Arrividerci Trieste: Reflections and Observations about Mental Health Services in Italy After 30 years of Reform

From March 10–15, 2008 I was able to visit mental health services in Milan, Brescia and Trieste. Milan has a population of 2.5 million, Brescia 400,000 and Trieste 240,000. The visits were arranged by Dr. Amelia Compagni, a health systems researcher at the Faculty of Management, Bocconi University, Milan. I am indebted to Amelia for connecting me with colleagues, providing language and systems interpretation, as well as good humour when we got on the wrong train to Trieste!

Italy has had 30 years of reform while Canada has had 30 years of rhetoric about reform. Despite this, both countries have much to share with each other as both jurisdictions try to improve their mental health services, and as an article I have referenced by De Girolamo (2007) suggests, comparative national studies of various aspects of our respective mental health systems could inform reform efforts in both countries.

In Italy, as in Canada there is much regional variation. Trieste and Verona would likely represent the high end of the continuum in terms of a community focused public mental health system, while areas in the south are reported to have more institutional care, higher rates of compulsory treatment, and more private care. Large cities like Milan would likely be in the middle given system complexity and size, and smaller communities such as Brescia would be moving toward a community focused system, especially given their focus on developing care networks and reciprocal relationships among providers. While there is a national users group, their influence on local service delivery/ design was not highly visible, nor does there appear to be a strong family voice influencing policy, although family burden is acknowledged. Both countries face challenges moving to evidence based practice, in terms of agreement regarding measures, standards, knowledge transfer and information systems.

However, while quality of care may be uneven and in need of improvement, ***Italy has demonstrated that it is possible to close large psychiatric facilities, shift services to the community, and decrease reliance on inpatient settings in favor of outpatient and community programs.*** Also the communities I visited had strong linkages with social cooperatives to provide employment opportunities for service users, although it is not clear that the employment rates for people with serious mental illness is much higher than here in Canada.

Italy has a health service that is organized similar to the NHS in the UK. Italy has 21 regions responsible for healthcare policies and budget, but mental health care is delivered on decentralized basis in each region through Departments of Mental Health (DSM). Each region has responsibility for meeting the conditions of Italy's legislated framework for mental health services and essential level of care that are discussed and approved in a State-Regions Joint meeting. There are 211 local departments of mental health and care is organized according to catchment areas. Addiction treatment services are separate, although in some areas there is collaboration.

In 1978, Italy passed a law phasing out its psychiatric hospitals. This law shifted care to community mental health centres and general hospital psychiatric units which provide inpatient and outpatient services. Admissions to psychiatric hospitals were stopped and the last psychiatric hospital was closed in 1999. The reform was designed to end the abuses that were occurring in the psychiatric hospital system. The result appears to be care that is focused in the community, as opposed to the general hospital, although there is more burden on families. There have also been cost savings. Living arrangements shifted from the hospitals to residential care facilities (24 hour staffing), light residential care, families and limited social housing.

Prior to 1978 Italy had 100,000 beds in psychiatric hospitals. At the time of the reform law Italy had 60,000 beds. There are now 325 psychiatric units in general hospitals with 3,997 public beds and a further 3956 accredited private beds for a total of close to 8,000 psychiatric beds. Hospital per diem cost is around €450. Unit size is by law no more than 20 beds.

As well there are 1552 psychiatric residences or residential care units (residenze) totaling 17,101 beds. These residences provide high support, 24-hour care to patients who can stay up to three years or more depending on the region. Generally the residences have about 20 beds, but there is a range. The average is 12.5 per facility. For example Trieste has closed their 20 bed facility and replace is with an 8 bed residence (San Giovanni) and 2 five bed residences. In southern Italy there are some residences with as many as 300 beds. Trieste also has a small number of apartments. Generally the focus in the residenze with time limited stays is to return people to their families. If this is not possible they go on a 2-3 year waitlist for social housing which is provided by the municipality. Unlike Toronto there does not seem to be a high demand for supportive housing in Trieste, Milan or Brescia, the three communities that I visited.

Residential care is paid for by the regional mental health service and staffing can be subcontracted to NGOs. Clients in the residences are connected to community mental health centres in each DSM who also provide multi-disciplinary team based interventions in people's homes, or outpatient services to local neighborhoods, covering the full spectrum of psychiatric disorders.

There are over 700 CMHCs in Italy but less than 10% provide over night care. In Trieste the CMHCs operate 24/7 and have 8 beds for "hospitality" where people requiring stabilization can stay over night. Night staffing consists of 2 nurses and an on-call psychiatrist. LOS seems to average 2 weeks. There are also outpatient programs.

There is variation in regional health systems in Italy. Lombardy, (which includes Milan and Brescia) is the only region where they have moved to a managed competition (purchaser-provider split) and rate-based funding system for mental health services. There are issues about whether the funding formulae capture critical functions, including the need to develop and sustain networks and reciprocal relationships among providers, but they are working on this. Because they have a case registry and a regional IT system,

they can count the number of patients and track number of visits across the system. They have also begun to compare costs and outcomes of various service packages.

Lombardy is able to demonstrate an increased community capacity since 2000 as the slide from Antonio Lora's presentation on mental health indicators shows:
Between 2000 and 2005 the rate of outpatient care for the treatment of schizophrenia has increased by 32%; residential care has increased by 142%, day care has increased by 59% and general hospital care has gone up by 2%. These data suggest that the region has been focusing on increasing access to community care.

Lombardy has also been able to calculate the gap between those treated for schizophrenia and prevalence. Lombardy is able to treat about 28,000 patients in their region (34/10,000) while prevalence is estimated at 48,000 (60/10,000) leaving a gap of 38% and calculate treated prevalence by geography in the region. There is considerable variation within the region.

At the same time Trieste has yet to develop an electronic health record system and records interventions in word files on community mental health centre computers.

However according to De Girolamo (2007), the Italian multi centre studies on quality of care that have been done show that prescribing practices are not consistent with evidence based guidelines and that there is limited application of a psychosocial approach to care. He notes that these phenomena are not unique to Italy, but apply to other jurisdictions as well.

There is also variation in continuity of care. While only one in six patients who were admitted to services for the first time in Lombardy maintained contact with the mental health service the following year, a south Verona study demonstrated that they were able to limit the drop out rate of people living with schizophrenia to 17%.

Compulsory admissions have declined from 50% in 1975. Compulsory treatment in Italy averages 4%, but is 6-8% in the larger urban centres such as Milan. Trieste hasn't used compulsory treatment for four years; there is no seclusion and the CMHCs, hospital units are open not locked.

Outside of Trieste, if someone with mental illness commits a crime they are generally admitted to the forensic hospital. Italy has 1200 forensic beds. Trieste is trying to avoid sending patients to forensic beds, and their CMHCs will support returning forensic patients in the local community. In Milan the psychiatric service has just begun providing assessments and treatment in the jails. 10 beds are available at San Vittore jail.

Like Canada, criminal acts committed by people with mental illness receive high visibility. Last year 27 murders out of 760 (4%) were committed by people living with mental illness. In Milan when people are discharged from the forensic or correctional system they are often homeless.

According to Dr. Mencacci director of one of Milan's DSM, the mental health workforce is configured as follows:
5, 561 psychiatrists (18%)
14,760 nurses (48%)
1,850 psychologists (6.0%)
2,095 rehabilitation personnel (6.8%)
1,551 social work assistants (5.1%)

Based on visits to Milan, Brescia and Trieste, there seems to be a multidisciplinary approach with psychiatrist leadership, although psychologists lead some clinical programs. Some of the residential programs which are run by NGOs are led by social workers or rehab staff. There did not appear to be a great deal of specialization. There is an emerging interest in early psychosis intervention programs; Milan is starting to focus on adolescent suicide and their mental health service has just developed an ambulatory program for women experiencing depression and anxiety disorders, as well as improve access to care for people with mild to moderate mental disorders.

Lombardy, due to their registry, has begun to track patient contact with the system. The Brescia/ Leno DSM data indicate 423 new cases per year. DSM Leno serves 1600 patients per year. 3% of patients have more than 50 contacts per year; 55% have less than 4; 15% have 11-50 per year and 27% have 4-10 contacts per year. The priority for services in Leno and Brescia is people with serious mental illness. There is increased social deprivation in the outskirts of Brescia where immigrants are settling. They are starting to access the mental health system and account for 8-10% of contacts.

Brescia/ Leno use small residential care facilities. The 20 bed facility we visited had 20 beds and costs 25% of an inpatient bed (170 €per day). It has 5 psychiatric nurses, one of whom is on duty at night and a psychiatrist who spends 6 hours per day on site. There is a daily program, cooking classes, gardening and other activities. Some residents are employed.

Trieste with a population of 240,000 represents, along with Verona, a mature community focused mental health system. There are four community mental health centres which provide care on site and in the community 24/7. Staffing for one community mental health centre consists of 25 nurses, 5 psychiatrists, 1 psychologist and 1 social worker and other rehabilitation staff. Clients come to the centre or the team visits them at home. There is a nurse at the centre 24/7 for assessments, triage and deployment of team members as required. Teams meet daily to review client issues and to support each other. There are also small residential facilities, 1-2 apartments and social cooperatives affiliated with each centre.

Trieste spends 304 million €on health services and the mental health service accounts for 17 million €which is about 5.5% of health spending. Mental health spending ranges from 3%- 5% of health spending in Italy.

Italy has developed a system of social cooperatives which employ people living with mental illness, people with physical disabilities, youth, people with alcohol or substance abuse, and inmates from the prison system. The social cooperatives must have a minimum of 30% of employees drawn from these target groups and can then remit a lower rate of taxes to the government for employee benefits Employment costs are reduced by 40%. Some municipalities and regional health authorities give contracts to these social cooperatives for various services. For example in Brescia which has the highest ratio of social cooperatives in the country (1 social cooperative/ 5000) the social cooperatives have contracts to send out municipal notices including parking tickets, book appointments and process x rays for hospitals, do laundry for the hospitals and nursing homes, a recycling service (with 110 trucks) and an industrial cleaning service. There is also a shutter manufacturer which uses Canadian lumber and exports finished products all over Italy.

In Brescia there are 1800 workers in the social cooperatives and 25% are people living with mental illness. 47% have physical disabilities. The birth of the social cooperatives in Brescia was due to the vision of the mayor who convened a meeting of community leaders and announced his intention to give the contracts for maintaining local parks and gardens to social cooperatives. Ironically one of the parks in Trieste (the birthplace of Italy's mental health reform) has a private contractor taking care of one of its parks. Trieste also has a tourist hotel and restaurant operated by social cooperatives where the 40% of the employees are people living with mental illness.

The existence of social cooperatives do provide access to work for some people living with mental illness, but it is unclear about what effect they are having with regard to unemployment rates for people with serious mental illness, as this type of outcome data is not readily available. There is also a law requiring companies to hire disadvantaged people, but many companies prefer to pay a fine rather than do so. Disadvantaged people are supposed to work in the social coops for up to 2 years and then find other employment, but it is not clear how many gain competitive employment.

Reflections

My visit to Milan, Brescia and Trieste provided me with evidence that mental health systems can become community focused and reduce their dependence on hospital care. It is also clear that this requires visionary leadership locally as well as legislative and policy incentives to do so. Italy uses a multidisciplinary approach to deliver care in the community and their mental health centres are able to provide home care as well. Residential facilities have taken the place of long stay hospitals and there have been cost savings. The development of social cooperatives to facilitate employment of people living with mental illness provides evidence of a social determinants approach to health care.

It is also clear that even with a legislative mandate for reform progress is slow and variable, based on local conditions. While Trieste and Verona have developed mature community focused systems, other parts of the country appear to be having difficulty, such as the south which still uses large residential facilities. **Trieste appears to affirm**

the notion that it is possible to create good local/regional systems if strong leadership is sustained and resources are focused on providing flexible, non institutional care.

Creating a community focused mental health care system at a national level is much more challenging. While Italy has closed its large hospitals, quality of care is uneven according to De Girolamo, and while overall costs have declined, family burden has increased. The implications of this for mental health reform in this country appear to be:

- ✓ Work with stakeholders to develop a national vision that simply describes what the system should look like- i.e., more multidisciplinary care in the community, less use of inpatient hospitalization, more residential alternatives to hospitals, more work opportunities etc.
- ✓ Align policy and funding to create high performing regional and local systems based on the national vision
- ✓ Recognize that the reform process will be multigenerational and non linear
- ✓ Ensure that while system goals address the improvement of health status and rights, that policy and funding is also directed to peer and family supports as key enablers of system goals.
- ✓ Avoid data lust (there is good evidence in Trieste's word files!) but develop clinical and system information systems that can measure access, client characteristics, outcomes and costs.
- ✓ Ensure that the vision addresses social determinants of health such as work.

Finally, there is value in creating opportunities for studies and educational exchanges between Canada and Italy. Areas to be explored through comparative study include: regional service delivery, client characteristics and outcomes, consumer empowerment and employment, as well as family burden. For example, a study comparing the effects of reform in St. John, Fredericton or Brandon with Trieste could be very interesting, or comparing Milan with Toronto, Brescia/Leno with Central LHIN. As well areas where Canada has developed specialized expertise, such as early psychosis intervention, mental health and justice services, community treatment orders, and ACT may be of interest to Italian colleagues. Some of the initiatives carried out through IIMHL, such as the comparative ACT and EPI studies demonstrate that some comparative work can be undertaken with limited or no additional funding.

Learning more about our respective journeys to create better performing regional and local mental health systems will benefit people living with mental illness and their families in both countries.

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