FREEDOM FIRST

A study of the experiences with community-based mental health care in Trieste, Italy, and its significance for the Netherlands
We would like to thank everybody who made this publication possible. Roberto Meggina and the other staff of the Departamento di Salute Mentale for their hospitality and cooperation to the research. Especially Christiana Sindici and Marina Schilliro, of MDHC Maddelena and Mario Goffredo, from MDHC Barcola, and of course Daniela Speh of the Community Health Department. She organised the visits and introduced us to many interview partners. We owe many thanks to all the people we spoke to working in other organisations such as the associations; the police, homeless care and the micro-areas. Their contribution to this project was very valuable. And of course a word of thanks goes out to Jan Berndsen and Niels Mulder for their enthusiasm and encouragement during the process of this project.
# INDEX

Preface ................................................................. 4

Summary of Freedom First ........................................ 6

Freedom First - Tradizione in Italiano ......................... 14

Introduction ......................................................... 22

1 The starting point: Developments in the Netherlands .... 25
   1.1 Outpatient care and community support ................. 26
   1.2 Personal recovery and social inclusion ................. 28
   1.3 Conclusion ................................................. 30

2 On the road: Description of the mental health practices in Trieste 33
   2.1 On the road: Description of the mental health practices in Trieste 35
   2.2 History of Trieste in a nutshell: beyond the institution 36
   2.3 Guiding principles ...................................... 39
   2.4 Description of the CMHC model ......................... 41
   2.5 Description of the practice in Trieste .................. 44

3 Home again: Four guiding motives .......................... 60
   3.1 From civil rights to citizenship .......................... 62
   3.2 'Freedom First' as the guiding principle .............. 72
   3.3 Value-driven action: onwards towards another professionalism 74
   3.4 Autonomy and good care ................................ 88

4 Concluding remarks ............................................. 95
   4.1 Summary and the results ................................ 97
   4.2 Connection with the health care practice in the Netherlands 100
   4.3 Summary and conclusion ................................ 106

Appendix
Appendix 1: Key figures for Trieste and background information 110
Appendix 2: Programme for family support .................. 121
Appendix 3: Treatment format .................................. 124

Literature ............................................................ 138
It is with great pleasure that we offer you this report with the striking but perhaps somewhat mysterious name: Freedom First.

In 2008, we, from Lister, first got inspired by the Trieste mental health practices. We were not the first from the Netherlands, but will certainly also not be the last. Based on the ideas of a RIBW (sheltered housing), which originally emerged as an alternative to inpatient psychiatry, we saw Trieste as the classic example of how things can be done differently - or rather, how they should be done. However, after a number of visits to our Italian colleagues, we found out that we did not clearly understand what the underlying values and principles were that their work was based on. The generally somewhat fleeting visits and also the language barrier did not help us to find the answers. For this reason, Lister, together with the European Assertive Outreach Foundation (EAOF), initiated a thorough investigation into this practice, with financial contributions from Altrecht GGZ and GGZ Breburg.

Before you lies a beautiful and expressive ‘travelogue.’ It is a view of the everyday practices in Trieste, with the good aspects of the system and also the imperfections. But it also has depth and examines the system from the anthropological angle. In this way, we hope to provide answers to all the intractable questions we received over the years about our dream that it can be different in the Netherlands. Comments include: there are many more homeless, many clients are imprisoned or in the forensic circuit, they are given a lot more medication, etc. etc. Our description of the practices in Trieste proves otherwise. Here, too, it is possible to
organise the entire outpatient and community-based mental health care with a minimum of beds. Freedom First! This is the guiding motto of the health care providers in Trieste. First and foremost, they are committed to the freedom of their clients. This is done, in the most literal sense, by the absence of psychiatric hospitals and closed wards or closed doors and, in more figurative sense, by strengthening their civil rights and supporting personal wishes and choices.

Freedom First: we have the resources and knowledge in the Netherlands, what are we waiting for! Be inspired to use this report as a basis for your work in your own practice, work that could be done differently.

Marlies van Loon en Jan Berndsen
Board of Directors, Lister
SUMMARY OF ‘FREEDOM FIRST’

Summary of the findings of the project ‘Freedom First: the de-institutionalization process in the Netherlands and the lessons learned from Trieste’.

Starting point of the project are the recent developments in the Dutch health care system. Different transitions in the Health care and funding system raise questions about how to shape this system transformation in a way that supports social inclusion and participation of service users. We went to Trieste to extract lessons from the way community based psychiatry is brought into practise. The project entailed three phases: two weeks of field research in Trieste and a counter visit of Italian workers to the Netherlands. Hereby we give an overview of the qualitative analysis we made from the material collected.

During our first visit to Trieste, we noticed how ideologically driven the employees of the mental health community centers were. When answering questions about the current practice, they time and again referred to the importance of ‘the revolution’ and the legacy of Basaglia: a humane, community-based psychiatry. We were impressed by the absence of closed wards and longstay departments. By being present all the time and by investing in the relationship with clients, the aid workers were able to handle crises without separating and closing clients in – even complex cases. Yet, we also had questions: were they using the newest insights in the treatment of chronic problems? And how about the support of the youth?

When the Italian workers visited the Netherlands, they were primarily impressed with the consumerrun initiatives, and by the utilization of peer support. But they wondered why we would promote the principle ‘Housing First’, when at the same time clients would be locked up in long-stay wards? They pleaded for ‘Freedom First’ as a guiding principle in the Netherlands. In Trieste, this is seen as a precondition for good care and recovery.

During our second visit to Trieste there was more room to discuss problematic issues, doubts and dilemmas. From these conversations it became clearer how the
guiding principles in Trieste provide a framework for the mental health care practice, even and especially in difficult situations. This applies not only to the staff of mental health services, but also to external organizations in their network such as homeless care, social work, the judiciary and even the police.

In order to understand how in Trieste the theory relates to the actual practice of mental health care, we identified three domains of 'guiding principles': the ideas, ideals and values that guide practice. We are aware that the theory is not static, but is informed by practice, through a process of continuous reflection by the teams. The three domains are:

1. **A holistic approach**: mental health care emphasizes not the disorder but the individual. There are no patients or clients, but users, 'utenti'. Social exclusion is seen as a result of the medical model with its particular language, hierarchical relations and structure. The 'relational world view' is expressed by the following:
   a. An individual's needs are assessed on the basis of his personal (his)story, which also addresses his social relations, from family to neighbourhood.
   b. In order to meet the needs of a user, personal relations between care workers and users are considered central.
   c. Services are evaluated in terms of personal routes to recovery and empowerment. To back up this idea, the community service center is open 24-7.

2. **An ecological approach**: the emphasis is on the social context, the network and the social groups to which an individual belongs. Care is offered by the community, is outreaching, proactive and accessible, and aims at social inclusion. Care workers enter into relations with the individual and his family, with housing services etc. The community center offers prevention, and basic and specialist treatment for all users in the region for which it is responsible; because of its 'territorial responsibility' for users, the community center cannot transfer patients with complex problems to other centers.

3. **A legal approach**: there is an emphasis on the civil rights of individuals with psychiatric problems, both in a legal and a social perspective. To create a community which guarantees inclusion and the possibility that everyone can exercise their social rights, a support network is essential. De-institutionalization means having individual control over one’s own route to recovery.
The care services can be depicted in rings
In the center are the community mental health centers, which are open 24/7 for intake, admission, acute psychiatry, prevention, outreach, individual and group treatment, short-term stay, family support, and medication dispensing. The first circle around this contains other mental health services. The second contains services which collaborate closely in the care within the community: social organizations, client organizations and family organizations, peer support groups. The third circle contains services such as the family physicians, homeless organizations, substance abuse care organizations (that is run by a different department so far).

Four themes relevant for the Dutch practice
The fieldwork in Trieste disclosed four themes that might be relevant for the current Dutch situation and the challenges we face:
1. From civil rights to citizenship
2. ‘Freedom First’ as the main guiding principle
3. Value-driven professional practice: toward a different kind of professionalism
4. Personal autonomy and good care

1. From civil rights to citizenship
To attain social inclusion, the focus in Trieste is on equal citizenship. This concept combines classical human rights (such as liberty and equality) with civil rights such as the right to education, employment and social security. This is done in two ways: by strengthening the position of the individual (through skills and networks) and by strengthening the ‘social fabric’ of the individual’s environment, through social corporations or anti-stigma activities. Because of the holistic approach, these two ways are intertwined organisationally and in the daily practice of workers.
The principle of ‘territorial responsibility’ means that a community centre in Trieste offers prevention as well as basic and specialised (mental health) care. This makes it possible to tackle urgent problems directly and in conjunction with each other. It also ensures continuity of care by one team and one organisation.

Citizenship as a means to attain social inclusion has also been widely discussed in the Netherlands. A possible lesson from Trieste is that the strengthening of the social
fabric should be an integral part of mental health care, along with individual support and creating personal networks. This requires a new vision on how care is organized and funded.

2. ‘Freedom first’ as the main guiding principle

Why is ‘Housing First’ a guiding principle in the Netherlands, and not ‘Freedom First’, as in Italy? For workers in Trieste de-institutionalization is not completed by transferring care to the community. Inclusion and reintegration of people, who, because of their psychiatric problems, continually deal with exclusion mechanisms in society, is an ongoing process. Apart from the legal right to freedom, the restoration of social relations is essential for recovery, and isolation by locking people up counteracts this. In Trieste it is therefore a recurring, conscious decision not to lock up people: ‘open doors’ at all time. To the Dutch policy aim to of reducing the hospital capacity and building a good support system in the community, a third mission emerges: reducing coercion in treatment, seclusion and long stay (closed doors). Shaping good ‘time-out’-facilities where people can be admitted in times of crisis, when outpatient counseling and (intensive) treatment (temporarily) is no longer sufficient, should be a focus point as well.

3. Value-driven professional practice: toward a different kind of professionalism

To the Dutch visitor it is striking that in Trieste the de-institutionalization revolution of the early 1970’s is still a common reference point for all aid workers. It creates direction and unity in language and in practice. This is done through continuous reflection in team meetings. The values underlying the de-institutionalization practice might clash with the Dutch practice in mental health, where professionalism is based on a less explicit set of values. We identified three examples where this might create tension: reflection, creativity and reciprocity in daily work.

Reflection: a pillar of the work in Trieste are the daily team meetings where the actual cases are discussed. This is the start of ‘recognizing the circular relationship between service, practice and thinking’ (Mezzina, 2014). In the meeting, workers consult each other about problems or difficulties. The team tries to connect their approach of each case with their values and goals. This reflection also involves referring to cases from the past. Every participant takes part in the collective
learning process, and it is therefore also a form of continuous professional training of the team members. This principle of reflection on the daily practice and its underlying values is in the literature sometimes referred to as ‘trialogic learning’ (where values and aims are the third party in the dialogue between workers) or normative professionalism.

**Creativity:** During our observations in the mental health care community centers, on house calls, in the team meetings and meetings with organizations as the police, we noticed that all employees often have to come up with creative solutions. For example, when there is no family to support clients living at home. The workers look at possibilities of the care system and other organizations, but also emphatically at the possibilities in the neighbourhood. People with mental health problems might live for free with an elderly person, whom they care for (a form of reciprocity, which we return to later). This creative solution makes it possible for people with chronic mental problems to stay out of longstay wards in hospitals; although in some cases this system is vulnerable for exploitation of vulnerable people. When dealing with clients in crisis, the workers at the community use what is called ‘assertive negotiation’ (Mezzina 2014). In practice, this means for instance that a psychiatrist might have to spend 6 hours of his workday to defuse a crisis. This way of working requires an open organization and space for flexibility for care workers to shape a personal relation. What happens if a user refuses medication? Answer: “Is it absolutely necessary that someone take his medication at this moment. If not, then I will return an hour later. Avoid the confrontation if possible, protocols are not leading.”

**Reciprocity:** In cultural anthropology the principle of reciprocity is described as a way to create and perpetuate equal relationships of exchange. An active giver (or professional) and a passive receiver (client) have an unequal (power) relationship. In Trieste, the creation of situations where a client who receives care or support in exchange works, or provides housing, support or something else, is intended to shape more equal relationships. This might promote the empowerment and recovery of patients. Following this line of reasoning, the next step might be to swap the attitude of professional distance for a more personal relationship. This aligns with theories for supportive recovery care.
The use of psychotherapy in Trieste is a good example of this value-driven professional practice. The professionals do not like to use protocolled interventions. They set their personalized approach diametrically against a ‘technical-methodical’ approach. At first this led to some cultural misunderstandings. To our surprise, during our first visit the Italian staff stressed that no individual psychotherapy took place. During our second visit, however, we observed that many employees and psychiatrists are trained in and deploy psychotherapeutic techniques such as cognitive behavioral therapy. But the point is that these techniques are not offered as separate interventions, but as integral to the personalized ‘project’ for a client. In interviews the psychiatrist and psychologist affirmed that they indeed use specialized techniques.

Hence, our questions about ‘methodologies’ were answered negatively, but not because they were not employed. The starting point in Trieste is that a client should not be offered a series of interventions, but that the system must conform to the life path and needs of a client. The importance of language implies that terms as ‘methodologies’ are not used. The principles of creativity, reciprocity and reflection on practice make it possible to bring ideals about good care into practise. Although the historical context in Trieste cannot be transferred to the Netherlands, the way in which Trieste has created a connection between practice and underlying values may serve as an inspiration for the Dutch practice.

4. Personal autonomy and good care

In the Dutch situation, health care is obviously also guided by several ethical principles: to not damage clients, to do good, to respect the autonomy of the client and to do justice. In practice, respect for autonomy of the client and to do good are often at odds with each other. This tension is also visible in Trieste. Here the principle to do good is linked to the pursuit of continuity of care and to a holistic approach, in which aid workers focus on all areas of a client’s life. This certainly has advantages and is often necessary, but it may in the long run also reduce the autonomy of clients. For instance, even when their psychiatric symptoms are in remission, the clients remain in care with the center eternally. This is offers protection but at the same time may prevent the clients from stepping out of their ‘client role’ and participate fully in the society.
While promoting social inclusion, some Italian employees think the community centers should look across their own fence more, and involve other partners. For instance, in the case of supported employment in paid work for clients. The boundary between good care and respect for autonomy is a dilemma in both the Netherlands and Trieste. In Trieste the pursuit of ‘good care’ sometimes seems to weigh heavier than the respect for autonomy. The organization is not provisioned at letting go of clients when they are doing better.

Sometimes criticism is voiced, mainly by users, that in the fields of recovery and peer expertise there is much to be gained. It is pointed out that in Trieste, only recently initiatives have started with recovery processes and the use of experts by experience. In the Netherlands, agitating against coercion in mental health was a binding factor for an independent client movement. In Trieste, the strong connection of user and family organizations with the Community Mental Health Centers had advantages but also a disadvantage: it prevented users from finding their own, independent voice.

The dilemma of intervening versus letting go is also visible in the Dutch health care practice. There is decidedly a group of clients that could live according to the ideal of the autonomous citizen, and another group that would need longterm support. This requires customization across the entire spectrum of care, from selfmanagement to intensive community-based care. The new care structure should be able to offer recovery-oriented care that considers the capabilities but also the limitations of individuals. Protocolled treatment pathways might hamper such customized care.

An interesting model is provided by the ‘framework of support’, developed by Trianor (1997). The model emphasizes that any reorganization of ambulatory care should not start with mental health organizations, because these will always tend to overshadow other forms of support such as general services, peer support, family support and self-help. Also, in creating alternatives to out-patient clinical care, it is important to prevent the creation of new institutions which ‘take over’ in all areas of life, even though they might do this in a way directed at recovery. Any organization should facilitate the easy scaling-up of care as well as the phasing out of care, so that both the principles of autonomy and good care can be put into practice.
The report presented here has the structure of a journey. It starts with questions surrounding the de-institutionalisation process in the Netherlands. ‘On the road’ the practice in Trieste is described. Central was the question which lessons we can learn from the process that has taken place there. What can we conclude back home? We described a practice with a radically different approach. Most prominent is the connection made in Trieste between daily practise and underlying values, and the strong emphasis on a human right approach. Trieste has gone through a specific historical development, at a time when there was room for change. Within the Dutch context it is important to look at the specific circumstances and developments taking place here, if we want to implement a number of principles as described above. In the Netherlands we see a growing support for an ambulantory organization of care (community based F-ACT teams), but also for recovery orientated care. The experiences in Trieste can raise the awareness of the importance of the right-based approach and value-driven care. These values could be more central in the current discussion about ambulatory care and reduction of beds.
Riassunto dei primi risultati della ricerca qualitativa 'Freedom first' (la libertà al primo posto): il processo di smantellamento dei posti letti (deistituzionalizzazione) nei Paesi Bassi e gli insegnamenti da trarre dall'esperienza di Trieste.

Il punto di partenza della ricerca sono gli sviluppi recenti nei servizi di salute mentale nei Paesi Bassi. Diverse trasformazioni nei servizi di salute mentale - la diminuzione del numero dei posti letti negli ospedali psichiatrici e l’intensificazione dell’assistenza psichiatrica sul livello ambulatoriale - pongono delle domande sulla possibilità di realizzare questa trasformazione in una maniera che rinforza l’inclusione sociale e la par-tecipazione dei utenti dei servizi. Siamo andati a Trieste per provare di trarre insegnamenti per la situazione olandese dalla pratica dei servizi territoriali, fondata nella comunità. Il progetto consisteva di due settimane di ricerca in loco e una controvisita degli operatori Italiani ai Paesi Bassi. In questo documento proponiamo una vision delle analisi qualitative dei nostri materiali.

Durante la nostra prima visita a Trieste, abbiamo notato come gli operatori dei quattro servizi territoriali di salute mentale fossero ampiamente motivati dall’ideologia. Rispondendo alle domande sulla loro pratica attuale, hanno riferito continuamente all’importanza della ‘rivoluzione’ e l’eredità di Basaglia: una psichiatria umana e basata nella comunità. Eravamo impressionati dell’assenza di reparti chiusi e di dipartimenti di lungo soggiorno. Essendo presenti sempre e investendo nella relazione con gli utenti, gli operatori erano capaci di maneggiare le crisi senza usare camere di separazione o altre misure di contenzione o coercizione - anche nei casi complessi. Ma d’altra parte avevamo domande: utilizzavano le conoscenze recenti delle cure per i problemi cronici? E come si sta con il supporto dei giovani? Quelli sono i fattori chiave?

Quando gli operatori Italiani hanno visitato i Paesi Bassi, erano molto impressioni dalle iniziative dirette dagli utenti (consumer run) e sull’uso dei peer support
Ma si chiedevano perché noi possiamo promuovere il principio di ‘housing first’ (un progetto di supporto abitativo per i senza tetto senza condizioni in anticipo; il primo scopo è abitare, il secondo aiuto di salute mentale), mentre nello stesso tempo i clienti/utenti erano chiusi nei dipartimenti di lungo soggiorno? Hanno pronunciato l’arringa di ‘Freedom first’ come principio di guida per i Paesi Bassi. A Trieste, questo è visto come una precondizione di buona qualità delle cure e di ricoveri (recovery).

Durante la nostra seconda visita a Trieste abbiamo avuto più spesso la possibilità di dibattito sugli argomenti problematici, i dubbi e i dilemmi. Questi dialoghi hanno chiarito come i principi guida Trieste danno un quadro per la pratica nei servizi di salute mentale, perfino e specialmente nelle situazioni difficili. Questo si applica non solo per lo staff dei servizi, ma anche per le organizzazioni esterne nella loro rete come la cura per persone senza tetto, l’aiuto sociale, i processi e pure la polizia.

Al fine di capire come a Trieste la teoria si connette alla pratica attuale della cura psichiatrica, abbiamo identificato tre campi di ‘principi guida’: le idee, gli ideali e i valori che guidano la pratica. Siamo consapevoli che la teoria non è statica, ma è stata influenzata dalla pratica tramite un processo di riflessione continua dei team. Questi tre campi sono:

1) l’approccio olistico/globale: l’assistenza di salute mentale non mette l’ enfasi sulla malattia ma sulla persona e l’individuo e sulla restituzione della soggettività. Non si parla di pazienti o clienti, ma di utenti o ospiti. L’esclusione sociale è considerata come risultato del modello medico con il suo linguaggio particolare, le sue relazioni e la sua struttura gerarchica. ‘Il punto di vista relazionale’ è stato spiegato così:

a) i bisogni personali sono stati fissati sulla base della storia personale dell’utente e questi si riferiscono anche alle relazioni sociali, dalla cerchia familiare al contesto della persona;

b) per rispondere ai bisogni dell’utente, le relazioni fra operatori e utenti sono considerate come essenziali;

c) i servizi sono stati valutati secondo criteri di passi personali verso recovery e empowerment. Per sostenere questa idea, il servizio di salute mentale territoriale è aperto 24-7 ore.
2) **L’approccio ecologico:** l’enfasi è messa sul contesto sociale, la rete personale e i gruppi sociali a cui appartiene un individuo. Le cure sono offerte nella comunità, sono outreaching, pro attive accessibili e hanno l’inclusione sociale come scopo. Gli operatori si mettono in contatto con l’individuo, la sua famiglia, i servizi di alloggio, ecc. Il centro di salute mentale offre servizi di prevenzione e cure generali e specialistiche per tutti gli utenti della regione/del quartiere per cui ha la responsabilità. A causa di sua ‘responsabilità territoriale’ per gli utenti, il centro di salute mentale non può trasferire i pazienti con gravi problemi in altri centri.

3) **L’approccio giuridico:** l’enfasi è messa sui diritti umani delle persone con problemi psichiatrici, tanto dalla prospettiva giuridica quanto sociale. Per creare una comunità che garantisce l’inclusione e la possibilità che ognuno possa esercitare i suoi diritti sociali, sia necessario di creare una rete di sostegno.

**I servizi di salute mentale possono essere rappresentati come cerchi**

Nel centro si trovano i quattro centri di salute mentale che sono aperti 24/7 ore per fare il colloquio orientativo, l’ammissione, la psichiatria d’emergenza, la prevenzione, outreach, le cure individuali e in gruppo, il soggiorno breve, il sostegno delle famiglie e la distribuzione dei farmaci. Il cerchio attorno al centro consiste negli altri servizi di salute mentale. Il secondo cerchio contiene servizi che lavorano insieme per la cura nella società: organizzazioni sociali, organizzazioni di utenti e di famiglie, gruppi di peer support. Il terzo cerchio contiene servizi come il dottore della famiglia, le organizzazioni per i senza tetto e organizzazioni per i tossicomani.

**Quattro temi per la pratica olandese**

La ricerca della pratica a Trieste ha indicato quattro temi che potessero essere i fattori chiave per la trasformazione dei sistemi attuali in Olanda e per le sfide da affrontare:

1. Un movimento deidiritti civili per la cittadinanza
2. ‘Freedom first’ (prima la libertà) come il principio guida più importante
3. Una pratica basata su valori per realizzare un’altra modalità professionale
   n altro modo di professionale
4. L’autodeterminazione personale e la buona cura /cura di buona qualità

1. **Un movimento dei diritti civili per la cittadinanza**
Per realizzare l’inclusione sociale, il punto principale a Trieste è la parità civile. Questo concetto fa la combinazione dei diritti umani di base (come la libertà e la parità) e i diritti civili come il diritto di istruzione, di lavoro e reddito, dell’abitare e della sicurezza sociale. La realizzazione è fatta in due modi: rafforzando la posizione dell’individuo (tramite conoscenze e rete sociale) e rafforzando la ‘fabbrica sociale’ della cerchia/ambito dell’individuo, tramite le corporazioni o attività anti-stigma. Attraverso l’approccio olistico, questi due modi sono stati collegati a livello organizzativo e nella pratica quotidiana degli operatori. Il principio della responsabilità territoriale dà la necessità al centro di salute mentale a Trieste di offrire non solo prevenzione ma anche la cura psichiatrica di base e specialistica. Questa maniera costringe gli operatori di attaccare i problemi direttamente e congiuntamente. Questa garantisce la continuità delle cure di un solo team e una sola organizzazione.

La cittadinanza come modo di realizzare l’inclusione sociale è stata discussa molto nei Paesi Bassi. Una lezione possibile da trarre da Trieste è che il rafforzamento della fabbrica sociale dovrebbe essere una parte integrale delle cure psichiatriche, insieme con il supporto individuale e la creazione di reti sociali personali. Tutto questo richiede una nuova visione sull’organizzazione e il pagamento dei servizi di cura.

2. Freedom first come il più importante principio guida

Perché nei Paesi Bassi ’housing first’ (prima la casa/ l’abitare) é il principio guida e non Freedom first, come in Italia? Per gli operatori a Trieste la deistituzionalizzazione non può essere completa senza il trasferimento delle cure alla comunità. L’inclusione e la partecipazione delle persone che a causa di disturbi mentali soffrono continuamente di meccanismi d’esclusione nella società, sono un processo permanente. Oltre al diritto legale alla libertà, la restaurazione delle relazioni sociali è essenziale per la recovery e l’isolamento nei dipartimenti chiusi negli ospedali impedisce questo. E la ragione per cui a Trieste si prende regolarmente e consciamente la decisione di non rinchiudere le persone: sempre e dappertutto porte aperte. Per gli obiettivi olandesi di ridurre la capacità ospedaliera e di costruire un buon sistema di sostegno nella comunità, una terza missione si presenta: ridurre la coercizione nel trattamento, l’isolamento e il lungo soggiorno (con porte chiuse). Lo sviluppo di buoni servizi di ‘time out’ dove le persone possono essere ammesse durante le crisi, quando il sostegno ambulatorio e il trattamento intensivo (temporaneo) non sono più sufficienti,
dovrebbe anche essere un obiettivo principale.

3. Una pratica basata su valori per realizzare un’altra modalità professionale

Che la rivoluzione di deistituzionalizzazione degli anni 70 sia sempre un punto di riferimento abituale per tutti gli operatori nei servizi, è un contrasto sorprendente per il visitatore olandese. Questo punto di riferimento comune offre direzione e unità nel linguaggio e nella pratica, che sono realizzati attraverso delle riunioni di riflessione nei team. I valori che sono alla base della pratica di deistituzionalizzazione potrebbero contraddistinguere la pratica olandese di cure psichiatriche, dove il professionismo è basato su un numero di valori meno espliciti. Abbiamo identificato tre esempi dove questa situazione potrebbe creare tensioni: la riflessione, la creatività e la reciprocità nella pratica giornaliera.

**Riflessione:** un pilastro del lavoro a Trieste sono le riunioni giornaliere dei team dove gli utenti attuali sono stati discussi. Questo è il punto di partenza del ‘riconoscimento della relazione circolare tra il servizio, la pratica e il sapere’ (Mezzina 2014). Durante la riunione, gli operatori si consultano l’un l’altro su problemi e obiettivi. Il contenuto di questa riflessione è anche il riferimento agli utenti del passato. Tutti i partecipanti prendono parte al processo collettivo di insegnamento e allora è anche una forma di training professionale dei membri del team. Il principio di riflessione sulla pratica giornaliera e sui valori di base è qualche volta menzionato nella letteratura come ‘trialogic learning’ (insegnamento trialogico, dove valori e obiettivi sono la terza parte nel dialogo fra operatori) o professionismo normativo.

**Creatività:** durante le nostre osservazioni nei servizi di salute mentale, le visite a casa, le riunioni dei team e le interviste con la polizia, abbiamo notato che tutto il personale spesso mostra delle soluzioni creative. Per esempio, quando non c’è la famiglia per sostenere gli utenti a casa. Gli operatori indagano le possibilità del cerchio familiare dell’utente e di altre organizzazioni per offrire cura, ma anche studiano con empatia tutte le possibilità nei contesti sociali. Le persone con disturbo mentale potrebbero vivere gratuitamente con una persona anziana, offrendo cure (una forma di reciprocità). Questa soluzione creativa rende possibile per le persone con problemi mentali cronici di stare fuori dai dipartimenti di lungo soggiorno degli ospedali; benché in vari casi il sistema sia sensibile allo sfruttamento di persone...
vulnerabili. Maneggiando gli utenti in crisi, gli operatori che lavorano nella comunità utilizzano un metodo che si chiama ‘assertive negotiation’ (negoziato assertivo) (Mezzina 2014). Nella pratica, questo significa per esempio che uno psichiatra dovrebbe mettere 6 ore del suo giorno di lavoro per calmare la crisi. Questo modo di lavorare richiede un’organizzazione aperta e l’opportunità di flessibilità per gli operatori per creare una relazione personale. Che cosa succede quando un utente rifiuta lo psicofarmaco? Risposta: “È veramente necessario che l’utente prenda il suo psicofarmaco in questo momento? Se no, ritornerò dopo un’ora. Evitate se possibile il confronto, i protocolli non sono dominanti.”

**Reciprocità:** Nell’ antropologia culturale il principio di reciprocità è stato descritto come un modo di creare e perpetuare delle relazioni uguali di scambio. Un elargitore attivo (o professionista) e un ricevitore passivo (l’utente) hanno una relazione (di potere) ineguale. A Trieste, la creazione di situazioni dove un utente che riceve delle cure o il sostegno e come scambio, fa un lavoro, da l’abitare, il sostegno o qualcos’altro, tende a affrontare delle relazioni più uguali. Questo potrebbe rafforzare l’empowerment e il recovery degli utenti. Seguendo questa linea di ragionamento, il passo successivo potrebbe essere scambiare l’approccio di distanza professionale contro una relazione più personale.

L’uso di psicoterapia a Trieste è un buon esempio della pratica basata su valori. I pro-fessionisti sono esitanti nell’utilizzare interventi protocollari. Mettono il loro approccio personalizzato in modo diametrale all’approccio ‘tecnico medicale’.

Prima questo ha causato dei malintesi culturali. A nostra sorpresa, durante la nostra prima visita gli operatori Italiani hanno detto con enfasi che non c’era psicoterapia individuale. Ma durante la seconda visita abbiamo visto che molti operatori e psichiatri utilizzavano delle tecniche psicoterapeutiche come la terapia cognitiva comportamentale (cognitive behavioral therapy). Ma queste tecniche non sono offerte come interventi separati ma formano parte integrale del progetto personalizzato per un utente. Nelle interviste lo psichiatra e lo psicologo hanno affermato che in effetti usano tecniche specialistiche.

Allora, nostre domande su ‘metodologia’ sono state risposte con un no, ma non perché non sono utilizzate. Il punto di partenza a Trieste è che non si dovrebbe offrire
alla persona con disturbo mentale una serie di interventi, ma che il sistema di cura dovrebbe concordare con il corso della vita e i bisogni dell’utente.

I principi di creatività, reciprocità e riflessione sulla pratica rendono possibile di praticare gli ideali sulla buona qualità delle cure. Il contesto storico a Trieste non può essere trasportato in Olanda, ma il modo in cui Trieste ha creato una connessione fra la pratica e i valori di base potrebbe essere una ispirazione per la pratica olandese.

4. L’autodeterminazione e la buona cura.

Nella situazione olandese, i servizi di salute mentale si basano anche su diversi principi etici: non causare danni ai pazienti, dare assistenza per promuovere il benessere, dare rispetto per l’autodeterminazione e l’equità (i quattro valori classici della medicina). Nella pratica il rispetto per l’autodeterminazione dell’utente e l’assistenza per il benessere sono spesso due valori di base discordanti. Questa tensione è anche visibile a Trieste. Qui il valore dell’assistenza è collegato con l’aspirazione per la continuità delle cure e l’approccio olistico, in cui gli operatori si concentrano su tutti gli aspetti della vita di un utente. Questo ha dei vantaggi e è spesso necessario, ma alla lunga potrebbe anche ridurre l’autodeterminazione degli utenti. Per esempio, anche quando i sintomi psichiatrici sono in remissione, gli utenti rimangono per sempre nei servizi del centro di salute mentale. Questo è fatto per dare protezione, ma nello stesso tempo potrebbe prevenire che gli utenti abbandonino il loro ruolo di utente e partecipino totalmente nella società. Promuovendo l’inclusione sociale, alcuni operatori italiani pensano che i centri di salute mentale dovrebbero più spesso guardare fuori dai loro limiti e coinvolgere altri partner. Per esempio nel caso di lavoro supporto per ottenere lavoro pagato per gli utenti. Il limite fra buone cure e il rispetto per l’autodeterminazione è un dilemma non solo in Olanda ma anche a Trieste. A Trieste l’aspirazione per le buone cure qualche volta sembra avere un’importanza più grave che il rispetto per l’autodeterminazione. L’organizzazione non è capace di lasciare gli utenti quando vanno meglio.

Qualche volta si incontra la critica, essenzialmente di utenti, che sul campo di recovery e esperienze dei ‘peer’, molto dovrebbe essere guadagnato. Mostrano che a Trieste solo recentemente sono delle iniziative con processi di recovery e l’uso di esperti di esperienza.

In Olanda, azioni contro la coercizione nei servizi di salute mentale fu un fattore
di collegamento per il movimento indipendente degli utenti. A Trieste, la connessione forte tra gli organizzazioni familiari e degli utenti e i servizi di salute mentale aveva dei vantaggi ma anche uno svantaggio: ha prevenuto agli utenti di trovare la loro propria voce.

Il dilemma di intervento contro lasciare è anche visibile nella pratica per la salute mentale in Olanda. Sicuramente esiste un gruppo di utenti che potrebbero vivere secondo l’ideale del cittadino indipendente/autodeterminante e un altro gruppo di utenti che avrebbero bisogno di sopporto a lungo termine. Questa situazione richiede una offerta lungo tutta la gamma di cura, a partire dall’ autogestione fino alla cura intensiva basata nella comunità. La nuova struttura di cure dovrebbe essere capace di offrire cura orientata su recovery che considera le capacità ma anche le limitazioni degli individui. Il trattamento protocollato potrebbe essere d’ intralcio a questa cura su misura. Un modello interessante è procurato dal quadro di supporto’ sviluppato da Trianor (1997). Il modello dà enfasi che alcuna riorganizzazione delle cure ambulatorie non dovrebbero incominciare con servizi di salute mentale, perché questi tendono sempre a oscurare altre forme di supporto come servizi generali, il supporto dei peer, il supporto dei familiari e self help. Anche, creando alternative per la cura ambulatoria, è importante prevenirla. Reazione di nuove istituzioni che ‘assumono’ tutti i campi della vita, comunque sia fatto in un modo orientato verso recovery. Ciascuna organizzazione dovrebbe facilitare tanto il facile scaling up la cura quanto la diminuzione dell’ intensità delle cure, purché tutti i due principi dell’ autodeterminazione e la buona cura possano essere praticati.

**Trimbos istituto**

**Traduzione in italiano: Dorine Bauduin, 2015**
INTRODUCTION

The Italian city of Trieste (236,000 residents), located in the north – on the border with Slovenia – has long been a source of inspiration for other European countries which are orienting themselves on ways to organise mental health care differently: outpatient, with a minimum number of beds and neighbourhood-oriented. The Netherlands also regularly organise working visits by managers, policy makers and professionals working in the mental health care sector. Now that, in the Netherlands, the mental health policy is more focused than before on a drastic reduction of beds, the experiences in Trieste again seem relevant.

Whereas, ever since the nineties of the last century, the government has been encouraging the reduction of the number of beds in psychiatric hospitals and replacing them with outpatient alternatives – more of this in Chapter 1 – despite all good efforts, this has barely resulted in a substantial reduction of beds. It is, therefore, all the more intriguing that Trieste succeeded, as early as the 1970s, in closing the psychiatric hospital and, in its place, introducing an outreaching community-based mental health care model. This was even done while it must be remembered that there are far fewer financial resources available in Italy and that an incentive, such as the Zorginnovatiefonds (Care Renewal Fund for the mental health sector) in the nineties in the Netherlands for mental health care, did not exist in Italy.

Nevertheless, Trieste managed, from idealistic motives, to reform the organisation of mental health care drastically and to humanize it so that clients were, in the first place, ‘citizens’ instead of patients. This was an important reason for Lister (formerly SBWU) in cooperation with GGZ Breburg, Altrecht GGZ and the European Assertive Outreach Foundation (EAOF) to commission a more detailed study of Trieste on the move towards out-patient care and community support for people with severe mental illness (SMI).

In 2014, researchers at the Trimbos Institute spent two study periods of four days each with staff from two of the four Community Mental Health Centres in Trieste and conducted extensive interviews there with staff members, clients and family members, as well as with employees of other social organisations such as social teams,
homeless care, police and the judiciary. The research was focused on the lessons we in the Netherlands can learn from the experiences in Trieste: How was the de-institutionalisation (closure of the psychiatric hospital) and the community support for people with SMI implemented there? What are the lessons learned and how can we take advantage of them to make the out-patient process successful in the Netherlands?

**Presentation of the questions**

In the coming years, many changes will occur in mental health care in the Netherlands. The Administrative Agreement of 2012 states that a third of inpatient mental health care capacity needs to be phased out in the coming years (with 2008 taken as the base year) and that there should be simultaneous investment in out-patient care. Thus, the out-patient process in mental health care has gained significant momentum. Organisations for mental health care are now faced with important questions. How can a good infrastructure of community-based outpatient care and social support be established so that clients are able to participate in society according to their abilities? How can outpatient care contribute to the recovery processes of clients? In the study, we wanted to focus on the primary core idea of out-patient care. That is that out-patient care contributes to participation and social inclusion for people with mental disorders which are, in essence, the main substantive motives behind the process of out-patient care and perhaps the most difficult tasks to accomplish (Van Hoof, 2014). In that respect, it is interesting to conduct research in Trieste, a region where, even in a much earlier stage, bed numbers were reduced on a major scale and where a change has been made to Community Mental Health Centres (CMHC). Based on this, the idea arose to conduct further research and to obtain more insight into the success factors of the out-patient care process there and what lessons can be learned with respect to the Dutch situation. Where possible, we compared some numbers and key figures on the situation in Trieste with Utrecht, a city with a somewhat similar population (316,000). For this, we refer to Appendix 1.

The report at hand has been prepared as a travelogue. Within the recovery tradition, the metaphor of a journey is often used to depict personal recovery processes. Here, we use the metaphor of the journey when seeking in ‘lessons from Trieste’ how to handle the outpatient care process in the Netherlands. We begin in Chapter 1 by
starting in the Netherlands with the developments around outpatient care and community support. Subsequently, we narrate, in Chapter 2, our trip to Trieste and we describe our findings. In Chapter 3, we are ‘back home’. In this chapter, the analysis of the material collected during the field research in Trieste is presented. What is the relevance for the situation in mental health care in the Netherlands and what conclusions can we attach to it? What values are guiding in Trieste and what connecting factors can we derive from them? We formulate a number of key issues we consider important to discuss in the Netherlands, also in connection with the question of how content and form can be given to the process of establishing outpatient care. In Chapter 5, we present the concluding remarks in connection with the developments in the Netherlands.

It is important to note that it is emphatically not the idea to become a copy of a ‘Trieste model’ – if such a model even exists. Nor do we intend to idealise it. Our goal is to utilise the experience in Northern Italy to reflect on the Dutch mental health care system. We started our journey with the question of what we could learn from the experiences in Trieste. We have come back with a number of core issues, which reveal how daily practice and underlying values are intertwined there. These values seem to be, in some ways, difficult to relate to the way in which Dutch mental health care is organised. The discussion paper which you have before you is also an invitation, when entering into the discussion on outpatient care in the Netherlands, to explicitly reflect on the values and ideals that we want to achieve in this process. We invite you to take part in the debate.
Chapter 1

THE STARTING POINT: DEVELOPMENTS IN THE NETHERLANDS
1.1 Outpatient care and community support

As of 2015, the Netherlands still have a relatively large inpatient mental health care capacity compared to other European countries. The Trend Report 2012 on mental health care stated that at least half of the mental health expenditure is spent on hospital care (Van Hoof et al, 2012). Again, the aim of bed reduction is on the agenda, including in the (recently released) Agreement ‘Bestuurlijk Akkoord’ which provided that the mental health inpatient capacity should be reduced by a third compared to 2008 and replaced by outpatient care.

The target of bed reduction in mental health care is not new and dates back to the seventies and eighties of the last century. In the seventies, there was an emerging client movement that demanded attention for improvements in psychiatry. This was a prelude to a more emphatic extramural policy by the government in the following decades. Well known is the so-called Moratorium Action in 1982, in which a committee, including the professors of social psychiatry, Trimbos and Romme, called for a freeze on construction plans of psychiatric hospitals, in order to gain time to develop alternatives. This resulted, a year later, in a Motion passed by the Lower House to postpone the construction of new psychiatric facilities. From that time on, a change was visible in the views on the design of mental health care and there was an explicit request for decentralisation and the establishment of outpatient care (see e.g. Van Hoof et al, 2012; Underhill et al, 2009). This was also reflected in the New Memorandum (Nieuwe Nota) dated 1984. In this policy memorandum on mental health, it was determined that large-scale establishments support processes of exclusion and it, furthermore, called for smaller-scale admissions facilities and substituting them for small-scale residential facilities. However, this did not lead to the desired bed reduction.

Almost ten years later, the Policy Document ‘Among Others’ (Onder Anderen, Ministry of Health, Welfare and Sport, 1993) was published and became an even more explicit argument for substitution of residential facilities for sheltered housing, the reduction and decentralisation of admissions facilities and the development of outpatient forms of mental health care. In this policy document, the term community support was first introduced, along with the guideline that mental health care should pay more attention to the needs of clients for a meaningful social and interactive life.
(Wennink, 1998). It was also indicated that, in order to achieve this, mental health care should seek cooperation with other social organisations. What was extraordinary was that, in 1993, a temporary Care Renewal Fund was established that was funded by reductions in the budgets of the psychiatric hospitals. Money from this fund could be used for projects focusing on outpatient care, case management and regional cooperation. This impulse paid off and various projects were developed for psychiatric home care, case management, vocational rehabilitation and consumer-run initiatives. There was also, apart from sheltered housing, a substantial reduction in bed capacity of 14% (Van Hoof et al, 2014).

The former extramural policy was part of a national mental health policy aimed at better coordination and integration of the various inpatient and outpatient mental health functions and the regional organisation of mental health care. An integrated administrative and regional organisation was successfully established. However de-institutionalisation did not live up to expectations. It was only in the period 1996 - 2002 that there was a temporary reduction of inpatient capacity, thanks to financial incentives from the national government, the previously mentioned, Care Renewal Fund (Van Hoof et al, 2012). After that, the pursuit of de-institutionalisation of mental health care disappeared from the policy agenda and a national policy directive was missing. In that period, clinical care again increased slightly (8% excluding sheltered housing) and can be seen as a re-muralisation. In addition, the growth of sheltered housing started booming. In 2009, the total capacity of clinical care and sheltered housing was 30% higher than in 2002 and more than 25% higher than in 1993.

The year 2010 can be marked, in retrospect, as a turning point for mental health care. The policy context changed dramatically and health insurers obtained a dominant position in the policy. Partly because of that, in 2010 the bed reduction, i.e. de-institutionalisation was put back on the policy agenda. In 2012, the government, insurers, providers and client organisations agreed to reduce the capacity of the hospital care by a third over a period of eight years and replace it with a strong emphasis on outpatient care for people with severe mental illness (SMI). Since 2010, it seems the growth of sheltered housing has been decreasing and the capacity for long-term inpatient care is stabilising, according to the Trend Report on Mental Health (Van Hoof et al, 2014), while the short-term inpatient care, in 2012, started to
decline for the first time. After decades of almost uninterrupted growth, it now seems that, fairly recently, a start is being made in bed reduction.

We can conclude, for the Netherlands, that the incentives from the national government for extramural care and de-institutionalisation have, for long periods, been much more informal than in neighbouring countries in Europe. Many people with persistent and severe mental illness ‘obviously’ had to rely on a ‘stay’ in one of the psychiatric hospitals or sheltered forms of housing. In the above, we stated that there is now much more control by insurers and the government on the reduction of inpatient capacity. The Trend Report on Mental Health (2014) talks, in this context, about major policy developments that will ensure that the care landscape will change dramatically. Incidentally, it should not go unmentioned that the vast majority of people with SMI (Severe Mental Illness) who are in mental health care – an estimated 160,000 people – receive outpatient care. The Trend Report 2012 shows that more than 35,000 people, most with long-term and severe mental health problems, receive care from a Flexible Assertive Community Treatment (F-ACT) team, which is estimated to be 15 to 20% of all people with SMI. In the future, the municipal district social teams could also have a role in this.

Nevertheless, there are still important steps to be taken. Although rehabilitation, recovery and participation are indeed becoming increasingly important as key concepts in the care of people with severe mental illness, promoting recovery and participation, however, is not easy and requires a more community-oriented mental health. With this we, namely, touch upon the core of the outpatient care process: substitution of beds is not an end in itself but is intended to contribute to personal recovery and participation. Below, we briefly outline the state of affairs, based on the Trend Report on Mental Health, and then specifically the theme report Personal and social rehabilitation of people with severe mental illness (Van Hoof et al, 2014).

1.2 **Personal recovery and social inclusion**

The above-mentioned theme report states that, in the Netherlands, there is the general wish to set up the care landscape in such a way that people with mental illness are, themselves, given the opportunity to exercise control over their lives, to tap into their own strengths and capabilities and exploit them, to function
optimally within their own social network and to participate in society in accordance with their own wishes and aspirations (p.5). It is therefore important to penetrate the processes of stagnation and to strongly stimulate personal and social recovery. It is important in this to provide space for initiatives by people themselves – such as client-driven projects and deployment of experts by experience in rehabilitation and recovery support – but also, the professional care sector should make a contribution to recovery-oriented care. Medical-psychiatric knowledge should receive a less superordinate and more supportive and subservient role in supporting recovery processes. In order to take serious follow-up steps in supporting personal and social rehabilitation of people with SMI, attention is needed for the context in which aid workers operate, as stated in the theme report. That includes the current diagnostic frameworks, other institution frameworks, the organisation of care, the social context and the system of laws and regulations. Common frameworks and procedures require more room for manoeuvre for health care providers and the facilitation of reflection and exchange of knowledge and experiences, ideas and visions. The deployment of experts by experience is indispensable.

Given the organisation of the care, there is a need for consistency and continuity, flexibility and responsiveness, and social and societal embeddedness. F-ACT (Flexible Assertive Community Treatment) is a well proven model – although not without criticism – and there is a call for a qualitative boost and scenarios for F-ACT with client-driven services and recovery-oriented support networks. The social context is obviously a determining factor in achieving personal recovery and social inclusion. Community support of care has been a major theme within the Dutch mental health care sector, but there is a need to organise a more systematic and structured approach to social engagement. This includes advocating the encouragement and facilitation of all kinds of support based on general and specialised facilities with respect to education and work.

If we examine the prevailing principles in health care policy, then this meshes well with that of recovery-orientated care. In particular, the ideas of the WMO (Social Support Act) emerge: care close to home, enhancing participation, citizenship and personal strength. This essentially provides opportunities for consumer-run initiatives, personal and social recovery. However, the caveat is the large degree of
fluidity and the absence of sufficient guarantees and financial resources. There is fear of too much emphasis on the client’s own strengths and too little investment in appropriate individual support for the most vulnerable people, as stated in the theme report. The authors propose, as one of the specific suggestions, to bring together resources from various sources (ZVW, WLZ, WMO and the Participation Act) for structural financing of more integrated, individualised support processes, as well as for peer initiatives, recovery-support networks and other facilities at the interface of care and social support. It involves supportive projects across the boundaries of various funding frameworks. The suggestion has also been made to stimulate health insurers to facilitate recovery-oriented care. Within the health care system, a product structure could be sought that better reflects recovery-oriented diagnostics and the resulting categories of supportive needs and requirements. Finally, we mention the establishment of a knowledge agenda and the facilitation of the systematic transfer of experiential and scientific knowledge concerning recovery support to municipalities and health insurers.

1.3 Conclusion
While home care, F-ACT and other forms of outpatient care have been developed relatively easily, the move towards social inclusion and participation and the creation of the necessary social support and infrastructure seem much more difficult to bring about. In order to achieve that, the cooperation is required from many parties, sectors and financiers. Although the WMO does provide a supportive framework, it is – as noted – still a somewhat voluntary framework with few guarantees. In many municipalities, social community teams have been established. Surveys, thus far, indicate that they are frequently called in for more specialist care needs and therefore have less time for promoting social inclusion and participation. At the same time, mental health care, in administrative terms, has become parcelled out over various funding frameworks and financiers and the principle of regional planning has been abandoned (Van Hoof et al, 2012). All this requires vigorous efforts by regional parties in order to provide a cohesive regional offer of facilities. Various regions are actively trying to think about a future care landscape for people with serious mental illnesses (SMI) who belong to the target group. Thus, in late 2014, a Task Force on SMI was set up in Utrecht in which community, health care providers, insurers and experts by experience take part. The guiding principle behind this is that only by joint efforts can
regional, cohesive, socially-oriented provisions be offered and can (corresponding) support networks be realised. Other regions are also hard at work orienting themselves and relevant regional partners consult with each other to discuss how they can create a new health care landscape which can meet all of the personal and social recovery needs of people with severe mental disorders. What can we learn in this regard from Trieste?
Chapter 2

ON THE ROAD: DESCRIPTION OF THE MENTAL HEALTH PRACTICES IN TRIESTE
2.1 Description of the study

As described in Chapter 1, we went in Trieste in search of lessons we can learn about the ambulatory care process and de-institutionalisation of psychiatric care now that, here in the Netherlands, we are on the threshold of major changes in the health care system. This is not with the intention to copy the Trieste model, but to see what the practice there has to offer for the challenges we face here. The study consisted, alongside of a literature review, of three periods of fieldwork:

First visit to Trieste in May 2014: in two teams over a four day period, we shadowed staff members in two mental health community centres. We spoke with case managers, rehabilitation workers, psychiatrists, a family organisation and a number of clients. We went along on home visits, spoke with addiction care and visited the crisis unit of the hospital. We talked to people from social cooperatives, visited residential facilities and attended team meetings. We noticed how ideologically driven the staff members were in their actions. When we asked about current practice, our hosts referred, again and again, to the past, the importance of the revolution and the legacy of Basaglia: humane, community-oriented psychiatry.

In practice, we saw that, also in Trieste, the reality is that there are people who face severe problems, have difficulty integrating, hang around seemingly aimlessly all day in the mental health community centre, smoking many cigarettes and drinking a great deal of coffee. This is, admittedly, not in a closed ward, but in one of the four mental health community centres. The absence of a closed section and long-stay wards impressed us. By being present and investing in the relationship and in time, it becomes possible to manage crises without closed settings, even when it comes to complex cases. But we also had a lot of questions, for example: is use is being made of new insights into the treatment of severe mental health problems and how
are young people with early psychoses supported? Initially, it was not easy to have a discussion about this: the discussions always seemed to end up being about values, while we were curious about how the employees in the mental health community centres work and deal with difficult dilemmas in practice.

Visit to the Netherlands in June 2014: 10 employees from Trieste came to the Netherlands for a four day working visit. They visited F-ACT (Flexible - Assertive Community Treatment) teams, peer support projects, projects for the homeless, Housing First, long-stay wards and assisted living projects. At a final meeting, experiences were exchanged. Here, some projects in the Netherlands were seen as inspiring by the Italians and an exchange arose about what constitutes good care and how to shape it. The Italians were especially impressed by the client initiatives and the deployment of experiential experts in the Netherlands. But there was also confusion: how is it possible that we now work with a principle such as Housing First, while, in other departments, we keep people in closed wards for long periods? They advocated 'Freedom First' as a guiding principle in the Netherlands. This is, in Trieste, seen as a prerequisite for proper care and recovery.

Second visit to Trieste in July 2014: In our second fieldwork period, more visits were made to external services such as the prison, welfare work, homeless shelters, police, judiciary and various trade unions. We had discussions with policy advisers, former managers, clients and health care providers and observed in the centres where we already knew each other rather well. Now, they seemed to have more space to also talk about the things that do not go so well, the doubts and dilemmas. Is it feasible for everyone to live independently in Trieste or would they still have to have more group homes? How can the care for people with a dual diagnosis be improved? From these discussions, it became clearer how the guiding principles of care in Trieste provide guidance and direction for actions, even – or actually, when – it becomes difficult. This is true not only for the staff of
the CMHC, but also for people who work in tertiary services, such as welfare work, the judiciary and even the police.

From this visit, the idea developed to base the analysis of the visits on a number of leading motives for the work, motives that kept coming up in these talks. These motifs are the focus of Chapter 3.

The information presented in this chapter and in Chapter 3 is based on ideas, interviews and observations during the fieldwork period in Trieste, supplemented with literature. In the analysis programme, Maxqda, the first thematic analysis was made of the collected material. The literal quotes in this report from clients and family members in Trieste are anonymous and authorised by those involved.

### 2.2 History of Trieste in a nutshell: beyond the institution

In 1978 in Italy, the Law 180 went into effect: From that moment, it was regulated by law that no new patients could be admitted to psychiatric hospitals in Italy. The hospitals were closed and replaced by ambulatory care, focusing on the socialisation of clients. In Trieste, famous for its model of democratic psychiatry, the dismantling of the traditional psychiatric hospital, San Giovanni, had already been underway for a long time. As early as 1971, they made a start here, when the psychiatrist, Franco Basaglia, came to Trieste to give shape to his ideas about psychiatry. Basaglia considered the classical psychiatric hospital to be pathogenic and wanted it replaced with a model aimed at restoring the civil rights of psychiatric patients. In Trieste, he started in the psychiatric hospital by changing the role of the patients; by no longer giving them work on a therapeutic basis, but by paying them for their cleaning work. Thus, the first social cooperative was founded. Also, physical coercion and electroshock treatments were abolished. Gradually, the clients were transferred to the community. The Psychiatric Hospital was closed in 1980 as a hospital, and a small number of patients remained in group homes supported by staff and later by social co-ops type A (see further on). The hospital grounds have, in the meantime, been given a different function: they were turned into schools, a restaurant and other facilities for the neighbourhood.

1 Nowadays there are 19 people living in 3 small group homes on the former hospital ground, that is now part of the community, but there is a decision and a plan for providing them with a supported housing scheme in another part of the city within a year (personal note Meggina, 2015).
Along with the dismantling of the psychiatric hospital, attention was given to the establishment of support and care in the neighbourhood. For this, Basaglia put together a team of young doctors, psychologists, social workers and volunteers who could identify with his critical analysis of psychiatry as a ‘total institution’. These employees were given new opportunities with on site-training during the transformation of the wards and in the community service provision. The basis of Basaglia’s thinking was that a mental hospital has absolutely no therapeutic value, and that a transformation of the psychiatric system is needed in order to realise a more humane psychiatry. This was done by establishing mental health community centres: low-threshold centres where temporary accommodation is also possible. The family was also closely involved in the changes and in supporting the clients. The model was designed by ideologically inspired health care providers who strongly believed in the ideal of a different psychiatry, aimed not at exclusion but at inclusion.

The development that Trieste went through can be divided into several stages (Dell’Acqua, 1995):

**First stage: the hospital is still operational but the first changes take place**: the first initiatives that took shape were aimed at reducing forced admissions, restructuring the spaces in the hospital and transforming internal communication: the emphasis shifted to daily, patients-accessible discussions. This took the place of the existing hierarchical structure. The role of nurses was given special attention here: they had to let go of their traditional role as ‘guards’. The clinic adopted an open-door policy and all forms of physical coercion and electro-convulsive therapy were abolished. Also, patients were encouraged to go into town: something which, at that time, was met with a lot of resistance from the community. Substantively, a turnaround was made in the thinking. No longer was the psychiatric illness the central focus, but, rather, the re-evaluation of the person as the subject and owner of his own story and his own needs and the rebuilding of relations with the neighbourhood. In the hospital, communal groups were established who would later move into the first group of facilities in the city and, in 1973, the first cooperative was founded in which patients (under a collective labour agreement) performed work as employees. The hospital grounds were also opened for concerts and parties.
Symbolic for this first period was the project in which the first empty hospital wards were used as an art studio: the legendary horse, Marco, was built here. This blue horse made of papier-mâché (Cavallo Blu) had, in his belly, the wishes of patients and, in March 1973, was symbolically – as a Trojan horse – carried from the hospital grounds into the city. This symbolism stood for the isolation of patients in the hospital; only the horses pulling the laundry carts were able to leave the premises. The horse also symbolised the return of patients to society.

In 2013-2014, the horse still has a symbolic function: in a campaign to also reform the forensic psychiatric care, one of the former chairmen of the mental health service, Giuseppe Dell’Acqua, took the horse on a journey across Italy in order to raise awareness for the poor conditions within forensic psychiatric care.

Second phase: the building of community-based mental health centres and new networks
When a start was made with outpatient care, there were two parallel systems, intramural and ambulatory. This required a great deal of commitment. This was also the phase in which opposition arose among staff in the psychiatric hospital and there was more resistance from society to the arrival of psychiatric patients. Some examples that we heard about were that clients were not always allowed to rent a house: volunteers or staff then had to do that on their behalf. Accessibility, reliability and the ability to immediately respond to requests for help were important in creating further support. Partly for this reason, the decision was made to concentrate completely on ambulatory care and to set up an urgent care department in a general hospital for crisis care so that there was an alternative to compulsory admissions. The first community mental health centres were also established. A start was made on further enhancing the neighbourhood support and the social undertakings.

Third phase: The hospital is no longer active
Although it took several years before the last patients were to leave the hospital, the former hospital was officially and administratively closed in 1980. Work continued on
the design of neighbourhood support. Integration with other services in the city was reinforced and new services were established, such as the coordination of rehabilitation and housing (SAR: Foundation for Alternative Relationship Mediation) in 2000: a service that organises and coordinates rehabilitation activities.

2.3 Guiding principles

Both in the literature and in practice, there is continuous reference to the values, ideals and vision from which employees work in Trieste and from which care is organised. These values and ideas are associated with the practice by reflecting on one’s own actions and by acting as a team, for example, in the daily team meetings. Through this continuous reflection, a cyclical movement is developed between practice and theory (Mezzina, 2014). In order to emphasise the connection between the practice level and the level of ideas, in this work, we talk about guiding principles: by this, we mean the values, ideas and ideals that guide our actions. Through the process of continuous reflection on one’s own actions and acting as a team, these ideas are not static, but are fed by practical experience. The guiding principles also become substantive by the sharing of a specific language. Based on the idea that a language can create a reality, there is consistent and conscious use of the relevant language. There are no more clients or patients, but ‘Utenti’ (users) of services, and, in a more sensitive approach, in recent years, they are simply called people. It is not about treating illness or symptoms, but about ‘meeting the needs of the person’, and there is no mention of treatment, but a ‘life project’ that is set up. The guiding principles that give direction to the actions in CMHC in Trieste can be classified around the following three clusters:

1. **Holistic**: Focusing on the whole person rather than the disease: This principle is opposed to the dominance of the medical model in psychiatry and advocates non-hierarchical structures. It moves from total institution to organisations based on relationships, not focused on control and not dominated by fixed differentiated pathways where people may be excluded. The idea is that such structures actually lead to exclusion. De-institutionalisation is seen as a continuous process, also in shaping the relationship to the patient, in which the whole person is of paramount importance as an autonomous subject and not as an object with a symptom or diagnosis. The starting point is a relational portrayal of mankind. This takes
shape in practice through (Mezzina, 2005):

a. **Looking at the needs of a person** from a historical-personal perspective, focusing on one’s life story. It is important to consider the history of the individual but also the community at large: the immediate environment, but also the neighbourhood. In this manner, all aspects of support (rehabilitation, prevention, care) form a cohesive whole. It is within an integrated service model (mental health community centres) that this is best expressed. Continuity of care is an important starting point here.

b. **Dedicating oneself to the relationship**: meeting the needs of clients means that a ‘mechanical’ division of work must be avoided. Employees are held accountable for their own responsibilities and autonomy. Through consultations, informal contacts and discussion in the team, the health care providers are given the opportunity to work actively on their personal relationship with clients and to reflect on their own actions.

c. **The shifting of services is measured in terms of effectiveness, based on an idea of personal pathways to recovery and empowerment.** Someone with a vulnerability is not a passive recipient of care who is evaluated by professionals in ‘objective terms’ (clinical and epidemiological ‘outcomes’).

2. **Ecological: focus on the context, the network and the social ties**

Interventions are not offered from an institution but from the community. Important principles here are responsibility, accessibility and reliability: all relevant services are present and employees enter into relationships with involved parties, including family, housing associations, etc. Outreaching and proactive work prevents crisis. The central focus is entering into a ‘total relationship’, focused on the person who is suffering, based on his request for help and the complexity of his situation. The problem must be solved within the context in which it originated. What is important here is the idea of territorial responsibility where a CMHC is responsible for its entire service area. The centre offers prevention, primary, secondary and tertiary care: the shuffling back and forth of ‘difficult’ patients is, therefore, not possible.
3. **Rights-based approach: an emphasis on civil rights of people with mental health problems; both legal and social rights**

Civil rights are about the right to have one’s own place to live, the right to an active and productive role in society and recognition of differences in gender, ethnicity and culture. To create a community where this inclusion and practice of social rights is possible, the support of networks is essential: this is the key for the building of communities. De-institutionalisation is, therefore, more than preventing exclusion by institutions or forced treatment: it is about having control over one’s own route to recovery; personally, but also in the organisation of one’s care. Social firms are of great importance in this: initiatives that combine work opportunities and reintegration with participation in an economic structure in which the community is also involved.

In Trieste, the work is based on historically formed guiding principles: by this, we mean the values, ideas and ideals that guide the actions of the employees within the district teams, but also with external partners. Through the process of continuous reflection on one’s own actions and acting as a team, these ideas are not static, but they are fed by practical experience. We have clustered the guiding principles around three domains:

- **Holistic**: Focusing on the whole person rather than the disease, this means looking at needs of a person from a historical and personal perspective, taking into account a person's life story and a focus on personal routes to recovery.
- **Ecological**: focusing on the context, the network and the social groups which someone is part of. Support should contribute to inclusion rather than exclusion and is aimed at this.
- **Rights-based approach**: emphasis on the civil rights of people with psychiatric problems: both legal and social rights (e.g. the right to socially meaningful work).

2.4 **Description of the CMHC model**

The way in which mental health services in Trieste are organised is based on the principle of territorial responsibility: the city is divided into four districts, each of
which has a CMHC. This community centre is responsible for people with mental health problems in their area. The centre offers both a first point of contact for walk-in services, treatment, care and continuity of care for people with mental health problems, regardless of severity. Around the district centres are a number of other services which are part of the CMHC, including rehabilitation services and work activities and a crisis unit. The centres also work with services that are closely related to mental health care, such as social cooperatives, self-help groups and family organisations. In addition, the CMHC maintain relationships with various external services. They work with the prison, the police, social neighbourhood teams and welfare organisations in Trieste. Because of the territorial responsibility, the lines with these social services are often short. The main facilities and their functions are described below.

1. CMHC centres
2. other services of the CMHC
3. external services that have a close cooperation to provide care in the district: social cooperatives, client and family organisations and self-help groups.
4. external services that work together: family doctors, homeless care, prison, welfare and addiction care.

<table>
<thead>
<tr>
<th>Services</th>
<th>Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health community centres</td>
<td>Walk-in services, registration, care, prevention, outreach, individual and group therapy, crisis relief and short stays, family support, medication dispensing, basic socialisation, food and lodging, daycare.</td>
</tr>
<tr>
<td>SAR: coordination of rehabilitation and housing</td>
<td>Monitoring and coordinating of housing, training and work, inclusion. Works closely with the cooperatives and associations (NGO's).</td>
</tr>
<tr>
<td>Crisis-Department General Hospital (PDHC)</td>
<td>Crisis relief, diagnostics and referral to mental health community centres. Hospital consultation. Six beds and inflow through the emergency room.</td>
</tr>
<tr>
<td>Services</td>
<td>Tasks</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Special programmes</td>
<td>Special, cross-community centre programmes are organised, such as a Phone Support, a programme to combat loneliness, programmes for suicide prevention, programmes offered for family members, etc.</td>
</tr>
<tr>
<td>Client- and family associations</td>
<td>Offer of long-term support and peer support in the district. The organisations are independent but are facilitated by the mental health care centre and are historically linked to them.</td>
</tr>
<tr>
<td>Social cooperatives</td>
<td><strong>Type A:</strong> offers support and housing counseling to people with vulnerabilities, such as in housing facilities.</td>
</tr>
<tr>
<td></td>
<td><strong>Type B:</strong> Companies where at least 30% of employees have a so-called ‘social disadvantage’, e.g. a mental or physical disability. Some of these social cooperatives were closely linked with the creation of the district psychiatry. The B-cooperatives provide work, in particular, to people who are under the care of the mental health community centres.</td>
</tr>
<tr>
<td>Addiction Care</td>
<td>The addiction care is organised on an outpatient basis and has, itself, no beds. There are a number of therapeutic communities. There is collaboration with the CMHC but the approach is not fully integrated.</td>
</tr>
<tr>
<td>Homeless Care</td>
<td>Run by municipal services, also through the Caritas Foundation, aid and relief are offered to people who are homeless. There is a night shelter for a maximum period of 1 year.</td>
</tr>
<tr>
<td>Police</td>
<td>The police and CMHC have close contacts, also in case of necessary emergency care. Employees of the police and the CMHC take joint training sessions.</td>
</tr>
<tr>
<td>Welfare/Micro-area programmes</td>
<td>Approachable neighbourhood teams that operate mainly in the poorer districts and are the ‘eyes and ears’ of the neighbourhood. When there are mental health problems, there is close collaboration with the mental health community centres. The social teams have an accessible</td>
</tr>
</tbody>
</table>
2.5 Description of the practice in Trieste

2.5.1 Community Mental Health Centres (CMHC)

In Trieste, there are four CMHCs from which support is provided. During our study, we shadowed workers in Barcola and Maddalena. Each of the CMHC offers 6-8 beds where people can stay, if necessary. The average stay is 12 days, but this may also be much shorter or much longer. At night, there are two nurses present and there is a psychiatrist on call. The doors are not locked. Alongside of the short-stay function, the community centre has a function as a walk-in facility and a first point of contact. There is a reception desk where nurses work in rotation and people can ask questions or make a call.

The community centre also serves as a day hospital, where people can come in daily after, for example, a hospital admission. There are afternoon and evening meals provided for those who want them. For example, some people live independently, but come to the centre every day for a meal and the company and also for (informal) contact with health care providers. The centres also organise activities such as support groups, group therapy and social activities, such as a knitting club. The range of such activities is for basic socialisation, and it is not very extensive. This is stated a choice, in order to favour the use of external programmes, such as the various day centre activities, and to avoid the Centre becomes a ghetto. Other workers also state that lack of money and time are reasons for this. At the CMHC, there are team meetings every day and, from the centres, outreach outpatient care is provided that is similar to the care by F-ACT teams. On a limited scale, external services also make use of the spaces in the CMHC, so that an exchange is made.

<table>
<thead>
<tr>
<th>Services</th>
<th>Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prison Programme</td>
<td>walk-in policy and do outreach work. Providing psychiatric support to inmates; both for people who were already under treatment and for people who develop psychiatric problems during detention. Preventing the use of forensic hospitals and fostering the use of community alternatives to jail and forensic hospitals.</td>
</tr>
</tbody>
</table>
2.5.2 Teams

Each community centre has a multidisciplinary team, consisting of 4-5 psychiatrists, two psychologists, two rehabilitation workers, two social workers and about 30 nurses. There are also a team of focus officers in various areas: for example, in housing, finances, employment, physical health and contacts with the prison. These focus officers maintain relationships with external organisations in that area. Every day, there is a team meeting (client discussion) where the most urgent clients are discussed and there is reflection on the way that was handled. This is seen as extremely important: “The daily consultation is very important, the team is your base, you cannot do it alone.” During the discussion, they often refer to previous cases. They do not work with a fixed agenda. The team meetings take place in an open space in the community centre. Through regular reflection on the actions as a team, a cycle of action, reflection and thinking about improving the organisation of care is created (Mezzina, 2014). In addition, they invest in employee training – sometimes along with employees from external services such as the police – to promote the exchange of ideas and develop a shared action framework. Cooperation with other services is also seen as important in order to strengthen the community-based work and to counteract the ‘re-institutionalising’ of mental health services as a separate institution. The psychiatrist has a coordinating role within a team and is responsible for putting individual programmes into effect and he also has a coordinating function for new registrations. Every client has a contact person.

2.5.3 Treatment

The point of departure in treatment is to meet the needs of a person with problems and to work from a holistic vision: people are approached as responsible beings, with their own history and social network. The starting point in the treatment is to build a relationship with clients. Medication is used and, in interviews with clients, the image is presented that open communication about it is possible. During this fieldwork period, no targeted study into medication provision was done; it had already been done in previous visits and it is available in the literature (Palcic, e.a. 2011). Veldhuizen reports, for example, that during their visit in 2008, a number of psychiatrists immersed themselves briefly in the prescription policy. The impression at the time was that the medication policy is not much different from the Dutch policy. Alongside of classical anti-psychotics, clozapine was also prescribed.
Clients have their own treatment plans. They are not closely involved in drawing it up, but there are ideas to give better shape to the clients’ participation. The treatment may further consist of group therapy and individual and family sessions. Moreover, a great deal of outreach work is done and people are visited at home: 1/3 of the interventions of the team now take place in the neighbourhood, 2/3 in the centre. The aim is to make it 50-50.

One important part of the guidance are the more accessible contacts: in the community centre, clients can always walk-in and there is always someone there to answer their questions or to talk to. Based on the ideas of democratic psychiatry, there was, for a long time, resistance to more psychotherapeutic interventions, arising from a resistance to individualising psychological problems instead of seeing them as social problems. Meanwhile, psychotherapeutic interventions are certainly offered and most psychiatrists have been trained in this. In Chapter 4, we delve deeper into this. The treatment is in structured collaboration with other partners, for example, with addiction care. In caring for people with a dual diagnosis, there are co-managed care plans with the Dependency Dept, although there is no fully integrated approach yet, about 200 persons a year are receiving interventions in co-management with the Addiction Department (numbers Mental Health Department/MHD). Still, workers noted that sometimes it happens that people are shuffled back and forth between institutions.

An important part of treatment is also activating the clients’ social network, or creating alternatives if no network is present. This will be explained in more depth further on (see case study 1).

**2.5.4 Case management and personal budgets**
The collaboration between the CMHC, mental health services and other external organisations are shaped at the individual level through the use of case management. In complex cases, the case manager is responsible for the coordination between the focus officers within the team and a specific ‘project’ is drawn up to organise good collaboration between the CMHC team and external organisations. This involves at least two different professions and two external services. If case management is brought in, the situation is then mapped out in a structured manner for a number of
areas of life, the targets are established and the responsible parties are appointed. An example of such a plan can be found in Appendix 3.

Staff members indicate that the concept of case management within the tradition of Trieste is still sometimes controversial because it has traditionally been highly valued to do things as a team and be flexible, instead of recording things on paper and having one person provide a coordinating role. The reason to start working anyway with intensive group case management is the belief that this is a more effective way to prevent crises and relapse, and it contributes to reducing the number of hospitalisation days.

**Personal budgets**

In Trieste, starting in 2005, they have worked, in some cases, with personal budgets to support the personal housing (instead of group housing) and home care, as well as socialisation and community integration. The aim was to strengthen the financial and personal independence of the clients. Money for guidance and counseling previously went from the department to an NGO (usually an association or type-A and type B cooperative) that offered support and compete in a tender for allocation of these resources. Now, a number of people have money in their own names, which can be used to pay for home care. An increasing percentage consists of direct payments to the client or his legal representative to be used to hire the person they want. Due to this system, four group homes have closed since 2008. With respect to the personal budgets, there are monthly consultations between the involved parties in the rehabilitation service, the cooperatives and the CMHC. In the consultations, it is decided who qualifies for such a personal budget. For the people in question, a plan is drawn up for an individual programme. The participation of clients could still be increased here. A personal plan is reviewed every six months to ensure that it dovetails well with the needs of the client and to evaluate whether the effort is still necessary (to that extent). This provides the possibility to, for example, offer very intensive care for a short period, but to scale it back again after a time. For young people, it is, for example, very important to be able to scale up care in case of crisis, while prolonged, intensive support is not always a necessity. Working with the personal budget system – with the plans attached to it – requires a cultural change in the community centres in Trieste. It is a systematic way of working where more is written and recorded. A plan
begins with one’s life story and there are also clear targets set. One example of a plan is given in Appendix 3. Not everyone receives help through personal budgets: in 2013, there were 160 clients per year (Mezzina, 2014; Mezzina and Ridente, 2015).

2.5.5 Involvement of family and network
From the guiding principle that problems should be resolved within the client’s existing social context, family members and the social network are involved in the treatment. It is important here that the mental health care provider is accessible and reliable for the family members. From the CMHC itself, courses are organised, psycho-education given and there are long-term peer support groups. When a new client comes in, the family is first given brief information, then they are given a course in psycho-education in which attention is also paid to the existence of family organisations, whereby the step towards long-term peer support is encouraged. Also, family groups are established within the CMHC centres. Not all individual cases seem to actually involve the family directly in treatment, but certainly there are some levels of information and engagement. When family links are missed, different carers, such as neighbours, friends, colleagues or even client advocates are involved in the case management. Interviews with clients revealed that the focus is mainly on parents of young people with, for example, a first psychosis and less on supporting children of parents with psychiatric problems. In the case of more intensive programmes (case management), the burden on family members is a particular focus of attention and this issue was also the focus of several studies. In contact with staff, the burden of the family is presented as something that, unfortunately, is sometimes unavoidable: “You would also take care of your son with a broken leg, wouldn’t you?” The interviews with family members of patients revealed that it actually requires a lot of people, especially considering the stigma that surrounds psychiatric problems. It is crucial here that the CMHC is accessible for family and other carers, so that they can get support at times when it is necessary, even outside office hours.

2.5.6 Dealing with crisis
In the event of a crisis, the community centre is the first point of contact. The starting point here is to provide care and personal support. De-escalation and taking the time that is required are key concepts in the event of crisis and, also, the social network is involved where possible. In addition, time is invested in building a relationship in
order to stay in touch – and, in this way, also to work preventively – to be able to spot arising escalations earlier so as to prevent crises. The starting point is always to stay with the client – instead of isolating him – in the belief that isolation and confinement cannot contribute to healing and violates the rights of a client. This is not so much based on the management of risks, but on solving the crisis together in the most humane way possible. There is no separate crisis team: based on the integrated approach, people in crisis are received in the CMHC centre. The community centre is open between eight o’clock in the morning and eight o’clock in the evening and has the possibility to admit someone immediately and also to let them stay. It is important to note that 24 hour hospitality is one of the possibilities: someone can stay overnight as a ‘guest’ if necessary, without a formal admission.

The principles of crisis are described in Mezzina and Johnson (2008):

**Working principles of crisis management in the Trieste community mental health centres**
- Accessibility and mobility of services and the ability to respond to a wide variety of crises. Crisis management is not a special or separate programme but a basic function of the comprehensive service. Selection criteria based on type or severity of illness is not imposed to regulate access to the service, nor does illness of a particular type or severity automatically trigger hospital admission. Promptness of response to crises is very reassuring to referrers, such as family or neighbours, minimising the need to admit users to hospital or even to the CMHC.
- Integrated and comprehensive response (social and medical). Therapeutic plans are based on individual history, needs and wishes rather than on a fixed therapeutic model. Establishing a relationship is the first priority, and basing plans on individual needs allows the service to obtain and maintain consent to and engagement in treatment by service users.
- Continuity of care. This is a guiding principle and involves treating service users within the usual care system and maintaining them in their usual social context, thus avoiding de-socialisation and institutionalisation. Follow-up is provided wherever service users are, even in prison.
- Avoiding hospitalisation. Most people remain at home, but when this
is not possible the aim is to avoid hospitalisation in favour of more flexible interventions, such as 24-hour residence (‘hospitality’) at the CMHC.
(Source: Mezzina & Johnson 2008)

Crisis Unit in the hospital
At night, clients in crisis turn to the emergency room of the general hospital, after which admission to the psychiatric ward is possible. This unit is under the management of the district teams. A person may also be admitted for observation (48 hours). In the hospital, just as in the district centres, they do not work with closed doors and there is no separation unit. The ward at the hospital has an informal atmosphere, with seating areas and the possibility to watch television. The offices have open access. There are six beds available, which are not always in use. The average stay of people here is less than three days. During the day, there are 2-3 nurses present and a psychiatrist. At night, one of the psychiatrists (in rotation) of the centre is on call and there are two nurses.

After a night admission in the hospital, the relevant community centre in the client’s area is contacted the next day and a joint plan is drawn up. One of the goals in a crisis is to create continuity of care. If necessary, an extensive assessment is made of the problems that are present. The aim is always to get people to be able to take part in their daily lives as quickly as possible in order to avoid hospitalisation. Sometimes an exception must be made here, for example, if someone is in danger of being declared not accountable for his actions with respect to a criminal offence. In order to prevent admission to a forensic psychiatric hospital, the person is then, for example, kept longer in the psychiatric ward until the psychiatric picture is more stabilised or simply to reassure the judicial system. If the situation escalates, the police can be called in for support: their presence often has a de-escalating effect. The explanation for this way of working is that the unit is part of the community, and a threatening behaviour should be discouraged, as it is everywhere in public places. An estimate by the nurses we spoke to is that this happens once every two months. A great deal is prevented by entering into the relationship. Because the staff in the crisis department all have worked in one of the centres, they know many of the clients, they know their background and can act quickly to de-escalate the situation.
Police and mental health workers attend training sessions together and the attitude of the police towards people with mental illness is usually benevolent. The psychiatric ward is open to family members of people in crisis and provides information, primarily aimed at removing anxiety.

2.5.7 Compulsory treatment

In Trieste, compulsory treatment is instigated in some cases, but this is also done without closed doors. In the case of compulsory treatment, a 'project' (programme) is drawn up to provide the client with counseling. The consideration for compulsory treatment is not the danger criterion (that is officially excluded from legal requirements (Law n. 833) but the question of what help a person needs. Compulsory treatment can be used if someone is in urgent need of treatment, refuses treatment himself and every other avenue of involving the person in a treatment programme has failed.

If there is a question of compulsory treatment, more staff are deployed in the community centre: there are then always two or three people coupled to the client who has been admitted and is undergoing treatment. This is based on the idea that, in this, way, there is always someone to meet the needs of the person in a crisis. Family members are also deployed, in order to have the client retain as much connection as possible to his daily life. During a compulsory treatment, the client can, for example, simply go into town to drink a cup of coffee, but there is always someone with him. Also, the client is always free to receive visitors. The starting point is not to be ‘guarding’ but to be ‘responding to the needs of a client’ by offering what is termed, ‘personal assistance’. Compulsory treatment is requested by two psychiatrists and endorsed by the mayor because he is responsible for the public order. Compulsory treatment may be extended several times by seven days, but can also be withdrawn after, for example, three days.

In the case of a forensic framework, compulsory treatment is also possible. During our visit, for example, there was a woman who had committed murder. From the guiding principle that humanity always comes first, an effort was being made to prevent an indefinite admission to a forensic psychiatric hospital. In such cases, a treatment plan may be submitted to the court such that the mental health
staff takes responsibility for someone and provides intensive support. In the above example, this meant that the woman could stay at the centre for a longer time and was always coupled to a staff member or a volunteer who offered support. Another possibility to avoid forensic admission is certainly by emphasising the mental competence of a person: in that case, the person is placed for a certain period of time in the regular prison and is given support from the CMHC for mental health problems.

### 2.5.8 Work and social participation

From the moment community-based mental health care developed, they have been working with so-called social cooperatives that employ persons with disabilities. The ‘therapeutic work’ as it was conducted in the facility, was replaced by work under a CAO through the establishment of the first cooperative in 1972. Based on the ideals of citizenship, the role of patient shifted to that of employee. After that time, several other social cooperatives were established in which people with disabilities worked together with people without disabilities. Social cooperatives offer work in the areas of landscaping and cleaning, but also in transportation, furniture manufacturing, the hotel and restaurant sector, maintaining a beach pavilion and administrative services. There are of two types of social co-operatives:

1. **Type A social cooperatives** are collectives for workers who provide support to psychiatric clients: they work closely with the staff from the CMHC teams and provide, for example, sheltered housing supervision.

2. In **type B social cooperatives**, 30% of the employees have disabilities but everyone has the same role in the cooperatives and also has, through a membership, a say in the company. These cooperatives receive a tax benefit.

In Trieste, there are about 600 people working through social cooperatives, of whom about 70% have a disability. In order to work in a cooperative and to belong to the 30%, there is the requirement that a person has contact with the CMHC. This will be updated annually. The cooperatives fill the gap between the labour market and the benefits system. Social cooperatives always have a double objective: to make and sell products (commercial interests) but also to promote inclusion and participation. Many people who do not need assistance make the conscious choice to work in a cooperative precisely to emphasise normalisation.
Besides working in cooperatives, there are other opportunities for participation:

- **Working Grants:** working grants are issued for 2 years and the people are given an allowance for work training - not only in a cooperative (around 50%), but also in a business (15-20%) or in another training and work project specifically created for this purpose. The municipality, the mental health community centres and addiction and rehabilitation departments have the possibility to issue working grants. A working grant is not an ordinary job; it is a track that is intended to have a therapeutic effect, aimed at rehabilitation, as well as at providing an opportunity to access the job market within a placement-and-training principle. Through the province, special projects are set up where people can work with such a working grant: for example, the refurbishment of a tunnel to the beach in Trieste or renovating an old beach club. Such projects provide mostly young people with a chance to get started, but also have an anti-stigma objective: the social benefit makes is clear that people with psychiatric problems do contribute to the welfare of the city. Due to the protracted economic crisis, working grants are often used for longer than was intended because the move to other forms of work is stagnating. In 2013, after 2 years 10% have a regular job; before the crisis, the outflow to regular work after 2 years was approximately 20-25%.

- **Supported Employment:** Within personal action plans, there is also focus on guiding clients towards regular jobs with a more personalised support than the usual working grants. While a rehabilitation staff member indicates that the stigma about psychiatric problems often makes it difficult to create such places, the importance of Supported Employment is endorsed by a number of people.

- **Tutors:** similar to SE, for people who have difficulty functioning in a social cooperative, there is a system of tutors (job coaches) to give people direct guidance and support while working in the cooperative or elsewhere.

Providing work support towards and within work in regular jobs (Supported Employment) can still be further developed here, but the provision of supports is limited.
Family and client organisations

From the guiding principle that the support of people should focus on providing support in all areas of life, there are, in Trieste, those who are actively working on the creation of associations that operate independently but have close links with the CMHC. There is a group for family members, a group for youth and sports, a group for computer activities, a group for emancipation of clients etc. These groups are linked to client or family organisations, which collaborate with the mental health department and receive funds for specific projects, so they maintain close ties with mainstream mental health care and are also supported by them. In some groups, social workers and clients come together to discuss improvements needed.

In developing the system in Trieste, this is partly the reason why no strong independent client movement has arisen: this is possibly one of the reasons why, in the areas of recovery, empowerment and experiential expertise, not a great deal has, as yet, been developed. In the teams, for example, there are no permanent positions for experiential experts.

2.5.9 Housing

In Trieste, there are three forms of support for people who cannot live independently:

1. Small apartments where two or three people live together and where up to 24-hour support is available from the CMHC. These are often people who receive support with a personal budget and previously lived in larger group homes. The guidance is aimed at integration.

2. Four group homes where people live who need ongoing support, such as a group of elderly people who previously spent long periods in the psychiatric hospital. The guidance is provided by social cooperatives in close collaboration with the CMHC. The houses are owned by the Department of Health and managed by the rehabilitation service. The apartments and group homes together comprise today about 45 beds (Mezzina, 2014).

3. Transition Houses: These are houses where people can stay temporarily and that are made available by the local housing association (40 to 50 beds). The houses are in the name of one of the residents. If a group functions well, it is also sometimes ‘flipped’. One of these has recently developed into an experimental ‘recovery house’ for 6 young people (May 2015).
Alongside of these housing facilities, we saw in Trieste that there is creative thinking about solutions for people who are (temporarily) unable to live independently. Thus, in case 3 (Chapter 4) it is described how a woman offers housing to a mother and daughter with mental health problems and, in return, gets assistance with her daily care. From the rehabilitation office, it is indicated that there is a need for group homes for people with specific problems, such as people with a dual diagnosis. Also, staff members indicate that independent living should not always been seen as the highest ideal. Certainly for people who are experiencing loneliness, various forms of assisted living in small group homes might be a good alternative. This idea is, according to others, at odds with the values of autonomy and citizenship and leads, in practice, to a field of tension between autonomy and good care. This dilemma is further elaborated upon in Chapter 3.

2.5.10 Collaboration with external services

The community centres in Trieste work closely with other community services. This is secured by the organisational model: The mental health care department is one of the operative structures of Health care Agency (and Authority) in the city of Trieste (AAS1), that encompasses all services operating outside hospitals. Apart from the Mental Health Department, there is the Department of Dependency (Addiction), the department of Prevention, and eventually the four Health care districts, operating on the same community areas of the four CMHCs.

This way the mental health care is not isolated, but also, on an organisational level, connected to other services. On a team level, the connection is further strengthened by appointing contact persons within the district teams, who are responsible for contacts with the specific partners. This involves working with a range of services and partners. We will single out a few here, which we visited during our fieldwork.

The police

There is no formal cooperation with the values and ideas of mental health care and the police, but there is informal collaboration. Police are familiar with the values and ideas of the Mental Health Center and do their best to work along in finding creative solutions for clients, the extent to which is dependent on the person in question. From the CMHC and the crisis department at the hospital, the police are called in during
escalations. This collaboration is described as good. In a crisis, sometimes the presence of the police can help: they usually do not need to intervene further and they support the values which are used. At the community level, the police officers and health care providers from the centres know each other well and take courses together.

**The prison**

Via the community centres, mental health services in the prison are coordinated. From each centre, 4-5 health care providers are involved: the psychiatrist and psychologist and several nurses. People inside and outside the prison receive support in the same way, based on the same ideology. It is estimated that approximately one third of the prison population suffers from mental health problems. The prison medical service decides whether someone qualifies for support. Support may include medication, conversation sessions, diagnostics, contact with family, etc. Both the social workers and the guards at the prison are given information and training on mental health issues. For addiction problems, addiction care offers addicts support but there is always coordination with the community centres. As of 2015, there is a joint health service in the jail run by the AAS1, with all services managed together.

Trieste services work in order to avoid the use of forensic hospitals by supporting the person in the normal judiciary route and providing alternatives to the judge at every stage. The underpinning ideology is that a person’s capacity assessment is the rule, even in the case of severe mental health problems. This must result in a normal criminal conviction, with diminished duration, just as is accorded every citizen with rights and obligations. Since 2006, there have been no people from Trieste in forensic hospitals. Since June 2014, there is a new law that states that the Forensic Hospital must be closed. However, there are no good alternatives available. In Trieste, they want to look for ambulatory solutions, not to create mini-clinics for the clients from the forensic care. They want money for customised programmes instead of money for new buildings. However, this is not a done deal. In anticipation of the new situation, new treatment programmes are being set up. In view of contributing to the closure of all forensic hospitals in Italy in the year 2015, as of May 2015, there are also two forensic beds in a day centre, with the open door approach, to be used for people with restrictive measures coming from the whole region (Mezzina, personal notes).
The homeless care
People who are in treatment at a CMHC and have housing problems are given support and guidance, and can be also hosted in the Centre while the service helps to put them in a housing project. However, from our conversation with the homeless care, it appears that, among the homeless people, there is a small group who are struggling with mental problems, but are not (yet) in care. The opinion of homeless care is that the CMHC could do more outreach work for this group. Our conversation partner points out that, in particular, the care for people with both psychiatric and addiction problems (dual disorders) could be improved. The major part of this group does have a roof over their heads: there is no shortage of beds in the night shelter and the MHD does work together in projects provided by the municipality and organisations for homeless care and refugees. Explanations that are given for this are that there is a lack of time and money at the centres. It also concerns a group of people who often avoids care. During the visit to Netherlands in June 2014, the staff members from Trieste were interested in the care model, with hostels, for homeless people as has been developed in the Netherlands.

Health and social work in micro-areas
From the health district, social support is organised via micro-areas: small community-based teams which are the ‘eyes and ears’ of the neighbourhood and, their own terms, are ‘vulnerability monitors’. The teams work in an approachable manner to support social and economic problems together with all available health and social welfare services, as well as with the volunteer sector. If there are any psychiatric issues, they also work closely with the CMHC. In Trieste, there are ten micro-areas; in the most vulnerable and poorest districts, there are four. One of the teams that we visited was housed in an apartment in the social housing projects and had a living room function for the neighbourhood: a man with problems was given coffee and a listening ear, a young girl got help with homework. The teams have a very outreaching way of working; every year, they literally go from door to door in their catchment areas to see if there are problems. They also offer activities that are compatible with the environment of residents, in order to make contact: a training session for dogs, for example, (because many people have a dog but have no idea how to deal with it), or sporting activities. The coordination with the CMHC is going well and there is a clear division of labour: the micro-areas do low-threshold work, organise activities
and walk-in activities and sessions, the CMHC provides treatment and support. There is regular consultation and, within the mental health community teams, there is one staff member who is the contact person for the micro-area, so that they can easily reach each other. Creativity and principles of reciprocity are of paramount importance: people are always asked to do something in return for support. This could include, for example, the offer of homework support, or a visit to an elderly person. In the poor neighbourhoods, it is mostly alcoholism and loneliness that are the major problems. People in crisis are sent to the CMHC and the people in the micro-areas know people who are in treatment.

In addition to micro-area programmes, there is also cooperation in other ways with other health services: there are district health centres where, for a few hours per month, psychiatrists or psychologists from the centres provide low-threshold support to people with less severe symptoms, such as anxiety and mood disorders. Also for individual cases, there are regular consultations and joint supervision plans drawn up when intensive case management is deployed.

General Practitioners
The collaboration with GPs is not optimal, even though it is recognised that cooperation is important in order to be able to carry out community-based work. From the CMHC, doctors are kept informed of the situation of clients. Efforts have been made to improve the contact: GPs are invited to attend conferences of the CMHC and a list of phone numbers of psychiatrists is distributed to GPs. People who come into care in the CMHC for psychiatric problems are not, as a matter of course, referred back to their GP after a certain period of time, but remain under treatment or continue to be monitored by the CMHC. They usually get their medication through the CMHC, in the belief that continuity of care is important in supporting people. One of the explanations given for the difficulty in working with GPs is that they work from different principles: in the centre, nurses have an important role in the team and often act as a point of contact, while GPs tend more to work from a hierarchical structure and, as doctors, prefer to consult with the psychiatrists.
Chapter 3

HOME AGAIN: FOUR GUIDING MOTIVES
Are there lessons to be derived from the mental health practices in Trieste that can help to further shape the out-patient care process in the Netherlands? In this chapter, we present four core motives into which we have clustered our observations and the analysis of our fieldwork in Trieste and which may be relevant to the current Dutch situation and the challenges we face:

1. From civil rights to citizenship
2. ‘Freedom First’ as the guiding principle
3. Value-driven action: onwards towards a different professionalism
4. Autonomy and good care

We give below a description of these four core motives and illustrate these with case studies and practical descriptions, in which also the dilemmas are visible that health care providers in Trieste come up against. Each section ends with the question of what the significance of this for the Netherlands could be.

3.1 From civil rights to citizenship

The actual ‘discovery’, we have made in many years of commitment and fighting exclusion, is that those who suffer from mental disturbances must be, first of all, helped to safeguard and preserve their own rights within the social space: both in the more private and daily life and in the network of relationships and exchanges in the community they belong to. These rights are not supported by abstract juridical and administrative regulations, but by resources which must be actively looked for and formalised, in addition to actions and interventions guaranteeing access and the actual use.

Source: Dell’Acqua, website www.triestesalutementale.it

Equivalent or full citizenship\(^1\) is a much discussed ideal when talking about the social inclusion of people with psychiatric problems, both in the Dutch context, as elsewhere (Tew, 2012; Ootes, 2012). In Trieste, there is specific attention paid to the restoration of rights of clients. In addition to classic fundamental rights, such as equality and liberty, attention is paid to what is termed ‘social rights’ or ‘civil rights’: right to education, right to employment, right to social security. This approach to

---

\(^1\) We consider citizenship here to be the ability for people to bring their civil rights into practice, for example, by focusing on activities that increase inclusion and participation of people.
rights was given shape as early as the beginning of the de-institutionalisation process; inside the hospital, living groups and social cooperatives were set up based on the idea that patients should again have the opportunity to participate in society as citizens. “These initial achievements (co-ops and living groups) made it clear that the real obstacle to any true transformation and rehabilitation process was the legal and administrative status of the patient (i.e. inmate) and not the illness-related disability” (Dell'Acqua, 1995). Social inclusion and citizenship of patients was – and will be – therefore expressly linked to the legal rights of patients.

**Citizenship has two dimensions**

Do they succeed, in the daily practice in Trieste, to give shape to this ideal of citizenship? And what role does the rights-based approach play here?

Enhancing citizenship and the restoration of civil rights is shaped via two dimensions. First of all, the focus is on supporting individual clients to bring their capabilities to achieve civil rights into practice and to increase them. Increasing social skills and the restoration of social networks are seen as key issues here (Mezzina, 2006). Alongside of this, they also work on creating places to bring the above-mentioned civil rights into practice (for example, the establishment of social cooperatives, anti-stigma activities). Interestingly, these two dimensions cannot be seen as two separate activities, but as activities that are, in the daily actions of staff members and the organisational structures, intertwined with each other. “The DMH provides care through a network of community services, but also places great emphasis on working with the wider community with a view to promoting mental health and taking care of the social fabric (Mezzina, 2014).”

This bilateralism of the interpretation of citizenship: the strengthening of the position of the individual (through skills and networks) and the strengthening of the ‘social fabric’ (social cohesion), is reflected in various projects. Thus, social cooperatives always have a double objective: they are aimed at creating places where people with disabilities can perform meaningful work and can generate income, but they are also aimed at increasing participation and acceptance for psychiatric problems. Through this, we discuss, at different levels, how this bilateral task of increasing social inclusion and citizenship will be designed.
Working for equal citizenship occurs in two dimensions: there is an aim at strengthening the position of the individual (through skills and networks) and at strengthening the ‘social fabric’ (social cohesion). Through the holistic view that is used in counseling and treatment, these two dimensions are intertwined, both organisationally and in the everyday actions of staff members.

**Strengthening citizenship on an individual level**

By utilising, at the individual level, a holistic approach in the care and treatment of people, connections are continuously made in the support between one’s goals in various areas of life and his past experiences. Counseling and treatment are bound closely together, in an integrated, unfragmented manner. One example of this can be seen in an interview with a client at one of the centres we visited.

**Case 1, Thomas**

The interviewed man is critical of the system which, he believes, rests too much in the old tradition and has not been sufficiently modernised in recent years. As a child of a depressed mother who committed suicide, he experienced little support at that time. He is, however, satisfied about his own experience in the community centre after its own suicide attempt: The psychiatrist and a nurse understood that he had to do something, that he had to find again a purpose in life. During his admission, they talked about the fact that he had been a teacher and they came up with the idea to use these skills. The idea to set up a work project was a joint idea; it arose from the dialogue between him, the nurse and the psychiatrist. Thomas had, in recent months, lost all hope and perspective and the people at the CMHC tried together to give him something meaningful in his life. In the end, we see that Thomas still works in the project that was set up with him at that time. The project provides a place for young people to gain skills and, through his position as a ‘peer worker’ and professional, he sets an example for others.

*From: Interview 2nd visit*
Strengthening citizenship by involving family

The most direct way to strengthen social networks in order to increase inclusion and citizenship is to involve the family in the treatment from the very beginning. This is done through a range of family support that is described in Chapter 2 and the open, walk-in function for family at the CMHC. Because the support is generally ambulatory, the family itself often takes on a large part of the daily care for clients. If there is no family who can take on this task, a search will be made for alternatives, for instance by arranging support in exchange for housing (see case 3).

Even in Trieste, the involvement of the family is not always easy. The pressure on family members can sometimes be great. Direct inquiries about this, initially yielded few concrete answers. Here, undoubtedly, cultural notions about family ties are involved; talking to outsiders about the care and burden as a family member, seemed to be a taboo. In longer interviews with family members, however, it emerged that it is, indeed, perceived as a burden, not only because of the worries about the client but also, for example, because of the stigma attached (see case study 2). In setting up the personal plans of clients (Appendix 1), attention to the burden for family is a separate component that must be monitored. The burden for the family is also a research subject in Trieste itself (Mezzina, 2014).

Despite these caveats, we saw that, both for families and for health care providers, it is much more natural to involve the family in supporting clients. Interestingly, the family is considered more directly accountable for their role in caring for family members with psychiatric problems. This happens, for example, during a crisis: family is then deployed to stay with the client, if necessary. This direct approach gives family members a fuller role in the triad between client-family-counselor. This is a win-win situation for all parties: it works as empowering for clients and family and, for health care providers, involving the family becomes an integral part of the work and not something that is ‘added’. It is crucial that the mental health care worker is, at all times, approachable and reliable for the family members and can also provide them with the necessary support and a listening ear.

Case 2, Alberto

Mother: “In 2011, my son developed psychological problems and was
admitted to the psychiatric ward of the hospital and, from there, referred to a CMHC. I have another son of 27 who lives independently. My first impression of the CMHC was positive; I had a conversation with the psychiatrist and the psychologist. My son was then already under treatment by an independent psychotherapist.”

After a stay in the community centre, her son came back home and, after that, there was not much contact with the centre. The parents were given information about the effects of the medication and on how to handle a crisis.

Currently, Alberto has again been admitted to the CMHC. After the initial admission, the mother thought that contact with the community centre, for her, was not so very necessary. Training courses were offered to her, but she felt that she could not really participate because she knew nothing about psychiatry; she had no prior knowledge. Moreover, the relationship with the community centre was not really good because, as a mother, she felt that she was not really being taken seriously by the psychiatrist. She gave the example that when her child was back home after the admission, he was often ill and aggressive, but this was not initially picked up well by the psychiatrist because her son, in her own words, was outwardly still functioning nicely and ‘bottled up’ a great deal. It wasn’t until recently, when there was a crisis with violence at home, that there was more attention to the concerns of the family. Her son did not want contact with the health care provider, but there will be a mandatory psychiatric examination. Also, someone comes to the house every day to administer medication. That support in a crisis is very important. At this time, she also has meetings in the centre, together with her ex-partner, about how they can support their son.

How does Alberto’s mother experience caring for her son? The mother experiences it as difficult, but something that is taken for granted. She has a demanding job, but the care for her son comes first. She does
everything she can to be with her son. Her former boss, whom she worked for at the time of the first crisis, knew of the problems and also took that into account. Her current boss does not know about this. She says that she does not talk to anyone at work about her problems. This is, in the first place, because she is an introvert and not much of a talker, but she is also afraid of the prejudice.

What does she think of the way her son is being dealt with? In the Netherlands, this very well might have ended in a hospital admission. She thinks it is better that her son is at home. She is, ultimately, the mother, but when the situation was acute, of course she also sometimes thought: admit him and let him sleep for 15 days. In that situation, a closed ward seemed like a good idea. But somehow she knows that it is better that it has all gone like this, she says

*From: Interview with mother, 2nd visit*

---

**Creating networks together with services outside the CMHC**

As described in Chapter 2, the CMHC work closely with other services, such as the aforementioned micro-area programmes, which can be regarded as small health care and social community teams. The reason for the creation of this was that the poorer people in the neighbourhood often did not appeal to the social infrastructure in the health care district and did not know where to find them. It is important, therefore, to be present in the neighbourhood itself. The micro-area is a connection between the neighbourhood and other community facilities. They have a signalling function (the eyes and ears of the neighbourhood), they provide referrals, provide very low-threshold support and they ‘monitor vulnerability’. The CMHC teams collaborate with various services (from addiction care to the prison) and, as mentioned earlier, each team has its own contacts for the various external partners. In that way, there are many (informal) partnerships. The principle of territorial responsibility within these partnerships is a crucial point because, in this way, a shared responsibility is felt. The principle of territorial responsibility was, years ago, identified as a promising practice for the Netherlands (Van Weeghel, 1998). The CMHC are, in fact, multi-purpose centres and broadly responsible for the mental health of the residents in the neighbourhood district, from prevention to primary care and
specialised mental health care. This creates the urgency to address problems directly and in collaboration with each other: the shuffling back and forth of difficult cases is, indeed, almost impossible. Also, through this system, the continuity of care by one team and one organisation is then guaranteed. In this, the practice in Trieste differs from, for example, the F-ACT model in the Netherlands, which does not so much have a preventive function, but is used when a scale-up of care is needed.

Although the principle of territorial responsibility seems to work well for most of the people for whom the CMHC operates, is also room for improvement. From our conversation with the homeless care, it appears that, among the homeless people, there is a small group who are struggling with mental problems, but are not (yet) in care. The opinion of homeless care is that the CMHC could do more outreach work for this group. Also, with respect to care for people with co-morbidity (addiction and psychiatric issues), people are sometimes shuffled back and forth between the two departments.

The principle of territorial responsibility is pre-eminently focused on addressing problems immediately and in collaboration with others. The CMHC are, in fact, multi-purpose centres and broadly responsible for the mental health of the residents in the neighbourhood district, from prevention to primary care and specialised mental health care. The continuity of care is taken on by one team and one organisation.

Creating networks through strengthening initiatives in society
In Trieste, from the moment that the psychiatric hospital was closed, they have worked on the development of social support. This includes the 15 social cooperatives with which they collaborate and where people with psychiatric vulnerability can work. Also, the cooperatives are mobilised to increase the acceptance of people with psychiatric problems.

An early start was also made with setting up and working with ‘associations’: organisations for families and clients which can offer long-term support in the form of self-help and which work closely with the CMHC. The ‘associations’ have a variety of objectives: standing up for the rights of clients, organising youth activities, provi-
ding family peer support, self-help for the elderly and for drug users. One organisation is more focused on self-help and social contacts, another is more focused on support, also in the form of housing projects. They see as their main objective to defend the rights of people (and their families) with mental health problems (MHD Trieste, 2004). Some groups were set up and supported by the CMHC, other groups were already independent NGOs with which there is collaboration. They also contribute to the “various Day Centre” activities in the areas of wellbeing, participation, socialisation, gender programmes, art and creative expression, with the aim of combating stigma and discrimination.

**Associations**

One of the associations that we visited during our visit was the “Fuoric’entro.” This sports club was founded in 1998 for young people who have had a first crisis in order to enable them to connect again with society. The organisation is doing that chiefly by organising sporting activities.

We talked to the chairman. He himself was involved in the organisation in 2002 as a client. He was, at that time, still ‘stoned from the medication’ as he says himself, but began playing football. From this experience, he became increasingly involved with the organisation. In the course of time, the organisation has undergone a change. While the organisation was formerly focused on people with mental health problems, now they are also open to other target groups, namely immigrants, people with alcohol and drug problems, etc. This was a conscious choice; they did not want to be an organisation that was a ‘mental health ghetto’. So, they decided to go for a broader orientation and also attract people with different backgrounds, in order to create a ‘microcosm’. The approach is that it is about people with vulnerabilities who need a stepping stone for social participation, but this need not be a mental health problem.

*From: Interview 2nd visit*
The associations, therefore, offer a way to strengthen networks in society. It is striking that, in Trieste, as well as in Italy, in general an independent client movement which focuses on recovery and experiential expertise, has not yet got off the ground. In the Netherlands, there is a strong recovery movement, which has developed its own structure in which people can find support, apart from the CMHC. This is done in client initiatives, recovery activities and in ‘recovery academies’ that have taken shape in some places in the Netherlands. These initiatives, mostly independent of the CMHC and rooted in the recovery movement, are powerful and promising tools in creating social networks that can be supportive to personal recovery. In the Plan of Action for SMI, for example, there is a movement advocating regional recovery academies to create such networks (Plan van aanpak EPA, 2014). That such initiatives in Trieste are much less strongly under way, is possibly due to the close cooperation between associations and the psychiatric health care system, so that there is less space ‘left over’ for an independent client movement.

From civil rights to citizenship: significance for the Netherlands
Is there, in the way in which the CMHC in Trieste focuses on civil rights and shapes citizenship, an important lesson for the Netherlands? In the Dutch CMHC, we also talk a great deal about citizenship. Ootes (2012) presents, in her dissertation, an analysis of documents from MGV (former Journal for Mental Health and Addiction) over a period of five years. Here, she shows that citizenship often acts as an umbrella term in which both supporters and opponents can find each other. She describes how, in the discussion on citizenship in the 80s and 90s, the citizenship ideals of autonomy and independence took centre stage and were closely connected with ideals of de-institutionalisation and social inclusion. She also points out that these ideals sometimes ignored the vulnerability of some groups or that too much was asked of clients, while the importance of assistance in creating networks remained underexposed. In the Netherlands, various initiatives were later developed to combat social exclusion by creating social networks or setting up community support systems. But these initiatives regularly retain, in practice, the status of individual projects (or are financially cut back) because they are not embedded in the everyday activities of health care providers and are not included in the organisational structure of mental health institutions. They are often seen as ‘extra’. In a comparative study between Denmark, England and the Netherlands on community support and outpatient care,
it was also noted that the Netherlands has formulated relatively few specific policy plans and objectives to achieve social support and social inclusion (Van Hoof et al, 2011).

The vision document of the Dutch mental health care organisation dated 2009: ‘Towards recovery and equal citizenship’, sets equal citizenship as the objective. Citizenship is used here together with such ideals as social inclusion and participation as a counterpart to ‘being a patient’. Also, in the plan of approach for SMI ‘Over de Brug’ (2014) there is reference to citizenship. Here, citizenship is mainly described as a mandate for the welfare sector: “Formulate a shared vision of good treatment and support; the core of this vision is that good treatment and support must contribute to people in the target group realising their potential for recovery and citizenship.” Here, reference is made to the notion of competencies: “The pursuit of full citizenship requires two strategies: on the one hand, offer opportunities to develop competencies; on the other hand, create opportunities where these competencies can be exercised. According to Ware, et al (2007), the first is a task for the mental health sector and other aid agencies, while the second is a task for the whole society.” (Plan van aanpak EPA, 2014).

In this vision by Ware that is cited in the publication ‘Over de Brug’, the mental health care and society each have a separate (partially overlapping) mandate. This contrasts with the holistic view that is used in Trieste, with the emphasis on the personal approach to the treatment, where there is no differentiation between the treatment, the strengthening of social networks and the promoting of social inclusion.

Herein lies a possible major significance for the Netherlands: to support recovery processes, it is necessary that the CMHC sees the support of social networks and the promotion of social inclusion of people as its responsibility and that it integrates that into other forms of support and treatment. This is also the conclusion of Tew et al (2012) in a review on the importance of social contacts: “Nevertheless, supporting the development of positive relationships is supporting recovery, because it connects people with their social world. To achieve this, a fundamental paradigm shift is required away from an individualised ‘treatment-oriented’ practice to one in which working with family and friends, and promoting social inclusion, are no longer optional extras.”
In the article, the authors are calling for a pro-active agenda for the mental health sector and the social domain (social work) to work with families and the wider community to prevent social exclusion. The concept of territorial responsibility, as is assumed in Trieste, would be useful to give a more integral form to this task, but that calls not only for a culture change but also for a matching financing structure. Also in the Trend Report and ‘Over de Brug’, a ‘population-related funding structure’ is mentioned as one of the ways to facilitate restorative care (Van Hoof, 2014; Plan van aanpak EPA, 2014).

3.2 ‘Freedom First’ as the guiding principle

*Why Housing First and not Freedom First* was the question asked by staff members from Trieste who visited projects in the Netherlands during a working visit. They thus touched on one of their main principles: that care and support should be aimed at inclusion, not isolation. Open doors are and were the symbol of the de-institutionalisation process in Trieste: the blue horse that breaks out of the hospital. Everything is based on the conviction that one cannot get better from isolation, but that a condition for recovery is precisely the strengthening and repairing of social connections. From the rights-based approach, a person’s illness is not a valid argument to deprive someone of his liberty. An important starting point is not to see de-institutionalisation as a process which ends in moving care from hospitals to the community, but as a continuous process that is about inclusion and reintegration of people who, due to psychiatric problems, are faced with stigma and exclusion. The critical examination of the usefulness and necessity of forced isolation and confinement are important benchmarks. It is always a conscious choice not to exclude people and to prevent people from ending up in a forensic psychiatric hospital: a place in Italy where lengthy closed admissions still occurred until this year (but are now being restricted and will be closed down in a short time).

Staff members in Trieste emphasise that adhering to the principle of ‘Freedom First’ is a continuous process. There was even a discussion in one of the centres to work temporarily with closed doors for a couple of hours because of the heavy workload and lack of staff. A number of staff members vehemently opposed this in the belief that you will then find yourself on a slippery slope. Client representatives have even raised the question of the extent to which freedom really is the guiding principle and how large the space is for empowerment:
'Re-institutionalisation'
The chairman of an association for young people with whom we spoke indicates that you should always be alert to the process that he calls 're-institutionalisation': falling back on old patterns that restrict the freedom and empowerment of people: "In Trieste, they have started with the dismantling of the institute hospital, but an institution is always something that comes back again in a different way: after a revolution, the walls are broken down, others come into power, but these people make new rules and new walls. Maybe these are not literally hospital walls, but they are certainly institutions. The people who themselves work in the centres do not see it; they are too close and are even part of it. They are trapped in their centres and give pills and run their activities, but the idea to truly create a mix in society, true inclusion, that has been abandoned over the course of time."

*Interview with the association chairman, 2nd visit*

**Significance for the Netherlands**
The principle of open doors is perhaps the most important foundation of the work and actions in Trieste and also, at the same time, the practice that raises the most questions in the Netherlands. How is that possible: psychiatry without closed doors: not even for a short time, not even for a crisis, not even for aggression? Are we not talking about a different target group? In Chapter 2, we describe the practice with respect to crisis and admission and outline how crises are handled. As the figures in Appendix 1 show, there is no reason to assume that the CMHC in Trieste focuses on very different populations with less severe problems than in the Netherlands. However, it may be said that Trieste has fewer 'big city' mental health problems to cope with.

The motive Freedom First is about the principle that, by de-institutionalisation, a power shift occurs that allows for the empowering of clients, whereby the structures of institutions are broken down so that the client can gain more control over his own life and circumstances and is more able to exercise influence over it. In the Netherlands, through the recovery movement, a growing amount of attention and space for empowerment has emerged. The recovery vision is widely supported by experts by experience and embraced by mental health organisations. The mirror
that the practice in Trieste holds up to the Dutch mental health is how this recovery orientation is related to the practice of separation units and closed wards that, in our country, are still part of the everyday practice in psychiatry. The use of coercion is also noted, in the Action Plan, as one of the areas in which we lag behind in the treatment and care of people with serious psychiatric problems (Plan van aanpak EPA, 2014; Van de Sande et al, 2011; Van Mierlo & Van Aart, 2013). The pursuit ambulatory care could be interpreted as a call to deploy more initiatives for the reduction of force and coercion. One example is the development of HICs (Van Mierlo et al, 2013): High Intensive Care units, designed for short inpatient admissions that are embedded in intensive outpatient care. In addition to thinking about the dismantling of institutional capacity and the building of a good support system in the district, a third mandate is created: Shaping good ‘time-out’ facilities where people can be admitted in times of crisis when outpatient counselling and intensive therapy are (temporarily) no longer sufficient.

3.3 Value-driven action: onwards towards another professionalism

In Chapter 2, it was described how mental health care in Trieste is shaped by clearly articulated values related to the de-institutionalisation process. These values help to give direction to the actions of professionals and the choices made by professionals in daily practice. In the same chapter, we stated that the main guiding principles for daily actions were developed during the de-institutionalisation process in the 1970s. This process, often referred to as ‘the revolution’, serves as a common point of reference.

In practice, this value framework provides health care providers, personally and as a team, with clear guidelines and legitimacy for action. The clearly articulated and recurring references to ‘the revolution’ and ‘Basaglia’ also provide a framework in the cooperation with external partners, because they create unity in language and action. They understand from each other where they come from and where they want to go. This gives people motivation and support. On the other hand, there is also internal criticism of the guiding principles that are applied. In particular, we heard criticism from the clients we spoke to. Someone described the work of the CMHC, for example, as closed strongholds that continue to fall back on the tradition of de-institutionalisation, but that few are open to innovation and change. The small steps that
have been made so far in setting up recovery initiatives and the use of experiential experts, are referred to as examples.

Below, we show what working within the framework of a guiding principle means for the professional actions of workers. We will then give three examples from our field work which clearly demonstrate how the daily mental health practice in Trieste is connected to the values arising from the period of de-institutionalisation.

3.3.1 Professional actions based on values

The interpretation of what constitutes professional actions, can sometimes conflict with attitudes in the Dutch practice, where we work from a different and less explicit value framework. This tension is particularly visible with respect to what we term reflective actions, creative actions, and reciprocity.

Reflecting on actions

One of the pillars of the method in the CMHC is the daily team meeting in which actual cases are discussed. These consultations are the starting point of “recognising the circular relationship between service, practice and thinking” (Mezzina, 2014). The team meeting will last approximately 1.5 hours and as many people as possible who are working that day will attend. The function of these meetings is to think as a team about problems or difficult dilemmas and to connect the actions with the underlying values and goals from which is worked. There is an assessment within the team about the right way to act in any given situation and, in this way, the responsibility is shared among the team members. In this way, each team member participates in the collective learning process that takes place during the team meetings. In this way, the team meetings also provide a contribution to the continuous professional development of the team members. During these meetings, this reflecting on the actions is also shaped by linking them to past experiences. From these experiences, there is collective reflection on the current situation and thinking about what a next step could be.

Elsewhere, this principle of reflection on one’s own actions and the involvement of underlying values is termed trialogical learning (Paavola et al, 2004; Veen et al, 2007). Kunneman (2013) uses the term ‘normative professionalism’, in order to indicate that
professionalism is not just about acting in a technical and methodical sense, but is also connected with morality and underlying values. The work method of the CMHC teams in Trieste can be understood as an opportunity to put this connection between action and underlying values into practice. In the daily consultations, but also in individual meetings with health care providers, it becomes clear how, in making choices, there is a continuous connection with the values that underlie the work. It is striking that this value framework is extremely pronounced and that the revolution of the early 1970s serves as a common point of reference that provides direction and creates unity. The historical reality of the de-institutionalisation process now has a symbolic significance, which is still important in current practice.

The upheaval in the CMHC in Trieste in the early 1970s acts as a common reference point for current staff members, providing direction and creating unity. The historical reality of the de-institutionalisation process now has a symbolic significance, which is still valuable in current practice.

Acting creatively
We saw, during the observations we did in the CMHC and during team meetings we attended, that, in the support and treatment, they often work with creative solutions, such as when there is no family to support clients. In doing this, they not only examine possibilities provided by the CMHC, but also explicitly consider the possibilities offered by the environment to let someone live at home. Below is an illustration of this on the basis of a number of cases.

Case 3: home visits
Tuesday, we went along on home visits with the case manager we are shadowing during this visit. The first working visit was mainly a medication round (providing pills and depot medication). These were short visits of about 10 to 20 minutes. This time, the case manager took more time. The clients knew that we were coming and there was time set aside to talk with us.
First, we visited two middle-aged men, Tony and Alex, who, for the past 2 years, have been sharing a flat in an apartment house. We were welcomed in the kitchen. One of them made coffee. The house looks austere but well kept and clean. This is mainly due to the efforts of Catharina, a domestic worker, who comes in every day. She cooks, cleans, regulates various issues and ensures balance. The men are very fond of her.

Tony is 54 years old, Alex is 46. Both men have had major problems in the past and have led totally desperate lives as a result of SMI. To my mind, there is considerable chronicity. Tony first leaned on his brother for good long while. After the death of his brother, his life was completely disrupted. He then came into contact with Barcola (community centre). Alex drifted around Europe for many years. He had occasional jobs, but sometimes spent long periods in a clinic because of psychoses. He is now stable but relies on medication. Alex saunters back and forth in the house. He makes coffee, joins briefly in the conversation and then drops out. I asked him if he works or was able to work. Alex did work for six months, but he no longer wants to and does not have enough energy for it.

Both men are a good match and are very calm together. They watch TV and do not do much more than that. They go to Barcola almost every day. Alex even goes alone by bus. He picks up his medication at the centre. Tony is brought by Catharina. He often eats there and stays throughout the afternoon (sits indoors or in the garden with some friends). Tony smokes a lot. Catharina distributes the cigarettes because otherwise they will be gone in a few hours (one pack per day). For these men, living independently is not an option. A small residential group is fine for both of them.

Catharina is invaluable, says the case manager. The current balance is, for a large part, thanks to her. There is almost daily contact between Catharina and the centre (she often brings Tony to the centre). In this
way, there is low-threshold contact. Problems are quickly identified and discussed.

We then visited three women who live together. They also live in a flat in a low apartment building. The flat is good and is in a quiet neighbour-ourhood. These are a mother and daughter who come from Moldova. The daughter (a young woman around 20 years old) suffers from psychosis and is a client in the Barcola centre. Her mother works and was not home when we came. The mother and daughter live free of charge with an elderly woman with significant physical problems. She has difficulty walking and is asthmatic. Furthermore, this woman has, I suspect, both a mental disability and psychological problems. The house belongs to the older woman. I also went along on the first visit to her. The woman was then given depot medication. The case manager says that three times a week someone from social services comes to take the woman out. The woman also gets physiotherapy.

This form of shared housing is common in Trieste but is also reminiscent of the system of having a caregiver for an elderly person living at home which is a common solution for support in Italy. The mother and daughter live free of charge (and share a bedroom) but, in return, provide care for the elderly woman. In practice, a great deal of the burden is on the shoulders of the young girl. She does all this without complaining. The older (rather dominant) woman holds sway but the mother does set limits. This is an economic exchange of services. They do not, for example, eat together. In the afternoon, a hot meal is brought for the older woman (meal service), the Moldovan family cooks for themselves. Mother and daughter often also eat separately due to unusual work hours.

Currently, it is not going well with the mental health of the daughter. She was with her mother on holiday in Moldova but it did not go well and they returned to Trieste. She has bad memories of the time she was in the psychiatric hospital in Moldova. It is not possible to talk to her
extensively, but she says she gets a lot of support from Barcola. She is there under the programme for early psychosis. A few times a week, she can participate in a discussion group for young people. This group is supervised by Barcola. They often cook together (part of the group evening). She is happy with this offer. It is a distraction and it gets her out of the house for a little while. She has also learned to deal with her voices, which are very negative. The daughter has a working grant and works in a shop of a social cooperative. She has, moreover, also taken a course for the care of the elderly woman and learned that it is not good to take over everything.

Afterwards, we discussed this case with the case manager. Although it is a nice solution that the two women from Moldova can live with the elderly women, the mutual dependence is not positive in all respects, particularly for the daughter. She should actually be living with peers. I asked the case manager about this. He agreed but also did not see an immediate solution. I wondered why she does not qualify for a transition house. The answer was that the financial means were lacking.

*From: Report 2nd visit*

The cases described above demonstrate the possibilities for acting creatively. Obviously, such unorthodox solutions must be well thought out because they can easily lead to abuse of people in a vulnerable position. The mental health community centre keeps a finger on the pulse and is following the situation closely, but it seems to have no real criteria under which people who do not know each other, can be housed together, apart from a meeting and an agreement among people who must be monitored. Reciprocity is, here too, an important driving force. Also, we saw that other agencies that work with the mental health services were reasonably willing to seek creative solutions, based on a shared value framework. Cooperation with the police is one example of this.

**Cooperation with the police**

Our contact person talked to us in a personal capacity. We talked to the police contact in one of the districts. He appeared to be well informed
of the ideas as then propagated by Basaglia. The police agree with the idea of avoiding hospitalisation unless it is completely unavoidable. There is no formal collaboration between the CMHC and the police, he says, but there is an informal one. This usually runs smoothly. At the same time, the interviewee points out that it is a compromise for the police and that it requires a willingness to act according to the ideas of Basaglia. It varies per person to what extent police officers are willing to do this. “As a police officer, you are expected to act from a position of ‘authority,’ not as a social worker. There can be a great distance between the two. You can give someone a citation because he is walking down the street without any pants on, or you could also bring him to the community centre. If the person is known (by the police and the community centre), it is preferable to first contact the centre. But if people do not want to go or are not clients of the centre, it becomes more difficult. And certainly not all colleagues at the police know the ropes and know how to use the informal structures (and extra-legal options).” Nevertheless, there is a predominately positive feeling that the police are trying to make use of the grey area. They are trying to prevent people from being brought to court. The police also have, after all, a preventive role. But again, those interviewed stressed that, as a police officer, you must act very carefully, so it cannot be used against you. From: Report 2nd working visit

To provide creative solutions that fit their personal situation, one necessary condition is that there is sufficient room for manoeuvre so that health care providers can actually do this. This can be clearly seen, for example, in the way that they deal with crisis situations. Solving a crisis without resorting to (or being able to resort to) the use of closed doors or separation, takes a lot of time and energy. In difficult cases, they use what is called ‘assertive negotiation’ (Mezzina, 2014). In practice, this may mean that a psychiatrist is busy for, perhaps, five or six hours with the ‘averting’ of a crisis. The psychiatrist is the responsible person and the situation can only be transferred to the nurses if it is stable and safe for the client (and others). The tasks in the CMHC must, therefore, be distributed so flexibly that this is actually possible.
There is a deliberate decision not to act on the basis of methodologies. One of the staff explained to us that there was, for a long time, resistance to the writing of treatment plans, as this could make the treatment static. It was – and is – the ideal to discuss everything in the team and to reflect on what has been done and what the next step might be.

In the evening, we paid another visit to Barcola. It was quiet in the centre. There were four people staying overnight. We spoke with the nurse on duty and we talked about drug use, what does he do if someone refuses medication? His response was: “How necessary is it that someone takes his medication NOW. How about later? Then I come back in an hour. You do not seek confrontation when it is not needed; protocols are not the guiding factor.” However, should it come to a confrontation that gets out of hand, then the health care providers can, in extreme situations, call in the police. The nurse indicated that it is very important to build a good relationship with the clients and to know their story well. In many cases, that prevents situations from getting out of hand.

From: Report 2nd working visit

Reciprocity

It is clear from the above case description of the mother and daughter who live with an elderly woman, and other examples, that the principle of reciprocity plays an important role. Reciprocity is a principle that has been described extensively in cultural anthropology as a means of exchange to create and perpetuate relationships (Maus, 1924; Keesing, 1998). The principle of ‘quid pro quo’ creates a relationship, a mutual dependence, but, in this way, also a relationship in which both parties have an active role. An active giver and passive recipient create an unequal (power) relationship, where the power lies with the giver. If you translate this principle to health care provider relationships, this means that providing unilateral help creates a certain degree of power imbalance: it is precisely the creation of situations where someone can also provide an ‘exchange service’ in the form of employment, housing, support or something else – such as in the examples in Trieste – that contributes to more equal relationships and can thus be conducive to empowerment and recovery.
In line with this reasoning, one could also argue that more reciprocity in relationships could also mean that professional distance is exchanged for a more personal relationship (see Ootes, 2012). This idea is consistent with the presence-approach and theories dealing with recovery-supportive care. The principle of reciprocity was also visible in the work of the micro-area programmes.

During a visit to one of the micro-areas, the social worker emphasised the importance of what he called the ‘matching of needs.’ He talked about a woman who had a very small benefit allowance, could not get by and asked for help. He arranged for extra food from the supermarket (rejected food), but asked her if she wanted to do something in return. She now supports an elderly woman with dementia – who does have money – for four hours/day. She gets 200 Euros for this. He also tries to match needs among residents. The staff stressed that if you do not have much money, you have to be creative in your solutions. He always asks people who receive help to do something in return.

From: Report 2nd working visit

3.3.2 Value-driven actions

Here are two examples from Trieste which clearly demonstrate how value-driven actions take shape in practice.

Working with values, example 1: Discussing cases

In order to achieve a better understanding of the practice in Trieste and how to deal with dilemmas in health care provision – such as intervention versus respect for autonomy – we decided, for our second visit, to present a number of case studies from the Netherlands to two nurses and a psychiatrist. In each case, we formulated a dilemma and asked our contacts to think about the cases so that we could discuss them during our visit. Below is an account of the conversation about this with a case manager and nurse from the Maddalena centre. It shows how they, too, wrestle with dilemmas and how the value framework serves as a reference point in their actions.

Case 4: male, 27 years old (Mark)

Mark lives alone, has no work, no social network, no income. His parents give him money but for some time he has also been avoiding
contact with his parents. The mother slides money under the door every week. The parents tell their General Practitioner what is happening and the GP brings in ACT (Assertive Community Treatment). The ACT team is not given access and then contacts the parents to gain information about Mark. The picture emerges of a psychotic man. The parents, local police officer and the ACT-team all make every effort to make contact, but to no avail. Eventually, an RM (court authorisation) is requested and the door is forced open. Mark is at home, anxious but not resistant, and allows himself to be hospitalised. He takes medication to calm himself down. The medication works, but after some time he leaves the hospital. Once home, he is, at first, willing to have contact, but later on he is not. A repetition of the previous situation threatens to occur: once stable, Mark stops his medication and slips back again.

Dilemma: How do you break this pattern? How do you prevent loneliness and neglect?

From the initial reaction, it appears that the case study is not completely clear for our partners, because they have the impression that no one ever comes to see Mark at home. The term ACT is, for us, significant enough, but not for them.

The first reaction of the two nurses is striking, in our eyes: “This is a very medical description.” Then this: “The question we always ask ourselves is in such a case is: What would this person be able to do and what would he want? The focus lies in giving meaning and make contact.” They think that Mark left the clinic because he wanted more or something else. “As a health care provider, you can respond to this. Look at such issues as employment, housing and leisure activities.”

How do they do that in practice?

“You could ask him: shall we go to your house together, what do you do in your spare time? Or go with him to a movie.” Here, they use the metaphor of a journey. The destination is selected by the client, but you can, as the health care provider, help organise the trip. “Of course, it
could happen that he again becomes psychotic, but it is not about that, that’s not always so bad. The point is that he becomes aware of what the crisis does in his life and how he can deal with it.”

I asked if he will then have an insight into his illness, but I am corrected:
“It is not about a disease but a disorder in functioning. Psycho-education may well be important in order to gain insight into risk factors. You also must make the importance of social contacts clear to someone and support him in this.” They emphasise that, for them, the continuity of treatment and continuity of rehabilitation are intertwined: “The moment someone is hospitalised or hosted ‘as a guest’ in a Centre, you have to gain his trust by taking small steps: let someone see how he can shower himself, get together to clean the house etc. Once someone knows and trusts you, more steps are possible. Putting together a complex project (here, they mean individual case management) is always the result of many small things.”

Then the dilemma: do they recognise that someone appears to be in a vicious circle, with admissions and relapses? In the Netherlands, this often results in ethical dilemmas among the health care providers: must they intervene and, if so, how? Have they had a similar incident, how do they see this?
They gave an example of a man who is homeless. He actually has a house but does not really use it as a dwelling, more as a place to escape to: he defecates everywhere, has set his mattress on fire etc. He actually lives on the street. They help him to clean his house, but the man also has cognitive problems. He has no memory, is unresponsive and often steals, always comes back on the streets and in contact with the police. When he comes to court, the centre is called in as an expert witness. They are then asked whether this man should be in prison or should be given an alternative punishment (for example, working in a cooperative). First, they went for the alternative punishment, but not anymore, because they have noticed that he does much better in
prison. There, he is clean and functions extremely well. The dilemma is clear: Is Freedom First valid in all cases?

I raised the point that this example could be an argument for working with closed doors for a particular group; how do they see this? The nurses said that they have also heard that remark in Trieste. They acknowledged that the ideology sometimes goes too far. They do not see the case as an argument for closed doors and definitely not for prison, but they are gradually letting go of the idea that everyone is better off with independent living. They are therefore thinking more and more about the opportunities for group homes and have gained inspiration for this during the visit in the Netherlands. They think that, for example, group homes are a way to avoid loneliness, because that is a major problem. Then there is more chance of balance in one’s life.

From: Report 2nd working visit.

Working with values, example 2: psychotherapy

By paying attention to the role of underlying values in the choices made in practice, it is also easier to understand why, in Trieste, little use is made of set interventions. Based on the Basaglian tradition, a personal approach, which fits with one’s personal life path and is connected to underlying values, is the diametrical opposite of acting in a ‘technical-methodical’ manner. The way they deal with psychotherapy is an example of this. Psychotherapy has, historically, had a negative reputation in Trieste. In the first discussions, it was explicitly stressed that no individual therapy took place, also no motivational interviewing or cognitive behavioural therapy. This surprised us, and we wondered if this could lead to undertreatment of (groups of) clients, if the support is focused exclusively on medication, group therapy and social integration. During our second visit, however, it appeared that there are indeed conversation techniques and that CBT (Cognitive Behavioural Therapy) is used, and that many staff members and psychiatrists have also been trained in this. In practice, however, in Trieste this is not offered as a separate intervention, but as one of the methods that is integrated into a personal ‘project’ for a client. In interviews with the psychiatrist and psychologist, it appeared that they did, indeed, certainly use specialised techniques.
Psychotherapy

“You see that, today, almost all psychiatrists also studied psychotherapy in addition to their regular training in psychiatry. Psychotherapy in Trieste has long had poor standing because it was linked to the individualisation of problems. It was seen as a technique that did not fit the holistic approach, but that is starting to change. It is now seen as an asset if you can do that as well. Basaglia was himself a psychotherapist but took the view that you had to fulfil this role in the least technical way, and not give someone a ‘package of psychotherapy’ at a fixed time every week. But psychotherapy is certainly one of the things that are offered; this is done in individual contacts and in groups for young people and women. They work more in groups than individually, which also has to do with money. The groups that are organised here are always designed so that there is also a link to the society by, for example, inviting someone from outside.”

From: Report of interview with psychiatrist 2nd visit.

The previous firm denial of any kind of individual therapy is perhaps understandable from the sometimes ‘ideological armour’ rhetoric with which many staff members face the outside world (see also Van Weeghel, 1998). Questions about ‘methodologies’ are answered with a negative, while methodologies are indeed used. However, the premise is that someone must not conform to a series of interventions offered, but the system must conform to the course of life and needs of a client. For similar reasons, many questions about target groups and burden of care often became deadlocked because, from underlying values, they do not think about the clinical picture but about connecting with the needs of the client. The belief that a language can create a reality and that it can exclude people was strictly adhered to here, which sometimes made a dialogue about good care difficult. After a working visit to the Netherlands, the discussion became easier: a mutual understanding developed and this created room for discussions about the provision of care and about what is good care.

Value-driven action: significance for the Netherlands

In the report ‘Over de Brug’ (2014) and the Trend Report on mental health care over
personal and social recovery (Van Hoof et al, 2014), a plea is made to create a range of support from a shared vision of good treatment and support in which the core must be that people with serious mental health problems will use their own potential for recovery and citizenship. How such a vision is then translated into practice and finds a place in our daily actions is hard to predict. The practice in Trieste shows how you can connect, in the organisation of care, the underlying values with daily actions and that, by a process of continuous reflection on this, the private counselor-client relationship is transcended. The daily consultations contribute to continuous and systematically integrated professional development through the reflection on one’s own thinking and actions. By applying the principles of creativity, reciprocity and reflection on their own actions as staff members and as a team, ideals with respect to the provision of care can be put into practice and perpetuated. An important condition is to create room for manoeuvre for health care providers so that they can give substance to a personal approach. This requires an open organisation, in which the professional can enter into an equal relationship with the client.

Incidentally, there could certainly be some criticism on the practical implementation of these principles in Trieste, such as the way some alternative housing solutions take shape. It would also be desirable to transcend the dichotomy created between ‘technical and methodical’ actions and the ‘personal approach’, as we often encountered in interviews with staff members, so that both can learn from each other. In the Netherlands, as well, we have noted that there is a dichotomy between the more medical approach to mental illness and recovery-oriented interventions (Van Hoof et al, 2014). It is precisely the overcoming of this dichotomy that is seen as one of the challenges to truly achieving a recovery-oriented care: “The challenge is (..) for ‘medical-psychiatric knowledge’ and ‘treatment knowledge’ to be given a less high-level and more supportive and subservient role in supporting the rehabilitation processes” (Van Hoof et al, 2014).

Although the historical context of Trieste cannot be transferred, the way in which Trieste can create a connection between practice and underlying values can serve as an inspiration for the Dutch situation.
3.4 Autonomy and good care

Actions are never value neutral: just as, in Trieste, they work from guiding principles, the ambulatory care process in the Netherlands is also based on underlying values. Bauduin (2001) describes how, in health care, a number of ethical principles are guiding: do no harm, do good, have respect for autonomy and justice. These principles have played an important role in shaping community support. In practice, it is, in particular, the respect for autonomy on the one hand, and doing good on the other hand, that are often at odds with one another (Goldsteen in Bauduin). This tension was evident in the Trieste practice. The principle of doing good in the CMHC teams in Trieste is linked to the pursuit of continuity of care and a holistic approach in which health care providers have an eye for all areas of the client's life. In practice, this means that the CMHC 'enters' many areas of the clients' lives for long periods of time. This certainly has advantages and is often necessary, but it can also adversely affect the autonomy of the clients. Below, we give some examples.

Continuity of care and autonomy

The pursuit of continuity of care in Trieste regularly has the consequence that someone remains in care at a CMHC for the rest of his life, even though it is a low-frequency contact. People in a stable situation, for example, are generally not referred back to their GP, even if they are in remission. The CMHC provides a protective environment, perhaps almost a niche, which can sometimes hinder people from participating socially and leaving 'being a client' behind them. The continuity offered is often very much appreciated by many clients, but one of the clients we spoke to also reported that they experienced it as suffocating:

She feels that the approach at the centre is too paternalistic, sometimes they call her 'little one' and 'sweetheart' but she does not tolerate that, she's not a child! She does not want to be friends with the people who help her, she would like a more professional attitude, in which it is clear who has what role. An admission, then home and then finished.

*From: Interview with client 2nd visit*

The target of the teams is to expressly promote social inclusion, but according to some of the staff, they still do not sufficiently transcend the boundaries of the
organisation and the immediate partners. This applies, for example, to work, whereby supported employment is still not often used:

The staff member also stressed the importance of creating mainstream workplaces, apart from the cooperatives, because they have much more to do with genuine participation and inclusion. In a way, social cooperatives are, according to her, also a protected world. She now puts a lot of energy into creating regular workplaces, and does this by going along to employers. But there is not always support in the team for this. A place in a social cooperative has the advantage that it offers a lot of security and people are often well looked after. That is why many colleagues prefer this.

*From: Interview with staff member 1st visit*

The pursuit of good care is, in practice, sometimes at odds with the ideal of autonomous citizenship, whereby it is assumed that people with psychiatric problems should also function independently, as much as possible. Where the critical boundary lies between ‘taking over’ the decisions of the client temporarily and respect for the autonomy of the client is, both in the Dutch Mental health care sector and in Trieste, sometimes a major dilemma. What we noticed was that, in Trieste, seeking ‘proper and continuous care’ sometimes seems to weigh more heavily than respect for the autonomy and that the organisation is less equipped to let go of clients at times when they are doing better. On the other hand, efforts are made especially through personal budgets to help the recovery process in a powerful way: that is, a way out from a passive and dependent recipient position and a step toward a more active role. The difficult balance between long term support and an empowering ‘discharge’ of the client toward emancipation is, according to Mezzina, one of the dilemmas of the system in Trieste. A study on crisis care (Mezzina, 2005) confirmed that duration of relationships with the centre have a wide distribution, that is a possible indication of a stepwise approach to this problem (personal notes Mezzina).

**Client participation**

Trieste is increasingly working with personal planning. Clients are involved in choices and an open discussion about the plan is possible, but they do not work with
a methodology such as shared decision making, in which the voice of the client is also safeguarded. There are, however, plans to put more emphasis on this (including from the SAR) and research is also being done on this topic. Several people we spoke to, indicated that empowerment and personal recovery are not yet key objectives in the current system.

“The job of a health care provider is primarily that he or she needs to know how to empower a client.” A social worker reports that people in Italy are used to a welfare state in which the client was always dependent on the health care provider. However, the approach of health care providers should be: ‘I am working for your freedom.’ This is an adjustment that has to be made, even among clients, this realisation is not always present. There should be more effort deployed in the CMHC teams to strengthen the position of the clients.

*From: Interview with the association 2nd visit*

“What could be better in the practice in Trieste? I think the support in the area of empowerment could be much better, that is a current weakness.”

*From: Interview with ex-administrator 2nd visit*

“The services in Trieste are not very focused on empowerment.”

*From: Interview with social worker 2nd visit*

Although a lot of work is being done on empowerment, there also seems to be a need to invest more in client participation. This was expressed by several respondents. In the field of recovery and experiential expertise, there is much to be developed. The first initiatives for this have been put in motion. Lectures are being given on recovery and, in the CMHCs, they are thinking about using experts by experience. In the call for more attention to recovery-oriented care, the client movement in the Netherlands plays an important role. In Trieste, the organisations into which clients have organised themselves (the associations) are closely linked to the mental health district teams. The associations see themselves as part of this system and share a common history. This strengthens the integration of client interests into the system,
but it also has a downside: there was little room (and possibly less need) for clients to develop their own movement and their own voice. Practically speaking, there was less to object to. In the Netherlands, for example, you see that agitating against force and coercion was a binding factor for the client movement. You might see this as the dialectics of progress. In an interview with the president of the youth association, this was also mentioned as a possible pitfall. He mentioned that the connection of client and family organisations with the CMHC system sometimes makes the processes of empowerment difficult. He does see that there is an important role for a stronger client movement in order to counteract the process of re-institutionalisation. There is actually, according to him a new ‘revolution’ needed to achieve this; one that fights for empowerment.

**Autonomy and good care: the significance for the Netherlands**
In shaping the ambulatory care process, various moral convictions play a role in what is good for a client. In this ethics of care, it is chiefly the principles of good care versus respect for autonomy that are sometimes at odds with each other. The holistic approach of Trieste and the principle of continuity in care ensure that the CMHC system has a ‘long arm’: long because it touches all areas of a client’s life and is also prolonged in time. Staff in Trieste indicate that empowering clients could be brought more to the foreground, without losing the positive aspects of continuity of care and the holistic approach.

The dilemma of intervention versus letting go is also a major dilemma in the Dutch health care practice. The question always arises of how to responsibly implement the ‘ideal’ of autonomous citizenship and when to implement the necessary intervention. This requires tailoring across the entire spectrum, from self-management to assertive outreach. The organisation will have to be arranged in such a way as to provide recovery-oriented care that does justice to the possibilities – but also the limitations – of people. Fixed treatment programmes may be at odds with this. In the Netherlands some people have criticised the DTC system (Diagnostic-Treatment-Combination), which would stand in the way of recovery-oriented care (see Van Hoof et al, 2014). Some aspects of the system in Trieste, on the other hand, might be too heavily focused on long-term guidance and support in all areas of life.
The ‘framework of support’, developed by Trianor (in Bauduin, 2001) is perhaps interesting here: this highlights the importance, in the redesign of (outpatient) care, not to start with the mental health care itself, because the tendency is that the mental health care will overshadow other forms of social support, such as general services, peer support, family support and self-help, whereby clients become increasingly isolated from their natural support providers and network. Also, in the creation of alternatives for clinical care and in building ambulatory alternatives, it is important to be prepared for the creation of new institutions that, in various areas, will take over the affairs of clients, even if it is in a different, more recovery-oriented manner. Conversely, it is important to organise the care in flexible networks that do justice to the demands and possibilities of clients.
Chapter 4

CONCLUDING REMARKS
In this report, we have used the metaphor of a journey in the reporting of the study in Trieste. The starting point is the current situation in the out-patient care process in the Netherlands (Ch.1) and what preceded it. In “On the road” (Ch2), we gave a description of the model which we found in Trieste and, in ‘Back home,’ we gave an analysis of the collected material in a number of guiding principles that can be valuable for the Dutch mental health practice (Ch3). The most eye-catching were three observations:

- In Trieste, working from a human rights perspective is of central importance: it is seen as a task of mental health care to defend the civil rights of clients and to create an environment where rights, such as meaningful work, relationships, housing, etc. can be put into practice.

- In Trieste, the daily mental health practice is closely linked to the values and ideals which can be traced back to the reforms in the 1970s. In daily practice, a connection is made – through continuous reflection – to underlying values, for example, by consistently choosing to work with open doors.

- The ambulatory care process in Trieste has been implemented to a high degree: the number of beds and the length of hospital stays are much lower than in the Netherlands. Due to differences in the system, a precise comparison is difficult, but it can be stated that the number of admission beds and sheltered housing is 10 times lower in Trieste than in the Netherlands. Also, there are major differences in the number of compulsory admissions and the duration of these admissions.

In this chapter, we will take stock: How is the analysis of the Community Mental Health Care practice in Trieste of value for the Netherlands? In discussions about the study, the question arose of how, for example, the practice in Trieste is related to the recovery discourse that is gaining ground in the Dutch Mental Health Care. In this chapter, we provide an overview of the main conclusions of the study (4.1) and we will discuss what this, specifically (4.2) and organisationally (4.3), can mean for the current Dutch Mental Health Care. In conclusion, we will summarise and give recommendations for a follow-up.
4.1 Summary and the results

Description of the CMHC teams in Trieste

The study in Trieste is largely descriptive in nature and is based on interviews with clients, staff members and other interested parties, observations and an analysis of the literature. In the analysis, we have come up with four core motifs from which lessons can be drawn for the mental health care practice in the Netherlands:

- **From civil rights to citizenship:** In Trieste mental health care, there is a highly developed concept of civil rights in daily practice, such that it is also seen as the task of the mental health care sector to ensure that people can exercise these rights: Here, then, is the connection between civil rights (different from patients’ rights) and citizenship. The emphasis is both on strengthening individual competencies and on working towards a more inclusive society by strengthening networks.

- **‘Freedom First’** as the guiding principle: In Trieste, based on their strong awareness of civil rights, they do not work with closed doors or closed wards, isolation cells and long-stay wards. This is seen as a shift in power, from a position of domination and control (who holds the keys) to a more negotiable one that takes a positive risk with the client responsibility and capacity (Mezzina, personal notes). Important is also the view that the restoration of social bonds is a prerequisite for recovery: isolation is at odds with that. This goes along with a different view what kind of care someone who is in a crisis needs. The emphasis is on restoring contact and keeping in touch. In practice, this means literally that someone stays with the client during the crisis. As a preventive measure for crisis, there is an intensive effort made to build good, long-term relationships with clients that pay close attention to one’s personal story and life history.

- **Value-driven action, onwards towards another professionalism:** the practice in the CMHC in Trieste is shaped by clearly articulated values related to the de-institutionalisation process of the 1970s. These values also give direction to the actions of professionals. This practice in Trieste touches on what we call normative professionalism. We differentiate here among three principles that guide the daily actions:
  - **Reciprocity:** by creating and supporting networks where people are not only
recipients of aid but also deploy reciprocal services, the relationship of caregiver-receiver changes into a more equal sharing of services and/or goods. This was evident among clients of the CMHC and also in the social community teams that are active (micro-areas). If you translate this principle into the relationship of health care provider-client, this can be an important ingredient in implementing a more recovery-supportive manner of providing health care.

- **Creativity:** in order to make a mental health care practice without locked doors and long-term admissions possible, creativity is a necessity. This calls for room for manoeuvre for health care providers.

- **Reflection:** the process of continuous reflection on one’s own actions and acting as a team creates a cycle of collective learning and establishes a link between ‘values’ and ‘practice.’ This is also being done in the daily meetings that take place within each team.

• Autonomy and good care
The pursuit of good care is, in practice, sometimes at odds with the ideal of autonomous citizenship, whereby it is assumed that people with psychiatric problems should also function independently, as much as possible. This tension was evident in the Trieste practice. The principle of good care provision in Trieste is linked to the pursuit of continuity of care and a holistic approach in which health care providers have an eye for all areas of the client’s life. In practice, this means that the CMHC plays a role in many areas of the clients’ lives for long periods of time. This certainly has advantages and is often necessary, but it can also adversely affect the autonomy of the clients. The boundary between ‘taking over’ and respect for autonomy is, both in the Dutch mental health care practice and in Trieste, sometimes a dilemma.

The recurring theme in these core motifs are the underlying principles from which they work in Trieste and which we classified in Chapter 2 around three clusters: a holistic approach, an ecological approach and a strong rights-based approach which underlie the actions of the health care providers. If the practice in Trieste proves one thing, then it is how such a value framework can be, through a process of continuous reflection, intertwined with daily practice and the actions of the staff. Thus, one can consistently adhere to the principle of ‘Freedom First’.
Key Figures

Are clients ‘better off’ in such a value-driven system? We were frequently asked this question during the implementation of this project. Of course, the answer depends on which definition of ‘better off’ is used. Thus, we saw that the two countries have different approaches. It can be stated that the health care providers in the CMHC teams in Trieste are well able to build personal relationships with a large number of the clients. It seems that, because of this, compulsory admissions and crisis interventions are kept to a minimum. But we also saw room for improvement. For example, caring for clients who suffer from dual diagnosis and the provision of more specialist care. How do you estimate that value and how do you compare it? We have chosen mostly to stay out of this equation and to continue to focus, in this project, on the core question of this study: What can we learn from the experiences in Trieste with respect to out-patient care process in the Netherlands? What is interesting is to be able to place our findings in context. In Appendix 1, we have listed a number of key figures in order to give an indication of the state of affairs in Trieste. These were compared with figures for the city of Utrecht and at the national level, to the extent that they were available. Here, the following key figures are most striking:

Trieste has, in comparison with the Dutch mental health care sector:
- 20% of the number of Dutch admission beds
- 18% of the Dutch number of BW [sheltered housing] places
- 40% of the number of Dutch admissions
- 8% of the number of Dutch compulsory admissions
- 23% of the budget (per capita)
- much shorter admissions
- no long-stay admission facilities
- a similar suicide rate
- only open doors. In the Netherlands, 25% of the admission capacity is located on a closed ward.

These figures are interesting in light of the efforts of the Dutch mental health care in the direction of more ambulatory care. It should, moreover, be noted that the mental health care offered in Trieste is less comprehensive than in the Netherlands.
4.2 Connection with the health care practice in the Netherlands

How do we now connect these observations from Trieste with the current mental health care practice in the Netherlands, where we are currently dealing with major system changes that offer opportunities, but also threats to shaping outpatient alternatives that actually contribute to the social participation, inclusion and recovery processes of clients?

First, it is important to emphasise that this question is not so much about a ‘model’ that we should or should not adopt, but rather the question of how we can use the experience and tradition in Trieste to reflect on our own ways of working and, where necessary, improve or change them. Therefore, it is important to examine how the findings relate to developments taking place here. We do that in this chapter at care-specific and organisational levels:

- Care-specific: how do the findings from Trieste relate to the developments surrounding recovery and recovery-orientated care here?
- Organisational: What lessons can be learned from the experience in Trieste in the organisation of mental health care and how does this relate to the organisational realignments taking place at the moment?

4.2.1 Care-specific: Connections with the recovery discourse

In the Dutch Trend Report 2014 on personal and social recovery, it was noted that major changes are planned in the health care landscape, but there also seems to be a common denominator: the growing endeavour of mental health care to contribute to the personal and social recovery of people. This means mental health care and support that is not simply about reducing illness, but is aimed at building or rediscovering one’s own direction, a health care system that gives people the opportunity to regain the control over their own lives, makes use of their own strengths and ability to function in society according to their own wishes and desires (Van Hoof et al, 2014).

A widely cited definition of recovery is that by Anthony (1993): “Recovery is an intensely personal, unique process of change in one’s attitudes, values, feelings, goals, skills and/or roles. It is a way of life, a way of living a satisfying, hopeful and meaningful life within the limitations that the psychological symptoms entail. Recovery relates to out-growing the catastrophic effects of psychiatric illness and developing a new meaning and a new purpose in one’s life.” Recovery emerges, in this definition,
as a personal process for people with mental illness who, with and in spite of their vulnerability, pick up their lives again. Recovery, in this sense, places the emphasis on opportunities, significance and growth, without denying limitations and vulnerabilities. This vision of recovery is endorsed in many mental health care institutions and is given shape by offering so-called recovery orientated care: personal care that facilitates and supports the recovery process. If we place this vision of recovery and the offer of recovery orientated care alongside of the observations from Trieste, it is, first of all, the similarities that stand out: in Trieste, an approach is used that is characterised by the statement, ‘looking at the needs behind the disease.’ Within the recovery discourse in the Netherlands, one refers to the unique and the personal recovery process of an individual. There is a great deal of overlap here: a relationship-based approach in which not the diagnosis but the unique circumstances needs and desires of a person are the guiding factors.

Care and support must then be directed to be in line with this personal approach. Important elements in this are reciprocity, entering into a personal relationship and attention to the client’s life story; what in Trieste is described as the ‘whole life approach’. (Mezzina, 2014). This contains similarities with recovery-orientated care, for example, with what Andries Baart (2013) calls relationship-centred care, as well as attention to personal recovery stories such as those that emerge in the recovery work groups. Other similarities between the tradition in Trieste and the Dutch recovery discourse lie in the emphasis on reciprocity and the importance of manoeuvring space for health care providers.

If we step back and look at the value framework which is so decisive for the practice in Trieste, we see that the agreements with the recovery discourse lie chiefly on what we have previously described as holistic values: an emphasis on focusing on the whole person rather than the disease. This means looking at needs of a person from a historical and personal perspective, taking into account a person’s life story and a focus on personal routes to recovery. There are also a number of differences to be identified. These concern the focus on the social network ( ecological approach) and the attention to civil rights ( rights based approach).
Value-driven actions: the ecological perspective
The broad attention to the social relationships of people and the networks that one is part of, have been described as the ecological perspective. This perspective goes beyond immediate family and close relatives, but is characterised by a relational human vision in which recovery is seen as a restoration of social relationships: the ties with family, work and the neighbourhood, as well as other social networks. The focus on the network makes room for an interpretation of a definition of citizenship that is not about the individual with skills and abilities, but precisely about the commitment to others. This could be an addition to the current recovery discourse within the Dutch mental health care system. The recovery movement in the Netherlands has a strong tradition in providing alternative networks in the form of recovery and self-help groups and consumer-run initiatives. However, it has often been stated that the recovery discourse embodies the risk of unilaterally emphasising the role and responsibility of the individual and focusing less on the relationships and networks in which the client finds himself (see also Vandekinderen, 2012). The emphasis on the ecological perspective in Trieste is also reflected in their own official ‘Regolamento’ of the MH Dept., (1995) formulated in three points:

- The CMHC team will strive to reduce all forms of stigmatisation, discrimination and exclusion of people with mental illnesses.
- The mental health district team is committed to actively improving the full civil rights of people with mental illnesses.
- The CMHC district team ensures that the district centred care is organised in a coherent and cohesive manner through the proper coordination of tasks, by making connections with other health services and by focusing on collaboration with other institutions in the district.

*From: Mezzina, 2012*

These principles have implications for the tasks the mental health care system stands for when it comes to participation and inclusion. They not only work actively to increase the competencies of clients, but the CMHC also has the responsibility to work on strengthening social cohesion in the society, so that inclusion is possible. In this discussion paper, we have formulated this as a bilateral interpretation of
citizenship: the strengthening of the position of the individual (via skills and networks) and the strengthening of the ‘social fabric’ (social cohesion). This is accomplished by maintaining close contacts with organisations for clients and family members, working with social cooperatives, seeking connections with other social sectors and by integrating the focus on anti-stigmatisation into many projects.

From this ecological vision, the connections between treatment, support and the client’s social network also become more obvious. We saw in Trieste that the burden on the family is sometimes heavy, but also that the family has easy access to the CMHC centres and can also go there for help themselves. Also, the family has a more obvious role in the support and treatment because the family is more directly accountable for their role in caring for family members with psychiatric problems. This happens, for example, during a crisis: family is then deployed to stay with the client, if necessary. This direct approach gives family members a fuller role in the triangular relationship between client-family-counselor. But, despite different cultural notions of family ties, it also occurs in Italy that the burden of care is sometimes very heavy, or that family ties are broken. From the relational human approach which continually looks at the networks one belongs to (or which are missing), in such situations they do not so much look at what the CMHC itself should provide, but also how the CMHC can facilitate or support alternative networks. The principle of reciprocity plays an important role here. The CMHC does not necessarily take over the care tasks, but facilitates in the creation of reciprocal long-term relationships, so people can continue to live independently within their own networks, wherever possible and desirable.

The rights-based approach
The emphasis on civil rights in Trieste ensures that the discussion about actions is not just about ideas on what constitutes good care and which ethical principles go along with that, but that, in this debate, there is a continuous, resounding awareness of the fundamental civil rights that are central to this discussion: the right to liberty, the right to a valuable role in society and the right to equality. Citizenship is, in this, seen as a social process: not so much a legal status, but rather aimed at increasing social inclusion and restoring relationships. This emphasis on rights and the vision of citizenship in the Netherlands could possibly be an addition to the above
described recovery discourse and contribute to a discussion about what values psychiatric care wants to introduce in practice, for example, with respect to measures related to force and coercion. It is, in the reduction of force and coercion, especially important to instigate a cultural shift in thinking and action with respect to a crisis (Voskes, 2015). Voskes advocates, in her dissertation, more space for the ethics of care in thinking about force and coercion. A strong emphasis on safeguarding (civil) rights could fit in with this and would also reinforce it. Relevant here are also existing initiatives to safeguard civil rights of people with physical and mental limitations, such as the ratification of the CRPD and ‘Agenda 22’ in Utrecht where, at the local level, detailed arrangements are made to ensure the rights of people with disabilities and where it has been noted that there should be more attention for people with long-term psychiatric vulnerabilities.

4.2.2  Organisational issues

In the Netherlands, the mental health care services are changing at a fast and drastic pace and there are various realignments taking place in the organisation and financing. Is it possible to learn a lesson from the process that took place in Trieste about how a more ambulatory and community-based care can be organised in such a way that it contributes to the interpretation of the core idea behind the ambulatory care process, namely increasing participation and inclusion? In Trieste, we saw a number of practices which may serve as an example for the Netherlands, to organise a more local and regional form of care, focusing on participation and inclusion:

• First of all, there are the social cooperatives with which the CMHC in Trieste closely cooperates. Several of the cooperatives were set up during the revolution from hospital to community-based care. The cooperatives offer, in addition to a basic income, a workplace where people with disabilities can work on an equal basis alongside of people without disabilities. The social cooperatives are distinguished from many social work places in the Netherlands because people without disabilities also work there and cooperatives have both a social and an economic objective. In the Netherlands, there are initiatives being created to invest more in social enterprises in order to create workplaces for people with disabilities. Alongside the focus on supported employment or or Individual Placement and Support (IPS), the further expansion of such initiatives may be of value to people in the Netherlands with long-term mental health problems.

• Micro-areas: the micro-areas in Trieste can be compared with small and acces-

1 Convention on the Rights of Persons with Disabilities, UN.
2 Utrecht has drafted the Policy Agenda 22for 2012-2018. This is derived from the 22 rules established by the United Nations; Standard Rules on Equal Opportunities for Persons with Disabilities (www.utrecht.nl).
sible social community care teams. By being present in the community, being in contact, knowing the neighbourhood and bringing people into contact with each other, the staff have a signalling function and form an easily accessible point of contact. The coordination and cooperation with the CMHC team takes place from a shared vision on dealing with psychiatric and addiction problems: preventing isolation by strengthening social ties and networks. In the Netherlands, we currently see a parallel development in the form of RACT (Resource Assertive Community Treatment) – the use of resources and contacts in the immediate vicinity of the client.

- In Trieste, striving for a more humane psychiatry goes hand in hand with a different way of organising care, from the hospital to the district. In the 1990s, this was further developed through the organisation of care on the basis of territorial responsibility. Each community centre is responsible for everyone in the ‘catchment area’ of a centre: from entrance and prevention to treatment, rehabilitation and crisis prevention. One team is responsible for the counseling and treatment of clients. The community centres are also responsible for the crisis unit at the hospital. This makes it possible to provide integrated care. The financing structure also contributes to this: this is connected to the communities. In the Netherlands, pilot projects are also being initiated at the local or regional level in order to develop a more integrated approach, in collaboration with various departments and health care providers. The experience here could be of value and should be monitored. In ‘Over de brug’, there is also a call for the formation of regional networks from which the care for people with severe mental illness should be organised.

- The revolution from the psychiatric hospital to CMHC’s was a radical change in Trieste in the 1970s: not a gradual phasing out of beds, but a radical choice for community-based care, whereby the use of closed doors was consistently avoided. The ‘lack’ of closed doors made it almost easier, in practice – because it was suddenly a necessity – to organise the care so that it focused on inclusion rather than isolation. The lack of isolation facilities continuously calls upon the creativity of CMHC staff to deal in a different way with crisis and escalations.

- We saw that, in Trieste, they invest extensively in contacts with other services and community initiatives. When drawing up a personal case management action plan, it is, for example, a requirement to involve two relevant external parties. The close collaboration between authorities also ensures a unity of vision and action:
all third parties with whom we spoke endorsed the approach to psychiatric problems in the tradition of ‘Basaglia’. This unity of vision has been realised through a long tradition of co-operation, but also by continuously investing in these relationships. Staff members at the police and members of the emergency services have, for example, taken courses together.

4.3 Summary and conclusion

We have set up this report in the form of a journey which starts with the questions surrounding the ambulatory care process which the Netherlands is facing at this time. The practice in Trieste is viewed from the question of what lessons can be learned from the process that has taken place there and from the current practice. This report is based on the material collected during two periods of fieldwork in Trieste, where we talked with involved parties both inside and outside the CMHC and shadowed staff members during their daily work. We had an open attitude while doing this. We wanted to gain insight into the practice in Trieste by focusing on the daily routines in two community centres: Barcola and Maddalena. We were present at the daily team meetings, during home visits, during an evening shift in a centre and we talked to visitors to the CMHC centres. These observations were supplemented by interviews with staff, family, social cooperatives, the police, the homeless care and other stakeholders (see Chapter 2 for an overview) and we studied background literature. This broad approach has led to a good understanding of the CMHC practices in these centres.

By dividing the fieldwork into two periods, we could, during the second visit, use the relationship we had created with employees and clients to enter into discussions about dilemmas and obstacles, in order to gain a deeper understanding of what a consistent commitment to community-based care entails. The return visit of the staff from Trieste to Netherlands was also important for this: thus, mutual understanding was created and clichés about the differences in health care systems could be transcended and a dialogue was started. We think we have gained, in this way, a better understanding of the community based and value-driven psychiatry in Trieste.

The analysis of the research material gives rise to further deepening: what is it precisely about our observation concerning the importance of reciprocity in relation-
ships? In depth research on the exact way in which crisis interventions in Trieste are handled and how clients can be approached during compulsory admissions could also be of value. How do they act in crisis situations and how do the health care providers try, in a positive way, to stay in touch with their clients?

What can we conclude at the end of this project? ’On the road’ we saw, in Trieste, many similarities with the Dutch situation: here, too, the days of largescale hospital sites are far behind us and we are working on giving shape to recovery orientated care. But, in Italy, we also saw a practice with a radically different approach, organisationally (fully ambulatory) and substantively. Substantively, what is most striking is the connection between underlying values, daily practice and the focus on civil rights. This is reflected at all levels: the organisation of care, the content of the treatment and support, and even in the language of the staff who refer to ‘utenti’ (users) rather than clients, in order to emphasise that people with psychiatric problems are first and foremost citizens. Central to this is still a personcentred approach which is the basis for shaping the guidance and support that meets the wishes and needs of people and increases their capacity to participate fully in society.

Trieste went through a specific historical development with an enthusiastic group of psychiatrists and other health professionals at a time when there was support for change. Within the Dutch context, it is important to look at the specific circumstances and developments taking place here, if we want to include a number of the principles as described above. In the Netherlands, we see a growing support for a realignment in the organisation of care (community based F-ACT teams), but also substantively through, for example, the commitment to recovery discourse and the use of experiential experts. From the experiences in Trieste, we see that a greater awareness of the importance of civil rights and the relational, holistic view could be a welcome addition here. It could be of value to reflect more explicitly, in the discussion, on the ambulatory care process in the Netherlands, on the values and ideals that we want to achieve in this process. This paper hopes to provide the first steps in this and to offer material for discussion.
APPENDIX
APPENDIX 1: KEY FIGURES FOR TRIESTE AND BACKGROUND INFORMATION

The city of Trieste is part of the FVG region: Friuli Venezia Giulia (see map). The funding of mental health care in Trieste is similar to the other health care sectors: nationally, there is a budget and standard packet of care determined per region. It contains no specifications about the kind of care that needs to be given, which gives individual organisations the freedom to organise the care. It is interesting to mention that the FVG region Trieste falls under one of the five so-called ‘autonomous’ regions in Italy. This means that they have more control over their own administration and finance, and also more autonomy in the areas of, for example, health care and education. The region is divided into provinces; the city of Trieste is the capital of the province of Trieste.

Organisation
The city has 236,000 residents and is divided into four districts for health care. The care in the districts is managed by the Health Agency. It has three divisions (mental health, addiction, prevention) and two specialised centres (Cardiovascular and Oncology). Each district has a catchment area of about 60,000 people and has one CMHC centre. It employs, in total, 236 people in CMHC: 26 psychiatrists, 10 psychologists, 9 social workers, 136 nurses, 10 rehabilitation staff, 27 social workers, 15 administrative workers and 20 members of social cooperatives/trainers. The CMHC teams are responsible for the entire spectrum of mental health care, including sheltered housing and crisis care. The care that is offered from the centre is described in detail in Chapter 2.

Key Figures
In 2013, there were a total of 4908 clients registered with the CMHC teams. Each community centre has 1000-1300 registered clients. In 2013, 311 clients were admitted to either the community centre or the SPDC (a total of 643 admissions), with an aver-
age duration of 12 days. People who face a compulsory treatment were admitted here twice as often. In 2013, 18 clients were admitted for compulsory treatment to the hospital and 15 to one of the CMHC centres. Of the 4908 clients, there were 802 (16.3%) who were classified as clients with a high intensive care need. These are clients who need more care and are more often in contact with staff of the CMHC centre. 2275 (46.4%) clients were designated in 2013 as chronic CMHC clients.

Costs
The total costs of CMHC services in Trieste were, in 2013, 18,395,379 Euros. This money was distributed among the following items:

Staff costs comprise the largest part of the expenditure of CMHC services in Trieste. In an internal comparison of mental health services in Trieste, the costs of the psychiatric hospital in 1971 were compared to the costs of the mental health care in 2011. This revealed that the costs have, in proportion, decreased from 28 million Euros in 1971 (then 5 billion lire) to 18 million Euros in 2011 (Mezzina, 2012, PowerPoint). The community-based mental health care therefore appears to be cheaper than working with a major psychiatric hospital. Here, we note that we do not have data to calculate the costs per client. Mezzina (2014) shows that 94% of the mental health care budget is spent on CMHC centres and 6% in the acute ward in the general hospital (SPDC).
Outcomes

Mezzina (2014) points out in a recent article that, due to the interconnectedness of interventions, no efficacy studies of individual interventions are available, but a number of surveys and outcome studies have been carried out. A study into crisis interventions shows that this is effective in the prevention of crisis and relapse of clients (Mezzina & Vidoni, 1995). A national survey shows that the crisis care in a CMHC team is more effective after a 2 year follow-up, especially if it is related to a good relationship, flexibility of care and integrated care (Mezzina, 2014). In an internal survey of 27, high-intensive care clients who were followed for 5 years, a reduction of 20% of the symptoms was found (as measured with the BPRS), as well as a great improvement in social functioning. Nine clients from this group found regular jobs and 12 were able to live independently. There was also a 70% decrease in hospital days (and one client who dropped out). A study on medication compliance (Palcic et al, 2011; Mezzina, 2014) shows 75% compliance with taking anti-psychotics.

Comparison of Utrecht and Trieste in key figures

In the study, we have chosen to compare outcomes on main features of Utrecht with that of Trieste, in order to be able to place observations and results of the mental health care practice in Trieste more easily within the Dutch context. Utrecht was the most logical place, as the initiator of this study (Lister) is an organisation in Utrecht for sheltered housing. The study described in this report was mainly qualitative; but the figures presented here provide a framework within which these observations and conclusions can be placed. It should be emphasised that because of the differences in organisation and financing, but also because of the way numbers are generated, the possibilities to make comparisons are limited and therefore the figures presented here should be viewed with some reservation. Despite these limitations, however, the figures provide an image of the similarities and differences between the two cities. The figures in the tables below are based on the year 2013, unless otherwise stated. Source of the figures from Trieste is the data base of the Health Agency in Trieste in 2013, unless otherwise stated.
Table 1a: Key figures from Utrecht and Trieste (2013)

<table>
<thead>
<tr>
<th>Number of residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trieste 236,000</td>
</tr>
<tr>
<td>Utrecht 321,916</td>
</tr>
<tr>
<td>Netherlands 16,779,575</td>
</tr>
</tbody>
</table>

Table 1b: Key figures from Utrecht and Trieste (2012-2013)

<table>
<thead>
<tr>
<th>Number of people in mental health care</th>
<th>Number of people in mental health care per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trieste 4908</td>
<td>2080</td>
</tr>
<tr>
<td>Utrecht ≈17,000*</td>
<td>5000 à 6000</td>
</tr>
<tr>
<td>of which 14.939 EPA ***</td>
<td>of which 1534 EPA ***</td>
</tr>
<tr>
<td>Netherlands ≈ 900,000**</td>
<td>5000 à 6000</td>
</tr>
<tr>
<td>of which 160,000 EPA ***</td>
<td>of which 954 EPA ***</td>
</tr>
</tbody>
</table>

* Based on the national estimate, this is 17,000 for a region of 320,000. It should be noted that the care prevalence in a city region is, in practice, slightly higher than average. Both in Trieste and in the Netherlands, the youth mental health care is not included.


*** SMI group: people between 18 - 65 years of age with serious mental illness (source: SMI reporting conjoint analysis).

As seen from the above tables, Utrecht has a larger population than Trieste. Moreover, Utrecht is a large city in the Netherlands and Trieste, by Italian standards, is a small town. Both are university cities.

Above are the Dutch figures for both SMI clients and the total number of CMHC clients. This is because, in the Netherlands, the percentage of people with a mental disorder who, at some point, receive formal or informal assistance, is relatively high compared to other European countries. This applies to all diagnostic groups (mental health care in tables, 2014). The number of clients in care is, therefore, difficult to compare precisely between Trieste and the Netherlands.
### Table 2: Inpatient mental health care capacity in 2013

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Admission facilities</th>
<th>Long stay care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Netherlands: Acute and short-term inpatient care</td>
<td>Trieste: CMHC centres and emergency department</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of places</td>
<td>Per 100,000</td>
<td>Number of places</td>
</tr>
<tr>
<td>Trieste</td>
<td>77</td>
<td>32.6</td>
<td>32</td>
</tr>
<tr>
<td>Utrecht*</td>
<td>712.3</td>
<td>221</td>
<td>273.5</td>
</tr>
<tr>
<td>Netherlands</td>
<td>37198</td>
<td>222</td>
<td>11069</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Admission facilities</th>
<th>Sheltered housing facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Number of places</td>
</tr>
<tr>
<td>Trieste</td>
<td>-</td>
<td>45</td>
</tr>
<tr>
<td>Utrecht*</td>
<td>37.5</td>
<td>401.3</td>
</tr>
<tr>
<td>Netherlands</td>
<td>8181</td>
<td>17,948</td>
</tr>
</tbody>
</table>

* National monitor inpatient mental health care (LMIG), 2nd measurement, 2013. The places are calculated based on actual days of stay per year and converted to numbers using the formula: 365 days of stay is one place. Because beds are sometimes not occupied, the number of physical locations/beds in the Netherlands will be higher. For Italy, we do not have data displayed in days stayed and the actual number of beds is shown and calculated per 100,000 population.

** These are 26 places spread over 4 CMHC centres and 6 beds in the acute psychiatric ward of the general hospital.

Trieste has 45 beds in apartments/group houses as opposed to 401.3 sheltered housing places (based on days of stay) in Utrecht. This is a difference of about a factor of 10. The ratio of beds in admission wards is comparable: In Trieste, there are 26 beds in four district centres and the acute psychiatry ward of the hospital has six beds. These 32 beds in Trieste also differ by about a factor of 10 with a total of 311 places for Acute and short-term inpatient care and Long stay care in Utrecht. In the Netherlands, 25% of the available admission places (Acute and short-term inpatient care and Long stay care) are situated in a closed ward. In Trieste, they do not work with closed doors. Obviously, there is a big difference in the type of beds offered: In
Trieste, for example, there are no beds similar to the ‘long stays (of more than 1 year)’ as we know in the Netherlands.

From the above table, it can be concluded that Trieste, compared to the Dutch mental health care:

• works with 20% of the number of Dutch admission beds;
• works with 18% of the Dutch number of sheltered housing places;
• has no places for long stays;
• works exclusively with open doors compared to 25% admission places in closed wards in the Netherlands.

**Table 3a: number of admissions to mental health care facilities in 2013 (per 100,000 inhabitants)**

<table>
<thead>
<tr>
<th></th>
<th>Trieste</th>
<th>Netherlands</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>272</td>
<td>≈ 420*</td>
</tr>
</tbody>
</table>

* Figure based on National monitor inpatient mental health care (LMIG): 60,000 admission periods by 80% of the participating facilities. For the Netherlands, the estimation on this basis is that there are about 70,000 admission periods.

**Table 3b: duration of stay inpatient services, by type of facility (2013)**

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Admission facilities</th>
<th>Admission facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Netherlands: Acute and short-term inpatient care</td>
<td>Long stay care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trieste: CMHC centres and emergency department</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trieste</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Netherlands*</td>
<td>185</td>
<td>50% &lt; 1 month</td>
<td>56% &gt;4 years</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Community centres Trieste</th>
<th>Crisis department Trieste</th>
<th>Sheltered housing facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trieste</td>
<td>Au. 12 days</td>
<td>Au. 3 days</td>
<td>not known</td>
</tr>
<tr>
<td>Netherlands*</td>
<td></td>
<td></td>
<td>40 %&gt;4 years</td>
</tr>
</tbody>
</table>

* National monitor inpatient mental health care (LMIG) 2nd measurement, 2013.
In addition to the much smaller number of beds, it is striking how short the stay of clients is who are admitted in Trieste. The duration of stay in the sheltered housing facilities in Trieste is unknown. It can be assumed that this is long-term, because major efforts are made to help people live as independently as possible. People who do reside in group homes have such serious problems that living independently is not a realistic option in the short term. We visited, for example, a residential facility at the former hospital site where elderly people live who also have severe physical and cognitive disabilities in addition to psychiatric problems.

Table 4: Compulsory admissions in 2013 (per 100,000 residents)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trieste</td>
<td>11</td>
</tr>
<tr>
<td>Utrecht</td>
<td>213*  (RM and IBS)</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>136** (RM and IBS)</td>
</tr>
</tbody>
</table>

* Source: RIVM [National Institute for Public Health and the Environment] care atlas 2009. This figure is calculated based on the number of involuntary admissions in 2009 in Utrecht, by calculating the proportion of the total involuntary admissions (IBS and RM) in 2009 that took place in the city of Utrecht (3%). This percentage is then used to estimate the number of involuntary admissions in the Utrecht region in 2013, assuming that Utrecht took on the same share of the RM/IBS as in 2009.

** Source: Council for the Judiciary.

Although involuntary admissions are avoided as much as possible, in Trieste this is also sometimes one of the means that will be used to avert serious danger or deterioration. The involuntary admissions took place in one of the CMHC centres or in the acute ward of the psychiatric hospital. From Table 3 and 4, it can be concluded that, in Trieste, in comparison to the Dutch mental health care system:

- on an annual basis: 40% fewer admissions;
- the duration of admission is much shorter;
- they work with 8% of the Dutch number of involuntary admissions.

Table 5: Suicides (per 100,000 residents)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trieste</td>
<td>10,6*</td>
</tr>
<tr>
<td>Utrecht</td>
<td>15,45**</td>
</tr>
<tr>
<td>Netherlands</td>
<td>11,04***</td>
</tr>
</tbody>
</table>

* Source: Meggina, 2014
** Figure for 2012, 15+ group. Source: G4 / User
*** Source: CBS / Statlin
In Trieste, a project has been set up (Amalia) aimed at reducing suicide. For Trieste, the figure amounts to, on average, 10.6 per 100,000 residents. This figure was for the whole of Italy in 2012, 6.67 per 100,000 inhabitants (source: Eurostat). Dell ‘Aqua reported in 2003 that the suicide rate in 20 years in Trieste had been reduced from 25 to 12 per 100,000 residents (Dell’ Aqua / Mezzina in 2014).

Table 6a: Cost of mental health care in Euros (2012)

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Per capita</th>
<th>Per patient in care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trieste</td>
<td>18,395,379.02*</td>
<td>79,40</td>
<td>3748</td>
</tr>
<tr>
<td>Netherlands</td>
<td>5,820,000000**</td>
<td>347</td>
<td>-</td>
</tr>
</tbody>
</table>

* Source: data base MHD Trieste and PowerPoint A Cassin, 10 December 2014
** CBS

For Utrecht, we do not have the total mental health care costs at our disposal, but we do have the costs of SMI clients for 2013:

Table 6b: Costs of SMI clients in Utrecht (2013)

<table>
<thead>
<tr>
<th>Costs</th>
<th>Total</th>
<th>Per capita</th>
<th>Per SMI client</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utrecht</td>
<td>85,057,552</td>
<td>264</td>
<td>17,222</td>
</tr>
</tbody>
</table>

Source: Reporting conjoint analysis Health Insurers Netherlands (2014)

From the above table, it can be concluded that Trieste, in comparison to the Dutch mental health care, works with 23% of the budget (per capita).

Clients in prison and homeless care

Both for the Netherlands and for Trieste there are no conclusive figures on the prevalence of psychiatric problems among detainees. Based on interviews with staff at the prison programme that is run by the MHD (Mental Health District) in Trieste, an estimated 30% of the detainees suffer from psychiatric problems. These could be clients who, during treatment, were remanded in detention, or those who, during detention were found to have psychiatric problems. Staff members of the prison are being trained by CMHC staff to be able to identify this better. As described in Chapter 2, the MHD has a programme in which clients are visited in prison and
receive treatment. From each centre, there are 4 or 5 health care providers involved. In addition, in Italy there are forensic psychiatric hospitals. At the moment, there is no one from Trieste staying in such a facility. The forensic sector is in the process of reorganisation at this time.

Dutch research shows that 4-6% of the detainees suffer from a psychotic disorder, 17% have a mental disability, 14-35% suffer from a mood disorder and 30% have an adjustment disorder and meet the criteria for substance dependence. Also, personality disorders are overrepresented among prisoners. The Council for Social Development (2007) estimates that, in total, around 70% of the prisoners have psychological or psychiatric problems.

Homeless Care

In Trieste, the homeless care is organised by the municipality which has contracted it out to various charities (Campo San Martino, ICS and Caritas). There are the following facilities:

- 23 beds for nighttime shelter
- 40 beds for long-term stays through Caritas
- 12-15 beds for longer stays through the municipality

After staying in one of these facilities, there is the possibility via the social housing association (Alter) to obtain a home. They are required to provide houses for ‘special groups’. The homeless care has no figures on the total number of homeless people, but it does have figures on the number of people using the facilities (report by the municipal social service).

<table>
<thead>
<tr>
<th>Table 7: Homeless care in Trieste (2012-2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nighttime shelter</strong></td>
</tr>
<tr>
<td><strong>Daytime shelter</strong></td>
</tr>
<tr>
<td>** Longer stay Caritas and municipality**</td>
</tr>
</tbody>
</table>

Source: Annual Report 2012-2013 Campo San Martino
Our contact person of the homeless care organisation indicates that the number of people actually living on the streets of Trieste is small, but that many people who use day care provisions have no ‘usable’ house (no water, electricity etc). People who are in care at the CMHC in Trieste are also supported in case of housing problems and, if necessary, temporarily housed in a CMHC. Based on this policy, it is argued that there is no homelessness among the clients in Trieste (Mezzina, 2014). However, from our conversation with the homeless care, it appears that, among the homeless people, there is a small group who are struggling with mental problems, but are not (yet) in care. The opinion of homeless care is that the CMHC could do more outreach work for this group. Our conversation partner points out that in particular, the care for people with both psychiatric and addiction problems (dual disorders) could be improved. The major part of this group does have a roof over their heads: there is no shortage of beds in the night shelter and the MHD does work together in projects provided by the municipality and organisations for homeless care and refugees. Explanations that are given for this are that there is a lack of time and money at the centres. It also concerns a group of people who often avoid care.

In Utrecht, the project ‘Binnenplaats’ is strongly committed to finding shelter for the substantial group of homeless people. In 2002, the covenant ‘for a Healthier Utrecht’ was concluded between the municipality of Utrecht, the health care administration office, Agis, and all involved parties in addiction care, social care and mental health care. Various health care providers, including SBWU (now Lister), were set the task to establish hostels: permanent housing facilities where long-term addicted homeless people could stay and where drug use was allowed in their rooms. Guidance was aimed at offering everyone a personal care path. In an evaluation of this approach, it is clear that it leads to, among other things, a decrease and stabilisation of drug use and the reduction of judicial problems (Vermeulen et al, 2005).

Clients with work/daytime activities
In Trieste, there is a focus on employment in social cooperatives, working grants and training in regular jobs. In 2013, a total of 176 adults (83 women, 93 men) were enrolled in job placement. The majority of people who took part in the job placement were in the ICD-10 diagnostic categories F20 - F29 (schizophrenia, schizotypal and delusional disorders, 50% of clients). In Trieste, social cooperatives employ 600 people,
of whom 70% have a disability. There are 200 people annually with a working grant, of whom about 10% transfer to regular work after 2 years. Before the crisis, the figure was 20-25%.

A survey by the Dutch panel Psychisch Gezien [Psychologically Speaking], shows that, in the Netherlands, 17% of respondents between 15-64 years of age have work (> 12 hours). Clients who have been in treatment at a mental health care facility have work less often than people who are struggling with persistent mental health problems, but do not receive mental health care (16% versus 24%).

Conclusion
The focus of this study was a qualitative analysis of practice in Trieste and the lessons that can be learned from this for the practice in the Netherlands. In this appendix, some key figures about Utrecht and Trieste have been put into tables in order to place the previously presented analysis within a framework. Although the possibilities of comparing the mental health care system in Utrecht/the Netherlands and Trieste are limited, several key figures deserve special attention. This is, in particular, the ratio of beds in psychiatry and sheltered housing, where, in Trieste, there is a factor 10 less of both. In addition, the number of people involuntarily admitted is substantially lower. There are no indications that there are many more people in Trieste staying in alternative facilities such as prison, forensic care or homeless care. However, there does seem to be a shortage of outreach care for the homeless.

We have no figures on private practices of mental health care professionals: from discussions about this with staff members of the CMHC’s and clients, the picture emerges that, while private practices are present and offer therapy, these practices have no facilities where people with serious psychiatric problems can stay for longer periods.
APPENDIX 2: PROGRAMME FOR FAMILY SUPPORT

The burden on family members of persons with a mental disorder

Information, organisations, networks, mutual support

Programme 2014
Since 1987, the CMHC in Trieste has supported initiatives for information, education and active participation for family groups. Increasing knowledge of family members and setting up concrete programmes aimed at mutual aid (peer support) are some of the services that are designed to support families and to use their experiences to help themselves and others.

Treatment and recovery for people with mental health problems is impossible without the active involvement of the family. The importance of family participation in the work of the CMHC is, by now, abundantly clear. The course of mental disorders changes significantly when one is able to create a positive atmosphere within the family and if all of the parties involved are given the proper tools and knowledge to be empowered to put the problems in perspective and to regard them in a positive light. This approach makes the cooperation and synergy between family members, the person directly involved, and CMHC easier.

Family support comes from the need of families to cope, through organised support, with emotional and psychological problems and with the concern they experience daily in dealing with a family member with mental illness.

The family programme is conceived as an integral part of the treatment services for the clients (utenti) and their families. The family gatherings are intended to increase knowledge about mental disorders, to promote dialogue regarding the beliefs and ideas and to discuss how irrational the experiences with mental illness sometimes are. At the same time, it is also an opportunity to see these experiences as a
moment for growth and change. The programme would like, in this way, to offer parents the tools to come out of the tunnel of the 'guilt,' to be a true support for their relatives and to support their loved one on his way to recovery and cure.

**General goals of the family programme 2013 -2014**

- To increase the parents' knowledge about mental illness and the expectations and limitations of treatment in relation to the capacity, resources and goals of the CMHC services.
- To reduce the stress, anxiety and tension by making the group a participant in (part of) their own experiences and burden and to talk, listen and discuss it together.
- To strengthen the social network and to expand and intensify the contact between family members and with other groups (cultural organisations, politics, sports, leisure, etc.) so that mutual aid and interpersonal relationships are strengthened.
- To actively involve the family group in defending the fundamental rights of persons suffering from a mental disorder and to involve their families and adequate resources for treatment and recovery.
- To make contact with the government with more focus and awareness.

The participation of families in the educational and informational programmes shows the following effects:

- An improvement of the quality of life of both the person with a mental disorder and the family;
- A reduction or absence of crises and relapses;
- An improvement in the social functioning of people with a mental disorder.

The participation of family members/parents in these programmes is not only useful but also absolutely essential for improving the treatment outcome.

**Activities for family members 2014**

The CMHC organises a fortnightly, joint informative programme consisting of three modules. The first module examines the roles of the family and the resources that
will allow them to better understand the experiences of their loved ones. The second module is aimed at deepening the communication style and strategy. Through the work in the group, the issue of the ‘relationship’ with one’s loved ones is dealt with and we try to give concrete pointers on how to improve communication within the family. In the third module, we deal with common questions that come up about crises, daily schedules, what the CMHC has to offer, the effect of medication and the facilitation of recovery. You can participate in this programme at the invitation of the Center for Mental Health (community centres) as part of the overall treatment plan.

The programme was developed by experts and focuses on family members who live together with people who have gone through a psychotic disorder. The meetings are organised centrally and are open to family members of clients from all CMHC centres. The location of the programme is the building of the Directorate of the Department of Mental Health in the Via Weiss 5.

Furthermore, the following is organised:
1. Four informational meetings for family members of children with a first psychosis to provide information quickly and to deal with the fear and anxiety about the first crisis.
2. Meetings where general information is provided for family members and local residents.
3. Group meetings for family members, at least once or twice a month, aimed at information exchange and mutual support.

Translation from Italian: Karin van Bentum
## APPENDIX 3: TREATMENT FORMAT

Center for Mental Health (Centro Salute Mental) Trieste

Treatment proposal focused on the personal budget  
(Individual care plan)

Date:

Description of situation, background, history, reason for problems:

### Personal information

<table>
<thead>
<tr>
<th>Surname</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
</tbody>
</table>

Are the socio-demographic data present in the file?  
(1 = No 2 = Yes)

If not present, **collect data at:**

<table>
<thead>
<tr>
<th>Nationality</th>
<th>(1 = Italian 2 = EU member 3 = Not an EU member but with a residence permit or tourist visa 4 = Not an EU member; without a residence permit)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Marital status</th>
<th>(1 = Single, Unmarried 2 = Married 3 = Separated 4 = Divorced 5 = Widower/Widow)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Living situation</th>
<th>(1 = Alone 2 = Living with family (parents/brothers/sisters) 3 = Only with spouse or partner 4 = Only with children 5 = Living with partner and children 6 = Living with other relatives or friends (other than partner, parents, brothers/sisters) 7 = Living in a group home (group of clients who live together) 8 = Living in an old-people’s home or other institution without a psychiatric character 9 = Without fixed place of residence 10 = Other)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>School career</th>
<th>(1 = Alpha/beta without diploma 2 = Primary school 3 = Lower classes of high school 4 = Vocational school 5 = Secondary school diploma 6 = University diploma 7 = Graduate degree)</th>
</tr>
</thead>
</table>
**Work situation** (1 = permanent work, 2 = temporary work 3 = practical training course - internship 4 = unemployed 5 = looking for a first job 6 = out of work 7 = a student 8 = housewife 9 = work-disabled 10 = other)

**Occupation** (0 = none 1 = entrepreneur 2 = profession (whereby master's degree is required) 3 = profession (whereby bachelor's degree is required) 4 = shopkeeper (permanent position) 5 = craftsman 6 = outreach work 7 = office worker 8 = clerk, hospitality industry 9 = skilled labourer 10 = unskilled labourer 11 = farmer 12 = other)

**Income** (1 = personal income 2 = family income 3 = other)

---

**Relationship with the Center for Mental Health (CSM) and typology of the interventions. How often has he/she visited the CSM?**

Base this on the times when he/she feels good and not the moments of crisis

1 = Almost daily
2 = 2 to 3 times a week
3 = Once a week
4 = 2 to 3 times per month
5 = Once a month
6 = Less than once a month

**Why does he/she come to the CSM?**

1 = Pharmacological treatments
2 = Supportive talks
3 = Interventions aimed at recovery and participation (A.A.R.S., A.F.L. ==> These are a kind of ‘working grants’ for people with disabilities)
4 = Conversations with relatives, neighbours, friends, work environment
5 = Financial support

**Is there an organic pathology?** (1 = No 2 = Yes 99 = unknown)

If yes, **what substance is most commonly used?**

**Is there alcohol abuse?** (1 = No 2 = Yes)

**Is there abuse of psychotropic substances?** (1 = No 2 = Yes)

If yes, **what substance is most commonly used?**

1 = Opiates, Cannabis, Cocaine, Ecstasy and similar substances, Amphetamine
2 = Bengodiazepine
### Gravity/severity
The team assesses the relationship with the person with respect to his/her attitudes and behaviour toward the centre

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Constant behavioural difficulties due to poor therapy adherence</td>
</tr>
<tr>
<td>2</td>
<td>Regular behavioural difficulties due to poor therapy adherence</td>
</tr>
<tr>
<td>3</td>
<td>Occasional behavioural difficulties</td>
</tr>
<tr>
<td>4</td>
<td>Some minor behavioural problems</td>
</tr>
<tr>
<td>5</td>
<td>Has a good relationship with the centre</td>
</tr>
</tbody>
</table>

### Inclusion criteria in the Individual Care Plan

#### Presence of a severe mental disorder

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Schizophrenia, schizotypal syndromes and delusions, including psychotic disorders due to the use of drugs</td>
</tr>
<tr>
<td>2</td>
<td>Personality disorders</td>
</tr>
<tr>
<td>3</td>
<td>Mood Disorders</td>
</tr>
</tbody>
</table>

#### Why is the current Individual Care Plan being used?

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Insufficient life skills with respect to age and gender</td>
</tr>
<tr>
<td>2</td>
<td>Limited ability to cope with the disorder</td>
</tr>
<tr>
<td>3</td>
<td>Insufficient and/or weak social or family network</td>
</tr>
<tr>
<td>4</td>
<td>Other (example: passing final exams)</td>
</tr>
</tbody>
</table>

### Commencing date of current Individual Care Plan:

- **Involved professionals from the medical and social sector and the social network**

<table>
<thead>
<tr>
<th>Are there one or more psychiatrists and/or psychologists involved</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = No 2 = Yes</td>
<td></td>
</tr>
</tbody>
</table>

If yes, **specify**

<table>
<thead>
<tr>
<th>1 = Psychiatrist</th>
<th>2 = Psychologist</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is there one person responsible for the Individual Care Plan?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = No 2 = Yes (note name of the person responsible)</td>
<td></td>
</tr>
</tbody>
</table>

If yes, **what is his/her professional profile?**
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Nurse M.E.</td>
</tr>
<tr>
<td>2</td>
<td>Social worker</td>
</tr>
<tr>
<td>3</td>
<td>Rehab Specialist</td>
</tr>
</tbody>
</table>

Is there a designated case manager, other than the head and/or the person responsible for the Individual Care Plan? (0 = No 1 = Yes)

If yes, what is his/her professional profile? (1 = Nurse 2 = Social Worker 3 = Rehab Specialist 4 = Professional caregiver)

Note the first and last names

Are there people in the social, non-institutional network involved in the Individual Care Plan? (1 = No 2 = Yes)

If yes, specify

1 = Family

2 = Neighbours

3 = Friends, colleagues

4 = Other persons

In what areas in the Individual Care Plan must a contact person from the CSM be deployed? (Indicate the contact person)

1 Young people:

2 Training and work:

3 Social integration and participation:

4 Family:

5 Social management:

6 PGB (Personal Care Budget) and integrated care:

7 Housing assistance:

8 Women:

9 Eating Disorders:

10 Trans-culturalism:

11 Medication:

12 Prison:

13 Micro Area (neighbourhood team):

14 Health - Right to health:

15 Other:
**Are there other societal and health services and/or professionals involved?**

(1 = No 2 = Yes)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>2</td>
<td>District</td>
</tr>
<tr>
<td>3</td>
<td>Addiction Care</td>
</tr>
<tr>
<td>4</td>
<td>Micro Area (neighbourhood team)</td>
</tr>
<tr>
<td>5</td>
<td>Municipal Social Services</td>
</tr>
<tr>
<td>6</td>
<td>Other services: School, etc</td>
</tr>
<tr>
<td>7</td>
<td>Administrator</td>
</tr>
<tr>
<td>8</td>
<td>Other: Social cooperative</td>
</tr>
</tbody>
</table>

**Has the coordination consultation working group planned to work with other societal and health services and/or professionals?** (1 = No 2 = Yes)

If yes, specify the frequency and the service and/or the professional

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Once a week</td>
</tr>
<tr>
<td>2</td>
<td>Twice a month</td>
</tr>
<tr>
<td>3</td>
<td>Once a month</td>
</tr>
<tr>
<td>4</td>
<td>If necessary</td>
</tr>
<tr>
<td>5</td>
<td>Other</td>
</tr>
</tbody>
</table>

**Has the working group planned follow-up meetings for the Individual Care Plan?**

(1 = No 2 = Yes)

If yes, specify the frequency

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Once a week</td>
</tr>
<tr>
<td>2</td>
<td>Twice a month</td>
</tr>
<tr>
<td>3</td>
<td>Once a month</td>
</tr>
<tr>
<td>4</td>
<td>If necessary</td>
</tr>
<tr>
<td>5</td>
<td>Other</td>
</tr>
</tbody>
</table>

**Criteria for starting case management:**

- The main problem concerns the mental health;
- There is a profound change that the client must learn to deal with;
- There is a definitive multidisciplinary plan with common objectives;
There are at least two areas of intervention (contacts within the centre);
There is at least one service in question from outside the departmental area.

Useful numbers

Assessment of the current Individual Care Plan

Illness awareness of the client

1. Does not understand where his sense of unease comes from, does not connect it to a mental disorder and does not realise the impact it has on his quality of life

2. Does not understand where his sense of unease comes from and does not connect it to a mental disorder

3. Understands that his sense of unease may be caused by a mental illness but attributes this solely to the events of his life

4. Understands that his sense of unease is caused by a mental disorder that has been, to a large extent, affecting the events in his life

5. He is aware of his mental illness and the impact that the events in his life have had on this

Control over the disorder

1 = No autonomy in dealing with the disorder partly due to lack of illness awareness

2 = Little autonomy in dealing with the disorder and/or does not set any personal goals

3 = Sets goals and looks for ways to deal with the disorder, but usually it does not work

4 = Deals effectively with the disorder (detects and identifies signs of a crisis, effectively applies control strategies and symptom control), sets life goals and strives to achieve them but with some problems, which are
visible only to people who know him well (staff, family, social network)  
5 = as 4, but without any problems  

<table>
<thead>
<tr>
<th>Daily care for himself</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = Is unable or struggles with 1-2 or nearly all areas (dressing, bathing, using toilet and showering, grooming, choice of foods)</td>
<td></td>
</tr>
<tr>
<td>2 = Clear problems in areas 1-3, but no incompetence</td>
<td></td>
</tr>
<tr>
<td>3 = Marked difficulties, easy to recognise, but not severe</td>
<td></td>
</tr>
<tr>
<td>4 = Problems exist, but are not obvious (for example, a good daily facial care but a reluctance to shower)</td>
<td></td>
</tr>
<tr>
<td>5 = Autonomy in caring for himself in keeping with his/her age, gender and social role</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Autonomy in daily activities</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = Unable or has great difficulty with activities 1-2 or obvious problems with almost all activities (managing money, shopping, using public transportation, use of telephone, care for his own living space)</td>
<td></td>
</tr>
<tr>
<td>2 = Clear problems with 1-3 activities, but not serious</td>
<td></td>
</tr>
<tr>
<td>3 = Clear difficulties, easily recognised through one or more activities</td>
<td></td>
</tr>
<tr>
<td>4 = No obvious problems with daily activities</td>
<td></td>
</tr>
<tr>
<td>5 = Normal autonomy in daily activities that are required, in keeping with age, gender and social role</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Work, study and activities that are considered socially useful</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = If unemployed and/or looking for a first job in the ‘Personal Data’ section</td>
<td></td>
</tr>
<tr>
<td>1 = Does nothing or almost nothing or what he/she does is regarded as highly inappropriate or disruptive</td>
<td></td>
</tr>
<tr>
<td>2 = Clear performance issues or problems in the relationship with colleagues/superiors at work or at school or he/she only carries out activities that are considered useful irregularly</td>
<td></td>
</tr>
<tr>
<td>3 = Problems with punctuality and performance or in the relationship with colleagues/superiors at work or at school that occur during most of the day</td>
<td></td>
</tr>
</tbody>
</table>
4 = Some problems with punctuality and performance or in the relationship with colleagues/superiors
5 = No significant problems in terms of work, study or other activities

**Living situation**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Without fixed abode</td>
</tr>
<tr>
<td>2</td>
<td>Severe problems with housing situation (e.g. no heating, water, etc.)</td>
</tr>
<tr>
<td>3</td>
<td>Clear problems, but not as severe as in 1 (e.g. lives in a remote area or has a few maintenance issues)</td>
</tr>
<tr>
<td>4</td>
<td>A few issues (e.g. unpainted, household equipment must be replaced, no shower curtain)</td>
</tr>
<tr>
<td>5</td>
<td>Normal situation, good conditions</td>
</tr>
</tbody>
</table>

**Financial situation**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No income</td>
</tr>
<tr>
<td>2</td>
<td>Insufficient income to buy food and/or clothing (e.g., welfare benefits, disability benefits, minimum pension, etc.)</td>
</tr>
<tr>
<td>3</td>
<td>Insufficient income to make irregular expenditure (purchase household appliance, have painting done, extraordinary expenses)</td>
</tr>
<tr>
<td>4</td>
<td>Insufficient income to pay for luxuries or extraordinary expenses (holidays, maintaining means of transport)</td>
</tr>
<tr>
<td>5</td>
<td>Adequate income, good conditions</td>
</tr>
</tbody>
</table>

**Social and family network**

**Leisure activities**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Spends almost all free time doing nothing</td>
</tr>
<tr>
<td>2</td>
<td>Spends most of the free time doing nothing</td>
</tr>
<tr>
<td>3</td>
<td>Spends about half the free time with individual activities that have little to no purpose (watching TV, going to the city or going shopping without clear purpose)</td>
</tr>
<tr>
<td>4</td>
<td>Spends some of the free time with individual activities that have no clear purpose, but spends much of the remaining leisure time on active hobbies and interests</td>
</tr>
<tr>
<td>Level</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td>5</td>
<td>Spends half or more of the free time on active hobbies and interests (sports, movies, reading, cooking, walking), social activities or volunteer work</td>
</tr>
</tbody>
</table>

**Social relationships**

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Total or almost total social isolation</td>
</tr>
<tr>
<td>2</td>
<td>Friendships and support lacking</td>
</tr>
<tr>
<td>3</td>
<td>Few and superficial social relations</td>
</tr>
<tr>
<td>4</td>
<td>Some lack of friendships and/or social support outside the family</td>
</tr>
<tr>
<td>5</td>
<td>Good social relationships</td>
</tr>
</tbody>
</table>

**Partner Relationships**

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No relationship or sexual contact</td>
</tr>
<tr>
<td>2</td>
<td>Obvious problems characterised by poor communication or impending breech</td>
</tr>
<tr>
<td>3</td>
<td>Clear problems; disagreement or lack of support in the partner relationship</td>
</tr>
<tr>
<td>4</td>
<td>Greater problems than usual</td>
</tr>
<tr>
<td>5</td>
<td>Good, stable relationships in which people support one another</td>
</tr>
</tbody>
</table>

**Relationship with family**

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Family ties broken, major fracture</td>
</tr>
<tr>
<td>2</td>
<td>Conflict situations or lack of communication</td>
</tr>
<tr>
<td>3</td>
<td>Shortage of ties or lack of support from family and roommates</td>
</tr>
<tr>
<td>4</td>
<td>Greater problems than usual</td>
</tr>
<tr>
<td>5</td>
<td>Good family relationships where trust and support can be found</td>
</tr>
</tbody>
</table>

**Willingness and ability of the informal network outside the institution to help and cooperate**

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Totally unwilling to help or even against it</td>
</tr>
<tr>
<td>2</td>
<td>Barely willing, despite the fact that one is possibly able to do so</td>
</tr>
<tr>
<td>3</td>
<td>Willing, but has trouble cooperating for various reasons</td>
</tr>
<tr>
<td>4</td>
<td>Extremely willing to help, and at least one person is able to do so</td>
</tr>
<tr>
<td>5</td>
<td>As 3, and a participant in activities supported by the centre</td>
</tr>
</tbody>
</table>
Family burden (99 in the absence of family or if there is a breech in family relations)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Heavy burden on family/roommates for the benefit of the person in question</td>
</tr>
<tr>
<td>2</td>
<td>Objective and/or subjective burden for at least one member of the family</td>
</tr>
<tr>
<td>3</td>
<td>Frequent refusals or difficulties for at least one member of the family</td>
</tr>
<tr>
<td>4</td>
<td>Irregular refusals (parties or holidays in which the family would participate if the person did not suffer from the disorder)</td>
</tr>
<tr>
<td>5</td>
<td>No particular problems</td>
</tr>
</tbody>
</table>

Total number of points

---

---
<table>
<thead>
<tr>
<th>Area Goals</th>
<th>Points</th>
<th>Goals</th>
<th>Actions</th>
<th>Expected Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-care</td>
<td>5</td>
<td>Maintaining good care of oneself.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independence in activities</td>
<td>3</td>
<td>Reducing the distrust of oneself. Increasing self-esteem and improving ability to deal with stress. Support in one's study and in organising it.</td>
<td>Interviews, care of personal living space, study support.</td>
<td>Daily.</td>
</tr>
<tr>
<td>Work, study or activities that are considered socially useful</td>
<td></td>
<td>Increase concentration. Improve interpersonal relationships and network. Increase of effort and of accuracy. Study support. Passing final state exams and graduating from high school.</td>
<td>Study support. Volunteer work in project Hubility and, possibly, working grant after leaving school cycle.</td>
<td>Study support 2x week (6 hours per week). Daily organisation of studies. Project Hubility 2x per week.</td>
</tr>
<tr>
<td>Living circumstances</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial situation</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff CSM</td>
<td>Staff other services</td>
<td>Timetable Evaluation</td>
<td>Outcome-indicator</td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>----------------------</td>
<td>----------------------</td>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td>Properly.</td>
<td></td>
<td>Handling the disorder. Active participation in the making of the therapeutic plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintaining.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health care providers.</td>
<td>Educational social cooperative/enterprise.</td>
<td>Weekly</td>
<td>Normal autonomy in the desired activities, in keeping with age, gender and social role.</td>
<td></td>
</tr>
<tr>
<td>Parenting.</td>
<td>3 (school) months 6 months (working grant).</td>
<td>Pass final exam and earn high school diploma. No clear problems in work or study.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Area Goals</td>
<td>Points</td>
<td>Goals</td>
<td>Actions</td>
<td>Expected Frequency</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>--------</td>
<td>----------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Leisure activities</td>
<td>3</td>
<td>Part of the day engaged in structured and focused activities, letting go of deviant friendships, involving family.</td>
<td>Youth group. Participation in outings with the sports clinic.</td>
<td>3 times a week.</td>
</tr>
<tr>
<td>Social relationships</td>
<td>4</td>
<td>Increased awareness of the necessity of healthy friendships.</td>
<td>Participation in youth group Sailing Activities Hubility project. Interviews.</td>
<td>Daily.</td>
</tr>
</tbody>
</table>
| Relationship with family                      | 4      | Improve communication of the family members.  
Learn to recognise one's own needs and desires and to express them.  
Dealing with one's own role. Improving ability to deal with indoor and outdoor areas. | Sessions together with family.  
Individual sessions.  
Sessions with family members.                                             | Daily.               |
| Willingness and opportunity of the informal network outside the institution to help and cooperate | 4 | More involvement of family and friends network in supporting the client in improving his lifestyle and habits. | Sessions with family members.  
Individual sessions.  
Meeting friends.                                                             | Weekly.              |
| Family burden                                 | 1      | Decreasing family burden Making the family receptive to the inconvenience. | Participation in family group.  
Individual sessions with family members.                                              | Weekly.              |
<table>
<thead>
<tr>
<th>Personnel involved CSM</th>
<th>Personnel involved other services</th>
<th>Timeline Evaluation</th>
<th>Outcome indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting skills at addiction centre (Sert).</td>
<td>3 months.</td>
<td>Spending part of the time on hobbies and focused activities.</td>
<td></td>
</tr>
<tr>
<td>Parenting.</td>
<td>3 months.</td>
<td>Good social relations.</td>
<td></td>
</tr>
<tr>
<td>Educator at addiction centre (Sert).</td>
<td>6 months.</td>
<td>Positive and stable relationships.</td>
<td></td>
</tr>
<tr>
<td>Educator.</td>
<td>6 months.</td>
<td>Good family relationships where trust and support can be found.</td>
<td></td>
</tr>
<tr>
<td>6 months.</td>
<td>Willingness of family and friends to join in with some activities organised by the Centre.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 months.</td>
<td>Reducing stress and burden without denying oneself specific things.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Kunneman, H. (2013). *Kleine waarden en grote waarden; normatieve professionalisering als politiek perspectief* (Small values and large values; normative professionalisation as a political perspective). Publisher: SWP. Inaugural lecture.


Literature consulted:

Altrecht bezoekt Trieste: Report of 6-day visit to ‘the Italian psychiatry.
8 t/m 13 December 2002.

Baarn: Ambo.


Deviant, 20, 18-21.

Dell’Acqua, G. (2012). “From the Asylum to territorial services for mental health” - IDEASS 2012.


Hefford, M., Ehrenberg (2010). La Via Triëst. Discussion paper 1: comparing the Triëst approach to delivering mental health services with New Zealand models. LECG.


Ramon, S.E. & Williams, J.E. (2005). Mental Health at the crossroads; the promise of the psychosocial approach. Aldershot: Ashgate.


Websites consulted
www.triestesalutementale.it/english/index.htm

http://statline.cbs.nl/Statweb/

www.cbs.nl

www.zorgatlas.nl

www.utrecht.nl

Project management
Sonja van Rooijen
Christien Muusse

Authors
Christien Muusse
Sonja van Rooijen

With the cooperation from
Dorine Bauduin
Karin van Bentum
Frank van Hoof
Samuele Marsura
Ionela Petrea

Translation
Sandy Reijnhart, TVcN

Financing
Lister, Altrecht GGZ, GGZ Breburg, European Assertive Outreach Foundation/EAOF

Layout
Lister, communications department
Illustration cover: Anne Gadellaa

ISBN
978-90-78908-00-5
This publication can be ordered: www.lister.nl/FreedomFirst

Lister
Furkaplateau 15
3524 ZH Utrecht
The Netherlands
T + 31 30 236 10 70
E info@lister.nl
www.lister.nl

© 2015, Trimbos-instituut, Utrecht