opinion in court and ongoing care in prison if a custodial sentence is the outcome. These situations are effectively co-managed by the legal and mental health teams

The courts consider pleas of diminished responsibility, after a psychiatric assessment is provided, and are encouraged to do so because of the presence of appropriate services in the community. These services have transformed the perception once held that a person diagnosed with mental illness is both incapacitated and dangerous, to one whereby the community is confident that services and care are in place to deal with the illness and to prevent violent incidents

According to the 1978 law, the city mayor (as the main health authority for citizens) signs treatment orders at the request of two doctors. Urban police are present, alongside mental health workers, during the administration of medication.

Social cooperatives and other employment initiatives

The genesis of Trieste's social cooperatives was in 1973 when patients, supported by health professionals, won the right to turn their "work therapy" cleaning tasks into a maintenance contract that applied union rules and salaries under a cooperative. The administration resisted this move but capitulated after a strike supported by the union. These 'inmates' became workers with jobs, salaries and rights.

In 1987 the E.E.C. Social Fund designated the cooperatives in Trieste as the reference point for the "youth at risk" vocational training projects. To the original cleaning cooperative were added four Department-initiated cooperatives with a wide range of activities, and another 10 developed independently in the community. There are now 2,500 social cooperatives across Italy.

In 1991 a national law (no. 381) was passed establishing the rules for two types of social cooperatives;Type A cooperatives provide community services such as home care, educational centres, social support, group homes, nursery schools, etc. serving for example, the elderly and those with physical or mental disability, children and adolescents, disadvantaged youth, drug addicts and people affected by AIDS. Type A cooperatives are similar in some respects to Australian NGOs and compete for service delivery contracts.Type B cooperatives operate as businesses and employ people who encounter systemic limitations or difficulties in achieving

acceptable standards in working and social life. These include those with disabilities, psychiatric service users, drug addicts, convicted people, the long term unemployed, youth at risk and immigrants.

Type B cooperatives receive individual tax exemptions for employing disadvantaged people and business tax cuts of 25%. Member-employees are paid normal wages and profits from the business must be re-invested

Every member of the cooperative has a vote on decisions and elects the executive committee.

In 2004 in the **Trieste** region there were:

- Five type A social cooperatives with 962 working members, 9 trainees and a turnover of 18.6 million euros,
- 13 type B social cooperatives with 651 working members, of which 255 (43%) were disadvantaged, 115 trainees and a turnover of 10.75 million euros
- Three consortiums: 12 workers, 1 trainees and a turnover of 1.78 million euros

Type B cooperatives conduct contracts for general administrative services, cleaning and building maintenance, canteens and catering including a service to an aged care facility, porterage and transport, laundry, tailoring, bookbinding, archives for councils, furniture and design, cafeteria and restaurant services. There is a beautifully refurbished, thriving café – Posto Delle Fragole - in one of the old asylum buildings, staffed by people who have had a mental illness where doctors, students and occupants of other 'renewed' buildings happily interact with people who were once in-patients there.

They operate hotels, provide front office and call centre services for public agencies and museum staff, are involved in agricultural production, gardening and craft, carpentry, photo and video production and run a radio station. They also provide IT services, publishing and serigraphics.Every year there are 120-150 trainees in social cooperatives and open employment, of which 30 became employees.

The indicators of rehabilitation through work include improved socialisation, self-care, family relationships, lower admission rates and less medication.The theory is that work settings should be capable of promoting and widening other fields of interest, develop worker/employer partnerships, job attachment and a sense of identity and belonging. The challenge is to overcome the passive status of being 'assisted' and to involve people as 'subjects' with their own abilities.

The Small Grants program

The European Social Fund 2000/2006 provides small grants that are used in the Trieste region to fund micro projects run by not-for-profit organisations which employ people with mental illness and other disadvantage.

The grants can be used to pay the wages of people for up to three years, purchase technological aids for people with physical handicaps, subsidise social-education interventions, purchase personal support and training services; fund the cost of obtaining a drivers license, trade or other certificate, recognise educational qualifications obtained abroad; partially fund home improvement costs and provide incentives for participating in social and integration projects.

They are also used to support self employment, business creation, productive and market diversification (new sectors and spin-offs) and process innovation for products and systems aimed at increasing employment opportunities for recipients.

During the 1st quarter of 2005, the program financed 113 projects involving 134 disadvantaged people with a financial investment of 1,136,000 euros.

Future plans

The challenge being taken up now is to bring community based mental health services to more distant communities of around 1,000 residents. The Treiste region is also exploring opportunities for expanding the deinstitutionalisation model into other health areas; to for instance establish centres of specialisation in the community for those with cancer.

The vision

A cycle is ending in Trieste and Italy. It is our hope that in the new Europe of 'citizens' (and in the rest of the world as well) the century of the asylum is about to end forever.

In our country, the mental health reform and the total closure of asylums represent the first such effort, anywhere in the world, to create effective prevention and to cope with isolation, disability, stigma and discrimination.