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Deinstitutionalization today: person-centered focus and system change toward community mental health

Long term institutions have been for many years considered as relics of the past, but they still absorb the majority of economic resources of mental healthcare and are vehemently resisting to change. Most reforms in Europe are now trying to develop community services, which are integrated within welfare systems and social networks, but they are loosely coupled with a radical institutional transformation. Deinstitutionalization is mentioned in many international charters and documents, as the WHO Report and the UN Committee for Convention on the Rights of Persons with Disabilities. While there is a substantial agreement on the basic definition as far as it is referred to patients (e.g., the release from the institution), nonetheless the process is widely misunderstood. It regards not just the downsizing, and final closure of total institutions, or the discharge of their patients, but a whole system change and moreover a full transformation of psychiatry towards community mental health. Deinstitutionalization must be seen as the main strategy to overturn old forms of oppression of people with mental health conditions and disabilities and to mobilize resources and supports for their recovery and social integration. Community-based services can promote the response to needs and the fulfillment of citizenship rights by catalyzing resources and opportunities. The Italian experience, and especially the one in Trieste, is a demonstration that this is possible, by acting in a way that fosters subjectivity, empowerment, recovery and social inclusion, while embracing a human rights approach (e.g. principles of open door, no restraint). To complete deinstitutionalization of mental healthcare, we thus need the convergence of human rights, person-centered and recovery approaches with comprehensive, strong, and responsive community-centric services.

Key words: *psychiatric institutions, human rights, social inclusion, recovery, community-based care.*

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Deinstitutionalizacija danes: osredotočenost na osebo in spreminjanje sistema v smeri skupnostne skrbi za duševno zdravje

Totalne ustanove že veliko let veljajo za relikte preteklosti, vendar še vedno poberejo večino ekonomskih virov za duševno zdravje in se trdovratno upirajo spremembam. Večina reform v Evropi zdaj poskuša razviti skupnostne storitve, ki so integrirane v socialne sisteme in socialna omrežja, vendar so slabo povezane s korenito institucionalno preobrazbo. Deinstitucionalizacija je omenjena v številnih mednarodnih dokumentih, kot so poročilo Svetovne zdravstvene organizacije in Odbor ZN za konvencijo o pravicah invalidov. Čeprav obstaja pomembno soglasje glede osnovne definicije deinstitutionalizacije, ko gre za paciente (npr. odpust iz ustanove), pa je proces na splošno napačno razumljen. Gre ne le za zmanjševanje števila in zaprtje totalnih institucij ali odpust njihovih pacientov, temveč za celotno sistemsko spremembo, še več, za popolno transformacijo psihiatrije v smeri skupnostne skrbi za duševno zdravje. Deinstitucionalizacija mora biti poglavitna strategija za premagovanje starih oblik zatiranja ljudi z duševnimi težavami in ovirami ter za mobilizacijo virov in podpore za njihovo okrevanje in socialno integracijo. Skupnostne storitve lahko promovirajo odziv na potrebe in uresničevanje pravic do državljanstva z aktivacijo virov in priložnosti. Italijanska izkušnja, še posebej ta v Trstu, dokazuje, da je to mogoče, če delujemo na način, ki spodbuja subjektivnost, krepitev moči, okrevanje in socialno vključenost, pri tem pa upoštevamo človekove pravice (npr. načelo odprtih vrat, nobene prisile). Za dokončanje deinstitucionalizacije na področju duševnega zdravja potrebujemo sinergijo človekovih pravic, pristopov, osredotočenih na posameznika in okrevanje, ter obsežne, učinkovite in odzivne skupnostno usmerjene storitve.

Ključne besede: *psihiatrične ustanove, človekove pravice, socialna vključenost, okrevanje, skupnostna oskrba.*

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Introduction: defining deinstitutionalization and its legal framework

A large part of mental healthcare (and related expenditures, about 70% worldwide, WHO, 2021a) is still dominated by psychiatric institutions, with slow reduction in the number of beds in such institutions and insufficient development of alternatives. Sometimes these are also hindered by (mostly insurance-based) financial systems that are rigidly linked to remuneration of hospitalization instead of outpatient care.

The lack of synchronicity in closing or downsizing institution-based services with scaling-up community-based services has engendered a whole list of problems. This is observed in the wake of "trans-institutionalization," or the act of transferring patients from mental hospitals to other institutions such as homeless shelters, custodial institutions, and prisons. For twenty years epidemiological research has suggested a European trend towards "re-institutionalization" of care (Priebe *et al.*, 2005), marked by the rising number of involuntary treatments, as well as the residential and supported housing facilities, forensic psychiatric beds and penitentiaries (e.g. correctional facilities, jails, prisons), in addition to existing asylums, mental hospitals and private clinics.

The knowledge gained in the course of deinstitutionalization processes is related to the complexity of each person's existence, and thus focused on the subjective needs of recovery and social inclusion. Especially from the enforcement of the Convention on the Rights of Persons with Disabilities, deinstitutionalization is still mentioned in recent international charters and documents, as the WHO Report and the UN Convention on the Rights of Persons with Disabilities Committee guidelines. Recently, the latter issued recommendations on deinstitutionalization (OHCHR, 2022). Deinstitutionalization comprises interconnected processes that should focus on restoring autonomy, choice and control to persons with disabilities as to how, where and with whom they decide to live. The focus is on the individual in the achievement of human rights: services as community-based supports for independent life and social participation, and personal assistance.

Guidelines were issued some years ago by a EU Expert Group, in order to address the delivery of dedicated funds to countries. Very clearly, they define an institution as

> any residential care where residents are isolated from the broader community and/or compelled to live together, do not have sufficient control over their lives and over decisions which affect them; and the requirements of the organization itself tend to take precedence over the residents' individual needs. (European Union, 2012)

The legal framework included, as key components, the right to live in the community, access to mainstream services and facilities, affirmation of legal capacity by reducing guardianship, involuntary placement and involuntary

treatment, and provision of community-based services. Developing individual plans, supporting also carers and communities, and developing appropriate workforce, are other components of these Guidelines, then reinforced by a more recent guidance (European Union, 2022).

Deinstitutionalization is therefore seen as the main strategy to overturn old forms of oppression of people with mental health conditions and disabilities, and to mobilize resources and supports for their recovery and social integration. Anyway, while there is a substantial agreement on the basic definition of deinstitutionalization as far as it is referred to individuals as inpatients (e.g., the release from the institution where the process of institutionalization confined them), nonetheless the process that this entails is poorly focused and widely misunderstood. It regards not just the downsizing, and final closure of total institutions as asylums, or the discharge of their patients, but a whole system change and moreover a full transformation of psychiatry towards community mental health. This can require a variety of approaches and models.

"Deinstitutionalization involves simultaneously increasing discharges, reducing admissions, and scaling up care in the community" (WHO, 2022, p. 200). This latter is defined as to "build up a network of coordinated and linked community-based mental health services and social care to support anyone living with a mental health condition."

Community-based services can be developed autonomously from the process of phasing out psychiatric institutions, but anyway, as suggested by WHO, they must be linked to the overall process of shifting the focus of care, and thus they can promote the response to needs and the fulfillment of citizenship rights by catalyzing resources and opportunities.

Sustaining country reforms

The Italian example: forty-year development

In a key essay that stressed the originality of the Italian way of deinstitutionalization (De Leonardis *et al.*, 1986), Italian authors listed the fundamentals of this transformation process, defined as a "homeopathic process", as it has been done in Italy, and particularly in Trieste:

- mobilizing all the actors involved in the system of institutional action;
- giving absolute priority to transforming the power relations existing between the institution and all the subjects with which it is involved, beginning with the patients;
- understanding deinstitutionalization as a homeopathic process that uses the internal energies of the institution in order to dismantle and deconstruct it;
- "freeing society from the need for internment" by establishing completely alternative services.

> Deinstitutionalization does away with the necessity for detention by constructing services which are a complete substitute for it. (De Leonardis *et al.*, 1986)

Deinstitutionalization has been completed in Italy till the very closure of all psychiatric hospitals in two decades (1978–1999). After another 20 year period also forensic hospitals were overcome (2014–2018) (Barbui *et al.*, 2018; Mezzina, 2018).

The suppression of the psychiatric hospital, in its central role, should coincide with the creation of networks of totally alternative services capable of providing care for a given population (as in sector policies), but which stresses recovery and re-inclusion of inpatients.

Europe and beyond

Despite the significant disparities due to national and local contexts, I believe that while this process can be instigated by a top-down impetus and be guided by a responsible institutional leadership, it can only be fully achieved thanks to a bottom-up process which mobilizes its actors and resources.

Many countries are stuck nowadays in the process of transition and are re-building new "modern" mental hospitals (as in the UK, Australia); some countries' reforms even don't include processes of deinstitutionalization.

In Latin America, important achievements marked the action of PAHO and international cooperation in the Caribbean (e.g. the Dominican Republic), but the focus is mostly on integrating mental health in primary care. The most important action, and the benchmark, of transition from psychiatric institutions (hospitals) to community-based care is still offered by Brazil and, quite recently, by Peru (WHO, 2022).

There is a consistent variation in the provision of institutional care across the world. Especially in East Europe, a result of old forms of state provision (we can call it "archaic welfare"), a form of medium and long term institutionalization is realized by a wide number of "social" institutions, run by separate ministries.

In this context, Slovenia has declared a policy on deinstitutionalization in social care, due to the presence of long-term institutions as separate for the 5 psychiatric hospitals which belong to health care. These efforts have been piloted through projects run by EU structural funds, which are anyway hindered by a number of factors resulting in resistance to change. Even when residential solutions, such as group homes and shared flats, supported by new community teams run by social care, are in place and people started to be discharged, the lack of linkage with a network of multidisciplinary community mental teams and services can be a serious limitation for ongoing psychiatric care and especially in the prevention of crises and relapses. These are still addressed by psychiatric hospitals, with the risk of dramatically regressing and creating a revolving door system. Then, the use of coercion in a

locked section of a social care institution, that is against the Convention on the Rights of Persons with Disabilities, is still encompassed by the national law. Thus the lessons learned is to act simultaneously on health and welfare system (Urek, 2021; OHCHR, 2024).

Concrete reform efforts have been recently conducted in countries like Belgium and the Czech Republic. Both these countries are not directly addressing the issue of large psychiatric hospitals, but chose to develop community (mobile) teams to provide alternatives to hospitalization. The two systems are very different, as well as the level of resources: the Czech reform, supported by structural European funds, is mixing up welfare components in these teams, that seems to be promising for social integration; while the Belgian reform (Jacob *et al.*, 2016; Borgermans *et al.*, 2018) is promoting wide ranging mobile teams but loosely linked with the downsizing of psychiatric hospitals (see further on).

Challenges of policy change

It looks difficult to conceive what can be a country reform without including the two main elements of (i) deinstitutionalization and (ii) legislation change, with (iii) a policy plan for implementation that (iv) operates a concurrent re-definition of welfare community where mental healthcare has to be included or inserted. Very often levels of resistance are raised by the established apparatus including professional bodies and related powers, as demonstrated in Argentina, especially when there is very weak effort of a wide-raging policy transformation plan (Rosen *et al.*, 2022).

The need for clear legislation and policy framework, with dedicated investment and implementation planning, is paramount. Research show that "mental health policy has greater effectiveness when it is accompanied by a mental health plan or law since they help translate the vision, values and principles articulated in policy into concrete strategies and activities" (Shen and Snowden, 2014), while "investment is an explicit, observable, and irrevocable proxy of a focal government's commitment to a mental health policy innovation" (*ibid.*). Of course, "governments face difficult choices in prioritizing mental health over other issues, especially in the midst of a global economic downturn".

The MHEEN initiative (Medeiros *et al.*, 2008) had already identified a number of challenges for the process of deinstitutionalization, starting from financial aspects including (i) insufficient and unspecified budget allocations, (ii) rigid funding systems with lack of "ring-fencing" of funds, particularly when hospitals close, (iii) lack of parallel funding for the development of community care while hospitals run down to eventual closure and (iv) DRG-related reimbursement systems. These budgetary issues fail to provide the support needed by people with mental health problems living outside institutions, while shortage of trained staff to provide good community care,

together with lack of services and their coordination, hampered a full developed process of transition in Europe. Eventually, opposition from the psychiatric profession and the community itself raised other cultural barriers.

Benchmarking service models

A general framework for community mental healthcare

Lack of synchronicity between the closure of institutions and community-based services ultimately resulted in system fragmentation, lack of quality assurance over available services, financial cutbacks, and workforce shortages (Shen and Snowden, 2014). Thus the importance of a comprehensive alternative service. According to EuCOMS, a high quality community-based mental health care: 1) protects human rights; 2) has a public health focus; 3) supports service users in their recovery journey; 4) makes use of effective interventions based on evidence and client goals; 5) promotes a wide network of support in the community and; 6) makes use of peer expertise in service design and delivery (Keet *et al.*, 2019).

The role of (public health) services is to be comprehensive and holistic – to aggregate needs not just to contrast marginalization and social exclusion, or treatment gap. The concept of responsibility and accountability toward a community has to be rooted in policies and practices. These services must be "embedded" in the community, that means responding to needs of individuals and social groups.

These services must be "coproduced" with the Third Sector/NGOs, in a common strategy for the community where they operate. Social needs and clinical needs must be integrated also to address social determinants. This should be complemented by the inclusion of sectoral problems into a general health and social development framework (a comprehensive community-based approach), with the shift from a technical approach to a social development action (e.g. founded on social determinants of mental health and human rights).

In terms of services, also the *OECD Mental Health Performance Network* (OECD, 2021) set 6 principles for a high performing mental health sector:

- Focuses on individual who is experiencing mental ill-health
- Has accessible, high-quality mental health services
- Takes an integrated, multi-sectoral approach to mental health
- Prevents mental illness and promotes mental wellbeing
- Has strong leadership and good governance
- Is future-focused and innovative

The OECD developed the *People-Centred Health Systems Framework* to describe and measure people-centredness systematically and enable the benchmarking of people-centredness across OECD countries (OECD, 2018).

Key issues about community mental health care services

1. *Holistic/wholistic care*

   The focus must be on the construction of processes of care (or taking charge of it) that give overall answers to the entire range of life needs, in integration with welfare systems and services. Working hypotheses should go beyond the medical and/or psychological model, to respond to social determinants of mental health, and which therefore move towards integration between social and health care.

2. *Functions vs structures of care*

   Functions overlap across different structures, override them and force us to think along paths and responses, integrated in a continuum, to care needs.

3. *Specialization*

   With respect to the emergence of new range of needs, there is a tension between comprehensive vs specialized services in high-income countries. Instead, specialized functions should be defined rather than separate services, in order to avoid the risk of fragmentation of care pathways.

4. *Organizations based on principles*

   The issue of rights, traditionally connected in Italy to the issue of citizenship of people with mental disorders, avoiding their discrimination and social exclusion, is today updated on the horizon of human rights established by the Convention on the Rights of Persons with Disabilities of United Nations.

5. *Mobile, integrated service with 24-hour response*

   The most diffused but outdated outpatient service model to overcome, is the delivery of "sedentary" services, based on psychiatric visits and a few meetings that can seldom involve the family, but seldom the social network and the community context where the person lives. Instead, community-based teams and services, even if complemented (as usual) by general hospital services and units, must function as a full alternative to hospitals, thus they need to guarantee a 24-hour response (as required by the European Action Plan of Helsinki, WHO, 2005). This requires to integrate a rapid and mobile response to crisis with the subsequent continuity of care, linked to rehabilitation developed in its community dimension, linked to processes of social inclusion.

Network's "center of gravity"

Different community evidence-based models are available as alternatives to hospitalization, from crisis teams to crisis homes and "sanctuaries" to foster families up to community mental health centers open 24 hours with a few beds, integrated by a small general hospital unit. Moreover, mental

health policies in low-and middle-income countries have historically paid little attention to the community work of mobile teams, which are sometimes functionalized or specialized (on crisis or on continuity of care), whose models (such as the *Assertive Community Treatment*) are among the few evaluated and validated in the literature (Marshall and Lockwood, 2000), and where the actors are other professional figures than doctors (nurses, social workers, occupational or rehabilitation therapists, etc.). Usually, the full coverage of functional model based on distinct multidisciplinary teams is seen as too expensive and somehow complicated for service integration.

What seems clear is the need that, in the network system outlined by the WHO, there is a center of gravity, a point of coordination and integration, but also of responsibility, which we can identify in a "strong" service, equipped with resources and capacity to take charge, a crossroads of care pathways. Its axis can be identified with 24-hour community mental health centers, "invented" in Trieste in 1978 (Dell'Acqua and Cogliati Dezza, 1986; De Leonardis *et al.*, 1986; Mezzina, 2014, 2016). This model has been defined, paradoxically, a "centralized model", but it is truly de-centralized to territories and people (Gooding, 2021).

Why should 24 hours be set as the gold standard of territorial services? A multifunctional community mental health centers with a wide range of responses must be provided with beds to accommodate people in stressful conditions and in crises (Mezzina and Vidoni, 1995; Mezzina and Johnson, 2008). It necessarily operates with the door open, overcoming restraint and respecting rights, while the team operates flexibly. Few beds avoid concentration of people in acute conditions and the consequent management difficulties. It can also simply offer a moment of respite and withdrawal from a stressful situation, even for one night.

Furthermore, 24-hour community mental health centers can act as a unique point of reference of the territory throughout the demand for care, as well as a place of integration of the multidisciplinary team, that works inside and out and constantly connects; thus it integrates all answers and therefore facilitates a global management, and ensures that people are followed by the same team, which knows them, starting from crisis. This creates an immediate continuity between overcoming the crisis and continuity of care, facilitating rehabilitation and housing solution and reducing the need for residential care (Mezzina, 2014, 2016).

Supported housing and community rehabilitation

A psychiatry made up of long-term residential "places", even displaced in the community, is among the new risks which can be envisaged. These places can become new "deposits" and containers, as the whole wide spectrum of residential solutions. For the Committee on Human Rights, it is important

> to prevent the emergence of new segregated services, such as group housing – including small group homes – sheltered workshops, institutions for the provision of respite care, transit homes, day-care centres, or coercive measures such as community treatment orders, which are not community-based services. (OHCHR, 2022)

The right "examples of residential services are social housing, self-managed co-housing, free matching services, and assistance in challenging housing discrimination" (*ibid.*). Also …

> aggregating persons leaving institutions into communal housing arrangements or in assigned neighbourhoods, or bundling housing with medical or support packages, are incompatible with articles 19 and 18 of the Convention … Housing should be neither under the control of the mental health system or other service providers that have managed institutions, nor conditioned on the acceptance of medical treatment or specific support services. (*Ibid.*)

Residential care and supported housing are two models of accommodation for people with mental disorders in post-institutional mental health systems (Barbato *et al.*, 2020). In residential care, the emphasis is on treatment and rehabilitation provided by professionals in staffed facilities belonging to community psychiatric services, whereas in supported housing the emphasis is on outreach need-led support to people living on a permanent basis in their own home, integrated in the community.

The supported housing approach grew from a dissatisfaction with the original model of residential facilities, developed in the early wave of downsizing or closure of mental hospitals. This is based on the concept of a "linear continuum" (Ridgway and Zipple, 1990), in which persons were supposed to gradually progress from hospitals, through less supervised accommodations, halfway houses, group homes, to reach finally independent housing. However, this model failed in most cases to move people toward independent lives and trapped many people in small segregated residential settings. This was also due to the confusion between accommodation and care. Instead, a core aspect of the supported housing model is the separation between accommodation and treatment services. The overall quality of residential care must be combined with the necessary continuity of care to be guaranteed by community-based services, including 24 hour in-home crisis care and respite instead of the traditional hospitalization.

Right to housing

The right to independent living and participation in society (Article 19 of the Convention on the Rights of Persons with Disabilities) is particularly relevant to this theme, that means guaranteeing everyone the prospect of their own home, where to live receiving due support. This requires policies dedicated to realize this right, as they place it at the center of the reconstruction

of citizenship and respond to a whole range of social needs and determinants of mental health. Anyway, it is essential to ensure full respect for all human rights and fundamental freedoms, in particular with regard to the restrictiveness of the environments where "residential" rehabilitation is carried out, which must provide for freedom of movement and movement, and insertions and stays with the full consent of the subject, so that every residential or housing solution is really open to community.

Personalized care packages in rehabilitation

The personalized project is the basis of rehabilitation programs and must be developed in close collaboration with the person and his social network, through a perspective that places personal recovery and social inclusion at the center of the process. According to NICE (2020), person-centered care planning should be achieved through the comprehensive assessment of their bio-psycho-social needs, including physical health, and the formulation of a personalized care plan/project. It should: (i) be developed in collaboration with the person, (ii) cover the areas of need identified during the assessment, including mental and physical health, (iii) include personal recovery goals and (iv) clarify the actions and responsibilities for the staff, the person himself and his family or carers.

Rehabilitation programs and interventions must include skills of daily living, interpersonal and social, engagement in community activities, including leisure, education and work, substance abuse; psychological therapies and pharmacological treatments; physical health care and the promotion of healthy lifestyles.

Governance: individual budgets

In terms of governance, in order to reduce the duration of stay in residential structures, which can induce further chronicization and creeping forms of institutionalization, paths of autonomy and reintegration into normal living environments must be activated. The shift from a system of daily fees to the personal health budget instrument is necessary in order to mobilize and dynamize the economic and human capital invested in residential care towards assisted living and personalized projects. This means moving from payment of the bed/day in a residential structure to a share of economic investment on human capital which is realized by the instrument "individual (personal) health(care) budget". It also requires laws, regulations, appropriate policies, and a governance of individual and collective processes carried out by all partners and stakeholders.

Systematic reviews on the topic of personal healthcare budgets reported positive results in terms of user awareness and responsibility, improvements in clinical and psychosocial aspects, and consequently an increase in quality

of life. Some studies consider qualitative outcomes on the overall system of services, both formal and informal, leading to the transformation of the relationship between all the actors involved (Ridente and Mezzina, 2016).

Co-production

Co-production (Boyle and Harris, 2009) is a key issue for the implementation of housing programs and projects, which must be developed in collaboration, co-design and co-management with the stakeholders and the Third Sector. In this way, experimentation of innovative methods and programs in the residential area should be guaranteed, supported and encouraged, such as, among others, recovery houses, network systems between structures and peer review and evaluation, integration with job placement programs, and inclusion and social participation (Ridente and Mezzina, 2016).

Service coordination and governance by organizational networks

The department of mental health

Service networks which are based in the community need forms of coordination not just of structures and facilities, but of care pathways. The department of mental health (sometimes including children – adolescent psychiatry and drug addiction) is the model (also in Italy) to coordinate all mental health services and also to integrate them within healthcare organizations, in relation to a given population. This simple overarching structure does not ensure an integration of service components that creates a continuum of a wide range of offers, ultimately at the level of the individual client, but it is a good point where to start.

Integrated public-private entities

Examples of integrated healthcare and welfare organizations can be found in Spain and Belgium. Since 1993, health sector and welfare interventions in Andalusia were coordinated by FAISEM foundation aimed at social inclusion, encompassing community residences and social enterprises for work integration (López, 2004).

In the course of Belgian reform, that is now identified as a model for a number of components by the European Union (the Joint Action *ImpleMental*[1] recently aimed at implementing some of its good practices in many other countries), the constitution of community networks is seen as an efficient way to involve stakeholders, local governance entities and services in a shared strategic plan for reform, and to deliver new instruments of care.

1 See website https://ja-implemental.eu/highlights/

Mental healthcare networks

In Belgium, the concept of intersectoral care networks was introduced by a change in the Hospital Law through the Hospitals Act of 2008 (Nicaise *et al.*, 2014). The network structure allows consultations among all service providers and stakeholders in a view of collaboration and of avoiding fragmented responses. There is a network coordinator that is responsible for change-management processes, and the strategic network committee comprises the network coordinator as well as the representatives of the local network partners, e.g. social sector, welfare, school/work, leisure, health care. User and family representatives are always present through councils and in the individual's care planning. The final result is an individualized service/care plan, that is the formalized operating model for the specific network.

A possible whole system model

A mature example of a comprehensive network is offered by the historical developments in the city of Trieste, Italy. Fifty years ago, it moved from the provincial psychiatric hospital (a huge asylum) to a fully alternative network of 24-hour community services, such as community mental health centers, social cooperatives, personal budgets, daycare programs in the community. It happened in healthcare. Trieste has provided an enduring example of comprehensive, human rights and person centered "whole system" of care (WHO, 2021b, 2022).

The 24-hour community mental health centers build a system of opportunities for care and are hubs of care for their areas, ensuring continuity. They offer free open access with immediate response; a holistic, ecological, person centered, recovery oriented approach; the inclusion of social networks, and non-clinical resources, e.g. "diffused" daycare with associations (wellness-wellbeing, social aggregation, participation, expression, gender, work). Mental healthcare is mainstreamed in community health systems (healthcare districts for community-based medicine for elderly, young and adolescent, disabled, specialized medicine, etc). The social determinants of health are addressed by individual and collective responses, i.e. personal budgets and "microareas", work training grants, socialization funds, that is building bridges toward the community – "The Caring City". The personal healthcare budget system is meant to tailor individual recovery and social inclusion plans of care, which include congregate supported housing for about 100 persons located in the city, and social co-operatives providing place-and-train in a system of real job opportunities for more than 200 service users annually (Mezzina, 2014, 2016, 2018).

This was then scaled up to the whole Friuli-Venezia Giulia Region (1,200,000 inhabitants) based on "strong" mental health departments in order to co-ordinate all services according to principles of contrasting

social exclusion, stigma and discrimination and promoting social inclusion. A clear transition from residential structures to transitional houses to supported housing, to independent living flats, also thanks to personal budgets, is in progress across the whole region. The Trieste model, in its historical declination, has influenced many country reforms (e.g. Brazil and Argentina), instigated groundbreaking experiences such as in Greece (Leros asylum), Central America (the Dominican Republic), and the Balkans after war, and inspired many other community focused experiences in Europe, America, Asia and Oceania over the last 40 years. It has been adopted, more recently, in the Czech Republic, Wales, Crakow (Poland), Los Angeles, and other places (Mezzina and Sashidharan, 2025). Currently this model is inspiring the pilot 24/7 neighborhhodd service project in England (Aria *et al.*, 2025).

Currently in Trieste and in the Region this has been hampered by the reduction of resources and by the leadership change, also influenced by politics; but we hope its lessons will survive (Mezzina, 2021).

Conclusion: what is relevant for deinstitutionalization

Deinstitutionalization is not just closing long-term asylums and discharging people from them, but transforming their lives and mindset, as the one of care providers. A correct deinstitutionalization process – that is not just downsizing or even suppressing psychiatric hospitals – requires undertaking a complex process focused on "the person" with their subjectivity, needs, life story, significant relationships, social networks, and social capital. In order to do that, it is necessary to shift the power, that is empowering people with mental health problems as citizens; to shift resources from hospitals to a range of community-based services useful for his/her whole life; to open pathways of care and programs that integrate social and health responses and actions.

It needs a clear mandate for local powers, administrative and political, since it happens either top down or bottom up, but it also requires social participation and co-production, stemming from stakeholders. This complex process of change involves users, carers, professionals and the general citizenry, and extends to the legislative and political level. This latter means no longer managing processes for exclusion through the segregation of persons, but placing the individual at the center of the system, with their human and social rights, and their needs, in a perspective which is based on "whole life" of a person engaged in a process of recovery from mental disorder. This process is not just relocating people outside, even with the right support. Comprehensive mental healthcare includes responding to whole life needs as well as providing clinical care.

Resistance to change is always the main problem, thus transformation plans of institutions must begin with changes of the institutional life and

routines. Rehabilitation and recovery of inpatients have to include also professionals and their mindset, starting from within.

Based on what I have described above, the transformation process required by deinstitutionalization takes place at the multiple levels: social movements (civil society), politics, legislation, the adoption of new service models and practices, networks of organized actors, autonomously or through the institutions, and eventually community development, as a general raising of awareness regarding these issues, and the activation of non-technical resources and initiatives.

Deinstitutionalization must accomplish the closure of total institutions, otherwise a parallel system will be created, with the risk of reverting reforms, the balance can go back in favor of the old institutional system.

Main change for users to be achieved in a process that is "democratization of care", are realization of human rights, citizenship and participation to community. Choice about personal issues, such as home and relationships, can fulfil this role shift from inmates to citizens, that is using the services and supports they need, but also (re)acquiring new identities, e.g. as worker.

It's definitely a whole system change, of practice, thinking and service, to liberate a community from the need of institutions, by creating an effective service alternative. All this requires not just a technical refurbishment of treatment procedures, but a paradigm change that puts the person "over the institution", at the center of care.

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