Best Practice in Teaching and Learning of:

ASUITS, Trieste, Italy

1. What is your definition of experienced based learning?

Experience based learning is the capacity of drawing from our own lived experience, to reflect on it and be in a real and authentic relationship with the other person. Every one has an experience based learning and be mindful of it enable the person to accept the fact that we have different experiences, belief systems and motivation. Be a "peer supporter" means therefore relying on this "lived expertise", which enable the person to work on him/her in a ongoing process of recovery.

We think that recovery is not just something for people diagnosed with a sever mental health problem but regards all the people that want to emancipate themselves and grow up. It is the responsibility and duty of each person that act/work in the "helping" sector to not take away hope from those that are in a difficult moment of their life.

Experience based learning is at the core of user movement, that claim the right for service user to be recognized as "expert by experience" ad therefor to have the same amount of power of professionals that are "expert by profession": user lead movements represent the mayor form of challenge to the medical ideology as they overcome the use of diagnosis and claim the dignity of their unusual belief and perceptions. They think that the right question in psychiatry should not be "*what is wrong with you?*" but rather "*what happen to you?*".

2. What do / would you call your best practice?

- Community based mental health services
- Aurisina Rems
- Personal healthcare budget system
- Recovery learning community centred around a recovery house
- Peer support workers
- Widespread day centre

3-4-5. Brief description / goal of your best practice
What were the reasons / motives to introduce and continue your best practice?
What was your starting situation?
When did you start it?
Which learning goal/targets does your best practice have?
Which (learning or teaching) methods are used?
Which themes are addressed?
Which ressources are used?
What requirements do the participants have to fulfil?
What standards does your best practice have?

1) <u>Community Based Mental Health Services</u>:
   Trieste is an internationally known experience that started from the first closure of a psychiatric hospital in Europe (1971-1980) as a process of change of thinking, practice and services. The current organization of the Trieste DMH derives from the deinstitutionalization

of the San Giovanni Mental Hospital, which, in its heyday, had approximately 1200 inpatients. While phasing it out, a complete alternative network of community services was set up and today comprises the following:

- 4 Community-based Mental Health Centers, each looking after a catchment area of 50,000 to 65,000 inhabitants, all open 24 hours a day, with four to eight beds each;
- 1 one General Hospital Psychiatric Unit with six beds, mainly used for emergencies at night, with very short stays of usually less than 24 hours;
- the Habilitation and Residential Service, which has its own staff and liaises with nongovernmental organizations (NGOs) in managing approximately 45 beds in group homes and supported housing facilities at different levels of supervision up to 24 hours a day, as well as two day-care centers;

The DMH also collaborates with a network of 15 social cooperatives and promotes a number of programs provided by NGOs, for example, associations of users and caregivers, such as club-style centers, self-help centers, workshops qualified to provide cultural and educational activities, professional training, and cultural promotion on the issues of rights and citizenship. DMH human resources encompass approximately 210 staff, not including NGO support services for housing and community living.

This model of community-based mental health services has been implemented in the whole Region Friuli Venezia Giulia (1.217.864 population) as a regional model, based on “strong” comprehensive 24 hours CMHCs, capable to deal with the most severe conditions and to support clients in their ordinary life in a view of recovery and social inclusion.

2) Aurisina Rems (*engl*: Residence for the execution of security measure).
The date of March 31, 2015, following the Law 81/2014, has marked a historical transition with the final closure of the six forensic psychiatric hospitals in Italy. This law identifies a new pathway of care that involves small-scale high therapeutic profile facilities (Residenze per la Esecuzione della Misura di Sicurezza, REMS) instead of the old forensic psychiatric hospitals. The Law promotes a new recovery-oriented rehabilitation approach for the persons with mental health issues who committed a criminal offence, but lack criminal responsibility and deemed as socially dangerous.

The Friuli Venezia Gulia region has privileged a community based approach consistently to the principles of person centered services operating without seclusion or restraints procedures. Rather, the approach is based on the integration with local care and social services, in a framework of collaboration and shared responsibility at all the different levels. In this way, Friuli Venezia Giulia region has activated three REMS in the regional area, for a total amount of 8 beds divided in three cities: Pordenone (4 beds), Udine (2 beds) and Trieste (2 beds).

The Aurisina REMS, in Trieste, was open in 2015; it is a small unit in a daycare centre that operate “open doors” in co-production with the MHS of Trieste and Gorizia. The choice was made in order to maximize the therapiutic potential right because the unit it is well connected with the day center (and its social network) promoting activities and events that foster health and inclusion counteracting social discrimination and stigma.

3) Personal Healthcare Budget System:
Personalization has been one of the main themes in social and health care in the last two decades. Deinstitutionalization demanded, and at the same time made it possible, to create person centered responses to human needs. Many experiences in developing personal budgets have shown that it is not enough just to create services around a person but also to fully include them in the community. To engage service users and for them to fully integrate and connect with others there is a need for collective services that not only seek to empower the community but also make it possible for service users to gain more collective contractual power. An independent life is not really possible without social connections, comradeship and solidarity between people. Therefore, personalized health

budget are a shared tool which is able to support social inclusion, capability, recovery processes, facilitating cultural changes and qualification of economical investment.

In the last few years Trieste has built up the possibility of investing large sums of money to help service users through personalized healthcare budgets, by setting up person centered projects with the support of local NGOs. Nowadays 160 clients per year receive a personal budget in order to fulfill the aims of a joint and shared recovery plan in the areas of housing, work and social relationships.

The implementation of Personal healthcare budgets leads to the reduction of therapeutic communities and home-care like environments in favor of independent living opportunities. The personal budgets represented about 17% of the overall budget of the DMH in 2011, while about 4% is devoted to economic aid, training grants, leisure and projects with NGOs (s.c. extra-clinical activities).

4) Recovery Learning Community Centered around a Recovery House:
it is an experience promoted and supported by the MHD through the instrument of "Personal Healthcare Budgets". The collaboration between the MHD, social cooperatives, associations/NGO, family members, users and peer support workers is core of the experience. The Recovery Learning Community offers opportunities for individual service users, their family members and co-workers to work together in new way to examine their life stories and the importance to their recovery journey in a framework of co-production, inclusion and reciprocity.

Individual service users which spend a 6 month period at the Recovery House already receive support and treatment from the Trieste Mental Health Services, many of them hear voices and experience other unusual states but still have a distressing relationship with these experiences. Family members are fully involved in the program from the beginning. The Recovery House location is near San Giovanni Campus. It accommodates six in six rooms; it has a pleasant garden with scope for gardening and horticultural activities with a space for reflection and exercise. The house of Brandesia used to be a long term staying therapeutic facility for people with severe mental health problems. In 2015, through collaboration with the International Mental Health Collaborating Network it became a Recovery House. Over there, over the course of the six months staying, people develops a recovery action plan, local circles of support within their own communities to be supported in their recovery journey even after the staying at the recovery house.

5) Peer Support Workers:
the peer support workers project has started in 2015 with a 390 hours course for 14 service users, organized by MHD with ENAIP (Professional Training Institute). Presently, 6 of them have started a working experience in the field of mental health care, for the first time since the "helper" project. These "experts by experience" are pioneers in the system and their recognition has a groundbreaking value in innovation.

6) Widespread Day Centre:
The actions and activities of the Widespread Day Center address the re-socialization, participatory processes and user involvement, training, social and professional skills learning, working inclusion, well-being, body care and sports activities aimed at tackle stigma, gender-sensitive issues. The idea is therefore to promote social inclusion / integration of people with mental health issues through the development of expressive laboratories, arts and culture, literacy, education and schooling, across the city which are proposed in collaboration with local association and social cooperatives which are essential partners for the development and prosecution of the initiatives. The activities target specific assets:

- "Wellbeing" programs are aimed to awareness improvement, understanding and respect of our own body, stimulating the protagonism by promoting activities - group and individual - general physical education , the organization of courses and activities

relating to general motor skills.

- "Aggregation, socialization and inclusion" activities involve the support and the direct involvement of people or groups with the purpose of promoting the development of capacity and expressive/interpersonal skills other then the re-appropriation of a positive identity, sense of self and autonomy.
- "Self expression and fight to the stigma," through culturally expressive programs, with particular reference to workshops (theater, music, painting), in collaboration with theaters, public places, associations and other public and private entities, finalized to the organization of performances, exhibitions, theatrical piece, concerts and other activities at a local, national and international level.
- “Participation", activation of mixed groups, made up of family members and people with experience in the field of mental distress, as well as professionals, representatives of associations and citizens, in order to promote information and raising public awareness. They participate to the design and implementation of specific programs such as the "peer support worker course". They are actually particularly involved in the enhancement of the role of peer support worker in mental health services, the organization of self-help groups and the involvement in participatory research around service quality in MHSs;
- “Gender Specific" programs aim at growing gender awareness throughout the ongoing dialogue made of participation, exchange and peer support as well as through the 'impulse’ to cultural and awareness activities on gender issues in co-production with other associations and institutional organizations of the territory;
- “Training and job placement", enabling individualized paths of training, pre-training and job placement - supported by "training grants to work" or "individual health budget" - aimed at skills and competences development, in collaboration with the Municipality, the Province and local training institutions.

6. What did you learn from your experiences with your best practice?

A holistic approach:
in mental healthcare, the individual, and not the disorder, is emphasized. There are no patients or clients, but people that uses services for a period of their life. 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:

- An individual’s needs are assessed on the basis of his personal story/history, which also addresses his social relations, from family to neighborhood.
- In order to meet the needs of a user, personal relations between care workers and users are considered central.
- Services are evaluated in terms of personal routes to recovery and empowerment. To back up this idea, the community service centre is open 24-7.

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 relationships with the individual and his family, with housing services etc. The community centre offers prevention, as well as basic and specialist treatment for all users in the area for which it is responsible; because of its ‘territorial responsibility’ for users, the community centre cannot transfer patients with complex problems to other centers.

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. Deinstitutionalization means having individual control over one’s own route to recovery:

- Citizenship should be interpreted as a social process that brings about individual and social transformation not a status but a ‘practice’, which is essentially the exercise of social rights (De Leonardis).
- Hence, it involves a re-distribution of power, and the exercise and development of capabilities (Sen).
- Basaglia affirmed that “recoverability” has a price, and is an economic-social fact more than a technical-scientific one.
- As we demonstrated in qualitative cross-cultural researches, a lived citizenship, ‘having a whole life’ can be captured to be at the heart of a recovery process, as stated by individuals themselves in their narratives.

The overarching principles of MHSs practice in Trieste:

The experience in Trieste, from 1971 to the present, demonstrates that it is possible to establish a network of mental healthcare services which are totally alternative and antagonistic to the psychiatric hospital, and which are able to respond to the needs of the local population.

The main principles which have inspired mental healthcare practice in Trieste for nearly 35 years now are:

- total opposition to any form of internment or confinement typical of asylum-based or institutional psychiatry;
- the overriding awareness of the paramount importance of the person’s needs as the sole point of reference for the organization of the mental health services;
- the need to provide services which are cost effective and which meet overall healthcare budget requirements.
- These principles define a transformation process which is never linear and automatic, but which requires a constant and collective ethical, political, cultural and scientific effort. In fact, the work of deinstitutionalization cannot be enacted by decree but must be conceived – and carried out – as a process, a journey, in which anyone can take part and which involves personal and collective research, primarily practical initiatives and an ongoing verification by all the actors involved.

The following factors are indispensable in order to achieve a successful and effective strategy of community-based mental healthcare:

- a fundamental shift in terms of approach and interventions from the hospital to the community;
- shifting the centre of attention from an exclusive focus on the illness to the person and their social disabilities;
- shifting from individual to collective action focussed on the user and their context(s); a collective work strategy requires (at least) the following conditions:
  multi-disciplinary widening of the skills and abilities employed
  - enhancing/promoting the user’s self-help resources
  - enhancing/promoting family resources
  - raising public awareness regarding the mythical nature of the concept of danger and other irrational prejudices concerning the mentally ill through primarily cultural initiatives that can provide a more positive social image of mental illness
    increasing greatly the collaboration of non-professionals
  - re-evaluating the effectiveness of exclusively biological therapies and orthodox forms of psychotherapy
  - utilizing the active forms of solidarity provided by the most aware, attentive and well-disposed social groups, as well as local institutions/agencies open to forms of collaboration
  - the "open door".
- the community dimension of collective action, ie. establishing a theoretical and organizational point of reference made up of a specific territory and population and the progressive assumption of responsibility and organization of the services based upon and referring to that territory and population, and not referred to a single institution

- the practical-affective dimension of the intervention, especially in terms of meeting even the most elementary needs of users and the paramount importance given to collective action in responding to these needs; improving even minimally the user's objective living conditions is of utmost importance.

What are the outcomes of your best practice?

Freedom in care, with no need for new asylums is demonstrated to be successful by a series of data and key-facts/outcomes:

1) Community based mental health services:

- The Trieste MHSs organization has become the regional model for all mh Services in Region Friuli-Venezia Giulia (1.200.000) but not for the whole country, despite the request of family and user organisations.
- Many organisations from all over the world visit Trieste every year (up to 900 persons as professionals, managers, politicians and stakeholders in general).
- The practice was recognised as an experimental pilot area of mental health de-institutionalisation by the World Health Organisation in 1974, became a WHO Collaborating Centre in 1987 and is reconfirmed as such until 2018. This means assisting WHO in guiding other countries in de- institutionalisation and development of integrated and comprehensive Community Mental Health services, contributing to WHO work on person centred care and supporting WHO in strengthening Human Resources for Mental Health.
- Because de-institutionalisation was so successful in Trieste, the community-based approach has been implemented in the whole Friuli Venezia Giulia region and is acting as inspiring model for services, organisations and countries in more than 30 countries - so far particularly in Europe, Asia, South America, Australia and New Zealand.
- Compulsory Treatment Orders (CTOs) discharge rates in the Region Friuli Venezia Giulia are one of the lowest in Italy, with 13 cases per 100 000 population per year compared to a national average of 17 (Ministry of Health, 2011). Moreover, about two thirds of people under the CTOs were treated within CMHCs rather than at GHPU, anyway with an open door policy.

ETHICS	EVIDENCE	EXPERIENCE
No restraint / Open door	Low rate of accidents and offense Low rate of compulsion / involuntary treatments	"Humane" negotiation Innovative practices to avoid closing doors Alternative crisis management Attention to welcoming serices and social habitat High degree of freedom

- Mental health services do no make use of restraint measures, such as locked doors and mechanical restraint.
- Suicide ratio has been lowered from 25/100.000 to 13/100.000 in the city of Trieste over the last 15 years, also as a result of a proactive prevention programme.
- Independent living (instead of institutional or residential care) is supported also for people with severe disabilities as regards to housing, work and social integration.
- The personal budget system is a great aid now: approx. About 160 clients per year receive a personal budget in order to fulfill the aims of a joint and shared plan of

recovery in the areas of housing, work and social relationships.

- About 180 people are in professional training every year on work grants, and 20-25 of these find proper jobs each year in the Trieste job market, many in the field of social cooperation and about a third in private firms.
    - The sustainability is demonstrated because the overall cost of services provided by the MHD is no more than 60% of the cost of the former asylum (with less than the half of staff, and the number of beds decreased from 1200 to 75). Personal budgets is about 20% of the overall budget of the DMH, while about 4% is devoted to economic aid, training grants, leisure and projects with NGOs - s.c. extra-clinical activities.
    - The number of people treated in a more humane system of care is more than 5000 as compared to 1200 in 1971.
    - Hospitality in the CMHCs replaced most of the admissions in the GHPU. Only one person spends a night in the hospital service for every 10 who spend a night in the Community Mental Health Centres throughout the year.
    - Crisis care in the community is effective and sustainable. All figures and rates concerning emergencies, acute presentations and crises decreased. Even the use of CMHC beds constantly decreased through these decades to 1/3 of the original value. Readmission rate to a CMHCs is about 30%.

2) Aurisna Rems

- There are no people in forensic hospitals from Trieste from 2006.
- After 18 months of Aurisina Resm: 5 people have been welcomed since June 2015. When the people arrive in Aurisina, welcoming, assessment and planning are made within the 45 days according to the law. This was done in collaboration with the territorial health and social services. There was maximum collaboration with justice in respect of reciprocal roles. It has always been claimed that “social dangerousness” is an aleatory concept; rather, dangerousness should be assessed in each single real situation. People have been discharged after about 6 months on average with respect to the juridical situation always with attenuated security measures and a individualised project planned in collaboration with the MHSs. The follow up is positive as there are is not been any case of reiteration. No one escaped/leaved Aurisina, no police intervention were ever necessary, neither hospitalisation in GHPU or CMHC. This proves the efficacy of the deconstruction of the aspects of restraint, segregation and sanction.

3) Personal healthcare budget system

- The personalized health budget, has shown remarkable advantages in terms of efficiency, effectiveness and, ultimately, cost-effectiveness. More specifically, it showed to be a viable tool to re-qualify and make social the healthcare spending, contributing to build a new welfare community. The partnership relations developed with private non-profit organizations, represent a strategical outsourcing for Public agencies. The process of shared decision-making that brings together many kinds of expertise, allowed to shift from a ‘gift model’ to a ‘citizenship model’ with the individual at the center of the service system. Finally, as Trieste’s experience is demonstrating, within this methodology, it’s possible to move conspicuous resources from residential structures to co-housing projects, supported work training and social programs, more closely to the concrete needs of people, contrasting new forms of institutionalization.

4) Recovery learning community centred around a recovery house

- The Experience of the Recovery Learning Community centered around a Recovery House has been one of the most important happenings of the 2015 in Trieste Mental Health Department and that was co-created by all the people involved though a democratic, bottom-up process. The 6 monthes pilot period lasted till November 2015. Today, 4 groups of young people have joined the experience and some people of the previous group have been employed as peer workers.
- There has been a partecipatory evaluation of the experience taking into account all the

different stakeholders. The results are positive on different levels (i.e. symptoms, recovery stages progression, subgective wellbeing, relationship with MHSs etc.). May 2017 will be the follow up for the first and second group to check whether the good results are mantained onece the person is out of the recovery house.

5) Peer support workers:

- There is a strong group in which people support each other. Many of the Peer support workers are employed by local social cooperatives: 4 of them works whithin the mental health centres in Trieste, organizing activities and self-help groups inside and outside the Centres. Some other peer support workers operate a in different circumstances such as gender specific projects (ie. “Una casa tutta per noi”, “Recovery House”, “Club Zyp” etc) or in the voulontary sector (ie. “Green Recovery”) and participatory groups/forum in mental health (ie.“Articolo 32”).

7. How might these experiences be useful to the Empowerment College?

- A ‘systemic’ vision has to be based on the person’s whole life. Creating personalised itineraries is the organizational-strategic key, in which the person has an active role and contractual power of negotiation. All the pathways of care are aimed at a program of restitution and re-construction of full rights of citizenship for individuals suffering by mental health problems.
- The subjectivitiy of clients, their life stories and their aspirations are considered as the main tools for providing treatments and developing services totally alternative to psychiatric hospitals.
- The community has to be an active part of the process at each single stage.

8. Is there anything else that is important in this context?

9. List of Research or Literature in connection with your project:

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