GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

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Dai Lloyd AM
Chair
Health, Social Care & Sport Committee
National Assembly for Wales
Cardiff Bay
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By email only: [redacted]

Dear Mr Lloyd

RE: Trieste Model of Mental Health Care

Further to your email of 27 September 2017 in which the committee requested a further explanation of the Trieste Model of Mental Health Care.

The requested briefing paper is attached, and providing an overview of the Trieste model and the way in which this will be adapted within Hywel Dda University Health Board.

Yours sincerely

Steve Moore
Chief Executive

HYWEL DDA UNIVERSITY HEALTH BOARD'S RESPONSE TO THE HEALTH, SOCIAL CARE & SPORT COMMITTEE

The Trieste Model of Mental Health Care

(i) Background

- The current organisation of the Trieste Department of Mental Health (DMH) derives from the deinstitutionalisation 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
- Trieste has played an international benchmark role in community mental health care
- Moving from deinstitutionalization, the Department of Mental Health (DMH) has become a laboratory for innovation on social psychiatry, developing a model that can be defined as the "whole system, whole community" approach
- The Trieste DMH provides care through a network of community services but also places great emphasis on working with the wider community with a view to promoting mental health and taking care of the social fabric
- The network of services is based on 24/7 Community Mental Health Services.

(ii) The Model of Care

- Four Community Mental Health Centres (CMHCs) 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
- One General Hospital Psychiatric Unit (GHPU) with six beds, mainly used for emergencies at night with very short stays of usually less than 24 hours
- A Rehabilitation 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 centres
- 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 centres, self-help centres, workshops qualified to provide cultural and educational activities, professional training, and cultural promotion on the issues of rights and citizenship.

(iii) 24 hour Community Mental Health Centres

- CMHCs are responsible for a specific catchment area, and each one is run by a multi-disciplinary team composed of nurses, social workers, psychologists, rehabilitation specialists, and psychiatrists
- Each CMHC directly responds to the full range of psychiatric needs in its catchment area, including acute conditions, which are not referred to a specific service but managed with a view to prevention, treatment, and rehabilitation
- The CMHCs stress a continuity in therapeutic-rehabilitation interventions, especially for persons with severe mental disorders. This approach involves supporting the person in the exercise of their fundamental rights and in accessing social opportunities (housing,

education, occupational training, health management and leisure activities), accompanying them in their rehabilitation processes and orienting them in their relations with other services and institutions

- The 24/7 CMHCs are located in nonhospital residential facilities, usually a two- or three-story house. The homelike quality of their environment is seen as a ‘‘social habitat’’ and is consistent with staff attitudes that mainly focus on flexibility and reasonable negotiation with users, according to their concerns and needs.
- CMHCs are walk-in services and the intake is problem based, rather than diagnosis based. If the problem is urgent, even from the subjective viewpoint of the person or the caregiver, then it is addressed immediately
- From 8 a.m. to 8 p.m., CMHCs can admit patients to their beds directly and informally. Crises occurring overnight are managed at the general hospital casualty department, where they receive psychiatric consultation, and patients may be admitted to the GHPU if needed
- Service users are considered not as inpatients but as ‘‘guests,’’ and they can receive visits without restrictions. They are also encouraged to keep up their ordinary life activities and the links to their environment. Professionals and volunteers do outdoor activities with them every day
- The CMHCs are also a place where users come as outpatients for everyday care and rehabilitation, so that crisis tends to be defused, diluted in everyday life. It is often followed by a period of day hospital attendance, with a view to strengthening the therapeutic relationship and developing an ongoing plan of care.

(iv) **The General Hospital Psychiatric Unit**

- The GHPU is a DMH-run unit housed in the general hospital but directly managed by the community service network, with a quick turnover and low bed occupancy rate. It provides consultation/liaison for the whole hospital and the emergency department (ED)
- A patient coming to the ED may be referred to a local CMHC or kept under observation, especially during night shifts. On the following day, he/she is usually referred to his/her CMHC.
- CMHCs control and manage GHPU activities directly and are responsible for activating community interventions as quickly as possible.

(v) **Principles from the Trieste Department of Mental Health (DMH):**

1. DMH is responsible for the mental health of the community. All psychiatric needs must be met, without any selection.
2. DMH has an active attitude and practices outreach, in particular:
    - There is no waiting list for urgent cases
    - DMH promotes the approach of ‘‘shouldering the burden’’ in the user’s living environment
3. DMH promotes high accessibility, through:
    - Walk-in, drop-in service
    - Quick response after referral
4. DMH guarantees therapeutic continuity in space and time, through:
    - Interventions taking place in the patient’s actual living environments, within social-health institutions, in forensic settings (courts of law, prison, forensic hospitals)

- Time planning of interventions based on need for care and the threefold criteria of prevention, treatment, and rehabilitation

5. DMH responds to crisis in the community through:
    - Alternatives to hospitalization (home treatment, respite at the CMHC)
    - Its organization of CMHCs able to deal with emergencies and, if necessary, effecting compulsory treatments
6. DMH provides comprehensive care, through:
    - Integrated responses between social and health care, making readily available the resources by CMHCs, other health services, social services, and those coming from the person's microsocial context
7. DMH practices team work, through:
    - Collective formulation of therapeutic projects
    - Coordination between various professional figures
    - Multidisciplinary and multiprofessional approaches
    - Constant on-site training and team intervision activities
    - Circulation of information within the service
    - Integration of nonprofessional and volunteer work.

The Proposed Consensus Model for Adult Mental Health Services in Hywel Dda

(i) The vision of care for Mental Health Services in Hywel Dda

The vision for a modern mental health service for provides the opportunity for the much needed cultural shift and one which is aligned in many aspects to the Trieste model of care. The principles set out for this in Hywel Dda are as follows:

- **Be accessible by all 24hrs a day** – The person who needs help or their supporters need to be able to walk into a mental health centre at any time and establish a safe relationship to discuss their needs and agree immediate support.

- **Have no waiting lists** – The first contact should take place within 24hrs after the request with planned meetings to follow that agree the support and treatment which will be available in the context of choice.

- **Move away from hospital admission and treatment to hospitality and time out** – The mental health centre would provide night hospitality as an instrument to address the crisis during periods when there is higher need for care and / or to support the needs of the family. Intermediate access for those "stepping-down" from the central admission units back to the community would be available to support their transition.

(ii) The Proposed Model of Care for Hywel Dda.

- Extensive engagement brought about the co- design of a model of care which clearly reflected aspects of the Trieste community model. This is as follows:

- The development of 24 hours Community Mental Health Centres in each county. Each 24/7 CMHC will include:

- Central town location for ease of access
- A friendly welcoming environment, unlike traditional clinical centres
- Access to clinicians, outpatient appointments and other health related needs.
- Access to experts in social care, housing and finances
- Co-delivery with other experts with a lived experience of mental health problems, such as peer mentors and family support workers
- Consideration of social enterprises that can add value to the local community as well as offering meaningful engagement and/or employment to people with mental health difficulties
- Four crisis & recovery or 'hospitality' beds within a welcoming environment, supported by staffing from the third sector.
- A local Section 136 facility

- A single point of access with which to contact services or to receive advice, making services more accessible.
- A move to centralise inpatient provision to Carmarthenshire through a:
  - Central assessment unit that has 14 assessment beds and a dedicated Section 136 facility comprising of two additional beds. This allows for a greater provision of senior clinical staff, available through extended hours and at weekends.
  - Central treatment unit with 15 treatment and recovery beds. This will be able to provide a greater presence of senior staff available through extended hours. It will also include people with a lived experience of mental health problems through the provision of peer mentors and family support workers as a core part of the service.
- There are no significant changes to available adult admission beds. The above proposals include a total of 41 adult beds with an additional 2 dedicated Section 136 beds.