Trieste 50 years after: a more humane, person-centred whole system of care is now at risk.

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1. The roots

From 1961 on, in Gorizia Franco Basaglia with his team started the process of change within the local psychiatric hospital, applying his critical approach to the dominating paradigm of psychiatry, that was to ensure custody of an ill person, or of a 'sick body'. At the first International Congress of Social Psychiatry in London (Basaglia, 1964) Basaglia revealed the final objective of his work (also inspired by the Therapeutic Community of Maxwell Jones in Dingleton): "the destruction of mental hospital as a place of institutionalization and social exclusion". The practice inside the institution achieved to abolish restraint and set up an open-door policy, as well as democratization of the life in the hospital through meetings and assemblies, while a reconstruction of social links with the external world was pursued.

At the national level, a first act enforced in 1968 (the s.c. Mariotti Law) established the possibility of voluntary treatment in psychiatric hospitals as well as the opening of 'Mental Hygiene' Centres. The dismantling of psychiatric hospital from within and the creation of novel community based services (Pulino, 2017) was addressed during the 70's, by the experiences of Trieste, Perugia and Arezzo, where asylums were definitively closed. A new model of community care was therefore designed to coincide with the transformation of Psychiatric Hospitals. This is the most original contribution of the Italian experience of transforming psychiatry and approaching mental health.

Democratic mobilization and participation of civil society was important in the 70's as part of a social movement aimed at a number of reforms (abortion, divorce, the statute of workers and other civil rights). This opened the way to the enforcement of the Reform Law n. 180 of 13 May 1978, to which Basaglia contributed (Mezzina, 2018). According to Goffmann (1961), Basaglia had denounced the "anomia" of the person in the asylum, where there are suspended all constitutional rules, as a prelude to an irreversible loss of rights, and first of all of civil rights. Abolishing the equation mental disorder / dangerousness raised the issue of a new psychiatric service in (and for) the community, with new principles, stemming from citizenship rights. With the end of the asylum, the right to mental health, and the emancipation from need of the ill person, constituted a precondition for the exercise of civil liberties and the whole bundle of human rights (Piccione, 2013). The movement begun in psychiatry resonated elsewhere in Italy and abroad in the 70's and 80's. Practices of deinstitutionalization as means to realize human rights entered a range of institutional arenas, from medicine to school, to prison, to residential care homes for the elderly, to institutions for children and disabled. That is the entire ambit of welfare policies. Total institutions were all identified by this movement as the source of a culture of oppression and violation of human rights, of stigmatization and social exclusion, and must be overcome.

2. The example of Trieste

The experience in Trieste became internationally known because it was first in Europe to close its psychiatric hospital (Bennett, 1978). This paradigmatic action dismantled the whole custodial system, with its institutional norms applied on an oppressed person, the patient as 'an object of the psychiatric institution' (Dell'Acqua, 2010; Mezzina, 2020) toward the 'discovery of the person'.

The first years (1971-1974) were focused on transformation of the asylum and restitution of basic human rights for the inmates: opening of wards and gates, assemblies, reviewing the status of hospitalization in favor of the one of 'guest', decreasing the use of involuntary admissions and custodial guardianships, providing economic subsidies for the discharged, creating the first social work cooperative. This was followed by the phase (1975-1978) of the implementation of Community Mental Health Centers (CMHCs) together with the search for housing solutions for an increasing number of discharged patients (mainly group-apartments). Finally, the closure of the asylum with its total substitution by the territorial network (1978-1980) that organized CMHCs with around the clock service with beds. These have been supported by the new director Franco Rotelli as the axis of the alternative to the asylum (Gallio et al. 1983; Rotelli et al. 1986; Rotelli, 1988).
After the premature Basaglia's death on 1980, deinstitutionalization was eventually completed in the entire Italy, even if it took more than twenty years for the closure of all asylums (1978-1999) and another two decades for all large forensic hospitals (2018), overcoming huge technical and political resistances. The fall of the political dimension during the 80's in the country, the attacks on the law and the impressive number of bills attempting to change it, led to a strong defense even within the specific psychiatric field.

Trieste moved on from Basaglia's legacy also by showing that 'it was possible'. All this meant strengthening a 'service model', making factual and effective alternatives, exploring new solutions, even changing the language in a more strictly therapeutic one.

Trieste is a city with no asylum for more than 40 years so far, with a totally open door – open access system of care. It became a demonstration that is possible to act in a new way to foster recovery and social inclusion in the community, while embracing a human rights approach. The Mental Health Department became a WHO Collaborating Centre in 1987, because it was considered a sustainable model for service development with demonstration of cost-effectiveness (WHO, 2001).

In this respect, professionals, mangers, policy-makers, users and carers came in the following years from all over the world, little to see the history of Trieste, much its outcome in the present: a system of services and a different approach to care and social inclusion, as a 'demonstration site'.

The process of changing the thinking, the practice and the services have led from a clinical model - based on the illness and its treatment - to a wider concept of community mental health focused on the whole person within the community. This can be described as a full 'paradigm shift' with a number of cascading implications in terms of processes and outcomes (Mezzina, 2005).

3. The model

The organization is still based on fully accessible 24 hour CMHCs, responsible for small scale areas (about 50-80.000 inhabitants), with a few community beds in each of them, and supported by a very small General Hospital Unit that is usually by-passed. Their function is to provide a single point of entry for people living in that community area, with no selection based on severity, also involving families and social networks including all relevant institutions and services who have contacts with service users. There is a strong partnership

with NGOs / third sector (social coops, associations of stakeholders) using NHS fund provided through the Mental Health Dept, aiming at a co-produced set of responses to personal and social recovery factors (housing, work, social relationships, training) – with the use of personal budgets to art, sport, wellbeing.
The personal healthcare budget system helps to tailor individual recovery and social inclusion plans of care, entering the daily life domains especially for those with complex health and social care needs (about 150 people per year). Several social co-operatives provided place-and-train in a system of real job opportunities.
In 2019, before the unification with Gorizia mental health services, 94% of the budget of the Mental Health Department of Trieste was spent in the community (only 6% of the budget going to a 6-bed general hospital-based service that acted as an emergency first aid station at night). A clear shift from residential facilities to transitional and supported housing aimed at the highest level of independent living (Ridente and Mezzina, 2016; Zero Project, 2015). The wide range of responses included supported housing schemes for about a hundred persons; job training and placement for about 200 service users annually, with about 1/10 becoming full-time members/employees in the participating social co-ops and businesses each year; and day centers, social clubs, community agencies and associations, including sport and cultural ones, as active partners for human development and social inclusion (Mezzina, 2014).

The 25% of mental health budget directly targets a person's life (Mezzina, 2010, 2014, 2016) through personal budgets, work grants, economic aids and subsides, while total expenditure is 37% of the one of the mental hospital (prospected for today). Beyond psychiatry, the integration of mental health services in a system of healthcare districts for community based medicine (elderly, young and adolescent, disabled, specialized medicine, etc.) ensures the mainstreaming of the right to adequate healthcare.

We pointed out that the service is value and ethical based, with a whole person / whole life approach respecting human rights with no restraint and minimised use of involuntary care. As a matter of fact, involuntary treatment (TSO) figures show some of the lowest rate in Italy; TSOs are mostly managed by the CMHCs keeping open doors and without any restraint. In the whole region Friuli Venezia Giulia, just few (6) forensic beds were available in three community facilities that are managed with an open door policy. Stemming from psychiatry, a regional deliberation in 2017 proscribed mechanical restraints in all healthcare and social care facilities, including nursing homes and general hospitals.

If "freedom is therapeutic" was the original motto in the Trieste experience, nowadays it is particularly relevant that principles such as open doors, hospitality, negotiation and alternatives to coercion are embedded in the service vision and culture. Nowadays the statement 'Freedom first' (Muusse and Van Rooijen, 2015) emphasizes that personal liberty is not the outcome but a pre-condition for care which overturns control mechanisms and supersedes them with empowerment of people. Services operating within a 'practice of freedom' (Mezzina et al. 2018) recognize the need to empower all stakeholders, and ensure participation through networking, forms of co-production, cooperation and exchange. For this reason Trieste is also a human rights banner for the United Nations (OHCHR, 2018) and has been included as an example of comprehensive service network in the recent WHO Guidance for Community Mental health services promoting person-centered and human rights approaches (WHO, 2021).

This rights-based approach must be valued indeed in the prospect of "the person as a whole". We know that it can be healing as far as it "recognizes" the person, and thus refers to shared basic values of humanity, a recognition of the human commune beyond the disease. The person as such calls into question a whole life, in all its domains, with a whole system, a whole community around (IMHCN, 2018).

Besides contributing to the deinstitutionalization and reform processes in many countries over forty years and more, from Latin America to the former Yugoslavia, from Greece (especially the Leros asylum) to Palestine and Mozambique, Trieste has spread the ideas and above all the practical outcomes of the action of Basaglia and his team - overcoming the asylum and reconversion into a network of territorial services – also in the English-speaking countries, e.g. Australia, New Zealand, UK, Ireland, USA (Frances, 2021; Sashidharan, 2021). There are also many experiences to adapt the model to several contexts, from Brazil to the UK, from Sweden to Czech Republic.

The Trieste model of care in their main components (e.g. 24 hrs CMHCs, social coops, personal budgets) has been scaled up in the whole region Friuli Venezia Giulia for about 20 years so far, but also in other Italian cities and in the South of this country. Invoked by users and families as a national standard, endorsed by a Parliamentary Commission in 2013, it is anyway still contested by psychiatrists who fear to enter the open sea of community mental health – and to be accountable to a whole community. The accusation of radicalism has not been completely reversed by the practical demonstration of the feasibility of this action.

4. Current threats

While the service was still exploring a set of innovations (e.g. from 2014 to 2019, recovery house, participation committee, peer support, adolescent service with an open space for day care, open dialogue, crisis team and others), the new right-wing regional administration started to challenge both principles and organization. Even it is now a major threat, it is happening in a sneaky way, through the insecurity of institutional leadership, the impoverishment of teams, the linear cuts in services, at a time when the Covid-19 has signaled the absolute need for territorial health systems, of which mental health has been the forerunner (Mezzina et al. 2020; IMHCN, 2021).

There are now fears of a backlash over the fragile 24-hour CMHC's arrangements, with their practice based on investment 'on people', with a positive risk-taking, that resulted in open doors, accommodation of the crisis outside hospitals, recovery pathways for individuals through healthcare budgets, supported accommodations instead of residential facilities, the critical practice toward forensic seclusion. The principles mentioned before are realized by a coherent and seamless organization in which they are embedded.

There is a concrete prospect to close some of the centers, to reduce their opening from 24/7 to office hours, and take out the 'community' beds (back to hospital), to withdraw continuity of care – guaranteed by CMHC's teams - during crises. This is an attack to the heart of the system. To avoid mandatory health treatments, favoring voluntary care, as indicated by the WHO and the Italian law, it is necessary to engage people in crisis where they live, and their family members. To achieve what the law prescribes, namely the search for consent and all alternative territorial measures, requires an active attitude and not bureaucratic decisions on the part of a passive service.

Moreover, services could be 'normalized', emptied by users, carers and other citizens and become more medically orientated, while investments in the third sector, e.g. in job placement guaranteed by the social cooperatives, and in social inclusion provided through associations and their fundamental activities, could be no more guaranteed. The result could be a dramatic regression to a more traditional system, even weak and incomplete, while a new private sector can cover the gaps.

These events and concrete risks have been addressed in the last months by local and national media and the news has now rebounded on major international newspapers, such as the Independent, and in prestigious

scientific journals such as the British Medical Journal, the Lancet, the BJP and others (Day, 2021; Sashidharan, 2021; Frances, 2021).

We hope the world will help us to stop the disaster, and to keep the legacy of this great history for the future. As a symbol of community mental health movement, Trieste belongs to all.

Table - Service principles for a community centered work in mental health (Mezzina, IMHCN, 2021)

1. Internal and external integration, in the welfare system, of social and health interventions.
Hypothesis of the mental health service already integrated in the premise (see Czech Republic, Denmark etc), with social workers and managed by local authorities (however risk of cleavage from healthcare, in this case from psychiatry).
Construction of co-planning and co-management areas. It recalls the multisectoriality of the approach and interventions.

2. Mainstreaming
Integration in mental health in welfare must provide that psychiatry relates to medicine and this must take place at the level of community health or territorial medicine. Not only for CMDs but for all conditions, regardless of the level of development of secondary and tertiary care systems.

3. Co-production
Participation and empowerment of the "extended" user are expected both in the evaluation and in the programming and in the management of the services themselves.
The energies of transformation come from those who use the services for their needs. A "socialist" principle.
The participation of stakeholders reduces the weight of professionalism.
Identify what are the areas, methods, spaces of power. From information to consultation to decision making.

4. No coercion
At all levels of the imposed treatments: open door - open access - no restraint - no involuntary treatment (negative indicator).
It is counterbalanced not only by the legal aspect but by the balance of power (see co-production).
No secure beds / units etc. it means doing without institutional forms of limiting freedom. Don't foresee them a priori. And as far as crimes are concerned, to manage the contradictions of the downstream sanction within the prison.

5. No long term hospitals
The process of deinstitutionalization and closure of psychiatric hospitals, both in their acute management and chronicity aspect, is a qualifying aspect of community based care. Their coexistence invalidates the quality and radicality of the user citizen's rights statute.

6. Proximity
The services are offered in the places of life, or in the greatest possible proximity to home, as in a neighborhood service.
Person / group / network / local community / institutions / society. This is the progression from the individual to the collective and social dimension.
Community based service: small scale / accountable / responsible / accessible / mobile / flexible, not only

physically located in the community.

7. Wholistic / in every part

The approach to all aspects of life (health determinants) must provide that globality, which does not separate the disease, the disorder, from the overall existence of the person, is a principle, antithetical to biomedical reductionism, which applies to every organizational and system level, approach and intervention.

8. Ethical evidence based

The adoption of an ethical, or bioethical, or rights-based value horizon must be combined with the recognition of the person and his centrality. If this happens, once again through a passage of power, it becomes an alliance, an a priori dialogue and collaborative position, which cannot fail to influence the results (it is intrinsically therapeutic).

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