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Why teamwork is necessary in community-based mental health intervention: quality indicators and nature of this work .

Transcription of a spoken intervention.

Dr. Norcio: I want to begin by saying that this type of presentation, when it's requested by the person co-ordinating the course, is, for me at any rate, an important commitment. Because I believe that this issue, this theme which the title defines as: "why teamwork is necessary in community-based work and what are its possible quality indicators" requires a thorough analysis, something which I don't think has been done yet, or at least not completely. In any case, it's an issue which has changed, and continues to change over time and which poses a fundamental question, and that is: "what does it mean to work together as a team?".

I've prepared a written presentation which, to be honest, is neither exhaustive nor fully developed. I was intending to do this but with all my other commitments I didn't have the time… I should probably read it because I tend to talk too much and go beyond my allotted time. However, let's see what happens, taking as my point of departure our co-ordinator's remarks, who has also asked the speakers to be as brief as possible, so that we can move on to the discussion.

Therefore, I'll make a brief presentation in order to open up the discussion and

provide a stimulus for a more thorough analysis later on.
Okay, in preparing for today the first thing I did was look up the word "équipe" in the Treccani dictionary, and not because I didn't know what it meant…

Voice in the audience: I used the Zingarelli dictionary...

Dr. Norcio (continued): An excellent dictionary. Anyway, in looking up this word I discovered that "équipe" derives from the verb "*equiper*", which originally meant "to embark", from the German "Skip", which means "ship".

This seems to me to be extremely interesting, because it alludes to what will become evident during the course of my presentation, and that is that beginning to work "in équipe", as a team, was exactly like embarking on something completely new.

What is the definition of 'équipe'? It's defined as a group of people who pursue a common goal and collaborate in the same area of activity, including intellectual.

Working in équipe is the work that is performed by a group that includes experts from various disciplines or from various branches of the same discipline.

Now, this is a very simple, plain definition which posits a synergy among diverse technical abilities that unite with one another in order to arrive at a synthesis. And therefore to produce an intervention which is more or less the sum but also, at times, the exponential effect of these individual abilities.

As regards this definition of 'équipe', I think there is a certain difference between a community-based mental health team and a team which works, for example (Grazia was talking about his earlier) in a hospital and probably also in a Health Care District. However, I'll leave it to Grazia to explain later what the differences are in working as a team in a hospital or a Community-based District, and thus also in the community.

For example, I think all of you realise that in the hospital, the heart surgery team has a certain number of actors who all have very precise, clearly defined tasks which are all necessary in order to arrive at the final result, which is that of

a complex operation.

I believe that our mental health teams today are much more differentiated than in the past, in terms of the professional figures involved.

There are various types of nurses and, I think, still a number of the original psychiatric nurses. There are professional nurses, professional nurses specialised in psychiatry and then there are general nurses, psychologists, social workers, doctors and rehabilitation technicians. However, I don't think it was possible, or perhaps better, I don't think there was the desire to set precise limits to the tasks and duties of these professional figures.

Now, there are certainly very clear distinctions between managers and non-managers, which therefore has more to do with categories of power. However, if we consider the categories of knowledge, including disciplinary knowledge or knowledge related to competencies, the situation becomes much more complicated in terms of defining professional relations, competencies and roles.

I know you're all experts in this area but, as is my wont, I going to refer to the past here, because I believe it provides us with a matrix and a paradigm for the roles and competencies in mental health today.

In other words, technical knowledge in psychiatry originates with the psychiatric hospital. We should never forget this fact.

And, in particular, the difference between traditional medical knowledge and traditional nursing knowledge in psychiatry originates with the total institution, where there was a very clear definition of roles.

Therefore, it is precisely the history of de-institutionalisation which helps us to understand how from this very clearly defined situation there was a transition to the community-based team.

So. The asylum, a closed situation, you are all familiar with this scenario. Many nurses. Few doctors. The occasional, different professional figure. What did they administrate? They administrated *chronicity*. And in the acute wards, all of the more violent and dangerous behaviours.

Therefore, custody and care according to the old dictates of the 1904

psychiatric law.

What was the relationship that existed between doctors and nurses with respect to knowledge? The psychiatrist had a cultural baggage which, at least in Italy, we can define as crudely biological.

As you all know, in Italy the phenomenological culture practised in a few German "Kliniks" had penetrated only minimally or not at all.

The doctor diligently wrote up his clinical reports. I don't know how many of you have had the opportunity to read any of these, but they generally contained an extremely accurate description of the somatic aspects and behaviours. A minute and accurate description, and based for the most part on descriptive categories. And then there was an extremely detailed annotation of the therapies.

As you know, until the early 1950's, these therapies were primarily physical therapies, i.e. hot and cold baths. And then there was electroshock, malario-therapy, and so forth.

What did nurses do in this situation? Nurses were responsible for surveillance and were required to do practically everything the doctor ordered them to do.

In fact, this is generally how a nurse is defined in the dictionary. As you well know, the nurse is responsible for "care", for "shouldering the burden", which in the traditional institutions was of a very crude and custodial nature.

In reality, the relationship between nurses and inmates was a relationship that was linked to the ritual forms of the institution.

Therefore, there were no direct or personal relationships, because such relationships tended to deviate or distance themselves from the institutional rituals.

There was also the psychologist. And the social worker. However, their functions were minimal and insignificant. In fact, the psychologist collaborated in the diagnoses through the administration of tests. The social worker … as far as I can recall, social workers didn't even work in the psychiatric hospital, but were generally located in a sort of bureaucratic-administrative structure called CIM where, beginning in the '50's or early '60's, people went for check-ups and

therapy.

So, in a situation of this sort, there was no teamwork. There was no form of collective effort in which each person contributed their ideas and knowledge, but also their own point of view regarding a given situation.

There was absolutely no discussion of projects or programmes. It was situation of total delegation, in terms of knowledge and power, which referred to the figure of the doctor. And this figure referred in turn and in very pyramid-fashion, to the Director, who had enormous medical-legal powers, such that the destiny of the inmates was entirely in his hands.

The "stair-casing" of power and knowledge was thus very pronounced.

I don't know if you know this, but the courses that were held for the psychiatric nurses in the old asylum were, for the most part, oriented towards ways of avoiding the risks that could result from a sudden crisis or unexpected behaviour on the part of the inmates.

We could say that we were taught the techniques for custody, surveillance and safety with respect to something unexpected and unforeseeable that was always just around the corner.

And, as I mentioned earlier, even when psychologists and social workers began to appear in this institutional setting, they were insignificant. And in any case subordinated, not only in terms of power but also in terms of knowledge, to the figure of the doctor.

What was the fundamental, conceptual core of de-institutionalisation as practised and taught by Basaglia? It was placing the illness between parentheses

You've all heard this phrase many times, but I believe that it's precisely in this concept that we find the real, concrete possibility for collaboration and alliance, also among professional figures, and the initial elements for possibly working as a team. And seen in the perspective, as I said earlier, of embarking on journey of liberation, of emancipation for the patients, the users.

This, in my opinion, is the conceptual proposition which opened up the different forms of disciplinary knowledge. Because, at this point, every act, a myriad,

thousands of individual acts… the possibility of doing them, practical acts and their implementation, theorising in the course of the therapeutic project, all these elements now constituted – and constitute - the new training-ground. And also in terms of the self-training of all the professional categories present. Because all of the professional figures involved had to go outside, into the community, and experience this reality together "ex novo", because in reality no one knew what would happen after opening up the asylum, with the community coming into direct contact with all of the problems created by this spectre of mental illness. A spectre composed of fear and danger.

In other words… Going to a patient's house and relating with their family and neighbours opened up new possibilities of work and social relationships for former inmates. Activating the solidarity of social groups and discussing stigma and prejudice associated with mental disorder, thereby setting into motion healing itineraries within the social context - what we now call 'recovery' - became the basis, the stimulus for a new professional culture and thus the premise for re-founding disciplinary knowledge.

I believe the experience in Trieste was virtually unique in Italy because it was one of the very few psychiatric hospitals where work was begun outside, in the community, using all of the existing internal resources of the old asylum. Elsewhere, new people were hired, with different professional curricula, etc.. I'm speaking primarily about the nurses, because in Trieste there was a long phase for the "re-conversion" of the nurses that had worked in the psychiatric hospital.

So, there was this very particular mix, especially among the nurses, of personal motivations for going out and working in the community. There was the original training, which was as I described it, a training based primarily on self-defence and control. And then there was the discovery of these new categories, these new approaches which the work in the community was provoking and bringing into being.

During this phase, a great deal of effort was thus dedicated to nurses who, from the academic, technical-professional standpoint were not particularly well-

trained but who, for the most part, were highly motivated in terms of carrying out these processes of liberation and who were also very willing to deal with situations which were unknown, or certainly very different from what they had been accustomed to inside the psychiatric hospital.

Therefore, at this point, teamwork not only meant working as a group, something which had been clearly impossible in a setting in which the ideology and the technical relationship with the patient was dual in nature, but it also became the real, tangible terrain for the various groups to engage in a collective confrontation and active participation in the therapeutic projects. People began to assume new tasks and duties. To deal with risk. Another very important factor was that the perspective or approach, especially during this first phase, was aimed at reducing the hierarchy. And also at reducing the technical nature of the interventions, a *de-technicalisation* of the intervention, if you will.

However, we have be careful how we use this term, because "de-technicalisation" could also mean working in an ingenuous or naive way, i.e. a work-style which lacks the *dignity* of acquiring knowledge and professionalism for the actions which one performs.

Instead, I believe that in this phase, in this process of *de-technicalisation*, there was also an acquisition of new professional categories.

And in terms of functions, of tasks, there is no doubt that there was, as the English say, an "overlapping" of roles. And specifically with respect to the production of responses.

I'll give you an example, and one which I was personally involved in. In this case, there was a rehabilitative action begun in the psychiatric hospital and then continued outside, which involved someone who had lived in the asylum for years with a diagnosis of residual schizophrenia, but who still had a great desire to live and a good relational capacity. Now, this person owned a house and some vineyards and when the time came we decided that we should all go and help him with the harvest. Was this decision to help him harvest his grapes which involved all of the professional figures, did this act have a technical or, how should I say, a

disciplinary value, or not?

It was certainly a normal, everyday action. But, in our view, it was also an action which precisely because it involved all of the professional figures, ended up acquiring the dignity of a technical action which referred to an extremely important process, that of establishing a new disciplinary knowledge.

Thus, interventions which became less specific in terms of traditional roles and the power attached to them, together with the acquisition of a new, shared knowledge. An action which reduced the "knowledge gap" among the various operators, while producing a real, tangible rehabilitative act by focusing not on the residual schizophrenia as a diagnostic category, but on the person in flesh and blood, with his unique personal history.

We had many experiences of this kind. I'm sure Grazia also remembers some of these … Such as the street parties, in various neighbourhoods, and interventions in the workplace. For example, I remember a number of exhibitions on mental health problems which took place in factories. At that time, the concept of the factory was closely linked to that of workers and thus to a form of underclass. So the possibility of bringing this discourse directly into the factory was also an extremely important form of *ante litteram* prevention.

These interventions involved all the operators working together and constituted a little explored territory in which the doctor or psychologist certainly had a status, an authority which was perhaps greater than that of the nurse. However, this did not mean that he or she was someone who at that moment possessed a knowledge which was separate and linked to a hierarchy.

In the practice of the Trieste mental health centres, viewed as laboratories for the deconstruction of the illness and thus as an attempt to respond to the personal, specific needs of users, this sort of teamwork, which did not juxtapose specific and separate techniques or, in any case, was not based on a definite hierarchy but on the participation of all of the operators whose proposals were given equal respect, was fairly common, constant and uniform during this period.

I believe that this is more or less the *imprinting* that has been transmitted over

the years. I also think that this aspect of working together was what distinguished us from other experiences which were moving forward at the same time, in social psychiatry but also in various parts of Italy, after the 1978 reform law.

A couple of days ago I was rereading a journal from that period which lumped all these experiences together as the "transformation in Italy". Well, in some regions of Italy, and this is something which I find remarkable ….

(Sorry: record interruption)

Dr. Norcio (continued): ... was assigned the task of doing home visits. The psychologist did the family therapy interventions in the out-patient clinic and the doctor distributed medication.

There was thus a division, not just of specific locations, but also a very sectorial re-attribution of so-called disciplinary knowledge.

In my view, whoever set up community-based mental health actions in this way didn't do much to modify the pre-existing categories.

In any case, as you well know, in the more than 25 years of the psychiatric reform process, with respect to the implementation of the law and also of the criteria, which are indicated quite clearly in the projects-goals of the specific competencies associated with the various professional figures, I think we've seen just about every kind of distortion imaginable.

One need only consider the relationship that exists today between the Diagnostic and Care Unit team and the community services team. Very little in the Diagnostic and Care Unit team – and I'm speaking of Diagnosis and Care Units in Italy in general – has changed with respect to the traditional logic of the hospital. Here, we often find the same scheme of the hierarchy of power, in which the nurse (who together with the doctor is one of the two professional figures present in Diagnosis and Care) re-attribute to each other the same functions which were attributed previously in the asylum.

That said, however, I think that over the last 25 years the situation has changed considerably here in Trieste. Naturally, there has been the progressive replacement of the psychiatric nurses who were involved in the de-institutionalisation process. And then there are the new professional figures, such as rehabilitation technicians which unfortunately, at least in Trieste, can no longer be trained because the school has been suspended and we don't when or if it will reopen. I think this was an interesting experience because these new, or relatively new professional figures, at least in Italy, don't have a medical imprinting. Medical in the sense of a precise definition of the medical or health care tasks to be performed by each professional figure.

Which means that there was a situation of contamination. In addition, many doctors and psychologists, a certain number of psychologists, have never worked in the asylum and have no direct experience of it. There is also the presence of private social welfare, which offers a new reference framework. Private welfare has developed a great deal over the years, and while its operators have had very diverse forms of training, they are not contaminated by a rigid medical paradigm.

And then there's the academic disciplinary training. Certainly nurses today are trained differently, also with respect to the function of "nursing", which some people consider to be an actual science.

Recently, I was watching a late night programme on television, one of these programmes for insomniacs, and there was someone who taught "nursing" theory at the University of Padua, a very capable teacher in my opinion, who was talking about the representation of a non-paradigmatic model. However, a model based on certain principles of reference in order to justify nursing as an independent science and not as a science dependent on medical science. Which is precisely the traditional view of nursing.

This vision of nursing, of the nurse which provides an even greater justification for working within the community, as well as the hospital, as an autonomous professional figure. And this is very important.

Now, I'd like to pose a number of questions. First question: how can we

define the work of the community-based mental health team in a context in which it's taken for granted - even though it shouldn't be taken for granted - that the community, the territory is the only possible and intelligent setting for care? Which is why there is this different professional organisation.

As regards the Trieste Mental Health Centres, for 30 years we've considered it essential to operate without any selection process for users. This is a very important concept, because it influences the characteristics of the team's organisation and therefore its work.

Voice in the audience: Can I make a comment here regarding the fact that nothing can be taken for granted? In the written exam for the hiring of new psychologists 3 days ago there was a question concerning the "project-goal '99-2000 for the MHC's" (Mental Health Centres). One of the people taking the test answered that the "MHC" was a diagnostic evaluation scale. No joke.

Dr. Norcio: Well, there are still doctors who say: "this person has to be hospitalised because they constitute a danger for themselves and for others". Perhaps, it was all these medical certificates which gave someone the idea of introducing a new bill [for a counter-reform in Italian psychiatry] in Parliament.

Okay. Let me just very quickly make 2 or 3 more points here and then I'll hand it over to Grazia.

So, how should one work in a cultural, organisational setting like that of the 24 hr mental health centres, with a strong organisation and a significant and incisive presence in the community. I think we need to refer to criteria that all of you are familiar with and which derive from this focus, this attention to the person and his story and not the illness.

An attention directed at that person's personal experience, his family and his social context. These are the basic principles: A maximum reduction of the *medicalising* aspects, and of hospitalisation. A comprehensive approach to all of the person's problems and the problems within their context. Interaction with the

family. Responding in a co-ordinated and interconnected fashion, and in a perspective of integration and collaboration with all of the agencies in the community that deal with social welfare, training and work. Taking responsibility for all aspects of the user's problems, including criminal acts and possible internment in a Forensic Hospital. And then, obviously, interaction with the decentralised community health care districts. Empowerment of users. Organising those periods when things are "stalled". And so forth.

These are the co-ordinates which we continue to indicate in our projects … (?) and elements which all of the members of the community teams must equip themselves to deal with.

Now, my question is this: does this type of work, which is organised along these axes, and therefore not organised according to an approach based on phenomenological theory or on … (?) or upon systemic psycho-therapy, does this type of work involve differences, absolute specifics of a technical nature? This is the question.

Personally, I believe the answer is no. That is, I believe that where criteria for this type of assumption of responsibility for the user is applied, and along all of these axes, and thus not just a simple technical response to an illness, there is an ample overlapping of knowledge for all of the operators on the team.

However, what we can begin to discuss today is the fact that, especially in the last few years, we have begun to specify certain functions in our organisations. Functions which are related to dealing primarily with some of these areas, these problems.

But you're the ones who can give me some examples here. I've noted here, for example, the operator who works specifically on the problem of work and who therefore acquires a much greater experience in this area than other operators. An experience which includes knowledge and information regarding laws and regulations, the specific activities of various agencies, characteristics of the job market, and so forth. Which, as I say, ultimately makes them more of an expert in this area than other operators.

I'm also thinking here of the operators who work with prisons and forensic hospitals. And then there are all those examples connected with special projects, etc..

However, an aspect that was, is and must be, I underline three times, *must be* present is that these forms of knowledge, which may pertain to an operator who is more expert, must be socialised within the team. Which doesn't mean that everyone then possesses this knowledge to the same degree, in all of its ramifications and scope. However, this knowledge becomes part of the terrain, for everyone concerned, for the comparison, analysis, discussion and elaboration of an individual's project, the project for an activity or the group's project.

Therefore, becoming an expert operator within our mental health centres and our Diagnostic and Care Unit does not mean acquiring technical knowledge that endows these operators with a different position in the hierarchy.

These forms of knowledge may create certain problems, as is happening now, in terms of organising the work. However, this is a different issue, and a very important one.

In other words, in my view, in community based mental health there exist today various ways of understanding the work of a community team. One solution is a cultural and organisational model that simply modernises certain "Psy" categories and brings the distribution of professional tasks and roles up to date.

However, it does this by parcelling things out. With the rather obvious limitation that an operator deals only with their area of strict psychiatric or psychological or psycho-therapeutic competency. And with the tendency to delegate various aspects of their interventions to social welfare organisations.

And then there's the English model, in which the social welfare area is fairly autonomous and developed and is delegated to deal with a series of more social interventions

With this model, the psychiatric team, and certainly the community-based team, has a stronger identity in terms of its specialised forms of knowledge. Its more defined in its make-up. However, a first criticism is that it once again

appears as a team with a strong hierarchy. For example, I've written here: nurses in the new role of psychotherapists subordinated to doctors.

Other criticisms of this model: psychologists who continue to integrate the diagnosis with measurement tests and questionnaires which are, in many cases, as detailed as they are useless,

Rehabilitation therapists who implement rehabilitation protocols and procedures which are, at times, totally ludicrous, in day centres separated from the community.

Pedagogical specialists. I was reading the other day that in Sicily, in the province of Siracusa I think, the pedagogical specialist is delegated by a local Mental Health Centre, for example, to carry out, how should I say, very sectorial interventions in schools. Now, this is certainly a useful and important function, but one which has little connection with the other interventions carried out by that Centre and therefore not very significant in and of itself.

The doctors. Okay, even in this type of system which is modernised and in which the functions are re-attributed and modernised in turn, the doctor almost always functions as a manager. And therefore someone who co-ordinates. This function can be overlapped fairly easily.

Another problem that generally exists in these models is that when the community teams are organised in this way, if one analyses the entire circuit of services, and therefore not just the community service but the entire pool of users and all of the structures present in that catchments area, sooner or later one discovers that there exists a point of sedimentation that is identical with the old asylum.

Why does this occur? If my task is completely independent from those of other operators, such that I say: "I work in psychotherapy, you deal with managing serious cases", it's inevitable that the person managing a sector or segment of psycho-therapeutic interventions doesn't particularly want to be "contaminated" by a user who instead needs essentially a strong form of "holding" (so to speak).

And this also occurs in Italy. This also occurs in Italy where in many Italian Regions, even in those which have developed a decentralised health care organisation, the Diagnosis and Cure Units and especially the private clinics that have contracts with the public sector (and let's hope that the Progress research we're doing and for which we also have an important function of co-ordination, finally provides the actual figures on how many of these contract-clinics there really are) continue to hospitalise patients and operate in a way that is very similar to the old asylum; so these things also occur in Italy.

So, this is one cultural model for a mental health service and a community mental health team.

The other cultural and organisational model, which has a completely community-based approach without any selection process of users and which I think we in Trieste have made an important contribution to, results in a situation in which even though the professional roles continue to maintain some differences, especially with respect to power (and we have to be honest about this, because the issue of power exists and there are responsibilities, including legal responsibility) but in operational terms the criteria for dealing with problems allow for considerable overlapping, in terms of the Service's functions. In this model, the most defined task of team members with management functions, i.e. the doctor or psychologist, is certainly not that of affirming, how should I say, the *supremacy* of their technical-disciplinary power. Because operators who are not managers can also produce valuable and pertinent elements of knowledge and evaluation with respect to user needs. I am absolutely convinced of this.

In personally I have received very valuable analyses, input and insights from non-medical operators many times which was certainly superior to that received from doctors, who tend to maintain their therapeutic distance and not respond to needs.

This has always been the strength of our organisation, and should remain so.

The title of my presentation today speaks of quality indicators, and I was asked to mention some of these indicators. As regards the work of our community

teams, 3 parameters come to mind, which derive directly from our experience of de-institutionalisation.

First. That all the operators share the same general philosophy in terms of approach. This means responding to mental health problems in the way that we have defined and developed over the years, in practice as well as theory, and with the fundamental corollary of not selecting users based on the severity their condition.

A second quality indicator, in my view, is the responsibility all operators have for doing whatever is necessary, beyond a rigid, predefined definition of job tasks and duties, for the emancipation of users, without delegating this responsibility to others. This is a very important concept.

Third, and which is related to this, is the indicator of autonomy. I think that the community team should have increasingly autonomous operators, and also sub-groups. This is related to the responsibility for individual or group projects, but also to the inclusion of the entire team in the decision-making process for programming such plans and projects.

These a some indicators which should be stressed, or at least borne in mind in the course of developing our practices.

I'd like to conclude my brief intervention with a couple of questions, questions which are a bit provocative and which we – or you – can discuss if you like.

Does this vision which is alternative and, in certain respects unique, always correspond to the work of our community teams here in Trieste?

Are the activities carried out by individuals and groups always consistent with these principles and these desirable practices?

Does the indubitable increase in the professionalism and culture of the various kinds of operators represent a factor which facilitates the team's overall ability to intervene, as should be the case? Does it facilitate the responsibility and autonomy of team members?

Do we also sometimes have the tendency to establish or configure more technical roles, as in the first model which I described, which place in doubt the

comprehensive and non-selective assumption of responsibility for users? The discussion is open and people can respond now.