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ARC GROUP

...COLLABORATING TO LEAD INNOVATION AND CHANGE

La via Trieste

Discussion paper #1: Comparing the Trieste approach to delivering mental health services with New Zealand models

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LECG

Executive summary

Purpose

This paper compares and contrasts the Trieste approach to providing mental health services with the dominant New Zealand paradigm. The goal is to raise awareness that major change is possible and that other ways of providing services exist that may deliver better outcomes in a more humane way and be more cost effective. It is intended to be part of a wider campaign of advocating for a less hospital-focused and more community-oriented approach to mental health delivery in New Zealand, by providing concrete alternatives to the current model of service delivery.

Trieste model of care

- The city of Trieste, population 240,000, has four community mental health centres, each offering a holistic and comprehensive set of services to their catchment population of approximately 60,000.
- The staff at the centre provides overnight hospitality, early intervention, ongoing treatment, informal support, home based assertive care and link to a range of other services.
- The service values and philosophy are as important as the structural configuration in defining the service. Key values include: helping the person, not treating an illness; respecting the user as a citizen with rights; maintaining social roles and networks; and addressing practical needs – housing, employment, study, relationships, etc. Numerous observers have noted that Trieste's values are consistently espoused by staff and are adhered to throughout the delivery of services.

Outcomes

- The Trieste service prides itself on easy accessibility, with no prioritisation or screening of referrals. It has impressive results in avoiding compulsion and seclusion. Seclusion is never used, and compulsory treatment rates are 7 events per 100,000 population (2009)compared to New Zealand's 120 per 100,000 on average.
- The results of the financial comparison need to be treated with some caution, nonetheless, this review suggests that successful implementation of a version of the Trieste model could be expected to cost no more than, and up to $100 million a year less than current services. The main difference would be a reduction in the cost of acute inpatient services.

Foreword by Rob Warriner, CEO Walsh Trust

The last 12 months have been very much dominated by assessments, evaluations, predictions and commentary on the extent to which we are [not] recovering from a global economic downturn. Government spending, including the provision of health care services ,will not have escaped the repercussions of this downturn.

However, the challenges in funding health services, particularly in New Zealand may not just be consequent to a static global economy. Last year Temple Capital Investment Specialists completed a report headed: "New Zealand's addiction to healthcare". It presented the quite sobering realities that spending on health is now approximately 20% of government spend. It has been growing at a rate that far outstrips our national income, or our population growth; a reality that the most simple arithmetic suggests is just not sustainable. Of great concern to the authors was that language commonly being used to develop responses to such a sobering reality was very much focused on issues caused by inflation and the economic crisis, rather than underlying structural issues inherent within how we have designed our system.

This is just as much a reality for the provision of mental health services. We can no longer depend upon the scale of extra investment that has occurred over the last 10-15 years to continue. However, discussions of change and reform are beginning to emerge; driven not only by the need to be more cost effective (although this will need to be a by-product), but also a determination to improve the effectiveness of mental health services; in fact to deliver services that are "better, sooner and more convenient".

A growing body of thought in New Zealand and world-wide argues that these kinds of changes demand a transformation of mental health service provision away from a medically dominated (and expensive) over reliance on diagnoses, responses and treatment, to an approach that is far more informed by the realities and challenges of community living in the 21st Century. Mental health must now be considered more a social reality, rather than purely a clinical priority. This means that we must now acknowledge and respond to "poor mental health", not just "mental illness". In developing community based services, we need to address the association between poverty and mental health and physical health inequalities through investment in employment, housing services, and initiatives that reverse the social exclusion of disadvantaged groups.

Foreword, continued…

While theses notions may have been argued conceptually for some time now, we now need to be prepared to articulate service delivery systems and structures, informed explicitly by contemporary values and philosophies, that can respond to community needs, challenges and expectations.

In the UK, there is emerging recognition [if not activity] of the need for fundamental change in health service provision in the UK. “We need…an NHS capable of facilitating a “fully engaged” population… will need to shift its focus from a “national sickness service” which treats disease, to a “national health service” which prevents it. (Securing Good Health For The Whole Population,: report for UK Government prepared by Derek Wanless, HM Treasury, 2003). In the UK, investment in the NGO (or third sector as it is referred to there) is increasing as this sector is seen as being able to offer flexible, values-driven, innovative local solutions.

In the current fiscal environment, the New Zealand Government is compelled to look for new solutions to old problems; “new models of care, in particular care closer to home”, (Horn Report, 2009). Community based and owned NGOs account for nearly a third of expenditure on mental health services, employing a significant number of New Zealanders and are a significant part of the solution (Frontline, 2010).

During the 1990s in particular, New Zealand earned a reputation for innovation in developing mental health services. Community-based, not for profit organisations are commonly credited with leading these innovations. In fact New Zealand is both unique and envied in having such a strong community based commitment to service delivery. We now have in this country a community-based workforce, infrastructure and experience in developing and delivering cutting edge services.

There is nascent potential here. Services in Trieste present a number of challenges to some basic assumptions held in New Zealand. Blending the experience and learning’s from Trieste with our own uniquely New Zealand experience, in a time which demands not just change, but reform, offers an exciting opportunity which is too valuable to ignore. There is a way; the question remains as to whether there is the will.

Contents

Why compare NZ to Trieste?

The Arc Group is an alliance of four NGOs from across New Zealand: Comcare (Christchurch), Pact (Dunedin), WALSH Trust, (Auckland) and Wellink Trust (Wellington). These organisations are collaborating to develop and deliver exceptional mental health support services – and to encourage and support the future strategic development of more community based mental health services. Three members of the Arc Group experienced first hand mental health services in Trieste – and observed the quite remarkable differences compared to New Zealand. Consequent to this visit, the Arc Group commissioned the development of this report.

Context & History

- Trieste is a city and province in North East Italy.
- Its Mental Health Department serves a population of 236,512 (2009) [(1)].
- The psychiatrist- driven service is renowned worldwide for its commitment to de-institutionalisation and emphasis on community services.
- Trieste's current mental health services were established in 1970s (championed by psychiatrist Dr. Franco Basaglia) to replace psychiatric hospital services [(2)].
- Since 1999, all stand alone psychiatric hospitals have been closed in Italy [(3)].
- In Trieste the psychiatric hospital services have been replaced mainly by four community mental health centres (CMHCs) each serving a population of about 60,000 [(4)].
- The service is responsible for improving mental health overall, not just treating mental illness or crises; and addresses this through a range of social interventions, as well as health-specific ones.
- Trieste has achieved very low levels of compulsory treatment, high levels of re-engagement in community life, and an absence of restraints or seclusion (see outcome comparison p.33).
- In Trieste, mental health services costs have decreased from EUR$40 million in 1971 to EUR$19 in 2009 [(1)].
- It is not possible, or perhaps even desirable, to transplant the Trieste model of service to New Zealand, but we may be able to learn from aspects of the Trieste model of service delivery – even if it is just that there are other alternatives and other experiences of system change.

Trieste mental health service model

Key components

- 4 community mental health centres (one of them equipped with 4 beds, one with 6 beds and 2 of them with 8 beds). There are about 40 – 46 staff per centre.[4]
- 1 small unit in the General Hospital near the emergency department with 6 emergency beds.[3]
- Rehabilitation and residential support services:
  - 7 group homes with a total of 53 beds).[3]
  - a day centre (development of educational/training activities, social skills and scholastic learning and for a wide variety of group activities).
  - 14 accredited social cooperatives providing employment and training.[4]
- An arrangement with the University Psychiatric Clinic, (in San Giovanni area), to carry out research. [5]
- Families and users associations, clubs and recovery homes.

Staff mix

- Approximately 236 staff in the province (2009):
  - 26 psychiatrists
  - 10 psychologists
  - 136 nurses
  - 9 social workers
  - 10 psychosocial rehabilitation workers[3]
  - 27 social/ health care operators (known as practitioners in NZ)
  - 15 admin/ auxiliary personnel
  - 20 social co-op members and educators [5]

Community Mental Health Centres

- CMHC are the central component of the current system, intended as tools against hospitalisation, by providing flexible responses to mental health problems across user's whole life-span.
- Each of the four CMHCs is responsible for improving mental health in a geographic area with a population of around 60,000 people.
- They provide psychiatric assistance 24 hours a day, 7 days a week. The services available include:
  - Overnight hospitality
  - Crisis management
  - Outpatient service
  - Home treatment (including assertive follow up)
  - Individual and group (and family) therapy
  - Psychosocial support, and psychosocial rehabilitation
  - Support for group homes
  - Support for accessing education, vocational training and job placements (through links to a network of employment collectives)
  - Social activities, self-help and leisure activities
- CMHCs are all large well presented houses which are open to anyone and everyone on a drop-in basis, with 6 to 8 beds in each (people who use these are considered guests).
- CMHCs are augmented by a small (6 bed) unit attached to the local emergency department, which provides psychiatric emergency care for new clients between 8pm and 8am.
- The work of CHMCs is carried out through a variety of highly integrated social and community services.
- Length of Stay in CMHC hospitality beds: 10 days (2009) [(1)].
- The CMHCs work closely with separately structured alcohol and drug services and child health services in each catchment area.

Background on Trieste's values and service philosophy

- The development and success of contemporary mental health services in Italy has been attributed to widespread buy-in to Basaglia's values and service philosophy.
- CMHCs aim to seamlessly integrate prevention, treatment and rehabilitation for their whole catchment. They are the single point of contact in their community- allowing them to achieve a high profile and reducing the need for emergency services (e.g. police and ambulances). This set up also promotes continuity of care and the building of long, trusting relationships with users (including family and significant others). Trieste's service aims to "assume full responsibility", meaning it responds to poor mental health, not just mental illness; and it does so through an array of closely integrated social services, not just health-specific ones.
- An underlying premise is that "language shapes behaviour". Everyday language used in the context of mental health services reflects the values championed by Basaglia and is a key driver of service philosophy and approach to delivery. An example of this is the term "the therapeutic value of freedom". This concept is based on Basaglia's idea that "the first step towards the cure of the patient is his return to liberty of which, until now, the psychiatrist had deprived him" [(6)].
- Low rates of compulsion (the lowest in Italy) and the fact inpatient beds are rarely full, reflect the commitment to these values. The word "hospitality" is also used deliberately in Trieste as it shapes and reflects how the service is delivered; users of CMHC beds are referred to as guests and staff are expected to provide 'hospitality'. Mental health service users in Trieste are often referred to as *subjects* – meaning individuals with their own unique subjective view of the world.
- In delivering services, emphasis is placed on recognising the complexity of life and individuals. Building close relationships with service users and understanding their context is considered essential for providing a fluid and flexible service that is able to adapt its responses to best fit the situation. The approach is in direct contrast with traditional ones based on the centrality of the psychiatric diagnosis, where crises tends to be over simplified and characterised by way of specific symptoms and associated treatments.

Main values and principles

Values

- Helping the person, not treating an illness
- Respecting the user as a citizen with rights
- Maintaining social roles and networks
- Developing growth potential (recovery) and real opportunities (empowerment)
- Addressing practical needs – housing, employment, study, relationships, etc.

Numerous observers have noted that Trieste's values are consistently espoused by staff and are adhered to throughout the delivery of services.

Principles of service delivery

- **Open entry -** no requirement for formal referral and no assessment against criteria or prioritisation of referrals prior to seeing the person. Who is received and treated is not based on specific therapeutic models or severity thresholds.
- **24 / 7 availability** of clinical staff.
- **Non hospitalisation and deinstitutionalisation** - non hospitalisation is the reduction of bed numbers, while deinstitutionalisation is a complex process of gradual reallocation of economic and human resources from a mental hospital to a range of community based services. CHMCs are open door (unlocked) community hospitality centres and every effort is made to establish a trusting relationship with the user and ensure consent for treatment.
- High degree of **flexibility and mobility** to maximise responsiveness and accessibility - intervention is usually in user's home or in other community settings.
- **Comprehensive care and a multidisciplinary approach** to therapeutic and support programmes - including social care, other community services, non-professionals, and volunteers.
- **Persistence –** CMHC staff will persist assertively in trying to form a therapeutic relationship with someone in need even if they have withdrawn or are refusing help.
- **No restraints** is a principle engrained in the system. Compulsory treatment is seen as a measure taken because strategies to establish the therapeutic relationship have failed, not because of the presentation of illness itself [(4)].

Legislative framework - a comparison

	Trieste (Italy) [8]	New Zealand [9]
Institutional rules	• Ban on building new psychiatric hospitals • Maximum of 15 beds in units for Psychiatric Diagnosis and Treatment within General Hospitals (1/10,000).	• No ban on building new psychiatric hospitals • No limit on the number of beds in hospital units
Involuntary treatment	• Principle that treatment and rehabilitation of the mentally ill will normally be carried out in community services. • Involuntary Health Treatment can be applied only when the disorder requires urgent therapeutic intervention, the patient refuses treatment, and there is no possibility of alternative treatment in community services. Every attempt must be made to obtain consent from patients. • The rationale for involuntary treatment is not that the patient is dangerous, but that the patient needs help.	• Expectation that compulsory assessment and treatment occur as an outpatient unless clinician considers patient cannot be treated adequately as an outpatient. • Compulsory assessment/treatment orders can only be made if person is mentally disordered and a danger to themselves or others, or cannot care for themselves. • Requirement that consent for treatment be gained if possible. • Responsible clinician has considerable power.
Service user's rights	• Compulsory treatment must be done in full respect of civil and political rights (incl. free choice of physician and place of treatment) • Allowed to communicate with whomever they wish, have legal representation, and may appeal the decision	• Certain rights enshrined in law including: respect for cultural identity; appropriate medical treatment; consultation with a psychiatrist of his or her own choice in order to get a second opinion; right to legal representation.

Comparing legislative frameworks continued

Similar…

- Both NZ & Italy require consideration of community based and voluntary alternatives
- Both NZ & Italy protect certain political rights under involuntary treatment
- Although Italy has one mental health law, it is interpreted differently in each region – resulting in regional differences similar to the differences between DHBs in NZ.

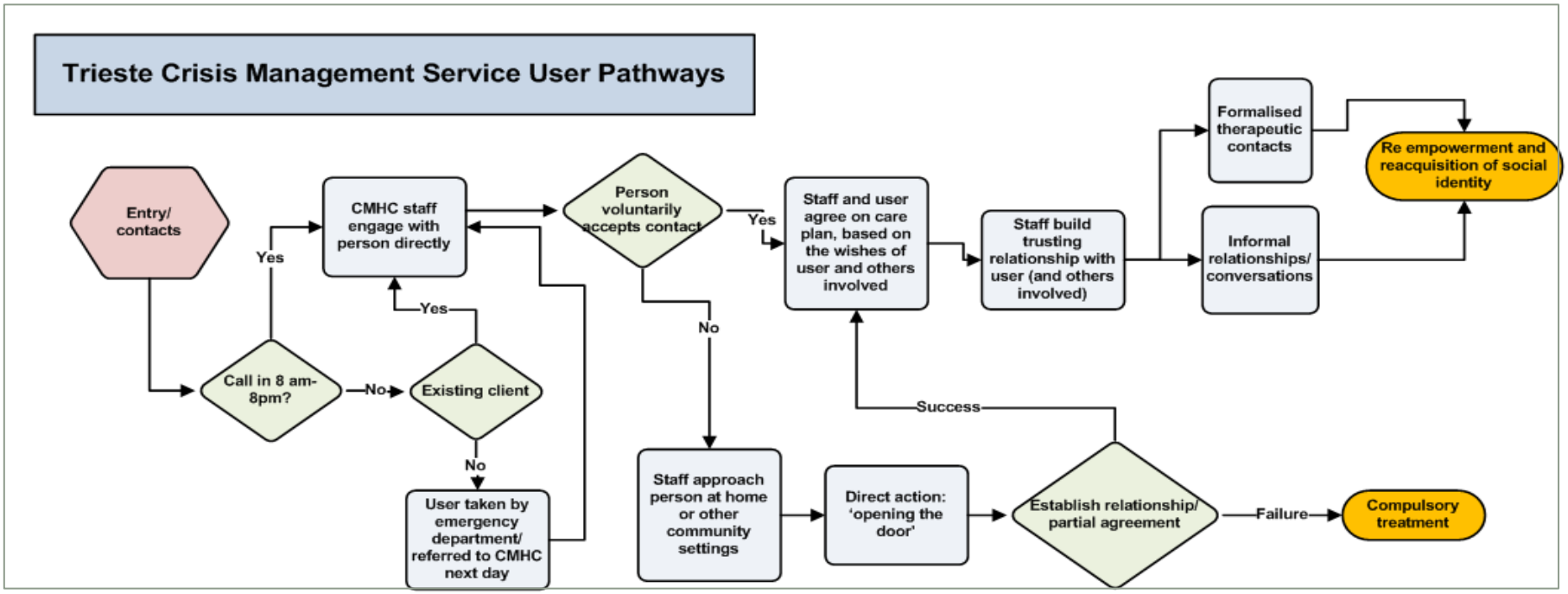
But different…

- Italian law proscribes investment in mental hospitals.
- NZ law is more indifferent to the community / inpatient treatment choice and does not prohibit new psychiatric hospitals or acute units above a certain size.
- Involuntary treatment in Italy is based on a 'needs help and won't accept it' premise, whereas NZ law is based on right to refuse treatment unless danger to self or others precondition.
- Italian law reflects the service philosophy and values; these values also permeate the delivery of services.

Managing crises in Trieste

- Crisis is seen as an opportunity; an “engine for change and transformation” .
- Because Trieste’s CMHCs ‘shoulder the whole burden’ of psychiatric morbidity in the region, and prevention, acute care, and rehabilitation are integrated, crises are managed within this comprehensive system. This facilitates the use of a wide range of resources (incl. social and welfare).
- Service provision during crises is centred around the people and their experiences, as opposed to symptoms and risks. The service attempts to establish a close relationship with the user, as much as possible, in the user’s normal environment.
- The goal of the CMHCs during a crisis is to improve the quality of life of service users and translate psychiatric technical terms into concrete problems and develop tailored solutions to address these problems.
- Hospitality (i.e. overnights stays) in Trieste is a part of treatment, not a response to a crisis in itself. It is used as a tool to explore and refine the therapeutic relationship.
- The flow-chart below illustrates the service user pathway in Trieste.
- A question that often arises is how difficult cases are managed in Trieste, for example, those that refuse treatment.
- In the most extreme of cases, the team discusses all the options available, seeking the most innovative solutions to avoid compulsory admission. This is done without getting overly concerned with diagnosis or clinical details. The variety and intensity of strategies for engaging the subject increases. Occasionally the situation escalates and the person continues to refuse contact (usually when users live alone and have few relationships with the outside world). The service is always responsive and flexible, but may act assertively, to the point that, on rare occasions there is a forceful act of ‘opening the door’- in order to reach the subject and break the cycle of isolation. This again attempts the establishment of a trusting relationship or at the very least some type of partial agreement [4] [7]

Managing crises continued



Service user crisis pathway - comparison with NZ

In NZ there is no standard service user crisis pathway; there are a variety of service models followed throughout the country. However, more often than not NZ DHBs have split off responsibility for crises to separate crisis teams. The table below illustrates the advantages and disadvantages of having an integrated catchment team approach to crises, as is the model in Trieste, versus multiple team approaches, as is common in NZ.

Approach	Advantages	Disadvantages
Single integrated team (Trieste).	• Greater visibility • Ease of access (more straightforward) • Single point of contact for all mental health matters • Continuity of care	• Less specialisation • Less variety in options for treatment • Greater demands on staff to provide 24/7 services
Separate crisis team (common in NZ).	• More options • More specialised care • Lower burden of out of hours care	• Less clarity around access • Fragmentation of care • Emergency approach to crises contributes to negative perceptions of the mentally ill

Overall patient pathway comparison

The two high level pathways show the similarity in the overall pattern of service provision, and some of the important differences at various points in the process – particularly around entry and exit, with many DHB service having team referral and prioritisation criteria to manage access.

Trieste: high level pathway

NZ: high level pathway

Patient stories illustrating values and model of care

When subject refuses treatment (Trieste)

Martha works at one of the CMHCs in Trieste. She receives a call in the early evening from Sarah - a woman who is very concerned about her brother Antonio 's suicidal thoughts and asks Martha for help. Martha suggests Sarah come to the centre with her brother, or if Antonio prefers, he could come on his own. The next day Sarah phones Martha again and says Antonio doesn't want to go to the centre or have anything to do with her. Martha asks Sarah where Antonio spends most of his time and then goes to find him at his local bar. Antonio leaves as soon as Martha introduces herself. Martha speaks with Sarah and tries to start building the picture of Antonio's life. She also asks Sarah to keep an eye on Antonio and tell everyone around him to do the same; to just 'be there'. During that week Martha tries to phone the brother and leaves notes for him under his door, but there's no reply. Martha also makes her colleagues aware of the situation and they discuss different options. The CMHC is now responsible, assertively involved and concerned about Antonio as Sarah is.

A few days after, Sarah calls again worried because her brother has not come out of the room in a few days and she can't hear anything through the door. Martha goes to the brother's house with the support of 2 colleagues and the police. They force open the door and despite difficulties, they manage to engage in face to face conversation with Antonio. They return several times a day and the therapeutic relationship begins.

When subject refuses treatment (NZ)

Maureen works in a crisis team. She receives a call in the early evening from Sarah - a woman who is very concerned about her brother Anthony's suicidal thoughts and asks for help. Maureen ask some questions and establishes that Anthony is not high risk. She advises Sarah to call the community mental health team in the morning. Sarah calls the CMHT who recommend taking Anthony to see his GP. Anthony refuses to go to his GP, so Sarah calls the CMHT again. A different case worker takes the details and says that they will see Anthony in 3 weeks time if he comes to the centre. Anthony refuses and so the CMHT case worker suggests calling the crisis team if Sarah is very concerned.

Sarah later becomes very worried about her brother because he has not come out of his room for a few days. She calls the crisis team who come around to the house. There is no reply so they call the police who force entry. Anthony is considered mentally disordered and a danger to himself and taken into the local acute unit for a period of compulsory assessment and treatment. He takes a long time to engage therapeutically with the acute staff and has difficult re-establishing himself in society when discharged.

Patient stories illustrating values and model of care

When someone with mild – moderate mental illness wants treatment (Trieste)

Max has felt like he has a dark cloud over his head for about a month or maybe longer. He can't explain why, he just feels like he wants to cry all the time. His local CMHC and associated social coops are very visible in the community. He decided to drop in the centre and see if anyone could help him. He walks into a bright and comfortable-looking house; there seems to be a hive of activity; different people milling around. Everyone seems busy, but one of the workers speaks to him almost immediately and arranges a time for him to speak informally with a psychologist. He is also invited for lunch with other staff members and other service users. This is an opportunity to share and exchange thoughts on different problems. He meets other with similar issues and they share experiences of what has worked for them .

When someone with mild – moderate mental illness wants treatment (NZ)

Max has felt like he has a dark cloud over his head for about a month or maybe longer. He can't explain why, he just feels like he wants to cry all the time. He doesn't know who to turn to for help, but has seen the depression campaign adds on TV, so he makes an appointment to see his GP. His GP diagnoses depression and prescribes a course of SSRIs.

Max takes them for a while and they seem to help. But as soon as he feels a bit better he stops taking them because he doesn't like the idea of being on pills.

The reader should note that the patient stories on this and the preceding page are fictional – designed to illustrate differences in overall approach. The NZ depictions will be more representative of some DHB areas than others.

Social cooperatives in Trieste

- Social cooperatives were set up as a resource for the rehabilitation of persons with mental disorders.
  They provide vocational services, creating jobs and enterprises that compete for service delivery contracts.
- There are 2 types of social cooperatives:
  1. Management of social, educational, and rehabilitative services, such as home care, social support, group homes, etc. serving the elderly and those with physical or mental disability, children and adolescents, disadvantaged youth, and drug addicts (type A cooperatives).
  2. Encouraging the inclusion of disadvantaged people into the workforce through employment in agricultural, industrial, commercial, and service activities (type B cooperatives).
- Disadvantaged people must form at least 30% of type B cooperative workers.
- Type B cooperatives receive tax exemptions for employing disadvantaged people and business tax cuts of 25%.
- Cooperatives are an attractive option for many "non-disabled" unemployed people in Trieste.

Examples of social cooperatives

- 'Duemilauno Agenzia Sociale' Cooperative (type A)

  - Provides preventive services, education and recreation for the general public, and pre-employment training to people who are at a disadvantage.

- 'Monte S. Pantaleone' Agricultural Coop (type B)

  - Main objective is to "create new job opportunities for men and women who live or have lived stories of suffering". Users of the service receive training before and during employment to ensure professionalism.

  - Works closely with the Office for the employment of the Department of Mental Health of Trieste.

- Other coops are involved in running a hotel, a restaurant, a radio station, farming, and maintenance work.

Rehabilitation and residential services in Trieste

The Rehabilitation and Residence Service (RRS) in the San Giovanni area, plans, coordinates and monitors:

- residential rehabilitation activities (in collaboration with Type A Coops);
- occupational training and placement programmes (in collaboration with Type B Coops and other public/ private training agencies; and
- day centre activities (in collaboration with various training agencies).

These services are funded through the regional mental health service and staffing can be subcontracted to NGOs.

There are three types of residential structures available [13]:

1. **Residences for social integration (day support services)** are managed directly by the CMHCs hosting a total of 52 guests in 18 different living groups (2009) [1].

   The residences are intended for people with reduced autonomy due to mental disorder, in need of support in their day to day lives. People who may benefit significantly from collective living situation are also hosted.

2. **Therapeutic/rehabilitation residences** are houses or apartments managed either directly (through its own operators) or indirectly (through contracts with type A coops or volunteer associations), but always in close collaboration with the relevant CMHC. There are 7 such residences, for a total of 53 guests.

   The residences are for persons with serious disorders and disabilities who have no family/social network and who require a personalised, ongoing therapeutic-rehabilitative programme. Users of this service include a small number of former long term inmates of the psychiatric hospital.

   The residences are rented or owned by the Local Healthcare Agency and managed by the RRS.

3. **Transitional residences** directly managed by the CMHCs, they host a total of 13 guests in 7 different group homes. A regional law (n. 15) granted to the CMHCs some apartments as temporary residences (max 36 months) for people with sufficient levels of autonomy.

Personalised care plans and pakcages of care

Trieste- Personalised Plans [15]

- Personalised Plans (PP) are funded under individual healthcare budgets managed by CMHCs.
- The (PP) is the main tool for affirming the central role of the person and their needs and guaranteeing care continuity. The user's consent and participation is a key component of the plan. The PP works as much as possible within the user's family, physical and social setting, identifying for each patient:
  - needs/goals
  - expected results
  - interconnections between interventions
  - resources required
  - role/duties of professionals and services
- Achieving full social functioning and empowerment entails three broad aspects of an individual's life: housing, work, and socialisation.
- In 2008 the distribution of personalised plan budgets was:
  - Very high intensity: 1
  - High intensity: 57
  - Medium intensity: 10
  - Low intensity: 113

New Zealand- Flexible Packages of Care

- A number of DHBs in NZ make available partial or full flexible packages of care. These are intended as responsive support interventions, tailored to meet an individual's need for a period of time.
- They are an example of enabling providers to adapt their services to meet the needs of specific clients by:
  - supplying a one off mix of services required by a particular client or client cohort
  - combining funding from a number of distinct output groups to deliver a responsive or integrated service for clients.
- However, these arrangements tend to be at the margin; most services are funded on FTEs and beds, with limited measurement of effectiveness, or ability to purchase an individual care plan.

Trieste according to visitors

There is a long tradition of visiting psychiatrists and staff from other countries spending time at Trieste. Many write of their experiences. We have gathered some excerpts below.

- *"It seems to be a very open system; people pick up the work as it comes in. There doesn't seem to be any obvious caseload system… superficially at least, devoid of conflict or personal rivalry"*- Tony Gardner, UK, 2006
- *"A significant difference between the Italian and Australian systems is that mental health services provided to people with mental illnesses are delivered by specialists in the community. GPs are not involved. The team of mental health workers at each of the community based mental health centres (MHC) is headed up by a psychiatrist but the responsibility for care is shared with psychologists, social workers and psychiatric nurses. Staff morale and commitment is high".* Lyn Allison, Australia 2006
- *"To understand the success and culture of the Trieste model it is important to acknowledge that Franco Basaglia's personal charisma and style facilitated a truly co-operative and socially inclusive redesign of services".* Hellen Killaspy, UK, 2005
- *"A significant difference was the nature of the relationship between the "patient" and the professional. There seemed to be a greater willingness and ability on the part of mental health professionals to invest their "selves" in the relationship with clients"*
- *"A key lesson for us to take from Trieste is the form of discourse, analysis and reflection that has informed and continues to guide developments".* Robert Warriner, New Zealand, 1998.

Service model comparison

Referral management vs. direct entry

- In NZ, referrals are often made through a GP. In Trieste, access to service usually involves self referral, it is informal, walk-in, no waiting lists.
- The common NZ approach is to prioritise/assess patients against criteria before engagement; Trieste's approach is to accept all referrals and to assess the patient upon engagement.

Use of specialist subteams / services

- The usual model in NZ is to use separate sub-teams (including subcontracted NGOs) to provide crisis intervention, crisis respite and home based treatment services. In Trieste the overnight, crisis and assertive care response is all delivered by the same team for everyone in their geographic area.
- The use of the emergency department to cover overnight emergencies for new clients is common to Trieste and many parts of NZ.

Psychiatrist placement

- The Trieste psychiatrist roles are mainly community psychiatry positions. There are 2 positions in the general hospital to attend the psychiatric diagnosis and treatment service.

Service model comparison (continued)

Discharge vs. Empowerment

- The "dissolution of the therapeutic relationship" on Trieste is not conditioned by the concept of "cure" in the clinical sense, but rather arises out of the re integration of the user's life within the community. In NZ, patients are discharged when they no longer need specialist treatment.

Language

- The difference in language used is key to the differences in approaches. For example, "re-acquiring social identity" as opposed to "discharging" and "therapeutic relationship" as opposed to "treatment" reflects a much more humane approach.

"Assuming full responsibility"

- In Trieste there is greater emphasis on the system's responsibility in addressing poor mental health holistically, as well as focusing on mental illness or crises and there is greater integration between health and other social services in addressing mental health issues.

Service model comparison (continued)

GP / primary care involvement

- Use of GPs: NZ uses primary care to support psychiatry in mild to moderate cases.
- Trieste's approach can be described as psychiatry-led primary mental health care in that the CMHT is the first and single point of contact for the whole spectrum of mental health issues.

Service user involvement

- In terms of user involvement in service planning and delivery; in NZ, users are required to be formally involved in DHB service development and quality improvement; in Trieste users are involved in a more informal way through day to day interactions, but there are no formal service user leadership roles.

Use of group homes and employment ventures

- The separate group home services and independently run employment ventures in Trieste are similar to aspects of NZ's health mental health model.
- The presence of regulatory support for social coops (e.g. by way of tax concessions) appears to put them on a stronger footing than social enterprises in NZ.

Service model comparison (continued)

Role of NGOs

- In NZ, NGOs compete for service delivery contracts. In Trieste there are two types of social cooperatives that also compete for service delivery (Frontline 2010)

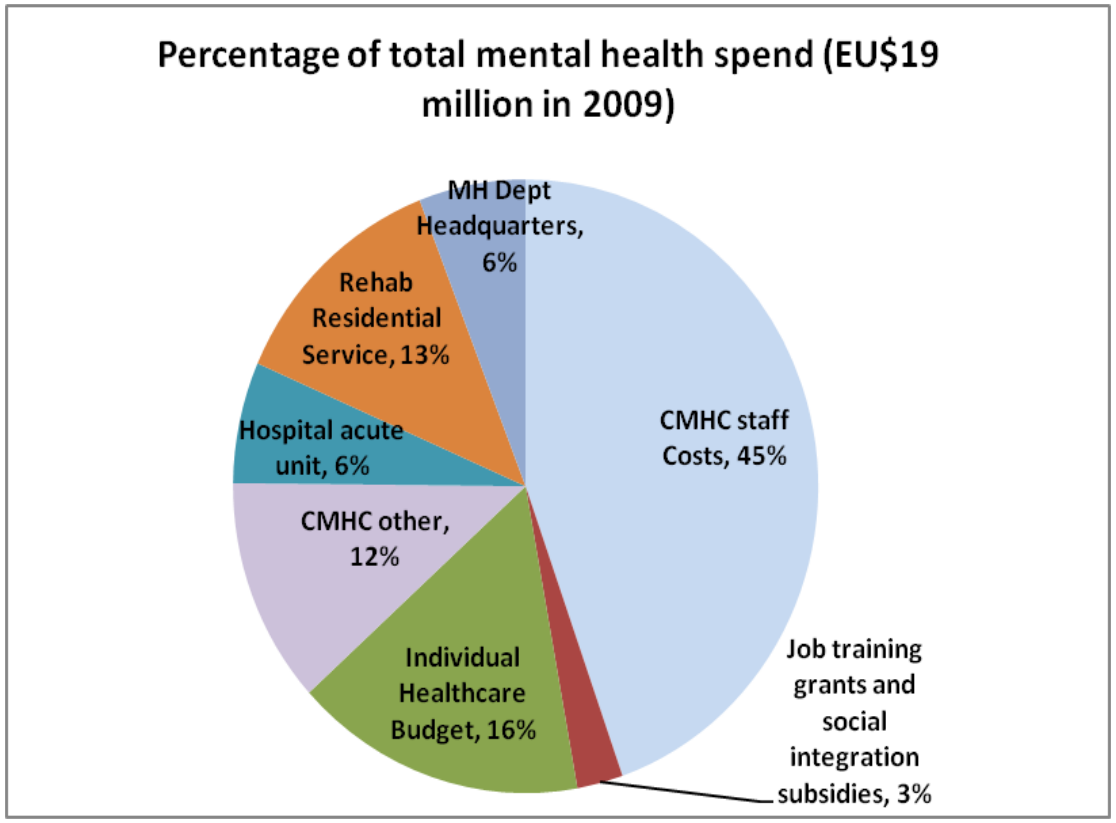
Use of volunteers

- In Trieste, there are associations of volunteers and users who participate in day centres, and organise self-help activities and training meeting cycles. In NZ, clinical services generally do not seek or receive significant support from vounteers, though they are often invovled in NGO services.

Use of compulsion and restraints

- Due to Trieste's service philosophy upholding the "therapeutic value of freedom", compulsion and restraint is avoided and used only in very rare instances. In NZ these approaches are used with more frequency.

Breakdown of Trieste's mental health budget



- Trieste supplied us with a break down of their 2009 year mental health budget in Euros. The total funding was EU$19 million (2009) [1].
- The largest portion of the budget is for CMHC staff costs, followed by individual plan budgets and residential rehabilitation. Some 6% is spent on hospital acute beds.
- In the next section we estimate the cost of providing the Trieste CMHC and acute services in NZ.

Approach to costing Trieste CMHC model in NZ prices

Limitations

- International comparisons are fraught with difficulties – staff FTEs may be measured differently, currencies may have different purchase power, statistics may not be comparable and words may have bespoke meanings that do not translate well. Hence the figures presented below should be treated with caution, they give a broad view of what it might cost to provide a Trieste style service in NZ, and how that compares with NZ aggregate clinical mental health costs now.
- NZ DHBs do not always use national purchase units, and often pay their provider arms an amount more or less than the reference price. Sometimes they pay for bed capacity and sometimes for actual bed days used.
- DHB contracts with NGOs (e.g. for crisis respite) are not included in the NZ current actual figures.
- Trieste CMHC FTEs also provide overnight 'hospitality' services – which makes comparisons more difficult, since NZ bed day costs include the FTEs needed to provide the service.
- Populations have not been age standardised, and Maori and Pacific differences have not been taken into account.

Approach

- We have taken the major service inputs (staff numbers and hospital bed numbers) in each of the Trieste CMHCs, and priced these services using NZ purchase units and 2010 prices.
- Since the CMHC FTE numbers already include staffing for the community beds, we included only an incremental amount to represent the cost of providing hospitality over and above usual CMHT staff costs.
- This provides a standard configuration and cost per 60,000 population for 'the Trieste approach'. We then multiply that out to get a cost for NZ as a whole and for each DHB, based on their population.
- The resulting staff, bed number and cost figures are then compared with data provided by the MOH showing actual DHB District Annual Plan internal purchase volumes by DHB for the 2008/09 year. We excluded DHB drug and alcohol , forensic, child and youth service volumes, and 'programme' expenditure.
- The resulting volumes are aggregated into simplified categories to allow comparison with Trieste: community medical FTEs, community other FTEs and acute beds.

Costing the Trieste model in NZ prices

Trieste CMHC service inputs per 60,000 population				
CMHC Staff	**NZ p'unit**	**FTE/#**	**NZ $/unit**	**Cost total/yr**
Psychiatrists	MHCS06B	4.5	$ 269,231	$ 1,211,538
Nursing	MHCS06A	26.5	$ 107,681	$ 2,853,547
Psychologists	MHCS06A	1.5	$ 107,681	$ 161,522
Social workers	MHCS06A	1.5	$ 107,681	$ 161,522
OT/ rehabilitation specialists	MHCS06A	1.5	$ 107,681	$ 161,522
Total		35.5		$ 4,549,650
Acute inpatient beds				
Local share of hospital psychiatric emergency beds (including staff costs)	MHIS09	2	$ 838	$ 611,572
CMHT crisis/ hospitality beds (excluding staff costs included above)	MHIS01	7	$ 182	$ 465,817
Total cost per 60,000 pop				$ 5,627,039

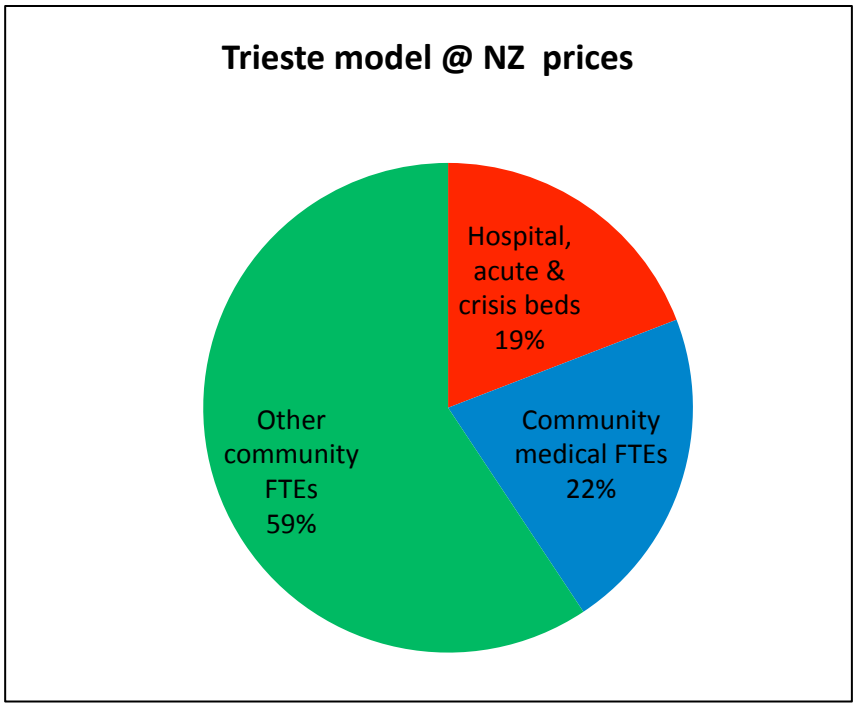
Comparing Trieste clinical service inputs with NZ

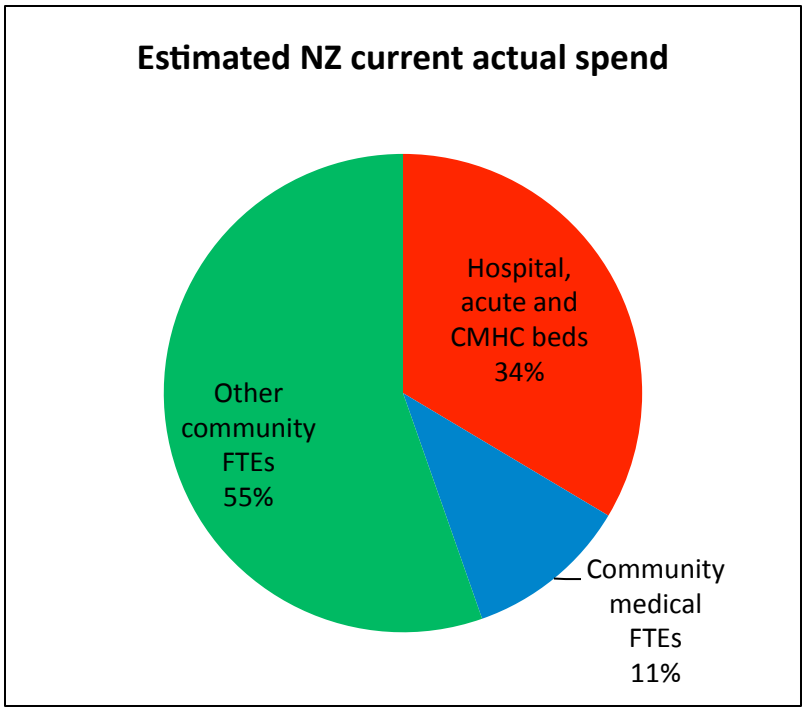
Service component	Per 60,000 pop		Per 4.2 million pop (i.e. NZ)	
	NZ 2008/09	Trieste	NZ	Trieste
Community medical FTES	2.9	4.5	204	314
Community other FTEs	37	31 (includes staffing for CMHC beds)	2,551	2,162
Total Community FTEs	40	35.5	2,755	2,476
CMHC costs	$ 4,726,442	$ 4,549,650	$ 329,617,329	$ 317,288,011
Total acute, intensive care and crisis beds	10 (excl. NGO crisis beds)	9	700	628
Acute bed costs	$ 2,387,650	$ 1,077,389 (excluding staffing for CMHC beds)	$ 166,512,318	$ 75,136,065
Total clinical services costs	$ 7,114,092	$ 5,627,039	$ 496,129,647	$ 392,424,076

Trieste services have similar input levels overall, but a notably greater number of community psychiatrists, fewer community staff and slightly fewer acute/crisis beds. The two analyses suggests that a version of the Trieste model, if successfully applied to NZ, would cost up to $100 million less than current models of care.

Comparing the cost of service components

- Although the numbers of acute beds are similar, most of the beds in Trieste are staffed by the CMHC staff – hence the actual difference in cost is much greater than the difference in volumes of beds or staff would suggest.
- The two pie charts below reveal the difference more clearly.





Cost by DHB of the Trieste service model

DHB	Cost	DHB	Cost
Auckland	$ 40,168,618	Southern (was Otago)	$ 16,627,900
Bay of Plenty	$ 18,836,513	South Canterbury	$ 5,169,373
Canterbury	$ 45,334,240	Southern (was Southland	$ 10,994,296
Capital & Coast	$ 26,801,587	Tairawhiti	$ 4,306,561
Counties Manukau	$ 42,651,080	Taranaki	$ 10,077,089
Hawkes Bay	$ 14,313,312	Waikato	$ 33,321,450
Hutt	$ 13,215,101	Wairarapa	$ 3,712,908
Lakes	$ 9,520,950	Waitemata	$ 47,333,715
MidCentral	$ 14,650,934	West Coast	$ 3,014,217
Nelson-Marlborough	$ 12,532,354	Whanganui	$ 5,523,877
Northland	$ 14,318,001	**New Zealand**	**$ 392,424,076**

Comparing service outcomes

Domain	Trieste (Data for Italy if Trieste not available)	New Zealand
Proportion of the population seen per year by the service	• 20.80 per 1,000 (excl. A&D and child services) (2009)	• Approx 23 per 1,000 - including A&D & child mental health (2006/7) [10]
Average length of stay	• 10 days (2009) [1]	• 19 days (2006/7) [10]
Use of seclusion	• Nil	• 2,946 seclusion events in 2008 [14]
Involuntary treatment	• 7/100,000 (2009) [1] (vs. national ratio in Italy: 20/100,000)	• 120/ 100,000 (2008) [14]
Suicide rate (age standardised)	• 14.2 per 100,000 (2009) [1] • 38% reduction in past 11 years in Trieste, compared to 26% reduction in Italy [1]	• 12.2 per 100,000 (2009) [11] • 9% reduction in NZ (from 1990 to 2006) [11]
% of total health budget spent on Mental Health services	• 3.35% [1]	• 9% [12]
Labour force participation rate of service users	• Social coops employ 400 disadvantaged persons, 30% of whom suffered psychosis • 209 trainees (2009) [1] in social coops, of whom 20 became employees	• Data unavailable
Emergency services	• Fall in contacts from 3,397 in 1988 to 1,745 in 2009 [1]	• Comparable data unavailable

Reflections

- The Trieste service outcomes highlight the importance of lived values and service philosophy, as well as service configuration and models of care.
- The continuity of care aspects with a geographically bounded team taking full responsibility for mental health outcomes in their catchment area will be attractive to many.
- The extent to which the services may be a reflection of the energy and leadership of a few key individuals gives pause; do we have psychiatrists and other leaders with the enthusiasm and drive to take NZ to a similar level of community integration?
- New Zealand may not have a Franco Basaglia to lead the such a profound reform process; however unlike Basaglia we are confronted by time, environment and reality which has deemed the status quo as having limited viability, socially, economically – and increasingly, clinically. Unlike Basagalia's Italy of the early 1970s, New Zealand in 2010 does have a tradition of innovation, and a skilled, broad based, community-connected non government sector with corresponding infrastructure.
- A critical question in thinking through lessons for NZ from Trieste is the differences in primary care services. However, geographically bounded CMHCs with easy entry and an emphasis on longer term relationships would, at least conceptually, fit well with NZ's capitated primary care sector. One could envisage CMHC staff 'tagged' to each primary care clinic – and strong relationship with the local psychiatrists.
- Observers may note that the Trieste model requires a higher number of community psychiatrists than are currently funded in NZ: 314 FTEs required versus only 204 currently funded. However, the NZ Medical Council workforce figures show that NZ, in 2008 had 564 individuals with vocational registration in psychiatry and a current annual practicing certificate – plus another 168 individuals in vocational training posts. It appears that we do not have insufficient psychiatrists to implement the model – just a mal-distribution – not enough are in the core community psychiatry roles.
- The results of the financial comparison need to be treated with some caution – international comparisons are always fraught. Nonetheless, this quick review suggests that successful implementation of some version of the Trieste model might result in better outcomes, with less compulsion at the same or lower cost.

Opportunities for further exploration

- A more in-depth comparison of the treatment of co-morbidities in Trieste and NZ
- Use of medicines - whether maintaining a close relationship with users reduces the need for pharmaceuticals.
- More detailed comparison with one or more DHB service configurations
- Development of a more detailed NZ version of the Trieste approach.
- Consideration of what regulatory aids and financial incentives might be useful to promote employment and social cooperatives such as are present in Italy.
- Study of the change process – what factors led to such successful, consistent change?

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