**Consultation on Mental Health and Human Rights**

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Italy pioneered a radical and complete deinstitutionalization, and enforced a famous mental health reform law in 1978. The Law 180 was the first act worldwide to abolish the psychiatric hospital and to give back the full rights of citizenship to people with mental health disorders. De-institutionalization has been completed till the very closure of all Psychiatric Hospitals in two decades (1978-1999), and after another 20 year period also forensic hospitals have been definitely overcome (2017).

The Legislation of 1978 was based on the discovery of rights as the key tool in mental healthcare. This act was one of the achievements of a social movement for expanding civil and social rights, and a promise of a true paradigm shift; not only in psychiatry, but also in the way of providing an adequate welfare community to citizens.

The experience in Trieste, with the first total psychiatric institution closed down in Europe, was established as WHO pilot area and then Collaborating Centre for 45 years so far. The current MH Department, that is a model for the whole Region Friuli Venezia Giulia, with 1.200.000 population, works without asylum from 1980. It is a complete open door / no restraint system of care, based on 24 CMH Centres with 6 beds for every sector (50-60.000 inhabitants) to provide ‘hospitality’ instead of ‘hospitalization’ and a 6 beds Assessment and Emergency Unit for a first contact in general hospital, with a home treatment team adopting the principle of Open Dialogue. The personal healthcare budget system (20% of the overall mh budget) helps to taylor individual recovery and social inclusion plans of care, as well as the integration of MH services in a system of healthcare districts for community based medicine (elderly, young and adolescent, disabled, specialized medicine). Social co-operatives provide place-and-train in a system of real job opportunities for about 200 service users annually, with about 1/10 becoming full-time members/employees per year; day centers and social clubs have been realized with community agencies and associations, including sport and cultural activities and gender programs, as active partners for human development and social inclusion. In the whole region just 6 beds forensic beds are available in three community facilities that are managed with open door policy. There is a clear shift from residential facilities, through supported and transitional housing for a hundred of clients, toward independent living accommodations as far as possible, while a regional deliberation plans to overcome mechanical restraint in all healthcare and social care facilities, etc. including nursing homes, general hospitals. Involuntary treatments show some of the lowest rate in Italy (7 per 100.000) and about 40% of them are managed in CMH Centres with the open door. The vast majority (94%) of the mental health budget is spent in the community.

“Liberty is therapeutic” was the original motto in the Trieste experience. The experience of Trieste can be emphasized especially as far as principles such as open door, hospitality, negotiation and alternatives to coercion are concerned. ‘Freedom first’, the new slogan, emphasizes that personal liberty is not the outcome but a pre-condition for care.

We know that Human Rights can be healing as far as they "recognize the person”, and thus refer to shared basic values of humanity. A new epistemology of a mental health should be based on a person-centered paradigm valuing the personal and social experience of individuals as human beings and social actors, and not on a paradigm of disease (Mezzina 2005).

Proclaiming equality today can leave inequality based on power untouched. The advocacy of rights is connected to the condition of true citizenship, that has a contractual nature in the relationship with the State, and related duties and responsibilities of an individual who is entitled of rights. It is linked to participation to a society, hence to democracy and social justice. Achieving equity and equality also entails challenging social exclusion, by acting on social determinants of health to achieve greater equity of quality and stability of home, work, income, social supports, relationships.

A paradigm shift from the institutions to the community, and from the illness to the person’s subjectivity and social being can bring a move toward community mental health care. This requires full accessibility, low threshold, proactive and assertive care, rapid response to crisis, open door, no restraint, and continuity of care. Choice, personalization and negotiation – but with a citizen with rights - are the main principles. Instead of coercion and locked doors, or mechanical restraint, the effort is to promote shared responsibility, dialogical approaches, recovery services, early support.

If organizations are driven by principles and values embedding the human rights approach, their practice can prove to be inherently healing.

Eventually, the right to be a citizen is the right to have a life. We must speak about entitlements: social and human development can converge, not conflict, with substantive, individual rights. This requires a focus on exclusion in society: a political and social action must be combined with a change of institutional practice and thinking in mental health and social care.

The closure of the asylums realized the return of people to possibility of having a life worth living. Elements of change are rights, opportunities, empowerment of users and other significant actors. The involvement of stakeholders as partners for service provision (i.e. NGOs like social cooperatives for work and support, carers and users associations) is also crucial for social inclusion. The person in the social context calls into action a whole life (in all domains), a whole systems, a whole community (IMHCN). The capability to deal with power issues and microsocial conflicts is based on a form of empowerment that recognizes “the other” in a conversation and a negotiation towards a therapeutic alliance that respects people’s wills and preferences and that is displayed in their living environments (on ‘their turf and terms’). It also recognizes the value of participation through networking, forms of coproduction, cooperation and exchange. These are basic values related to “democracy” as probably the main shift in mental healthcare.