Community Mental Health Care in Trieste and Beyond

An ''Open Door–No Restraint'' System of Care for Recovery and Citizenship

Roberto Mezzina, MD

Abstract: Since Franco Basaglia's appointment in 1971 as director of the former San Giovanni mental hospital, 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 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, whose organization and activities are here described in detail. Data are provided on activity and outcome. The performance of DMH as a World Health Organization collaborating center disseminating best community mental health practices is also reviewed.

Key Words: Community Mental Health Services, deinstitutionalization, whole life–whole system approach, international cooperation, Lead World Health Organization Collaborating Centre for Service Development.

(*J Nerv Ment Dis* 2014;202: 440–445)

In 1971, Franco Basaglia was appointed as director of the San Giovanni Mental Hospital in Trieste after his pioneering work in Gorizia and Parma. Under his direction, Trieste became an internationally acknowledged laboratory for innovation in mental health care and, in 1973, became a World Health Organization (WHO) pilot center for deinstitutionalization and community mental health care (Bennett, 1985). Kept alive by his team, Basaglia's spirit has long survived in Trieste after his premature death in 1980, the very same year in which the San Giovanni hospital became the first in Europe to close (De Leonardis et al., 1986; Dell'Acqua and Cogliati Dezza, 1986). The striving for innovation has never stopped in the following 3 decades, leading to a model of community care that today is a national and international benchmark. The Department of Mental Health (DMH) was formally declared a WHO collaborating center in 1987.

Trieste (a city of 236,000 inhabitants in the northeastern region Friuli Venezia Giulia) changed from a clinical model based on treating illness to a wider concept of mental health that looks at the whole person and the social background. The core of the organization is a network of Community Mental Health Centers active 24 hours a day, 7 days a week (24/7 CMHCs), with relatively few beds in each of them. The system coordinated by the DMH also comprises one general hospital psychiatric unit (GHPU), a network of supported housing facilities and several social enterprises.

Dipartimento di Salute Mentale/World Health Organization Collaborating Centre for Research and Training, Trieste, Italy.
Send reprint requests to Roberto Mezzina, MD, Dipartimento di Salute Mentale/World Health Organization Collaborating Centre for Research and Training, Via Giulia 4, 34126 Trieste, Italy. E-mail: romezzin@gmail.com; who.cc@ass1.sanita.fvg.it.

ISSN: 0022-3018/14/20206–0440
DOI: 10.1097/NMD.0000000000000142

The Regional Government of Friuli Venezia Giulia (population of 1,200,000) based its mental health policy on the Trieste, Pordenone, and then Udine pilot experiences, replicating that model all over the region. All regional services have now implemented a similar organization with comparable outcomes in terms of low rates of hospitalization, low compulsory treatment rates, effective job placement, a low number of forensic patients, and a decreasing (−30%) suicide rate during the last 15 years (Source SISSR, Regional Data Service).

THE TRIESTE MODEL

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:

- four 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 GHPU 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. A summary of DMH Trieste functions and activities is outlined in Table 1.

The 24/7 CMHCs

CMHCs are responsible for a specific catchment area, and each one is run by a team composed of approximately 30 nurses, 2 social workers, 2 psychologists, 2 rehabilitation specialists, and 4 to 5 psychiatrists. The 24/7 CMHC operates around-the-clock; is provided with four to eight beds; and, during night shifts, has two professionals on clinical duty. 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 24/7 CMHCs are located in nonhospital residential facilities, usually a two- or three-story house. They cannot be considered crisis centers but multifunctional spaces to which people have easy access. The homelike quality of their environment—seen as a "social habitat"—is consistent with staff attitudes that mainly focus on flexibility and reasonable negotiation with users, according to their concerns and needs. A single multidisciplinary team rotates on a

TABLE 1. Overview of the Trieste DMH Work

Functions and activities
Day-night hospitality
Outpatient visits
Home treatment
Assertive community treatment
Day care
Individual, family, and group therapy
Social support, enhancement of social networks
Supported housing
Social inclusion through job placement, sport, art, leisure time
Department programs
User social and cultural training and involvement, participation, and advocacy
Family program (psychoeducation, self-help, multifamily groups)
Involvement of GP for health care and comorbidity with chronic physical conditions
Prison consultancy service
Support network for prevention of suicide and of "lonely deaths" in the elderly
Facilitating itineraries for membership in associations, etc.
Promotion of social enterprise activities
Creative/play/sport/leisure activities with community agencies
Promotion of self-help groups, programs, clubs with associations
Collaborations with health care districts and general hospitals, *e.g.*, the elderly, child and adolescent, persons with disability, specialist medicine, eating disorders, early detection and intervention in psychosis
Relationships with the city's cultural agencies (theaters, university, etc.)
Programs on sex difference and mental health

GP indicates general practitioner.

24-hour scheme covering all functions, from care of guests admitted to beds to outpatients and outreach activities.

CMHCs are walk-in services and meet all requests usually within 1 to 2 hours, with no waiting list. The whole staff rotates on reception duties. The intake is problem based, rather than diagnosis based, and 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. An extended assessment can also be provided up to 24 hours. Usually, the day afterward, the CMHC team visits the GHPU and works out a plan for ongoing care. Options include transfer to 24/7 CMHCs, if they require respite or detachment from the home environment, or simply outpatient care and home support.

The 24/7 hospitality plan at the CMHC is based on informal agreement among users, the team, and caregivers, when appropriate. In extremely conflictive situations, when agreement seems hard to reach, the team operates by assertive negotiation, which may take hours, and several attempts involving significant others, as required by the letter of the law, instead of applying compulsory psychiatric treatment orders (CPTOs). 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. This work is carried out at the CMHC, which is also the 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. The mean duration of admissions to 24/7 CMHCs is 10 to 12 days. Patients who require reformulation of their rehabilitation plans or whose social needs are temporarily not being met (*e.g.*, homeless) may be hosted in the CMHC, to avoid deterioration or social drift. Practices implemented at the 24/7 CMHCs are summarized in Table 2.

The shift from hospitalization to hospitality (Mezzina and Johnson, 2008) has considerable advantages over traditional services. CMHCs are clear round-the-clock reference points, staff rotate more flexibly and can provide a wider range of responses, patients get immediate contact with a system of resources and options, continuity of care is ensured by the same team, admission and discharge are arranged as and when needed with no bureaucracy involved, while the stigma connected with hospitalization is greatly reduced. The CMHC care process, especially in dealing with crisis, has been described extensively elsewhere and goes beyond the scope of this article (Dell'Acqua and Mezzina, 1988a, 1988b; Mezzina and Johnson, 2008). It has been pointed out that social network intervention and particularly the involvement of families and other caregivers in care plans, either through psychoeducational programs or mutual support groups (Dell'Acqua et al., 1992a; Dell'Acqua and Mezzina, 1991; Dell'Acqua et al., 1992b,), are the key to preventing social drift as well as to enhancing the social capital of individuals and communities (Terzian et al., 2013).

The GHPU

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. In fact, CMHCs control and manage GHPU activities directly and are responsible for activating community interventions as quickly as possible, usually transferring patients to the 24/7 CMHC within the same day. When hospitalization occurs, one of the six beds is used, which is quite rare. This is planned with a view to ensuring continuity with the CMHC, which anyway makes a point of visiting and comanaging patients at the GHPU. All measures are taken to avoid the risk for hospitalization as being separate from community responses. CPTOs can be issued both by 24/7 CMHCs (which cope with more than two thirds of the overall duration of CPTOs) and by the GHPU. The proportion

TABLE 2. Crisis Management Principles for People Hosted 24/7 at the CMHC in Trieste

Do not separate persons receiving hospitality from other users ("dissolve" the crisis in normal, everyday living)
Minimize barriers between operators/users
Reduce the compartmentalization and "turf" issues connected to individual locations/facilities (no to roles/spaces)
Open door, even for compulsory treatments
Do normal things in a normal environment
Share together and live together
Negotiate and be accountable for everything
Continuous effort to obtain compliance with treatment/care through a relationship based on trust
Inclusion of the user in crisis in both structured and nonstructured activities, inside and outside the CMHC

between days of hospitality at CMHCs and days of inpatient care at a GHPU is 10:1. The mean stay for people who are admitted to 24/7 CMHCs in a state of crisis is 7 days, whereas it is less than 3 for people who are admitted to the GHPU. In recent years, all figures and rates concerning emergencies, acute presentations, and crises have decreased. The community-based system therefore seems to be sustainable in the long-term and able to improve the population's mental health as shown by the dramatic change in illness presentation and intrinsic phenomenology.

Organization and Quality of Work

Recognizing the circular relationship between service, practice, and thinking, Trieste has invested in constant training, motivation, and professional development of staff, starting from lengthy daily team meetings at every CMHC. A high standard of positive attitudes and skills, stemming directly from the practice and thinking of the deinstitutionalization process (De Leonardis et al., 1986; Dell'Acqua and Cogliati Dezza, 1986; Vicente et al., 1993a), is required not only to keep the system going but also to go on developing it. The DMH in Trieste bases its activity on a set of principles listed in Table 3, which also underpin the culture and training of all staff.

Working With the Community

In keeping with its mental health care vision, the DMH developed a strategy to deploy the human and financial resources of the former mental hospital in the wider community as the process of closure began to cut in (De Leonardis et al., 1986; Rotelli, 1988). The DMH and the local administration found resources directly for users (benefits, jobs, subsidies, housing), worked to generate other resources (institutional and NGO), and appealed for volunteers available for creative civic involvement. The DMH promoted the starting up of integrated, productive social enterprises (cooperatives) offering diversified job opportunities and educational/vocational training with user involvement in their decisional processes, in an effort to bridge the gap between the labor market and the welfare system.

Cooperatives now cover a wide range of jobs such as cleaning; building maintenance; transport; furniture; design; cafeteria; catering; hotel and restaurant services; management of a beach resort; gardening; handicrafts; photo, video, and radio production; computer service; serigraphy; administrative services; and personal services. The purchasers are public agencies and private citizens (Leff and Warner, 2006; Rotelli et al., 1994; Warner, 2012; Warner and Mandiberg, 2006). There are approximately 600 persons working in these cooperatives in the town, approximately 70% of whom are "disadvantaged," according to national work legislation definitions, whereas there are approximately 200 trainees receiving work grants, mostly users of mental health, drug addiction, or handicap services, or "youths at risk." There are managers, mental health professionals, teaching experts, and collaborators for each specific sector. Because the DMH considers all this as forms of "treatment," cooperatives can be considered "services." At the same time, they are a workshop for vocational training and a system for the creation of new jobs generating an independent income.

User involvement in planning, delivering, and evaluating services is an important development of the last few decades in Trieste. As in most advanced mental health experiences around the world, Trieste has witnessed the emergence of users and caregivers as new social actors in the field of mental health. Their empowerment through active participation in mental health promotion has meant that they in turn contribute to further modifications of the mental health service, in a common action against institutional inertia and passive dependence on welfare, against the overall "medicalization" of individual and social needs, as well as against new forms of institutionalization (Mezzina et al., 1992).

Networking with other community services ensures that mental health care is a fundamental component of community care. This synergy is implemented basically through individualized and joint plans of care entailing liaison with well-organized district health care teams and tackling problems of the elderly, adolescents and young adults, families, and persons with disability. Such help is provided outside the general hospital and mostly at home.

TABLE 3. The Trieste DMH Principles of Community Practice

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

ACTIVITIY AND OUTCOME SURVEYS

Fewer than 10 people per 100,000 of the population receive a CPTO, usually for approximately 7 to 10 days. This is approximately 1% of all episodes of residential care, and most of them are handled by the CMHCs, which have come to take over most GHPU admissions. The readmission rate to 24/7 CMHCs is 30%. The use of CMHC beds has steadily decreased during these decades. The "no-restraint" principle extends to every service, and electroconvulsive therapy is not practiced. There are no homeless clients because the CMHCs to some extent function as shelters until accommodation can be found, and no people from Trieste are currently in forensic hospitals. Among the most important programs of the service, there is a suicide prevention project that has contributed to reducing the suicide rate by half (from 25 to 12 per 100,000 in 20 years; Dell'Acqua et al., 2003).

Approximately 250 people are in professional training every year using work grants, and some 30 of these find employment in competitive jobs, mostly in the field of social cooperation, and

approximately one third by private employers. In town now, there are almost 50 different sites of various kinds where mental health activities are being carried out.

Furthermore, in the last few years, we have built up the possibility of investing large sums of money in a short time span to help particularly difficult patients using personalized health care budgets and setting up special projects with the support of NGOs. Approximately 160 clients per year receive personal budgets to be spent on a joint recovery plan in the areas of housing, work, and social relationships. This is approximately 18% of the overall DMH budget, whereas another 4% goes on economic aid, training grants, leisure, and projects involving NGOs.

The budget of the DMH is mostly spent in community services (94%), and only a small part goes to the GHPU (6%). Dividing the DMH financial budget per head of population, we get a theoretical sum of 80 euros per citizen spent on mental health services.

In Trieste, it has not been possible to evaluate the effectiveness of single interventions (*i.e.*, psychoeducational, rehabilitative, psychotherapeutic) because these are interwoven in its "whole system" approach. Nevertheless, some surveys and outcome studies have been conducted, notably cohort studies on patients with psychosis, family burden studies, research on crisis intervention, user and family member satisfaction, and attitude toward community care.

The first follow-up study after the reform law (1983–1987) showed better outcomes for 20 patients with schizophrenia in Trieste and Arezzo than in the other 18 Italian centers (Kemali et al., 1989). Crisis management at CMHCs also proved effective in preventing relapses and chronic courses (Mezzina and Vidoni, 1995). A national survey carried out in 13 centers showed that crisis care provided by 24/7 CMHCs is more effective in crisis resolution and at 2-year follow-up, particularly when related to trusting therapeutic relationships, continuity and flexibility of care, and service comprehensiveness (Mezzina et al., 2005a, 2005b). A 50% reduction occurred in emergency presentation of general hospital casualty for approximately 20 years.

In a sample of 27 high-priority users at a 5-year follow-up, we found a high rate of social recovery (personal data). We found a significant reduction of symptoms (approximately 20% of the total Brief Psychiatric Rating Scale [BPRS] score in the group with a BPRS rate of 65 at baseline) and a remarkable improvement in social functioning (score increased by 50%). Nine users got competitive jobs, 12 managed to live independently, and the overall Camberwell Assessment of needs unmet needs score dropped from 75% to 25%. There was also a 70% reduction in days of admission, and only one client dropped out (DMH survey).

Qualitative research particularly highlighted some major social factors connected to services and the connection between recovery, social inclusion, and participatory citizenship (Borg et al., 2005; Marin and Mezzina, 2006; Mezzina, 2006; Mezzina et al., 2006a, 2006b, 2005a; Sells et al., 2006).

Recent data suggest 75% compliance with antipsychotic medication ($n = 587$), a situation related to the quality of therapeutic relationship and social network enhancement (Palcic et al., 2011). User satisfaction with services has been high right from the early years (Vicente et al., 1993b) and, more recently, recorded 83% in two CMHCs.

DISCUSSION

More than 30 years on since the closure of its mental hospital, Trieste has developed an original model of mental health based on assertiveness, continuity, and work with the community, although some similarities can be found with other comprehensive approaches such as Integrated Community Treatment (Falloon and Fadden, 1993) or single evidence based programs such as Assertive Community Treatment (Stein and Test, 1978, 1985). In Trieste, such models are seen more as functions of a single team rather than as separate specialized services, whereas greater emphasis is placed on consistent organization—in terms of values and principles—related to user needs that are reflected in any single component, instead of standardized protocols and procedures. Hence, the Trieste model can be described more in terms of practices and care relationships than techniques and treatments (De Leonardis et al., 1986). All in all, it is a "whole system, recovery-oriented approach" to community mental health care (Mezzina, 2010b).

For instance, rehabilitation in Trieste has been conceived as a program of restitution and reconstruction of full rights of citizenship for individuals with mental health problems and the material construction of these rights (Rotelli et al., 1994). This implies the legal recognition of not only civil rights for mental health users but also social rights. Resources relating to housing, jobs, goods, services, and relationships were acquired through deinstitutionalization, then ensured by the community network. Access to resources can be improved either by developing user capabilities through training (living and vocational skills, education) and information (psychoeducation, social awareness, cultural programs) or by creating social support networks, which are managed by comprehensive community services that are a complete alternative to the psychiatric hospital.

Such a comprehensive, holistic approach works by combining health with welfare systems in a powerful synergy, consistent with a "whole life" vision (Jenkins and Rix, 2003). The focus on individuals and the rights of citizenship raises the issue of the values underpinning the practice of "value-based" services (Fulford, 2004). A shift from reparative medicine to participatory health is occurring in Trieste on a par with some of the most advanced experiences and stretching far beyond the boundaries of mental health.

Since Basaglia's day, Trieste has played an important role in the international scenario (Rosen et al., 2012), as witnessed by recognition of the DMH as a WHO Collaborating Center for Research and Training. It was considered as a sustainable and cost-effective example and model for service development by WHO Geneva and Copenhagen and was declared Lead World Health Organization Collaborating Centre for Service Development in the Helsinki Action Plan, 2005. Within this framework, the DMH currently provides the following:

a) Support and guidance to various national governments for deinstitutionalization and development of integrated/comprehensive Community Mental Health services, such as:
   drafting of policies at the local and national level
   development of leadership and management skills
   implementation and development of a local services network
   staff training and professional development
b) Collaboration, partnership, and networking with departments or networks with excellence in the field of community-based mental health care.
c) Dissemination of a "whole systems and recovery approach," comprising innovative practices in community mental health (*e.g.* alternatives for acute care; comprehensive CMHCs; rehabilitation, recovery, and social inclusion services; deinstitutionalization and whole systems change; an early intervention integrated network; social enterprises and cooperatives technology, operation and policies).

Programs of cooperation have been developed for more than 30 years in all continents, with a particular focus on Latin America, South and East Europe, and Palestine—often under WHO patronage and in collaboration with other organizations. Although the flow of study visits has risen to a thousand people every year, Trieste has established connections with some of the most innovative experiences in community mental health worldwide, leading to a mutual support network (Mezzina, 2010a; Jenkins, 2010). Twinning schemes and other forms of international mutual learning have generated

know-how about setting up innovative services and programs. Apart from what has been outlined here for Trieste, in terms of social coops and multipurpose integrated CMHCs, we may quote, for example, the Lille foster family schemes and practices for community integration; the South Stockholm user involvement schemes; Asturias with its liaison with primary care and social firms; and the multidisciplinary community mobile teams as developed in North Birmingham, Monaghan, and Ireland.

Trieste is also considered a model in western countries such as the United Kingdom, Scandinavia, Australia and New Zealand, and the United States and Canada, whereas strong interest has been expressed by Japan, Korea, China, Iran, Malaysia, and other Asian countries. The problem seems to be "what is replicable" because, apart from requiring reliable, apparently simple but actually very complex and coherent organization of services, the Trieste approach is subtly different, still based on a strongly critical view of mainstream clinical psychiatry.

CONCLUSIONS

Trieste, in connection with other advanced experiences in community mental health care, has developed a paradigm derived from deinstitutionalization but geared to the complexity of daily living in the community (Mezzina, 2005). At a theoretical level, it implies a flexible interaction between observer and observed, between "scientists" and "patients" (Maccacaro, 1978). What is pivotal is the ability to make sense and meaning within new therapeutic action, which could be called "whole life projects" for the people in need (Jenkins and Rix, 2003). It could be defined as an "interactive comprehension model" (Mezzina, 2005). Community care cannot really be effective if it aims simply at efficiency in the management of target populations, defined by their illness and/or related deviant behaviors (Basaglia, 1987). It must strive to preserve the idea of the person as a whole, while combating social exclusion and new forms of institutionalization.

This approach is based on five cornerstones: individualize care plans through active negotiation, ensuring comprehensive responsibility of CMHC in all phases of treatment, working on the environment and the social fabric, supporting individual strengths in vivo, and fostering service accountability toward the community.

Deinstitutionalization today means positive risk taking and serious rethinking of questions such as distance, power, and language. Historically, Trieste pioneered the shift from relationships based on domination/control to the therapeutic relationship seen as reciprocal, based on rediscovering the whole person. From this point of view, deinstitutionalization can be seen as a change in relations of power. As we demonstrated by qualitative cross-cultural research, participatory citizenship, "having a whole life," lies at the heart of a recovery process, as individuals themselves have stated in their narratives (Davidson et al., 2005, 2010). This really means putting the person, and not the illness, at the center of the process (Marin et al., 2005).

DISCLOSURE

The author declares no conflict of interest.

REFERENCES

Basaglia F (1987) The disease and its double and the deviant majority. In Hughes NS, Lowell A (Eds), *Psychiatry inside out. Selected writings of Franco Basaglia* (pp 101–126). New York: Columbia University Press.

Bennett DH (1985) The changing pattern of mental health care in Trieste. *Int J Ment Health*. 14:7–92.

Borg M, Sells D, Topor A, Mezzina R, Marin I, Davidson L (2005) What makes a house a home: The Role of material resources in recovery from severe mental illness. *Am J Psychiatr Rehabil*. 8:243–256.

Davidson L, Borg M, Marin I, Topor A, Mezzina R, Sells D, Process of Recovery in Serious Mental Illness (2005) Findings from a multinational study. *Am J Psychiatr Rehabil*. 8:177–201.

Davidson L, Mezzina R, Rowe M, Thompson K (2010) A life in the community: Italian mental health reform and recovery. *J Ment Health*. 19:436–443.

De Leonardis O, Mauri D, Rotelli F (1986) Deinstitutionalization: A different path. The Italian Mental Health Reform. *Health Promot*. 2:151–165.

Dell'Acqua G, Belviso D, Crusiz C, Costantinides F (2003) Trieste e il suicidio: Un progetto di prevenzione. *In Quaderni Italiani Di Psichiatria*. 22:11–23.

Dell'Acqua G, Cogliati Dezza MG (1986) The end of the mental hospital: A review of the psychiatric experience in Trieste. *Acta Psychiatr Scand Suppl*. 316:45–69.

Dell'Acqua G, Evaristo P, Impagnatiello M, Mezzina R (1992a) Il centro di salute mentale e il carico familiar. *Riv di Riab Psich e Psicosociale*. 1:1–3. Naples, Idelson.

Dell'Acqua G, Mezzina R (1988a) Approaching mental distress. In Ramon S, Giannichedda MG (Eds), *Psychiatry in transition. The British and Italian experiences* (pp 60–71). London: Pluto Press.

Dell'Acqua G, Mezzina R (1988b) *Responding to crisis: Strategies and intentionality in community psychiatric intervention*. Trieste, Italy: Per La Salute Mentale/For Mental Health, Centro Studi Salute Mentale.

Dell'Acqua G, Mezzina R (1991) Il centro di salute mentale 24 ore come comunita terapeutica allargata: La riabilitazione e lo sviluppo di una rete partecipativa, in Riabilitazione Psicosociale in Psichiatria, Atti del II Congresso Nazionale della S.I.R.P., Naples, Idelson.

Dell'Acqua G, Mezzina R, Vidoni D (1992b) Utenti, famiglie e servizi di salute mentale. In Tranchina P, Pirella A (Eds), *Venti anni di Fogli d'Informazione*. Pistoia, Italy: Centro di Documentazione.

Falloon IRH, Fadden G (1993) *Integrated mental health care: A comprehensive community based approach*. New York: Cambridge University Press.

Fulford KWM (2004) Ten principles of values-based medicine. In Radden J (Ed), *The philosophy of psychiatry: A companion*. New York: Oxford University Press.

Jenkins J (2010) The construction of the European network of the most advanced experiences of deinstitutionalisation. In Toresini L, Mezzina R (Eds), *Beyond the walls. Deinstitutionalisation in European best practices in mental health*. Merano, Italy: Alpha Beta Verlag.

Jenkins J, Rix S (2003) *The Whole Life Programme. NIMHE East Region*. London: NHS.

Kemali D, Maj M, Carpiniello B, Giurazza RD, Impagnatiello M, Lojacono D, Martini P, Morandini G (1989) Patterns of care in Italian psychiatric services and psycho-social outcome of schizophrenic patients. A three-year prospective study. *Psychiatry Psychobiol*. 4:23–31.

Leff J, Warner R (2006) *Social inclusion of people with mental illness*. Cambridge, UK: Cambridge University Press.

Maccacaro GA (1978) Appunti per una ricerca su: epidemiologia della istituzione psichiatrica come malattia sociale. *Fogli d'Informazione*. 50:306–310.

Marin I, Mezzina R (2006) Percorsi soggettivi di guarigione. Studio pilota sui fattori di recovery in salute mentale. *Rivista Sperimentale di Freniatria*. 130/1:129–152.

Marin I, Mezzina R, Borg M, Topor A, Staeheli-Lawless M, Sells D, Davidson L (2005) The person's role in recovery. *Am J Psychiatr Rehabil*. 8/3:223–242.

Mezzina R (2005) Paradigm shift in psychiatry: Processes and outcomes. In Ramon S, Williams JE (Eds), *Mental health at the crossroads. The promise of the psychosocial approach* (pp 81–93). Hants, England: Ashgate.

Mezzina R (2006) Citizenship: The social dimension of recovery. In Robertson S, Kellehear K (Eds), *Dancing to the beat of a different drum. Mental health, social inclusion, citizenship. The MHS conference book of proceedings 2005* (pp 30–36). Sydney, Australia: The Mental Health Service Conference Inc.

Mezzina R (2010a) From Italy to Europe and back, practices for emancipation. In Toresini L, Mezzina R (Eds), *Beyond the walls. Deinstitutionalisation in European best practices in mental health* (pp 16–34). Merano, Italy: Alpha Beta Verlag.

Mezzina R (2010b) Outcomes of deinstitutionalisation in Trieste. In Toresini L, Mezzina R (Eds), *Beyond the walls. Deinstitutionalisation in European best practices in mental health* (pp 136–166). Merano, Italy: Alpha Beta Verlag.

Mezzina R, Borg M, Marin I, Sells D, Topor A, Davidson L (2006a) From participation to citizenship: How to regain a role, a status, and a life in the process of recovery. *Am J Psychiatr Rehabil*. 9:39–61.

Mezzina R, Davidson L, Borg M, Marin I, Topor A, Sells D (2006b) The social nature of recovery: Discussion and implications for practice. *Am J Psychiatr Rehabil*. 9:63–80.

Mezzina R, Johnson S (2008) Home treatment and 'hospitality' within a comprehensive community mental health centre. In Johnson S, Needle J, Bindman JP, Thornicroft G (Eds), *Home treatment and crisis resolution in mental health* (pp 251–265). Cambridge, UK: Cambridge University Press.

Mezzina R, Mazzuia M, Vidoni D, Impagnatiello M (1992) Networking consumers participation in a community mental health service: Mutual support groups, citizenship, coping strategies. *Int J Soc Psychiatry.* 38:68–73.

Mezzina R, Vidoni D (1995) Beyond the mental hospital: Crisis and continuity of care in Trieste. A four-year follow-up study in a community mental health centre. *Int J Soc Psychiatry.* 41:1–20.

Mezzina R, Vidoni D, Miceli M, Crusiz C, Accetta A, Interlandi G (2005a) *Crisi psichiatrica e sistemi sanitari. Una ricerca italiana*. Trieste, Italy: Asterios.

Mezzina R, Vidoni D, Miceli M, Crusiz C, Accetta A, Interlandi G (2005b) Gli interventi territoriali a 24 ore dalla crisi sono basati sull'evidenza? Indicazioni da uno studio multicentrico longitudinale. *In Psichiatria di Comunità*. 4:4.

Palcic S, Broussard P, Pettinelli A, Giraldi T, Martinis E, Furina C, Bracco R, Zanello E, Riolo A, Mezzina R (2011) Studio comparativo sull'utilizzo dei farmaci antipsicotici nel territorio dell'ASS n. 1 "Triestina". *G Ital Farm Clin*. 25:4.

Rosen A, O'Halloran P, Mezzina R (2012) International trends in community mental health services. In McQuiston H, Feldman J, Sowers W (Eds), *Handbook of community psychiatry* (pp 389–404). London: Springer.

Rotelli F (1988) Changing psychiatric services. In Italy. In Ramon S, Giannichedda MG (Eds), *Psychiatry in transition. The British and Italian experiences* (pp 182–190). London: Pluto Press.

Rotelli F, Mezzina R, De Leonardis O, Goergen R, Evaristo P (1994) Is rehabilitation a social enterprise? Initiative of support to people disabled by mental illness. Geneva, Switzerland: World Health Organisation. Retrieved from http://www.triestesalutementale.it/english/doc/rotelli-et-al_xxxx_rehabilitation.pdf. Retrieved April 21, 2014.

Sells D, Borg M, Marin I, Mezzina R, Topor A, Davidson L (2006) Arenas of recovery for persons with severe mental illness. *Am J Psychiatr Rehabil*. 9:3–16.

Stein LI, Test MA (1978) An alternative to mental hospital treatment. In Stein LA, Test MA (Eds), *Alternatives to mental hospital treatment*. New York: Plenum Press.

Stein LI, Test MA (Eds) (1985) The training in community living model: A decade of experience. *New Directions for Mental Health Services*. (No. 26). San Francisco: Jossey-Bass.

Terzian E, Tognoni G, Bracco R, De Rugieri E, Ficociello RA, Mezzina R, Pillo G (2013) Social network intervention in patients with schizophrenia and marked social withdrawal: AA randomized controlled study. *Can J Psychiatry.* 58:622–631.

Vicente B, Vielma M, Jenner FA, Mezzina R, Lliapas I (1993a) Attitudes of professional mental health workers to psychiatry. *Int J Soc Psychiatry.* 39:2.

Vicente B, Vielma M, Jenner FA, Mezzina R, Lliapas I (1993b) Users' satisfaction with mental health services. *Int J Soc Psychiatry.* 39:2.

Warner R (2012) Psychiatric rehabilitation methods. In McQuiston H, Feldman J, Sowers W (Eds), *Handbook of community psychiatry* (pp 223–232). London: Springer.

Warner R, Mandiberg J (2006) An update of affirmative businesses or social firms for people with mental illness. *Psychiatr Serv.* 57:1488–1492.