*In 2024, I was planning a long European trip connecting giving a keynote address at a Recovery Conference in the Czech Republic (it’s in the video section of my website) and going to Christmas markets with my wife. I love Venice, so it had to be a stop too. That’s when I noticed that Trieste, Italy was more or less on my way. Trieste may not be a big name in tourist circles, but it is a big name in mental health circles, and has been for decades. They’re supposed to have the best community mental health system anywhere in the world. Maybe I could stop by and see what they’re doing there.*

*I contacted Kerry Washington, the head of Heart Forward a community organizing group in Hollywood, because I knew she’d taken a delegation from Los Angeles to Trieste a few years ago trying to use it as a model to build better mental health services in Hollywood. It turned out that her world had been entirely changed by going to Trieste, “once you see it, you can’t unsee it.” She is devoting herself to promoting it as a model for reforming mental health services everywhere. She’s produced a series of podcasts about it and has taken seven groups of professionals to Trieste and brought some of them to Los Angeles.*

*It turned out that, with money from the Hilton Foundation, she was putting together an impressive, diverse nationwide group for an intensive weeklong study visit. I talked myself into the group and rearranged my itinerary.*

*Frankly, I was dazzled too. This article puts together my analysis and what structural changes we’d have to make to have their success. We could do this.*

**Rethinking out Mental Health System: Lessons from Trieste Italy**

**(2024)** by Mark Ragins MD

No one can help but be impressed by visiting Trieste’s mental health system. This is the way community mental health services are meant to be.

The most common reaction, however, is, “We could never do this where I’m from”. A litany of obstacles flow freely.

In October 2024, I went with a team of 20 very successful, diverse, accomplished, but frustrated people to study the mental health system in Trieste Italy looking for lessons. Originally begun by Dr Basaglia in 1968. Trieste developed and has sustained arguably the most successful community mental health system in the world over decades, changes in leadership, and world events. Trieste is recognized by the WHO as a world standard of care.

I first heard of the Trieste Model when I was shown a documentary film about it in my psychiatric residency 40 years ago. My supervisors dismissed it as irrelevant and unadaptable to our patients in the United States. That dismissal is a common reaction, even among other mental health workers in Italy. It leads to creating a long, depressing list of flaws in America (or anywhere except Trieste) rather than to reflection upon whether we can learn from and apply their success.

Going to Trieste felt like visiting an old college friend who had similar goals to me when we were young (After all, Basaglia was inspired to create their system by the Kennedy era CMHCs and the promise of deinstitutionalization just like I was.). But this lost friend has succeeded, while I have been mired in a fragmented, frustrating, and failing mental health system. Once again, it’s easy in this situation to point to the opportunities and breaks my successful friend benefited from rather than reflecting closely on the different decisions we had made that determined our futures. I was determined to be reflective during our week in Trieste.

Two initial observations stand out:

Firstly, every practice and program that they showed us has been done, or at least observed, in the US by someone in our group, and it had been successful for us too. But almost everything we do exists only on the fringes of our system, outside the norm, perhaps in a pilot program or an alternative to usual practice, not integrated within the standard system. This means that everything they do can actually be done successfully in America with Americans, but it has not been systematized to serve many people.

Secondly, there were several practices that many in our group consider essential in our work in America, that were barely in evidence in Trieste (for example focusing services on oppressed subgroups of patients including immigrants, an emphasis on including people with lived experience in leadership positions, an outcomes measurement and accountability process, and a robust partnership with the justice system). This could be because these practices are only needed if you’re fighting against a system instead of an essential part of it, or because these practices address uniquely American challenges, or maybe because we’re doing a few things better than they are, even if we haven’t systematized them, that they can learn from us.

I wanted to go beyond those initial observations to drill down to the narratives, decisions, priorities, values, and structure that form the underpinnings of their system and make it different, and far more successful, than ours. Here are the main contrasts I discovered:

1. **Trieste asserts that deinstitutionalization was initially motivated and made possible by liberating and rehumanizing people rather than by medicating them.**

In the US, our deinstitutionalization narrative begins with the invention of the “wonder drug” Thorazine, the first antipsychotic, that was claimed to be able to almost magically transform psychotic people back into their selves and made discharging them into the community a realistic possibility. We believe that success in community living depends on lifelong medication maintenance to control their illnesses. We built our community programs around medication services – outpatient clinics, day treatment, partial hospitalizations, assertive community teams (ACT) to bring medications to them in the community, even assisted outpatient Treatment (AOT) to court order community medications. We’ve invented many new, improved medications, and even long-acting injections (LAIs) to give someone a shot that keeps delivering medications reliably for weeks or even months. We identify the major reason for the failing of community treatment as medication non-compliance which is very widespread.

In Trieste, the deinstitutionalization narrative begins with Dr Basaglia unlocking the doors in the institution and freeing the patients. Like many of his team, he had been forcibly detained for his anti-fascist activities when he was younger. They believed that if we focus on rehumanizing people – undoing the damage caused by isolating, segregating, neglecting, abusing, coercing, and giving up hope for them – their mental health would recover. He focused on unlocking them, limiting coercion, including them in hospital administration and practice, and empowering them, especially their defiant voices. He spread liberation to the community involving it with art, poetry, theatre, philosophy, and public events. They felt the biggest challenge was staff refusing to give up power and professional authority. They emphasized “putting the diagnosis in parentheses” to connect more humanly to their patients.

In the US, the idea that a great deal of mental symptoms and deterioration were the result of institutional practices, was considered naïve because it ignored the grim reality of the severe underlying biological conditions these people had to deal with regardless of how we treat them. Considerable efforts, mostly unsuccessful, have gone into demonstrating these underlying biological conditions. Repeated studies where people were withdrawn from their antipsychotic medications without any other alternatives were published to show how poorly they did and studies that demonstrated high rates of recovery from schizophrenia without relying on medications both acutely (like Soteria) and over many years (like the Vermont longitudinal study) were largely ignored and repressed. If someone does not believe they have an underlying biological condition that needs lifelong medications, they are either ignorant, and widespread psychoeducation had been promoted, or they are too ill to realize they are ill, they have “anosognosia”, and therefore need involuntary medications to treat it.

In Trieste only about 30% of their patients take medications, especially those with the most serious, disruptive symptoms and especially at times of greatest need, rather than wiespread lifelong medication maintenance.

1. **Trieste renounced coercion and forced treatment, while the US became increasingly dependent on it.**

My first day in psychiatric residency, I was taught how to fill out the paperwork to keep someone in the hospital forcibly against their will. We learned the legal criteria and process for forcibly treating people and when someone did not meet those criteria we told them, their families, and the community that “there was nothing we could do” because of the restrictions in the law. The public hospitals serve almost exclusively involuntary patients, and Medicaid would not even pay for someone there to be voluntarily, because they didn’t need to be in a hospital if they weren’t dangerous and weren’t being forced to take medications. Threats of involuntary hospitalization are widely used to pressure people to take their medications.

In Trieste, they avoid coercion and forced treatment almost entirely. They only have 8 hospital beds for 300,000 people and they are usually not full. A psychiatrist described to me his first day working in Trieste: The nurse told the policeman to uncuff the patient. He was shocked and frightened, but she insisted, telling him, “This is how we do things here.” He told himself that “if Basaglia could do this, so can I” and after two hours with the patient had built a trusting relationship and a mutual plan how to proceed. Trieste believes that everything can be done without coercion.

That difference, between our almost total dependence on coercion (believing we can’t function without it) and their almost total repudiation of coercion (believing liberation and recovery is only possible without it), is crucial and pervasive.

All the public psychiatrists I trained with, whether psychoanalysts or biological psychiatrists, believed that deinstitutionalization had reduced their effectiveness because it limited their ability to force people to get the treatment they need. They felt helpless whenever their power to order treatment was restricted.

In Trieste they emphasize engagement and collaborative strategies including “radical hospitality”, “open door” access, “relentless negotiation” – including acknowledging and recognizing the power differential, “confronte” - an interplay of ideas with the patient, harm reduction, quality of life focus, clinic pharmacies for daily medication support, and home visits (not to hospitalize people, but to help them in the community using Open Dialogue pervasively before it was published as a technique).

When we asked them for a list of these skills and training materials for our staff, they replied that non-coercion is something you must learn by the painstaking process of doing it. Even before they left the hospital in the 1970s, the staff in Trieste began developing skills of engagement, empowerment, collaboration, shared responsibility, and relationship negotiation which they brought with them and further developed in the community. In America, and elsewhere in Italy, we closed the hospitals without staff ever developing those skills. While there are likely to be a few people beyond the reach of even skillful non-coercive approaches, unfortunately in the US we believe this number is very large because our skills are so poorly developed and skilled practitioners are so difficult to access.

Like other “nonviolent”, but not passive or neglectful, approaches, the Trieste approach requires humility and a lack of defensiveness, great patience, dedication, and skill. In America, we find it easier to either threaten people or abandon them, than to share responsibility.

1. **Trieste focuses on human rights instead of on civil rights.**

To protect people’s civil rights to refuse confinement or medications, US states passed laws limiting coercion to dangerous situations – generally danger to self, others, and gravely disabled. These define the social contract when people’s individual freedom can be taken away. Police and mental health professionals, especially psychiatrists, are required to learn and follow these laws.

To reduce neglect and mistreatment, when Italy passed laws heavily restricting forced hospitalization and restraints, they established a human right to public mental health treatment through a new government universal health plan. They went further, establishing a right to social health care, specifically including housing, employment, and social connections. Forced hospitalization was to ensure providing treatment if nothing else was possible, so the criteria are around emergency medical necessity, the care provided must be “necessary and urgent.”

Providing for those mental health and social health treatment human rights has been a government responsibility in Italy ever since. Similar rights do not exist in the US. (Consider as a contrast that Americans do have a right to primary education and how different universal and individualized special education services provision and legal battles look compared to mental health services and legal battles).

The US created extensive formal and informal legal processes around issues of legal competency – including hearings for habeas corpus, right to refuse treatment, to stand trial, not guilty by reason of insanity, etc., but also including mental health courts, drug courts, homeless courts, and now CARE courts. In addition, most legal suits asserting a right to services take place within jails and prisons where access is restricted, while community services can be cut since there is no right to treatment. Most of our remaining long-term state hospital beds have been converted to forensic beds and in many places considerable treatment resources have been allocated to forensic, usually locked institutional, settings away from the community. Overall, according to NAMI, the US spends more money on various legal processes with people with mental illnesses than on treating them. In Trieste they only have two people in a locked forensic program (and one goes regularly to work in the community with his attendant).

The common refrain in the US that we are “letting people die with their rights on” referring to preserving people’s civil right to refuse treatment while neglecting them on the streets, does not occur in Trieste because they preserve people’s human right to treatment, housing, employment, and social connections, meeting them where they’re at, negotiating collaborative plans, whether they agree to medications or not. Universal services are mandated and easily accessible in Trieste. They don’t involuntarily hospitalize someone for being unable to provide for their own food, clothing, or shelter and then release them a few days later without help in securing food, clothing, and shelter. In the US, because we have largely neglected developing engaging, collaborative services, and because of how fast and impressive medications can sometimes be, even if used clumsily or coercively, the two options available are too often neglect or oppression. Advocates in the US pressing for replacing oppressive, coercive services with more quality, trauma informed, culturally relevant, effective services are often portrayed as anti-treatment and pitted against people urging expansion of coercive medication and hospitalization services because that’s “better than nothing”.

1. **Trieste focuses on lifelong relationship-based responsibility for people and their communities rather than on responsibility for providing specialized, effective, targeted services.**

In America, mental health programs, both government run and contracted, are primarily reimbursed for the units of specific services they provide to the patients they have enrolled in their caseload or program. Eligibility is based on medical insurance status, creating multiple parallel programs and provider networks. Within these networks, services are authorized and paid for based on the illness being treated. Programs and professionals largely can determine which diagnoses they treat, which people they serve, what acuity of condition, what exclusionary conditions, which services they offer, and which staff will provide them. Services need to be authorized and approved by outside auditors working for the insurance company or the government payor. Services are authorized based upon their research=demonstrated effectiveness with the diagnoses and symptoms being treated. Cases are opened and closed so programs and staff aren’t responsible for the person when they’re not actively providing services to them. This payment / accountability / risk management system is extremely cumbersome and time consuming, often using the majority of the staff time and program resources, diverting it from time spent directly serving people.

This fragmentation does not support the engagement and collaboration strategies that are prevalent in Trieste. It also often leaves people with no one to call or access in times of crisis, so in America there is always a family and public demand for more crisis services to fill in the gaps. As mental health services usually have substantial waiting lists and accessibility issues, people turn to the police as our de facto mental health crisis response providers.

Each area in Trieste has a community clinic assigned to be responsible for all the people living in their catchment, whether they know them or not, or are actively working with them or not. (There are limits for non-citizens.) Anyone can walk in at any time for services, and anyone can request outreach services in the community. The staff meet as a team, each morning and after lunch, to decide how to prioritize the needs they’re facing and deploy their staff. In effect, the team takes responsibility for triaging, authorizing, and allocating their own services based on their own judgement. They are paid for doing the best they can with what they have each day.

The community, including the police, know what clinic to call and that they will take responsibility for providing both crisis and ongoing services. The clinic is open 24/7, does home visits, has monitored voluntary home-like crisis beds available and a “pharmacy” onsite for crisis services and supervised medications. They visit patients in the small hospital ward and coordinate transfer back to the community and their care. They visit people in jail and coordinate forensic treatment plans with the courts. The patient, family, and community are likely to be helped in a crisis by someone from a team they already know and has a history with them and is thinking long-term, seeking to make sustainable relationships and plans in the community. There is no need for a separate crisis program or system.

In America, wherever mental health services do exist, they are overwhelmed with large caseloads and waiting lists. This is usually viewed as the main reason we can’t have a system like Trieste does. (Because of the overlapping systems and their fragmentation, the highly unequable way staff are distributed geographically, and so many professionals operating outside the system, it is very difficult to know how our staff resource level in any community compares to that in Trieste. Certainly, many places in America spend more money on mental health than Trieste does, but still don’t get their results.)

To protect themselves, American programs and systems of care restrict who can get services, what services, and for how long. We have chosen to focus our services on people with mental illnesses rather than improving the community’s mental health. This was to avoid resources going to the “worried well”, while neglecting the more challenging people with severe (presumed to be biological) conditions. This leads to people having to be more symptomatic before they can receive services. We then restricted services even more so to just people with certain “major mental illnesses” and “severe persistent mental illnesses” regardless of level of distress or dysfunction. This has led to services being almost entirely medications, coping skills, and case management. Seemingly paradoxically, it also has led to America having by far the highest number of people identified with major mental Illnesses and on medications, and to our clinics having higher case loads than before these restrictions were implemented.

The American system has a “fail first” approach where people are expected to help themselves until they are too biologically ill to do so and a stepped approach to services when they are delivered, trying the least possible services first, only escalating services when they do poorly at lower levels and then reducing services when their symptoms improve. Service delivery decisions are entirely based upon the current symptom presentation rather than on their long-term life course. This system effectively eliminates prevention at all levels (primary, secondary, and tertiary).

The staff in Trieste expect people to come for services when they are most in need, but they also expect they will be living in their community and their responsibility for the long term. They can prioritize engagement, collaboration, community connections, protective factors, sustainability, and recovery in their plans from the beginning. This system effectively prioritizes prevention at all levels (primary, secondary, and tertiary).

In America, where everyone in the clinic is diagnosed with severe persistent mental illnesses, it impacts the culture of the program. The focus is on risk and crisis avoidance, stabilization, structure, and control. Staff and patients are segregated from the community and expect chronic disability, poverty, and social isolation. Employment and recovery are considered unlikely. Much of the helplessness and hopelessness and the passive, custodial culture that pervaded the old institutions has been recreated in our clinics.

In Trieste, where people are seen with a variety of conditions and everyone might need services at some point, the clinic’s culture remains connected to the “normal” community. Most patients are not on medications. Most patients work. Most patients recover. People don’t need to “fail first”, reaching intractable levels of distress before accessing help, and then be maintained at the “lowest level of service” barely functioning without rehabilitation or recovery. Seemingly paradoxically, it also has led to their clinics having manageable work loads even though the entire community is their case load.

We know that relationships are the most important protection against being sued, but because we de-emphasize long-term relationship-based responsibility in our system design, we feel forced to implement a whole array of “risk management” strategies that are often costly, time consuming, and counterproductive. Throughout Trieste’s system, at a variety of levels, they described fostering shared responsibilities and relationships instead of risk management and avoidance. The words “equipe”, meaning team, and ”cooperativo” are pervasive.

1. **Trieste “socializes” people’s problems and services, while the US “medicalizes” people’s problems and services.**

After the first diverse iterations of community mental health centers in the 1960s and 1970s, community mental health centers have been subsumed by the medical model that America has fully embraced since the publication of DSM 3 in 1980. The system was mostly turned over to Medicaid’s illness-driven funding and targeted to serve only people with serious persistent mental illnesses, staffed with medical-model professionals on treatment teams, while community-based approaches were largely neglected. Other social service systems followed suit: Income support from Social Security Disability is based on a having a “permanently disabling” diagnosis, rather than on poverty or need, vocational and educational rehabilitation services became illness disability based, housing vouchers were designated for permanent supported housing for people with disabilities rather than economic needs. Even things like bus passes, utility bill assistance, and having a pet have become dependent on having a diagnosis. Meanwhile public advocacy and educational campaigns like NAMI, Mental Health America, and Mental Health First Aid emphasize helping people identify their distress as signs of a mental illness and referring them to (already overwhelmed) mental health professionals for treatment. But diagnosis-driven treatment, usually meaning medications, without social support or protective factors, rarely works.

Trieste, beginning with the Basaglia law of 1978 that deinstitutionalized mental health, included both a human right to treatment and to social health, specifically housing, employment, and social connectedness. The first time someone comes to one of their clinics they get a mental health assessment. The second time, they get a social health assessment of their housing, employment, and social connectedness. Everyone has a specific social health plan. Not only are they connected to a reasonably robust federal social support system (based on financial need, not medical need), but they make an individualized plan, using mental health funds to fill in the gaps. Their system specifically includes an array of supported housing, with low waiting times, and connections with “social cooperatives” which, in return for certain financial and tax incentives agree to hire 30% people with disabilities and also provide small social activity centers that connect patients to community activities. Because of the emphasis on employment, these social centers do not become isolated, mental health communities, as clubhouses in America sometimes do. Most of their memebers are working and come to the social center during their off hours and continue to come, valuing the social connectedness even after their mental health crisis has passed and clinical services are no longer needed.

We know that secure housing, employment, and social connections are protective factors that help prevent the development and escalation of mental health symptoms. We also know that people without secure housing, employment or meaningful activity, and social connectedness don’t usually recover. It’s likely that Trieste’s universal attention to these factors is an enormous contributor to their good outcomes.

America spends more money on our medical care system than other countries and less on our social care system than other countries. We’re willing to pay thousands and thousands of dollars for medications and hospitals for someone, but balk at giving them money to live on, or a rental subsidy, or a supported job, or a clubhouse to hang out in and make friends and find purpose. It’s likely that our inattention to these factors is an enormous contributor to our poor outcomes.

Because of the funding imbalance the between treatment and social supports, there has been great pressure on mental health advocates to embrace the medical model in their messaging (for example, pressing for insurance coverage “parity” for mental illness with medical conditions and to make more social support services reimbursable by our Medicaid system). Regardless of effectiveness, in America we are better off asking for money standing with the interns and surgeons than with the Headstart teachers and the midnight basketball league.

Based on the inclusion of both treatment and social supports in the Basaglia law as basic human rights, in Trieste mental health funding can be allocated in either or both directions depending on personal need.

1. **Trieste includes a community focus in their treatments ranging from crisis response to prevention, while the US emphasizes individual services and psychiatric privacy.**

In America mental health care is a personal and very private endeavor. As the medical culture has pervaded our community mental health programs, services like family therapy and psychoeducation, peer support, milieu therapy, and community development have been curtailed in favor of 1:1 interviews in small private offices (even for social workers). We follow the medical model HIPPA confidentiality and privacy rules and often exceed them routinely (for example, by avoiding contact with other providers (that is not forbidden) and with people the patient would have consented to us talking to. We routinely make these communication decisions on our own, prioritizing privacy and isolation over patient consent and inclusion. We rarely contact family or community members or even police, not even the ones who called in crisis or who referred the person to us who could tell us what they think ~~happened~~ and who the patient will continue to be interacting with. Even our record systems don’t connect usually providers, let alone patients or families. We commonly use confidentiality as a wall to hide ourselves behind too, instead of developing relationships with families or the community for ourselves. Without these contacts and relationships, the community has very little trust in us or mental health services in general.

From the beginning in Trieste, they involved the community. Successful integration of the hospital inmates required community participation and collaboration. Instead of relying on their professional authority or scare tactics, they opened the gates to the institution and invited in all sorts of community members, especially including artists and writers, to create shared experiences of deinstitutionalization and ongoing personal relationships. Even today the name Basaglia and the symbolic blue horse are widely known in Trieste. This inclusive approach continues: Recently, when they created their small locked residential forensic program, they invited the neighbors to movie nights on the lawn there.

In Trieste they do follow basic confidentiality and record privacy rules, but they also have active relationships with the community and daily work in the community. When they outreach someone in the community or make a crisis plan, they regularly have a “third party”, usually family or other community relation, involved in the “relentless negotiations” to form collaborative service plans. Staff may mediate between patients and the third party or advocate for either one. They actively try to create a social network and social supports for people, both in times of crisis (remember that because the intervention is almost never about taking the person away and locking them up, but about what supports everyone around can give to help, there’s less reluctance for patients to agree to collaborate), and as a necessary part of ongoing life, (for example introducing a patient to a neighbor with a similar interest or hobby or taking them to a philosophy discussion group). In the same way they can “put the diagnosis in parenthesis” to have a human relationship with their patients, they can put it aside, along with the medical culture, to connect people in the community.

In America, we sometimes use service data to identify people who are “high utilizers” of services and likely to be of high risk for more proactive, intensive services. In Trieste, they go beyond this to use service data to identify “micro-neighborhoods” who are “high utilizers” (often impoverished areas [inclu](https://www.shamanism.org/workshops/way-of-the-shaman-the-basics/)ding subsidized “social housing” apartment buildings) and provide more proactive, intensive services to the community. They open a small office within the micro-community with social work / case management staff who actively problem-solve, mediate, and advocate for any person living there for any problem they may have. They also provide a social space for people to connect for activities they’re interested in like cooking groups, knitting, art, or putting on a small play. They also actively connect people with their neighbors on an individual basis, fostering new friendships. As we face, in both America and Trieste growing social disengagement and isolation, especially among older and younger people, these kinds of community development approaches, that don’t fit into America’s system, are becoming more and more essential.

Let’s conclude by backing away from all these details to get a broader perspective – and change metaphors. It appears to me that the mental health system in Trieste didn’t thrive and bear fruit while the system in America grew twisted and barren because theirs was planted in better soil or watered more. New, small trees can, and have been, planted and well cared for in America and become every bit as productive as Trieste. But our overall American system has been tended to terribly. We’ve cut away valuable branches and created so much scarring and gnarled overgrowth that much of our tree is twisted and almost lifeless. Suckers, pests, and parasites have grown on it diverting nourishment.

We need to change our approach to husbandry: We need to create different narratives, set different priorities, emphasize different values, strategies, and practices, and have different relationships if we are to have a system that is healthy and productive too. We can learn from and adapt the productive approaches of our colleagues in Trieste. They’ve given us a guidebook: We too can emphasize humanizing people more than medications, collaboration more than coercion, human rights more than civil rights, long term relationships and shared responsibility more than fragmented, specialized services, open access more than illness-based triage, social connections more than illness treatment, community health more than individual illnesses. By following their lead, we too can do better with the opportunities and challenges we have and create a better mental health system for ourselves.