International Meeting 1
Bremen, Germany
10 & 11/02/17

Intellectual Outputs

1. Please provide a brief summary describing your organisation (500 words maximum)

The current organisation of the Trieste MHD derives from the closure of the San Giovanni Mental Hospital and it is still recognised as an inspiring model for best practices regarding the values of open doors and no forced treatment The service is organised around four Community Mental Health Centres (CMHCs) with a low threshold for access, are open 24 hours a day, seven days a week (ref: forum salute mentale). This is complemented by a four person emergency unit in the general hospital. It also has a range of housing, cultural and social opportunities organised by independent cooperatives and associations that are coordinated by the service.

Franco Basaglia, who pioneered the closure of the Trieste Asylum and is highly respected throughout the world as one of the architects of deinstitutionalisation practice, placed great importance on building a relationship with patients and "putting into brackets" the diagnosis that prevented a meaningful relationships to be formed

2. Please write a summary on the 'best practice' elements of up to 5 recovery/empowerment focused services in your country. (200 words maximum per example).

When choosing the five please consider ***the extent to which they include educational elements/have an education focus***

NB. The proposal requires us to cover national practice, not only the practice relating to your organisation.

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.

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.
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.

Peer Support Workers: the peer support workers project has started in 2015 with a 390 hourscourse 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.

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.

3. Please describe the key principles that this best practice is based on. These principles are the factors that will inform the operation on Empowerment Colleges.

For example: valuing lived experience, coproduction, strong leadership, community participation/ inclusion

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.

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.

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