ARTICLE

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Barriers to Adapting the Trieste Model in America

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Abstract

Psychiatric institutions and asylums were detrimental to patient autonomy and liberty which inspired a sociopolitical movement to close these institutions (i.e. deinstitutionalization). Unfortunately, the lack of transitional care for the deinstitutionalized created an epidemic of homelessness. In contrast to America's uncoordinated process, Franco Basaglia created a successful transitional community mental healthcare model at Trieste, Italy. In order to replicate Trieste's success in America, an initial pilot study would need to provide adequate housing which, while it might appear to be a form of reinstitutionalization, has supportive ethical arguments and legal precedents. A proposal to implement Trieste in America could involve transitioning to a value-based healthcare model and building a network of facilities in smaller cities like Logan, Ogden, Provo, or Joplin which, with a higher probability of success, could provide the appropriate context to garner enough public and political support for larger application.

Keywords: deinstitutionalization, Basaglia, Trieste, reinstitutionalization

Introduction

Psychiatric institutions and asylums were created to address mental health from a purely paternalistic viewpoint. In other words, these institutions ensured beneficence and protection for the mentally ill individual and the community (Bremer, 2003). Despite the well-meaning intentions of these institutions, the reality of institutionalization was quite bleak. A *Life* magazine article called mental asylums "little more than concentration camps" (Hands, 2017). In response to the atrocities at the asylums and institutions, deinstitutionalization or closure of the psychiatric facilities was determined to be the solution.

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In a WHO expert survey, successful deinstitutionalization required five key principles or components: community-based services; a healthcare workforce committed to change; political support; timing; and additional financial resources (World Health Organization, 2014). Unfortunately, the American deinstitutionalization process focused on closing psychiatric institutions without providing any community services to support recently deinstitutionalized individuals (Arehart-Treichel, 2005). Deinstitutionalization appeared to simply be a "conservative effort to cut public budgets and impose privatization at the expense of people who were poor and vulnerable" (Bagenstos, 2012). As various Presidential acts and judicial rulings moved towards defunding mental health treatment, by 2013, states had cut $4.35 billion in public mental health spending which was the largest funding reduction since the initial 1960s deinstitutionalization process (Pan, 2013).

Franco Basaglia: Trieste Model

Despite the failures present in America's deinstitutionalization process, Franco Basaglia spent half a year studying America's process before attempting deinstitutionalization in Italy. While phasing out the San Giovanni Mental Hospital, a complex network of community services were set up: four community mental health centers open 24 hours a day with four to eight beds each; one general hospital psychiatric unit with six beds used for emergencies and short stays of less than 24 hours; and the Habilitation and Residential Service managing "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" (Mezzina, 2014). The Trieste model was designed around respect for each individual and the idea that strict rules, distance, and locked doors led to increased violence from the patients because the institution itself was violent (Waters, 2020). Basaglia was convinced that the stereotypes of madness were a consequence of oppressive and punitive institutions.

The Trieste pilot experiment was extremely effective. There were notable decreases in hospitalizations, involuntary treatments, joblessness, and suicide rates (Mezzina, 2014). Two years after treatment at the community centers, positive patient-physician relationships were maintained and mental health crises were minimalized. At the five-year follow-ups, symptom scores were reduced and social functioning improved by fifty percent (Mezzina, 2014). Although other European countries also explored community based mental healthcare, Trieste stood out as a unique system that created massive media attention and affected the entire country's mental health policy (Semrau, Barley, Law, and Thornicroft, 2011). From a theoretical standpoint, Trieste was the best model to study and build

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pilot studies upon in America as an ethical and logistically sustainable way to provide mental healthcare.

Trieste Model Implementation in America

Due to the rather abrupt deinstitutionalization process in California and the large mentally ill population in San Francisco, Mezzina, Basaglia's successor at Trieste, attempted to implement the Trieste model in San Francisco. Unfortunately, the attempt was unsuccessful due to major historical and structural differences between Trieste and San Francisco. In 2019, there was a proposal to implement the Trieste system in Los Angeles via five innovations which would essentially shift American healthcare's predominantly problematic fee-for-service reimbursement model towards a value-based model which would allow for improved patient-physician interactions (Los Angeles County Department of Mental Health, 2019). However, some additional issues remain when adapting the Trieste model in America.

Problems in Adaptation

Mental Illness and Homelessness

In the American deinstitutionalization process, recently emancipated psychiatric patients were abandoned to fend for themselves as homeless persons without reliable access to food and water. These individuals often ended up in prisons resulting in a phenomenon known as transinstitutionalization where individuals shifted from one entity (i.e. the asylum) to another. Thus, American deinstitutionalization shifted "lack of autonomy caused by forced long-term psychiatric hospitalization to lack of autonomy due to incarceration, short term involuntary hospitalization, and homelessness" which further marginalized the mentally ill (Douglas, 2021).

As state asylums and mental institutions emptied their patient population, the number of homeless individuals tripled in size in 182 of the largest American cities over the course of the 1980s (Bagenstos, 2012). Perhaps as a criticism of America's deinstitutionalization process, Basaglia stated that it was "not sufficient to liberate the ill to restore life [and] history to the persons who were deprived of their life [and] their history" (Upergy, 2016). Instead of defunding mental healthcare systems altogether, funding should be diverted towards alternative systems to replace the closed down asylum system (Waters, 2020). To make matters worse, federal and state governments further cut back on

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SSI and housing assistance during the same time period which alienated the recently emancipated individuals.

Treatment for the mentally ill would initially require housing the homeless which would actually be a net financial benefit for the nation at large. Forty-five percent, or about 250,000 homeless individuals, suffer from mental illness, costing $40,000 per year per individual in medical bills, social support systems, etc. (Hands, 2017). A RAND analysis in California revealed that, for every dollar the Los Angeles County invested in housing for the homeless, it saved “$1.20 in reduced healthcare and social service costs” (Tinoco, 2019). Similarly, spending an extra dollar on inpatient mental health saved $1.25 due to “shrinking jail populations” (Yoon, 2016). This statistically significant effect was not seen with any changes in per capita community mental health expenditure. Thus, there would be financial benefits to increasing funds specifically for inpatient services and housing.

In addition to financial benefits, there would also be ethical implications to housing mentally ill individuals. Increasing the availability of psychiatric beds would help promote equality for all mentally ill patients (Douglas, 2021). In Rawls’s theory of social justice, every individual deserves the most basic liberty compatible with the liberties of others. Ideally, there should be no socioeconomic differences that create unequal access (Rawls, 2005). Thus, for instance, outpatient community based programs would be biased for those who have access to the program itself and the ability and cognizance to function in that environment. Meanwhile, inpatient psychiatric facilities and residential housing would help mentally ill individuals regain stability while providing adequate resources to survive. While this does bring into question the possibility of paternalism, one could argue benefit from the viewpoint of utilitarianism (i.e. greatest good for the greatest number of people). Investing in long-term protection and housing for the mentally ill would result in better overall quality of care and have a positive impact on emergency rooms where mentally ill individuals are an incredibly resource intensive patient population (Substance Abuse and Mental Health Services Administration, 2020).

On the other hand, there are some ethical dilemmas in providing homes and access to treatment for the mentally ill. Admittedly, there is the potential danger of recreating the atrocities that deinstitutionalization sought to deconstruct since providing housing could be seen as a form of reinstitutionalization. Yet, even specialized community care services like Assertive Outreach could be seen as a “form of institutionalization due to the limited patient autonomy and [patient’s] dependency on intensive comprehensive care” (Chow and Priebe, 2013). Thus, institutionalization was not

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necessarily the primary issue but, rather, paternalistic treatment of patients which encouraged abuse and, ultimately, depersonalization. Depersonalization would then, in turn, create individuals who were so "dependent on receiving care from services" that they lost "confidence to make decisions and consequently become institutionalized" (Chow and Priebe, 2013).

Another ethical issue with housing clusters, or dedicated housing developments, would be perpetuating stigma against mental illness as something that is better placed far away from the public eye. Supportive staff who operate on a partnership and consensual model could help ameliorate these ethical dilemmas.

From a legal standpoint, there is room for a form of reinstitutionalization. Although, in the 1999 Olmstead case, the Supreme Court held that States were "required to place persons with mental disabilities in community settings rather than in institutions," the Supreme Court left some room for interpretation (Disability Justice, 2022). First, this requirement held only when "reasonable assessment [by] treatment professionals determined that community placement was appropriate and transfer from institutional care to a less restrictive setting [was] not opposed by the affected individual" (Disability Justice, 2022). Second, if a State lacked the financial ability to provide community treatment, "qualified persons with mental disabilities" could be placed in institutions with "less restrictive settings" (Disability Justice, 2022).

During the initial litigation of deinstitutionalization, many parents formed organizations to oppose deinstitutionalization. While some family members supported a movement towards community services, other family members were more against the idea of "bad institutions" but not necessarily the "idea of institutionalization itself" (Bagenstos, 2012). They recognized that, while the abuses at the asylums should end, "institutions were the best place for their children" and that these places were necessary for people with developmental disabilities to receive the services they required (Bagenstos, 2012). Providing housing which would provide access to treatment and facilitation of activities of daily living would be an initial step to making Trieste a reality.

Location

Since providing the basic requirement of housing could be difficult for some cities while easier for others, choosing a similar socioeconomic location to Trieste could help ensure the pilot study's success. Trieste was a "middle class, homogenous city with strong community support networks

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[deeply rooted in Italian culture], very limited drug abuse, and no homelessness" (Portacolone, Segal, Mezzina, Scheper-Hughes, and Okin, 2015). Trieste was a city with excellent public transportation and affordable trains and taxis (Riccobon, 2018). Drug use and crime levels were relatively low with a safety index of 75.21 (Numbeo, 2022). Although it would be tempting to attempt adaptation of this model in cities that require the services the most (like San Francisco and Los Angeles), it would be unfair to subject the pilot study to a more difficult and complicated arena with many unknown variables. Low socioeconomic status was shown to make people "two to three times as likely to have a mental disorder" due to the demand-resource imbalance where they do not have enough resources to help cope with life challenges resulting in stress on the family units, individual, and community (Kim and Cho, 2020). Thus, while theoretically the Trieste model seems to be a viable answer, an initial pilot study would need to be done in a smaller homogenous area to demonstrate its effectiveness in America.

When trying to choose a specific community that qualifies as similar to Trieste in America, various factors should be considered. According to the Brookings Future of the Middle Class Initiative, the differences in income and pricing across metro areas, as well as the average household size which impacts the resources available per person, can help determine what cities have the largest number of middle class families (Berube, 2018). By analyzing this list in conjunction with searching for a largely homogenous population with a high safety index, relatively good support systems, and low homelessness, Mormon communities such as Logan, Ogden, and Provo, Utah seem likely candidates. Other communities to consider include manufacturing centers such as Joplin, Mo where homelessness has dropped twenty-two percent in the last five years (Djukic, 2022).

Admittedly, any city in California would be difficult given the rising rate of housing prices and homelessness. To the credit of the newly proposed Los Angeles pilot, there is potential in revolutionizing the payment model in order to address the impact of socioeconomics on community mental healthcare. There will be different budgets for four or five categories of users with its own "per capita case rate" (Waters, 2020). Those who require the highest level of care would be in a tier with the highest per capita budget while those who can be more self-sufficient exist in a lower-cost tier. Users would be assigned to their respective tiers according to the Milestones of Recovery Scale and Determinants of Care which can change each month depending on how the user progresses. Yet, this system is quite complicated and, perhaps, a successful application of Trieste in a more homogenous

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neighborhood could garner enough public and political support to inspire the national government to help fund the Hollywood pilot and ensure its success.

Community and Government Support

A large component of the success at Trieste was overwhelming support from the community and the government. Loren R. Mosher, an American psychiatrist who studied the Italian mental health program, concluded that "strong professional leadership, a political climate that welcomed social reform and the availability of national health insurance money to pay for both medical and social services were key factors in successful deinstitutionalization" (Boffey, 1984). Basaglia's compassionate and strong personality inspired a book documenting Basaglia's changes at Gorizia and Trieste called *The Negated Institution: Report from a Psychiatric Hospital* in 1968. The account was extremely popular and was translated into French, German, Portuguese, and Spanish. Academics, journalists, photographers, and politicians flocked to Gorizia. Documentary filmmaker Sergio Zavoli, also known as "God's Socialist," made a twenty minute prime-time documentary that was shown on national television to over 13 million viewers. Eventually, by 1978, Gorizia inspired Italy's health minister Mariotti to pass laws and policies that began the deinstitutionalization process.

Without large community and government support, there will be low viability for long term success and implementation of any kind of experiment. Even Trieste is currently in danger due to right-wing politicians who want to move towards privatization like the American healthcare system (Poggioli, 2021). Meanwhile, in Long Beach, California, the Village Integrated Service Agency warns of the danger in funding coming from primarily private entities and the state. While the Village pilot program made significant strides in demonstrating the success of a value-based model, once the program was finished, all the parties involved were placed right back into Medicaid and the standard fee-for-service which undermined any strides it made (Los Angeles County Department of Mental Health, 2019). Some initiatives primarily funded by the state have "limited long-term funding" (Portacolone, Segal, Mezzina, Scheper-Hughes, and Okin, 2015).

Similar to the Village program, the Los Angeles pilot study attempts to address funding for community mental healthcare by changing the fee-for-service model to value-based. However, this shift would not necessarily "solve the shortages in personnel, in community mental health services, rehabilitation, or safety net services" which require more extensive long term funding (Portacolone,

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Segal, Mezzina, Scheper-Hughes, and Okin, 2015). Thankfully, Biden's strategy to address the national mental health crisis focuses on expanding community mental health services, mental health insurance coverage, and increasing mental health personnel. Thus, the potential for government support places America in a unique situation where political support for Trieste-like programs and a shift towards value-based care could become a reality.

Conclusion

When considering a Trieste-like pilot program in America, adequate housing for homeless and mentally ill individuals left stranded after the deinstitutionalization process would be an initial step before creating effective community programs. The financial benefits, ethical arguments, and American legal precedents allow for some room in reinstituting a less restrictive form of housing that, while it could be criticized as reinstitutionalization, steers away from the perspectives that made the atrocities of institutionalization a reality. Providing institutions for individuals instead of privatizing these institutions would ensure equality and justice where every person has access to the treatment they require regardless of their socioeconomic status.

An appropriate urban area with similar socioeconomic status to Trieste would be an easier place to start to ensure the pilot study receives widespread public and political support. Without larger community and government support, the study would have low viability in being a long-term and sustainable answer. The study would suffer the same fate as the Village experiment in California which, while proving the success of a holistic approach to healthcare, was not able to extend beyond a small experiment. Thus, a variation of a proposal to implement Trieste in America would involve transitioning to a value-based model of healthcare and building a network of community mental health centers, a general hospital psychiatric unit, and group homes and supported facilities in an appropriately sized and supportive city to determine how they interact with each other in the context of the complex American socioeconomic, political, and cultural environment.

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